Part One

Foundations of Women’s Health

1. Introduction to Women’s Health
2. The Economics of Women’s Health
3. Health Promotion and Disease Prevention
Chapter Objectives

On completion of this chapter, the student should be able to discuss:

1. The development of the women’s health movement since the early nineteenth century.

2. The contributions to the women’s health movement made by individuals, women’s health advocacy groups, grassroots organizations, healthcare professionals, and the federal government.

3. Government’s role in protecting and promoting the health of the public.

4. Health issues that come into question during a change in the presidential administration.

5. The responsibilities of the Office on Women’s Health and the Office of Research on Women’s Health.

6. The importance of investing in biomedical research and the inclusion of women and minorities in research studies.

7. The concept of sex/gender-based research.

8. Reproductive rights and the global gag rule.

9. Barriers encountered by women in accessing healthcare providers, services, and information.

10. The need for incorporating women’s health and cultural sensitivity training into health professional curricula.

11. The efforts throughout the world supporting women’s health and gender equity.
Introduction

The increased focus on women’s health over the past few decades has brought together a variety of groups that are attempting to improve access to and delivery of health care. Women’s health advocates from community groups, government institutions, and healthcare facilities have had significant success at increasing awareness of and creating solutions to key issues that affect women’s health. Women have advocated in various organizational forms for issues such as improved healthcare services, respected social status, and control over their own health decisions. Self-help groups, grassroots organizations, political advocacy groups, and healthcare professionals alike have become involved in the women’s health movement. As a result, there is now greater recognition of the many factors that contribute to the quality of women’s lives and their overall health status. Although significant gains have been made, important challenges remain.

This chapter gives a brief overview of the history of women’s health and some of the political issues surrounding the U.S. health system. It provides a framework for understanding key issues related to how priorities are set within the women’s health movement and how individuals play a key role in determining the future direction of women’s health care. A look at women’s health on a global scale is included as well.

Historical Dimensions: The Women’s Health Movement

The women’s health movement was first noted in the 1830s and 1840s (Figure 1.1). Small groups of women in towns and cities began the wave of women’s health advocacy. The movement, focusing on health education and disease prevention, was specifically targeted toward women as the caretakers of families.

1830s and 1840s: The Popular Health Movement

During this time period, women were encouraged to take control of their health as domestic healers and lay practitioners, as opposed to looking to formally trained physicians for treatment. Healthy lifestyles for women encouraged proper diet, exercise, the elimination of the corset, and sexual abstinence in marriage to control...
family size. For the first time, a few middle-class women who became interested in their own health sought entry into the medical profession. Elizabeth Blackwell, for example, entered medical school in 1847 and prompted the opening of a series of medical schools for women, including the Female Medical College of Pennsylvania, the New England Medical College, the Homeopathic New York Medical College for Women, and Elizabeth Blackwell’s own Women’s Medical College of the New York Infirmary. In 1848, the first women’s rights convention was held in Seneca Falls, New York; the convention marked the official beginning of the women’s rights movement.

1861–1865: The Civil War Period

The Civil War prompted many women to volunteer their services as doctors and nurses to the armies; a number of women even disguised themselves as men to tend to wounded soldiers on the battlefield. Dorothea Dix and Clara Barton were the leaders of a national effort to organize a nursing corps to care for the war’s wounded and sick. Dorothea Dix, Superintendent of Nurses for the Union Army, made headway by recruiting numerous women to work with her as nurses, thereby increasing the legitimacy of the role of women as professional healthcare providers. Clara Barton cared for soldiers who were returning to Washington, D.C., and later played an instrumental role in the creation of an American branch of the International Red Cross.
Women’s participation in the war also led to the opening of the first training schools for nurses in 1873, including those at Bellevue Hospital in New York City, Massachusetts General Hospital in Boston, and Connecticut Hospital in New Haven. By 1890, 35 such schools existed. Although this trend represented advancement for women, the relationship between male doctors and female nurses mirrored the domestic sexual division of labor, with males as the authority figures and females as the subordinates.

Mid- to Late 1800s: The Women’s Medical Movement

After the Civil War, educational and employment opportunities abounded for women. The Women’s Medical Movement was born as a consequence of the rapid growth in the number of women attending medical schools, their struggles to achieve equal status within the profession, and the popularity of challenging historical notions regarding women’s fragility.

1890s–1920s: The Progressive Era

The Women’s Medical Movement gave way to the intensely active Progressive Era, which advanced not only women’s health, but also the roles of women and women’s rights in general. In 1920, the 19th Amendment to the U.S. Constitution was ratified, which guaranteed women the right to vote. A few years later, the National Women’s Party, formed in 1917, proposed the Equal Rights Amendment (see It’s Your Health).

During this time, the birth control movement gained force and ultimately led to the legalization and medical acceptance of contraception. The maternal and child health movement also was working to promote healthy motherhood through prenatal care and child health services. Soon after the first birth control clinic in the United States was established in 1916, the Children’s Bureau was established, as was the first show of governmental support in the Shepard Towner Act of 1921—legislation that greatly increased the availability of prenatal and child health care.

1930s–1950s: World War II and Postwar Years

World War II opened doors for women’s employment opportunities, helping women gain confidence in themselves and bringing their presence in society to the forefront. Advances in anesthetics and delivery techniques made for safer and less painful childbirth; therapies for the treatment of menopause were explored; and a majority of women gave birth in hospitals. As the war drew to a close, many women returned to homemaking from their wartime jobs.

The 1950s were a period of redefining sexuality. Although many women used birth control, the link between sexuality and procreation was constantly reinforced. The Kinsey Report, issued in 1953, dispelled this link for some by revealing that marriage was not a prerequisite for sex for many women. During this time, lesbians began to organize groups to change public attitudes and advocate for equal rights.

It’s Your Health

Equal Rights Amendment

The Equal Rights Amendment was written in 1921 by suffragist Alice Paul. It has been introduced in Congress every session since 1923.

Section 1. Equality of Rights under the law shall not be denied or abridged by the United States or any state on account of sex.

Section 2. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.

Section 3. This amendment shall take effect two years after the date of ratification.
1960s–1970s: The Grassroots Movement

During the 1960s and 1970s, grassroots organizations challenged medical authority in the delivery of health care to women and addressed issues ranging from abortion to childbirth reform to unnecessary hysterectomies, cesarean sections, and mastectomies. Women demonstrated on the steps of Congress, and feminist health writers encouraged women to explore their own health. In 1960, the U.S. Food and Drug Administration (FDA) approved the birth control pill, and, for the first time, women were given a real sense of sexual freedom. The Civil Rights Movement also gained force during the 1960s with numerous sit-ins and Martin Luther King’s “I have a dream” speech in 1963. In 1964, Congress passed the Civil Rights Act, including Title VII, which protected women against employment discrimination. In 1972, Congress passed the Equal Rights Amendment, although ultimately it was ratified by only 35 states, three states short of the 38 states needed for ratification.

During this time, the self-help manual *Our Bodies, Ourselves* was introduced. In addition, a number of women’s health centers and workshops, health advocacy organizations, and disease-specific groups that provided support networks and raised national awareness were formed. By the mid-1970s, more than 250 advocacy, education, and healthcare service groups for women existed, as well as nearly 2,000 self-help groups and other projects focusing on the women’s health movement.

Another important development in the 1970s was the establishment of the bipartisan Congresswomen’s Caucus by 15 of the 18 women members of Congress. The initial discussions focused on spousal abuse; however, as the women continued to meet, their discussions branched out to cover issues of child care and job training to move women off welfare. In 1981, four years after its inception, the group admitted men and became known as the Congressional Caucus for Women’s Issues. Through the years, Caucus members have worked to improve the lives of women and families by opening up opportunities in education and work, promoting women’s health, and championing causes such as equitable pay, enforcement of child...
support, and protection for victims of domestic violence and sexual assault. This group was critical in inspiring the formation of two federal offices geared specifically toward women: the Public Health Service on Women's Health in the Department of Health and Human Services (DHHS) and the Office of Research on Women's Health at the National Institutes of Health (NIH). (See the Web sites listed at the end of this chapter for more information.)

As the women's health movement evolved, leadership in the women's groups remained mostly white and middle class. Eventually, organizations specific to certain races or ethnicities evolved and developed agendas that covered general women's health issues, as well as issues focusing on low-income women and diseases and conditions that disproportionately affect women of color. The National Black Women's Health Project (now called the Black Women's Health Imperative) was established by Byllye Avery and is an example of a successful organization dedicated to the promotion of optimal health for black women across the life span. Other nationally recognized groups include the National Latina Women's Health Organization, the National Asian Women's Health Organization, and the Native American Women's Health Education and Resource Center. The women's health movement also was growing globally as health activist groups for women sprouted up throughout the world.

1980s: Changing Public Policy

In the 1980s, the U.S. Public Health Service's Task Force on Women's Health Issues was formed to assess the status of women's health and recommend a course of action to address determined needs. The Task Force issued a series of recommendations, which included increasing gender equity in biomedical research and establishing guidelines for the inclusion of women in federally sponsored studies. Although NIH did formulate such guidelines, a 1990 inquiry by the General Accounting Office, requested by the Congressional Caucus for Women's Issues, reported that NIH had failed to implement its policy guidelines across the board. In response, NIH strengthened its guidelines and established the Office of Research on Women's Health (ORWH).2 The ORWH mandate focuses on ensuring women's participation in clinical trials, strengthening research on diseases affecting women, and promoting the career advancement of women in science. The Women's Health Equity Act also was passed, allocating money to fund health research on particular areas of concern to women, including contraception, infertility, breast cancer, ovarian cancer, HIV/AIDS, and osteoporosis. The Act also included coverage of Pap smear screening and mammography for Medicaid recipients, assistance for pregnant women with health care and other services, and increased access for all women to screening and treatment for sexually transmitted diseases.

1990s: Women's Health at the Forefront

The 1990s brought together government, healthcare institutions, academia, and advocacy organizations, which resulted in elevation of women's health and well-being to the forefront of public consciousness. The federal government formed many
women's health offices in federal agencies and in regional public health service offices. This trend, in turn, inspired the establishment of a number of women's health centers throughout the country. Existing centers broadened their scope beyond reproductive issues to take a more comprehensive look at health and disease among women.

In the 1993 NIH Revitalization Act, Congress required that women and minorities be included as subjects in all human subject research funded by NIH. This decision was a bold and innovative step. For the first time, women and minorities could not be excluded from studies based on the characteristics of race and sex. The legislation was greeted enthusiastically by many and skeptically by those who predicted a gradual ruin of clinical investigation. Some scientists suggested that recruitment and retention would suffer and costs would overwhelm and ultimately preclude undertaking many studies. These fears have not become reality, however. The inclusion of women in research has instead led to the expansion of the scientific knowledge base necessary for developing sex/gender-specific diagnostic techniques, preventive measures, and effective treatments for diseases and conditions affecting women throughout their life span.

Also in 1993, Congresswoman Patricia Schroeder introduced the Family and Medical Leave Act; the Act, signed by President Bill Clinton, gives employees unpaid medical leave for themselves or for the care of a family member or a newborn or adopted infant. A year later, President Clinton signed into law the Violence Against Women Act, which mandates a unified judicial response to sexual crimes committed against women.

The Future

Recent studies focusing on sex/gender differences have resulted in great promise for the future of research in women's health. The understanding that sex—specifically, being male or female—should be considered when designing and analyzing biomedical and health-related research has helped to validate the scientific study of sex differences. This knowledge has opened the door for scientists to conduct studies that account for sex-based differences and promote the development of new approaches to prevention, diagnosis, and treatment of disease.

The new millennium has continued to bring numerous contributions to improving the health of the public—for example, the identification of the human genome, the findings from the Women's Health Initiative, improvements in HIV/AIDS medications, public health programs targeting behavior-related health problems, and the inclusion of children in clinical trials. Nevertheless, women still face a number of challenges in the healthcare arena. There has been a rollback of many of the advances made in the 1990s, including curtailment of funding for reproductive health initiatives both domestically and internationally and politicizing of the women's health agenda. Many women struggle to find access to healthcare services; women are living longer but not necessarily with better quality of life; and women across the United States and the world continue to be victims of individual and societal violence and discrimination.
Political Dimensions of Women’s Health

By looking at women’s health within a political context, many of the advances that have been achieved and the barriers that remain can be better understood. Government at every level plays an important role in protecting and promoting the health of the public. It is involved in six main areas in relation to the health of the population:

1. Policy making
2. Financing
3. Protecting the health of the public
4. Collecting and disseminating information about health and healthcare delivery systems
5. Capacity building for population health

6. Managing of health services

Through policies, regulations, and the law, the government exercises control over many of the areas affecting women's health, both directly and indirectly. Within the context of these six areas, the federal government conducts such activities as ensuring that the food supply is safe, providing federal highway funding for states that adopt a legal drinking age, and regulating businesses that provide medications to the public.

During the 1990s, women's health issues garnered a significant amount of support and attention. Numerous organizations and government agencies devoted to women's health were established. The Department of Health and Human Services’ Office on Women's Health (DHHS-OWH) serves as the coordinating agency for all women's health initiatives throughout the agencies and offices of the U.S. DHHS (described earlier), including National Institutes of Health (NIH), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), and other agencies and departments. OWH works at recognizing and addressing inequities in research, healthcare services, and education that have placed the health of women at risk.6

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The Office of Research on Women's Health (ORWH) within NIH serves as a focal point for women's biomedical research. ORWH works to ensure that women’s health research is present within NIH and the surrounding scientific community:7

- ORWH advises the NIH Director and staff on matters relating to research on women’s health.
- It strengthens and enhances research related to diseases, disorders, and conditions that affect women.
- It ensures that research conducted and supported by NIH adequately addresses issues regarding women’s health.
- It ensures that women are appropriately represented in biomedical and behavioral research studies supported by NIH.
- It develops opportunities for and supports recruitment, retention, reentry, and advancement of women in biomedical careers.
- It supports research on women’s health issues.

Since its establishment in 1990, ORWH has been a driving force in these important areas of women’s health. It also has been critical in national and international collaborative efforts across government and private organizations to embed women’s health research into the scientific and educational infrastructure. Collaborative efforts have ranged from implementing research action on autoimmune diseases and the use and overuse of hysterectomy to returning scientists to active investigations. Working with scientists, practitioners, legislators, and lay advocates, ORWH has identified research priorities and set a comprehensive research agenda for the twenty-first century (outlined in its Report of the Task Force on the NIH Women’s Health Research Agenda for the 21st Century). In addition, ORWH is an
important collaborator in fostering a research agenda that examines the biological differences between the sexes—that is, gender-based biology—in an attempt to more fully understand each and thereby enhance knowledge and practice.

The Healthy Women 2000 initiative was one project that joined DHHS with other federal agencies, nonprofit organizations, and members of various medical industries in a mission to educate women and provide them with the knowledge needed to live long and healthy lives. By identifying diseases that have a significant impact on women, future research direction and goals can be determined.

DHHS also has implemented several programs to provide for family planning, prevent sexually transmitted diseases, and reduce unintended pregnancies. The Title X program provides funding to millions of people for reproductive health and family planning services. Funding has also increased for research and programs aimed at improving the health of older women, demonstrated in part by the development of a resource center launched by the Administration on Aging to educate older women about issues such as income security, housing, and caregiving. In addition, support has been increased for community nutrition services to combat nutrition-related illnesses of the elderly.6

The focus on women’s health issues is not always a priority in politics, however. Different political parties have different platforms and see healthcare reform in differing lights. Affordable, accessible, quality health care is a central concern for almost every family and is often mentioned as a major priority for both Congress and presidential administrations. Yet each political party envisions a different means of achieving this goal. A change in administration often has implications for health policy; a new president and Congress can bring a different focus and tone to U.S. health policy than that associated with the existing government. Campaign promises, active voters, and special-interest groups all play roles in shaping health policy and influencing the direction of the legislative agenda.

Today, the majority of healthcare reform seeks to address how health care is financed, which services are covered, and who is eligible for public assistance. Women specifically are fighting to ensure that access to vital services is available to all women, regardless of their age, income, or location. Topics high on the current national health agenda include the following:

- Investing in biomedical research for fighting disease
- Maintaining reproductive rights and the freedom of choice
- Ensuring access to healthcare providers and services and to health information

Other issues, such as prescription drug coverage for seniors, genetic testing, malpractice insurance/award reform, the future of Medicare and Medicaid, and federal regulation of health care, may be explored further on the companion Web site for this book (womenshealth.jbpub.com).

**Investment in Biomedical Research**

The federal government plays a critical role in funding biomedical research. NIH is the main federal agency responsible for distributing money to private and
public institutions and organizations for conducting medical and health research. Along with the CDC and other agencies, it helps to advance basic research so as to discover new and better methods of treatment and prevention of numerous health conditions. Funding also comes from the private sector, philanthropic organizations, and voluntary health agencies. Pharmaceutical companies and private corporations invest millions of dollars each year in research and development and continue to introduce hundreds of new drugs, vaccines, and technologies every year. Investment in biomedical research has led to increased life expectancy, improved health throughout the life span, and decreased cost of illness. Significant improvements in the understanding of basic science have enabled remarkable discoveries in prevention, treatment, and eradication of disease.

The investment in research also has shown potential in increasing the understanding of biological, psychological, and sociological factors of women’s health as well as improving the delivery of healthcare services to women. Research on women’s health has seen unprecedented growth in the past three decades, especially with the push for inclusion of women in clinical trials. Policies now ensure that women and minorities are included as subjects in federally sponsored research and in the evaluation of drugs and medical devices. By demanding that women are included in health research, women—not men—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 in regard to women and specific diseases. As a consequence, women’s health is no longer limited to diseases of the reproductive organs.

Another approach to improving women’s health relies on gender-based research—studies that examine the similarities and differences between men and women to learn more about the etiology of disease and responses to medication. Gender-based studies are committed to identifying the biological and physiological differences between men and women. Males and females can manifest different symptoms of a disease, experience the course of a disease differently, or respond differently to pharmaceuticals. By understanding and appreciating the differences between men and women and the way they develop and experience disease, researchers have realized the importance of no longer assuming that males and females are identical. Identifying and studying gender-based differences offers a remarkable potential for understanding disease epidemiology and health outcomes in both men and women. Some examples of areas of women’s health research that have benefited from increased funding and attention can be seen in Table 1.1. These topics are discussed in greater detail in later chapters of this book.

Fat and body water content, steroidal sex hormone levels, and genetic phenotype all affect drug metabolism through pharmacokinetics (concentration of the drug) and pharmacodynamics (ability to metabolize the drug). Some examples of how women and men metabolize drugs differently are described in the literature for commonly prescribed medications: theophylline, acetaminophen, aspirin, propranolol, and lidocaine. Heterogeneity among women also should be recognized in terms of drug metabolism. Variances to consider include age, hormonal status, race, ethnicity, and socioeconomic factors. The extent to which these differences
prevail among the range of drugs used to prevent and treat disease is still not fully known or understood.

Recent FDA guidelines urge drug investigators to account for pharmacodynamic and pharmacokinetic gender differences throughout the drug development process and to include women of childbearing age in both Phase I and Phase II clinical trials (Table 1.2). In its 1977 guidelines, the FDA excluded women of childbearing potential from clinical trials. Revised guidelines in 1993 called for gender-specific analyses of safety and effectiveness in new drugs and removed

Table 1.1 Women and Men: Ten Differences That Make a Difference

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<th>Difference</th>
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<tr>
<td>Heart Disease. Heart disease kills 500,000 American women each year—over 50,000 more women than men—and strikes women, on average, 10 years later than men. Women are more likely than men to have a second heart attack within a year of the first one.</td>
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<td>Depression. Women are two to three times more likely than men to suffer from depression, in part because women's brains make less of the hormone serotonin.</td>
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<td>Osteoporosis. Women account for 80% of the population suffering from osteoporosis, which is attributable to their higher rate of lost bone mass.</td>
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<td>Smoking. Smoking has a more negative effect on cardiovascular health in women than men. Women are also less successful in quitting smoking and have more severe withdrawal symptoms.</td>
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<td>Sexually Transmitted Diseases. Women are twice as likely as men to contract a sexually transmitted disease.</td>
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<td>Anesthesia. Women tend to wake up from anesthesia more quickly than men—an average of 7 minutes for women and 11 minutes for men.</td>
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<td>Drug Reactions. Even common drugs like antihistamines and antibiotics drugs can cause different reactions and side effects in women and men.</td>
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<td>Autoimmune Diseases. Three out of four people suffering from autoimmune diseases, such as multiple sclerosis, rheumatoid arthritis, and lupus, are women.</td>
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<td>Alcohol. Women produce less of the gastric enzyme that breaks down ethanol in the stomach. Therefore, after consuming the same amount of alcohol, women have a higher blood alcohol content than men, even allowing for size differences.</td>
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<tr>
<td>Pain. Some pain medications (known as kappa-opiates) are far more effective in relieving pain in women than in men.</td>
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the FDA's policy of excluding women of childbearing potential from early drug studies. These measures have helped the FDA acquire better information on drug effects in women.11

A serious issue in gender-based research has been the concern of pharmaceutical manufacturers that by identifying drugs as effective in only one gender, the

It's Your Health

Research Studies

1. Descriptive Studies examine general characteristics of distribution of a disease in relation to person, place, and time using indices such as basic demographic factors (i.e., age, sex, race), geography, and seasonal or yearly patterns.
   - Population or Correlational Studies: use data from entire populations to compare diseases between and among groups during the same time period or the same groups during different time periods.
   - Individual Studies: case report studies detail a profile of a single patient; case series describe a number of patients with a given disease; cross-sectional surveys involve questionnaires that inquire about presence or absence of disease and exposure or specific risk factors in groups of people.

2. Analytic Studies involve groups of individuals who are investigated to compare risk of disease in people exposed to a specific factor with those people not exposed.
   - Observational Studies: researcher observes course of events in either a case-control study or cohort study. A case-control study involves observing patients without a disease and comparing them with a control group of people with a disease. Cohort studies group people based on the presence or absence of a specific factor of interest and then follow the group to determine development of a disease.
     - Retrospective Observational Study—both disease and exposure have occurred and investigator is determining whether the exposure caused the disease.
     - Prospective Observational Study—the exposure has occurred but the disease has not; therefore, population is observed in comparison with unexposed subjects.
   - Intervention Studies: viewed as a type of prospective cohort study; however, the exposure status of the population is assigned by the researcher.
     - Clinical Trial—a research study designed to answer specific questions about vaccines or new therapies or new ways of using known treatments. Clinical trials are used to determine whether new drugs or treatments are both safe and effective.

Table 1.2 Phases of a Clinical Trial

- **Phase I:** new drug tested in a small group of healthy volunteers (20–80) to evaluate its safety, determine a safe dosage range, and identify side effects.
- **Phase II:** study drug is given to a larger group of people (100–300) to further evaluate its safety and effectiveness.
- **Phase III:** study drug is given to large groups in clinics and hospitals (1,000–3,000) to confirm its effectiveness, monitor side effects, and compare it with other treatments.
- **Phase IV:** study done after drug is marketed to continue collecting information regarding the drug's effects in various populations.
potential market for their drugs could be limited, thereby decreasing their expected profits. Recently, however, the pharmaceutical industry has been instrumental in meeting the special needs of women by increasing research devoted to medicines for treating diseases that disproportionately affect women. Pharmaceutical companies are currently developing over 350 new medicines targeting more than 30 diseases that disproportionately affect women. The potential medicines, all either in clinical trials or awaiting final approval by the FDA, target breast cancer, ovarian cancer, arthritis, diabetes, depression, osteoporosis, and multiple sclerosis. In addition, companies have medicines in their pipelines for heart disease, stroke, and lung cancer, three leading causes of death in women.12

Even with all of the advances toward inclusion of women and minority groups in research studies, one barrier to women's participation in biomedical research still exists. Many women are unable to take part in clinical trials because of a lack of insurance coverage. A growing number of states have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care that a woman may receive as a participant in a clinical trial. In 2000, Medicare began covering beneficiaries' patient care costs in clinical trials.13 Clinical trials still are considered experimental by some insurance companies, however, and therefore are not covered under all standard health policies.14

Including women in clinical studies may pose challenges, but leaving them out courts disaster through ignorance. Using women, particularly women of childbearing age, presents challenges to the investigation as the researchers must consider the effect of hormonal cycling on the hypothesis being tested. Furthermore, the potential for pregnancy and possible teratogenic effects in the fetus must be considered. These factors weigh heavily in designing and conducting any study.

Although information continues to emerge from ongoing women's health research, additional studies are needed to discover optimal preventive measures and interventions to reduce risk factors and improve health outcomes for women. This is particularly so in the case of sex differences in disease presentation, progression, and response to therapies. Standards of medical care and public health policies that recognize biological and psychosocial differences must be developed. Action on examining sex/gender differences in health has been promulgated by many of the federal agencies and organizations that initially brought about equity in women's health research. Several of these agencies and other private organizations commissioned a study by the National Academies of Science's Institute of Medicine to examine these differences. That study, Exploring the Biological Considerations of Health: Does Sex Matter?, was published in 2001 and has provoked a more intense focus on sex/gender differences in research and practice.4 The current challenge in women's health research is to establish a scientific knowledge base that permits reliable diagnoses and effective prevention and treatment strategies for all women.

Reproductive Rights

The history and politics of abortion are long and complex. (See Chapter 5 for a detailed history.) For nearly a century, abortion was illegal in the United States. On January 22, 1973, it was legalized in the United States through the landmark
Supreme Court decision *Roe v. Wade*. On January 22, 2001—President George W. Bush's second day in office and the twenty-eighth anniversary of the *Roe v. Wade* decision that legalized abortion—the “global gag rule” on international family planning assistance was reinstated. Previously known as the “Mexico City Policy” when the Reagan Administration imposed it in 1984, the rule had been eliminated by the Clinton Administration in 1993. Under the global gag rule, foreign family planning agencies may not receive U.S. assistance if they provide the following services, even if the funds used for these services are from another source:

- Perform abortion in cases of pregnancy that are not life-threatening to the woman or the result of rape or incest
- Provide counseling and referral for abortions
- Lobby to legalize abortion or increase its availability in the country in which the NGO is operating

Restrictions on funding can lead to an increase in unplanned pregnancies, abortions, maternal and infant deaths, and transmission of HIV in countries around the world. The global gag rule represents a step toward limiting reproductive freedom, just like the recent push to overturn the *Roe v. Wade* decision. Although the Supreme Court's decision on abortion still stands, state restrictions have been imposed that limit a woman's access to reproductive health services.

**Access to Healthcare Providers, Services, and Health Information**

Advances in public health and medicine have created significant improvements in the prevention, diagnosis, and treatment of disease. Many people are living longer and healthier lives as a result. Over the years, women have learned to seek out medical information on their own, thereby becoming informed consumers of medicine. As new findings lead to improved methods of prevention, public health officials and healthcare practitioners focus on encouraging healthcare consumers to practice health promotion and disease prevention.

Unfortunately, healthcare promotion and disease prevention are not simple. Many women encounter barriers to adequate health care, such as the following:

- Low socioeconomic status
- Lack of health insurance
- Lack of access to healthcare facilities
- Inability to understand medical personnel because of language barriers or illiteracy
- Unfair treatment by medical personnel because of race, ethnicity, or sexual orientation
- Inability to pay for the costs of medications needed for treatment
- Declined coverage for healthcare costs that are deemed unnecessary or experimental
- Fear of doctors and avoidance of seeking health care altogether
Lack of adequate access to healthcare services and information is a serious issue in the United States, with a lack of health insurance being one of the most formidable barriers. In 2001, 41.2 million Americans were uninsured and millions more were underinsured, meaning their health insurance coverage had limitations that restricted access to necessary services. Such restrictions could mean lack of coverage in the event of a serious illness, exclusion for preexisting conditions, increased co-payments and deductibles, increased patient responsibility for payment of prescription medications, gaps in Medicare service, and lack of coverage for long-term care. Often, as unemployment rates rise, the number of people covered by insurance steadily declines. Premiums for private health insurance are extremely expensive and, therefore, many people opt to take a chance and remain uninsured when an employer does not sponsor them. (For more information on this issue, see Chapter 2.)

Lack of cultural and gender sensitivity and failure to fully understand women’s health needs also create barriers for women. To bring women’s health into the mainstream of medical education, ORWH developed a model curriculum in women’s health for medical schools. Research findings and guidelines for the health care of women are being incorporated into education and training curricula for osteopathic and allopathic schools; dental, nursing, and pharmacy programs; and medical schools. Incorporating women’s health as part of the curriculum for medical students, nursing students, and other healthcare practitioners has reiterated the uniqueness of being female, along with emphasizing the heterogeneity of women as a population. Medical school graduates are now being trained in cultural and gender sensitivity and the use of medical interventions appropriate to different cultures and women. This minimization—and ideally elimination—of physicians treating all patients as a homogenous group should improve access to health care by removing the cultural and gender barriers for minorities and women. Other strategies for ensuring the inclusion of women’s health in educational curricula include sponsorship of residency training and fellowship programs in women’s health and demands for state licensing boards to evaluate a physician’s competency in women’s health.17,18

Global Perspective on Women’s Health

Throughout the world, inequities remain in women’s health care and research. Furthermore, there is a great difference in the leading causes of morbidity and mortality between developing countries and developed countries. Global threats to women’s health include poverty, underweight and malnutrition, HIV/AIDS, violence, and maternal morbidity and mortality. Women are burdened not only by disease, but also by violations of their human rights that directly affect their health. These problems include domestic and societal violence, female genital mutilation, honor killings, trafficking, and barriers to reproductive health services. The social, political, and economic determinants of health greatly affect women and children throughout the world. Access to clean water, nutritious food, and medical care, as well as protection from violence and poor working conditions, are basic rights
that should be afforded to all for the improvement of health on a global scale. Social inequalities, such as lack of education, money, and decision-making freedom, pose a greater threat to women than to men, as women consequently end up with a disproportionately higher burden of disease, poverty, and maternal morbidity and mortality. Women also have the double burden of work and family drawing on them. Alignment among women across the world has become a powerful force for change.

Since 1975, five world conferences on women convened by the United Nations (UN) have worked for the advancement of women to achieve gender equality. The first world conference on the status of women met in Mexico City and developed a World Plan of Action, which offered guidelines for governments and communities throughout the world to follow. The focus of these guidelines was to secure equal access for women to resources such as education, employment opportunities, political representation, health services, housing, nutrition, and family planning.

In 1980, the second world conference on women met to review and appraise the 1975 World Plan of Action. Significant progress had been made, including the adoption of the “Convention on the Elimination of All Forms of Discrimination Against Women,” also referred to as “the bill of rights for women.” It legally binds 165 member states of the UN to report on steps they have taken toward achieving women's equality. Despite the progress, members at the conference recognized that a discrepancy existed between secured legal rights and women's ability to exercise those rights. A variety of factors were noted as causing the discrepancies, including a lack of men involved in improving women's role in society; a lack of women in decision-making positions; insufficient supportive services for women and families, such as childcare facilities; and a lack of awareness among women about opportunities available to them.18

By the third world conference, held in 1985 in Nairobi, the women's movement toward gender equality had achieved international recognition. This conference became known as the “birth of global feminism.” While successes were being celebrated, evidence pointed to only a minority of women benefiting from the advances. A new approach toward the women's movement was identified—all issues...
were now declared to be women’s issues. Women’s active involvement in all issues, from education and employment to health and science to industry and the environment, was necessary if women were to attain equality.

In 1995, the fourth world conference on women was held in Beijing and was considered a great success. The conference led to the recognition that “the entire structure of society, and all relations between men and women within it, had to be re-evaluated.”

Twelve critical areas of concern were highlighted as the greatest obstacles to women’s advancement (Table 1.3).

In the five years since Beijing, culminating with the New York conference “Women 2000: Gender Equality, Development and Peace for the 21st Century,” also known as “Beijing + 5,” the achievements of governments have been evaluated and new action plans have been prepared. Additionally, the UN’s Millenium Development Goals specifically look at how the UN and other groups can measure countries’ progress toward promoting gender equity and empowering women. Indicators used to measure progress include the ratio of girls to boys in primary, secondary, and tertiary schools; the ratio of literate women to men; the percentage of women in waged employment; the proportion of seats held by women in parliament; the maternal mortality rate; and the percentage of births attended by a skilled health professional.

Advances have been recorded, although women still face discrimination and marginalization, and they continue to account for the majority of the world’s poor.

Much work remains to be done; yet the accomplishments that have arisen from the five world conferences deserve to be celebrated. By uniting the international community, women and men throughout the world have created a set of common objectives with the one final goal of equality for everyone.

### Table 1.3 Beijing Conference’s Platform of Action—Twelve Critical Areas of Concern

- Women and poverty
- Education and training of women
- Women and health
- Violence against women
- Women and armed conflict
- Women and the economy
- Women in power and decision making
- Institutional mechanisms for the advancement of women
- Human rights of women
- Women and the media
- Women and the environment
- The girl child

Informed Decision Making: Take Action

There are a number of ways to become involved in women's health advocacy. Many women's health organizations encourage becoming members by donating, getting involved by sending letters to legislators and helping to organize events, and educating oneself on women's health issues. Visiting the Internet can be a good first step in learning about various organizations and deciding where to focus personal interest and commitment. A number of organizations that offer ways for individuals to start becoming involved are listed in the Web sites section.

Summary

Women's health has become part of mainstream medicine, brought to the forefront of national attention and out of the auspices of solely feminist advocacy groups.
Although tremendous progress has been achieved in expanding the scope and depth of women's health research, major challenges remain. Continued success in the women's health movement is predicated on a series of factors: legislative mandates; 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. These factors have been catalysts driving the explosion in women's health research and are responsible for both the present state of success in developed countries and the advancements being made throughout the world. Biological, behavioral, and social sciences have provided critical insights and important data that have enhanced women's health and well-being. The research success from developed countries is slowly kindling international awareness such that women’s health and gender equity are improving across the world, albeit at a slower pace than many might desire.

**Topics for Discussion**

1. The women's health movement has played a critical role in bringing women’s health issues to the forefront. Has the success of the movement made it obsolete for the future? Why did the women’s health movement advance so rapidly during the 1990s?

2. Numerous women’s advocacy organizations exist today. What challenges do they face in representing their constituents? How can they maximize their impact while also competing for scarce funding resources?

3. How has the modern information age influenced women’s advocacy in both positive and negative ways?

4. What areas of health could benefit from gender-based research?

5. What are some gender inequities that are present throughout the world?

6. Discuss the ways the government is involved in the following areas in relation to health:
   - Policy making
   - Financing
   - Protecting the health of the public
   - Collecting and disseminating information about health and healthcare delivery systems
   - Capacity building for population health
   - Managing of health services

**Web Sites**

- Black Women’s Health Imperative: [http://www.blackwomenshealth.org](http://www.blackwomenshealth.org)
- Centers for Disease Control and Prevention: [http://www.cdc.gov/health/womens menu.htm](http://www.cdc.gov/health/womens menu.htm)
Equal Rights Amendment: http://www.equalrightsamendment.org
Feminist Women's Health Center: http://www.fwhc.org
National Organization for Women (NOW): http://www.now.org
The National Women's Health Information Center: http://www.4woman.gov
The Office on Women's Health: http://www.4woman.gov/owh/index.htm
Office of Research on Women's Health: http://orwh.od.nih.gov
Planned Parenthood Federation of America: http://www.plannedparenthood.org
Society for Women's Health Research: http://www.womenshealthresearch.org
U.S. Food and Drug Administration (FDA): http://www.fda.gov
Women's Issues in Congress: http://www.womenspolicy.org

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