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GRANDMOTHERS AND WOMEN'S HEALTH: FROM FRAGMENTATION TO COHERENCE

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There is a paucity of models that drive integrated research agendas, and coherent approaches to development and progress of knowledge about women's health. In this article, we review four major models of women's health, present conditions supporting more integrative and coherent models of women's health based on the recommendations by two international conferences, and address major paradoxes inherent in women's health areas. For integrative and coherent models of women's health, we propose to incorporate visions and insights of previous models in developing a more coherent model that includes three major components—integration, transition, and marginalization.

Owing to health activists' struggle to place women's health on the national agenda, and an increasing consciousness of the need for further research in women's health, there is a growing attention to women's health issues in many fields (Rosser, 1994; Ruzek, Olesen, & Clarke, 1997). Despite this increasing level of interest in women's health care issues, there is a paucity of models that reflect pertinent dimensions of women's health and illness, and a social, cultural, and historical context of women's health experiences. Consequently, the paucity of coherent models may contribute to fragmentation in women's health research and inhibit the development of an integrative body of knowledge to guide health care for women. In the absence of a coherent model that reflects the complexity of women's history and lived

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experiences, there may be a tendency to rely on models that reflect only one dimension or aspect of women's lives such as their biology or their maternal roles. Relying on such models further drives the limited scope of research agendas and acontextual and fragmented interpretations of findings. Fragmented findings constrain changes in health care policies in reflecting gender sensitivity, comprehensiveness, and equity in health care.

There are many examples of how significant health issues are ignored by researchers due to narrowly focused models (Grisso & Watkins, 1992). Grisso and Watkins (1992) indicated that health problems including heart disease and lung cancer were ignored in women because they are less prevalent among women than among men. There is mounting evidence that access to health care differs according to gender (Rosser, 1994). In a study by Steingart and colleagues (1991), only 4% of women with an abnormal report from a special heart scan were referred for a cardiac catheterization, and 40% of men with an abnormal report were referred for the procedure. It was also reported that women with kidney failure were less likely than men to receive an organ transplant (Rosser, 1994). In general, women tend to be underdiagnosed and inadequately treated (Rosser, 1994). Research findings tend to be distorted and misinterpreted, and women's health–illness experiences tend to be reduced to a physiological or pathological condition or event.

It is imperative to develop models that reflect women's own experiences, that uncover women's hidden voices and invisible experiences, that do not reduce women's health–illness experiences to a pathological and/or physiological condition or event, and that integrate research findings to transcend fragmentation inherent in women's health research. In this article, we review four models in women's health, and we present conditions supporting more integrative and coherent models of women's health based on the recommendations by two international conferences. Then, we address major paradoxes inherent in women's health. Based on the discussions, we propose three major components that need to be included in the model of women's health to bring a sense of coherence and integration to women's health research.

MODELS IN WOMEN'S HEALTH

Many models have been used to describe, explain, or predict women's health care needs, demands, and goals. Among the existing models in women's health, we present four: (a) grandmothers' model, (b) biomedical model, (c) reproductive and maternal model, and (d) morality model. Each of the models has many strengths and weakness, and none of them provides a rationale for more comprehensive care for women or for a more coherent research agenda. Each tends to support a limited view of women's health and health care.

The Grandmother Model

One of the earliest models for health care of women is the one based on grandmothers' insights and caring practices. Visions and insights of grandmothers have profoundly influenced health care for girls and women in many countries. In many Asian countries, grandmothers earn respect, wisdom, and power by sacrificing their lives for their families and by gaining a significant status when they become grandmothers (Lock, 1994). That is usually the stage of their life when they are released from many of their daily responsibilities and become the resident consultant on all matters, particularly those related to women's and children's health care issues. Many of these grandmothers, especially in developing countries, have limited formal-school education; however, experientially they tend to be exceptionally well educated. Members of their families pay attention to their advice and wisdom and accept their authority. Grandmothers, knowingly or unknowingly, provide their offspring with the first framework of how women's health is viewed and dealt with in their families.

The grandmother model for women's health is driven by components that include heavy doses of caring, nurturing, and supporting. Grandmothers make the family the center of their lives and make sure that their daughters and grandchildren are well supported when they experience salient life events and major transitions. Grandmothers influence all important decisions in their family lives, including circumcision of granddaughters, preventive programs, and birth control measures. The grandmother model is still significant in many parts of the world. To fully understand and explain health care of women would require uncovering the processes that grandmothers use to influence health care of girls and women in their families and the goals for health as viewed from their perspective. It would also require careful studies on those factors that should be maintained in more contemporary agendas for health care.

The Biomedical Model

Biomedical models have been dominant in women's health research. The biomedical model continues to be reinforced in the media and public policy as the model of choice for all health care (Ruzek et al., 1997). Biomedical modelists assume that making biomedicine more complete and more inclusive of multiple factors in health will cure any health problems of women. There are many indications that biomedicine and its models have contributed to the reduction of morbidity and mortality rates of many diseases. Yet proponents provide a disease orientation that ignores gender differences as well as gender-specific issues, and frequently social, historical, and cultural aspects of health-illness experience are ignored. There is limited support that biomedical models have made any substantive contribution to the quality of life of populations (Hall & Allen, 1995). Biomedical models failed in three

major ways in women's health care. First, they tended to explain women's responses to health and illness by reducing them to a biomedical process. For example, the biomedical model on menopause tends to drive a definition of menopause as a metabolic or endocrine disorder (Abrams & Berkow, 1990). They provide a view of middle-aged women who are experiencing a menopausal transition as patients who have hormone deficiency syndrome (Coney, 1994). Consequently, the view of menopausal transition is distorted and limited. Women's own experiences during menopausal transition are not accounted for in these models, and therefore have been missing in our understanding of women and their needs during this phase of their lives.

Biomedical models failed to incorporate another important aspect of women's health: gender sensitivity and gendered explanations of health and illness. As a consequence, most of the research on diseases or system dysfunction has relied on men as subjects, and male attributes are considered as the norm against which women's health care needs could be judged (Dauis & Youngkin, 1995). An example is women's cardiac disease, the management of which has been ignored, misdiagnosed, and/or delayed (Harris & Weissfeld, 1991; O'Toole, 1989; Wenger, Speroff, & Packard, 1993). Many other examples of neglect have been documented (Rosser, 1994).

A third limitation of biomedical models as applied to women's health is the fostering of dependency on physicians, consequently transferring control of the body and/or mind to physicians rather than to women themselves (Gannon & Ekstrom, 1993). In other words, biomedical models promote medicalization of women's normal health–illness experiences and tend to make women feel helpless thus promoting a loss of control of their own ways of managing these health and illness experiences that were formerly well managed by women in the grandmother model.

The Reproductive and Maternal Model

National and international evidence demonstrates that health care systems tend to reduce women's health care to their reproductive functions. When women's health is debated internationally, the focus tends to remain on how mortality and morbidity rates can be reduced and how women should plan the number and spacing of their children. The goal of health care for women within this model is to maintain women for their functions as reproducers. Clearly, the maternal model has contributed to the reduction of maternal mortality and morbidity with the biomedical models, and also contributed to the reduction of morbidity and mortality of women in general. However, this model tends to reduce women's health issues throughout their live spans only to pregnancy and reproductive health. Furthermore, this model has made women in nonreproductive stages invisible in health care systems, and the health care needs of older women are thus neglected or ignored.

This model tends to deemphasize many other health care needs of women driven by the multiplicity and complexity of their lives due to their roles as

workers, caregivers, spouses, and community members. This is a model that supports the myth that only women can care for children and that promulgates assumptions about women's limited spheres of functioning and influencing. This is a model that patriarchal societies are known to support and promote. This model has driven policies that exclude women from important clinical trials under the assumptions that women need to be protected because of their reproductive functions and/or embryos. Consequently, there is limited knowledge about the interaction of drugs and hormones and the effect on women at different stages in their lives (Dubois & Burris, 1994; Weisman, 1998).

The Morality Model

The morality model of women's health is based on the premise that morality and moral values provide a framework within which women should be cared, and what behaviors could be supported by a health care systems. Health beliefs, attitudes, behaviors, and health care practice, which are morally unacceptable in a society and a culture, are deemed unhealthy, and society takes the responsibility for requiring a healthy quality of life for these people until they meet the moral standards of a society. For example, homosexuality was regarded as a sin by theologians, as a legal problem or crime by legislators, as a biological anomaly by medical entrepreneurs, and as a psychic disturbance by psychiatrists/psychologists because of value systems that make homosexuality a deviance that must be corrected (Rosser, 1994). It was as recent as 1974 that the American Psychiatric Association eliminated homosexuality from its list of mental illnesses. In 1980 it was dropped from the list of mental illnesses in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (Stevens & Hall, 1991; Homosexuality, 2000). Since religious heritage of most societies tabooed homosexuality, it became a disease and/or unhealthy condition. Goals for health care within such a model call for reforming behaviors and for providing need-based health care to only those who are reformed.

Female circumcision is another example that has been regarded as a healthy practice in many cultures. The morality model explains why such a practice has endured for centuries, and why the practice of clitoridectomy/circumcision of females exists (Ebong, 1997; Wright, 1996). The morality model is a social and/or cultural value-laden model that drives a research agenda, which focuses on character problems and limited strategies to prevent illness for those considered immoral. It deprives many women from accessing and receiving health care in many parts of the world. It is a framework that permits health care only when women abide by society's rules. There is also the abortion issue, which is still debated throughout the world (Ping & Smith, 1995; Wu, 1994). The stigma associated with the morality model prevents prostitutes in some countries from preventive health care for HIV and other sexually transmitted diseases (Bunting, 1996; Sacks, 1996).

CONDITIONS AND PARADOXES IN WOMEN'S HEALTH CARE

Each of these models provides a limited goal for health care for women and a limited view of their needs. The question we ask is how we can develop a more integrative and coherent model that encompasses women's diverse roles, and health care needs, and which is gender sensitive. Before proposing the major components that must be included in the model of women's health to bring a sense of coherence and integration to women's health research, conditions supporting such models and several paradoxes must be considered.

The Conditions: International Recommendations

The Cairo and the Beijing conferences have been instrumental in solidifying the changing models for women's health (Becker & Robinson, 1998; Beeman, 1996; Craft, 1995, 1997; Gijsbers Van Wijk, Van Vliet, & Kolk, 1996; Mayhew, 1996; Nelson et al., 1996; Warren, 1996). The dialogues and the action plan of these conferences moved the goals and strategies for women's health care beyond any of the aforementioned models. These conferences changed the language of health care of women from reproduction, disease, and mothering to empowerment by education, employment, information, involvement, and social development (Becker & Robinson, 1998; Craft, 1997; Mayhew, 1996; Nelson et al., 1996). The recommendations made by these two conferences may help identify conditions supporting more integrative and coherent models of women's health.

The Cairo Action Document (Becker & Robinson, 1998; Beeman, 1996; Craft, 1997; Nelson et al., 1996) supported a shift from a biomedical world. Women were defined as persons and in terms of their lives rather than diseases or reproduction. The dialogues in the conference and the recommendations supported the fact that social conditions of poverty, lack of equality, and disempowerment affect women's health, that contexts are essential to understand women's health care needs, and that the delivery of health care that exists is inadequate. These recommendations address the choices women must have and the power to choose among these choices. Many prior global conferences about women have taken place, but none emphasized the status of women and their empowerment as profoundly as did the Cairo and the Beijing conferences (Nelson et al., 1996).

Participation of Women

Four features of these conferences are important for us to remember and emulate in the future. First, in preparation for these conferences, many women around the globe mobilized their efforts and took leadership in setting the agendas for the conference ("Women's Health," 1996). This may explain the lack of agenda limitation to population control and family planning concerns and to demographics as a framework. A second important

feature was the intense participation and high profile that women from developing countries played in the conference (Nelson et al., 1996; "Women's Health," 1996). These conferences reflected the needs of women from first- (the major industrialized noncommunist nations), second- (mostly communist and socialist nations), or third-world (economically developing nations) nations (based on their economic and social development, their natural resources, and their political systems) ("Third World," 2000). The preparation and dialogues reflected the opinions and the needs of women from the different regions of the world. The third feature of these conferences is the process of demystification about the silence of women (Gijsbers Van Wijk et al., 1996; Mayhew, 1996). Many myths were challenged, redefined, or debunked, such as the one that third-world women are unable to articulate their own issues and that others need to speak for them. Issues in women's health identified by first-world women were challenged and reprioritized when the third-world women spoke (Beeman, 1996; Nelson et al., 1996). The dialogues and challenges were possible because of international collaboration among women all around the world.

Women from a number of different religious groups were able to form coalitions despite their ecumenical differences because of the views they held in common: the importance of the family as well as their innate spirituality, no matter the form in which it played out as sect. For example, there were partnerships formed between the Vatican and the Islamic Republic of Iran, between Shiite Moslems from Iran and Sunni Moslems from Sudan, Libya, Egypt, and Kuwait, and Catholic states of Guatemala, Honduras, Ecuador, Peru, Bolivia, and the Philippines. These coalitions led to a more balanced agenda and recommendations that better reflected the diversity in the world (Catley-Carlson, 1997; Nelson et al., 1996; Winkel, 1995). Forming coalitions makes women's voices stronger and better heard (Gijsbers Van Wijk et al., 1996; Mayhew, 1996; "Women's Health," 1996).

Human Rights Issues of Women

The conference also focused on areas that previously were given little attention, such as human rights issues of women, including violence against women; increasing access to justice; and increasing opportunities for women to participate in conflict resolution ("Cairo Conference," 1994; Craft, 1997; Gijsbers Van Wijk, 1996). They also provided better and renewed attention to such marginalized groups as refugees, displaced women, disabled women, and minority women. They condemned gender-based discrimination, violence related to dowry, and degrading images of women in the media. For the first time, the needs of female children were included in the agenda. The discussions also went beyond reproductive health care and included promotion of breast-feeding, environmental hazards, and prevention of HIV/AIDS and other sexually transmitted diseases (Mayew, 1996). Of particular significance is the recommendation to condemn adolescent childbearing, unsafe abortions, and the practices that prevail in many parts of the world that deny

food and health care to females (Catley-Carlson, 1997; Gijsbers Van Wijk et al., 1996; Odlind, 1997; Winkel, 1995). It was also agreed that, without women in leadership positions, policies would continue to be biased. Strong recommendations were made for leadership/self-esteem training for women and girls and for studies on gender-congruent approaches to leadership.

Women's Own Needs

The conferences also addressed the needs of women and the help that they should get, help that does not deny the centrality of their family in their lives (Becker & Robinson, 1998). Developing women's potential does not mean at the expense of their families. A heavy emphasis was placed on the significance of viewing health from a more comprehensive framework and within the context of development. These conferences were action oriented, yet, even more important, they contained rich and open dialogues, an atmosphere of tolerance to diversity, which had an impact on the action plans that resulted (Nelson et al., 1996; "Women's Health," 1996).

Social Context

The social context of women and the development of an expanded model for women's health were well supported in the conference. It is a model that must become the driving force in our work. It reminds us that women's health is part and parcel of their entire life experiences, and that their health care must be imbedded in their social development (Catley-Carlson, 1997; Nelson et al., 1996).

Paradoxes

There are several paradoxes that we must consider when modeling women's health. The paradoxes are also those that we encounter as we try to operationalize and use a model in health care planning or in a research program. Among them, four are presented here: (a) essentialism and relativism, (b) global and local dialogues, (c) country development and women's development, and (d) one-stop comprehensive care and specialist-based care. The answer to quality health care for women lies in resolving the tension among these four paradoxes. This may be done through dialogues that reject or accept one side of the paradox or resolve the tension generated by confronting opposing views.

Essentialism and Relativism

A major paradox that has contributed to fragmentation of knowledge development of women's health is essentialism and relativism. Until recently, most of the research on women's health has been based on the premise that women's health experience is universal and has essential features. For example, menopausal research has been conducted with the assumption that all women experiences symptoms related to the cessation of menstruation. However, recent studies conducted in different parts of the world indicated

that women's symptom experience during menopausal transition is culturally different (Boulet, Oddens, Lehert, Vemeer, & Visser, 1994; Chompootweep, Tankeyoon, Yamarat, Poomsuwan, & Dusitsin, 1993; Haines, Chung, & Leung, 1994; Ismael, 1994; Lock, Kaufert, & Gilbert, 1988; McCarthy, 1994; Ramoso-Jalbuena, 1994; Samil & Wishnuwardhanni, 1994; Sukwatana et al., 1991; Tang, 1994; Wasti, Robinson, Akhtar, Khan, & Badaruddin, 1993; Wilbush, 1985). The researchers have reported that women in Asian cultures are more likely to perceive menopause as a normal process and rarely experience symptoms during menopausal transition. Diversities and complexities of menopausal experiences have also been indicated, and relativistic views of menopause experience have been reported. Then, how far can we accept the diversities and complexities of menopausal experience and relativistic views of menopausal transition? Has the relativistic view on women's health fragmented women's health issues more and contributed to deconstruction of knowledge of women's health?

There are several essential fundamental features in women's lives (Meleis & Aly, 1997):

1. Family and home are their first priority.
2. They have to juggle four sets of responsibilities, including nuclear family, extended family, care giving, and interfacing with communities (schools, health care systems, children's friends, and their own work outside the home).
3. They facilitate their family's transitions: They help daughters get married and settled, they monitor moves from rural to city life, and they ease their husband's return home from hospitals and from working abroad.
4. They have limited access to comprehensive care. Women's care is fragmented between gynecologists, obstetricians, pediatricians, gerontologists, and internists. It is difficult for them to get nutritional counseling, breast exams, and pap smears. Their schedule does not permit the many hours needed to wait for health care.
5. Women tend to be marginalized, oppressed, and/or put on a pedestal because they are mothers and are expected to sacrifice for everyone and deny their selfhood. In losing their own sense of self, the nature of seeking health care takes totally different dimensions.

How do we consider all these seemingly similar qualities of what women go through, and at the same time refrain from essentializing women's experiences and generalizing to the extent that we do not take into consideration the local situation and their lived experience? Relativism calls upon us to respect women's cultures and situations. If we become relativists and attempt to understand the situation of women within their own context, then how do we condone such practices as teen pregnancies in countries that allow marriages at 11 years of age? How do we condemn clitoridectomy in cultures that view it as essential?

Global and Local Dialogues

What mechanisms are countries taking to continue with the dialogues that were created through the Cairo and Beijing conferences on a local basis? When the conferences were held, there were many discussions on women's health issues, and there seemed to be a big movement toward enhancement of women's health and women's status. Yet, after the conferences, each country's representatives went back to their previous positions in patriarchal societies and cultures. Could their attempts at changing the focus of economic development to encompass women and their development fit with patriarchal societies' goals (Nelson et al., 1996; Winkel, 1995)? How can we ensure that the local social and political discussions are consistent in reflecting global dialogues and recommendations? What monitoring mechanisms must be established? How can the quality of monitoring mechanism be ensured?

Country Development and Women's Development

Although there may be a relationship between focusing on a country's development and how this may influence women's development, there are many indications that these factors may not go hand in hand. For example, China pursues an integrated program for socioeconomic development (country development), with family planning as a vital part (Wu, 1994). The aim of the country development is to ensure that population growth does not outpace economic development, the availability of natural resources, and environmental protection efforts (Wu, 1994). With this aim, there is a policy on family planning that includes the promotion of late marriage, deferred child bearing, and the practice of "one couple, one child" (Cooney & Li, 1994; Ping & Smith, 1995; Rigdon, 1996; Wu, 1994). The policy brought an increasing number of abortions, and the induced abortions may be threatening to women's health, as well as raising some issues related to abortion of female fetuses and/or perhaps murder of female babies in their country (Cooney & Li, 1994; Ping & Smith, 1995; Rigdon, 1996; Xiao & Zhao, 1997). The goals may be the development of a nation, but the consequences may be detrimental to women's health.

Comprehensive and Specialized Care

Another paradox that has never been adequately resolved is the planning of health care services for women that are comprehensive and integrate their gynecological problems, their developmental needs, health needs for children, care for battered women, and grieving among other health care needs (Chalich & White, 1997; Curbow, Khoury, & Weisman, 1998; Kanbour-Shakir, Harris, Johnson, & Kanbour, 1997). The need for one-step health care, which saves women's time, decreases their overload, and cares for them more holistically has been asserted (Chalich & White, 1997; Curbow et al., 1998). The other side of the paradox is the need for providing highly specialized care, and care that is chosen by women and that employs experts in their field. Women's health issues need to be dealt with in a comprehen-

sive way, but to treat or manage specific symptoms and/or diseases many women tend to prefer specialist-based models of care (Curbow et al., 1998; Kanbour-Shakir et al., 1997). How to provide both simultaneously is a challenge that needs to be carefully discussed, analyzed, and developed.

FOR AN INTEGRATIVE AND COHERENT MODEL OF WOMEN'S HEALTH

Despite the differences in the disciplines that deal with women's health care, all women's health care professionals share common goals (McBride, 1993; Ruzek, 1993; Woods, 1994). They are generally interested in goals related to improving health and health care for women, patterns of responses of women to their illnesses, ways in which women maintain their health, and how women cope with diagnosis, treatments, and interventions. The goal for all disciplines is better quality of life for women (Doyal, 1995). When establishing an integrative and coherent model for women's health, we should include some assumptions that may be common among different disciplines: (a) women's health care continues to be inadequate globally; (b) family and home continue to be women's domains, along with all the responsibilities and duties; (c) women have limited access to comprehensive health care; and (d) women tend to be marginalized.

Based on these shared assumptions, an integrative and coherent model for initiating, maintaining, or improving health care for women must have three components: integration, transitions, and marginalization. These three components can reflect and articulate the visions and the insights that are contained in previous models such as the grandmother model. Women learned from their grandmothers how to integrate the multiple roles in their daily lives and meet the demands imposed on them. Also, we learned from our grandmothers how to manage life transitions and watched how our grandmothers facilitated others' life transitions by anticipating them, supporting them, and healing them. Our grandmothers were aware of their own marginalization possibility because of their illiteracy and because of their own oppression and power simultaneously. They were empowered and they empowered others by creating continuity for themselves and their families by combining the biomedical model with many alternative ways of healing. We learned a great deal about how women viewed clitoridectomy, how women viewed traditional healing methods, how women delivered their babies by themselves in the fields, how women viewed their infant daughters, how they coped with the loss of their daughters through murder or through selling, how women viewed women's bodies, and how women dealt with their body experiences. We propose that the visions and insights of our grandmothers should be incorporated and articulated into the model of women's health. The model incorporating the visions and the insights could provide us with an integrative and coherent approach to women's health issues and prevent fragmentation and biased health needs assessment and treatments.

Integration

International studies on women's multiple roles were conducted in five countries: Brazil, Colombia, Egypt, Mexico, and the United States (Bernal & Meleis, 1995; Douglas, Meleis, Eribes, & Kim, 1996; Hall, Stevens, & Meleis, 1992a, 1992b; Lane & Meleis, 1992; Meleis & Bernal, 1994; Meleis, Douglas, Eribes, Shih, & Messias, 1996; Meleis, Norbeck, & Laffrey, 1989; Meleis & Stevens, 1992; Stevens, Hall, & Meleis, 1992; Stevens & Meleis, 1991). In each of the studies, women's three central roles (work, spousal, and maternal), their utilization patterns of health care, and understanding of their bodies and their functioning were explored. The women's stresses and satisfaction in each of the roles and the balance between the stress and satisfaction in all of the roles were also explored. The findings from the five studies showed the ways in which the women experienced the various aspects of their lives on a daily basis and the process that they used to integrate and balance the stress and the satisfaction, the losses and the gains, and the grieving and the celebrations in their lives. The women developed many strategies to integrate their different roles as caregivers, mothers, daughters, wives, partners, workers, homemakers, maids, and bosses. The issues they faced were not in each of these roles, but in the multiplicity of these roles. Becoming sick and taking care of themselves could not be understood without acquiring some attention to the demands in their lives and the conditions that determine priorities. The incidents of women not complying with diabetes monitoring, failing to control hypertension, and ignoring birth control were not isolated events for women. Rather, these behaviors and responses needed to be understood in terms of what else was going on in their lives, such as overload, competing demands on their time, impending spousal dissidence, and devaluation of their work role.

As the findings of the five international studies on women's multiple roles showed, women's health care issues must be viewed in context, including women's responses to chemotherapy, hormonal therapy, pain, sleeplessness, and diagnostic procedures, and must be explained within their patterns of interactions within their families and communities. More appropriate health services can be shaped by considering women's central roles such as work, marital, maternal, and caregiving, and their experiences such as menstruation, menopause, caregiving, and the violence to which they are exposed. Appropriate services that enable and empower women can be developed by attempting to understand the ways in which women integrate their roles and various responsibilities, rather than reducing women's lives to body parts or diseases (Hall, Stevens, & Meleis, 1992a, 1992b).

Transitions

Globally, we are all experiencing many major transitions, and women are at the center of these transitions, which include the move from home to work force, into leadership positions, into poverty, into the computer age,

into new health care systems, into new educational systems, and into the new millennium. Women tend to be the facilitators of their own and others' transitions.

It may be more productive to view women's health care needs within a transition perspective (Chick & Meleis, 1986; Schumacher & Meleis, 1994). Transitions precipitate changes in networks and create periods of disequilibrium, endings, beginnings, and reassessment in between. There are developmental transitions, situational transitions, and health–illness transitions, all leading to different responses and requiring different strategies. During periods of transitions, the health care needs of women and their families are always changing.

Transition perspectives have been widely applied to understand diverse types of life changes that we experience: pregnancy, caregiving, chronic illness, menopause, aging, migration, acculturation, and the list goes on (Meleis, Lipson, Muecke, & Smith, 1998). Additionally, a transition perspective provides a more comprehensive view of women's health experiences. For example, when we are considering menopause using a biomedical perspective, the focus is usually on the point of menstruation and hormonal imbalance. Consequently, hormone supplementation is placed in the center of health care for the menopausal women. Yet, when we are considering menopause within a transition perspective, menopause is viewed as a transition from one stage to another, and the focus of health care is given to facilitate healthy transition of the menopausal women. When women's health experiences are considered with a transition perspective, there can be more longevity and continuity in health care.

Marginalization

The final component to the equation of viewing women's health stems from women's history of oppression and current practices that render women vulnerable and at risk. Women have been marginalized because of their gender, or because of the devaluation of their contribution to work. Women's health needs to be considered in relationship to marginalization. Marginalization is defined as being distinguished from the norm in a situation, with negative attribution associated with being different. Margins are defined as "the peripheral, boundary-determining aspects of persons, social networks, communities, and environments" (Hall, Stevens, & Meleis, 1994). Marginalized people are distinguished by their lack of power or by having power that is not well understood by most people. The power at the center is usually uncontested; the power of people at the periphery is constantly challenged and contested. Marginalized people tend to have secrets and share information only with those with whom they have developed human bonds. They are voiceless, but they tend to be more reflexive about their behavior and the behavior of others and consequently share profound insights. Marginalized people live with many myths and they are constrained and limited by life at the periphery.

Im and Meleis (1999) studied Korean immigrant women and concluded that they neglected and ignored their menopausal symptoms because they were in the margin of this society and because they were in the margin of their ethnic group. Frequently, women's health is connected to their marginality in their patriarchal societies and their patriarchal cultural groups. Furthermore, their marginality is doubled and/or tripled when it is connected to their race, ethnicity, sexuality, and age. When considering a model for women's health, we should incorporate women's marginality into the model.

CONCLUSIONS AND IMPLICATIONS

We presented four models of women's health, conditions supporting more integrative and coherent models of women's health, and major paradoxes inherent in women's health areas; then we proposed three major components that need to be included in the model of women's health. These three components may reflect and articulate the visions and insights that our grandmothers gave us and may compose the model that makes women's health more coherent and integrated.

For further development of an integrative and coherent model of women's health, we must uncover, describe, and explain the levels of vulnerability inherent in (a) the work they do to integrate their roles and those of their families, (b) the work they do to facilitate all the transitions that they and all their family members experience, and (c) the extent to which they are aware of their influence on their own family and community. A future research agenda could include uncovering processes and strategies that women encounter during illness and health transitions as well as developmental transitions for example,

1. What processes do women use to cope with caregiving roles and to integrate these in their daily lives while coping with their other roles? How much are these roles shaped by their gender and experiences of marginalization?
2. What actions do women use to seek health care during transitions in their lives? Are there some points during such transitions at which health care seeking become critical?
3. In what ways does women's sense of societal oppression and marginalization contribute to such outcomes as staying in abusive home or work relationships?
4. What are the different patterns of care provided within a grandmother model? Why are grandmothers' models persisted in some countries and eliminated in others? What strategies do women use to cope with transitions and marginalization?
5. How are family health care outcomes related to marginalization of women?
6. How do women describe resources that they use to obtain different forms of care to maintain or improve their health care?

Many of the models used to drive the research agendas and the health care practices for women may provide a limited view of their situations and needs. A more integrated model that encompasses a special consideration of a history of inequity, societies that are in transitions, the paradoxes that women face in their daily lives, and the means they attribute to these paradoxes that they experience, may drive the development of more gender-friendly knowledge.

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