Gender equality and quality of life –
how gender equality can contribute
to development in Europe.
A study of Poland and Norway

Working paper no 1.5

"Gender Equality and Quality of Life - State of Art Report'

Quality of life and well-being

Barbara Woźniak,
Beata Tobiasz-Adamczyk

Jagiellonian University in Krakow
2014

The research leading to these results has received funding from the Polish-Norwegian Research Programme operated by the National Centre for Research and Development under the Norwegian Financial Mechanism 2009-2014 in the frame of Project Contract No Pol-Nor/200641/63/2013

ABSTRACT:

Presented paper discusses two different approaches to measuring quality of life in the research conducted in the field of social and medical science: objective approach, based on objective indicators/determinants of well-being and subjective perspective focused on individual's self-evaluation of his/her own quality of life. The latter perspective is recommended by the authors for usage in sociological research on quality of life analysed in the context of gender equality. As an example of subjective approach WHOQOL concept of quality of life (defined as individuals perception of their own position in life) is analysed in comparison with Nussbaum's list of capabilities and Holter's measuring strategy used in Gender Equality and Quality of Life research in Norway.

Key words: quality of life, multi-dimensional model of quality of life, well-being, health-related quality of life, gender equality

INTRODUCTION

The term "quality of life" is quite ambiguous and there are many ways to conceptualize it in the literature, which raises the need to review and systematize the existing knowledge on this topic. When it comes to the relationship between quality of life and gender equality the problem becomes even more complicated as the impact of gender equality on quality of life does not follow a simple pattern. For instance gender equality has a positive impact on health and quality of life for both genders but the persons who are the pioneers of gender equality and function in less equal environment may experience fewer benefits (including health benefits) than those whose GE practices are backed up by the environment (Backhans et al. 2009). Thus both concept of quality of life and its indicators/measures to be used in research projects focused on gender equality should be carefully selected.

According to Noll (2004: 156)

> Among the various efforts to operationalize welfare in general and the quality of life concept in particular, two rather contrary approaches are to be distinguished, which define the two extreme positions on a broad continuum of concepts currently available: the Scandinavian level of living approach and the American quality of life approach.

In Scandinavian welfare researches welfare measurements focus on objective indicators (Noll 2004). Among these indicators of quality of life first of all living conditions (favorable or unfavorable) are mentioned. It is underlined that comparing real conditions with normative criteria like value, goals or objectives is of crucial importance in quality of life assessment. Among other objective indicators are the level of unemployment, the level of crime in a given region, average income or educational level, age of retirement, etc. Welfare is understood in this models as the individuals command over, under given determinants mobilize resources, with whose help s/he can control and consciously direct his/her living conditions (Erikson 1993). When it comes to resources influencing individual's welfare money, property, knowledge, social relations and security are of major importance (Noll 2004).

Zofia Łapniewska in her chapter entitled „Well-being and Social Development in the Context of Gender Equality" has reviewed existing research on well-being and then compiled and compare objective indicators of quality of life that were used in selected

studies on the topic. She has chosen thirteen measurements from the portfolio of instruments discussed in her review and distinguished ten domains covered by those measurements (i.a. physical health, education, natural environment, finance, etc.). Each of domain in various studies was assessed using different, mainly objective indicators, e.g. in the evaluation of physical health the Basic Capabilities Index (BCI) bases on data concerning reproductive health (healthy and safe reproduction), the Human Developement Index (HDI) uses data on life expectancy, when the Index of Sustainable Economic Welfare (ISEW)/the Genuine Progress Indicator (GPI) take into consideration health expenditure. When it comes to education, BCI bases on registrations for primary schooling, literacy, numbers of children finishing 5th grade, HDI uses rate of literacy (measured by the completed years of education) and ISEW/GPI is based on state expenditures on education. It's worth noting that only three of thirteen measurements analyzed by Łapniewska include gender equality in the context of quality of life and well-being: ISEW/GPI (include unpaid work), the Value Aggregators Method (MAW)/the Social Diagnosis (include causes of low fertility in Poland) and the Quality of Life Indicator (uses gender pay gap data) (Łapniewska 2015).

In contrast to Scandinavian objective approach, the second approach distinguished by Noll (2004), i.e. an American (including British) approach bases welfare measurement on subjective indicators. This approach defines welfare as individual's subjective well-being and the representatives of this point of view underline that welfare and quality of life are supposed to be perceived and experienced by the individual. The subjective well-being of the individual is considered to be the main goal of societal development and the individual him/herself is considered to be an expert to evaluate own quality of life in terms of subjective well-being. The best indicators of well-being understood in such a subjective way are the measures of life satisfaction and happiness (Noll 2004).

When considering the distinction between objective and subjective way to assess quality of life, particularly in the context of gender equality, another aspect raised by Łapniewska (2015) should be noted. As the cited author writes, assuming that a good standard of living and high quality of life means a possibility of fulfilling one's needs and desires, a question should be ask on how do people know what they should desire and strive for? How, in other words, do they know what will make them happy? Desires do not arise from any objective, "natural" order of things, nor they are the result of individual choices, but the goals of human endeavors are constructed in a particular culture/society, whose members are taught what they should want. When analyzing the indicators of quality of life and happiness these reference points (i.e., as Łapniewska writes, a given

scope of the *imaginarium* that people are aware of) should be considered. Another problem connected with relying on a subjective assessment of quality of life is so-called "content slave" paradox – a slave makes rationalizations of the situation in which s/he is stuck, which obviously could influence subjective evaluation of quality of life. However, as Diener writes, evaluation based only on objective, economic indicators, „can tell us only part of the story about quality of life for an individual or a nation" (Diener et al., 2009: 4), so objective and subjective indicators should be seen as interdependent rather than mutually exclusive, what is apparent for many scholars conducting research on quality of life (Park 2013).

This distinction between objective and subjective indicators is reflected in many research studies on quality of life. One of them is Social Diagnosis (Czapiński, Panek 2013). The indicators used in this research project can be divided into those describing standards of living and those relating to the quality of life, which corresponds with the distinction on an objective description of life situation and its subjective evaluation, psychological meaning for the individual (i.e. subjectively perceived quality of life). Measurements of the standards of living in Social Diagnosis covers, among others, income of a given household members, nutrition, material affluence (including modern communication technologies), children's education, participation in culture, leisure, the use of healthcare, poverty, unemployment, disability and other aspects of social exclusion. Indicators of the quality of life of respondents covered, among others, general well-being (including the will to live, happiness, symptoms of depression), life satisfaction with various life domains, subjective assessment of the financial/material situation, experienced stress (eg. at work, parental, financial, ecological, marital, etc.), ways of coping with stress and the impact of stress on health, social capital and support. Such an approach, including the objective conditions of the lives and the satisfaction of individuals with their own situation, gives a full picture of the quality of life.

When Łapniewska focuses mainly on objective indicators, presented chapter discusses also subjective aspects of well-being, which stresses the importance of individual's perception of their life situation. However, to obtain the full picture, any analysis of quality of life should be performed with regard to objective determinants of well-being. It should be emphasis that in the studies focusing on gender equality taking into account subjective assessment of individual's quality of life is important as it allows us to compare men and women's levels of life satisfaction.

QUALITY OF LIFE AND WELL-BEING

As noted by Noll (2004: 153) "the concept of 'quality of life' was born as an alternative to the more and more questionable concept of material prosperity in the affluent society and was considered the new, multidimensional and much more complex goal of societal development." Over the last decades a lot of concepts and definitions of quality of life have been developed by the representatives of various disciplines. The majority of the definitions described quality of life as the degree of satisfaction or dissatisfaction felt by people with various aspects of their life, happiness/unhappiness, a person's sense of well-being in relation to the individual persons' experience and life situation reflecting individual's well-being. Quality of life encompasses the entire range of human experience, states, perceptions, and spheres of thought concerning the life of an individual or a community. According to Patrick and Erikson quality of life

> encompasses the entire range of human experience, states, perceptions, and spheres of thoughts concerning the life of an individual or a community. Both objective and subjective, quality of life can include cultural, physical, psychological, interpersonal, spiritual, financial, political, temporal, and philosophical dimension. Quality of life implies a judgment of value placed on the experience of communities, groups such as families or individuals. (Patrick, Erikson 1993: 424)

There are three major approaches to determining the quality of life (Brock, 1993; Hajduová, Andrejovský, Beslerová 2014):

1. Characteristics of the good life based on religious, philosophical or other systems.
2. Good life based on the satisfaction.
3. Quality of life in terms of the experiences of individuals: feelings of enjoy, pleasure, life satisfaction , i.e. subjective well-being.

Quality of life refers the general well-being of individuals and societies. According to The European Health Report (WHO 2012: 110) "Well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values." Researchers distinguish between two aspects of subjective well-being: evaluative (cognitive) and experiental (affective). Evaluative well-being (i.e. life satisfaction) is assessed through satisfaction with a range of life domains. Research has usually used this aspect of well-being to measure overall life satisfaction and happiness (global retrospective assessment, influenced

by the individual's current mood, memory and context). Experiential (hedonic) well-being refers to the moment-to-moment experienced positive and negative emotions (Kahneman, Krueger 2006). So subjective well-being can be defined as individuals' subjective experiences with their life, as conscious experiences – hedonistic feelings or cognitive satisfaction (i.e. how people feel about life in context of his or her own standards) (Diener, Suh 1997).

According to Sen living is a combination of various "doings and beings". In his approach quality of life is assessed in terms of individual's capability to achieve valuable "functionings" (Sen 1993). "Functionings represent parts of the state of a person – in particular the various things that he or she manages to do or be in leading a life." (Sen 1993: 31). Some functionings are elementary, like being nourished or in good health; others are much more complex (like being socially integrated).

For Diener and Suh (1997) subjective well-being consists of three components: life satisfaction and pleasant as well as unpleasant affects (mood and emotions). They stated that "both affect and reported satisfaction judgments represent people's evaluations of their lives and circumstances." (Diener, Suh 1997: 200). In consequence subjective well-being is not only an absence of negative emotions, but includes the presence of positive affect and satisfaction with different spheres of life (Diener, Suh 1997). Cobb (2000) suggested needs-based approach: quality of life involves the satisfaction of the desires of individuals. He defined good society as one that provides the maximum satisfaction or positive experiences for its citizens.

Research show that there is a link between how individuals' rate their overall life satifaction and their health status (especially in older age). Positive well-being has clearly a protective effect on health. The central element of well-being is a sense of satisfaction with one's life and positive affective experiences - in the context of one's most important values and goals. Cultural activities have a great impact on health and subjective well-being. According to research conducted among older people, increased participation over time in social and leisure activities improved perceived quality of life. It's due to the fact that the active cultural participation (being creative, producing art) has strong social participatory connotations. (Hyyppä 2010).

Figure 1. Conceptual model of how social capital impacts on well-being and health.

Source: Hyyppä 2010

Farquhar (1995) distinguishes four types of definitions of quality of life: global, component, focused and combination definition. Type I, global definitions represent the most common approach to defining quality of life. They are broad definitions and usually incorporate ideas of (dis)satisfaction or (un)happiness. Component definitions (type II) are those which break defined construct into a series of components or dimensions or identify certain characteristics essential to quality of life evaluation. This set of definitions is more useful in empirical research comparing with the type I definitions because they are closer to operationalizing the concept. Focused definitions (type III) are those that refer to one or a small number of the components of quality of life. The most common form in this type are those definitions that explicitly refers only to health and functional ability (i.e. health-related quality of life). Another example are "micro-economic definitions of quality of life" focused on the level of satisfaction achieved as a result of his/her consumption of market goods, leisure, public goods, etc. Type IV, i.e. combination definitions overlap types I and II, that they are global, but also specify components of quality of life (Farquhar 1995).

Among objective determinants of quality of life Gross Domestic Product (GDP) is frequently cited but this measure has several limitations (Fender, Haynes, Jones 2011), for example it:

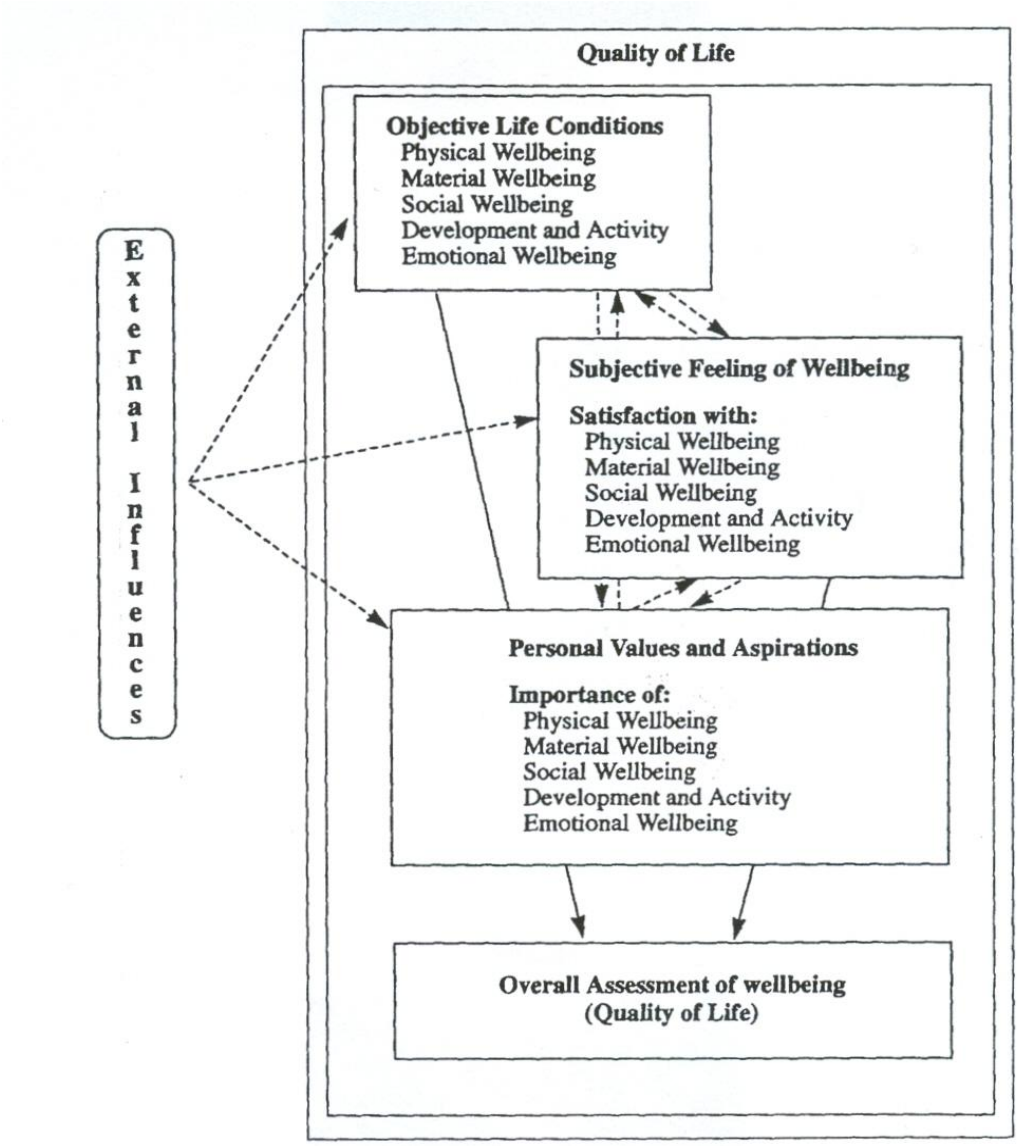
> excludes determinants of well-being outside the production boundary e.g. household production, leisure, externalities, quality of social relations, health and longevity, good institutions; includes economic activities that either reduce well-being or that remedy the costs of economic growth. Crime, war, pollution, and car accidents all cause people to spend money - and so they all increase the GDP but it is arguable whether or not these increase well-being; imperfectly measures the impact on well-being of some activities inside the production boundary e.g. the output of public services; does not inform on whether well-being can last over time (Fender, Haynes, Jones 2011: 2)

According to so-called "Easterlin Paradox" (Easterlin 1974) average happiness does not increase over long spans of time, in spite of large increases in income per capita. Having more money and, in consequence, higher standards of living does not necessarily result in greater happiness (the author of the paradox having summarize the results of social surveys concerning the sources of happiness suggested that to increase their level of happiness people should stop devoting time to making money and dedicate more time to nonpecuniary goals such as health or family life; Easterlin 2004).

As Diener and Suh (1997) noticed objective quality of life indicators must be quantifiable, cannot reflect the values of a specific culture (it should be possible to use developed objective measures internationally), and, last but not least, should be easy to understand and simple to construct. Among objective social indicators objective circumstances in a given cultural or geographical unit are underlined, like wealth, infant mortality, number of medical doctors per capita, rates of rape, longevity, homicide rates, police per capita, ecology, human rights, welfare and education (Diener, Suh 1997).

In the model of quality of life developed by Felce and Perry (1995), quality of life is defined as an overall general well-being that comprises objective indicators and subjective evaluations of physical, social, material and emotional well-being. Overall assessment of well-being (quality of life) is composed of three groups of factors: objective life conditions, personal values and aspirations and subjective feeling of well-being. As objective life conditions we may number physical well-being, material circumstances, social and emotional well-being, personal development and activity. All those indicators are weighted by a personal set of values. Subjective feeling of well-being means individual's satisfaction with aforementioned objective life conditions. The three abovementioned elements, are seen in interaction with each other (see: Figure 2).

Figure 2. A model of quality of life



Source: Felce and Perry 1995

According to Felce and Perry (1995) quality of life comprises of five domains: physical, material, social and emotional well-being as well as personal development and activity. As indicators of physical well-being we may number health, fitness, mobility and personal safety. Material well-being bases on finance or income, quality of the living environment, neighborhood (which are a source of a feeling of security and stability). Also such factors as possessions, privacy, transport and quality of food should be taken into account. Social well-being should be analyzed in two major dimensions: as an effect of interpersonal relations and in the context of community involvement. Among interpersonal relationships those with family and within household as well as those with relatives and friends are of particular importance. Community involvement encompasses participation in social activities and the level of acceptance and support obtained from others. As aspects

important for emotional well-being we may number positive affect, status (respect), satisfaction and feeling of fulfillment, self-esteem and faith (belief). Development and activity is concerned with the possession and use of skills in relation to self-determination (competence or independence and choice or control) and the pursuit of functional activities: job, housework, education and leisure (hobbies) and productivity or contribution.

Analysed in the context of well-being happiness may be defined as "the degree to which an individual judges the overall quality of his life favourably" (Veenhoven, 1991: 2). According to Blanchflower and Oswald (2002) psychologists draw a distinction between the well-being from life as a whole ("context-free" well-being) and the well-being associated with a single area of life ("context-specific"). Measures of happiness are a reflection of several factors like circumstances, aspirations, comparisons with others, and a person's dispositional outlook (e.g. Chen, Spector, 1991; Blanchflower, Oswald 2002).

Psychological concepts distinguish between positive and negative affect and define happiness as the balance between the two. In sociological concepts life satisfaction rather than happiness is a key indicator of well-being. Well-being may be defined as overall life satisfaction with specific domains, such as work, income, social relationships, etc.

HEALTH-RELATED QUALITY OF LIFE

According to WHO definition, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1946: 1). Constitution of the WHO states, that

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (…) Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures (WHO 1946: 1).

Health status and health-related quality of life (HRQOL) are two distinct conceptual terms. Health status is one domain of health-related quality of life. Current usage of health status implies a multifaceted concept, it overlaps with the broader concept of health-related quality of life. Both can encompass physical health (e.g. fitness, symptoms, signs of disease and wellness), physical functioning (ability to perform daily

activities and physical roles), social functioning, well-being and roles (relationships with others, social support and engagement in social activities), psychological well-being (depression, anxiety), emotional well-being (life satisfaction, morale, control, coping and adjustment) (Carr, Higginson, Robinson 2003).

The concepts of perceived health status, quality of life and health-related quality of life are multidimensional constructs and can be complex to analyse as they might be mediated by several variables, including self-related constructs (e.g. self-esteem, perceived control over life) and subjective evaluations could be influenced, in theory, by cognitive mechanisms (e.g. expectations of life, level of optimism or pessimism, social and cultural values, aspirations, standards for social comparisons of one's circumstances in life) (Bowling 2014).

Health-related quality of life is a major concept in both sociological and psychological research in relation to the experiences of illness and the outcome of health services. In the field of medical sociology the concept of health-related quality of life as well as issues related to its measurements were carefully analysed by Bowling (1995, 1997). Similarly to quality of life, also HRQOL is multifaceted and encompasses physical, psychological and social domains of health. Social well-being is a key component of health-related quality of life, understood in relation to the availability of practical and emotional support that is perceived by the individual to be satisfying.

Quality of life is defined by WHO (1993: 1) as

> an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad concept affected in a complex way by the person's physical and psychological health, functional status, social relationships, personal beliefs and relationships to salient features of their environment.

According to so-called hierarchical model of quality of life developed by Spilker (1996) there are three conceptual levels to understanding health-related quality of life: from the most general level (I) to a level identifying particular indicators of quality of life, which may be used to measure its different dimensions. According to the model general quality of life (level I) is related to general life satisfaction/general well-being. Level II encompasses different dimensions of quality of life, which are most often inclusive of psychological, social and physical functioning. Certain authors examined at this level also other dimensions of quality of life such as economic status, individual productivity and

professional activity, degree of cohesion with one's surroundings and the presence of chronic disease. At the level III specific indicators of each quality of life dimension are analysed. The model assumes that the most detailed indicators of quality of life (level III) significantly influence general quality of life (life satisfaction, well-being) (level I) (see: Tobiasz-Adamczyk 2013).

Health related quality of life is the value assigned to duration of life as modified by the impairments, functional states, perceptions and social opportunities that are influenced by disease, injury, treatment or policy. It is also defined as the degree of satisfaction or dissatisfaction felt by people with various aspects of their lives. There exist four underlying dimensions to the concept, two of which are objective and two of which reflect the personal judgment of the individual: general health and functional status; socio-economic status, life satisfaction and self-esteem. (Tobiasz-Adamczyk 2013).

Positive health is defined as an ability to cope with stressful situations, the maintenance of a strong social support system, integration in the community, high morale and life satisfaction, psychological well-being and level physical fitness and physical health. Quality of life is related to possession of resources necessary to the satisfaction of individual needs, wants, and desires; participation in activities enabling personal development and self-actualization and satisfactory comparison between oneself and others (Bowling 1997).

According to Bowling (2014) there is a wide range of domains of health-related quality of life, such as emotional well-being, psychological well-being (measured with indicators of anxiety or depression), physical well-being and social well-being (e.g. measured with indicators of social network, obtained social support, community integration, etc.) (Bowling 2014).

Among determinants of quality of life the following are mentioned:

- Physical (impaired function, pain)
- Psychological (depression, anxiety, well-being)
- Social (isolation, illness behaviors)
- Life setting before disease onset
- Acute illness (illness suddenly interrupts a person's way of life)
- Chronic illness and rehabilitation
- Effects of medical treatment, etc. (see: Fava 1990)

Apart from health-related quality of life also quality of life determined by ageing process is widely discussed in the literature. Positive ageing is defined through the prism of

ability to control own life, maintain social relationships, quality of environmental settings (Day 1991), mental health, cognitive efficacy, social competence and productivity, personal control and life satisfaction. Among dimensions of quality of life most frequently mentioned by older people are: contacts with family (children), social contacts, health status, mobility and ability, material circumstances, activities, level of happiness, youthfulness and home environment (Farquhar 1995).

As Bowling (1995) mentioned, quality of life research (including HRQOL) spans a range of topics and has a usage across many areas of social sciences. Quality of life is a multidimensional concept and theoretically incorporates all aspects of individual's life as well as society's life (Bowling 1995), therefore its adequate measuring poses a great challenge for the researchers.

CONCLUSION: MEASURING QUALITY OF LIFE IN THE CONTEXT OF GENDER EQUALITY STUDIES – AN EXAMPLE FROM GEQ RESEARCH PROJECT

For the purpose of measuring quality of life in the context of gender equality (like in GEQ research project) subjective approach as mixed with the analysis of objective indicators is recommended as more appropriate than purely objective perspective. As an example of such approach may serve WHO concept of quality of life, that is defined by the Organization as individuals perception of their position in life, affected by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to environment (WHO 1993). This conception is intrinsically influenced by the person's cultural context (McDowell 2006). WHOQOL complex, multidimensional approach to quality of life is reflected in the tools developed by the Organization for the purpose of measuring quality of life (full version of the instrument: WHOQOL-100; abbreviated version: WHOQOL-BREF; WHOQOL Group 1994). For usage in research conducted in the field of social science those tools could be modified by expanding the section devoted to social relationships.

In the case of quality of life assessment in GEQ project, that serves as an illustration in presented analysis of discussed accuracy of subjective measures of quality of life studied in the context of gender equality, the following domains were covered in the tool:

- **Physical health**. WHOQOL Group suggests to cover within this domain facets like energy and fatigue, pain and discomfort, etc.

- **Psychological state.** Psychological domain encompasses bodily image and appearance, negative feelings, positive feelings, self-esteem, learning, memory and concentration.
- **Social relationships.** Within this domains personal relationships, social support available from others and satisfaction with sexual activity should be assessed.
- **Environment.** This broad domain encompasses financial resources, freedom, physical safety and security, health and social care: accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure, transport and assessment of physical environment (pollution, noise, traffic, climate).
- Additionally **agency** (understood as the capacity and possibility to act in the world, a sense of having influence on own life, the possibility of acting for own good and the good of community/society, a sense of efficacy, etc.) should be included in the research on quality of life analyzed in the context of gender equality.

Presented approach to measuring quality of life is complex ("there is a broad entity encompassed by the term 'quality of life'"; WHOQOL Group 1993: 153), focuses upon people's perception of their life and offers holistic look at the measured construct. Facets distinguished by WHOQOL-BREF within each domains are clear and easy to measured. Moreover it allows to perform a comprehension evaluation of individual's self-assessed health.

Comparisons between WHOQOL Group's dimensions of quality of life and a list of capabilities proposed by Nussbaum (list of capabilities quoted from Anand, Hunter, Smith 2004: 44-52) shows that the vast majority of the WHOQOL instrument's dimensions coincide, at least in part, with Nussbaum's proposals. Nussbaum's list is wider and more detailed, but covers the same domains that were considered by the WHOQOL Group (e.g. WHOQOL's 'Physical health' domain corresponds with Nussbaum's 'Bodily health', WHOQOL's 'Psychological state' corresponds with Nussbaum's 'Emotions' and 'Senses, imagination and thoughts', etc.; see table 2). Some of Nussbaum's dimensions (capabilities) are not reflected in the WHOQOL Group's proposition - these are 'Life', 'Other species' (that actually can be treated as a part of WHOQOL's 'Environment') and 'Control over one's environment' in relation to political environment. 'Life' ("being able to live to the end of a human life of normal length, not dying prematurely, or before one's life is so reduced as to be not worth living", Anand, Hunter, Smith 2004: 44) can be seen as a

consequence of other dimensions (especially 'Bodily health') and in further analyzes existing data on life expectancy in a given country/region can be included. 'Control over one's political environment' ("Being able this participate effectively in political choices that govern one's life, having the right of political participation, protection of free speech and association", Anand, Hunter, Smith 2004: 51) are reflected in the concept of 'Agency' - an extra dimension suggested to supplemented the list of quality of life domains presented by WHOQOL Group. It should be underlined that Nussbaum attaches great importance to the issue of personal freedom and to the problem of violence – it is impossible to ignore these issues in studies on gender equality and quality of life (such as GEQ).

Table 2. WHOQOL Group's quality of life dimensions vs Nussbaum's list of capabilities

WHOQOL	Nussbaum's list of capabilities
PHYSICAL HEALTH (included in WHOQOL-BREF) Energy and fatigue Pain and discomfort Sleep and rest	**BODILY HEALTH** Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
LEVEL OF INDEPENDENCE Mobility Activities of daily living Dependence on medicinal substances and medical aids Work capacity	**CONTROL OVER ONE'S ENVIRONMENT** B. **Material**. Having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.
PSYCHOLOGICAL STATE (included in WHOQOL-BREF) Bodily image and appearance Negative feelings Positive feelings Self-esteem Thinking, learning, memory and concentration	**EMOTIONS** Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. **SENSES, IMAGINATION, AND THOUGHT** Being able to use the senses, to imagine, think, and reason - and to do these things in a 'truly human' way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain.
SOCIAL RELATIONSHIPS (included in WHOQOL-BREF) Personal relationships	**AFFILIATION** A. **Being able to live with and toward others**, to recognize and' show concern for other human beings, to

Social support Sexual activity	engage in various forms of social interaction; to be able to imagine the situation of another (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.) B. **Having the social bases of self-respect and non-humiliation**; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non-discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, and national origin. **BODILY INTEGRITY** Having opportunities for sexual satisfaction and for choice in matters of reproduction.
ENVIRONMENT (included in WHOQOL-BREF) Financial resources Freedom, physical safety and security Health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation/leisure Physical environment (pollution/noise/ traffic/climate) Transport	**BODILY INTEGRITY** Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence. **PLAY** Being able to laugh, to play, and to enjoy recreational activities. **CONTROL OVER ONE'S ENVIRONMENT** B. **Material**. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others.
SPIRITUALITY/RELIGION/PERSONAL BELIEFS	**PRACTICAL REASON** Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance.)
Not covered	**LIFE** Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.
Not covered	**OTHER SPECIES** Being able to live with concern for and in relation to animals, plants, and the world of nature.
Not covered	**CONTROL OVER ONE'S ENVIRONMENT** A. **Political**. Being able to participate effectively in political choices that govern one's life; having the right of political participation, protection of free speech and association.

Survey on gender equality and quality of life conducted in Norway in 2006 by Holter et al. (Holter, Svare, Egeland 2009) covered health and quality of life domains in 25 questions included in the Section 8 of the questionnaire developed by the researchers. These questions were based on personal's assessment of quality of life in various life spheres. The tool includes, apart from a question concerning overall quality of life evaluation also questions on lifestyle (exercising), ability to control one's emotions, contribution to a traffic accident resulting in injuries, self-esteem, satisfaction with one's

body, satisfaction with one's sexual life and problems with sexual desire (loss of desire), contacts with friends, mental health problems (stress, anxiety, depression, suicidal thoughts and other psychological complaints) including alcohol or drugs problems, physical health problems (weight gain, stomach problems, headache, stiff muscles, back pain), functional restrictions in everyday life experienced due to health problems, mobility, violence within circle of friends and outside the home, and strategies of coping with mental problems. Most of these domain are somewhat covered also by WHOQOL Group in their list of quality of life dimensions (see table 3; with line highlighted those aspects that are similar in both compared approaches). It should be noted that Holter attaches greater importance (than WHOQOL Group) to violence (including not only being a victim of violence, but also being a perpetrator). Norwegian project in the section devoted to health and quality of life includes questions on masculinity/femininity as well as about height and weight. In the context of quality of life such aspects as work capacity (covered in WHOQOL in the section 'Level of independence'), environment (WHOQOL Group suggests to ask questions about accessibility and quality of health and social care, home environment, participation in and opportunities for recreation/leisure, transport, physical environment: pollution/noise/traffic/climate) and personal beliefs/religion/spirituality are not taken into account. Especially the last one should be taken into account in these cultural contexts where the level of religious involvement is still relatively high (the case of Poland).

Table 3. WHOQOL Group's quality of life dimensions vs Gender Equality and Quality of Life (Norway 2006)

WHOQOL	Gender Equality and Quality of Life (Norway 2006)
PHYSICAL HEALTH (included in WHOQOL-BREF) Energy and fatigue Pain and discomfort Sleep and rest	Lifestyle (exercising) (110) Physical health problems (weight gain, stomach problems, headache, stiff muscles, back pain) (116)
LEVEL OF INDEPENDENCE Mobility Activities of daily living Dependence on medicinal substances and medical aids Work capacity	Reduced mobility (118) Functional restrictions in everyday life within the last year, experienced due to health problems (117)
PSYCHOLOGICAL STATE (included in WHOQOL-BREF) Bodily image and appearance Negative feelings Positive feelings Self-esteem Thinking, learning, memory and concentration	Emotions (ability to control) (110) Satisfaction with appearance/body (111) Satisfaction with one's life (111) Self-esteem (111) Loss of sexual desire (116) Mental health (stress, anxiety, depression, suicidal thoughts and other psychological complaints) (116) Addictions (alcohol, drugs) (116) Coping with mental problems (122)
SOCIAL RELATIONSHIPS (included in WHOQOL-BREF) Personal relationships Social support Sexual activity	Contacts with friends (112) Satisfaction with sexual life (111) Violence within circle of friends (119)
ENVIRONMENT (included in WHOQOL-BREF) Financial resources Freedom, physical safety and security Health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation/leisure Physical environment (pollution/noise/ traffic/climate) Transport	Violence outside the home (120, 121) Traffic accident (110)
SPIRITUALITY/RELIGION/PERSONAL BELIEFS	Not covered
Not covered	Masculinity/femininity scale (113)
Not covered	Height and weight (114, 115)

REFERENCES

1. Anand, Paul, Graham Hunter and Ron Smith. 2005. Capabilities and Wellbeing: Evidence Based on the Sen-Nussbaum Approach to Welfare. *Social Indicators Research* 74: 9-55.
2. Backhans, Mona Cristina, Bo Burström, Lars Lindholm and Anna Månsdotter. 2009. Pioneers and laggards - is the effect of gender equality on health dependent on context? *Social Science and Medicine* 68 (8): 1388-95.
3. Blanchflower, David and Andrew Oswald. 2002. Well-Being over time in Britain and the USA. *Journal of Public Economics* 88 (2004): 1359 – 1386.
4. Bowling, Ann. 1995. *Measuring disease.* Buckingham, Philadelphia: Open University Press.
5. Bowling, Ann, 1997. *Measuring health: a review of quality of life measurements scales.* Buckingham, Philadelphia: Open University Press.
6. Bowling, Ann. 2003. Current state of the art in quality of life measurement. In Alison Carr, Irene Higginson and Peter Robinson (eds). *Quality of life*. London: BMJ.
7. Bowling, Ann. 2014. *Research methods in health: investigating health and health services*. Buckingham, Philadelphia: Open University Press.
8. Brock, Dan, 1993. Quality of life measures in health care and medical ethics. In Martha Nussbuam and Amartya Sen (eds.) *The quality of life*. Oxford: Clarendon Press.
9. Chen, Peter and Paul Spector. 1991. Negative Affectivity as the Underlying Cause of Correlations Between Stressors and Strains. *Journal of Applied Psychology* 7: 398-407.
10. Cobb, Clifford. 2000. *Measurement tools and the quality of life*. San Francisco: Redefining Progress.
11. Czapiński Janusz and Tomasz Panek. 2013. *Diagnoza społeczna 2013. Warunki i jakość życia Polaków*. http://analizy.mpips.gov.pl/images/stories/publ_i_raporty/DS2013/Raport_glowny_Diagnoza_Spoleczna_2013.pdf. Accessed 15.07.2015.
12. Day, Alice. 1991. *Remarkable survivors: insights into successful aging among women*. Washington, D.C.: Urban Institute Press.

13. Diener, Ed and Eunkook Suh. 1997. Measuring quality of life: Economic, social, and subjective indicators. *Social Indicators Research* 40 (1-2): 189-216.
14. Diener, Ed, Richard Lucas, Urlich Schimmack and John Helliwell. 2009. *Well-being for public policy*. New York: Oxford University Press.
15. Easterlin, Richard. 1974. Does economic growth improve the human lot? Some empirical evidence. Paul David and Melvin Reder (eds). *Nations and households in economic growth: essays in honour of Moses Abramovitz*. New York: Academic Press.
16. Easterlin, Richard. 2004. Life satisfaction: can we produce it? In Wolfgang Glatzer, Susanne von Below and Matthias Stoffregen (eds). *Challenges for quality of life in the contemporary world. Advances in quality-of-life studies, theory and research*. New York: Spronger.
17. Erikson, Robert. 1993. Descriptions of inequality: The Swedish approach to welfare research. In Martha Nussbuam and Amartya Sen (eds.) The quality of life. Oxford: Clarendon Press.
18. Farquhar, Morag. 1995. Definitions of quality of life: a taxonomy. *Journal of Advanced Nursing* 22 (3): 502-508.
19. Fava, Giovanni. 1990. Methodological and Conceptual Issues in Research on Quality of Life. *Psychotherapy and Psychosomatics* 54: 70–76.
20. Felce, David and Jonathan Perry. 1995. Quality of life: Its definition and measurement. *Research in Developmental Disabilities* 16 (1): 51-74.
21. Fender, Valerie, Joseph Haynes and Richard Jones. 2011. *Measuring economic well-being*. Office for National Statistics. www.ons.gov.uk/ons/dcp171766_284260.pdf. Accessed 20.07.2015.
22. Hajduová, Zuzana, Pavol Andrejovský and Stela Beslerová. 2014. Development of Quality of Life Economic Indicators with Regard to the Environment. *Procedia—Social and Behavioral Sciences* 110: 747-754.
23. Holter, Øystein Gullvåg, Helge Svare, Cathrine Egeland. 2009. *Gender Equality and Quality of Life, a Norwegian Perspective*. The Nordic Gender Institute. http://www.nikk.no/wp-content/uploads/NIKKpub2009__ligestillingspolitik_M%C3%A6nd-og-maskuliniteter-_Gender-Equality-Qualit-yo-fLifeEng.pdf. Accessed 20.07.2015.
24. Hyyppä Markku. 2010. *Healthy ties. Social capital, population health and survival*. New York: Springer.

25. Daniel Kahneman and Alan Kruger. 2006. Developments in the measurement of subjective well-being. *Journal of Economic Perspectives* 20 (1): 3-24.
26. Łapniewska, Zofia. 2015. Well-being and social development in the context of gender equality. Krakow: Jagiellonian University.
27. McDowell, Ian. 2006. *Measuring Health: A guide to rating scales and questionnaires*. New York: Oxford University Press.
28. Noll, Heinz-Herbert. 2004. Social indicators and quality of life research: Background, achievements and current trends. In Nikolai Genov (ed). Advances in sociological knowledge, over half a century. VS Verlag für Sozialwissenschaften.
29. Park Seung-Min. 2013. A Conceptual Framework of the Multi-dimensional Model of the Quality of Life in Later Life. *Social and Public Policy Review* 7 (2): 1-22.
30. Patrick, Donald and Pennifer Erickson. 1993. *Health policy, quality of life: health care evaluation and resource allocation*. New York: Oxford University Press.
31. Sen, Amartya. 1993. Capability and well-being. In Martha Nussbuam and Amartya Sen (eds.) *The quality of life*. Oxford: Clarendon Press.
32. Spilker, Bert. 1990. Introduction. In Bert Spilker (ed). *Quality of life assessments in clinical trials*. New York: Raven Press.
33. Tobiasz-Adamczyk, Beata. 2013. The genesis of health: evolution of the concept of health-related quality of life. In Kalina Kawecka-Jaszcz, Martk Klocek, Beata Tobiasz-Adamczyk and Christopher Bulpitt (eds). *Health-related quality of life in cardiovascular patients*. New York: Springer.
34. Veenhoven, Ruut. 1991. Is Happiness Relative? *Social Indicators Research* 24 (1): 1-34.
35. WHO. 1946. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948.

    http://www.who.int/governance/eb/who_constitution_en.pdf. Accessed 20.07.2015.
36. WHO. 1993. *Measuring quality of life: the development of the World Health Organization Quality of Life Instrument (WHOQOL)*. Geneva: WHO.
37. WHO. 2012. The European Health Report. Charting the way to well-being. http://www.euro.who.int/en/data-and-evidence/european-health-report-2012. Accessed 20.07.2015.

38. WHOQOL Group. 1993. Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *Quality of Life Research* 2 (2): 153-159.
39. WHOQOL Group. 1994. The development of the World Health Organization quality of life assessment instrument (the WHOQOL). In John Orley and Willem Kuyken (eds). *Quality of life assessment: international perspectives*. Berlin: Springer-Verlag.
40. WHOQOL Group. 1996. WHOQOL-BREF, introduction, administration, scoring and generic version of the assessment.
http://www.who.int/mental_health/media/en/76.pdf. Accessed 15.07.2015.