

History of the Women's Health Movement in the 20th Century

Francine H. Nichols, RNC, PhD, FAAN

■ The Women's Health Movement (WHM) emerged during the 1960s and the 1970s with the primary goal to improve health care for all women. Despite setbacks in the area of reproductive rights during the 1980s, the WHM made significant gains in women's health at the federal policy level during the 1980s and 1990s. The WHM became a powerful political force. The achievements of the movement in improving women's health during the 20th century were numerous and significant. *JOGNN*, 29, 56-64; 2000.

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The Women's Health Movement (WHM) emerged during the 1960s and the 1970s during the second wave of feminism in the United States. It has striking similarities to the first wave of feminism that occurred in the 1830s and 1840s. During that time in the mid-1800s, women who were consumer health activists demanded changes in health care (the Popular Health Movement) and women's rights activists demanded equal rights for women (the Women's Liberation Movement) (Marieskind, 1975).

The Early Women's Health Movement

One can argue that the Women's Health Movement started in the early 1900s with Margaret Sanger's fight for women's rights to birth control (Wardell, 1980). However, the literature reveals that it is commonly thought the WHM

began in the 1960s (Marieskind, 1975). The focus of the woman activists during the 1960s and 1970s was fighting to gain control of their own reproductive rights (Ruzek, 1978). During the 1960s, abortion was illegal in all states except to save the life of the woman. Although there were approximately 8,000 therapeutic abortions done annually, there were more than 1 million illegal abortions annually. Approximately one-third of the women who had illegal abortion experienced complications requiring hospital admittance. Between 500 and 1,000 women died annually as a result of an illegal abortion (Geary, 1995). Activists in the WHM and other feminists groups formed a powerful force that culminated in the Supreme Court decision of *Roe v Wade* in 1973, which legalized abortion. Although reproductive rights continued to be a major focus, the WHM moved rapidly into many other areas that affected women's health. In a short time, the WHM had developed a comprehensive approach to women's health. Individuals within the WHM had widely divergent goals. However, one common goal united them all: "a demand for improved health care for all women and an end to sexism in the health system" (Marieskind, 1975, p. 219).

The first women's self-help health group in the United States is thought to have been formed in 1970. After that, new groups organized at phenomenal speed, and by 1973, there were more than 1,200 women's self-help health groups across the country (Schneir, 1994). The common theme of these groups was the dissatisfaction with health care. The common goals were women reclaiming power from the paternalistic and condescending medical community and assuming control of their own health (Geary, 1995).

Changing childbirth practices became a major effort of the WHM movement in the 1960s and 1970s as women sought to give birth without medical intervention and with their husbands present. During this time, women spearheaded the formation of two childbirth organizations, Lamaze International (formerly ASPO/Lamaze) and the International Childbirth Educational Association. The goals of these organizations were to change childbirth practices by advocating choice for expectant parents during childbirth and by preparing expectant parents for birth through childbirth education. In 1972, Doris Haire's expose *The Cultural Warping of Childbirth* described the negative effects of medical intervention during childbirth. In the book, medicalized birth in the United States was compared with humanistic birth conducted by midwives in other developed countries. The childbirth movement peaked in the 1980s when many hospitals began to change from traditional maternity care to family-centered care and when most hospitals began to offer prepared childbirth classes. Through the efforts of the WHM and concerned professionals, childbirth was changed for millions of women who wanted to give birth without medical intervention, be awake during birth, and have their husbands present.

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The WHM of the 1960s and 1970s was a grassroots advocacy movement that quickly swelled in numbers, thus gaining strength and power. It was fueled by the passion of women who experienced injustice and were fighting for their rights. The WHM became even more powerful because of its participants' commitment to the cause and their tireless activist efforts. Significant events in the WHM during the 20th century that were pivotal in creating awareness of problems and promoting needed changes are shown in Table 1.

The 1980s: An Era of Setbacks and Gains

The WHM flourished during the liberal political environment of the 1960s and 1970s. Ronald Reagan's election as president in 1980 heralded the beginning of

an increasingly conservative political environment. The New Right became firmly entrenched in American politics during the 1980s and wielded increasing power in political decisions. Legalized abortions were under attack from antiabortion activists. Feminist's health clinics became the targets of violence, and many clinics closed. In 1989, the Webster *v* Reproductive Health Services decision by the Supreme Court placed increased restrictions on abortion (Butler & Walbert, 1992; Geary, 1995). During the same time the WHM was experiencing setbacks in the area of reproductive rights, definite progress occurred with the establishment of federal task forces and agencies that were charged with the responsibility of ensuring that women's health needs were met.

Women's Health and Health Policy

During the 1980s and 1990s, significant gains were made in women's health at the federal policy level (see Table 1). The Congressional Caucus for Women's Issues was formed in 1977 as a Legislative Service Organization with an active bipartisan voice in the House of Representatives on the behalf of women (Remarks by the President at the Congressional Caucus for Women's Issues, 1997; Update—The Congressional Caucus for Women's Issues, 1999). When the Caucus was forced to reorganize as a Congressional Members Organization in the late 1990s, it had to close its office. However, the Caucus still provides a strong bipartisan voice for women at the federal level. The Caucus' Statement on Women's Health is shown in Table 2.

The first formal federal action was the establishment of the Task Force on Women's Health Issues in 1983 by the U. S. Public Health Service (USPHS). The Task Force was charged with the responsibility of ensuring that women's needs were being met and making recommendations (Kirschstein, 1987; Women's Health, 1985). The Task Force's first report, in 1985, was based only on data from women who were federal employees. To correct this deficiency, 11 regional meetings were held across the country to gather additional data from women in communities. The major finding from the original study and the additional meetings was women's dissatisfaction with access to information and medical care. The Task Force recommended research on women's health problems and research on contraceptive devices and approaches for both women and men (Geary, 1995).

In 1986, the National Institutes of Health (NIH) adopted a policy requiring the inclusion of women in clinical research. Women leaders, in 1989, voiced their concern to the Congressional Caucus for Women's Issues that research on women's health was still being neglected. A formal General Accounting Office (GAO) investigation of NIH research on women's health was

TABLE 1
Significant Events in the Women's Health Movement

<p>1969 <i>The Doctors' Case Against the Pill</i> was published. Written by Barbara Seaman, a health columnist, this exposé on the birth control pill described deadly side effects of the pill, including stroke, heart disease, depression. The controversy generated by the book cost Seaman her job but led to the 1970 federal hearing on the safety of the birth control pill.</p> <p>1973 <i>Our Bodies, Ourselves</i> published by the Boston Women's Health Collective; cost 30 cents per copy.</p> <p>1974 The National Women's Health Network, an advocacy clearinghouse was founded by Seaman and four other woman activists. There were nearly 2000 women's self-help medical projects across the United States.</p> <p>1975 The first International Conference on Women was held.</p> <p>1977 The Food and Drug Administration (FDA) banned the inclusion of women of childbearing years in Phase 1 and 2 drug trials.</p> <p>1983 First comprehensive national survey of women's health by The Commonwealth Fund, New York city.</p> <p>1984 Boogaard's article "Rehabilitation of the female patient after myocardial infarction" (Boogaard, 1984) was significant because it stimulated nurse researchers to explore women's experiences with cardiac disease. In the mid-1980s, women began to be viewed as a unique group in the investigations of cardiac patients, "rather than as a subgroup of the larger male-dominated paradigm (King & Paul, 1996).</p> <p>1989 The Congressional Caucus for Women's Issues (CCWI) exposed the National Institutes of Health (NIH) lack of research on women and demanded change. The Jacobs Institute of Women's Health was founded to "advance the understanding and practice of women's health care."</p> <p>1990 The Office of Research on Women's Health (ORWH) of NIH was established by Bernadine Healy, MD, the first female director of the NIH. The Society for the Advancement of Women's Health Research was established to bring public attention to the lack of research on women's health and to garner support for creating permanent change.</p>	<p>1991 The first issue of the <i>Journal of Women's Health</i> was published by the Society for the Advancement of Women's Health Research. <i>The Health of Women: A Global Perspective</i>, a report of the 1991 National Council for International Health (NCIH) Conference, was published.</p> <p>1992 The Women's Health Initiative, a \$625 million, 14-year randomized controlled trial, the largest study ever of women's diseases, began by NIH. The study examines the use of preventive measures, such as diet, behavior, and drug treatment, against cardiovascular disease, cancer, and osteoporosis in postmenopausal women.</p> <p>1993 FDA withdrew the 1977 federal ban on the inclusion of women in early drug trials and developed its new gender guideline, which recognized the need for adequate representation of women in drug trials and left decisions about including women of childbearing age in drug trials to the internal review boards, the women who were potential subjects, and their physicians. The US NIH Revitalization Act of 1993 required that any clinical trial involving the treatment of a disease be designed in a manner that would provide a valid analysis of if the variables being studied affect women or members of minority groups.</p> <p>1994 to 1995 Women's health issues were the focus of the International Year of the Family; The International Conference on Population and Development in Cairo, Egypt; the World Summit on Social Development in Copenhagen, Denmark; and the United Nations Fourth World Conference on Women, Beijing, PRC.</p> <p>1998 The New Mothers' Breastfeeding Promotion and Protection Act (H.R. 3531) was introduced by Representative Carolyn Maloney. The Act protects breastfeeding under the civil rights acts and provides provisions for unpaid time for breastfeeding mothers to express milk in the workplace.</p>
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Based on data from Meinert, C.L. (1995). The inclusion of women in clinical trials. *Science*, 269, 795-796; Sharp, N. (1993). Women's health: A powerful public issues. *Nursing Management*, 24(6), 17-19.

requested by the Congressional Caucus and Henry Waxman (D-California). The findings of the investigation confirmed that only 13.5% of NIH monies went for women's health research and that women were still being excluded from clinical studies (Congressional Re-

search Report, 1993). Angell (1993) summarized three ways that women were discriminated against in clinical research: diseases that affect women disproportionately were less likely to be studied, women were less likely to be included in clinical trials, and women were less likely

TABLE 2

The Congressional Caucus for Women's Issues Statement on Women's Health

Healthcare coverage should be available to all regardless of income or eligibility.

All basic health benefits packages must include essential preventive, diagnostic and treatment services.

Access to full information must be available about all treatment options and alternatives to treatment, so that women can make informed decisions.

Health care services should be available in a variety of settings, including an array of outpatient settings.

Health care services should be provided by a variety of providers, such as physicians, nurse-practitioners, and nurse midwives.

Individualized care should be the basis for health care to each woman.

Primary health care services should be community based.

Research on the most effective ways of promoting health and preventing illness in women should be included in health care reform.

Update—The Congressional Caucus for Women's Issues. (1999, March 15). [Online]. Available: <http://www.house.gov/lowey/caucus.htm>.

to be senior investigators conducting trials. LaRosa (1994) in an article on the Office of Research on Women's Health said the evidence did not indicate that women were being systematically excluded from biomedical research, but rather that the numbers of women included were not sufficient to detect gender differences or that they had been excluded from some studies.

In response to the GAO report, the NIH adopted a number of strategies to resolve the problem. In 1990, the Office of Research on Women's Health (ORWH) was established within NIH with the charge of ensuring that NIH research addressed women's health needs and that women were included in clinical trials. As a part of its mandate, the ORWH developed a women's health research agenda and designed a 14-year, \$625 million Women's Health Initiative study that has been implemented in 45 clinical centers across the United States and includes 160,000 postmenopausal women. The study examines the effect of hormone replacement therapy and diet and exercise on coronary heart disease, breast and colon cancers, and osteoporosis (Congressional Research Report, 1994).

Two other federal agencies were actively involved in women's health research. In 1993, the Food and Drug Administration eliminated the 1977 restriction excluding women of childbearing potential from participating in the early phases of drug testing and published revised guidelines that required sex-specific analyses of safety and efficacy be a part of all new drug applications (Merkatz & Junod, 1994). The Centers for Disease Control (CDC) 1994 budget appropriations from Congress included an additional \$2 million to initiate a

screening program for chlamydia in women and their partners and \$51 million designated for Papanicolaou smears and mammography screening for low-income women (Congressional Research Report, 1994). The CDC also established an Office of Women's Health which, provides leadership, guidance, and coordination on policy, programs, and activities related to women's health (CDC, 1999). A federal infrastructure for addressing women's health developed and expanded during the 1980s and 1990s, and there were substantial gains in federal funding for women's health research during this time.

Advocacy Organizations

Activists in the Women's Health Movement formed a powerful lobby that has brought the inequities in women's health care to the attention of legislators and the public. Through their efforts, women's health has become an important public and political issue that commands responses from individuals in public policy, medicine, research, and government. For example, the Older Women's League (OWL) worked hard to bring women's health issues to the attention of the public and to improve health care for women. The OWL coordinated the Campaign for Women's Health that consisted of more than 40 national organizations all working to create the changes needed to improve health care for women (Sharp, 1993). The WHM probably is one of the finest examples of grass-roots advocacy efforts that have resulted in widespread, needed changes from the community level to the level of the federal government.

Women's Health and Women's Health Nursing

Literature on issues and topics related to women's health is plentiful. However, the term women's health is rarely defined. In 1997, the Expert Panel on Women's Health of the American Academy of Nursing (AAN Expert Panel, 1997) defined women's health as health promotion, maintenance and restoration throughout the entire life span. The Panel (p. 7) emphasized that "Understanding women's health requires more than a biomedical view; it requires awareness of the context of women's lives." School of Nursing faculty at the University of Michigan (1999) describes women's health as pertaining "to the physical, psychological and social well-being of women," which includes the "diversity and heterogeneity of women as well as the variety of concerns that affect their well-being." The feminist perspective that "acknowledges the socio-political context which in many ways, determines the health of women" is an integral part of the definition (University of Michigan, 1999). The most comprehensive medical definition of women's health is one that was developed for the Women's Health Medical Education Program (Donoghue, 1996):

Women's health is devoted to facilitating the preservation of wellness and prevention of illness in women and includes screening, diagnosing and managing conditions which are *unique* to women, are *more common* in women, are *more serious* in women, have *manifestations, risk factors or interventions* which are different for women.

There is general agreement on core concepts related to women's health: recognition of the diversity of women's health needs throughout the life span (Donoghue, 1996; Fogel & Woods, 1995); emphasis on the empowerment of women as informed participants in their own health care (Donoghue; Fogel & Woods); the importance of research of gender differences in diseases and responses to drugs (Donoghue; Fogel & Woods); and the need for a multidisciplinary team approach (Donoghue; Fogel & Woods). Andrist (1997) declared that the goal of women's health care should be social transformation, which includes symmetry in provider-patient relationships, access to information, shared decision making, and striving for change in the larger social structure.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has been a leader in providing legislative testimony on women's health issues and pushing for needed changes in health care for women. Highly regarded by individuals in the political arena, government officials, and health care professionals throughout the years, AWHONN has contributed significantly to ensuring the passage of important legis-

lation to improve women's health. For example, in 1998, AWHONN provided testimony to the Congressional Caucus for Women's Issues in support of H.R. 3531 bill, the New Mothers' Breastfeeding Promotion and Protection Act. The bill clarified that breastfeeding was protected under the civil rights act and provided as much as 1 hour per day of unpaid time in the workplace for as long as 1 year for breastfeeding mothers to express milk (Harris, 1998). Although the bill was not passed that year, it was reintroduced the following year, and AWHONN's efforts to promote passage of the bill continues.

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Two other women's health organizations have made significant contributions to improving women's health: the National Association of Women's Health Professionals, which was formed in 1987, and the Jacobs Institute of Women's Health, which was founded in 1989. By the 1990s, the WHM had a strong voice that commanded the attention of health policy makers through the combined efforts of professional organizations and grass-roots advocacy organizations.

Development of Nursing and Medical Specialties in Women's Health

The number of women's health nurse practitioner programs expanded quickly in response to the need, and these practitioners were readily accepted by the women for whom they provided care and by many health care professionals (Chang et al., 1999; Myers, Lenci, & Sheldon, 1997; Ryan, 1999).

In an effort to end the discrimination against women in health care and to educate practitioners about women's health and the diseases that affect them, the medical profession established a new medical specialty in women's health. However, in contrast to the acceptance of the women's health nurse practitioner programs, this approach has met with opposition from some leaders in the WHM. Harrison (1992) argued that

a new women's health specialty would "marginalize" the care of women, and mainstream medical and health care would cease to focus on women and become exclusively for men. She suggests a medical specialty in men's health with mainstream health care being for women. Others have described a medical specialty in women's health as co-optation of the WHM. Surprisingly, this conflict appears to be a common theme when the goals of grass-roots advocacy organizations become an integral part of mainstream health care. This opposition to the incorporation of women's health as an integral part of medicine and health care and the view of co-optation parallels the responses of some childbirth advocacy leaders to the movement of childbirth education from the community and into the health care agency setting.

Achievements of the Women's Health Movement

The WHM confronted many problems and blatant discrimination against women that plagued women's health care. Undaunted, by the 1980s the WHM had attracted the attention of the media, government agencies, and researchers at the local, state, and federal levels. From that time forward, the WHM became a powerful political force to be reckoned with, from reproductive rights to prenatal care to hazards in the workplace (Sechzer, Griffin, & Pfafflin, 1994).

The WHM achievements were numerous and significant.

Women gained more control over their reproductive rights. Abortion was legalized, although restrictions remain, and new contraceptive technology became available.

Gender-based research emerged as an important area of biomedicine. Today, women are no longer automatically excluded from early drug trials. Research on conditions that affect women as well as men must adequately include women as subjects. Woods (1994) cautioned that merely adding a cohort of women to a study would not necessarily render appropriate findings that can be used to improve health care for women.

Significant progress has been made in research on cardiovascular diseases of women (King & Paul, 1996). The literature on cardiovascular disease during the 1960s and 1970s did not include gender-specific conclusions, even when women were included in the studies. It was not until the mid-1980s that there was interest in exploring the impact of cardiac disease and surgery on women. Significant progress was made since that time.

Violence and discrimination against women have been recognized as a significant problem worldwide, and numerous programs have been implemented to ad-

dress these issues (Varkevisser, 1995). The WHM is fighting to gain support for breastfeeding mothers in the workplace. The passion of the women involved in response to the discrimination against breastfeeding mothers in the workplace parallels that of the participants in the early WHM.

The Future of the Women's Health Movement

After a long, hard-fought battle, women's health has finally become an integral and important part of the health care system. Great strides have been made in understanding how diseases uniquely affect women and developing effective health promotion programs for women. However, there is still much to be accomplished. The recognition of the significant role that sex and gender play in scientific and medical practice will continue to be a major emphasis (Sechzer et al., 1994). Hormonal differences between women and men, women's unique responses to diseases and drugs, and gender equity in research programs will continue to be areas of important interest in the 21st century (Pinn, 1992). Nursing has always led in the development of needed and effective programs for women's health during the 20th century. Morse (1995) asserts that this will continue and that nursing "is likely to emerge as the profession that is the most responsive to women's health" (p. 273) because of its emphasis of active involvement of the individual in her own health care and the emphasis on health promotion and health maintenance and because nurses have viewed women's health care from feminist perspectives and have challenged patriarchal, paternalistic values.

Women's Health Centers

The development of women's health centers is emerging as a new model for the provision of women's health care at a rapid pace (Budoff, 1994; Levison, 1996). These centers provide primary care to women, including reproductive care, pregnancy and childbirth care, breast care programs, and other essential services, with easy access to specialists when they are needed. Women's health became an area of primary interest for medicine and health care agencies in the mid-1990s. By 1997, approximately one-third of hospitals in the United States had some kind of women's health center, compared with 19% in 1990 (Day, 1997).

An Integrative Science of Women's Health

Walker and Tinkle (1996) point out that women's health has been fragmented, with childbearing separated from general health promotion activities and the treatment of chronic diseases. These researchers provide a solid case for an integrative science of women's health

that would provide a knowledge base that “brings together phenomena relevant to women” (Walker & Tinkle, p. 379). This integrative science of women’s health has two significant dimensions:

- the incorporation of all of the sciences that study women’s health issues so that the woman is viewed as a “whole woman”; and
- linking childbearing with other women’s health needs and problems throughout life, with emphasis on health promotion, disease prevention, and management of chronic illness.

This would provide a basis for a comprehensive seamless approach to women’s health care that would promote improved health and well-being (Walker & Tinkle).

Women’s Health in Developing Countries

The WHM that started in the developed world is now a significant force in developing countries, and a global agenda for women’s health has emerged (Doyal, 1996). The political, economic, and social forces that affect all women’s health are of even greater significance in developing countries (Dyches & Rushing, 1993). The concerns of women in the developing world are different from those in industrialized countries. Many women still die of reproductive problems and diseases and childbirth-related problems that could be easily prevented or cured (Mann, 1995). Third World health care programs have focused primarily on Third World children, and the problems of their mothers are often ignored. During the 1960s, 1970s, and 1980s, while the deaths of children younger than 5 years were cut in half, pregnancy and childbirth-related problems continued to be the leading cause of maternal mortality (Nowak, 1995). The World Health Organization (WHO), the World Bank, and the United Nations Population Fund (UNFPA) launched the Safe Motherhood Initiative with the goal to decrease maternal mortality rates by the year 2000 by one-half. It is clear the goal for the year 2000 will not be reached, but progress has been made. In addition, the WHO goal of Health for All by the year 2000 has drawn the world’s attention to women’s lack of access and equity in health care.

Implications for Clinical Practice

Although there have been many gains in the area of women’s health in the United States during the 20th century, the goals of the WHM have been only partly achieved (Ruzek, 1993). Activism still is needed against potentially dangerous drugs and treatments, to gain health care services for women who are not being served, and probably most importantly, to help women gain power “over their own bodies and their own lives”

(Mann, 1995). Continued progress will be made only as women demand attention to their concerns and problems, and vigilance will be essential after changes are evoked.

Normal life transitions in a woman’s life, such as childbearing and menopause, are still “medicalized” (Taylor & Woods, 1996). Greater emphasis is needed on cultural diversity, effective means to decrease violence against women, and increasing the link between research and effective health care for women (Sechzer et al., 1994). Raftos, Mannix, and Jackson (1997), in a review of women’s health articles indexed by CINAHL between 1993 and 1995, concluded that although holism is claimed to be the key feature of women’s health, the articles approached women’s health “from a narrow and stereotypical perspective with a bio-medical focus” on reproductive, maternal, neonatal, family, and sexual health. Another concern is the quality and philosophy of some family-centered care maternity programs. Most birthing environments have changed to warmer, more home-like rooms where women labor and give birth, but the traditional medicalized approach to birth remains the same in many birthing agency settings (Nichols & Gennaro, in press). Clancy and Massion (1992) called American women’s health care a “patchwork quilt with gaps.” Although progress has been made in achieving more comprehensive and coordinated women’s health care, many gaps still remain in women’s health care in the early 21st century. Andrist (1997) voiced concern about the commercialization of women’s health, which has created a profitable industry for pharmaceutical companies, hospitals that use women’s health as a marketing tool, and other corporations that market products and services to women.

Nurses play an important role as political activists in promoting the WHM and gender equity and empowering women to take charge and assume an active role in their own health care (Taylor & Woods, 1996). Taylor and Woods cite the need for a “woman-centered health care delivery system” (p. 797) that would provide comprehensive women’s health care. Ruzek (1993) advocates using a more inclusive social model of health and well-being, as opposed to the current biomedical

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model, for women's health. The social model requires consideration of the total context of women's lives, such as economics, women's perceptions of their health risks, and the diversity of women's health needs across the life span. This implies that use of different health resources at various times in a woman's life are needed to improve women's health. In summary, LaRosa (1994) wrote that the success of women's health initiatives depends on the collaboration and cooperation of all concerned—the scientific community, health care providers, and the women who seek care. This remains true today in the 21st century.

REFERENCES

- AAN Expert Panel on Women's Health. (1997). Women's health and women's health care: Recommendations of the 1996 AAN Expert Panel on Women's Health. *Nursing Outlook*, 45(1), 7–15.
- Andrist, L. (1997). A feminist model for women's health care. *Nursing Inquiry*, 4, 268–274.
- Angell, M. (1993). Caring for women's health: What is the problem? *New England Journal of Medicine*, 329, 271–272.
- Boogaard, M. A. (1984). Rehabilitation of the female patient after myocardial infarction. *Nursing Clinics of North America*, 19, 433–440.
- Budoff, P. W. (1994). Women's centers: A model for future health care. *Annals of the New York Academy of Sciences*, 30, 165–170.
- Butler, J. D., & Walbert, D. F. (1992). *Abortion, medicine and the law* (4th ed.). New York: Facts on File, Inc.
- Centers for Disease Control (CDC). (1999, May 28). Office of Women's Health. [Online]. Available: <http://www.cdc.gov/maso/owhfs.htm>.
- Chang, E., Daly, J., Hawkins, A., McGirr, J., Fielding, K., Hemmings, L., O'Donoghue, A., & Dennis M. (1999). An evaluation of the nurse practitioner role in a major rural emergency department. *Journal of Advanced Nursing*, 30(1), 260–268.
- Clancy, C. M., & Massion, C. T. (1992). American women's health care. A patchwork quilt with gaps. *Journal of the American Medical Association*, 268, 1918–1920.
- Congressional Research Report. (1993, Spring). Selected women's health conditions: Federal spending and prevalence. Washington, DC: US Congress Publication No. 93–670.
- Congressional Research Report. (1994, Spring). Women's health research. Washington, DC: US Congress Publication No. 94–495.
- Day, K. (1997, June 26). A fever for women's health care. *Washington Post*, p. CO1.
- Donoghue, D. F. (ed.) (1996). *Women's health in the curriculum: A resource guide for faculty*. Philadelphia: National Academy on Women's Health Medical Education.
- Doyal, L. (1996). The politics of women's health: Setting a global agenda. *International Journal of Health Services*, 26, 47–65.
- Dyches, H., & Rushing, B. (1993). The health status of women in the world-system. *International Journal of Health Services*, 23, 359–371.
- Fogel, C. I., & Woods N. F. (1995). *Women's health care: A comprehensive handbook*. Thousand Oaks, CA: Sage.
- Geary, M.S. (1995). An analysis of the women's health movement and its impact on the delivery of health care within the United States. *Nurse Practitioner*, 20(11), 24, 27–28, 30–31.
- Haire, D. (1972). *The cultural warping of childbirth*. Seattle, WA: International Childbirth Education Association.
- Harris, J. (1998, July). Lactation in the workplace: What happens when a breastfeeding mother returns to work? Testimony of the Association of Women's Health, Obstetrics and Neonatal Nurses to The Bipartisan Congressional Caucus for Women's Issues. [Online]. Available: <http://www.awhonn.org/advocacy/testimony7-98.htm>.
- Harrison, M. (1992). Women's health as a specialty: A deceptive solution. *Journal of Women's Health*, 1, 101–106.
- King, K. M., & Paul, P. (1996). A historical review of the depiction of women in cardiovascular literature. *Western Journal of Nursing Research*, 18(1), 89–101.
- Kirschstein, R. (1987). Women's health: A course of action. *Public Health Reports*, July/August (Suppl), 7–8.
- LaRosa, J. H. (1994). Office of Research on Women's Health. National Institutes of Health and the women's health agenda. *Annals of the New York Academy of Sciences*, 30, 196–204.
- Levison, S. P. (1996). Multidisciplinary women's health centers: A viable option? *International Journal of Fertility and Menopausal Studies*, 41(2), 132–135.
- Mann, C. (1995). Women's health research blossoms. *Science*, 267 (5225), 766–770.
- Marieskind, H. (1975). The women's health movement. *International Journal of Health Services*, 5(2), 217–223.
- Meinert, C. L. (1995). The inclusion of women in clinical trials. *Science*, 269 (5225), 795–796.
- Merkatz, R. B., & Junod, S. W. (1994). Historical background of changes in FDA policy on the study and evaluation of drugs in women. *Academic Medicine*, 69(9), 703–707.
- Morse, G. G. (1995). Reframing women's health in nursing education: A feminist approach. *Nursing Outlook*, 43, 273–277.
- Myers, P. C., Lenci, B., & Sheldon, M. G. (1997). A nurse practitioner as the first point of contact for urgent medical problems in a general practice setting. *Family Practice*, 14, 492–497.
- Nichols, F., & Gennaro, S. (2000). The childbirth experience. In F. Nichols & S. Humenick (Eds.), *Childbirth birth education: Practice, research and theory* (2nd ed. [pp. 66–83]). Philadelphia: W. B. Saunders.
- Nowak, R. (1995). New push to reduce maternal mortality in poor countries. *Science*, 269 (5225), 780–782.
- Pinn, V. (1992, October 14). Women's health research. *Journal of the American Medical Association*, 268, 1921–1922.
- Raftos, M., Mannix, J., & Jackson, D. (1997). More than motherhood? A feminist exploration of women's

- health' in papers indexed by CINAHL 1993–1995. *Journal of Advanced Nursing*, 26, 1142–1149.
- Remarks by the President at Congressional Caucus for Women's Issues. Speech presented by President Clinton, Mellon Auditorium, Department of Commerce, Washington, DC, October 21, 1997 [Online]. Available: <http://www.usia.gov/usa/womenusa/speech5.htm> [1999, March 22].
- Ruzek, S. B. (1978). *The women's health movement: Feminist alternatives to medical control*. New York: Praeger.
- Ruzek, S. B. (1993). Towards a more inclusive model of women's health. *American Journal of Public Health*, 83(1), 6–8.
- Ryan, J. W. (1999). Collaboration of the nurse practitioner and physician in long-term care. *Lippincott's Primary Care Practice*, 3(2), 127–134.
- Schneir, M. (1994). *Feminism in our time*. New York: Vintage.
- Sechzer, J. A., Griffin, A., & Pfafflin, S. M. (1994). Women's health and paradigm change. *Annals of the New York Academy of Sciences*, 30, 2–20.
- Sharp, N. (1993). Women's health: A powerful public issue. *Nursing Management*, 24, 17–19.
- Taylor, D. L., & Woods, N. F. (1996). Changing women's health, changing nursing practice. *JOGNN*, 25, 791–802.
- University of Michigan School of Nursing (1999, March 15). Women's health. [Online]. Available: <http://www.umich.edu/~nursing/academics/phd/womenshlt.html>.
- Update—The Congressional Caucus for Women's Issues. (1999, March 15). [Online]. Available: <http://www.house.gov/lowey/caucus.htm>.
- Varkevisser, C. M. (1995). Women's health in a changing world. A continuous challenge. *Tropical and Geographical Medicine*, 47(5), 186–192.
- Walker, L. O., & Tinkle, M. B. (1996). Toward an integrative science of women's health. *JOGNN*, 25, 379–382.
- Wardell, D. (1980). Margaret Sanger: Birth control's successful revolutionary. *American Journal of Public Health*, 70, 736–742.
- Women's Health. (1985). Report of the Public Health Service Task Force on Women's Health Issues. *Public Health Reports*, 100(1), 73–106.
- Woods, N. R. (1994). The United States women's health research agenda analysis and critique. *Western Journal of Nursing Research*, 16, 467–479.

Francine H. Nichols is Professor and Coordinator of Women's Health in the School of Nursing at Georgetown University in Washington, DC.

Address for correspondence: Francine H. Nichols, RNC, PhD, FAAN, 2138 California Street, NW 203, Washington, DC 20008.