Women's health

A global perspective

AFAF I. MELEIS, FERIAL A.M. ALY

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. (p. 304)

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

wrong with them?); (2) mortality and morbidity related to reproduction; (3) why women are not capable of taking advantage of the great services provided by the ministries of health in the various countries; and (4) how it is that all of the grant money that is being allocated for these purposes appears not to be effective in halting the frightening growth in the world population. These questions do not address the ways in which women are constrained from using the services provided, nor do they address the parts played by other important variables (such as roles, societal expectations, and spousal demands) that may be far more compelling in influencing women's options, choices, and decisions. In addition, a focus on reproductive health tends to promote neglect of other health issues that women confront and women who are neither pregnant nor in the process of childbearing.

Another universal trend centers on women's caregiving roles. Women tend to be the caregivers in most regions of the world. They are expected to be either the primary or the sole care providers for children, spouses, parents, and the elderly in their families, and they are expected to teach sound health practices to future generations. In addition, they are expected to provide similar caregiving services and education to their spouses' extended families. These responsibilities are additive instead of substitutive in nature, the result of which is overload and limited time, energy, and resources to attend to their own personal needs. This continues to be true whether women are working inside or outside the home and whether their work is visible and acknowledged or invisible and unacknowledged.

However, most of women's work is invisible and devalued. Women who work extended hours as spouses and mothers are labeled nonworking women or housewives. They may be the farmers who carry the major bulk of domestic work and are paid minimally for it. They also tend to be the nurses, teachers, and clerical workers, for which their income is incongruent with their worth and their work. These no- or low-income positions bring with them limited resources, a lack of regulatory policies to protect women as laborers, and inadequate enforcement of their rights. Furthermore, in many countries women's contributions are falsely reflected in labor statistics (Population Crisis Committee, 1988) because of the invisible nature of their work that in turn makes their contributions even more invisible. Invisibility brings with it neglect, neglect breeds abuse, and abuse renders women more vulnerable and powerless. The cycle then continues, with more violence against women.

Women also have other invisible roles that consume their time and energy and are equally ignored. An example 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 as 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 nonreproductive 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, after their work becomes affected. Education of women in many countries influences their chances to obtain better jobs and affects their lifestyle and health practices (Population Crisis Committee, 1988). We have selected only six aspects of women's health to discuss here.

Eating disorders and nutritional problems

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 (Ojanuga & 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 B_{12} 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 machismo 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 sexual arousal of the female as a method of preserving her chastity before marriage. It is related to beliefs of purification and is called "Tahara," which means purification. It is reinforced by aggressive structural components in societies and by the matriarchal side of families (Baasher, Bannerman, Rushwan, & Sharas, 1982; Kaamel, 1987).

The origin of this custom is obscure. It is not a part of Islamic doctrine, but it is a part of the definition of rites of passage for women in many parts of Africa and the Middle East. This practice was alleged to have been based on religious practices, but it is now known beyond a doubt that this is not the case (Ahoyo & Kaamel, 1987). Female circumcision is against the law in most communities in the world but is still practiced, usually under unhealthy conditions, without anesthesia, and by practitioners who range from traditional birth attendants to so-called gypsies to health care providers. All forms of female circumcision have serious implications for female personal health in the form of shock, hemorrhage, infection, urine retention, and injury. There are still cases in the hospital records of developing countries of young girls being admitted in shock as a result of postcircumcision bleeding (WHO, 1979).

There are many other aftereffects of this practice, not the least of which is the psychological trauma for young girls. The effect on these women's sex lives is tremendously profound and shapes their view of sexuality and of their participation in the sexual encounter. These women are even blamed for their husbands' drug use, because it is claimed that men use drugs in order to derive sexual satisfaction from their "surgically mutilated frigid wives." Moreover, some of these extended circumcisions may have an effect on the process of childbirth, causing injuries and bleeding during labor. Contrary to popular belief, the custom of circumcision is carefully guided and supported by women in the family. Although men may condone it, they are not the ones who keep it in practice.

Circumcision is not the only form of violence against women. More compelling and more significant from the women's perspective are the laws that condone and support domestic violence under the pretense of men's obligation to preserve face or honor against women's so-called insubordination, infidelities, or freedoms. Women also consider the lack of regulatory laws to protect their rights in socially unequal societies and in systems that condone colonialism and patriarchy as aggressive acts that are invariably ignored. Nor are the Western or the "developed" countries immune from other forms of "circumcision" or "vaginal mutilation." Young women are socialized to deny early sexual abuse experiences (molestation and rape) in favor of adopting more sanctioned and socially acceptable roles that mirror purification and normative expectations. The influence of these experiences on women's mental health is well documented (Bickerton, Hall, & Williams, 1991; Orbach, 1986; Scott, 1992; Zimmerman, 1991).

Reproductive health

Reproductive and maternity 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, 1986). This maternal mortality is not evenly distributed in different parts of the world. For example, women in Bangladesh face a risk of dying that is 400 times greater than that of women in Scandinavia and 50 times greater than that of women in Portugal. The maternal mortality rate is as high as 900 per 100,000 in some countries, compared with a rate below 10 in 100,000 in developed countries (WHO, 1986). Moreover, according to a survey in India between 1974 and 1979, for each maternal death there were 16.5 illnesses related to pregnancy, childbirth, and the puerperium. Many authorities believe these figures to be underestimated (WHO, 1986).

The factors behind the immense difference in the effects of childbirth in developing versus developed countries have been widely examined. Some of them are health service factors while others are socioeconomic and medical; there are also reproductive factors that include pregnancy in girls younger than 18 years of age, pregnancy after age 35, pregnancy more than four times, and less than 2 years between pregnancies ("Family Planning Programs," 1984).

It has been estimated that the number of maternal deaths would decline by over 20% if the first through the fifth births were confined to women from 20 through 39 years of age (WHO, 1986). In addition, these changes would reduce the total number of births, lowering the general fertility rate by 25% (Trussell & Pebley, 1984). The number of maternal deaths would drop by one third and would decline even further if there were no births after age 35 or beyond the fourth child (Maine, 1982; Rochat, 1979). Women having more than four children are at risk; this is known as a *grand multigravida.* Different studies have shown that primigravidas have slightly higher mortality rates, which decrease during the second delivery and start rising again after the third, increasing with the number of pregnancies and the lack of adequate time between pregnancies. Not only parity and age, but also intervals between births, have an effect on maternal mortality. In Bangladesh and Indonesia, for example, the highest death rates are found in women under the age of 20 with three or more children (Chen, Geshe, Ahmed, Chowdhury, Mosely; Williams, 1973). There are, however, limited studies that have examined the effect of birth intervals independent of age and parity (Trussell & Pebley, 1984).

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 (Hassan, 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 promoted 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 them to hazards that have been overlooked because women'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' wives fall off roofs or are exposed to unwarranted illnesses and diseases while attending to their daily roles 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 overspraying 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

family. She is the one who teaches sound health practices to future generations, creates a home environment conducive to better health through factors such as clean water and nutrition, and ensures that the children are immunized and cared for during the crucial years of their lives. A good share of the essential elements of primary health care fall almost exclusively in the woman's domain at the family level (WHO, 1982).

The woman's role as primary health provider could be enhanced by considering this role within the totality of her daily life experiences. For example, it is recommended that women who live in rural areas boil drinking water; and the implications of this seemingly simple act, which are far-reaching for an already overburdened woman, must be considered. To boil water, women have to carry water receptacles for long distances, search for and obtain burning fuel, and use different containers for 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 babies, less time spent by women on sick children, and less money spent on formula (WHO, 1991). It also has a contraceptive 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 variables 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 heritage, gender plays an equally important role in limiting access to health care (Puentes-Markides, 1992). Limitation of access may also be due to poverty, to a mismatching of the explanatory frameworks of both the provider and recipient, or to a general lack of comprehensiveness 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 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 developed 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 document 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 attention on women and their health care issues. The participants in each of the conferences recognized the importance of constructing a framework that was more congruent with women's specific health care requirements—requirements that were subsequently incorporated into these policy documents by their respective authors.

To enhance women's health globally, health care programs should be established within a framework that acknowledges women's perspectives, experiences, and contexts. The context of the totality of women's daily situations and daily experiences and role responsibilities as women themselves see them must be captured, described, 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 (Stevens, 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 or state 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 unregulated. 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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