

and compensation for nurses. Migration and communication technology have led nursing to cultivate a more global character.

[See also International Red Cross; Nightingale, Florence; Settlement House Movement; and Wald, Lillian.]

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LISA STERN SLIFKA AND CYNTHIA A. CONNOLLY

HEALTH. The field of women's health recognizes the health of women to be determined not only by biological factors but also by the social, political, and economic contexts of women's lives. With both "sex" and "gender" under consideration, women's health research encompasses medical, social, and cultural studies. The term "women's health" is commonly taken to refer to health issues specific to human female anatomy—breasts and female genitalia—or to conditions caused by hormones specific to, or most prevalent in, women. By this account,

women's health issues may be limited to reproductive issues such as menstruation, contraception, pregnancy, childbirth, menopause, and breast cancer. Yet many health issues have been shown to present themselves differently in women than in men, so the purview of women's health can be broadened to include such nonreproductive issues as nutrition, mental health, autoimmunity, and cardiovascular health.

Proponents of women's health have rejected many features of the biomedical model in favor of various biopsychosocial frameworks that view health more holistically. With this broad conception of health and well-being, women's health researchers have gone beyond the traditional confines of medicine and medical issues to examine how various social, institutional, political, and economic arrangements influence women's health. Domestic violence, labor practices, social assistance, and international development policies have been examined from a women's health perspective. The field of women's health not only distinguishes women's health from men's but also highlights differences among women themselves, such as the unique health needs of lesbians, older women, refugee women, and Aboriginal women.

Global Perspectives on Women's Health. At the 1991 Conference on Women's Health held by the National Council of International Health, several hundred participants from developing countries were asked what resources were needed in order to improve the health of women in their respective countries. In addition to health-related requests for universal access to contraception, disease control, vaccines, and medical equipment, delegates made broad economic, social, and political demands: debt reduction, capital investment, equitable trade partnerships, and sustainable strategies for natural resources.

Globalization, ill-conceived development policies, and poverty have been cited as major hindrances to women's health around the world. Poverty, for instance, limits access to nutritious food, clean water, and adequate clothing and shelter. Engaged in a daily struggle to meet basic needs, people living in poverty often cannot avail themselves of preventive health care or cope with unexpected illness. Poor living and working conditions make people susceptible to chronic anemia, malnutrition, and severe fatigue. This is especially the case for women, who often put the needs of their family ahead of their own. Economic insecurity compounded by limited education also makes women more vulnerable to occupational injuries, domestic violence, and sexually transmitted diseases because they may lack the social power to negotiate their work and living arrangements.

Development policies and the impact of globalization in the nonindustrialized world have left a growing number of

households unable to meet their basic needs. Globalization has accelerated the negative trends of economic and social development for the world's very poor. Women have had to bear the biggest burden and, as a result, have succumbed to poor levels of health. For instance, global economics have created a migrating manual labor force of young men, leaving more female-run households than ever before. Internationally imposed debt-repayment efforts have resulted in lower per capita incomes and severe cuts to social services in many debt-ridden countries, making it increasingly difficult for these women to support their families. The health consequences of poverty are therefore exacerbated by these international economic arrangements.

Historical Origins: The Women's Health Movement.

While women have always had ailments, and have employed numerous and varying methods of treatment across time and geographical place (see, for example, Furth), "women's health" in its current and contemporary understanding as a distinct and contested medicalized category is a product of the women's health movement that arose in the United States in the 1970s in conjunction with the women's liberation movement. This movement also inspired grassroots women's health activism throughout the world. The women's health movement aimed to take women's bodies back from the oppressive institutions of medicine and to reframe women's knowledge and experiences of their bodies in ways not configured by sexism and androcentrism. The goal was to empower women by providing them with health-related knowledge that was rarely shared with female patients, thus limiting women's ability to participate in health care decision making.

The movement also aimed to develop new knowledge in under-researched areas of women's health. The Boston Women's Health Book Collective introduced the groundbreaking publication *Our Bodies, Ourselves* in 1973 to further this aim. The editors described the first edition as "contain[ing] real material about our bodies and ourselves that isn't available elsewhere, and we have tried to present it in a new way—an honest, humane, and powerful way of thinking about ourselves and our lives. We want to share the knowledge and power that comes with this way of thinking and we want to share the feeling we have for each other" (p. 2).

In a 2004 interview marking the collective's thirty-fifth anniversary and the upcoming publication of the book's twelfth edition, Nancy Miriam Hawley, one of the collective's founders, recalled that "At the time, there wasn't a single text written by women about women's health and sexuality. We weren't encouraged to ask questions, but to depend on the so-called experts. Not having a say in our own health care frustrated and angered us. We didn't have the information we needed, so we decided to find it on our own" (quoted in Ginty).

Current Challenges. In the West, the success of the women's health movement in getting the medical mainstream to acknowledge the importance of women's health has left the movement in an ambivalent position. Women's health is now easily thought of as a medical specialty like any other. This co-opting dilutes the movement's original political aims and runs the risk of returning women's health research to biological and reductionist paradigms. The grassroots activism of the 1970s and 1980s must negotiate roles and relationships with the newer, more professionalized, and disease-specific women's health organizations that burgeoned in the 1990s. The proliferation of these newer groups has minimized the role of grassroots women's health organizations to information brokers for women in the industrialized world.

The original spirit of self-help and self-knowledge that once inspired covert cervical self-examinations using plastic speculums, mirrors, and flashlights has been commandeered by health marketers. Women's health has become a wildly profitable market, as seen by the astounding array of health, nutrition, and wellness products and regimes aimed at women. Critics of consumer culture question whether direct health marketing to women constructs complicit consumers rather than empowering women through information, choice, and quality goods and services.

Having mapped out many of the intimate and intricate relations between women's reproductive health, mortality, and morbidity, with women's socioeconomic status and levels of education, patriarchal norms, and global economics, the current challenges to women's health in the developing world have no quick fixes. The increasingly gendered face of the HIV/AIDS pandemic amplifies the gravity of these problems. Because the determinants of women's health appear to be so broad in scope, narrowly focused medical and public health interventions may prove to have limited effect. In addition to the need for such resources as food, clean water, and health-care services, empowerment strategies are needed that permit women to augment the social arrangements that compromise their health. This requires massive creative collaborative efforts by local, national, and international agencies and governing offices in order to change attitudes and relations of power and oppression.

[See also Healing and Medicine and Welfare Rights Movement.]

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MAYA J. GOLDENBERG

HEARD, BETSY (1759–after 1812), Euro-African slave trader and merchant. In the last half of the eighteenth century, Betsy Heard developed a monopoly in the local slave trade at Bereira on the upper west coast of Africa. Born in 1759 to an English father and an African mother, Heard was one of a small number of Euro-African women in the region to acquire considerable wealth and political influence in the late eighteenth and early nineteenth centuries. Several of these women, like Heard, built upon their fathers' or husbands' positions, but ultimately the women's success lay in their commercial and intercultural skills.

Heard's father was most likely an English merchant from Liverpool whose slave-trading factory in Bereira (in the present-day Republic of Guinea) and political network Heard inherited. Her mother was probably the daughter of a local slave woman. Though the exact nature of the relationship between Heard's father and mother is unknown, her father likely followed local customs regulating "stranger" status along the coast. To establish a position in Bereira, he would have contracted with local African rulers to pay fees and marry his landlord's female slave or daughter by a slave woman. The merchant gained a translator and privileged insight into local customs; the woman's father was ensured an informant in the factory.

Heard, like other women in her situation, generally lacked local kin ties but benefited from opportunities on her father's side. He sent her to England, most likely near Liverpool, to study commerce and European culture. There she would have met other Africans and Euro-Africans, also children of traders. Returning to West Africa, she eventually took over her father's business. By 1794, Heard had gained a reputation as a successful merchant and possessed substantial political influence. She owned the main wharf in Bereira, several trading ships, and a warehouse stocked

with merchandise. She also frequently received visits and gifts from surrounding political elites. She was so well regarded that the ruler of a neighboring state asked her to mediate a dispute between several local groups and the British-founded Sierra Leone Company. Between 1800 and 1807, Heard's diplomacy spared the region immediate war. Her role as intermediary is representative of the space that some Euro-African women carved for themselves as important political and cultural brokers in the Atlantic slave trade. After these negotiations, Heard, near fifty, appears to have retired. Little is known of her after 1812.

Heard's commercial ventures follow traditions of Euro-African female entrepreneurs along the upper Guinea coast. A century earlier, Bibiana Vaz had married a Portuguese ship captain and established a commercial empire. During Heard's lifetime, several other female entrepreneurs competed with her for control of the local market. In the same region from the 1830s onward, women in Freetown, Sierra Leone, generated a reputation for their extensive trade in foods and other nonslave exports. To the north in the late 1700s, the *signares* (female traders and cultural mediators) of Saint-Louis and Gorée (both part of present-day Senegal) had also accumulated substantial property through relationships with European merchants. The biography of Heard intersects with larger historical questions of women and slavery and the transatlantic trade. Like other Euro-African children she was born in the context of the commercial relations of the slave trade and was likely descended from a slave mother or grandmother. However, in Heard's day, most enslaved women lacked opportunities to improve their social positions.

[See also Slave Trade.]

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Laura Ann Pechacek

HELENA (c. 250–c. 328), Roman empress, alleged discoverer of the True Cross, and the mother of the first Christian Roman emperor, Constantine I, the Great (r. 306–337). Helena was probably born in the city of Drepanon in Bithynia (northwest Turkey), later renamed Helenopolis in her honor. She was of low social origin but she climbed socially thanks to her relationship with Aurelius Valerius