

SECTION

I

Introduction to Women's Gynecologic Health

Women's Health from a Feminist Perspective

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What does gender have to do with women's health? The most obvious answer is that women's health is about women and their health; therefore gender is an issue. However, gender is an issue only because the focus is women. The true challenge to answering this question accurately lies in gaining the understanding that its answer depends on the definitions used. For example, if we were speaking about gender only as if it was synonymous with sex, then the stated answer "Women's health is about women; therefore gender is an issue" would be correct. Gender, however, is *not* synonymous with sex. *Gender* is defined as a person's self-representation as man or woman or the way in which social institutions respond to that person based on the individual's gender presentation. The term "gender" is used when referring to social and cultural influences based on sex (Pinn, 2003a). It is rooted in biology and shaped by the environment and experience (Pinn, 2003b). This broader definition of gender makes the answer to the question "What does gender have to do with women's health?" much more complex.

There are three aspects to consider when answering this question. The first is an aspect of comparison: exploring women's health as compared to men's health. The second aspect is context: exploring the context of gender, including and how it affects the process of providing healthcare services. The third aspect to consider is the social construction of gender, including how it affects women's health. The significance of answering the question from each of these perspectives is that each viewpoint has implications for the manner in which women access, receive, and respond to health care. These three aspects provide opportunities for us to better understand women's healthcare experiences. They also assist in the identification of some of the underlying factors that influence the healthcare disparities that women experience. The purpose of this chapter is to provide an overview of women's health using

gender considerations as a lens for exploring women's health in general and gynecologic health in particular.

Women's Health Care and Gynecologic Health

The state of women's health care today is a direct reflection of women's status and position in society. To date, many healthcare advances have been made under the rubric of women's health; however, there is still a long way to go before all women receive comprehensive, compassionate healthcare services that address the complexity and diversity of how women live their lives and experience health and disease.

This textbook is based on a feminist framework in an effort to advance the health care provided to women in today's society. The authors attempt to acknowledge the complexity of women's health by paying particular attention to women's status in society and their unequal access to opportunity, while focusing on women's gynecologic health and well-being.

Feminism

What is feminism? Feminism is not a singular "what." Indeed, there are multiple definitions of feminism. One definition that is well suited for addressing the context in which women experience health and wellness is that offered by bell hooks (2000): Feminism is a perspective that acknowledges the oppression of women within a patriarchal society, and struggles toward the elimination of sexist oppression and domination for all human beings. Acknowledging the oppression of women is increasingly more difficult within many Western societies. Affluence and increased opportunities within some sectors of employment or education are often construed as equal access or equity in opportunity for all women. However, oppression is defined as "not having a choice." When this definition is used, many more individuals are able to recognize constraints in their personal experiences, and acknowledgment of oppression in its various forms becomes possible. Examples include a range of extremes from forced marriage, forced sterilization, unfair labor practices, denial of access to pharmaceutical methods of contraception, to not being able to access desired healthcare providers. These ranges of extremes represent the vast breadth of experiences women may have within the context of a patriarchal society that denies equal access to power, resources, and opportunities for women.

Characteristics of a feminist perspective include the use of critical analysis to question assumptions about societal expectations and the value of various roles on both political and individual levels. The process of critical analysis is accomplished by rejecting conceptualizations of women as homogeneous. It acknowledges power imbalances, and uses the influence of gender as the foremost consideration in the analysis. Using a gender lens that is informed by feminism permits areas of disparity to be identified both between groups, based on gender, and within groups, based on the recognition of heterogeneity among women.

Feminism requires exploration of women's health within the context of how women live their lives both collectively and individually within a patriarchal society. The various

TABLE 1-1 Components of a Feminist Perspective in Women's Health

Works with women as opposed to for women
Uses heterogeneity as an assumption, not homogeneity
Minimizes or exposes power imbalances
Rejects androcentric models as normative
Challenges the medicalization and pathologizing of normal physiologic processes
Seeks social and political change to address women's health issues

social, environmental, and economic aspects become integral to understanding the context in which women are able to achieve health and well-being. Furthermore, feminism requires consideration of health, as influenced by the intersection of sexism, racism, class, nation, and gender, within a framework that acknowledges the role of oppression as it affects women and their health as individuals and as a group. **Table 1-1** offers components of a feminist perspective when considering women's health issues or models of care, thereby enabling you to reframe your view of women's health in a feminist perspective.

A Model of Care Based on a Feminist Perspective

A model of care that is based on a feminist perspective contrasts sharply with a biomedical model, particularly in areas of power and control. A feminist model supports egalitarian relationships and identifies the woman as the expert knower. The woman is the center of the healthcare model. The following key points provide further insights into a feminist-based model of care:

1. The model of care must focus on being *with* women, not *doing for* women. This frames the model of care as a partnership with women as opposed to a model of care that is directed by others and then assigned to women through a process of authoritative knowledge being handed down on the assumption that it is correct.
2. Heterogeneity, rather than homogeneity must be used as an assumption. Considerations of "all women," or offering grand theories regarding women, or using broad gender-based assumptions all serve to essentialize women rather than acknowledge the diversity within the larger group that comprises women. An assumption of heterogeneity considers women on an individual basis, tailoring health care and services to each woman's unique needs rather than treating all women as a group with the assumption of similarity across all considerations of health.
3. The feminist model of care must seek to minimize or expose power imbalances that are inherent in most current healthcare models, especially those based on a biomedical model. Power should be distributed equally within the healthcare interaction, and the interaction should be based on a belief in a woman's right to self-determination. There-

fore, the role of the clinician is providing support, information, and skillful knowledge, as opposed to asserting authority over the decision-making ability of the individual.

4. A feminist framework rejects androcentric models of health and disease as normative. The pervasiveness of male-based models being extrapolated and applied to women on the assumption that a woman is merely a biologic variant of man serves to constrain a full consideration of women's health issues. This misapplication of androcentric models to women's health also serves to medicalize or pathologize normal physiologic processes of women such as menstruation, childbirth, and menopause (Lorber, 1997).
5. A feminist perspective challenges the process of medicalization and pathologizing by identifying and exploring women's unique health experiences and normalizing them. Medicalizing is the process of labeling conditions as "diseases" or "disorders" as a basis for providing medical treatment. The medicalization of women's biologic functions, such as menstruation and pregnancy, frequently has been cited as an illustration of both the social construction of the disease and the general expansion of medical control into everyday life (Conrad, 1992; Zola, 1972).
6. A feminist framework acknowledges the broader context in which women live their lives and the subsequent challenges to their health as a result of living within a patriarchal society. It argues for a process of social and political change that would eliminate gender bias and sexism and result in the betterment of all human beings.

The Social Construction of Gender and Health

A discussion of the social construction of gender is provided here as a basis for exploring the value of a feminist framework in understanding women's health. This discussion is followed by strategies to analyze women's health issues from a feminist perspective. As Lorber (1997) notes:

[A]s a social phenomenon, illness has to be gendered because gender is one of the most important statuses in any society. Gender is also socially constructed. Girls and boys are taught their society's expectations of appropriate behavior; they grow up to enact their society's gendered social roles. Gender is a social institution that patterns interaction in everyday life and in major social organizations. (p. 5)

Gender influences which health services are offered, which health risks are identified for an individual, and which treatments are potentially offered at all levels of interaction. While many of these differences might be considered biologically based, a feminist perspective argues that gender and sexism instead are the key components of these differences. **Table 1-2** provides definitions of sex, gender, and biology so that the reader may gain an appreciation of the differences in the terms.

The significance of the social construction of gender is a critical consideration in the process of defining, providing, and receiving healthcare services. "The juxtaposition of gender and illness presents two major problems: sex differences versus gender differences and between group and within group differences" (Lorber, 1997, p. 5).

TABLE 1-2 Definitions of Sex, Gender, and Biology

Sex	The classification of living things as man or woman according to their reproductive organs and functions assigned by chromosomal complement
Gender	A person's self-representation as man or woman or who that person is responded to by social institutions based on the individual's gender presentation. Gender is rooted in biology and shaped by the environment and experience.
Biology	The study of life and living organisms, including the genetic, molecular, biochemical, hormonal, cellular, physiological, behavioral, and psychosocial aspects of life

Source: Adapted from Wizemann & Pardue, as cited in Pinn, 2003a.

Social construction is the process by which societal expectations of behavior become interpreted or ascribed as innate characteristics that are biologically determined. Thus attributes associated with femininity—attributes that are socially expected and, therefore, performed in compliance with social expectations—become confused with innately determined behaviors rather than being recognized as socially constructed behaviors. As a result, health risks, treatments, and approaches to care are not necessarily scientifically or biologically based aspects of women's health, but rather are determined by social expectations that are based on assumptions about gender differences. In addition, diagnoses can be influenced by gendered assumptions regarding behavior or what is socially constructed as feminine behavior. There is significant documentation of such influences affecting the manner of diagnosis and treatment, particularly within the mental health arena (Tavris, 1992) and in the misdiagnosis of women's cardiovascular risk (Healy, 1991).

What becomes evident when the considerations of gender are explored within the context of health is that gender interacts with many of the other variables that are considered factors affecting health outcomes. Women tend to ask more questions, receive more information about their health, and have a more partnership-building relationship with their healthcare providers than men (Xu & Borders, 2003). At the same time, women are more likely to be affected by financial barriers to health care than men. "In particular, women who had lower incomes were consistently less likely to have visited a physician while men were more deterred by nonfinancial barriers to health care such as the length of time in a waiting room" (Xu & Borders, 2003, p. 1077). Women as a group experience greater barriers to obtaining healthcare services compared to their male counterparts.

Poor or low-income women and women who are members of disadvantaged racial or ethnic minorities often obtain fewer or receive different health services compared to more affluent women. Women from disadvantaged backgrounds often experience different risks to their health and have worse health statuses than their wealthier counterparts (Weisman, 1998). In fact, low income predicts who receives health care. Low socioeconomic status is the single most powerful contributor to illness and premature death (Lantz, House, Lepkowski, Williams, Mero, & Chen, 1998). Therefore, while understanding gender differences in the

utilization of healthcare services is important, treating women as a homogeneous group has limitations, particularly when socioeconomic status and racial or ethnic identity are considered.

Nearly 40 million of the 140 million American women alive today are members of racial and ethnic minority groups (Satcher, 2001). Women of racial and ethnic minority groups experience many of the same health concerns as do white women; however, as a group, they are “in poorer health, use fewer health services, and continue to suffer disproportionately from premature death, disease, and disabilities” (Weisman, 1998, p. 11). Racial and ethnic health disparities have been explained by locating the differences in health outcomes in biologic explanations that presume homogeneity among racial and ethnic groups. Biologic explanations focus on biologic solutions rather than exploring the context in which health disparities occur. Today the use of race as a marker for capturing biologic divisions within the population has been challenged scientifically (Williams, 2002).

Our racial categories are more alike than different in terms of biologic characteristics and genetics, and they do not capture patterns of genetic variation well. Thus it is not biologically plausible for genetic differences alone to play a major role in racial or ethnic differences in health. (Williams, 2002, p. 590)

It is not sufficient to explore differences in health issues simply by ethnic or racial identity or simply by gender. Gender interacts with many social causes of health and illness—in particular, age, socioeconomic status, race, and ethnicity (Weisman, 1998). As previously stated, low socioeconomic status is a significant contributor to poor health outcomes, but female gender further increases that risk. It is also evident that women from ethnic minority groups receive lower-quality health care and less health care overall than wealthier, better-educated, higher-status white women (Davis & Huber, 2004). What is missing from this consideration is how socioeconomic status is often used as a proxy to explain racial and ethnic health differences in women's health outcomes. When specific health conditions such as hypertension are explored, socioeconomic status is found to be strongly associated with its prevalence. There are also significant differences in the incidence of hypertension between black and white women, roughly as large as the difference in the incidence of hypertension found in poor black women compared to black women of higher incomes.

According to public health expert David Williams (2002), examples such as these demonstrate the complexity of trying to cast health disparities as being based solely on race or solely on ethnic identity. The intersection of a variety of factors creates complexity when trying to research women's health issues such as health disparities. Williams argues for consideration of the social embeddedness of women's health and the need to attend to additional factors—such as types of medical care, geographic location, migration, acculturation and racism, exposure to stress, and access to resources—when exploring disparities in women's health. Only by incorporating these factors into the discussion can we fully and accurately appreciate the health disparities women experience.

Access to high-quality and culturally appropriate healthcare services is further limited by age and gendered assumptions. Social role differences between men and women are

thought to affect health primarily by influencing access to health-producing resources such as nutrition, shelter, education, paid employment, supportive social networks, healthcare insurance, and healthcare services (Weisman, 1998). The manner in which women negotiate the healthcare system also reflects gendered assumptions that promote differential access to resources, resulting in power imbalances, as opposed to assumptions that would promote equally open and accessible health care across genders.

Gender has important health consequences that are intertwined with cultural values and considerations. An estimated 94 million girls and women are “missing” worldwide as a result of discriminatory treatment that ultimately increases their mortality rate (Klassen & Wink, 2002). To the extent that social and economic resources are differentially allocated by gender, or that gender conceptions vary by subcultural context, specific subgroups of women may have health experiences that are quite different from those of other women (Weisman, 1998). Gender-based cultural rituals or social role expectations can create undue burdens for women and may subsequently lead to increased health risks. For example, being denied access to contraceptive options may create reproductive health risks for some women. The practice of female circumcision carries significant health risks and has long-lasting health implications for some young women (see Chapter 6). Being denied access to education by virtue of gender can decrease economic opportunities, thereby limiting life choices for women. Extensive cultural preoccupation with dieting and thinness may lead to unsafe dieting practices and precipitate eating disorders. When various health conditions are explored, a number of disease states appear to be prevalent among women despite the lack of a clear biologic explanation for them, such as anorexia and bulimia.

Another example of a gender-based health risk is the disproportionate amount of gender-based violence that women experience. Gender-based violence was defined by the United Nations General Assembly in 1993 as follows:

Any action of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life. (Velzeboer, Ellsberg, Arcas, & Garcia-Moreno, 2003)

The multiple health consequences of gender-based violence reveal the long-lasting layers of health consequences associated with a gender-based health risk. (Refer to Chapter 12 for further discussion of this topic.) “Gender-based violence is the most widespread human rights abuse and public health problem in the world today, affecting as many of one out of every three women” (Velzeboer et al., 2003, p. xi).

A Human Rights Perspective on Women's Health

The preceding examples provide evidence of the manner in which the social construction of gender creates undue health risks for women. This burden of risk that women endure has been the basis of addressing women's health disparities from a human rights perspective. A

TABLE 1-3 Human Rights Framework for Safe Motherhood

Rights relating to life, liberty, and security of the person
Rights relating to the foundation of families and of family life
Rights relating to the highest attainable standard of health and the benefits of scientific progress, including health information and education
Rights relating to equality and nondiscrimination on grounds such as sex, marital status, race, age, and class

human rights framework identifies a basic set of rights, regardless of gender, that members of a society should have access to or be guaranteed.

Basic human rights generally refer to respect as a person of worth/value (human dignity), safety or security of one's person, food and nutrition, shelter, privacy, freedom from any form of discrimination, a right to information and education ... and the right to health and equitable access to health and illness services of high quality. (Thompson, 2004, p. 177)

A feminist perspective is in concert with a human rights framework, but would argue that human rights are disproportionately denied to women.

While human rights have been defined within the World Health Organization (WHO) for many years, it is only in the last 20 years that reproductive rights were added to the basic human rights framework. More recently, a human rights framework has been advocated within the context of addressing maternal morbidity and mortality on a global level (Starrs, 1997; Thompson, 2004). Gender equity issues are a more recent consideration (Velzeboer et al., 2003). The goal of using a human rights framework is as follows:

[To] characterize women's multiple disempowerments not just during pregnancy and child-birth but from their own births as a cumulative injustice that societies are obligated to remedy. The re-characterization of maternal mortality from a health disadvantage to a social injustice places governments under a legal obligation to remedy the injustice. (Starrs, p. 9)

Table 1-3 lists the four categories of basic human rights relating to safe motherhood.

Definitions of Health: Social Model Versus Biomedical Model

As the discussion of the social construction of gender and its relationship to health has unfolded, it has become evident that a broader model of health must be employed to address the health consequences of gender bias and sexism and the implications for the overall health and well-being of women. While the use of a human rights framework is congruent with the components of a feminist framework, again the acknowledgment of gender equity has been limited and less transparent in its application to models of health. Furthermore, our

ability to hold governments accountable for a human rights framework remains in its infancy in regard to its application to the health rights of women (Starrs, 1997; Thompson, 2004; Velzeboer et al., 2003). A feminist framework encourages grassroots activism to promote acknowledgment of women's need for greater access to human rights and, therefore, provides an opportunity for increased awareness related to gender-based health disparities.

The first step in broadening the model of health requires redefining "health." *Health* is biomedically defined as the absence of disease. Of course, this narrow definition does not address the context in which the absence of disease may occur. As feminist health advocates note, "No single or singular view of women's health will adequately reflect the complexities of women's lives, although dominant biomedical models are often taken to represent 'all of women's health'" (Ruzek, Olsen, & Clark, 1997, p. 12). It is argued that the dominance of the medical model must be challenged in an effort to broaden the opportunities to understand this complexity within the healthcare system, health research, and the experiences of health within the individual and the collective community. The biomedical model, however, does not address health beyond an individual perspective.

An alternative to the biomedical definition of health is the definition developed in 1946 by WHO: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This broader definition is based on some assumptions of what must be present to secure health for individuals and the community in which they live. At least the following prerequisites must be in place before health can occur:

- Freedom from the fear of war
- Equal opportunity for all
- Satisfaction of basic needs for food, water and sanitation, education, and decent housing
- Secure work
- Useful role in society
- Political will
- Public support (Ruzek et al., 1997, p. 14)

Germane to this definition is WHO's commitment to address social injustice, equity, economic development and opportunity, and accessibility of healthcare services as a basic human right for all individuals in any society (Tejada de Rivero, 2003). The WHO definition of health requires that the community and environment in which women live their lives must also be considered in the same context as a new medical procedure. The constraints of an individualistic, disease-only focused biomedical model of health become readily apparent when WHO's broader context and definition of health are considered.

An alternative to the biomedical model that is more congruent with a feminist perspective is the social model of health. The social model of health places the focus of health on the community, rather than on the individual. There is then an opportunity to focus on health disparities that are rooted in the social and cultural forces that affect how women live their

lives. “Developing more inclusive models of health requires recognizing and dealing with complexities and differences in women’s lives. Educational levels, income, culture, ethnicity, race and a host of other identities and experiences shape women’s lives” (Ruzek et al., 1997, p. 20).

The interconnectedness of working and living conditions, environmental conditions, and access to community-based healthcare services becomes a focus when health and well-being are framed within a community context. Questions about health and well-being for an individual hone in on these factors as well as lifestyle decisions and health habits. The prevention of health problems becomes both a social burden and an individual responsibility. This wider emphasis forces greater consideration of the various social factors that can either create or destroy an individual’s health (Ruzek et al., 1997).

A social model of health also requires asking questions about the health effects of socially situated factors such as racism, sexism, and other forms of oppression. Consideration of women as central to the health model, rather than marginal to it, is a requirement of the feminist social model of health care. The broader social models do not ignore biologic or genetic components of health, nor is the significance of individual lifestyle health habits denied. However, the broader social model frames these issues as important to health, but no more so than women’s experiences within everyday life, their access to healthcare services, their socioeconomic status, their racial and ethnic identity, and their membership within a community (Schiebinger, 2003).

The health risks associated with the social construction of gender and the inequities associated with gender-based assumptions are essential components of the feminist social model of health. As links are forged between human rights, social models of health, women’s health disparities, and opportunities to address those disparities, a feminist perspective offers new strategies and ways of thinking or asking questions that can promote expanded approaches to women’s health issues.

Women’s Health from a Feminist Perspective

Several aspects of analysis are important when considering women’s health from a feminist perspective. The following strategies for analyzing women’s health using a feminist framework are adapted from Franz and Stewart’s (1994) strategies for conducting feminist research. Each of the strategies listed in **Table 1-4** can be used as a question to ask about women’s health issues. Taken together, they constitute a feminist lens that allows for new considerations to arise as health issues are reframed. The following discussion highlights the manner in which some of the strategies can be applied.

Look for What Has Been Left Out or What We Do Not Know

This strategy is particularly applicable to investigations into the scientific basis of women’s health. Much of what we know about women’s health needs, outside of reproductive health, is historically based on androcentric models of men’s health considerations (Rosser, 1994;

TABLE 1-4 Strategies for Analysis of Women's Health from a Feminist Perspective

Strategies	Questions
Look for what has been left out or what we do not know.	<ul style="list-style-type: none"> • What do we know, how do we know it, and who knows it? • Why don't we know? What do we want to know and why? • Who determines what is left out or who has access to what we want to know?
Analyze your own role or relationship to the issue or topic.	<ul style="list-style-type: none"> • Is it personal? Is it political? • Are you objective and removed, or engaged and subjective? • Are you invested in the outcome or topic or not? • Why do you care about the issue?
Identify women's agency in the midst of social constraint and the biomedical paradigm.	<ul style="list-style-type: none"> • Are woman really victims or are they acting with agency? • Are individuals making choices despite positions of powerlessness? Are the choices allowing individuals to remain in control or do they allow for some form of power in the context of the situation?
Consider the social construction of gender and how its assumptions may limit options or presume choices made within the context of health. This includes the social construction of health itself.	<ul style="list-style-type: none"> • What is defined as a health problem or concern? • Explore assumptions about the value of anatomy such as breasts or facial appearance. • Ask the question: "Would this health issue be defined or explored in the same manner if it primarily affected men or women?"
Explore the precise ways in which gender defines or affects power relationships and the implications of those power dynamics in terms of health.	<ul style="list-style-type: none"> • Doctor/nurse • Doctor/patient • Parent/adolescent • Husband/wife • Parent/child • Father/daughter • Married woman/single woman • Lesbian/heterosexual
Identify other significant aspects of an individual's or group's social position, and explore the implications of that position as it relates to health issues.	<ul style="list-style-type: none"> • Consider examples such as an adolescent who is seeking reproductive healthcare services or a same-sex couple seeking fertility services. • Ask who has access to what forms of healthcare services and resources and who does not. • Consider the intersections of race, class, gender, sexuality, and socioeconomic status. • Who has a choice, what constitutes a choice, and who is able to exercise their right to choices within the context of health?
Consider the risks and benefits of generalizations and speaking in terms of groups versus individuals.	<ul style="list-style-type: none"> • Who are "we" or "all women"? Are "all women" the same? • When is coherence or consistency the goal compared to diversity in the health care consideration or experience? Which reflects reality most accurately? • When "grouping" occurs, who is missing from the group or who might not be reflected in the group process?

Source: Adapted from Franz & Stewart, 1994.

Tavris, 1992). Almost all medical research (until recently) that was not related to gynecology was conducted in male participants (human and animal), with the findings then being generalized to women. Large-scale investigations focusing on health promotion have been based primarily on study populations composed of only men. This practice persisted until well into the 1990s (Schiebinger, 2003).

According to feminist scientist Londa Schiebinger's analysis, many common health promotion measures have been assumed to be true for both men and women despite the fact that the evidence supporting the measures came from research in which the study populations were composed of only men. Examples of such studies include the Physician's Heart Study, in which the findings led to recommendations on the use of aspirin to prevent heart disease, and the Multiple Risk Factor Intervention Trial, which evaluated correlations between blood pressure, smoking, cholesterol, and heart disease. The research populations in these studies were composed of only men. In fact, one of the first studies to investigate the use of estrogen for heart disease was conducted on a study population consisting of only men (Schiebinger, 2003)!

Research agendas often reflect a societal bias that favors powerful, white, middle- to upper-class men in the United States (Rosser, 1994). Similarly, although most large-scale research trials have focused on or recruited primarily from this population for their research participants, most of the scientific members of the team would arguably claim lack of awareness of the inherent sexism in these study designs (Schiebinger, 1999). "Reforming certain aspects of how medical research is conducted with respect to females required new judgments of social worth and a new political will" (Schiebinger, p. 973).

The lack of representation of women in research trials extended through 1988, when clinical trials of new drugs were routinely conducted predominately on men—even though women consume approximately 80% of pharmaceuticals in the United States (Schiebinger, 2003; Wood, 2001). What was left out? Considerations of women's biologic variations in processing drugs! We now know that acetaminophen is eliminated in women at 60% of the rate at which this drug is eliminated in men. This finding obviously has gender-related implications for prescribing dosage regimens (Schiebinger).

Examples abound of the problematic manner in which the scientific base for women's health, beyond that of reproductive health, was initially developed. Even when positive study examples are cited, limitations were often present in the design of the studies. Many key women's health studies, such as the Framingham Heart Study and the Nurses Health Study I and II, were either observational or epidemiological investigations instead of randomized clinical trials, even though the latter design has long been considered the gold standard for investigative research (Schiebinger, 2003). Clearly, women were being left out of the scientific understanding of many health issues that directly affected them.

Consumer health advocates, women's health activists, and members of the scientific community have been instrumental in coming together to address the many limitations concerning women's health care and scientific investigations of women's health issues. In 1993, the National Institutes of Health (NIH) Revitalization Act was considered a milestone in this regard:

[The act required that] women and minorities and their subpopulations be included in all NIH-supported biomedical and behavioral research, in phase III clinical trials in numbers adequate for valid analysis of differences, in intervention effects, and that cost not be the basis for exclusion, and that there needed to be support for outreach programs to recruit these individuals for clinical trials. (Schiebinger, 2003)

As a result of this policy change, the next decade saw a significantly greater inclusion of women and minorities in research investigations. Asking “what had been left out” or “what was missing” provided an opportunity to alter what had been left out of women’s health research. Even though much has been achieved, critics continue to call for continued innovation in medical theories and practice in this field (Ruzek et al., 1997; Schiebinger, 2003).

There is an ongoing need to employ this strategy to expose blind spots in what is being presented under the rubric of women’s health. An example can be found in the current focus on heart disease in women. Heart disease is now the number one killer of women in the United States. It has been argued that at every step in the healthcare process related to cardiovascular disease, from identification of symptoms to diagnosis, treatment, and referral, gender differences abound. Johnson, Karvonen, Phelps, Nader, and Sanborn (2003) reviewed the literature regarding cardiovascular disease and found 30 systematic reviews. The limitations identified in the studies focusing on women and cardiovascular disease gave rise to the conclusion that there were not enough large-scale clinical trials or meta-analyses focusing on cardiovascular disease in women. The need to explore this disease process in women becomes even clearer when the question of “what has been left out of prior studies” is asked. The answer can help frame new ways to address this health condition. Rather than accepting the inappropriate misapplication of findings to women when the research was conducted only in men, researchers are being charged with exploring new avenues of research and new ways of asking the research question.

Analyze Your Own Role or Relationship to the Issue or Topic

Traditionally, the focus of women’s health has been relegated to “between the breasts and the knees.” Pregnancy and childbirth were long the focus when it came to health care of women, if only as a means of securing the survival of human society. The value of women was based on their role in procreation and continuation of the citizenry. Many historical examples can be cited to illustrate how a focus on reproductive health created opportunities to promote maternal and child health reforms in the public health arena. In such cases, women typically took advantage of the focus on reproductive health to advance an agenda that addressed both maternal and child health. At the same time, the practice of focusing solely on reproductive health carried risks, as it enabled normal physiological reproductive processes to be medicalized within a biomedical context.

In response to the practice of medicalizing aspects of women’s health and traditional models of women’s health care, consumer activism by women has been directed at reframing women’s health and calling for reforms at even the most basic levels. The strategy of analyzing your own role or relationship to the issue may help reveal the role women play in

relation to the process of rejecting medicalization of many of the normal healthy physiologic processes they experience. Over the years, various aspects of women's health have become topics of public debate and of organized social action; taken together, these episodes could be considered waves in a women's health mega-movement (Weisman, 1998).

In recent decades, two notable waves have occurred in the women's health mega-movement. One wave coincided with social action movements such as the civil rights and women's rights movements. A key feature of this wave was that it was grassroots oriented, with a key focus on access to information and expanded knowledge regarding health. One outcome of this movement was the creation of the Boston Women's Health Book Collective (BWHBC) and its publication of *Our Bodies, Ourselves* for consumers in 1974. The BWHBC is composed of women who are healthcare consumers. They developed a consumer-oriented women's health textbook through a process of conducting individual research related to women's health. During this period, primary access to health-related information was available only through medical textbooks.

Eventually, a second wave emerged from the first—namely, the opportunity for women to reclaim control of their health and to offer new definitions or ways of thinking about physiological processes. A key aspect of this process, which continues to this day, is demystifying health conditions and processes in an effort to empower women with knowledge so they can ask questions about their health and pose these questions to their healthcare providers. This change supported women in taking responsibility for their healthcare decision making rather than simply adhering to the biomedical model of the 1960s and 1970s, which placed authority for decision making under the control of the healthcare provider.

This wave of reclaiming control of health care from clinicians and focusing on women's role and authority over their own health was initially promoted by well-educated women from middle- and higher-income groups. A critique of this wave of the women's health movement reveals that it generalized women's health issues as a global consideration that included ethnic and cultural variation. In response, women's health groups were organized based on ethnic and cultural considerations related to women's health.

Consider the Risks and Benefits of Speaking in Terms of Groups Versus Individuals

The strategy of “considering the risks and benefits of speaking in terms of groups versus individuals” addressed a problematic aspect of the women's health movements of the 1960s and 1970s. In an effort to be inclusive, many advocates of the women's health movement during this period claimed to be speaking collectively for all women—yet the primary focus and emphasis were on women who were privileged in society, rather than women who were marginalized. Schiebinger (2003) summarizes the progress of the women's health movement since then as follows: “Whereas the women's health movement of the 1970s sought to solidify sisterhood through the commonalities of female childbirth experiences, there is now an emphasis on the differing health needs of different racial and ethnic groups of women” (p. 974). Today, women's health activists demonstrate greater diversity and focus on a wider

range of issues affecting the health of women and their families. This also includes attention to ageism, which was inherent in much of the earlier waves of the women's health movement (Pohl & Boyd, 1993).

Consider the Social Construction and Gender and How Its Assumptions May Limit Options or Presume Choices That Are Made Within the Context of Health

Earlier discussions regarding the social construction of gender highlighted the implications of this strategy. An additional aspect to consider is the manner in which women's health issues are described—that is, the terminology used. The language used for many of women's health concerns has been described by anthropologist Emily Martin (1992) as reflecting an androcentric bias—for example, the image of menstruation in medical texts is that of “failed reproduction” (p. 92).

Another example is the practice of referring to a woman who has experienced sexual assault as a “victim” rather than as a “survivor” of the process, implying inherent weakness rather than strength. Descriptions of childbirth usually invoke the term “delivery” or a woman “being delivered” rather than “giving birth.” The former terms focus on the actions of the healthcare provider and place the woman in a passive position, rather than seeing her as the central figure: the one giving birth.

Explore the Precise Ways in Which Gender Defines Power Relationships and the Implications of Those Power Dynamics on Health

Creating health care from a feminist perspective requires the elimination of power differentials between the individuals who are consuming health care and the individuals who are providing it. A partnership model more accurately reflects the manner in which healthcare interactions should occur. In this model, rather than invoking a level of authority by virtue of being a healthcare provider, the healthcare provider acknowledges the life experiences and knowledge that the individual brings to the interaction. What makes a practice “feminist” is not who provides the health care, but how that care is provided, how the clinician thinks about his or her work, and the populations with whom the clinician works (Brown, 1994).

While hierarchical relationships and structures are typically elements of the traditional healthcare delivery system, feminist practice requires an active process of action to eliminate asymmetrical relationships. Simple actions, such as not having a woman undress prior to meeting her clinician, allow the woman to greet the healthcare provider as an equal rather than from a vulnerable position, undressed and wrapped in an ill-fitting paper gown. Having a woman check her own weight and urine, as opposed to having someone else do this for her, places some accountability for health on the woman's shoulders. It gives the message that she can control aspects of her health. Although these simple changes can be readily made in the healthcare office setting, each demonstrates power sharing rather than placing

the woman in a dependent position in relation to aspects of her health care that she should rightly control.

Each of the strategies discussed in this section provides an opportunity to consider the details as well as the global aspects of women's health care and women's health issues. The strategies can be applied both individually and collectively. They are not meant to be an exhaustive checklist to determine whether something is being considered from a feminist perspective, but rather are meant to serve as guidelines and considerations that allow for the identification of blind spots in how we are able to think about women's health issues when we are potentially constrained by the limitations of the biomedical model. Through the use of these strategies, healthcare providers, policy makers, and women themselves are able to reframe expectations, approaches, and the focus of women's health research, healthcare delivery, and even the receipt of healthcare services.

Why a Textbook on Gynecology?

Taking the same feminist strategies we use for analyzing women's health and applying them to this textbook on gynecologic aspects of women's health creates opportunities as well. Why, when a feminist perspective is being presented, along with the limitations of considering women's health as being equivalent to reproductive health, would a textbook purportedly using a feminist framework focus only on gynecologic aspects of women's health? The reason is that gynecologic health is still important. Focusing on gynecology for clinicians is important because reframing and expanding considerations of gynecologic health from a feminist perspective may more accurately reflect the experience for women in their everyday lives. By offering a feminist perspective throughout the chapters, we seek to dispel myths that pathologize normal gynecologic functioning, and we seek to support normality as opposed to medicalizing it. Rather than ignoring gynecologic health and allowing it to remain within the biomedical domain, this textbook seeks to reframe aspects of gynecologic health issues within a feminist framework. This perspective expands the opportunities for understanding gynecologic health from within a wellness-oriented, women-centered framework and encourages providers to look beyond the medical model and support normalcy instead of "manage" it.

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