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Women's health: A global perspective

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Abstract
The purpose of this chapter is to discuss global issues related to women's health. Several universal issues were selected for presentation to provide a context for understanding health care for women and to challenge readers to identify potential threats to quality care. In addition, principles that have been proposed for the development and implementation of a viable and comprehensive health care system for women are identified and discussed. The intent here is not to capture the situation and health experience of women in all parts of the world; nor is it possible to address all the contextual contingencies needed for addressing women's health. Rather, the intent is to provide a framework for understanding the neglect that women have encountered in all aspects of their lives, including health care. Furthermore, our aim is to provide those who have been committed to health care for women with support in their attempt to provide quality health care for other women. Finally, our goal is to raise the readers' consciousness of women's health needs beyond the United States. We fully realize that women's health issues cannot be understood in isolation from the specific sociocultural context of their situations; however, by highlighting some universals, perhaps we can underscore the need for global cooperation in taking a more coherent and coordinated approach to providing affordable and quality health care for women.

Keywords
nursing, women's health

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Women's health
A global perspective

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The purpose of this chapter is to discuss global issues related to women's health. Several universal issues were selected for presentation to provide a context for understanding health care for women and to challenge readers to identify potential threats to quality care. In addition, principles that have been proposed for the development and implementation of a viable and comprehensive health care system for women are identified and discussed. The intent here is not to capture the situation and health experience of women in all parts of the world; nor is it possible to address all the contextual contingencies needed for addressing women's health. Rather, the intent is to provide a framework for understanding the neglect that women have encountered in all aspects of their lives, including health care. Furthermore, our aim is to provide those who have been committed to health care for women with support in their attempt to provide quality health care for other women. Finally, our goal is to raise the readers' consciousness of women's health needs beyond the United States. We fully realize that women's health issues cannot be understood in isolation from the specific sociocultural context of their situations; however, by highlighting some universals, perhaps we can underscore the need for global cooperation in taking a more coherent and coordinated approach to providing affordable and quality health care for women.

There are certain contextual patterns of the treatment of women that are global. There is a universal tendency to define women by their marital status, and there is an overall pressure on women to conform to certain global expectations that are considered normative and ideal. Women are expected to attach themselves to a father, a brother, a husband, or a son. Although the intensity and the quality of this normative ideal differs from one country to another, from one culture to another, and from one class to another, there is a general agreement that young girls are socialized to prepare themselves for spousal and maternal roles. These expectations decrease the potential for promoting and supporting educational or career goals and increase the potential for status and power issues.

Similarly, there is a global focus on reproductive health and on reducing women's health concerns to only the reproductive aspects of their life cycle. The focus on physical reproduction, as opposed to socially productive tasks of women, tends to decrease the potential for understanding and attending to the critical needs of women throughout the life cycle and beyond conceiving and delivering a healthy baby (National Council for International Health, 1991). The focus on reproductive aspects of women's health also tends to take these issues out of context and render the results unsatisfactory for both the planners and recipients of health care. Family planning programs that focus on birth control are a good example of how an important issue in women's lives that is bound to the family and society is reduced to the question of birth control methods. This in turn tends to decrease the potential success of these programs. McFarland (1988) reviewed the literature on development theory and women and made the following assertion:

In the population policy and reproductive rights area, women's perspective has been ignored. Planners have had little understanding of women's mixed responses to family planning. The role of children as workers, old age security, and property inheritors has been ignored, as well as the fact that all or most of the birth control methods are unsafe or unsatisfactory.

Questions and studies about family planning that are inspired by such an approach, that is, one with a focus on women as defective reproductive beings, tend to center on (1) why women are unable to plan the size of their families and the spacing of their children (i.e., what is...
ample is women's work in facilitating health care for family members. Women are consistently expected to be the first gatekeepers to preventive, promotive, and curative health care; they are the key providing access to and utilization of health care for others in the family and the community (Meleis & Rogers, 1987).

Despite the apparent involvement of women in productive work in or outside the home, and despite their needs for "development" and for better compensation, development programs have focused primarily on men. These programs are designed to make men's lives easier by developing the technology to support their work, whether that work is on a farm or in the business world. Even when development programs have considered women, they have tended to label their work as craftwork, which means that it is extra and not central to a country's economy as other forms of productive work (McFarland, 1988). There is a growing discomfort with development programs in general because of the lack of clarity of their missions. Questions such as development of what, for whom, by whom, and for whose benefit need to be debated carefully and ethically. Exploitation of resources and labor in developing countries for the benefit of "first world" white males is being questioned and debated in both developing and developed countries.

**HEALTH AND ILLNESS EXPERIENCES AND RESPONSES**

Within this context, we describe and discuss some aspects of women's health related to the experience of and response to illness. In addition to the communicable diseases and other illnesses shared by both sexes, there are a number of illnesses and injuries that are primarily associated with women (Rodin & Ickovics, 1990). These non-reproductive health problems are less likely to be detected and treated because of the narrow framework used in considering health care for women that results from the lack of awareness of both the recipients and providers regarding the extent of women's health care needs and their need for comprehensive care. By and large, women are either not aware of such health care needs; they are aware but tend to ignore these needs because of their demanding role responsibilities, workload, and other caregiving activities; or they have been prevented from seeking health care and from maintaining their health by limited resources and structural constraints. Personal health hazards that make women more vulnerable thus remain obscured until the women show symptoms related to reproductive health, which makes their illness situation more legitimate. Or women seek health care later than they should because of the financial cost of the condition or because they feel more comfortable staying home. Women's chances of securing health care are further reduced by the health professionals' inability to detect illness. Women have selected as their helpers in patterns of care to which they are accustomed.
Women make up the bulk of the population who consume fewer calories than needed. Similarly, the death rate for female children is higher than that for their male counterparts in some parts of the world such as India and Egypt. One reason for this discrepancy is society-imposed eating conditions that increase the probability of nutritional deficiencies in women—"they eat last and least" (WHO, 1984; 1985).

In some developing countries, male and female children are fed differently, with boys getting more nutrients and larger quantities of food than girls. The pattern begins early in life: boys are breast-fed longer and given more solid foods after weaning than girls (Ojangua & Gilbert, 1992). For example, in one country a study of intrafamilial sex bias in the allocation of food and health care showed that among children the caloric consumption was on average 16% higher for boys than for girls. This was reflected in a significantly higher prevalence of malnutrition among the female children—11% of them being severely malnourished compared with 5% of the male children (WHO, 1984). Moreover, girls start work early as helpers in household chores. Accordingly, the increased energy needs and deficient caloric intake affect girls' weights and heights. In addition, many of these girls start their reproductive lives early, which drains more of their energy reserves, leading to pregnancy-related complications. These nutritionally deficient women give birth to children with low birth weights, to start the vicious cycle again (WHO, 1985).

Nutritional anemias in women warrant special emphasis. Nutritional anemias are due to metabolic defects, hemorrhage, or chronic blood loss. However, they are also due to deficiencies in the diet that restrict the formation of new blood cells. Shortage of iron, folate, or vitamin B₁₂ in the diet can contribute to anemia. Anemia occurs more commonly in women because of dietary restrictions and increased iron needs during reproductive years. It has been estimated that 47% of all women and 59% of all pregnant women in developing countries are anemic (Bruce, 1981).

Another nutritional deficiency of importance that affects these women is rickets. Rachitic osteomalacia and contracted pelvis—a condition that still occurs in developing countries—is almost extinct in the more economically advantaged countries. The same story is repeated in many other nutritional deficiency conditions that are aggravated by the maternal depletion syndrome. Studies have shown that poor nutritional status can lead to low-birth-weight babies, unfavorable reproductive histories, obstetrical complications, and increased susceptibility to infection (Bruce, 1981). Similar nutritional status is manifested in more economically advantaged countries, where they are labeled eating disorders. Examples are obesity, bulimia, and anorexia nervosa. These eating disorders can only be adequately understood when considered within the context of societal expectations of women and the myths surrounding women's figures and weight.

Infections

Infections and reinfections of the female organs are numerous, widespread, and increasing, and continue to be ignored. They are caused by viruses, yeasts, bacteria, and other agents that are acquired through poor hygiene around the menstrual period; through sexual intercourse, childbirth, or abortion; or through the use of intrauterine devices (IUDs). IUDs were introduced to help planners control family size and to help women gain control over their lives. However, limited long-term, careful research resulted in the creation of another menace to women's health and a threat to the quality of their lives; more infections resulted or were aggravated by the use of IUDs.

These genital infections, besides their effect on the general health of the woman, affect reproductive health by causing infertility or by forming the basis for later ectopic pregnancies and other problems such as low birth weights and congenital anomalies. Pelvic inflammatory disease (PID), which involves the fallopian tubes and/or the ovaries and uterus, follows genital infection, particularly gonorrhea. In many developing countries, endemic diseases such as schistosomiasis and filariasis weaken tubal tissue and make it more vulnerable to secondary infection, and may also affect the incidence of PID.

These genital infections are of serious consequence and may lead to infertility. It is estimated that 10% to 17% of all women who suffer from genital inflammatory disease become infertile because of blockage of fallopian tubes. In addition, in Central and West Africa it was estimated that 30% or more of these genital infections not only affect the women but also the offspring, with effects ranging from low birth weight to congenital deformity to death of the newborn (Bruce, 1981).

Women are also prone to communicable diseases that are acquired through their caregiving activities for the sick members of their families. In addition, during their
household duties they are exposed to many unsanitary conditions that put them at risk. Predisposition to diseases is counteracted by resistance, but this is compromised by malnutrition and complications of pregnancy.

Violence against women

The lower status of women in the family in many cultures makes them more susceptible to violence (Russo, 1990). In some communities and nations, manliness and masculinity tend to support a system in which the wife and the child are considered the property of the men in the family; such systems condone "disciplinary" actions through all forms of abuse. In wars and other upheavals, women are usually very susceptible to violence. For example, there are many chilling historical accounts of violence to, and abuse and rape of, women in the Pakistan-Bangladesh war, during the coup against Salvador Allende in Chile, and in the Persian Gulf War. Newspaper accounts in the United States included incidents of women in the military being abused by their colleagues and superiors. These women were afraid to discuss their abuse. Reporting of violent incidents is minimal for fear that exposure will bring dishonor to the woman and her family and for fear of reprisal.

Female circumcision is a practice that is carried out in some societies and is considered by many to be a form of violence. There are three types of circumcision: clitoridectomy, excision, and infibulation. Depending on the type, either the clitoris only is excised; the clitoris and the labia minora are excised; or the clitoris, the labia minora, and the labia majora are excised and stitched together, causing scar tissue (Koso-Thomas, 1987). All forms of female circumcision are done to diminish or prevent the violence. In several countries immune from other forms of "circumcision" or otherwise, child mortality rates remain at alarmingly high levels, although men may condone it, they are not the ones who keep it in practice.

Reproductive health

Reproductive and maternal health are an important aspect of women's health and are considered an element of primary health care, especially as they relate to maternal-child health. Also, women usually enter the health care system for reproductive care. In a number of countries, maternal mortality rates remain at alarmingly high levels, as does the low nutritional status of women throughout their reproductive cycles ("Family Planning Programs," 1984; WHO, 1991). It has been estimated that there are at least half a million preventable maternal deaths in the world each year (WHO, 1991). For example, it is estimated that 40 to 50 million girls are circumcised each year in the world alone. The mortality is high, and it is estimated that 100,000 girls die each year as a result of circumcision. The mortality is high, and it is estimated that 100,000 girls die each year as a result of circumcision.

The influence of these experiences on women's mental health is well documented (Bickerton, Hall, & Williams, 1991; Orbach, 1986; Scott, 1992; Zimmerman, 1991). Maternal mortality. It is estimated that 20 million women die as a result of unsafe abortions. It is estimated that 20 million women die as a result of unsafe abortions.
Women's health

The other factor affecting the reproductive health of women and their general health is age at marriage. Early marriage is the norm in many parts of the world; for some, puberty marks a milestone for marriage. In Bangladesh, for example, two thirds of all women 19 years of age or younger are already married (Bangladesh Ministry of Health and Population Control, 1978), and in Afghanistan, Malawi, Mali, Nepal, North Yemen, and Egypt more than half of all women 19 or younger are married (Hasan, 1988). In the Middle East, South Asia and parts of Africa, marriages arranged by families are often between adolescent girls and considerably older men. These conditions increase women's risk of morbidity and mortality and decrease women's options for education and employment. In turn, decreased options may influence women's awareness of their health needs and their access to quality health care. Developed countries are not immune to adolescent pregnancy. In the United States, adolescent pregnancy has been linked to low birth weight and maternal complications (Zambrana, 1988). However, the availability of health care resources in the high-income countries acts as a buffer against these complications.

Abortion is an important factor that also affects women's health in general. Abortion is considered illegal in most of the Christian and Islamic doctrines and is viewed as a defiance of God's will. Religious law forbids the killing of innocent children, yet innocent mothers who are trying to exercise control over their own bodies become victims. Induced abortions, which are unregulated because of restrictive laws, expose women to another set of major risks. This is particularly problematic. In the majority of developing countries, abortion is illegal but is the most widely used method of fertility regulation. It is estimated that 35 to 55 million pregnancies worldwide are terminated each year through induced abortion (Blair, 1980). Infection, hemorrhage, and trauma are quite common. Tetanus is a serious danger accompanying criminal abortion. Its effect on the procedure, even if that procedure spares the woman's life, seriously affects her fertility and personal health later.

Even in those developing countries where laws are liberal, as in India, lack of facilities renders legal abortion unobtainable for most women; therefore, women resort to ways of ending their unwanted pregnancies that increase their health risks. Such ways include introducing plant stems or foreign bodies into the uterus through the vaginal canal or herbal pastes prepared by an herbalist. Recently, developing countries have been watching the United States struggle as it attempts to resolve the issues surrounding abortion in a way that addresses and encompasses the rights of women as well as those of their unborn children. Limiting and regulating conception is considered a woman's problem in most of the world. Even when methods are developed to help women decrease the
health problems related to reproduction, these methods are not carefully developed and monitored. Safety of contraceptive methods has been assumed more than proved, and not until recently have these methods been investigated through longitudinal research studies. As a result, a number of methods have been withdrawn from the market, after having been used for decades, because of new discoveries related to adverse long-term effects on women's health. For example, the relationship between smoking and contraceptive pills has prompted the issuance of new warnings (Population Crisis Committee, 1988). The interaction between contraceptives and other major lifestyle factors has been largely ignored. New discussions about the significance of these relationships are emerging in international conferences and in global agendas such as those at the recent United Nations Conferences in Cairo (1994) and Beijing (United Nations, 1995).

**Occupational health**

Women are equally exposed to the occurrence of health hazards as are men, whether in developed or developing countries. Some conditions, however, make women more vulnerable. For example, women's work at home exposes wives fall off roofs or are exposed to unwarranted ill­

Men's work is either invisible (e.g., housework, farm work) or devalued (e.g., clerical work, domestic work, hospital work). Lane and Meleis (1991) reported that farmers' and responsibilities such as scooping manure with their bare hands.

Agricultural workers exposed to chemicals used in pesticides are at risk for cancer, and pregnant women tend to suffer additional consequences that affect the health of their children. They may suffer from pregnancy complications such as miscarriage, or their babies may show birth defects. This occurs more often in developing countries, where over-spraying by untrained workers takes place and wearing of protective clothing is largely unknown. The toxic effect of the chemicals is passed to the infants through the mothers' milk. In addition, the effects of anesthetic gases that cause a higher incidence of miscarriage, congenital defects, and infertility among nurses working in the operating room have been inadequately studied and poorly regulated (Datta, Sharma, Razack, Ghosh, & Arora, 1980).

Women are also more vulnerable to overwork as an occupational hazard (Hibbard & Pope, 1991). Working women generally take care of their households and children in addition to their full-time jobs outside the home. The "double day," or second-shift phenomenon (Hoch­child, 1989), in which there is a combination of economic and family responsibilities, results in fatigue and predisposes women to mental health problems. A 1988 study analyzed 2.3 billion women (92% of the world's female population) in an effort to determine and score their social status (Population Crisis Committee, 1988). Five aspects were included: health, education, employment, marriage and children, and equality. Fifty-one of the 99 countries included in the study fell into the lowest third of the ranking. The results further indicated that 60% of all women and girls in the world live under conditions that threaten their health, deny them a chance to bear children, limit their educational attainment, restrict their economic participation, and fail to guarantee them equal rights and freedom from oppression.

One of the interesting findings of this study was how the number of births is related to the status score. In countries with higher scores, indicating a higher status for women, the pregnancy rate is lower as compared with the rate in countries with poor or lower rankings in social status. The number of births in the countries with high ranking ("very good" to "good" categories) averages two per woman, while it is four or above in the "poor," "very poor," and "extremely poor" countries.

Better education and work that produces financial re­muneration increase women's options and resources and enhance their power base. However, women seem to be disenfranchised even as they attempt to exercise these options. Sons are favored over daughters to receive education. Even when they enter the educational sector, girls get less time to study; and in some countries, their education is terminated at puberty under the false pretense of preserving their honor and their chastity. Education and employment, key in women's health, are both related to resources and to a level of consciousness. A unique situation is that, as health care providers, women often constitute a majority. Available statistics suggest that in most countries the labor force in the formal health care system tends to be predominantly female. But here again, women tend to feel underpaid, holding the less prestigious jobs rather than those with status and decision-making power.

Women also constitute the majority of the volunteers in hospitals, clinics, and other community health organizations. The unique predominance of women in the health care system makes them a major target of impor­tance in primary health care. It is also the woman who is expected to be the health provider and educator in the

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boiling and for storing the water. Another example is
breast-feeding. Breast-feeding for prolonged periods of
time (2 years) has been proved to result in healthier ba­
ies, less time spent by women on sick children, and less
money spent on formula (WHO, 1991). It also has a con­
traceptive effect (although this is questionable because of
factors such as length of feeding and amount of milk).
However, breast-feeding for a prolonged time has also
been related to an increased likelihood of anemia in
these women.

Limited access to health care

Although access issues are most often related to vari­
bles such as a country's socioeconomic level, the status
of women in a particular culture, the position of women
in the workforce, and a country's cultural and ethnic heri­
tage, gender plays an equally important role in limiting
access to health care (Puentes-Markides, 1992). Limita­
tion of access may also be due to poverty, to a mis­
matching of the explanatory frameworks of both the pro­
vider and recipient, or to a general lack of comprehen­
siveness in health care services (Bernal & Meleis, 1995).
Additionally, role overload and work responsibilities have
also prevented women from seeking out health care and
have promoted self-neglect (Walker & Best, 1991).

Other structural barriers exist for women, particularly
in some developing countries. Women are generally not
included in the planning and designing of health care ser­
\services; therefore, their issues and concerns may not be reflected
in the resulting programs. Furthermore, these programs,
which are developed by men, tend not to meet specific
female health care needs as perceived by women. In these
countries, young girls often face additional limitations
placed on them by their families, who give preferential
treatment to their male children when both children are
sick (Chen, Huq, & D'Souza, 1981), or by the health care
system through institutional discrimination (Gopalan &
Naidu, 1972). It is vitally important to increase women's
access to health care services in developing countries
(Ojanuga & Gilbert, 1992), as well as to improve access of
disenfranchised populations (including women) in de­
veloped countries (Stevens, 1993).

WOMEN’S HEALTH: A CHANGING AGENDA

Women's health issues have emerged at the top of the
worldwide health care agenda. This global concern was
evidenced during two milestone conferences that resulted
in the Cairo Action Document (United Nations, 1994)
and the Beijing Document (United Nations, 1995). The
Cairo Action Document identified women, their status,
and their development as central to population programs,
and to global development efforts, and the Beijing docu­
ment emphasized attention to women's human rights.
Both of these documents called for the strengthening of
political commitments to population-related policies,
to family planning programs, and to women's health and
development in general. The heated debates related to the
development of these documents attracted the interest of
the international media, thereby focusing even more at­
tention on women and their health care issues. The par­
ticipants in each of the conferences recognized the im­
portance of constructing a framework that was more
congruent with women's specific health care require­
ments—that is, requirements that were subsequently incor­
porated into these policy documents by their respective au­
thors.

To enhance women's health globally, health care pro­
cgrams should be established within a framework that
acknowledges women's perspectives, experiences, and con­
texts. The context of the totality of women's daily
situations and daily experiences and role responsibili­
ties as women themselves see them must be captured, de­
scribed, and carefully integrated into health care plans
(Meleis et al., 1990). It is through such an approach that
groups of women who are most vulnerable to health risks
may be identified and that appropriate resources that are
more congruent with their needs may be developed (Ste­
vens, Hall, & Meleis, 1992). To do these things, health care
researchers, planners, and providers need to think of
ways in which the women's different voices can be heard.
Gaps in knowledge related to women's situations should become a top priority. The ways in which women tend to integrate their roles on a daily basis and the patterns of management of the complex and intricate aspects of each of their daily roles need to be uncovered and addressed (Meleis & Bernal, 1995; Meleis & Stevens, 1992). Special attention should be given to how women perceive and enact their roles as providers, mothers, caregivers, spouses, daughters, and workers, and to experiences that render them vulnerable. Vulnerability is defined as "the process of persons being unprotected or open to damage in their interactions with a challenging or threatening environment" (Hall, Stevens, & Meleis, 1992, p. 755). A focus on women's roles, integrations, and vulnerabilities could help to identify women's critical needs.

Strategies are needed for the development of nursing therapeutics to empower women. A focus on empowerment is holistic, encompassing, and potentially fruitful. Empowerment does not only include increased understanding of women and their problems or enhancement of their education; more importantly, it means providing them with resources and a social structure that support them in carrying out their various roles. It also means providing them with accessible services. Health service accessibility includes cost, convenience, and compatibility. Cost involves not only the cost of the service but also the cost of transportation to the service for the mother and/or child. The convenience of the service, including the time schedule, should be compatible with the scheme of the mother's life. Women cannot easily leave their day-to-day chores and responsibilities. Compatibility of services includes compatibility with the woman's beliefs, her preferences, and her habits. The most outstanding example of incompatibility would be the discomfort of some women in dealing with an unfamiliar male health provider. In this respect, the use and upgrading of already existing services, such as traditional birth attendants, can be of great benefit. Careful analysis and consideration of laws that put women at risk, and of the gaps between the spirit of the law and its implementation, should be a context for any discourse related to women's health. Examples of relevant laws are those that govern age requirements for marriage, leaves of absence for domestic workers, and working with hazardous materials. Discourse about laws related to such issues as female circumcision should be handled within sociocultural and historical contexts. To have a viable women's health program, women need to think both locally and globally. The development of a united front is the single most powerful strategy to improve women's status and situation, which in turn could have a profound effect on women's health. Examples of the effects of a united front are the United Nations Decade of Women that started in 1975 in Mexico City and ended in 1985 at the world conference in Nairobi, and the review of accomplishments that occurred in Copenhagen in 1980. These brought women from around the world together to address women's issues (Pietila & Vickers, 1990). These international meetings were powerful in enabling women to initiate more local changes.

Involvement of women's organizations at different levels in the upgrading of women's health has been continually suggested. This approach has been followed in some parts of the world and proved to be effective-for example, in Indonesia. Involvement of other sectors of the community in programs to ensure better health for women is mandatory. Participation by members of the grass roots in each community should be promoted. The framework to guide women's health care should attempt to capture all the work that is defined as nonwork and thus goes unreported, undocumented, unrewarded, and regulated. Therefore, a crucial role for governments is providing priority social supports for women in all their roles, instead of relying on the informal social support of their extended families (Leonard, 1989).

Finally, a commitment to women's health is needed at all levels to advance the development of policies to protect and promote it. Action agendas similar to those provided by the U.S. National Council for International Health (NCIH, 1991) are significant in providing local frameworks. However, policies and international aid programs that are developed without careful consideration of the diversity of women and without recognition of their critical needs and the extensiveness of their tasks and responsibilities ignore their contributions, stifle their potential, and decrease the likelihood of their long and active participation.

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