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POSITIVE APPROACHES TO PROMOTING WOMEN'S HEALTH

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## 1. Women's health: a growing social issue

### 1.1 Background and purpose

The World Health Organization and other international and national organizations and government bodies are increasingly responsive to the particular health needs of women. This paper reflects issues and ideas about women's health which appeared as dominant themes at the WHO Conference on Women and Health held in Edinburgh, United Kingdom, in May 1983. The themes themselves have appeared in virtually every conference on women and health held in Europe and North America over the past decade (see Annex 1 for a list of officially sponsored national and international meetings which reflect these concerns).

These themes represent a vision of women's health which has emerged from the women's health movement throughout Europe and North America over the past 15 years. This movement consists of women who participate in hundreds of women's self-help health groups, health clinics, health rights organizations and groups which write and publish timely health information for women (ISIS, 1980; Boston Women's Health Book Collective, 1976; Doyal, 1983; Freeman, 1982; Kickbusch, 1978; Ruzek, 1978; Kleiber and Light, 1978; Rodenstein, 1980; Women's Health Information Centre, 1983). For example, one of the best known groups, the Boston Women's Health Book Collective, in the United States, has sold over two million copies of the US edition of their enormously popular health manual, Our bodies, ourselves.

The book is now available in 14 foreign editions, including Dutch, French, German, Italian, Spanish and Swedish (Boston Women's Health Book Collective, 1976). Other well-known groups include the Dispensaire des Femme in Geneva, Switzerland, which operates a women's clinic providing humanistic care designed to meet the needs of both patients and health workers (Gramoni and Chipier, 1983) and Feministisches Frauen Gesundheits Zentrum in West Berlin which offers self-help health courses and publicizes information on hazardous drugs. The purpose of this paper is to show how the views on women's health, which are reflected in the presentations, discussions and recommendations at Edinburgh and in women's health activities in communities, are the foundation for a positive approach to women's health education and promotion worldwide. Here, we articulate these ideas into a conceptual framework and action strategy to illustrate what health education and promotion must rest on to meet women's health needs. The positive approach we propose is a contribution of the World Health Organization to the United Nations Decade for Women. As such, it is intended to stimulate discussions and provide guidance for developing and assessing ongoing activities designed to meet the goal of health for all by the year 2000.

### 1.2 Why positive health education must be sex-specific or the importance of a gender analysis to health education

Traditionally, health promotion and education has been criticized for focusing entirely on individual behaviour and "lifestyle" issues. The social model of health (Kickbusch, 1981), which identified the significance of social support, social action and broader notions of health, provided a more complete model of health and allows for the development of more effective health promotion strategies. What we propose here extends and elaborates the social model of health, focusing on the centrality of sex and gender in all aspects of health, illness, caring and curing. We argue that the underlying gender systems, which are socially and politically constructed, affect women's biological and psychological life experience in fundamental ways. We emphasize this because, to develop positive, meaningful approaches to promoting women's health and experience of wellbeing, it is essential to understand the overall context of women's social and biological life experience.

To do this, we briefly describe the life context of women's health by examining female sexuality, reproduction, work in the family, work in the paid labour market, and quality of life issues. We also consider how social forces and social changes affect all of these spheres of life and, necessarily, the central health issues women themselves experience. Against this back-drop of women's life and health experiences, we examine broad trends in the field of health education and promotion and note how the gender neutrality of concepts and approaches now extant may obscure women's most salient health needs.

Since women's own definitions of health problems are not always the same as those which professionals define as "important", we suggest ways in which the existing knowledge base for health education must be redefined. Thus, we call for a critical assessment of epidemiological and clinical knowledge, as well as the inclusion of experiential knowledge and women's own suppressed and devalued knowledge to further develop health education and promotion programmes.

Taking as a starting point a revised knowledge base, we then examine what women themselves define as essential criteria for positive health education and promotion efforts: (1) increasing women's self-determination; (2) reprising women's values to transform social relations which affect health; and (3) incorporating a political analysis which leads to structural change in society to promote health. Finally, we present general strategies for health education and promotion which incorporate these key concepts. These strategies - (1) providing health information; (2) facilitating popular education and consciousness-raising; (3) supporting community development; (4) promoting regulatory action; and (5) proposing legislation and judicial enforcement - can, of course, be used to generate a public health approach to health education and promotion for all persons in society. For the purpose of this paper, we focus on the importance of this approach to enhance women's health.

## 2. Positive approaches to women's health

### 2.1 Towards a holistic social model of women's health

Worldwide, experts and lay persons recognize the limits of medicine in improving the health status of populations (McKeown, 1979; Cochrane, 1971; Illich, 1976). For women, the medicalization of uniquely female biological life events from puberty through menopause is viewed as especially problematic because it reduces women's sense of control, confidence and competence to manage their own lives. Furthermore, there is serious questioning of the overall benefit to women of medical interventions such as oral contraceptives, injectable contraceptives, intrauterine devices (IUDs), high technology childbirth management, mood-altering drugs and some forms of gynaecological surgery relative to their benefits defined either in terms of significant reductions in morbidity and mortality or quality of life (Ruzek, 1978, 1983).

It is recognized that a new balance must develop between resources spent on curative medical services and environmental changes and prevention services and education programmes which prevent disease and promote wellbeing for the totality of women's lives. A holistic social model of health, assuring women adequate income to meet basic needs, providing societally funded child care and other services to reduce women's "double burden" of work and creating social institutions which promote rather than undermine mental and physical health are as salient as providing medical services which are safe and effective. What, then, is the role of health education and promotion in improving women's health?

### 2.2 Trends in health education and promotion

Kickbusch (1981) notes that in the WHO European Region, a social model of health education is gaining prominence. The social model she describes represents a significant move away from an individualistic orientation to health education and greater attention to the social context of health. Traditionally, health promotion has been an extension of the biomedical model of health, which focuses on individual efforts to modify health behaviour without incorporating an understanding of the social and political context of people's health and the health care system.

Health promotion strategies have been developed with little attention to the barriers to health facing individuals in all societies. Employment, housing and occupational health hazards are examples of factors which must be considered in health promotion programme development.

The social model of health which Kickbusch describes emphasizes moving from health prescription to health promotion, from individualistic behaviour modification to a systematic public health approach, from a medical orientation to the recognition of lay competence, and from authoritarian health education to supportive health education. Inherent in a social approach is the goal of reducing inequities in health which arise from all forms of social stratification, such as class and race. Too often, however, the health consequences of sex-gender inequalities remain "invisible". The priorities and content of traditional health promotion programmes have often placed a further burden on women's lives by prescribing health behaviours which are unrealistic and in some instances not designed to improve women's health but instead the health of the family. Indeed, the sex-neutral language of health education and promotion literature obscures the fact that women and men play very different roles in the prevention and treatment of disease. When we bring this into focus, we must confront issues relating to women's provision of unpaid care and to professional dominance.

Because women are the primary care-givers in lay health systems, increasing recognition of lay competence and increasing reliance on lay care potentially threatens to increase women's overall burden of work in society. Schemes to reimburse women for their lay care-giving activities - either through grants for small organizations or through providing individuals with direct payments or credits towards retirement and other social benefits - are also problematic. Incorporating informal caregiving into the formal system would likely be done at a very low level of pay, further institutionalizing women's economic disadvantage and reducing opportunities for paid work.

An additional difficulty which policy-makers must recognize is that, increasingly, women work in the paid labour force to support their families and are simply not "available" to provide extensive care-giving to their families.

As lay competence gains recognition, efforts must be made to prevent it from becoming subordinated to formal medical authority or it will become an unpaid or poorly paid ancillary service under the control of health care systems. We have much to learn yet about the actual nature of caring and the ways in which professional training and centralized authority and supervision in health service institutions may undermine the qualities of particularism and flexibility which may be central to effective caring. We need more research into the actual nature of effective caring before we assume that "lay approaches" can be replicated on a large scale for little money and produce good results. Efforts to expand health promotion and education activities to ensure that they in fact meet the perceived needs of persons who will use them - not just the needs "experts" declare exist - is a central issue. Lay-organized self-help approaches are effective in large part because they address the felt needs of both the providers and receivers of care - to provide is to receive, in part. To ignore this element is to return to the authoritarian, proscriptive approach to health education which Kickbusch and others view as anachronistic in light of the efficacy of supportive approaches to health education. To ensure that supportive health education approaches evolve, women themselves must be the architects as well as the builders and users of health education and promotion schemes.

### 2.3 The mandate of health education and promotion

Some of the health issues we raise clearly go beyond the bounds of what health education and promotion *per se* can or should do. Improving women's health and wellbeing requires raising women's status in society, which in turn involves fundamental social, political, cultural and economic changes. Obviously, these are beyond the scope of health interventions. Nonetheless, we believe that many of the positive health education and promotion efforts which could be undertaken would have positive effects on women's health and, over time, contribute to their improved status in society. This positive health education is based on a model of human behaviour which is embedded in a social context. Thus, health behaviour is most effectively changed when key elements of the social context are addressed. It is our belief that the mandate of health education and promotion clearly encompasses improving the social context. Indeed, this is a classic public health approach. Here, we establish a social-contextual framework for assessing women's health needs.

### 3. The life context of women's health

The view which emerges from the Edinburgh conference, other national and international meetings and the growing literature on women is that health encompasses all areas of life. While all of women's life experiences are interrelated and have an effect upon each other, for conceptual clarity it is useful to describe women's health concerns within four primary spheres of life.

Women's lives are embedded in the interrelated spheres of (1) sexuality; (2) reproduction; (3) the family and the socialization of children; and (4) economic production (Mitchell, 1971). In each of these spheres, the social and cultural organization of activities have particular effects on women's biological and sociopsychological selves. All of these spheres of life are affected by broad social and political forces and systems of social stratification: age, race and social class. Thus, the quality of women's lives and their experience of health and illness result from their entire life context. Changes in one sphere of life affect women's health in other spheres. Clearly, life changes often have both positive and negative health consequences. Thus, for example, some women who enter paid work may suffer less than women working in the home from depression associated with social isolation but are increasingly at risk of other forms of ill health from industrial hazards, occupational stress-related disorders and poor nutrition which results from inadequate time to shop and prepare food.

Here, we consider how certain social forces affect women's health status and identify some salient health issues in each life sphere. We also discuss quality of life and quality of care issues which cross-cut all spheres of life. Our intention is not to provide a comprehensive picture of women's health needs, but rather to provide a conceptual framework within which we can see how women's health is fundamentally shaped by social forces and social relationships. This perspective must be understood clearly because it has profound implications for health education and promotion strategies.

### 4. Social forces which affect women's experience of health and wellbeing

Three social forces which have profound implications for the health status and experience of wellbeing for women are the age distribution of populations, changing family structures and levels of economic development. Here, we briefly consider these social forces and identify some of the major health implications associated with each.

#### 4.1 The age distribution of populations

Recent demographic shifts in both developing and developed nations have profound implications for women's health. In many developed countries, life expectancy after the age of 65 years has risen considerably. Coupled with stable or slightly declining birth rates, the increased life expectancy results in an ever growing proportion of the population being elderly. Worldwide United Nations projections, based on current demographic trends, show that by the year 2000, the industrialized nations will all face planning health services for increasingly elderly populations which require more medical and at home health care (United Nations, 1982).

Analyses of these demographic shifts in the United States reveal that in 1960, persons aged 65 years or over comprised 9.1% of the population. By 1980, this group constituted 11.1%, and by 2000 it is estimated it will comprise 13.2% of the population. Because of significant sex differences in life expectancy, women are disproportionately found in the age population. Projections suggest that, by the year 2000, there will be 21.8 million elderly women compared to 14.4 million elderly men in the United States. The sex difference is especially notable in those aged 75 years or over - the population most in need of medical services and nursing home care (Rice and Feldman, 1983).

In the elderly population, chronic conditions are of great significance, and the care of the elderly who are no longer completely self-sufficient is increasingly required. For elderly women, conditions such as chronic arthritis, rheumatism, Alzheimer's disease and osteoporosis will increase the need for in home social services and self-care as well as institutional care.

Because women's pensions are typically lower than men's, elderly women more often live in poverty and have inadequate resources to meet their health and welfare needs. In some countries, women are less likely to have adequate health insurance coverage than men.

In developing countries which continue to have lower life expectancy than developed countries, improvements in rates of infant and childhood mortality will also result in an increase in the proportion of the dependent population under the age of 14 years. In these countries, women's control over their life experience is affected by the ability of societies to increase the food supply rapidly enough to prevent maternal and child morbidity and mortality from malnutrition. Where cultural practices limit women's access to food, strategies must be developed to increase women's caloric and nutritional intake.

#### 4.2 Changing family structures

Changes in family composition and size have major implications for women's health. The extended family and nuclear family are increasingly replaced by family units which consist of (1) mothers and dependent children; (2) groups of unrelated adults; and (3) single adult households. The first pattern, mother-children households, is a major factor in the "feminization of poverty". An increasing number of single-person households consist of elderly women, a large proportion of whom are poor. We need to understand the actual contribution of various forms of social support to health and wellbeing and determine how and in what ways neighbours, friends and others can fulfil the functions previously provided by family and tighter-knit communities.

New strategies are needed to provide both social and economic support to maintain the health and wellbeing of women in these increasingly common life circumstances. Implicit in the call for new strategies is the need to address the underlying issue of women's disadvantaged social and economic status combined with cultural expectations regarding men's compared to women's responsibility for child-rearing and child support and care-giving in old age.

Social and cultural forces also affect the range of years in which childbearing and child-rearing are prominent features of women's lives. In developed countries, delayed childbearing is increasingly practised among highly educated women. This pattern may pose an array of health benefits and hazards to women and their children. Because delayed childbearing typically follows long-term use of contraceptives, problems of infertility associated with oral contraceptives and IUDs are growing. Because older first-time mothers are typically well educated and economically secure, better nutrition and care during pregnancy may provide for better pregnancy outcomes. The incidence of some birth defects such as Down's syndrome, however, increases with maternal and paternal age.

In some segments of developed countries, there are also increases in the rates of teenage pregnancy - especially in young (under the age of 16 years) teenage girls. Health problems for both mothers and babies need to be examined carefully. Greater attention must be directed to

determining what people themselves (as contrasted to medical personnel) define as acceptable and unacceptable risks in preventing pregnancy, protecting fertility, and in giving birth at different stages of the life cycle. It is only in relation to these perceptions of risk that appropriate and effective health education and promotion efforts can be designed.

#### 4.3 Economic development

Women's roles in economic production are changing rapidly in both developed and developing countries. An increasing proportion of the paid labour force is female in all countries and the proportion of women with young children who hold paid positions is increasing. Women are clustered in the lower paying and less stable sectors of the economy, leading to cycles of unemployment and low pay, both of which are known to have negative health effects.

Historically, women's participation in paid employment has been associated with decreased levels of fertility. The shift to paid employment is also associated with migration from rural to urban settings, where environmental supports and impediments to health are quite different. Various forms of migration - be it from rural to urban areas or from one country to another - require women to adapt to many conditions which affect their health. Women who are culturally displaced or transported have particular needs for health information and education which women growing up in the country of their parents are more likely to have acquired informally in the family and through schools and other institutions.

#### 5. Health issues associated with women's life experience

Women's roles, as mentioned earlier, in sexuality, reproduction, the family and economic production are all affected by the social forces we have described. Here, we seek to identify critical health issues for women which are specifically associated with each of these aspects of women's lives and also with quality of life and quality of care which cross-cut all spheres of women's lives.

##### 5.1 Sexuality

Women are viewed as sexual objects in many societies, and their sexual function is often defined in terms of male gratification. New definitions of female sexuality are emerging which reflect a valuation of women's own experience of their sexuality. Creating a positive experience of sexuality is complicated by the fact that violence against women in all societies involves various forms of sexual assault - through rape, incest and sexual harassment in public as well as in private spheres. Eliminating all forms of sexual abuse and ensuring that women have control of their sexuality are central to promoting women's experience of health and wellbeing. Ensuring disabled women and women who are otherwise stigmatized, such as aged women, opportunities for sexual expression is also essential. Accepting the rights of the elderly and handicapped women to a satisfying sexual life may require substantial attitudinal changes.

Little research has been done on normal sexological changes in aging women. It is generally accepted that women experience little serious loss of sexual capacity due to age alone. Those changes that do occur (mainly in the shape, flexibility and lubrication of the vagina) can usually be traded directly to lowered levels of the hormone estrogen during and after menopause. In the past, women who had severe problems were usually treated with estrogen, but this practice is now being questioned because of concern about estrogen's side effects.

A society's laws, attitudes and prejudice to homosexuality to a great extent prevent lesbian women from leading a good sexual life in freedom from guilt, shame and fear. Furthermore, a society without visible homosexuality - which is common in the western world today - offers no possibilities for social and sexual identification for a homosexual person.

##### 5.2 Reproduction

Women's childbearing function is a major factor in women's health regardless of whether a woman chooses to bear children or not. Reproduction and reproductive potential affect women's physical and mental health in numerous ways. Women's preference for bearing or not bearing children is socially and culturally conditioned and is not simply an individual "choice". A woman's personal preference for bearing many, few or no children is problematic if it contradicts sociocultural expectations. Women who do not fulfil sociocultural expectations about childbearing (either by choice or because of social or biological impediments) may experience considerable psychological disturbance. Coercive and authoritarian health education approaches to family planning can result from either pro-natalist or anti-natalist policies.

Women in all societies are concerned about preventing and terminating unwanted pregnancies. The availability, safety and efficacy of contraceptive drugs and devices and abortion procedures are major health issues. Preventing loss of reproductive potential or the ability to reproduce healthy offspring are growing concerns as women are exposed to new environmental toxins. Some contraceptive drugs and devices are known to impair reproductive capacity in a small proportion of women, especially if used for long periods.

Childbirth practices vary tremendously from society to society, and women's definitions of what is desirable vary considerably within countries as well as between countries. Reproduction is increasingly medicalized and professionalized, a trend which many women would like to reverse. The safety, efficacy and cost-benefit of high technology interventions, such as electronic foetal monitoring and Caesarean section, are increasingly questioned (Banta and Thacker, 1979; Young, 1982)). At the same time, maternal and infant mortality remain too high in many countries, especially among disadvantaged groups who receive inadequate nutrition, prenatal, delivery and postpartum care.

Manipulative reproductive technologies, ranging from amniocentesis to *in vitro* fertilization, raise new opportunities and hazards to women's health. Beyond the technical issues of direct health risks and benefits, there are fundamental questions about allocating scarce resources to develop technologies with limited marginal utility and/or which are too costly for wide dissemination. Increasing reliance on these technologies to produce "perfect children" also raises moral and ethical dilemmas for women, their families and health care providers.

Disabled women are particularly disturbed by the implications of policies which channel resources to preventing persons such as themselves from being born rather than providing resources and social support to enhance their health and wellbeing.

### 5.3 Women's family roles

The central health issues related to women's role in the family arise out of the societal devaluation of women's roles and unrecognized hazards associated with unpaid work. Social and economic rewards and support must be afforded to women who engage in the essential human activities of child-rearing, caring for the sick, preparing food, and providing social and psychological support to sustain the family. When these functions are assigned exclusively to women, particularly in societies organized around small nuclear families or units consisting of mothers and children or single adults, women may become socially isolated and particularly subject to depressive disorders. In some countries, it is evident that the state's intention to support and strengthen families does not translate into policies which are, in fact, supportive to women and children. When women engage in poorly paid work outside the home without adequate child care and domestic assistance, fatigue and depression from the "double burden" of work in both arenas may result. The long-term consequences of the "double burden" for women's physical and mental health are not yet adequately understood. More attention also needs to be directed towards reducing health risks associated with activities such as the use of household chemicals, lifting and carrying and accidents ranging from stove burns to falls on wet floors.

### 5.4 Production

As women enter the paid labour force, they are most typically recruited into low-paying jobs characterized by instability, part-time employment and few opportunities for advancement.

The sex segregation of most labour forces means that the occupational hazards women face are often different from those experienced by men. Because of historical concern over protecting women's fertility and preventing foetal damage, protective legislation is a typical strategy to maintain health. Such legislation must be re-examined to ensure that it does not bar women from access to better paying jobs and that removal from hazardous worksites does not reduce women's economic status. Greater concern needs to be directed towards preventing sperm damage in males and preventing transfer of toxic materials to children and other family members. As women move into economic production outside the home, sexual harassment and assault in the workplace or while travelling to and from work must also be recognized as hazards which require intervention to prevent.

### 5.5 Quality of life and quality of care

The quality of women's lives is affected by structural, cultural and sociopsychological factors. Rather than viewing health behaviour as the result of individual "choice," it is necessary to understand and address the social conditions and government policies which shape these choices and health problems. Brown's The social origins of depression, for example, illustrates the importance of life events and structural factors, such as poverty, as determinants of depression, an increasingly common health problem for women.

Societal gender expectations are often not conducive to women's health. For health promotion efforts to be successful, they must take into account and challenge the sex role expectations embedded in social institutions as well as the individual.

Yet to improve the overall status of women's lives, there may be situations or periods of time when their health will be at risk or in conflict with the interests of others - employers, spouses, children and the manufacturers of health damaging substances - and cultural expectations. From this perspective, one would be interested in eliminating advertising which portrays women negatively and eliminating products which are harmful to women's health and seek to reduce the strain stemming from inadequate child care, blocked occupational mobility and social marketing which portrays physical beauty as a commodity. Policies which promote women's equality in society would be health-enhancing.

Women's health also involves the experience of chronic conditions in everyday life throughout the life cycle. Routine problems, such as vaginal infections, bladder infections, premenstrual tension, arthritic and rheumatoid conditions, muscular-skeletal problems, headaches and osteoporosis, all have significant consequences for women's experience of health. Western medicine has not defined these chronic disorders as "serious" problems, and fewer resources are available to manage them than more "acute" conditions. Similarly, most physicians pay inadequate attention to the physical, psychological and sexual consequences of gynaecological surgery or mastectomy - defining only the technical aspects of surgery as significant health matters. A redefinition of what constitutes conditions worthy of serious intervention is called for by women themselves.

#### 6. Redefining the knowledge base for promoting women's health

For organizations to set priorities for health education and promotion programmes, some reference is usually made to a knowledge base for assigning priority. Historically in the health field, clinical medical experts and scientists were viewed as the only persons who needed to be involved in defining the parameters and content of this knowledge base. In recent years, increasing attention has focused on the need for lay knowledge as well as knowledge of lay concerns.

Professional and lay persons do not always share the same definitions of what constitutes an "important" health problem. Nor is there agreement on when lay as compared to professional treatment for health problems is most appropriate or effective. The difference between lay and professional perspectives are not uniform either, but differ between and within countries depending on political and economic conditions as well as the relative level of education of both providers and lay persons.

Public health officials, professional providers and lay persons base their definitions of problems in part on different knowledge bases: epidemiological, clinical and experiential. Here, we discuss these knowledge bases and what we conceive of as women's suppressed and devalued knowledge.

##### 6.1 Epidemiological knowledge

Public health officials typically rely heavily on epidemiological data for defining health problems and setting priorities for interventions. The fundamental premise of this approach is that interventions are called for when the condition is "significant", i.e. causes considerable excess mortality or severe morbidity and affects large populations.

Public health approaches in developed countries increasingly focus on reducing mortality and certain forms of morbidity which affect people's ability to carry out their economic roles. Because women in many countries spend considerable years in childbearing, child-rearing and unpaid community work, definitions of problems in terms of preventing days lost from paid work are not adequate.

In some countries, increasing attention is directed at formalized "cost-effectiveness" or "cost-benefit" formulations in policy arenas. Because these analyses are typically based on maximizing "saved" wages and lifetime projected (discounted) earnings of people by preventing disease in "target populations", women and children are de facto "low priority" populations. Such approaches favour expenditures to prevent, for example, coronary heart disease in upper-income men and give low priority, for example, to nutrition programmes for pregnant women or the elderly who have "little economic value". Neither WHO nor any responsible public organization or government can endorse setting programme priorities on the basis of formulae which institutionalize the disadvantaged economic status of women in the paid labour force and the unrecognized economic contribution of women's unpaid work in the family and community.

Care must also be taken to interpret epidemiological data with caution where sex differences suggest women are at an "advantage" in terms of overall health status. Although in developed countries women typically live longer than men, women may actually have a greater burden of ill health over the life cycle than do men. In elderly populations, women survive to experience the diseases of aging and chronic disabilities - often without the support of a living spouse to assist in their care. Because not all disease is "preventable" or "curable", we need to know more about the needs of such women for supportive health educational programmes.

New definitions of significant health problems, especially problems related to chronic illness and mental health, must emerge within the epidemiological framework. For example, women's experience of violence (rape, assault, domestic violence, war) and experience of economic insecurity (low wages, high unemployment, threat of loss of income through divorce, widowhood, spousal disability) need to be investigated as major sources of mental and physical ill health for women. If we knew more about the distribution of these experiences of impaired wellbeing, we might alter our perception of the relative importance of the so-called "killer diseases", such as cancer and heart disease. A new epidemiology of violence and of chronic impairments of everyday life might suggest new priorities for allocating resources for preventive care and supportive services. In the framework of this new epidemiology, "healthy lifestyles" would no longer focus on individual "risk factor reduction" to prevent heart disease and cancer.

Instead, we might focus our efforts on creating and sustaining social and environmental conditions which prevent or reduce occupational stress, sexual harassment, rape and economic insecurity through an array of sociopolitical interventions. These could range from stringent regulation of sociopsychological working conditions to surer punishment of rapists and other perpetrators of violence and provision of restitution for victims of violence.

Most fundamentally, we would have to ask what economic, social and psychological conditions foster violence and seek to change these underlying conditions. In the case of chronic impairments, we need to know how widespread the limitations and disabilities are and what might be done to maximize women's ability to maintain their health and wellbeing on a day-to-day basis given the probability that the limitation will continue.

## 6.2 Clinical knowledge

Greater emphasis is often placed on complex medical technologies and "clinically interesting diseases" in medical education than on conditions which are epidemiologically significant or which reflect patients' own concerns. Physicians trained in major medical centres often experience disillusionment upon entering practice where the great majority of medical complaints are routine, not life-threatening and require minimal technological intervention. In this milieu, certain health conditions which patients regard as important are disregarded by clinicians as "trivial".

Thus, for example, surgeons typically concern themselves with the healing of tissue after a mastectomy for breast cancer, whereas women themselves may be as concerned with how the disfigurement affects their feelings of sexual attractiveness, their ability to hold a job, the probability of dying or having a daughter develop the disease. Drawing on clinical and epidemiological knowledge which focuses on the biomedical aspects of disease, professional health education efforts typically emphasize disease prevention and detection rather than the caring support required to assist people to live comfortably with disruptive incidences or disabling conditions. The content of health education is often restricted to providing just enough information about the disease and the treatment regimen in order to convince patients to take the prescribed medication, refrain from obviously damaging behaviour and return for follow-up visits. Such efforts may serve more to promote medical control over patients' lives than to promote wellbeing.

We do not wish to suggest that it is the proper role of clinical medicine to provide all the care, support and assistance needed by persons adapting to disease. There is ample evidence that lay persons who share the disease experience are better able than professional experts to provide the care, support and sharing of strategies for managing everyday life. What is lacking, then, in the clinical knowledge and training is a recognition of the importance of providing patients with support and assisting them to locate the most suitable community resources.

## 6.3 Experiential knowledge

In recent years, increasing emphasis has been placed on experiential knowledge as a basis for health education. The lay self-help movement highlights the centrality of experiential knowledge for defining, preventing and managing health problems. A central tenet of lay self-help groups is that persons who have experienced a health problem have an understanding of that condition which

those without it do not fully comprehend. For women, experiential knowledge includes the meaning and management of routine health matters, chronic conditions and threats to health. Experiential knowledge also alerts us to health problems which may be highly significant for women's experience of wellbeing but which have been largely ignored by clinicians or epidemiologists. For example, routine urinary tract and vaginal infections may be experienced as having a negative impact on health and wellbeing far beyond their currently defined clinical or epidemiological "significance".

Central to the women's vision of health which emerged in western Europe and North America over the past 15 years is the premise that the individual is or can become knowledgeable about her own body. In contrast, the professional medical assumption is that women are largely not reliable to interpret signs or symptoms adequately or to provide care for her own health conditions. Women's belief in the health competence of the individual is bolstered by the experience in community-based health projects where, with access to health information and encouragement to pay attention to one's body, individual women can recognize potential health problems at an early stage and seek appropriate care - lay or professional. Optimism about the efficacy of individuals caring for themselves rests on the availability of understandable health information, services, opportunities and resources to engage in self-care and mutual aid, which may not yet exist in some countries or for some segments of the population. More research is needed on the limits as well as the possibilities of experiential knowledge as a guide to appropriate health education and promotion activities. However, this is not yet viewed as a research priority in most countries.

Examined in the light of health promotion philosophy, the experiential approach suggests that, given adequate information, knowledge and skills as well as supportive environmental conditions, individuals will be likely to "choose" health-promoting behaviour. This is in contrast to prescriptive approaches to health education and promotion programmes and the social control that is likely to be invoked on those who fail to "choose" healthy behaviours or lifestyles. We emphasize that many "unhealthy choices" as currently defined must be viewed in their wider social context - the social conditions under which health-damaging "choices" reflect efforts at stress management, a desire to conform to peer group norms or a minimal expression of power in the context of lives characterized by isolation, alienation or excessive strain. From an experiential perspective, we must also ask if some risk reduction campaigns and screening programmes have a negative impact on health by increasing women's fear of cancer and some of the other so-called "killer diseases". We need to expand our experiential knowledge base to include assessments of the social and psychological consequences of increased awareness of risk factors and prevention approaches ranging from changes in diet to changes in individual behaviour designed to prevent rape. We need to ask if there are "tipping points" in health information beyond which individuals experience everything they do as so "risky" that it is best to ignore all such advice - or even take up especially hazardous activities or behaviours. The experience of probable death from nuclear war, for example, must be explored as a factor which undermines motivating people to reduce ordinary risks in everyday life.

Overall, our experiential knowledge base is least well developed and recognized. We believe that the expansion of this knowledge base is essential to the long-term development of priorities for health promotion and education programmes for women. While this knowledge base is being expanded, we could profitably focus on conditions or behaviours which are already recognized as health-damaging or threatening to women.

Because health education efforts are often most effective when recipients already perceive themselves at risk of damage or in need of preventing something they wish to prevent, we might focus on areas such as contraceptive and abortion information and access, childbirth education, and occupational health and safety education, for instance the proper use of video display terminals or toxic chemicals. All of these are health issues which women have identified as priorities for themselves.

#### 6.4 Suppressed and devalued knowledge

An additional knowledge base for health education and promotion for women is women's own suppressed and devalued health knowledge. Women's folk practices and systems of caring, such as lay midwifery, have been ignored or directly suppressed by medical authorities in many countries. Despite active efforts to suppress such practices, they continue - because they are experienced as effective and enhancing of wellbeing (Houd and Oakley, 1983). Women's knowledge of caring - a concept which we discuss in more detail in subsequent sections - must become part of the fundamental knowledge base on which health education and promotion programmes are built.

Although many widely disseminated medical practices, especially in the field of obstetrics and gynaecology, have never been shown to be safe and effective, women's traditional health-caring activities are attacked on the grounds that they do not test on a "scientific knowledge base". We

believe that health educators and promoters must question this logic and give serious consideration to women's approaches to care. An obvious parallel might be made between western medicine's devaluation of women's practices and the devaluation of traditional eastern healing practices, such as acupuncture, which in recent years have gained recognition.

We must learn that much of what is valuable for health and healing does not fit the dominant paradigm of western scientific medicine, which is oriented towards an exclusively biomedical definition of disease and intervention.

#### 6.5 Research needs for expanding the knowledge base

To create a knowledge base adequate for meeting women's health needs, we must transform the value orientation, methods and social organization of research.

Implied in our discussion of the knowledge base for health education and promotion is a reordering of research priorities and questions. We need epidemiology to identify the distribution of chronic disorders and personally experienced ill health or impaired wellbeing. We need to research how users as well as health providers or scientists define the safety and efficacy of drugs, medical devices and technologies. We need to research systematically the effects of nurturing and caring on experienced wellbeing as well as on conventional morbidity and mortality outcomes. We also need to research how informal care-giving is performed in all societies in ways which explicitly address the sex of both care-givers and care-receivers and the implications of gender for both the delivery and receipt of health-promoting activities. To do this, qualitative as well as quantitative methodologies must be used or we will fail to discover the actual meaning and consequences of health and illness for women.

#### 7. Central concepts for promoting women's health

Efforts to undertake positive health education and promotion strategies for women must incorporate three key concepts which women themselves identify as central to ensuring their wellbeing: (1) increasing women's self-determination and self-definition of problems and solutions; (2) reprising women's values to transform social relationships and health care systems; and (3) incorporating a political analysis of health as it applies specifically to women. All three of these concepts are central tenets of the contemporary women's health movement in both Europe and North America.

##### 7.1 Increasing women's self-determination

In order to support women's self-determination, it is necessary to recognize that women often have been expected or required to put the needs of their families before their own. For instance, to ensure that their children and partners have sufficient food, mothers may eat last and suffer malnutrition. The tension between self-interest and familial and social responsibility is one which must not be assigned to women alone but be shared by men and society as a whole. Ensuring women's self-determination by definition involves assuring women control over decisions to have or not to have children, the frequency with which they give birth, the conditions under which they give birth, and the methods by which they limit their fertility. Self-determination also involves protecting women's reproductive potential so that they are able to bear children and to do so under conditions which minimize environmental hazards. To assure this, women must be involved in the policy-making and research regarding all fertility-related matters.

Similarly, health promotion policy and programmes must be examined to determine whether it is, in fact, women's health which is being supported. For example, considerable attention is being paid to foetal health in the industrialized nations. Strategies for protecting foetal health have been based on limited scientific evidence of how critical factors such as nutrition, tobacco, alcohol, the environment and social class affect the probability of having a healthy or impaired baby. We actually know very little about the interaction of these health behaviours and social factors. Yet health promotion programmes are being developed on the basis of very limited evidence. There is also inadequate attention to the context in which women make health decisions. Messages to women are too often prescriptive and simplistic - women should not drink if they are thinking about becoming pregnant or are pregnant. Such slogans do not accurately represent scientific evidence and may, in fact, cause fear and anxiety about pregnancy outcomes which undermine women's wellbeing.

Supportive health education programmes can play a major role in furthering self-determination if information is based on the belief that women will make the best decisions for themselves within their own life context, which includes a valuation of health relative to other life goals.

Strategies to promote women's health must recognize the complexity of determining the configuration of multiple risks to a person's health. Health promotion philosophy must incorporate a more complex analysis of health needs and health risks from the perspective of women's lived experience. An analysis of health promotion policies on this basis is more likely to facilitate self-determination and self-definition of health problems and solutions than one based only on medical and scientific risk factor concepts.

## 7.2 Reprising women's values to transform social relations

Sharing, caring and nurturing have characterized women's roles in relation to other people in their world. These values underlie what is increasingly referred to as social "support", a factor in health which only recently has been acknowledged as significant. Sharing, caring and nurturing have figured prominently in women's self-help activities throughout the world. Indeed, these aspects of self-help, while central, are too often overlooked when efforts are made to evaluate them or incorporate them into service delivery systems.

Many countries, e.g. the Scandinavian countries, are becoming concerned about the erosion of natural caring systems in communities such as extended families and an array of informal groups and networks. Many of these systems traditionally comprise women. As women enter the paid labour force in increasing numbers and as public and private institutions must take over providing community services including care of the sick, society as a whole must address the need for reallocating sharing and caring functions more equitably between men and women. We need to identify, legitimize and find ways to develop the capacity for sharing, caring and nurturing in both men and women. Persons who provide these essential elements in life, both informally without pay and as part of formally defined jobs for which they are paid, must be given both social recognition and economic rewards. Society as a whole will benefit from men learning these skills and assuming a greater responsibility for practising them. To make this a reality, the entire organization of work must be reshaped to facilitate men's participation in child care, care of the elderly and care of the chronically ill.

We must seriously rethink the value systems which afford greater prestige to the manipulation of objects and technologies than to the provision of human care which nurtures a sense of wellbeing in ways which are not yet fully understood in western, scientific, rational terms.

Supportive health education and promotion (Kickbusch 1981) is consistent with these values as it incorporates providing information and skills through self-help and mutual aid as well as emphasizing the importance of support to effective decision-making. Self-help within the women's movement and other social movements has provided women with opportunities to care for each other and, through the receiving and giving, to gain new confidence and skills.

## 7.3 Incorporating a political analysis

The women's movement has emphasized the importance of understanding the political, economic and cultural forces which affect opportunities for health and the experience of health and wellbeing for all people. Thus, health is described as being simultaneously personal and political. From this perspective, the dynamics of race, class and gender stratification all affect one's experience of health and must be taken into account to plan positive strategies to improve women's health. Any strategy to educate women or promote women's health must take into account all of these realities to have truly positive effects and avoid the "victim-blaming" message which is too often embedded in health education and promotion efforts.

Programmes designed on the basis of women's lived experience, including cultural, social and economic dimensions, are more likely than narrow prescriptive approaches to incorporate the important element of human agency - the ability of women to act on the world. This contributes to empowering women and empowerment fundamentally enhances wellbeing.

## 8. Strategies for health education and promotion of women

The strategies which we propose are to be considered in the context of community-based health promotion. The shift from a medical model of health to a holistic social model of health is implicit in the strategies we suggest. Each of the concepts described above can be put into action creatively to promote women's health, using these general strategies:

- designing and providing health information;
- facilitating popular education and consciousness-raising;
- supporting community development and organizing;
- stimulating regulatory action;
- promoting change through legislative and judicial measures.

Taken together, these strategies can bring about positive changes which reinforce one another. A synergistic effect can be facilitated working at different levels, from the individual, the community and the nation or state. These strategies and concepts can, of course, be applied to improve the health of both men and women. Here, we focus on sex-specific approaches to underscore the need for planning in sex-specific terms and with adequate knowledge of the gender system in any society or subculture.

All of the strategies discussed have been used in a variety of countries and within a variety of movements directed at social and political change. In this way, they have been demonstrated as effective tools, which can now be applied to health promotion.

### 8.1 Designing and providing health information

Although in some countries there appears to be an overwhelming amount of health information, there remains a need for positive health information for women which reflects women's own experience of health and illness. The information must be presented in forms which take into account the specific sociocultural conditions of women who are the intended audience. Increased attention must be directed towards using media, printed materials and personal presentations which reflect the specific realities of social class, race, ethnicity and cultural values. Health information is particularly needed for women who are not literate and who experience a multitude of barriers to achieving health. The most effective information presents concrete, positive ways to achieve incremental change in health rather than simply stating an ideal or emphasizing what one "should" or "should not" do. Developing effective health education and promotion material often takes considerably more time than simplistic prescriptive material because the process requires attention to detail and consultation with groups and individuals who are knowledgeable about the intended audience.

### 8.2 Facilitating popular education and consciousness-raising

Consciousness-raising, as developed and practised by the women's movement, and the similar process called "popular education" developed by Paulo Friere in South America constitute powerful strategies for promoting women's health. In the women's movement, women come together in small groups to share their experiences and to affirm the commonality and differences in their lives. This process can break down women's physical and social isolation and can validate the importance of each and every woman. Consciousness-raising also provides an opportunity to grasp the collective reality of women's experience. In this context, health concerns are raised and explored and may lead to women feeling more confident to act on their own behalf.

"Popular education" has been used in many countries throughout the world to facilitate literacy, better nutrition, health care and working conditions. Popular education relies on facilitators to generate dialogue which elicits people's daily concerns. The learning that occurs is based on what people need and want to know in their sociopolitical context rather than what is considered important to know a priori by "experts".

Popular education goes one step further than consciousness-raising by drawing on the participants to define solutions to problems and then act on them as a group. The emphasis on collective decision-making and action gives participants a sense of power and responsibility (Nadeau, 1983).

The strength of the popular education method is that it fosters cooperation, support and sharing, all qualities with which women easily feel comfortable. Further, group decision-making and problem-solving encourage autonomy and self-determination (Nadeau, 1983). The role of the health educator is one of facilitator rather than teacher. She poses questions and provides a structure for the group to work in and yet she is a peer who will learn as much as the other participants.

Popular education can also be used as a method for organizing women which can lead to broader community-organizing initiatives. For example, health educators can facilitate the formation of support and discussion groups for women in workplaces to consider the health effects of their employment. The facilitator may also serve as a resource person who can make available information on particular health risks and what others have done to reduce them. Such information may stimulate grass roots organizing among participants.

### 8.3 Supporting community development and organizing

Health educators can engage in community development and organizing directly and explicitly or indirectly through popular education and consciousness-raising as just described. Some health education and promotion efforts require direct organizing. For example, efforts to establish food co-ops of particular importance to pregnant women and nursing mothers might best be stimulated by direct organizing. These efforts would, of course, involve organizing women in the community to define the problem in their own terms and develop solutions.

The health promoter could play a key role in identifying arenas in which negotiations in the public and/or private sectors could be carried out. In the example given, the health promoter could take major responsibility for locating food suppliers or companies which might be encouraged to locate in an area to produce and distribute a particular product. Activities such as these can also provide new opportunities for women to enter economically productive roles to produce goods and services which they actually need. An example might be developing infant and baby foods from indigenous products to be consumed locally rather than relying on the import of products which are both expensive and difficult to use safely and appropriately, given local customs, levels of sanitation and refrigeration and women's work schedules.

### 8.4 Stimulating regulatory action

Health educators can play significant roles in stimulating regulatory action which promotes women's health. Women's experience with many drugs and devices is that they are not adequately informed of possible side effects or long-term health hazards. Women require this information in order to make personal decisions about whether or not the benefits to them are great enough to warrant accepting the risks. Health educators and promoters can facilitate these opportunities by actively engaging in efforts to develop guidelines and regulations for the testing of drugs and devices, for including information on risks and hazards to users through many different channels and for developing lists of acceptable drugs for use in health services, group practices and countries. Health promoters who are sensitive to the benefits and risks which women themselves experience with drugs and devices must be involved in all levels of regulation and research which are used to assess safety and efficacy.

Health educators and promoters can play similar roles in other areas by serving as consumer representatives on health advisory committees at the local, regional, national and international levels and by involving themselves in political activities as private citizens.

### 8.5 Promoting change through legislative and judicial measures

Because many health-damaging factors are environmentally based, health educators and promoters must accept the mandate to involve themselves in efforts to reduce hazards through legislation and legal means. Health promoters cannot leave health-promoting legislation or enforcement through the courts to others. Through popular education and community organizing, health educators can stimulate the growth of constituencies to provide legislative bodies with research and public opinion which supports needed change. Organized groups can also develop skills for monitoring the progress of legislation, influence the likelihood of such legislation being passed and ensure that, where legal enforcement mechanisms are available, they are publicized and used. An obvious area in which such efforts would have an enormous influence on women's health is in the area of tobacco-related disease. Nascent antismoking groups in the community would benefit from financial support and research support to facilitate their efforts. Health educators can also stimulate legislative support for funding economic research on strategies for shifting economics away from tobacco production to the production of products which are health-promoting in both developing and developed countries. Strategies to do this can also incorporate positive mechanisms for providing women with new roles in economic production which have the potential to enhance their health through access to economic resources and social contact.

### 9. Summary and implications for planning

In this paper, we have argued that the social model of health can be elaborated by focusing on the centrality of sex and gender in all aspects of health, illness, caring and curing. We extended this argument to assess the appropriateness, strengths and weaknesses of the knowledge bases on which health education and promotion programmes for women are or could be built. For planning health programmes for women, we emphasize that the entire context of women's social and biological life experience must be taken into account. From this perspective, the most appropriate knowledge base is one which blends "objective" concepts of health with the subjective realities and meanings women construct in their live experience. Finally, we presented key concepts for positive health promotion efforts from the perspective of women themselves and suggested ways in which planners and policy-makers might use well established strategies to further these goals.

For planners, selecting priorities and designing positive programmes are best done with the active involvement of intended recipients of services. Women themselves want to be brought into the planning process and not to remain the recipients of health promotion and education efforts. How and in what ways this can be done most effectively can only be worked out in detail within the specific context of the setting in which the planning will be done. This paper is intended to provide both the ideas which will serve as a basis for discussion and planning and the impetus to undertake such efforts.

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Annex 1

OFFICIALLY SPONSORED CONFERENCES ON WOMEN AND HEALTH  
(partial list)

Women and their Health: Research Implications for a New Era. Sponsored by the US Public Health Service, National Center for Health Services Research, San Francisco, CA, August 1975.

Double Dynamics: Women's Roles in Health and Illness. Sponsored by the US Public Health Service, Office of Health Resources Opportunity, Philadelphia, PA, December 1975.

International Conference on Women in Health. Sponsored by US Public Health Service, Health Resources Administration, Washington, DC, June 1975.

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