Access to the world's resources: women's health*

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Women's health at any point in their lives, from before birth through old age, reflects a multitude of factors, including environmental, cultural, and socioeconomic. However, even in parts of the world where women have achieved control over family planning and family resources and equal men in educational opportunities, the increase in their life expectancy, although greater than men's, is flattening out. Questions on the effect the changing lifestyles have on women's health are posed, and the paper closes with a discussion of women as objects of research.

The right to health is the most basic of all human rights. The Constitution of the World Health Organization, signed July 22, 1946, and entered into force on April 7, 1948, asserts, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinc-
tion of race, religion, political belief, economic or social condition" [1]. Why is it that perhaps the most important distinction of them all, gender, is not included? The most simple answer is probably the correct one: legislators were not aware of the phenomenon. Women's health was not an issue in 1948; it is in 1995.

Women's health is influenced by biological, environmental, social, economic, and cultural factors; however, it was not until 1975 that the United Nations (UN) declared the International Women's Year and made women's issues questions of general concern. In appreciation of the growing global importance of women's issues, the UN General Assembly proclaimed 1976 to 1985 as the United Nations Decade for Women, "Equality, Development and Peace." This year was to be a time to intensify action "to promote equality between men and women" and "to ensure the full integration of women in the total development effort, especially by emphasizing women's responsibility and important role in economic, social, and cultural development" [2].

The next milestone on the road to women's equality was the adoption of the Convention on the Elimination of All Forms of Discrimination against Women, sometimes described as the "women's bill of rights," by the UN General Assembly on December 18, 1979. No doubt the good will was there. But what about reality?

In 1990, the Commission on the Status of Women undertook a five-year review of the implementation of the Nairobi Forward-Looking Strategies for the Advancement of Women, adopted by the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, held in Nairobi, Kenya, July 15–26, 1985. The commission found that the situation of women had deteriorated in many parts of the world, especially in the developing countries where economic stagnation, continued population growth, and reduction in public expenditures for social programs had further constrained opportunities for women to improve their situation. There was also evidence of an alarming regression in the status of women in the spheres of employment, education, and health.

The majority of health problems in the developing world could be solved by better nutrition, clean water, sanitation, access to maternal care and family planning, prevention of infections, immunization, and availability of essential drugs. But under the increasing economic pressure of recent years, approximately one-third of the poorest countries have cut health spending by 50% and education by 25%. "Half the developing world's annual expenditure goes to

* Presented at the 7th International Congress on Medical Librar-
defense and the servicing of debts, while the number of persons living in abject poverty increases” [3].

“Education is perhaps the single most important measure that can be taken to ensure the fuller integration of women in development” [4]. Education raises the social status and self-image of women; it delays marriage and hence the onset of childbearing; it reduces acceptance of traditional practices that may be harmful to health; and it can help to combat the fatalism that so often proves a barrier for women trying to improve their lives.

Women’s health at any point in their lives reflects a multitude of factors. The immediate environmental, cultural, and economic factors do not tell the whole story. Women’s health is the end point of a process that begins before birth, with each stage building upon the other. For the sake of simplicity, four different age periods will be reviewed.

INFANCY AND CHILDHOOD

Biologically, girls have an advantage over boys. They are more resistant to infection and malnutrition, and most inborn dysfunctions are more pronounced in boys than in girls. Nature has therefore given a small priority to the number of boys over girls; 51% of newborns are boys, and probably an even higher percentage of spontaneous abortions involve a male fetus. Although males are the vulnerable sex, this biological advantage is canceled out by the social disadvantage suffered by girls and women. Sex discrimination is a complex phenomenon and appears to act on the health of girls and women in a variety of ways, such as selective abortion of females, differential feeding, and the additional burden of work inside and outside of the home. There is also worldwide discrimination against girls in education, leaving them unprepared to find employment except poorly paid, insecure, and often exploitative casual work.

THE ADOLESCENT GIRL

Reproductive capability is reached before social and physical maturity is completed. Pregnancy and childbearing during adolescence involve considerable risks to both mother and child. Those who start having children early generally have more children at shorter intervals than those who embark upon parenthood later, thus adding to their health risks.

A growing problem in many parts of the world is that of adolescent pregnancy before marriage. Access to family-life education and information about sexuality; prevention of pregnancy; and sexually transmitted diseases, including AIDS, is frequently not available to young people. Many will seek unsafe abortions and face sterility or even death. Once again, information is the strongest weapon in our arsenal.

THE REPRODUCTIVE YEARS

In many parts of the world, women spend most of their reproductive years either pregnant or breastfeeding; this is reflected in patterns of mortality. In some developing countries, as many as half of the deaths of women of reproductive age are due to pregnancy-related causes. Hemorrhage, eclampsia, abortion, sepsis, and obstructed labor are usually five leading immediate causes of death.

A special problem is the circumcision of women, especially the kind where all the genital labia have been removed and the wounds have been closed by tight stitches. In those cases, labor is often prolonged and painful, resulting in severe ruptures with life-threatening bleeding, and in those countries, because blood is saved for men, few women will get transfusions. If they survive, women often develop fistulas, making them incontinent both for urine and feces. They are then regarded as unclean and are ostracized from their societies. No reliable numbers exist as to how many women have been circumcised this way; estimates vary between twenty and sixty million women.

Family planning has a vital role to play in saving lives and improving the quality of life. If all women who said they wanted no more children were actually enabled to stop childbearing, the number of births would be reduced by an average of 33% in Latin America, 35% in Asia, and 17% in Africa, and the number of maternal deaths would probably fall at least proportionally. Education and information are needed.

AGING WOMEN

The “graying” of populations in the industrialized world is fast becoming a feature of many developing countries. Yet the white- or gray-haired women are mostly a phenomenon of developed countries. Women are more liable to suffer from chronic but not fatal diseases, whereas men tend to suffer from acute but fatal diseases. Thus, older men have shorter life expectancy but relatively more years free from functional disability than women.

Disaggregation of data by sex and the analysis of roles, activities, and time of use and access to resources have helped to identify and highlight gender differences and factors that constrain or enhance the health and development of society as a whole. Knowledge is of supreme importance in this battle against ignorance and material and mental poverty.

A LIMIT TO HEALTH?

So far, our attention has been on the problems that women face in connection with reproduction and lack
of control over family planning and family resources, especially the need for better education and information to strengthen women's ability to make their own choices. What is the situation like in the parts of the world where women have achieved these goals, where primary- and secondary-level education for girls equals or even surpasses that of boys?

Denmark, a small, idyllic country with a high standard of health care and education, a rather homogeneous standard of living, and a reputation for having a nondiscriminatory and liberal state of mind, serves as an example. Last year, a group of Danish researchers presented a study on women's life expectancy and mortality that showed some very interesting tendencies [5]. For the past 150 years, there has been a steady increase in life expectancy for the Danes as well as for most other Europeans. This increase is now flattening out; the Danes as well as other Scandinavians seem to be reaching an upper limit for life expectancy. This is especially evident for the women. Between 1960 and 1970, life expectancy for Danish women increased by 1.8 years. Between 1980 and 1990, this increase was 0.2 years. The same tendency is seen for women from Sweden, Norway, Germany, the Netherlands, and England, for which there is data. However, women still have a longer life expectancy than men. In 1948, the difference in life expectancy between Danish men and women was 2.3 years. Then women's health improved rapidly compared to that of men, reaching a peak difference of 6.1 years in 1980. Now the men are closing the gap. In 1990/91, life expectancy for Danish women was 77.7 years, while Danish men could hope for 72.2 years. The difference is down to 5.5 years. What does this mean? Have we reached the human limit?

Life expectancy is influenced by events throughout life, such as infant mortality, adolescent accidents, and chronic diseases in old age. The data show that the changes in life expectancy are especially prominent for women between thirty-five and sixty-five years of age, meaning that most women in that age group have no better chances for survival than their mothers. It means that seen as a group, women have made no health gains during recent decades.

What do the Danes die from? In ranked order, the causes of death are cardiovascular diseases, chronic obstructive lung diseases, lung cancer, breast cancer, liver cirrhosis, and suicide. What is the role of socio-economic factors? Some say that it is unhealthy for women to work outside the home; Kinder, Küche, und Kirche (children, kitchen, and church) is better. Other studies on quality of life point to a benefit for those women who went into the labor market. Certain categories of the workforce run higher risk than others, especially unskilled women and those working in hotels and restaurants. Working women who have better health than the average are those in traditional female jobs such as health care, teaching, and secretarial jobs.

Some think that education about alcohol and tobacco consumption would be beneficial. Although that may be true, there is a rather disturbing French report. For men, mortality is lower the better educated they are, but the opposite is true for women. Academic French women have a higher mortality rate than their nonacademic sisters, while academic French men have a lower mortality rate that their nonacademic brothers. The same tendencies can be seen in the Danes who belong to the academic insurance system. This means, say the Danish researchers, that the negative development for middle-aged women in our societies seems to be a phenomenon that is related to general tendencies for most of our women. In short, there may be something generally unhealthy for middle-aged women in our societies, but no one knows.

**NEW LIFESTYLES**

To look for hypotheses for health risks, an idea of what health is all about is helpful. The World Health Organization's definition of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [6]. That implies that health is in reality a state of mind. An invalid may very well have the feeling of physical as well as social and mental well being. Health in this way seems most closely related to being happy, something very positive, a feeling of excess energy, without necessarily being very active. The times I have experienced this myself have been more like a wave of general well being. The holistic perspective is that health is linked to the subjective feeling of well-being in an interactive way. A woman's health is better when she is happy; women feel better when they are healthy. From this standpoint, are there changes in our present society that negatively affect women's well-being differently than that of male colleagues?

The most striking change in society over the past decades is women's participation in jobs outside the home. The next time the world's history is written, one great change to be described will be the silent revolution in which women took part. In that respect, women are all pioneers, explorers of new continents, continents so far inhabited by native men. What about these silent battles? Are women silent victims? Entering the job market can be a health gain, but is there also something negative about it?

Labor is sex-divided. Men work with men, mostly in the private sector and mostly in the top positions. Women work with women, mostly in caretaking jobs, mostly in the public sector, mostly in lower positions.
Women in these jobs have generally better health than the average. Unskilled women working in polluted industries may of course be subject to special health risks, but they are few.

Is there a combination of factors? Women have less free time than men, and women most frequently take the responsibility for making the time puzzle click in place. Is there too much stress? Does this stress lead to overconsumption of tobacco and alcohol? Women smoke more than men do in many of these groups, but that is not the case for well-educated women. Broken homes, divorces, and lack of social stability are also negative factors for men's health. Divorce results in the deterioration of a man's health; a woman's improves. Suicides and liver cirrhosis point to social problems like alcoholism, but these problems still occur primarily in males. The answer is that we do not know; we need to know more. More research on women and the special health risks and benefits in their lives is needed.

This leads to the final topic in this progression: women as objects of research.

**CLINICAL TRIALS AND WOMEN**

Number one on the list of present causes of death of women is cardiovascular disease. Most clinical decisions about the choice and dosage of drugs given to women with cardiovascular disorders are based on studies that were conducted predominantly or exclusively on middle-aged men [7]. Gender differences, when examined, suggest that the hormonal status, older age, and smaller body mass of women may be important contributors to the variability in drug levels, efficacy, side effects, and toxicity. Are women getting the wrong drugs or the wrong doses? There are few clinical trials with women participants despite the fact that if invited, women have a higher participation rate in studies and are conscientious in filling in the various forms. There are various explanations. One is that men are more interesting. There is more attention to men's diseases, probably because most researchers are men and therefore have a natural interest in finding out more about their own health risks. But in addition to that, it has been a part of the policy both in the public and the private sector not to include women in clinical trials for at least two reasons.

During the Second World War, the Nazis performed terrible experiments on concentration-camp prisoners. The Nuremberg Code of Ethics, enacted in the late 1940s following the war, declared that the fundamental dignity of human beings should be protected from exploitation [8]. Clinical trials of drugs were regarded as dangerous and a hazard to health.

The most vulnerable groups were to have a special protection, and the most vulnerable included women and ethnic minorities, who were considered unable to give informed consent to participate in such studies. Second, women could be in the early stages of pregnancy, when the fetus is especially vulnerable. Both of these reasons for excluding women reflect the paternalistic attitude that the woman herself is not able to make an independent choice—somebody else has to make this for her.

Naturally, in the long run, this attitude could not be accepted either by women or by other groups denied the right to make their own decisions. Attitudes toward participation in clinical trials have changed from being protected from research risks and potential burdens into getting the possible benefit from participating in a study of advanced medicine.

As a result of a national movement of women in the United States to focus on issues of their health care and to transform the male-oriented model of clinical research, the policy of the Food and Drug Administration (FDA) changed, and in a 1993 declaration, the FDA stated two important points relating to women's participation in drug trials:

- sex-specific analyses of the safety and efficacy of drugs will be required as part of all new drug applications; and
- it will no longer be recommended that women of childbearing potential be restricted from participation in the earliest phases of drug trials [9].

There is still much to investigate. There is much more we need to know, and there is an urgent need to have access to the new knowledge to attain a world that promotes the fundamental rights of health for all people, men and women alike. Librarians have a key role in this process.

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Received June 1995; accepted July 1995