CHANGING CONCEPTS OF WOMEN'S HEALTH—WHAT DOES THIS MEAN FOR OBSTETRICS AND GYNAECOLOGY?

May Cohen, MD, CCFP,

Professor Emeritus,
Department of Family Medicine,
McMaster University

ABSTRACT

Over the past decade, increased attention has focused on the topic of women's health. Traditionally, women's health was considered to encompass only reproductive health and health care. Currently, however, women's health is defined as involving women's social, cultural, spiritual, emotional and physical well-being, and is influenced by social, political and economic factors, as well as by a woman's biology. Therefore, in providing health care to women, one must address not only their biology and their reproductive functions but also the broader determinants of health and in particular the critical role of gender as a determinant of health. The health priorities women themselves identify, their own perceptions of their health and well-being and the diversity of women are all key components of optimal care for women. While obstetricians and gynaecologists have played a leading role in improving reproductive and gynaecologic care and outcomes, they must identify, acknowledge and address the multiple factors which influence the health and illness of their patients. Together with other physicians and health professionals, obstetricians and gynaecologists through their clinical work, their educational activities and their research must integrate and apply this broader understanding of women's health if they are to provide appropriate holistic care to their women patients.

RÉSUMÉ

Pendant la dernière décennie, on a accordé davantage d'attention à la santé des femmes. De tout temps, on a estimé que la santé des femmes n'englobait que la santé génésique et les soins de santé génésiques. Aujourd'hui, la définition de la santé des femmes comprend toutefois leur bien-être social, culturel, spirituel, affectif et physique, et elle est influencée par des facteurs sociaux, politiques et économiques, ainsi que par la biologie de la femme. Ainsi, pour dispenser des soins de santé aux femmes, il faut s'occuper non seulement de leur biologie et leurs fonctions de reproduction, mais aussi des facteurs plus vastes de la santé et, en particulier, du rôle essentiel du sexe comme déterminant de la santé. Les priorités en matière de santé établies par les femmes elles-mêmes, leurs propres perceptions de leur santé et de leur bien-être et la diversité des femmes sont tous des aspects clés des soins optimaux à l'intention des femmes. Bien que les obstétriciens et les gynécologues aient joué un rôle de chef de file dans l'amélioration des soins génésiques et gynécologiques et de leurs résultats, ils doivent déterminer et reconnaître les facteurs multiples qui influent sur la santé et la maladie de leurs patientes et exercer leur action sur ces facteurs. En collaboration avec les autres médecins et professionnels de la santé, les obstétriciens et les gynécologues, grâce à leurs travaux cliniques, leurs activités de formation et leurs recherches, doivent intégrer et appliquer cette compréhension globale de la santé des femmes s'ils souhaitent assurer des soins holistiques appropriés à leurs patientes.

J SOC OBSTET GYNAECOL CAN 1998;20(8):787-92

KEY WORDS

Women's health, gender, determinants of health, obstetrics, gynecology, health care.

Received and accepted on March 24th, 1998.

INTRODUCTION

Within the past decade, there has been a remarkable increase in the attention paid to "women's health." This is demonstrated by the publication of a number of journals and textbooks devoted to this topic and the development of medical school curricula, continuing education programmes and clinical service activities focusing on the health of women. Many conferences on women's health (at the local, national and international level) have been organized, and the Canadian government has been an active participant in many of these. Women's health research has been promoted through a number of activities, including the establishment of the Office for Research in Women's Health as part of the National Institutes of Health and the funding in 1996 of five Canadian Centres of Excellence in Women's Health.

For many obstetricians and gynaecologists who have traditionally provided care for women throughout their life cycles, this focus on women's health raises a number of questions. There is a need to understand what has prompted this intense scrutiny, what exactly "women's health" means, what are the factors contributing to the health of women and what role does the specialty of obstetrics and gynaecology play in women's health.

WHY WOMEN'S HEALTH?

Several factors have contributed to this evolution. An early influence was the rise in political activism beginning in the 1970s among women, who questioned the traditional approach of medicine to women and to their health and health care. Women objected to the over-medicalization of such normal life events as pregnancy and menopause, to the perceived paternalism in the doctor/patient relationship and to the failure of the profession as a whole to address what women perceived as their own health priorities. These concerns were followed by an increased awareness that traditionally, medicine has focused on male patients as the norm and as the standard, with the exception, of course, of reproductive issues. The result has been a failure to recognize important differences between men and women in the presentation, natural history and management of a large number of illnesses. The failure to incorporate such understanding has frequently led to misdiagnosis and mismanagement.

Studies of the effective use of health care and demographics have also stimulated a focus on women's health. Women are the largest group of health care consumers. In 1994, total health expenditure in Canada for men was $32 billion compared to $40 billion for women.[1] Women live longer than men (life expectancy at birth in 1995 was 81.3 years for women, 75.4 for men)[2]—a figure which often leads people to question why we need to focus on women's health. However, while women **do** live longer than men, they suffer greater morbidity and chronic illness. Indeed, health expectancy at birth differs between men and women by only three years.[3]

Increasing numbers of women in medicine have been a major influence in highlighting women's health. In 1997, 26 percent of physicians in active practice in Canada were women—a proportion which will continue to increase because, in the academic year 1996 to 97, 50 percent of medical school undergraduates were women.[4] Women in medicine, who are interested in **all** aspects of health and health care, have taken the lead in promoting women's health, and in emphasizing research which addresses women's priority health problems.

As a result of all these factors, "The year 1990 marked the beginning of a decade in which scientists, clinicians and the public became aware of the alarming inequities in women's health including the failure to include women as subjects in research studies, the inadequate attention to gender differences in research, the lack of funding for women's health concerns, the barriers to accessing health care services, the lack of focus on women's health concerns in public and health care professional education, and the dearth of women in senior medical and scientific positions."[5]

DEFINITION OF WOMEN'S HEALTH

Alongside this increased awareness of women's health has been a major change in our understanding of the meaning of women's health so that it no longer refers primarily to reproductive health. In 1985, a US Public Health Service Task Force defined women's health issues broadly as "diseases or conditions that are unique to, more prevalent or more serious in women, have distinct causes, manifest themselves differently in women or have different outcomes or interventions."[6] However, such a definition tended to focus more on disease than on health.

Currently, women's health is perceived as a continuum that extends throughout the life cycle, and is critically and intimately related to the conditions under which women live. Based on the initial work of the

Women's Health Office at McMaster University, the following definition of women's health was developed by the Ontario Women's Health Interschool Curriculum Committee (WHISCC): Women's health involves "women's emotional, social, cultural, spiritual, and physical well being and is determined by the social, political, and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs and experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health as defined by that woman herself to her full potential."[7] This definition also provided the framework for the discussions and recommendations on women and health at the 4th World Conference on Women (The Beijing Conference) held in September of 1995.[8] A similar understanding of women's health was published by the Commonwealth Secretariat which defined the scope of women's health as: 1) Women's health concerns extend over the life cycle and are not limited to reproductive problems; 2) women's health problems include but are not limited to conditions, diseases or disorders which are specific to women, occur more commonly in women, or have differing risk factors or course in women than in men and 3) health must be considered in broad terms and both positively as well as negatively. Dimensions of health include the physical, mental, social and spiritual.[9] Within the context of this overall definition of women's health, the Beijing Conference adopted a definition of reproductive health which focused not only on healthy reproduction, but also on the right of men and women to have freedom to make choices about their own reproduction and to be given the opportunity of having a satisfying and safe sex life.[8]

Implicit in this definition of women's health is the critically important recognition that women do not constitute a homogeneous group, and that women's diversity with respect to race/ethnicity, age, ability/disability, socio-economic class, education and sexual orientation must be taken into account whenever questions with respect to women's health are addressed.

DETERMINANTS OF WOMEN'S HEALTH

This new understanding of women's health is consistent with the widespread recognition that health status is influenced not only by biology or indeed by health care itself, but to a much larger extent by what have been termed the broader determinants of health. These determinants include education, economic status, employment, housing, environment, and discrimination based on culture and ethnic background. Powerlessness, i.e. a lack of control over ones destiny, has also been identified as a risk factor for disease, chronic stress and higher morbidity and mortality.[10]

All too frequently overlooked is the key role of gender as a determinant of health. The term "gender" incorporates not only biological differences but also socially mediated differences, and is understood as a social construct referring to the distinguishing characteristics of men and women. Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. Thus, gender is a social and cultural rather than a physiologic phenomenon, and while concepts of gender may differ widely from one group to another and over time, certain features are relatively common. Kaufert has stated that, "Access to political and economic resources is differentiated by gender in most societies. Power is usually allocated along gender lines and in favour of men."[11] She then goes on to emphasize that while many of the social determinants of health are the same for men and women, because of the interaction of these determinants with gender, we often see very different experiences of health and illness for men and women.

The Commonwealth Secretariat[9] report states that: "i) women's health is directly affected by a range of socio-cultural, physical, and psychological factors; ii) women have gender roles and responsibilities which directly affect their level of access to and control of resources necessary to protect their health. These resources are external (economic, political, information/education, a safe environment free of violence, and time) as well as internal (self esteem, initiative); iii) women are diverse in their age, class, race or ethnicity, religion, functional capacity, sexual orientation, and social circumstances. These factors may lead to inequities which adversely affect their health."

The constitution of the World Health Organization asserts that, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social conditions."[12] The Organization then goes on to state that many women,

however, throughout the world are being denied this basic human right, and **emphasizes** the fact that while some of women's health problems are determined by human biology, many others arise from or are aggravated by socio-economic factors. Thus, although girls are born with a biological advantage over boys, this is often cancelled out by the social disadvantages they suffer, and these social disadvantages are often related to "gender" differences. The World Health Organization concludes that, "the gender factor permeates **all** aspects of women's health."

The following examples demonstrate some of the ways in which gender interacts with other determinants of health to affect women's health and the relevance of this to the practice of obstetrics and gynaecology.

POVERTY

It has been stated that, "two out of three women around the world presently suffer from the most debilitating disease known to humanity. That disease is poverty."[13] In **all** societies, including our own, women lag behind men on virtually every indicator of social and economic status, and they constitute a larger proportion of the poor. Differential allocation of resources generally begins at birth, primarily because of gender bias.[14]

Poverty is frequently associated with many of those factors identified in health promotion programmes as contributing to poor health. The UCLA Center for Health Policy Research[15] reported that women with low incomes and those with a high school education or less are more likely to smoke, that overweight problems are more prevalent in low income women, that the proportion of women who engage in exercise increases as income and educational levels rise, and that screening rates for cervical and breast cancer are lower among those who are poor. Poverty is also associated with overall poorer health and shorter life expectancy.

VIOLENCE

The World Health Organization has stressed that the prevalence of violence against women world-wide, with its horrifying impact on health and indeed the lives of women, can **only** be understood and dealt with if one understands society itself, the socialization of men and women and the power differential between them.[16]

In July of 1997, the United Nations Agency, UNICEF, identified violence against women and girls as the most pervasive violation of human rights. It reported that 60 million women were missing in the world as a result of violence, and that gender violence is a major health and development issue with powerful implications for coming generations as well as for society in general. The SOGC has recognized the enormous influence of violence on the health of women and has actively promoted education, helping physicians to recognize and deal with violence against their women patients. It has recommended that its members routinely screen all women for abuse and offer counselling, education, advocacy and referrals. Of particular importance is the detection of wife abuse in pregnancy. A report on physical abuse and pregnancy stated that, "abused pregnant patients are a frequently undetected high risk group. Prenatal care should routinely include screening questions about domestic violence."[17]

HIV/AIDS

In dealing with HIV/AIDS infection in women, the same WHO[12] report emphasizes that we **must** address the fact that prevention and supportive care will be most effective if we recognize that no individual behaviour can be changed and maintained without an environment that can sustain and promote those actions. Women very often lack the power to be able to negotiate safer sex practices in their sexual relationships or to have access to care when they themselves become ill. A recent United Nations document[18] stresses that, "the low cultural and socio-economic status of women is facilitating and speeding up the heterosexual spread of AIDS in the world today... and that merely looking at 'Women and AIDS' from a health perspective is not enough." A gender analysis of socio-economic and cultural causes and effects of the epidemic is necessary to achieve a more comprehensive picture of the magnitude of the problem and the ideas on how to combat the epidemic effectively. Gynaecologists are in an excellent position to educate women about their sexuality, to explore the context within which women express their sexuality and to help them develop strategies to promote sexually healthy decisions and behaviours.

NUTRITION

Nutrition is another area which illustrates the relationship between gender and health. The consequences of nutritional problems in women can be life long. Gender discrimination plays an important role in putting

many of the world's girls and women at high risk due to grossly inadequate nutrition. At the same time, there is increasing recognition of the importance of nutritional problems in women in more affluent societies where eating disorders are closely linked with societally imposed unrealistic beliefs in the desirability of extreme slimness. Gynaecologists may frequently have the opportunity to recognize developing eating disorders in their adolescent patients who present with amenorrhoea or who are excessively concerned about their weight and body image.

WOMEN'S HEALTH PRIORITIES

If we are to care appropriately for women, we must also address what women see as their health priorities. In 1990, a policy document was developed by a working group of federal/provincial/territorial representatives called "Working Together for Women's Health: a Framework for the Development of Policies and Programs." This document identified a number of women's health priorities which included mental health (encompassing substance abuse, sexuality, body image and self-esteem), violence against women, reproductive health, occupational and environmental health, nutrition and fitness, chronic medical conditions and disability. The report emphasized the importance of addressing how these health priorities affected groups at special risk, or the "doubly disadvantaged." These groups included women with disabilities, immigrant women and women of colour, aboriginal women, adolescent and elderly women, and women who were poor, isolated and lived in rural areas. Several years later, focus groups conducted by the Canadian Advisory Council on the Status of Women agreed with many of these concerns but also stressed the importance of HIV and other sexually transmitted diseases, and the increase in heart disease, diabetes and obesity. It also focused on the effect of new reproductive technologies. Also stressed were the difficulties lesbian women encounter in gaining access to appropriate medical care because of homophobia, heterosexist assumptions made by their physicians and a lack of knowledge about lesbian health issues.[19]

In a recent study, persistent fatigue was the primary and most commonly cited health concern by women.[20]

In a 1992 study of Hamilton women, the author concluded that when women are given a voice, they identify as their major problems and worries health issues which sometimes have received little validation and have seldom been the focus of discussions on women's health.[21]

THE ROLE OF OBSTETRICIANS AND GYNAECOLOGISTS

Obstetricians and gynaecologists are privileged to care for women throughout their lives. Over the past few decades, they have played an important role in the enormous gains which have been made in promoting the health and well being of women. Advances in reproductive health care and improved outcomes in morbidity and mortality for both women and their babies, the recognition and improved management of gynaecological disease, the current approach to menopause and the promotion of good health in women who are increasingly living into their 80s and 90s are all major achievements. However, in order that women can receive optimal and holistic care, it is essential that obstetricians and gynaecologists understand and address the multiple factors that contribute to the health and well being of their patients as well as to their illnesses. While it would be unrealistic to expect that members of the discipline have expertise in the management of all aspects of women's health, many problems may first be identified during the course of a woman's obstetrical or gynaecologic care—such problems as wife abuse, a past history of sexual abuse, eating disorders and depression—to name but a few. It is essential that obstetrician/gynaecologists recognize and acknowledge these problems and the biologic, social, economic and cultural context in which they occur. To fail to address or refer (as in make a referral to another physician) these problems is to fall short of providing appropriate care to the women who look to their obstetricians and gynaecologists to help maintain and restore their health.

In summary, the broader definition of women's health and its determinants, the role of gender in our society and its influence on women's health, the social context in which women experience their lives and women's own perception of their health and well being are all key components of optimal health care for women. Together with other physicians and health professionals, obstetricians and gynaecologists through their clinical work, their educational activities both as learners and as teachers and as researchers, must apply and integrate this understanding.

REFERENCES

1. National Health Expenditures in Canada, 1975-1994—Full Report. Policy and Consultation Branch, Health Canada, January 1996.
2. Nault F. Narrowing mortality gaps, 1978-1995. Health Reports, Summer 1997, Vol 9, No.1: Pages 35-41.
3. Statistics Canada, Health Statistics. www.statcan.ca/english/Pgdb/People/Health/Expect.htmStatistics Canada, Health Statistics Division, 1991.
4. Cohen M. Cracking the glass ceiling. Can Med Assoc J 1997;157:1713-4.
5. Women's health in the medical school curriculum: report of a survey and recommendation. US Department of Health and Human Services, National Resources Administration and National Institutes of Health. HRSA-A-OEA-96-1:101.
6. Women's Health. Report of the Public Health Service Task Force on Women's Health Issue: Vol. 2. DHHS Pub. #PHS85-50206, May 1985.
7. Philips S. The social context of women's health: goals and objectives for medical education. Can Med Assoc J 1995;154(4):507-11.
8. Report of the Fourth World Conference on Women. Beijing, China. September, 1995:37. Published by United Nations, 1995. 95-31259.
9. Models of good practice relevant to women and health, December 1996. The Commonwealth Secretariat, London, England. December 1996.
10. Wallerstien N. Powerlessness, empowerment and health: implications for health promotion programs. Am J Health Promotion 1992;6(3):197-205.
11. Kaufert P. Gender as a determinant of health. The Canadian Perspective. The Canada/USA Women's Health Forum. Ottawa, Canada, 1996.
12. World Health Organization Report of the 1992 Technical Discussions. Women, health and development. Geneva: The World Health Organization, 1992.
13. Koblinski M, Timian J, Gay J (Eds). The Health of Women: a Global Perspective. Western Press, Boulder: Colorado, 1992.
14. Cohen M. Impact of poverty on women's health. Can Fam Phys 1994;40:949-57.
15. Fact Sheet. UCLA Center for Health Policy Research. Published by the Commonwealth Fund Commission on Women's Health, New York, NY, 1995.
16. The World Health Organization. Women's health: across age and frontier. Geneva: The World Health Organization, 1992.
17. Stewart DE, Cecutti A. Physical abuse and pregnancy. Can Med Assoc J 1993;149(9):1257-63.
18. DuGuerny J, Sjoberg E. Interrelationship between gender relations in the HIV/AIDS epidemic: some possible considerations for policies and programs. AIDS 1993;7(8):1027-34 (for the Advancement of Women Centre for Social Development and Humanitarian Affairs, United Nations Office, Vienna, Austria).
19. Fisher S. Lesbian health care issue: a guide for gynaecologists. J Soc Obstet Gynaecol Can 1995;17:1077-88.
20. Stewart D, Abbey S, Meana M, Boydell K. What makes women tired? A community sample. Women's Health 1998;7:69-75.
21. Walters V. Women's view of their main health problems. Can J Public Health 1992;83(5):371-4.