RESEARCH ARTICLE / *Araştırma Makalesi*

Health-Related Quality of Life of Women According to Their Employment Status

Kadınların Çalışma Durumlarına Göre Sağlıkla İlişkili Yaşam Kaliteleri

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Abstract

Objective — The aim of this study was to assess the health-related quality of life based on the women's employment status.

Materials and Methods — The population of the study was composed of the women who applied to the Family Health Centers (FHCs) in the city center of Bingol. The questionnaire with two parts, which was prepared with the help of the literature review made by the researchers about the subject, was applied to the women meeting the inclusion criteria. The first part of the questionnaire includes the socio-demographic characteristics of the participants and the second part includes the "Short Form Health Survey- SF-36".

Results — As the educational levels increased, the quality of life of the women enhanced. The Physical Functioning and Physical Role Functioning scores of the single women were significantly higher compared to their married counterparts ($p<0.05$). Physical Functioning, Physical Role Functioning, General Health, Vitality/Energy and Bodily Pain subscales of the health-related quality of life, were higher among the employed women.

Conclusion — The quality of life of the women participating in the study is moderate. Also, when the subscales' scores of the quality of life scale were examined, it was observed that the quality of life scale score of the employed women was higher compared to the housewives, and the quality of life of the employed women who were single, had high educational levels, and were civil servants was higher compared to the other employed women.

Keywords — Employment status, quality of life, the status of women, women.

Öz

Amaç — *Bu araştırma ile kadınların çalışma durumlarına göre sağlıkla ilişkili yaşam kalitesinin değerlendirilmesi amaçlanmıştır.*

Gereç ve Yöntemle — *Araştırmanın evrenini Bingöl ilinde Aile sağlığı Merkezlerine (ASM) başvuru yapan kadınlar oluşturmaktadır. Çalışmaya alınma kriterlerini karşılayan kadınlara, araştırmacı tarafından konu ile ilgili literatür değerlendirilmesi sonucu hazırlanan ve iki bölümden oluşan anket formu uygulanmıştır. Anketin birinci bölümünü, katılımcıların sosyo-demografik özellikleri, ikinci bölümünü ise, "Sağlıkla İlişkili Yaşam Kalitesi Ölçeği-36 (Short Form Health Survey- SF-36)" oluşturmaktadır.*

Bulgular — *Eğitim arttıkça kadınların yaşam kaliteleri artmaktadır. Bekâr olan kadınların evlilere göre Fiziksel Fonksiyon ve Fiziksel Rol Kısıtlılığı puanları da anlamlı derecede yüksektir ($p<0.05$). Çalışan kadınlar arasında sağlıkla ilişkili yaşam kalitesinin alt boyutları olan; Fiziksel Fonksiyon, Fiziksel Rol Kısıtlılığı, Genel Sağlık Durumu, Canlılık/Enerji ve Ağrı durumları daha yüksektir.*

Sonuç — *Araştırmaya katılan kadınların yaşam kaliteleri orta düzeydedir. Ayrıca yaşam kalitesi ölçeğinin alt puanlarına bakıldığında; çalışan kadınların yaşam kalitesi ölçek puanı, ev hanımlarına kıyasla daha yüksektir. Ayrıca, çalışan kadınlar arasında bekâr, eğitim düzeyi yüksek ve memur olanların yaşam kalitesi diğer çalışan kadınlara oranla daha yüksektir.*

Anahtar Kelimeler — *Çalışma durumu, kadın, kadın statüsü, yaşam kalitesi.*

INTRODUCTION

Work occupies a person's time, directs their energy towards useful purposes, and protects their mental health via the satisfaction they gain.[1] Working life has a significant meaning for individuals, families, and societies. Working life, which is a source of honor, satisfaction, and social communication for individuals, contributes to developing time structure and mediates for providing food, shelter, personal care, and other services. However, the ever-increasing involvement of women in paid employment increases the workload of women and diversifies their work. Women may have difficulties due to the new responsibilities among their working life, families, and their status in society. This brings along important questions about how much time women spend for paid and unpaid employment and how this duration is distributed.[2] Also, the employment of women and how to affect their health and quality of life have started to become the subject of studies.

While women try to fulfill the responsibilities required by their roles in their working and family lives, they have divided effort, time, concern, energy, experience, role conflict, and thus cannot express themselves. On the other hand, men both want to have a voice in women's work and maintain their economic superiority at home.[3] While women try to keep the balance between their responsibilities at home, their families, and friends, they are exposed to stress, resulting in impaired quality of life. Women- wherever in the world they are- are the last to get employed and the first to get fired from work. This is because women generally work in jobs which don't require training and specialization and can be done by machines. They have to quit their work due to birth but cannot find a job when they become ready to work. According to all these results, the fact that women work under these conditions in risky environments may pave the way for their quality of life to impair.

The World Health Organization (WHO) defines the quality of life as an individual's perception of their position in life and life perception varying based on their expectations and living standards. Psychological and physiological health is a broad concept including social relations, personal beliefs, and environment.[4] WHO defines "health as not only a state of complete physical, mental and social well-being but also the absence of disease and disability.".[5] This 'well-being' concept has caused a conceptual confusion about the health and quality of life. Then, most of the methodologists in social and health sciences have followed this definition, and they were of the opinion that at least three dimensions (physical, mental, and social interaction) should be included.[6] There are two main approaches in assessing the quality of life: profile and decision theory. The psychometric approach is used to present a profile summarizing the different dimensions of the quality of life. The SF-36 is the most known example of this. There are 8 health concepts in SF-36: Physical functioning, physical role functioning, bodily pain, general health perceptions, vitality, social functioning, emotional role functioning, and mental health. Also, mental health and physical health scores can be calculated separately. The decision theory approach tries to discuss different dimensions of health to provide a unique definition of the health status.

Understanding quality of life is important to prevent symptoms and enhance their care and rehabilitation. The problems associated with the quality of life reported by patients are effective in the assessment of response to treatment and may result in changes and improvement in the treatment and care. The criteria of quality of life may also be used to determine the problems that may affect the patients. This kind of information may also be used to help patients in predicting and understanding the results of their diseases and treatments. The quality of life is also important to make medical decisions, is an indicator for the success of treatment, and therefore, it has prognostic importance.[7]

The aim of this study was to assess the health-related quality of life based on the women's employment status.

MATERIALS and METHODS

Research Type

This research was a descriptive and cross-sectional study. This study was approved by Bingöl University's Ethics Committee (Approval date and number: 30.12.2019; 92342550/044 – E.26635).

The Population and Sample of the Study

The population of the study was composed of the women who applied to the Family Health Centers (FHCs) in the city center of Bingöl. The sample size was determined as 200 people using the G*Power 3.1 method (Effect size: 0.25, $\alpha = 0.05$, Power (1- β err probe) = 0.80, Number of Group = 5). Since the scale is the first study conducted with a group of working women without any disease, the medium effect value was taken as 0.25 according to Cohen's effect size table.[8]

Between the dates of 02.03.2020 and 03.31.2020, individuals who met the inclusion criteria were included in the study based on the purposeful sampling method. The inclusion criteria for the women were determined as follows; being aged between 20 and 55 years, being voluntary to participate in the study, being able to speak and understand Turkish, and having no psychological disorders. The written and verbal consents were obtained from the women who met the criteria and agreed to participate in the study.

Data Collection Tools

With the preliminary study of the questionnaire, 10 women included in the study were communicated, questionnaires were performed with the women, and the questions were reviewed again in terms of comprehensibility. In the stage of data collection, the women were informed about the aim of the study. Written and verbal consent were received from the women who voluntarily agreed to participate in the study. The data of the study were collected by the researcher by using data collection tools and conducting face-to-face interviews with the women included in the study. The questions were read aloud to each participant clearly and the answers were recorded.

The questionnaire with two parts, which was prepared with the help of the literature review made by the researchers about the subject, was applied to the women meeting the inclusion criteria. The first part of the questionnaire includes the socio-demographic characteristics of the participants and the second part includes "Short Form Health Survey- SF-36".

1. Personal Information Form (includes independent variables): This form aimed to determine some characteristics of the participants. It includes questions about age, gender, educational status, profession, habits, chronic diseases, and social status.

2. Short Form Health Survey- SF-36: SF-36, which is valid and commonly used in assessing the quality of life, was developed again by Ware and Sherborne (1992). SF-36 is used to assess health from physical and mental terms.9 Koçyiğit et al., translated the scale into Turkish in 1999 and conducted its validity and reliability study.[10] It is not specific to any age, disease, or treatment group. It includes the concepts related to general health. It is composed of eight subscales: Physical functioning, physical role functioning, bodily pain, general health perceptions, vitality, social functioning, emotional role functioning, and mental health and it has 36 questions (Table 1). It is a Likert-type scale (three-points and six-points), except for the fourth and fifth items, the fourth and fifth items are answered yes/no and separate scores are obtained for each subscale. The sum of the subscales varies between 0 and 100 points. As the score increases, the quality of life enhances. The scale can be interpreted by dividing these subscales into two components. These components are:

Table 1. SF-36 Short Form Health Survey's Assessment Criteria.			
Subscales	Items	Possible max. min scores	Possible score
Physical Functioning	3, 4, 5, 6, 7, 8, 9, 10, 11, 12	10–30	20
Physical Role Functioning	13, 14, 15, 16	0–8	4
General Health	1, 33, 34, 35, 36	5–25	20
Vitality/Energy	23, 27, 29, 31	4–24	20
Social Functioning	20, 32	2–11	9
Emotional Role Functioning	17, 18, 19	0–3	3
Mental Health	24, 25, 26, 28, 30	5–30	25
Bodily Pain	21, 22	2–11	9

A-Physical Components;

1. Physical Functioning: All the activities performed by an individual in a day (doing sports, lifting heavy things, carrying shopping bags, etc.)

2. Bodily Pain: The bodily pain level of an individual and how it affects his/her daily life.

3. Physical Role Functioning: Physical health problems developed because of a disease.

4. General Health: How the general health status is perceived by the individual, how she feels herself, self-comparison with other people.

Table 2. Some socio-demographic characteristics of the women					
Educational status of spouse	**n**	**%**	**Educational Status**	**n**	**%**
Literate	90	45.0	Literate	39	19.5
Primary school graduate	22	11.0	Primary school graduate	27	13.5
Secondary school graduate	24	12.0	Secondary school graduate	20	10.0
High school graduate	39	19.5	High school graduate	58	29.0
Undergraduate-Graduate	25	12.5	Undergraduate-Graduate	56	28.0
Total	200	100.0	Total	200	100.0
Employment status	**n**	**%**	**Employment status of spouse**	**n**	**%**
Civil servant	25	12.5	Civil servant	24	12.0
Employee	25	12.5	Employee	16	8.0
Craftsman	25	12.5	Craftsman	20	10.0
Other	25	12.5	Other	65	32.5
Housewife	100	50.00	Unemployed	75	37.5
Total	200	100.0	Total	200	100.0
Marital status	**n**	**%**	**Children**	**n**	**%**
Married	124	62.0	Yes	109	54.5
Single	76	38.0	No	91	45.5
Total	200	100.0	Total	200	100.0

Table 3. The SF-36 Mean Scores of the Participants			
Subscales	**Mean±sd**	**min**	**max**
Physical Functioning	74.05±25.72	0	100
Physical Role Functioning	60.75±43.15	0	100
General Health	49.22±21.50	0	95
Vitality/Energy	53.17±20.59	0	100
Social Functioning	63.43±26.49	0	100
Emotional Role Functioning	58.83±43.43	0	100
Mental Health	64.48±16.94	8	100
Bodily Pain	64.43±25.22	0	100

B- Mental Components

1. Emotional Role Functioning: The effect of the mental problems caused by a disease (anxiety, sadness, depression, etc.) on the other job and life activities of an individual.

2. Social Functioning: The effect level of the disease on an individual's social life areas and social interactions with his/her family, friends, and other groups.

3. Mental Health: Being silent, peaceful, well adjusted, nervous, still, sad, or happy.

4. Vitality/Energy: Feeling dynamic, active, lively, exhausted, depressed, or low energy.

The Cronbach's alpha reliability of the scale was found to be .943 in the current study.

Data Analysis

The data obtained as a result of the study were assessed by SPSS-22 software and error checks, tables, and statistical analyses were performed. The numeric and percentage values were presented in the statistical assessment. For the compatibility to the normal distribution, histogram drawings were made, skewness and kurtosis values were examined and Kolmogorov - Smirnov analyses were made. Mann Whitney U test and Kruskal Wallis test were performed between some situations and characteristics and the total and subscales' scores of the SF-36. Also, post hoc analyses were performed to find out which option caused the differences between the groups. $p<0.05$ was accepted to be statistically significant.

RESULTS

The average age of the women participating in the study was 34.19±10.96 (min:20, max:55). Table 2 shows some socio-demographic characteristics of the women.

It was determined that 22.50% of the women participating in the study had a chronic disease. 8.00% of the women with chronic disease had low back, neck, joint, and muscle pain, 5.00% of them had heart disease, 3.50% of them suffered from asthma, respiratory, and pulmonary diseases, 3% of them had diabetes and 2% of them had thyroid disease. 34% of the women had the habit of smoking, and 5% of them had the habit of using alcohol. Table 3 shows the scores obtained by the participants from the SF-36 Short Form Health Survey.

As a result of the assessment of the health-related quality of life of the women participating in the study, it was determined that the women obtained the highest score from physical functioning and the lowest score from vitality/energy. Table 4 shows the comparison of some characteristics of the women based on their employment status.

As a result of the comparison of the educational levels of the women based on their employment status, it was determined that the educational levels of the employed women was higher but the educational level of their spouses was lower. There was a significant difference between the employment status and the status of having children, and the women who were housewives had a higher level of having children. Also as a result of the statistical analyses, there were significant differences between the employment status and marital status, having chronic diseases, the habit of smoking, and using alcohol ($p<0.05$). Employed women were single at a higher rate, and their level of having a chronic diseases was low, and they had a higher rate of smoking and using alcohol. Table 5 shows the comparison of the SF-36 scores with some variables among the women participating in the study.

Physical Functioning, Physical Role Functioning, General Health, Vitality/Energy and Bodily Pain subscales of the health-related quality of life, were higher among the employed women. As a result of the statistical assessment performed based on the occupational groups of the employed women, the subscales' scores of the quality of life scale, except for Physical Functioning, were significantly higher

Table 4. Comparison of some characteristics of the women based on their employment status						
	Employment status of the women					
	Housewife		**Employed**		**Total**	
Educational Status	**n**	**%**	**n**	**%**	**n**	**%**
Literate	36	92.3	3	7.7	39	100.0
Primary school graduate	20	74.1	7	25.9	27	100.0
Secondary school graduate	11	55.0	9	45.0	20	100.0
High school graduate	19	32.8	39	67.2	58	100.0
Undergraduate-Graduate	14	25.0	42	75.0	56	100.0
Test Value						χ^2=55.279, **p=0.001**
Educational status of spouse	n	%	n	%	n	%
Literate	30	33.3	60	66.7	90	100.0
Primary school graduate	13	59.1	9	40.9	22	100.0
Secondary school graduate	18	75.0	6	25.0	24	100.0
High school graduate	25	64.1	14	35.9	39	100.0
Undergraduate-Graduate	14	56.0	11	44.0	25	100.0
Test Value						χ^2= 20.190, **p=0.001**
Children	n	%	n	%	n	%
Yes	72	66.1	37	33.9	109	100.0
No	28	30.8	63	69.2	91	100.0
Test Value						χ^2= 24.700, **p=0.001**
Chronic Disease	n	%	n	%	n	%
No	65	42.2	89	57.8	154	100.0
Yes	35	76.1	11	23.9	46	100.0
Test Value						χ^2= 16.262, **p=0.001**
Marital status	n	%	n	%	n	%
Married	78	62.9	46	37.1	124	100.0
Single	22	28.9	54	71.1	76	100.0
Test Value						χ^2= 21.732, **p=0.001**
Smoking	n	%	n	%	n	%
Yes	19	27.9	49	72.1	68	100.0
No	81	61.4	51	38.6	132	100.0
Test Value						χ^2= 20.053, **p=0.001**
Using alcohol	n	%	n	%	n	%
Yes	1	10.0	9	90.0	10	100.0
No	99	52.1	91	47.9	190	100.0
Test Value						χ^2= 6.737, **p=0.009**
X^2: Chi-square test, *Row percentage was taken.						

Table 5. Comparison of SF-36 scores and some variables in the women

	Physical Functioning	Physical Role Functioning	General Health	Vitality/Energy	Social Functioning	Emotional Role Functioning	Mental Health	Bodily Pain
	Median (95% CI)	**Median (95% CI)**	**Median (95% CI)**	**Median (95% CI)**	**Median (95 %CI)**	**Median (95% CI)**	**Median (95% CI)**	**Median (95 %CI)**
Employment status								
Housewife	70.11 (62.75-73.44)	50.83 (41.59-59.90)	45.66 (41.50-50.19)	49.83 (46.09-54.10)	61.11 (55.58-65.41)	53.70 (44.61-62.05)	66.62 (62.88-69.19)	60.44 (55.40-64.49)
Employed	82.50 (75.41-84.58)	73.05 (63.28-78.21)	53.00 (48.49-56.70)	56.33 (52.15-60.34)	67.77 (60.83-71.91)	65.92 (55.91-72.75)	63.37 (59.37-66.46)	70.66 (63.62-74.22)
Test value	U: 3493.50	U: 3873.00	U: 3984.50	U: 4089.00	U: 4343.00	U: 4391.00	U: 4485.00	U: 3882.50
	p: .001	**p: .003**	**p: .013**	**p: .025**	**p: .104**	**p: .111**	**p: .207**	**p: .006**
Occupational Status								
Civil servant	88.55 (78.48-94.31)	87.77 (70.38-97.61)[a]	62.83 (55.59-69.60)[a]	63.33 (55.82-69.77)[a]	84.58 (72.57-91.42)[a,c]	81.85 (62.83-94.49)[a]	71.15 (65.24-75.55)[a]	84.52 (74.03-91.56)[a,c]
Worker	76.83 (64.40-85.59)	54.44 (36.97-71.02)[b]	47.05 (36.75-55.64)[b]	44.72 (38.24-52.95)[b]	58.75 (45.37-70.62)[b,c]	50.74 (32.41-68.92)[b]	54.35 (46.70-60.17)[b]	63.30 (52.56-72.83)[b,c]
Craftsman	84.55 (73.90-90.89)	81.11 (64.57-91.42)[a]	55.88 (47.16-63.63)	65.05 (58.51-72.68)[a]	71.25 (59.78-80.21)[a]	81.85 (63.86-93.46)[a]	70.80 (63.46-77.33)[a]	75.75 (62.46-84.53)[a,b,c]
Other	78.94 (65.60-86.79)	68.88 (51.31-82.68)[a]	46.77 (38.40-53.99)[b]	51.50 (41.10-60.89)b	55.83 (44.75-66.24)[b,c]	49.25 (31.51-67.14)[b]	57.24 (49.50-65.37)[b]	57.44 (45.34-68.05)[b]
Test value	KW: 4.602	KW: 9.11	KW: 10.076	KW: 15.910	KW: 14.960	KW: 13.512	KW: 18.743	KW: 14.732
	p: .202	**p: .028**	**p: .018**	**p: .001**	**p: .002**	**p: .004**	**p: .001**	**p: .002**
Educational Status								
Literate	62.10 (52.02-69.76)[a]	27.92 (16.31-43.93)[a,c]	38.73 (31.01-48.21)[a]	45.73 (38.48-54.07)[a]	53.20 (43.56-62.20)[a]	31.48 (19.75-46.91)[a]	63.43 (58.43-68.33)	54.27 (45.15-62.53)[a]
Primary school graduate	65.76 (53.85-76.14)[a]	51.02 (33.91-67.94)[b]	42.33 (34.81-48.15)[a]	47.19 (40.20-54.98)[a]	55.29 (46.48-65.55)[a]	66.66 (42.36-76.15)[b]	63.07 (56.93-68.98)	57.05 (49.18-63.78)[a]
Secondary school graduate	66.11 (51.44-77.05)[a]	44.44 (25.42-64.57)[a,c]	42.77 (33.00-50.99)[a]	48.88 (40.45-57.54)[a,b]	53.47 (41.58-65.91)[a]	40.74 (21.50-61.83)[a]	59.55 (53.02-66.57)	54.02 (41.38-64.86)[a]
High school graduate	82.58 (72.87-86.08)[b]	73.46 (60.47-81.77)[b,c]	52.58 (47.12-57.70)[b]	57.97 (52.91-62.42)[b]	71.09 (62.76-76.03)[b]	73.62 (60.56-81.96)[b]	69.50 (63.56-72.98)	72.45 (64.44-77.10)[b]
Undergraduate-Graduate	86.70 (81.39-89.49)[b]	85.21 (73.47-89.92)[b,c]	58.90 (54.40-63.45)[b]	57.40 (52.01-62.98)[b]	72.22 (65.34-77.95)[b]	71.82 (59.11-80.17)[b]	64.12 (58.78-68.64)	74.94 (66.83-79.41)[b]
Test value	KW: 32.33	KW: 37.904	KW: 26.202	KW: 13.962	KW: 18.055	KW: 23.354	KW: 7.809	KW: 25.530
	p: .001	**p: .001**	p: .001	**p: .007**	**p: .001**	**p: .001**	**p: .099**	**p: .001**
Marital status								
Married	72.73 (65.95-75.41)	54.70 (46.10-62.36)	47.27 (43.37-51.22)	51.81 (48.15-55.63)	63.97 (58.07-67.93)	55.67 (47.25-62.69)	65.90 (62.63-68.33)	62.99 (57.79-66.55)
Single	82.06 (74.20-84.86)	73.75 (63.05-79.71)	52.36 (47.73-57.00)	55.13 (50.73-59.78)	65.05 (58.54-69.74)	66.56 (55.36-47.45)	63.39 (58.65-67.03)	69.72 (62.20-74.04)
Test value	U: 3664.500	U: 3784.000	U: 4025.500	U: 4248.500	U: 4672.000	U: 4179.500	U: 4367.000	U: 3991.500
	p: .008	**p: .012**	**p: .083**	**p: .241**	**p: .919**	**p: .151**	**p: .384**	**p: .068**
Children								
Yes	71.13 (64.39-74.31)	50.00 (41.35-58.64)	45.94 (41.90-50.38)	50.10 (46.33-54.30)	60.90 (54.95-65.45)	53.22 (44.50-61.30)	66.07 (61.61-67.77)	59.27 (54.18-63.29)
No	82.71 (74.62-84.71)	76.25 (66.04-81.20)	53.35 (48.75-57.06)	56.58 (52.48-60.69)	68.45 (62.17-72.43)	67.70 (57.27-74.59)	64.88 (60.49-67.93)	73.07 (66.03-76.49)
Test value	U: 3602.500	U: 3557.500	U: 3978.000	U: 4047.000	U: 4264.000	U: 4199.500	U: 4955.000	U: 3455.000
	p: .001	**p: .001**	**p: .016**	**p: .025**	**p: .084**	**p: .046**	**p: .991**	**p: .001**

KW: Kruskal Wallis Test, U: Mann Whitney U Test, CI: Confidence Intervals, a, b, c: Difference between the groups (Dunn's Test),

in the women working as civil servants compared to the other occupational groups. Based on the educational levels of the women, the subscales' scores of the quality of life scale of the women, except for Mental Health, were high. As the educational levels increased, the quality of life of the women enhanced. The Physical Functioning and Physical Role Functioning scores of the single women were significantly higher compared to their married counterparts ($p<0.05$, Table 5).

DISCUSSION

Today, the competition conditions increase day by day and the effects of economic crises resulted in an increase in the rate of the employment status of women. The increase in the employment of women has brought some questions forward. The fact that women have housework and motherhood responsibilities brings an additional load to working life. For this reason, the employment of women causes multi-roles for women may lead to some positive and/or negative results. In this study, aimed to assess the health related quality of life of the women based on their employment status, the age average of the employed women was 34.19±10.96 (min:20, max:55). It was observed that 50.00% of the women included in the current study worked actively.

In the present study, the employed women were single at a higher rate, and the educational levels of the employed women were higher. The employment rates have increased by the increased educational levels of women due to the projects and laws on obligatory education and the education of girls. Between 1988-2018, approximately 20-30% of the women who graduated from primary and high schools, and 60-70% of the women who graduated from vocational schools or universities were employed. As the educational levels increase, women have started to become employed in more qualified jobs in Turkey. Also, it is remarkable that the women who have lost their husbands and are married are less employed.[11]

In the present study, the status of having a chronic disease was lower in the employed women compared to their housewife counterparts. Also as a result of the statistical analyses, there were significant differences between the employment status and having chronic diseases. The employed women notify less chronic or acute symptoms and have fewer examinations, and their activities are less limited because of the diseases.[12,13]

When the SF-36 scores of the women were examined, as a result of the assessment of the health-related quality of life of the participants, it was determined that the women obtained the highest scores from physical functioning and the lowest score from the vitality/energy. As a result of the increasing involvement of women in the labor force in recent years, the victimization of women in workplaces has started to attract attention. The victimization of women in workplaces has certain effects on their mental and physical health besides its effect on their working performance.[14] In the literature, the studies, examining the employment status of women, have findings supporting those of the present study; on the other hand, some others have reported different results.[15-17] The main victimization types of women in workplaces are physical, emotional, sexual violence, and abuse. It has been suggested that certain characteristics come to the fore for the women who were exposed to violence.

Among the employed women, the Physical Functioning and Physical Role Functioning scores were significantly higher in the single women compared to the married women. In the study by Karabilgin, the quality of life score was found to be higher in the single and employed women. The marriage and partner-related characteristics have effects on the quality of life of the employed women. Having an unsupportive spouse or a spouse who has negative opinions about the paid employment of women may increase the stress levels of women.[18] Employed women have more stress levels compared to housewives and state more dissatisfaction about their marriage. In marital conflicts, the

employment of women is not effective on its own, and the fact that partners share the responsibilities gains importance especially when two of the spouses are employed. When household chores are shared unequally, women are exposed to a higher amount of workload and this results in more dissatisfaction in the employed spouses compared to the unemployed ones.

As a result of the statistical assessment performed based on the occupational groups of the employed women, the quality of life subscale scores, except for Physical Functioning, were significantly higher in the women working as civil servants compared to the other occupational groups. Based on the educational status of the women, the quality of life subscales of the women, except for Mental Health, were high. As the educational levels increased, the quality of life of the women enhanced. In a study conducted in Eskişehir, it was reported that the women with high educational levels had higher quality of life scores.[19] In a study conducted by Altıparmak, it was found that the women who were employed, were civil servants, and had higher education had higher quality of life scores.[20]

Physical Functioning, Physical Role Functioning, General Health, Vitality/Energy and Bodily Pain subscales of the health-related quality of life, were higher among the employed women. In their study, Kwesiga et al. reported that the women employed in the work-life with high statuses were exposed to more physical violence.[21] In the study, these women experienced gender role conflicts with the male employees in their workplaces due to their higher status and higher incomes. The fact that most of the women in this study were paid employees, they had higher educational levels, and they were exposed to violence in the workplace at a high rate is compatible with these findings. On the other hand, Anderson et al.,[22] stated in their study that workplaces may have a role in protecting women from violence. The employment of women may be an important source to avoid or stay away from abusive relationships, as well as the self-esteem and the other opportunities it provides.In the present study, which aimed to assess the health-related quality of life-based on the employment status of women, the quality of life was not at the desired level for most of the participants. In addition, when the subscales' scores of the quality of life scale were examined, it was observed that the scores of the quality of life scale of the employed women was higher compared to the housewives. Also, the quality of life of the employed women who were single had higher educational levels, and were civil servants was higher compared to the other employed women. In studies examining the employment status of women in the literature, different results have been reported as well as supporting our findings[23].

In order to increase the quality of life of all women, whether working or housewives;

- Reducing the burden of women by sharing the responsibilities of child-rearing and other familial responsibilities.
- Giving support to employed women by all the family members about the responsibilities in the families and providing the balance between the roles of women at home and in the workplaces,
- Encouraging all women, especially housewives, to avoid mental problems because they spend more time at home, to socialize, and to encourage various arts, hobbies, and sports courses in order to increase their quality of life,
- Improving the working conditions and working hours of the employed women would enhance their quality of life.

Ethical Approval

This study was approved by Bingöl University's Ethics Committee (Approval date and number: 30.12.2019; 92342550/044 – E.26635).

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Conflict of Interest

The authors have no potential conflicts to disclose.

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