Chapter 1

The Dimensions of Women's Health

LEARNING OUTCOMES

On completion of this chapter, the learner will be able to:

1. Explain the multiple dimensions of women's health.
2. Analyze the diversity of women's health needs over the life cycle and how these needs reflect differences in race, class, ethnicity, culture, sexual preference, levels of education, and access to health care.
3. Explain the historical background of the women's health movement.
4. Describe the advances made in reproductive rights, women's health research, and the political dimensions of women's health.
5. Distinguish barriers to access of adequate healthcare services, providers, and health information encountered by women.
6. Discuss the economic, social, cultural, and political factors that influence women's health throughout the world.
7. Distinguish priority health issues on the global agenda of women's health.

Introduction

The paradigm of women's health is a multifaceted, complex area encompassing practice, education, and research. Women's health concentrates on the physical, psychosocial, political, and economical well-being of women. Women's health facilitates the prevention of illness and the maintenance of wellness through screening, diagnosing, and managing conditions that are unique to women, are more common in women, are more serious in women, and have manifestations, risk factors, or interventions that are different for women. In essence, women's health includes the values and knowledge of women and their own experiences of health and illness (Donoghue, 1996).

Women's health acknowledges the diversity of women's health needs over the life cycle and how these needs reflect differences in race, class, ethnicity, culture, sexual preference, levels of education, and

access to health care (Donoghue, 1996). It emphasizes multidisciplinary team approaches to the health care of women and strives for the empowerment of women, as for all patients, to be informed participants in their own health care (Donoghue, 1996).

Women's health includes the study of disease as well as factors that enhance women's well-being and quality of life. It encompasses the entire body and brings to focus the simple recognition that men and women have some fundamentally different health needs and that women's health needs must be pursued in their own right (Office on Women's Health [OWH], 2002). Women's health is based on the study of biological characteristics distinctive to women, the most apparent being reproductive organs, but also differences in body structure, hormones, and brain chemistry. As such, women's health recognizes the importance of the study of gender differences as well as consideration of gender similarities.

Countless factors influence the ways women develop, sicken, recover, interact with others, reproduce, age, and receive health care. A variety of sociocultural issues impact women's health. Women's place in society influences the occurrence of sexual violence. Sociocultural issues affect women's entry into the workforce as well as the type of workplace they encounter. Women's ability to obtain and benefit from health care is also affected by sociocultural issues. Access to health care has emerged as an essential factor in women's health and an important priority in the research agenda. Access to health care includes physical accessibility to healthcare providers as well as the ability to trust providers, pay for health care, understand their health care, negotiate the healthcare system, and know if and when a health problem is developing. The issue of access to health care and healthcare decision making is especially important because women are more likely than men to make healthcare decisions for themselves and their families.

A full understanding of women's health requires biological, cultural, historical, social, and political perspectives. Frequently these perspectives uncover gender disparities whereby discrimination and unequal treatment threaten the lives and well-being of women in numerous ways. Feminism—the belief that women are entitled to the same political, economic, and social rights and opportunities as men—provides an essential viewpoint for the health and health care of women. The aim of a feminist viewpoint is to not only change how health care is delivered to women but to achieve social transformation. Social transformation involves attaining balance in provider–patient relationships, access to information, shared decision making, and striving for societal change (Andrist, 1997).

Historical Background of Women's Health

The 19th and 20th centuries were periods of extraordinary developments in women's health initiated by multiple waves of women's health movements. In order to understand the dramatic changes that have affected women's health throughout this stretch of time, it is essential to examine the social and cultural context that led up to and then underscored the resultant changes. The definition of women's health has evolved over time. Crucial to this evolution has been the shift of goals and perspectives of the advocates of women's health to reflect changing social mores and economic conditions. The dramatic changes in women's health that spanned the 19th and 20th centuries have produced a current level of health care that has nearly doubled the life span of women (OWH, 2002).

The Popular Health Movement

In the 19th century, industrialization brought changes in social and family structure that saw a decrease in the burden of women's work at home,

increased access of women to obtaining an education, a decrease in birth rates, and an increase in life expectancy. Populations shifted to cities where workers were pulled outside the home for employment. Initially women and children joined the labor force outside the home but this trend decreased as women became increasingly excluded from the workforce and were economically dependent on men to provide basic goods. During this period, physicians took control of medicine and ushered in an age known as "Heroic Medicine." Throughout this era, physicians (nearly all male) steered medicine away from the services of midwives, homeopaths, herbalists, and traditional healers of the times (many of whom were women) and used a variety of painful and intrusive procedures such as bloodletting, purgatives, surgery, and blistering (Geary, 1995).

Between 1830 and 1870, the Popular Health Movement arose in backlash to heroic medicine and physicians' efforts to discredit traditional practitioners. Activist groups consisting of middle-class women and working-class radicals advocated for education on physiology, nutrition, hygiene, self-determination, hydrotherapy, and disease prevention (Geary, 1995). Healthy lifestyles were advanced in order to avoid disease and the need for physicians. Elimination of the corset and other restrictive clothing, eating a healthy diet, the benefits of physical exercise, and limiting family size (through abstinence of marital relations) were also encouraged. The Popular Health Movement succeeded in reviving traditional types of healing and in promoting women as providers of medical care.

The Women's Medical Movement

The later part of the 19th century saw the emergence of the second wave of advocacy for women's health in the embodiment of the Women's Medical Movement. This era saw the creation of medical schools for women and women's hospitals in which women were able train and practice as physicians. Female physicians faced much difficulty being accepted by male physicians as well as patients of both genders and found more opportunities for acceptance in rural and frontier environments, where physicians were scarce. The first nursing schools opened in the late 1800s, admitting both men and women. Men dominated the field of nursing in the military and in the southern part of the country, but over the course of the 20th century nursing became professionalized and evolved into a predominantly female field. Consequently, it retained less status and lower pay as compared to other male-dominated medical professions (OWH, 2002).

The Women's Medical Movement challenged prevailing medical views that women were fragile, sickly, and prone to hysteria that was controlled by their reproductive organs. Popular medical beliefs associated female hysteria to a biological disposition that was deemed inferior, even pathological, coupled with advanced education that was thought to undermine normal female development. Thus, women were advised to not pursue education, in order to restore acceptance of their femininity (Geary, 1995). Female physicians challenged this view of women by advocating education, exercise, and useful work for women as well as supporting women's right to control their fertility by limiting marital sexual intercourse. Female physicians also espoused a special rapport with female patients that made them uniquely qualified as healthcare providers of women and children (OWH, 2002; Weisman, 2000).

The Progressive Era

The Progressive Era of 1890 to 1930 advanced the roles of women and women's rights as well as women's health. Not only did women gain the right to vote in 1920 through passage of the 19th Amendment to the U.S. Constitution, this period ushered in the third wave of advocacy for women's health. Two separate and often antagonistic movements

supported the creation of specific health services for women. One group of reformers consisting of white middle-class women, nurses, and female physicians from the Settlement House Movement raised public awareness regarding infant and maternal mortality at a time when national statistics were not available and prenatal care was not part of standard medical practice. These advocates influenced public policy in gaining the passage of the Sheppard–Towner Maternity and Infancy Act of 1921. This was the first federal program for the health care of women and children that established publically funded child health clinics, home visits by public health nurses, and nearly 3,000 local prenatal care clinics staffed predominantly by nurses and female physicians (Weisman, 2000).

During this time, the second group of activists advocated for the legalization of birth control. Contraceptives were not widely available to women, especially women who were poor, unmarried, and generally lacked access to private physicians. The Cornstock Law of 1873, the Act for the Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use, made it illegal to distribute information about birth control. Margaret Sanger was a nurse and social reformer who, with other advocates, challenged the Cornstock Law by disseminating birth control information and supplies. Sanger founded the first, although illegal, birth control clinic in 1916 and over a period of years established a nationwide network of family planning clinics to provide contraceptive counseling and methods to women who did not have access to private physicians. The clinics were privately funded by wealthy women and foundations, and staffed by nurses and women physicians (OWH, 2002; Weisman, 2000).

The Grassroots Movement

The fourth wave of advocacy for women's health occurred during the 1960s and 1970s when grassroots organizations led by women who were college educated challenged the authority of the nearly all-male medical profession in the delivery of health care to women, with resultant exposure of medical biases against women. Women were being excluded from making decisions about their own health care, and mainstream healthcare institutions were deemed unresponsive to women's specific needs and unwilling to engage women as partners in their healthcare decisions (Weisman, 2000). The movement advocated for reforms from a feminist perspective in areas such as unnecessary hysterectomies and cesarean sections, abortion, postpartum depression, and childbirth conditions. Women-specific alternatives were introduced, including abortion clinics, women-controlled health centers such as self-help gynecologic clinics and feminist women's clinics, and freestanding birth centers and other alternative childbirth practices (Weisman, 2000). The self-help manual *Our Bodies, Ourselves* was published in 1970 and contained validated information on issues such as heterosexuality, lesbianism, nutrition, birth control, abortion, childbearing, menopause, exercise, sexually transmitted diseases, self esteem, relationships, and the healthcare system (Geary, 1995). Written for women by women who were not medically trained, its goal was to teach women about their bodies and recognize the value of their personal experiences with the healthcare system. The book challenged women to be active in their own health care and to be critical consumers (OWH, 2002).

Women's admission to medical schools other than women's medical schools was severely restricted by quotas such that by 1960 only 7% of physicians were women. A gender discrimination suit against some medical schools in 1970 and a provision of the 1972 Civil Rights Act that prohibited gender discrimination in educational institutions paved the way for unrestricted admission of women to medical schools (OWH, 2002). Additional legal reforms gave greater rights to women, such as access to oral contraceptives,

protection against employment discrimination, and equal funding for men and women in school athletic programs. Also, the Women's Health Movement had been led by white middle-class women for decades. During this period, the movement became more enriched by the inclusion of women of diverse ethnic and racial backgrounds and was joined by women's health organizations that represented African American, Latina, Asian, and Native American women. In addition, organizations that represented older women and women with disabilities joined the Women's Health Movement to advocate for their health needs.

Gains and Setbacks of the 1980s

The liberal political environment of the 1970s encouraged the Women's Health Movement to flourish and make significant gains in addressing the health needs of women. With the advent of an increasingly conservative political environment in the 1980s, setbacks in the area of reproductive rights were experienced. Anti-abortion activists attacked legalized abortion. Violence toward feminist health clinics caused many to close. In 1989 the Supreme Court handed down the Webster v. Reproductive Health Services decision, which placed increased restrictions on abortion (Nichols, 2000).

In spite of the setbacks that occurred with reproductive rights, this period saw progress with the establishment of federal task forces and agencies that were charged with the responsibility of ensuring that women's health needs were met. The Task Force on Women's Issues was formed by the U.S. Public Health Service in 1983 to ensure that women's needs were being addressed, to report on this, and to make recommendations for change. The major findings of the task force were that women were dissatisfied with current access to information and quality health care; concern that women's health was a function of the social, cultural, and economic environment; and a lack of attention by physicians to the mental health aspects of physical disease. Major recommendations of the task force were for expansion of research to address problems unique to or prevalent in women and to increase research on contraceptive technologies for women and men (Nichols, 2000).

The National Institutes of Health (NIH) adopted a policy in 1986 that required inclusion of women in clinical research. By 1989, women leaders at the NIH found that research in women's health continued to be neglected. The Congressional Caucus for Women's Issues and Henry Waxman (D-California) requested a formal investigation of NIH research by the General Accounting Office. The investigation revealed that women were still excluded from clinical studies, and a mere 13.5% of NIH monies went toward women's health research. Furthermore, diseases that affected women disproportionately were less likely to be studied, women were more likely to be excluded from clinical trials, and women were less likely to be principal investigators conducting clinical trials. While the evidence did not suggest that women were being systematically excluded from biomedical research, the evidence did indicate that women were excluded from some studies and that the numbers of women included in studies were inadequate to detect gender differences (Nichols, 2000).

Bringing Women's Health to the National Agenda

The 1990s brought a fifth wave of advocacy for women's health, which was led by women in government, academia, medicine, and women's health advocacy and interest groups. Attention was drawn to gender inequities in society's investment in biomedical research and focused on increasing government support for women's health research and services beyond reproductive issues (Weisman, 2000). Funding for women's health research in areas such as heart disease, breast cancer, and

aging processes was increased by the NIH. Policies and guidelines within the NIH were changed to include women in clinical studies. Moreover, new federal offices were created to expand the infrastructure to coordinate a women's health agenda (Weisman, 2000). The Office of Research on Women's Health (ORWH) was established in 1990 as part of the NIH in order to verify that NIH research addressed women's health needs and the inclusion of increased numbers of women, including women of racial and ethnic minorities, in clinical trials. The ORWH developed a women's health research agenda. Furthermore, the ORWH designed the Women's Health Initiative study, which was a 14-year multisite investigation of postmenopausal women that focused on the efficacy of hormone replacement therapy, diet, and exercise on coronary heart disease, breast and colon cancer, and osteoporosis (Nichols, 2000).

During this period, two other federal agencies were actively involved in women's health research. The FDA removed restrictions excluding women of childbearing potential from participating in early phases of drug testing and revised guidelines requiring sex-specific analyses of drug safety and efficacy. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) initiated screening programs for chlamydia in women and their partners, and designated Papanicolaou smears and mammography screening for underserved women (Nichols, 2000). In 1994, the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) created the Office of Women's Health to provide advocacy, guidance, leadership, and coordination of policy, programs, and activities associated with women's health both within and outside the CDC/ATSDR (U.S. Department of Health and Human Services Centers for Disease Control and Prevention [CDC], 2010).

A powerful lobby has been created by the activists in the Women's Health Movement. This lobby has alerted legislators and the public regarding the inequities that exist in women's health care. Consequently, the efforts of the lobby have been successful in making women's health an important public and political concern that commands responses from leaders in public policy, medicine, research, and government. Widespread changes from local to federal levels have been achieved (Nichols, 2000).

Women's Health and the New Millennium

The new millennium has brought many improvements to the health of the public such as findings from the Women's Health Initiative study, improvement in medications for treating HIV/AIDS, inclusion of children in clinical trials, and public health programs that target behavior-related health problems. Nevertheless, women still face many difficulties in the healthcare arena. Setbacks have occurred in advances made in the 1990s, including curtailment of funding for domestic and international reproductive health initiatives and politicizing of the women's health agenda. Millions of Americans lack health insurance or are underinsured. Women are living longer but not necessarily with a better quality of life. Unhealthy behaviors such as smoking, lack of exercise, poor diet, overeating, alcohol abuse, illicit drug use, and unsafe sex continue to threaten women's health and increase their risk of disease. Women across the United States and around the world continue to be victims of individual and societal violence.

The Role of Government in Women's Health

Federal Agencies That Promote Women's Health

The federal government plays a significant role in protecting and promoting women's health.

Through direct and indirect means, the government exercises control over many areas that influence women's health. Actions such as ensuring a safe food supply and regulating companies that provide medications to the public can impact on the maintenance of wellness in women.

During the 1990s, federal agencies and organizations devoted to women's health were established. The Office on Women's Health of the Department of Health and Human Services (DHHS) was established in 1991 and serves as the coordinating agency for all women's health initiatives throughout the agencies and offices of the U.S. DHHS, including the NIH, FDA, and CDC. The OWH also collaborates with nonprofit organizations, consumer groups, associations of healthcare professionals, tribal organizations, and state, county, and local governments. The goals of the OWH are to develop and impact national women's health policy; to develop, adapt, and replicate model programs on women's health; and to educate, influence, and collaborate with health organizations, healthcare professionals, and the public. The OWH provides leadership to promote health equity for women and girls through sex /gender-specific approaches. The OWH develops innovative programs, educates health professionals, and motivates behavior change in consumers through the dissemination of health information (OWH, 2013).

The ORWH functions as a focal point for women's health research at the NIH. The ORWH coordinates women's health research funded by the NIH and advises the NIH director and staff on matters relating to research on women's health. This office works in partnership with the NIH institutes and centers to ensure that women's health research is part of the scientific framework not only at NIH but throughout the scientific community (Office of Research on Women's Health [ORWH], 2015). The ORWH has been vital in national and international efforts to make women's health research part of the scientific and educational infrastructure. Moreover, the ORWH works with scientists, practitioners, legislators, and lay advocates to identify research priorities and set a comprehensive research agenda.

The ORWH strengthens and enhances research related to diseases, disorders, and conditions that affect women and supports research on women's health issues. The ORWH also promotes, stimulates, and supports efforts to enhance the health of women through biomedical and behavioral research on the roles of sex (the biological characteristics of being female or male) and gender (the social influences based on sex) in health and disease. Furthermore, this office ensures that research funded and supported by the NIH adequately addresses issues associated with women's health and ensures that women are appropriately represented in biomedical and behavioral research studies supported by the NIH. The ORWH develops opportunities for and supports recruitment retention, re-entry, and advancement of women in biomedical careers (ORWH, 2015).

The DHHS has implemented programs to provide for family planning, prevent sexually transmitted diseases, and reduce unintended pregnancies. The Title X Family Planning program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. This program assists individuals in determining the number and spacing of their children in order to promote positive birth outcomes and healthy families. The Title X program provides access to contraceptive services, supplies, and information to women and men who want and need them. Priority for services is given, by law, to individuals from low-income families. Services are provided through a network of federally funded community-based clinics that include state and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies.

Approximately 75% of U.S. counties have at least one clinic funded by Title X that provides services as required under the Title X statute (Office of Population Affairs [OPA], 2015).

Title X provides funding for preventive services such as patient education and counseling, breast and pelvic examinations, breast and cervical cancer screening according to nationally recognized standards of care, pregnancy diagnosis and counseling, as well as sexually transmitted disease and HIV prevention, education, and counseling. Title X funding also supports training for family planning clinic personnel, data collection and family planning research aimed at improving delivery of services, as well as information dissemination and community-based education and outreach activities. Title X, by law, does not fund programs where abortion is a method of family planning (OPA, 2015).

Political Perspectives of Biomedical Research

The federal government plays an essential role in funding biomedical research. The NIH is responsible for distributing funds to private and public institutions and organizations for the purpose of conducting medical and health research. Along with the CDC and other agencies, the NIH advances basic research for the discovery of new and better methods of treatment and prevention of numerous health conditions. Funding for biomedical research is also provided by the private sector, philanthropic organizations, universities, and voluntary health agencies. Millions of dollars are invested each year by pharmaceutical companies and private corporations in order to develop new drugs, vaccines, and technologies. Such investments in biomedical research and technologies have produced advances that have increased life expectancy, improved health throughout the lifespan, and in many cases, decreased the cost of illness.

Nonetheless, discoveries of new medicines and technologies are not the only way to improve health. Approximately half of the mortality in the United States is directly or indirectly caused by unhealthy behavior choices. Research can also indicate better ways to educate people about basic measures to maintain health, such as disease prevention, eating a healthy balanced diet, exercising, maintaining a healthy weight, and avoiding tobacco and other drugs. Research on healthy behavior choices offers the potential to improve the health of millions of Americans. Promoting healthy behavior choices and the prevention of diseases are less costly, more efficacious strategies than intervention after diseases have occurred. Unfortunately, the funding for preventive programs is outdistanced by the funding of pharmaceuticals or technologies that promise the next "miracle cure" or, for the shareholder, the next source of revenue.

Research on women's health has witnessed unprecedented growth, especially in response to the inclusion of women in clinical trials. The inclusion of women in clinical trials has enabled both women and men to become the studied models for the conditions that affect them and the drugs used to treat these conditions. This trend has led to the integration of women-specific data into clinical practice and the formulation of new questions concerning women and particular diseases.

Gender-based research is research that examines the similarities and differences between women and men to learn more about the causes of disease and responses to medication. Gender-based studies identify and examine the biological and physiological differences between women and men. Females and males can manifest different symptoms of a disease, experience the course of a disease differently, or respond in dissimilar ways to pharmaceuticals. Identification and examination of gender-based differences offers a significant potential for understanding disease epidemiology and health outcomes for both women and men. Gender-based differences of various diseases and

conditions will be discussed in greater detail in subsequent chapters of this book.

Basic physiological differences between men and women often influence the way they react to and metabolize drugs. Women tend to have smaller-sized organs, higher percentage of body fat, higher body water content, lower body weight, and less muscle mass. Men and women process drugs differently at the molecular level. Sex differences in the way drugs are transported within the body as well as in enzymatic action in the process of drug metabolism can affect drug reactions. Sex hormones apparently influence the effects of many drugs. In women, the menstrual cycle, pregnancy, and menopause have significant effects on how drugs react in their bodies (Society for Women's Health Research [SWHR], 2004). Differences such as age, hormonal status, race, ethnicity, and socioeconomic status also affect how women metabolize drugs. The extent to which these differences prevail among the range of drugs used to prevent and treat disease is even now not fully known or understood.

FDA guidelines urge drug investigators to account for gender differences in drug metabolism throughout the development process. Also, women of childbearing age must be included in both Phase I and Phase II clinical trials. The phases of a clinical trial are explained in **Table 1–1**. Prior to the 1990s women of childbearing age were excluded from clinical trials. However, the call for gender-specific analyses of safety and effectiveness of new drugs brought about revision of its guidelines by the FDA as well as a change of policy for the inclusion of women of childbearing age in early drug studies. Participation of women in clinical trials has resulted in representation of the population most likely to use a disease therapy and determination of any sex differences in the disease therapy. Furthermore, women's participation in clinical trials provides insight into the scientific basis for individual therapy differences and provides future directions for research (U.S. Food and Drug Administration [FDA], 2014).

Gender-based research has posed challenges as well as opportunities for pharmaceutical manufacturers. If research shows that a drug is effective for only one gender, the potential market for that drug might likely be limited and could diminish the profits of the drug company. On the other hand, targeting drugs for women or other specific populations can also allow researchers and pharmaceutical companies to create much more effective products.

Table 1–1 Phases of a Clinical Trial

Phase I	Involves a small-scale study designed primarily to determine safety and tolerance of a newly developed drug or therapy and optimal dose or strength of the therapy.
Phase II	Involves a larger-scale study that seeks preliminary evidence of controlled effectiveness of the drug or therapy and possible side effects. It is sometimes considered as a pilot test of the drug or therapy.
Phase III	Involves a large-scale, multiple-site randomized controlled trial that seeks evidence of the efficacy of the drug or therapy, especially in comparison to other treatments, and to monitor adverse effects.
Phase IV	Involves studies of the effectiveness of the drug or therapy in the general population. Studies focus on post-approval safety surveillance and on long-term consequences over a larger population and time scale than was possible during earlier phases.

Modified from Polit, D., & Beck, C. (2014). *Essentials of nursing research: Appraising evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Although advances toward inclusion of women and minority groups in research studies have been made, a major barrier to the participation of women in biomedical research still remains. Many women are unable to participate in clinical trials because they lack health insurance coverage. Some insurance companies consider clinical trials experimental and, as such, are not covered under all standard health policies. Some states have passed legislation requiring health plans to pay for routine health care that a person may receive as a participant in a clinical trial.

Including women in clinical studies frequently poses challenges; however, their exclusion courts disaster through ignorance. Women, particularly those of childbearing age, present challenges to the investigation, as the researchers must consider the effects of hormonal cycling on the hypothesis being tested. Furthermore, the potential for pregnancy and possible fetal damage must be considered. These factors weigh heavily in designing and conducting any study.

Political Perspectives of Reproductive Rights

Birth control has been at the center of national attention for many years. The history and politics surrounding women's decision to control when and if to have children are long and complex. Although women today take the availability of birth control devices and information for granted, only in recent years has it been legal to use them. Over half a century ago, birth control pills were illegal in some states. Landmark legal decisions of the Supreme Court changed the status of contraception in this country. These included the 1965 decision, Griswold v. Connecticut, which struck down a statute that made the use of birth control illegal and criminalized spreading information about its use, and a 1972 decision, Eisenstadt v. Baird, that struck down a Massachusetts law that made it a felony to give contraceptives to anyone other than married persons. The Population Research and Voluntary Family Planning Programs Law was enacted in 1970 as Title X of the Public Health Service Act. As previously discussed, Title X is a federal grant program designed to provide individuals with access to contraceptive services, supplies, and information. However, women who relied on private medical insurance to defray their medical expenses frequently were required to pay out of pocket for birth control pills since numerous insurers did not offer reimbursement for oral contraception. Recent legal victories in the reproductive rights movement increased women's access to contraception through their health insurers. In 1998, federal employees won mandated coverage for contraception via an act of Congress. Additionally, women's advocacy groups have lobbied insurers and employers to include oral contraception in covered prescription drug benefits.

Federal restrictions on contraceptive development have resulted in the likelihood of the United States lagging behind many countries in this arena. U.S. couples possibly have fewer options for contraceptive choices than couples in other developed nations. U.S. women have a responsibility to stay informed as contraceptive technology continues to evolve, and to be cognizant of the political and economic forces that might facilitate or impede the availability of contraceptive devices or agents.

For nearly a century, abortion was illegal in the United States. In 1973, the landmark Supreme Court decision Roe v. Wade legalized abortion. Nonetheless, this decision has not prevented states from imposing restrictions that limit where and when women may receive abortions. Presently, the subject of abortion rights remains at the center of major debates in the political arena of this country, most notably in the election of political representatives and the selection of Supreme Court justices. The Roe v. Wade decision did not prevent the federal government from imposing abortion restrictions in countries that receive U.S. funding. The Mexico

City Policy, or "Global Gag Rule," was first enacted between 1985 and 1993 and stipulated that nongovernmental organizations receiving U.S. assistance cannot use separately obtained non-U.S. funds to inform the public or educate their government on the need to make safe abortion available. Neither could these organizations provide legal abortion services or provide advice regarding where to get an abortion. However, exemptions were allowed in the cases of rape, incest, and pregnancy that was life-threatening to the mother, but not for a woman's physical or mental health (Change: Center for Health and Gender Equity [CCHGE], 2015).

The Global Gag Rule has had serious effects on women's health in many developing countries. Under this rule, developing countries faced the dilemma that if they agreed to the policy and accepted U.S. family planning assistance, they risked an increase in death and injuries from unsafe, illegal abortions. However, by rejecting the U.S. assistance, they would lose funding for all areas of family planning, including reduction of unplanned pregnancy, preventing HIV, and reducing maternal and infant deaths. Documentation and analysis of the impact of the Global Gag Rule has indicated that the policy restricts a basic right to speech and the right to make informed health decisions. The policy also harms the health and lives of poor women by restricting access to family planning services. Furthermore, it has been shown that the policy does not reduce incidence of abortion (CCHGE, 2015).

The Global Gag Rule was eliminated in 1993 by President Clinton but was reinstated in 2001 by President George W. Bush. President Barack Obama repealed the policy on January 23. 2009. President Obama has called for a new approach to family planning that would end the politicization of women's health on a global scale. Advocates have also been working to prevent reenactment of the policy by future presidents without approval of Congress (CCHGE, 2015).

Access to Healthcare Services, Providers, and Health Information

Advances in public health and medicine have created major improvements in the prevention, diagnosis, and treatment of diseases in women. As a result, many women are living longer and healthier lives. Over the years women have learned to seek out medical information on their own, thereby becoming informed consumers. New discoveries have lead to improved methods of disease prevention, and as such, health promotion and disease prevention have become primary goals of health care. However, health promotion and disease prevention are complicated processes. Although women have made major strides in economic, social, and political aspects of health promotion and disease prevention, women continue to encounter barriers to obtaining adequate health care. Lower socioeconomic status creates a barrier that restricts women's ability to pay for needed healthcare services and medications. It frequently prevents women from being able to pay for transportation to health facilities or engage in healthy nutrition, activities, or lifestyle choices. Many women have inadequate health insurance coverage because they are underinsured or lack health insurance altogether due to unemployment or low socioeconomic status. Cultural factors such as lack of cultural and gender sensitivity among healthcare providers causes many women to encounter discrimination because of race, ethnicity, or sexual orientation. Social factors such as language barriers or low levels of literacy increase the likelihood that women will experience difficulty in understanding medical personnel and directives or in navigating the healthcare system. Furthermore, fear of medical personnel and procedures often results in women delaying health care or avoiding it altogether.

Although many gains in women's health have been obtained, women's health activists continue to lobby for improved healthcare services and legislation that will remove barriers from access of health care. More efforts and initiatives are needed to mitigate the factors that create barriers preventing women from accessing adequate health care. These include efforts that will make health care more affordable and accessible to women of lower socioeconomic means. Efforts are needed to increase cultural sensitivity and competency among healthcare providers. Lastly, more initiatives are needed that will improve the health literacy of women.

The National Priority of Women's Health

Women's health is now recognized as a national priority, and tremendous progress has been made in expanding the scope and depth of attention to women's health and women's health research. Continued success in the women's health movement depends on several factors: political commitment; sufficient funds; educated and interested scientific and lay communities; advocacy by professionals, patients, and the public; and involvement of women, men, and communities in working for equality and recognizing gender differences. These factors have been catalysts driving the advances in women's health research and are responsible for the achievements in women's health and well-being.

Women's Health: Global Perspectives

Women's health issues have moved beyond geographical and political boundaries and have gained international visibility at the top of the worldwide health agenda. Dramatic disparities in women's health exist in resource-rich and resource-poor countries. Many factors influence women's health throughout the world. These factors encompass women's economic status, level of literacy, opportunities for employment, race and ethnicity, as well as whether women reside in urban or rural environments and the particular countries or regions of the world in which they live. Women's health is also influenced by biological, social, and cultural factors, especially gender disparities and the value society places on women (Spielberg, 2011). In particular, women and girls are frequently prevented from benefiting from quality health services. The reasons that contribute to this situation include the disproportionate burden of poverty on women, the existence of unequal power relationships between men and women, social norms that reduce education and paid employment opportunities for women, an exclusive focus on women's reproductive roles, and the potential for—or actual experience of—physical, sexual, and emotional violence (World Health Organization [WHO], 2015b).

Females comprise approximately 52% of the world's population (Spielberg, 2011). Females worldwide have an average life expectancy of 73 years as compared to 68 years for males. World population has grown to 7.2 billion people, with growth greatest in developing countries (Population Reference Bureau, 2012; U.S. Census Bureau, 2015) Life expectancy is a common indicator of the overall health and well-being of a society. Throughout the world, women tend to live longer than men (Spielberg, 2011). Moreover, notable differences exist in life expectancy between countries and regions of the world. Women of developed countries tend to have a longer life expectancy than women of developing countries (WHO, 2015c).

Childhood Mortality

When considering global childhood mortality, girls are more likely to survive infancy than boys for reasons that are unclear. Yet, some countries

such as China, India, Nepal, and Pakistan have a higher mortality rate of girls relative to that of boys. Because of the dense population in China and India, the mortality rate for girls under 5 years of age for Asia as a whole (2005–2010) is higher (61 per 1,000) than for boys (56 per 1,000) (United Nations Department of Economic and Social Affairs, Population Division [UNDESA], 2010). In some societies, preferential treatment for boys in healthcare practices and nutrition, as well as the practice of female infanticide and sex-selective abortion, lead to a severe decrease in survival of baby girls. When the rate of survival of baby girls is not higher than or equivalent to the rate of survival of baby boys, this is likely a sign of specific gender-based discrimination (Spielberg, 2011).

Maternal Mortality

Women's reproductive years, mainly between the ages of 15 and 44, are years of highest risk regarding women's mortality in many parts of the world. In 2008, an estimated 358,000 women worldwide died from causes associated with pregnancy and childbirth. From a global perspective, that is 260 maternal deaths for every 100,000 live births. Although this estimate is a 34% decline from maternal deaths in 1990, developing countries account for 99% (355,000) of maternal deaths, out of which 87% of global maternal deaths are attributed to sub-Saharan Africa and South Asia. Common causes of maternal death are ascribed to direct obstetric deaths from obstetric complications that occur during pregnancy, delivery, or the post partum period. Maternal deaths are also attributed to indirect causes that result from previous existing diseases, diseases that develop during pregnancy, or diseases that were aggravated by the physiological effects of pregnancy (WHO, 2010a).

The disproportion in risk for maternal mortality between developing and developed countries and regions of the world is largely due to disparities in access to reproductive health care between resource-rich and resource-poor counties, and inequities within countries suffered by vulnerable populations and minorities. It is estimated that 99% of maternal deaths can be preventable through three types of services. These include family planning services to reduce unintended pregnancies, having a skilled attendant at deliveries, and provision of timely emergency care if obstetric complications occur (Spielberg, 2011). In developing countries, approximately 40% of births take place in a health facility and about 57% of deliveries are guided by a skilled birth attendant. Worldwide, women have a vast need for family planning services that will enable individuals and couples to decide whether or not to have children and to achieve the desired timing and spacing of children they decide to have (Spielberg, 2011).

A goal of the United Nations is to reduce maternal mortality to 213 deaths per 100,000 live births by 2015. The United Nations launched the Global Strategy for Women's and Children's Health in 2010. This strategy seeks to support the development and implementation of country-led plans to improve access to comprehensive integrated reproductive health services. The strategy also supports government initiatives to strengthen health systems to deliver high-quality healthcare services; implementation of national plans to train, retain, and deploy healthcare workers; and the development, funding, and implementation of a prioritized coordinated and innovative research agenda for women's and children's health. Presently, numerous countries are making progress toward reducing maternal mortality; however, there are still countries that have a long way to go in order to achieve this goal (WHO, 2010a).

Unsafe abortion is a procedure for terminating unintended pregnancy performed by persons who lack the necessary skills, or in an environment that is inconsistent with minimal medical standards, or both. In 2008, an estimated 21.6 million unsafe abortions took place, an increase from

19.7 million in 2003. Almost all unsafe abortions took place in developing countries. Overall, the unsafe abortion rate is approximately 14 per 1,000 women aged 15 to 44 years. Mortality attributed to unsafe abortions accounts for nearly 13% of all maternal deaths (WHO, 2011c). The World Health Organization (2011c) estimates that the number of unsafe abortions will continue to rise unless women have increased access to safe abortion and contraception, as well as stronger support to empower women with the freedom to decide whether and when to have a child. In order to reduce the number of unsafe abortions, women need access to safe and effective contraception, less restrictive abortion policies, access to sex education, and access to emergency contraception. Family planning is therefore crucial for the empowerment of women, reduction of poverty, and improvement of maternal and infant health (Spielberg, 2011).

Women's Health Issues in Adulthood

Sexually Transmitted Infections

Sexually transmitted infections (STIs) pose serious health risks for women worldwide. Spread person to person by sexual contact, an estimated 340 million curable new cases of STIs occur each year throughout the world in adults aged 15 to 49 years (WHO, 2013a). In developing countries the problem of STIs is prevalent to the extent that STIs and their complications are one of the top five reasons adults seek medical treatment. STIs pose serious risk for pregnant women and their unborn children. STIs can cause ectopic pregnancies, miscarriage, stillbirth, congenital infections, low birth weight, and newborn blindness. Pregnant women can transmit HIV and syphilis to their babies during pregnancy and delivery. For some women, STIs can interfere with fertility as a long-lasting complication. In some cultures, infertility can be a severe social stigma that can increase women's vulnerability to domestic abuse, divorce, and rejection by spouse, family, and community. In the presence of an untreated STI, the risk of acquiring and transmitting HIV increases tenfold. Strategies for treatment and prevention of STIs encompass education about safe sex, access to facilities for early diagnosis and treatment of disease, and actions to counteract the social prejudices and stigma surrounding STIs (Spielberg, 2011).

HIV/AIDS

Worldwide, some 33.3 million people are living with HIV infection, which is approximately 0.8% of the world's population. In 2009, an estimated 2.6 million people became newly infected with HIV (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010). Ninety five percent of new infections occur in developing countries. The hardest hit areas frequently are those where women lack economic independence, education, access to health services and information, and the ability to avoid infection (Spielberg, 2011). Africa is the most severely affected region, and sub-Saharan Africa bears an inordinate share of the global HIV burden. Seventy percent of the people infected with HIV live in sub-Saharan Africa (UNAIDS, 2010).

HIV is progressively becoming a woman's disease. More women than men live with HIV/AIDS, accounting for 52% of the total, and the disease claims the lives of over 1 million women each year. In 2009 approximately 370,000 children were infected with HIV through mother to child transmission. In recent years, the mode of transmission has shifted to where more than 80% of the HIV infections worldwide are contracted through heterosexual sex (UNAIDS, 2010). Current research geared toward preventive measures for women shows promising results. A tenofovir-based vaginal gel has shown encouraging potential as a female-initiated prevention option in reducing the acquisition of HIV infection, and may

soon become viable (UNAIDS, 2010). Other strategies that have shown to be effective in HIV prevention include male circumcision, consistent use of condoms, and treatment for other sexually transmitted infections. Strategies are needed to build stronger effective prevention and treatment responses. Non-stigmatizing health services and effective referral systems across behavior and social support services for HIV, tuberculosis, and STIs are needed. Further strategies necessitate increased investment in the capacities of individuals and key communities living with HIV to organize and empower themselves, and improved communication of social and behavioral changes regarding risk and treatment (UNAIDS, 2010).

Tuberculosis

In 2009, approximately 3.3 million women contracted tuberculosis (TB) and 600,000 died from the disease (WHO, 2010b). The World Health Organization estimates that approximately 200,000 women infected with HIV died of TB in 2008. TB is acknowledged as the third leading cause of death worldwide among women between the ages of 15 and 44 years and the fifth leading cause of death among girls and women between the ages of 10 and 19 years in low-income countries (WHO, 2014a).

Once infected with TB, women in their reproductive years are more susceptible to developing active disease than men of the same age. TB can cause infertility and can contribute to numerous poor outcomes associated with reproductive health, particularly for women infected with HIV. Since the feminization of the HIV epidemic, which has produced a greater burden of HIV among women worldwide, a quarter of deaths among women with HIV are linked to TB. Moreover, factors such as poverty, malnutrition, food insecurity, living in crowded conditions, the rising use of tobacco, and increased incidence of diabetes among women can intensify the risk of TB (WHO, 2014a).

Numerous social, cultural, and economic implications occur for women who have TB. In some societies, women who are sick with TB may be stigmatized, discriminated against, and are likely to remain unmarried or become divorced. The stigma associated with TB will impact quality of life. Women with TB may be ostracized from their families and communities. A female relative sick with TB is often unable to carry out family responsibilities. As such, children of the family are frequently forced out of school or work to care for family members. Cultural and financial barriers can severely impede women with TB from seeking care. Women tend to wait almost twice as long as men to seek care for TB. Consequently care is frequently delayed until the illness is severe, leading to a poorer prognosis and greater mortality (Spielberg, 2011; WHO, 2014a). An additional concern is that TB has become more difficult and expensive to treat since multidrug-resistant forms of the disease have developed. As a result women infected with multidrug-resistant strains of TB would be required to undergo many months of complicated treatment that carries a heavy burden for them and their families (Spielberg, 2011; WHO, 2014a).

Cancer

Worldwide, cancer is a leading cause of death (WHO, 2015a). The most common sites for cancer in women are breast, lung, stomach, and colon. Breast cancer is the most widespread cancer in women, with one million new cases occurring each year. The incidence of breast cancer is highest in women from North America and northern Europe and lowest in women from Asia (Spielberg, 2011). Breast cancer is the leading cause of cancer deaths in women around the world. Approximately 521,000 deaths from breast cancer occurred in 2012 (WHO, 2015a).

Cervical cancer is the second most common type of cancer in women and is linked to genital

infection with the human papillomavirus (HPV). It is estimated that 493,000 cases of cervical cancer occur each year worldwide. More than 90% of the deaths from cervical cancer occur in low-income countries where access to cervical cancer screening and treatment is scarce or nonexistent (WHO, 2013b).

The HPV infection is a common sexually transmitted infection. The risk of acquiring HPV is highest shortly after a woman begins engaging in sexual intercourse. Although most HPV infections are self-limiting and relatively harmless, persistent infection with cancer-causing strains of HPV can lead to the development of cervical cancer in women. Routine screening with Pap smears to achieve early detection of the disease is effective in decreasing the incidence of cervical cancer. Widespread screening programs that include successful treatment and follow-up of women with abnormal Pap smears have been effective in reducing cervical cancer incidence by 80%. In addition to early screening and treatment, vaccination of girls and women, age 9 years to 26 years, against HPV infection is being done to reduce the incidence of HPV-related cervical cancer (Spielberg, 2011).

Chronic Diseases

Chronic diseases are a substantial cause of disability and death among women. Cardiovascular disease and diabetes are the most common chronic diseases that women develop, with a higher incidence found among women of lower socioeconomic means. Many of the health problems that women develop as they age are associated with risk factors and unhealthy behaviors practiced in adolescence and young adulthood, such as smoking, poor diet, and sedentary lifestyle. Globally, cardiovascular diseases, such as heart attack, ischemic heart disease, and stroke, are the leading cause of death of older women (Spielberg, 2011).

Cardiovascular diseases have long been considered as problems of men, a misconception that has led to an underestimation of the impact of cardiovascular disease in women. Women are inclined to develop heart disease later in life and are more likely to present atypical symptoms as compared to men. These dynamics likely contribute to underdiagnosis of heart disease in women. It is also important to note that nearly 10% of cardiovascular disease in women is associated with tobacco use (Spielberg, 2011).

Diabetes is another significant chronic disease that impacts on women as they age. Currently, it is estimated that 122 million women worldwide have diabetes. The incidence of diabetes is increasing most rapidly in developed countries. Many of the outcomes of diabetes affect women more severely than men (Spielberg, 2011).

Advancing Age

The population of aging women is increasing. There are approximately 336 million women aged 60 and over worldwide. The proportion of women in the population increases with age. The health of older women is influenced by genetics, environment, and a lifetime of living circumstances and experiences. Older women are more likely to live in poverty, be depressed, and lack access to health care. This is due in part to the likelihood of older women to outlive their spouses/partners, and the consequences of lost income and increased social isolation brought by the change of marital status. In many societies, older women are assuming new responsibilities of raising grandchildren because of the loss of the parents in early adulthood to disease or other causes that remove them from parenting (Spielberg, 2011).

Violence Against Women

Women are burdened not only by disease but also by violations of their human rights that directly affect their health. Violence against women is a major global public health problem. Violence against women is any act of gender-based violence

occurring in public or private life that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty (WHO, 2014b).

Violence against women takes many forms (see **Box 1–1**) and exists in all parts of the world. The most common form is intimate partner violence. It is estimated that women between the ages of 15 and 44 are more likely to be injured or killed as a result of male-perpetrated violence than from cancer, traffic accidents, malaria, and war combined. Yearly, approximately 5,000 women worldwide are murdered by family members in the name of honor. Forced marriages and child marriages are widely practiced in many countries of Asia, the Middle East, and sub-Saharan Africa even though these practices violate the human rights of women and girls. Furthermore, as many as one in five women and one in ten men report having been sexually abused as children, making them more prone to encounter other forms of abuse later in life (WHO, 2014b). Research conducted by the World Health Organization has documented the widespread nature of gender-based violence in many countries. Among various findings that underscore the severity of the problem, a substantial number of women reported physical or sexual violence perpetrated by a husband or partner. Furthermore, a significant number of women reported that their first sexual experience was forced, and a considerable number of women reported being physically abused during pregnancy (WHO, 2005).

Numerous individual, family, and societal factors may increase the likelihood for the occurrence of violence against women. These factors comprise

Box 1–1: Forms of Gender-Based Violence

Violent acts include the following:

- Sexual, physical, or emotional abuse by an intimate partner
- Physical or sexual abuse by family members or others
- Sexual harassment and abuse by authority figures (such as teachers, police officers, employers)
- Trafficking for forced labor or sex
- Forced or child marriages
- Dowry-related violence
- Honor killings (women are murdered in the name of family honor)
- Systematic sexual abuse in conflict situations
- Female genital mutilation
- Infanticide of female infants
- Sex-selective abortion

Modified from World Health Organization. (2014b). Violence against women: Fact sheet No. 239. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

personal characteristics, familial characteristics, and aspects of the community and society. Potential risk factors for gender-based violence are presented in **Table 1–2**.

Common health consequences from violent acts or from the long-term effects of violence can include physical injury, death, harm to women's sexual and reproductive health, injury or death to unborn children, mental health disorders, long-term health problems, and higher rates of sexual risk-taking behaviors and substance use. The social and economic costs of gender-based violence are enormous and affect many aspects of society. Violence against women may cause women to experience social isolation, inability to work, lost productivity and wages, and lack of participation in regular activities. Violence against women can limit women's ability to care for themselves and their children. In many situations, women do not seek help or report violence when it takes place (WHO, 2014b).

Numerous preventive strategies have been developed that are aimed at reducing risk factors. These strategies have been initiated in various communities to address the problem of gender-based violence and include increasing education

Table 1–2 Potential Risk Factors for Gender-Based Violence

Level of Social Category	Characteristics That Increase the Risk of Violence
Individual	Limited education Young age History of abuse and substance use
Partner	Alcohol or substance use Low education level Negative attitudes about women Witnessing domestic violence against women History of being abused as a child
Family	Marital conflicts Male dominance Economic stress Poor family functioning
Community	Gender inequality Lack of community cohesion Limited resources
Society	Traditional gender norms Cultural customs Lack of autonomy for women Restrictive laws on divorce Restrictive laws on property ownership and inheritance Social breakdown due to wars, conflicts, or disasters Military presence in a country Dislocation and displacement of populations

Modified from World Health Organization. (2014b). Violence against women: Fact sheet No. 239. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

and opportunities for women and girls, improving their self-esteem, and reducing gender inequities in communities. So far, these interventions have shown promising results. Additional initiatives that have shown positive outcomes consist of programs that provide support for children who have witnessed intimate partner violence, mass public education campaigns, and work with men and boys to change their attitudes toward gender inequities and acceptability of violence. Measures that reduce the consequences of violence include advocacy for victims of violence and increasing awareness of health workers regarding violence and its consequences and their awareness of available resources for abused women (WHO, 2014b).

It is essential that further evaluation of the effectiveness of preventive measures takes place. Further efforts aimed at building evidence on the scope and types of violence in different settings are essential for understanding the enormity and nature of the problem at a global level. Governments and health professionals must receive further guidance in preventing violence and in strengthening the response of the health sector to violence. Initiatives must also include dissemination of information to countries, support for national efforts to advance women's rights and prevent violence, and collaboration of international agencies and organizations to deter violence against women worldwide (WHO, 2014b).

The International Priority of Women's Health

In recent decades, extraordinary advances have been achieved in women's health, particularly in improvement in prevention and treatment of women's diseases. Great progress has been made in early screening and treatment of breast and cervical cancer, reducing maternal mortality, developing the HPV vaccine to prevent cervical cancer, and increasing the availability of family planning techniques (Spielberg, 2011). Many discoveries in women's health have led to longer lives, healthier women, and enhanced quality of life. Nevertheless, many of the basics such as regular preventative health care, family planning services, and obstetric care in sanitary conditions remain inaccessible to women around the world. Unstable political and economic situations, such as wars, poverty, political volatility, and disease pandemics continue to adversely impact women's health and quality of life. In due course, the essential aspects in solving many of the health problems of women will entail political willingness, provision of adequate resources, and women's education (Spielberg, 2011).

Research Review

Will intentionally integrating a human rights framework into women's health research advance women's freedoms, equity, and equality?

Baptiste, D., Kapungu, C., Khare, M., Lewis, Y., & Barlow-Mosha, L. (2010). Integrating women's human rights into global health research: An action framework. *Journal of Women's Health, 19*(11), 2091–2099.

The authors of this article put forth the premise that research into the etiology, diagnosis, treatment, and prevention of women's illness, and also research into women's wellness, can advance women's freedoms, equity, and human rights. The authors state that this is not an automatic process. An essential part of the process is the integration of a human

rights framework into the research, which begins with recognition of the social impact of studies. The authors hypothesize that recognition of the social impact of studies can occur at two broad levels. The first level of impact is that a study can provide health benefits for women, such as a new clinical procedure or medication. While individual health outcomes may improve, the existing social templates that intensify women's vulnerability to disease conditions, such as gender inequality and discrimination, likely remain unchanged. To improve women's human rights conditions as well as health outcomes, global researchers must aim for a second level of impact. In addition to providing individualized health benefits, this deeper level decisively illuminates elements of the social and community contexts that drive women's diseases, such as cultural and social norms that disadvantage women. The authors suggest using the Scale of Change Theory as a framework to guide six strategies that target this deeper level of impact without necessarily requiring a vast output of financial resources. The strategies include: (1) becoming fully informed of women's human rights directives to integrate them into research, (2) mainstreaming gender into research—that is, making both women's and men's concerns and experiences an integral dimension of the research so that both genders benefit equally, (3) using the expertise of local grassroots women's organizations in the setting, (4) showcasing women's equity and equality in the organizational infrastructure, (5) disseminating research findings to policymakers to advocate for improved services, and (6) publicizing specific and global oppressions driving women's illnesses. Logistical and conceptual dilemmas in transforming a study using these principles were discussed. The authors provided a case study to illustrate how these strategies can be operationalized. A feasible approach to health researchers who desire to link women's health outcomes to social and cultural conditions through practical implementation strategies was offered.

Chapter Summary Points

- Women's health is a multifaceted, complex area of study that includes practice, education, and research, which concentrates on the physical, psychosocial, political, and economical well-being of women.
- Women's health facilitates the prevention of illness and the maintenance of wellness through screening, diagnosing, and managing conditions that are unique to women, are more common in women, are more serious in women, and have manifestations, risk factors, or interventions that are different for women.
- Women's health encompasses the entire body and brings to focus the simple recognition that men and women have some fundamentally different health needs and that women's health needs must be pursued in their own right. As such, women's health recognizes the importance of the study of gender differences.
- Women's health acknowledges the diversity of women's health needs over the life cycle and

how these needs reflect differences in race, class, ethnicity, culture, sexual preference, levels of education, and access to health care.

- The 19th and 20th centuries were periods of extraordinary developments in women's health, initiated by multiple waves of women's health movements. In order to understand the dramatic changes that have affected women's health throughout this stretch of time, it is essential to examine the social and cultural context that led up to and then underscored the resultant changes.
- The federal government plays a significant role in protecting and promoting women's health. Through direct and indirect means, the government exercises control over many areas that influence women's health.
- Research on women's health has witnessed unprecedented growth, especially in response to the inclusion of women in clinical trials, which has enabled both women and men to become the studied models for the conditions that affect them and the drugs used to treat these conditions.
- Reproductive rights have been at the center of national attention for many years. The history and politics surrounding women's decisions to control when and if to have children as well as when and if to terminate pregnancy are long and complex.
- Although women have made major strides in economic, social, and political aspects of health promotion and disease prevention, women continue to encounter barriers to obtaining adequate health care.
- Continued success in the women's health movement depends on political commitment; sufficient funds; educated and interested scientific and lay communities; advocacy by professionals, patients, and the public; and involvement of women, men, and communities in working for equality and recognizing gender differences.
- Women's health issues have moved beyond geographical and political boundaries and have gained international visibility at the top of the worldwide health agenda.
- Aspects that influence women's health throughout the world include women's economic status, level of literacy, employment opportunities, race and ethnicity, whether living in an urban or rural environment, and living in a particular country or region of the world. Women's health is also influenced by biological, social, and cultural factors, especially gender disparities and the value society places on women.
- In recent decades, extraordinary advances have been achieved in women's health, particularly in improvement in prevention and treatment of women's diseases, leading to longer lives, healthier women, and enhanced quality of life.
- Many basic healthcare services remain inaccessible to women around the world. Unstable political and economic situations, such as wars, poverty, political volatility, and disease pandemics continue to adversely impact women's health.
- The essential aspects in solving many of the global health problems of women will entail political willingness, provision of adequate resources, and women's education.

Critical Thinking Exercise

Questions for Seminar Discussion

1. What are the multiple dimensions of women's health? What does women's health encompass?
2. Discuss the diversity of women's health needs over the life cycle and how these needs reflect differences in race, class, ethnicity, culture, sexual preference, levels of education, and access to health care.
3. What is feminism? Why is a feminist model of practice essential to the health and health care of women?
4. Discuss the historical background of the women's health movements. Why is it essential to examine the social and cultural context that led up to and then underscored the resultant changes in women's health?
5. Discuss the key issues surrounding reproductive rights. Why is it imperative that women have control over their reproductive rights?
6. Why were women excluded from clinical trials in the past? What impact did this practice have on women's health care? Why is it important for women to be included in clinical trials?
7. Discuss gender-based research. What areas of health could benefit from further gender-based research?
8. Discuss the ways that government is involved in women's health.
9. Why do women continue to encounter barriers to obtaining adequate health care? What factors contribute to these barriers?
10. What are the economic, social, cultural, and political factors that can adversely influence women's health throughout the world?
11. Discuss the issues associated with worldwide childhood mortality. What are indicators of specific gender-based discrimination?
12. Discuss the disproportion in risk for maternal mortality between developing and developed countries and regions of the world. Why does this disparity exist? How can maternal deaths be prevented?
13. Discuss issues surrounding prevalent diseases of adult and older women worldwide. What economic, social, and cultural implications do these diseases and conditions have for women?
14. Discuss the forms of violence against women. What are the physical, social, and economic consequences? What factors increase women's risk for violence? Discuss measures for prevention and management of violence against women.
15. Despite extraordinary global advancements in women's health, many of the basics of health care remain inaccessible to women around the world. What factors contribute to this situation?

Internet Resources

Black Women's Health Imperative: provides information, advocacy, and resources for advancing the health and wellness of Black women. http://www.blackwomenshealth.org

Centers for Disease Control and Prevention: provides information, education and resources on disease prevention and health promotion. http://www.cdc.gov

Feminist Women's Health Center: provides comprehensive gynecological healthcare services, education, and advocacy. http://www.feministcenter.org

Global Health Council: membership alliance promoting global health through information, education, and advocacy. http://www.globalhealth.org

Kaiser Family Foundation: non-profit, private operating foundation providing non-partisan policy analysis and research of healthcare issues for policy makers and the general public. http://www.kff.org

National Organization of Women: largest organization of feminist activists in the United States providing information, education, and advocacy. http://www.now.org

Office of Research on Women's Health: provides information, education and resources on women's health research. http://orwh.od.nih.gov

Office on Women's Health: provides program coordination and oversight, information, education and resources on women's health. http://www.womenshealth.gov

Our Bodies Ourselves (Boston Woman's Health Book Collective): nonprofit public interest and consulting organization providing women's health information, education, and advocacy. http://www.ourbodiesourselves.org

Planned Parenthood Federation of America: provides reproductive healthcare services, information, education, and advocacy. http://www.plannedparenthood.org

Society for Women's Health Research: national nonprofit organization provides information, education, advocacy, and support for women's health research and research on sex differences. http://www.womenshealthresearch.org

U. S. Food and Drug Administration: information, education, and resources on safety of drugs, food, medical devices, biological products, cosmetics, radiation emitting products, veterinary drugs, and tobacco. http://www.fda.gov.

Women's Health: provides information, education, advocacy, and program coordination on women's health. http://www.cdc.gov/women/

Women's Policy, Inc.: nonpartisan, nonprofit organization ensuring informed decision making on key women's issues by policy makers at the federal, state, and local levels. http://www.womenspolicy.org

World Health Organization: information and resources on women's health around the world. http://www.who.int/en/

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