<table>
<thead>
<tr>
<th>Manuscript Number:</th>
<th>TMBE-D-15-00037</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Title:</td>
<td>Medicine Through a Feminist Lens: From Research to Practice to Policy in Comprehensive Women’s Health Care</td>
</tr>
<tr>
<td>Article Type:</td>
<td>Article</td>
</tr>
<tr>
<td>Keywords:</td>
<td>Women’s Health; Feminist Science Studies; Health Policy</td>
</tr>
<tr>
<td>Corresponding Author:</td>
<td>Jamie Ross</td>
</tr>
<tr>
<td></td>
<td>Portland, Oregon UNITED STATES</td>
</tr>
<tr>
<td>Corresponding Author Secondary Information:</td>
<td></td>
</tr>
<tr>
<td>Corresponding Author’s Institution:</td>
<td></td>
</tr>
<tr>
<td>Corresponding Author’s Secondary Institution:</td>
<td></td>
</tr>
<tr>
<td>First Author:</td>
<td>Jamie Ross</td>
</tr>
<tr>
<td>First Author Secondary Information:</td>
<td></td>
</tr>
<tr>
<td>Order of Authors:</td>
<td>Jamie Ross</td>
</tr>
<tr>
<td>Order of Authors Secondary Information:</td>
<td></td>
</tr>
<tr>
<td>Funding Information:</td>
<td>none (none)</td>
</tr>
<tr>
<td>Abstract:</td>
<td>Evidence-based research that is planned, performed and distributed with feminist methodologies provide support for the policy efforts and legislative decision-making of service community organizations. Linking this type of medical research to policy facilitates and sustains positive health outcomes in women’s lives. The effectiveness of the legislation can be monitored. Instead of showing that the lack of policy disadvantages women, we can show how policy can reduce disparities. Coordinating policy indicator variables with health indicator variables produces a powerful means for understanding which health indicators need further policy support. Feminist analysis forms the basis for the kind of successful legislative outcomes experienced in Oregon--outcomes that can and do improve women’s health.</td>
</tr>
</tbody>
</table>
Medicine Through a Feminist Lens:
From Research to Practice to Policy in Comprehensive Women’s Health Care

Jamie P. Ross
PhD. Philosophy
Assistant Professor
Women, Gender & Sexuality
Studies Department
Portland State University
221 XSB, Park Blocks
PO Box 751
Portland, Oregon 97201
503-725-8370 (o)
503-279-9184 (f)
rossj@pdx.edu
Abstract
Evidence-based research that is planned, performed and distributed with feminist methodologies provide support for the policy efforts and legislative decision-making of service community organizations. Linking this type of medical research to policy facilitates and sustains positive health outcomes in women’s lives. The effectiveness of the legislation can be monitored. Instead of showing that the lack of policy disadvantages women, we can show how policy can reduce disparities. Coordinating policy indicator variables with health indicator variables produces a powerful means for understanding which health indicators need further policy support. Feminist analysis forms the basis for the kind of successful legislative outcomes experienced in Oregon—outcomes that can and do improve women’s health.

*Theory is only as good as its interpretation and only as good as those who are meant to benefit from the theory can understand it.*

bell hooks (1994)

The emergence of feminist theory in the 1970’s and subsequent feminist philosophy’s critique of objectivity since then opened up an arena in which long-held theories could be critiqued and improved. The resulting emergence of feminist activism has required that theoretical insight be translated into pragmatic action. Within the broad genre of feminist theory, feminist critiques of science have opened up the space to think, practice, and focus on women’s
health care. This paper describes how evidence-based medicine (EBM) can encourage more effective legislation that makes it easier for women to get the preventive help and treatments they need. Key to the success of this endeavor is the incorporation of feminist epistemology and philosophy of science into medical research and practice.

**Progress: Early Feminist Views on Medicine to Today’s Legislative Actions**

Historically, the differences in women’s bodies were all but invisible within the medical research tradition, particularly in longitudinal studies. It didn’t help that many cultural traditions can obscure and de-emphasize how women’s lives differ from men’s. Over time, it became clear that service organizations and medical researchers and practitioners needed to incorporate feminist health priorities in order to push the kind of policies that were needed to affect health outcomes.

In the spring of 1969, at a women’s liberation conference in Boston, seeds were planted for the Boston Women’s Health Book Collective (BWHBC). The following year marked the publication of Our Bodies, Ourselves, the landmark book about women’s health and sexuality. In a review of the history of these two events, participants “discovered that every one of us had a "doctor story," that we had all experienced feelings of frustration and anger toward the medical maze in general, and toward those doctors who were condescending, paternalistic, judgmental, and uninformative in particular. As we talked and shared our experiences, we realized just how much we had

---

1 It wasn’t until the Feminization of Poverty movement in the 1980’s that as a society we became aware the extent of women in poverty and poor health.
to learn about our bodies, that simply finding a "good doctor" was not the solution to whatever problems we might have.”

The publication of Our Bodies, Ourselves was only one of the consequences of these sentiments. The conference also resulted in the founding of the Women’s Health Information Center (WHIC),

“and two decades of networking and information sharing that has extended beyond the publication of OBOS to a number of women’s health education, activist, and advocacy projects involving us locally, nationally, and internationally. [WHIC] supported the founding of the National Women’s Health Network—the first national women’s health advocacy membership organization. We were also among the few women’s organizations calling for universal health care in the 1970s, and we supported Congressman Ron Dellums’ National Health Services Act, a visionary bill that included provisions for contraceptive, sexually transmitted disease, and abortion services, and access to midwives and out-of-hospital childbearing options.”

Among the many successful activities that have since continued to take place, the relationship between medical research and legislative policy that has emerged in the state of

2 Cited from: http://www.ourbodiesourselves.org/about/jamwa3.asp


“Organizations such as the National Women’s Health Network, the National Black Women’s Health Project, the National Latino Health Organization, the National Asian Women’s Health Organization, and the Native American
Oregon deserves special recognition. This relationship, formed with a strong feminist sensibility, is based on the social determinants of health theory, whose premise includes, “Policies affect the pathways through which inequality affects health” (Daniels et al., 1999). The research of Michelle Berlin highlights several different ways that changes in policy can achieve positive health outcomes for women.

Berlin’s article, “Relating Health Policy to Women’s Health Outcomes” (Wisdom, Berlin, and Lapidusa, 2005) conceptualizes “current state policy as a valid measure of the state’s efforts to address gender inequalities by enacting policies that benefit underrepresented populations” (1783). By including the moderating variable of policy, Berlin’s study found that, across the nation,

“policies that more strongly protect women’s health are modestly associated with lower cause-specific mortality rates. Policies that were the most strongly associated with health outcomes were in the Access to Care block policy domain, including Medicaid eligibility and methods to expand Medicaid, and the Community block policy domain, concerning environmental health and violence against women” (1781).

Women’s Health Education Resource Center, to name just a few, could play a key role in insuring that lay and consumer voices are part of any larger women’s health debate. The inclusion of such groups by the office of Women’s Health Research at the National Institutes of Health already has enriched discussions concerning research affecting women.”

http://www.ourbodiesourselves.org/about/jamwa3.asp

Dr. Berlin MD, MPH is Associate Professor and Vice Chair of OHSU Department of Obstetrics and Gynecology; Co-Director of OHSU Center for Women's Health; Director of OHSU National Center of Excellence in Women’s Health; and research director of PATH (Policy Advisory Towards Health) for women, a program in partnership with Oregon’s Portland State University, Department of Women, Gender & Sexuality Studies.

This work adds to previous work on gender disparity and health outcomes (for example, Kahn et al. 2000; Kawachi et al. 1999).
Berlin has used evidence-based medicine (EBM) to show empirically that policy has an impact on health outcomes. Coordinating policy indicators with health indicators produces a powerful means for understanding what health indicators need further policy support. And recognizing policies around women’s health introduced a dimension of feminist priorities beyond reproductive issues that were absent.

When asked to provide testimony to the Oregon state legislature regarding health indicators that need policy support, Berlin demonstrated a direct link between medical research and policy implementation. In this way, direct service organizations with feminist health priorities were empowered to push the kind of policies needed to affect health outcomes.

As a result, the Oregon 2005 legislative session was the first to pass a Basic Women’s Health Care Package that allowed for the continuation of existing health insurance requirements for cervical and breast cancer screening as well as pregnancy coverage, which were set to expire in 2005. This legislation covered all health service contractors and insurers that sold coverage in Oregon and prohibited insurance plans from excluding coverage for mammograms, clinical breast exams, Pap smears, pelvic exams and pregnancy.6

The Oregon legislative successes, as well as others addressed in the body of this article, are the result of the focused efforts of individuals to more broadly inform legislators of the specific medical and cultural needs that women face.

**Objectives**

6 The mammogram and Pap smear requirements were originally passed in 1993 and again in 1999. The pregnancy coverage mandate was passed in 1999.
This article is not to serve as a blueprint or a model for translational research, but rather to identify the community connections that draw links among community coalitions, researchers/practitioners, and legislators.

First, what follows is a reflection on the growth of feminist analysis and feminist philosophy of science. This growth has led to advances both in scientific theory and practice, including: 1. a broadening of research questions; 2. the incorporation of qualitative methodologies into “hard” scientific research (beyond the social sciences); 3. the inclusion of evidence that otherwise was not considered scientific evidence or fell outside the bounds of traditional notions of what counts as evidence within science; and 4. the fostering of more expansive interpretations of data than were traditionally conceivable.\(^7\) Importantly, these


By the late 1990s, feminists and feminist allies were fully aware of the obstacles, yet they were also aware of the tentative strength of their footings. Our most politically strategic strengths were in the advantages provided by a full public view of the academic, scientific, and everyday challenges to long-held traditions (Lloyd [2005] 2008; Messing [1995] 2008; Rogers 2004; Terry [1990] 2008; Zinn et al. 2008). Yet also open to full view were feminists’ own conceptual and practical flaws that allowed race and class, among other categories of analysis, to remain shadowed. Women of color and third-wave feminists both demanded and received widespread recognition of the intersectionality of race, class, gender, ableism, and ageism. Grassroots political action, aimed toward changing as many women’s lives as possible, was coupled with the demand to analyze the dynamics of power. Deconstructionist philosophies encompassed the academic modus operandi of this period. An analysis of the category “women”
advances have made it possible to forge intellectual links between researchers/practitioners and the legislators who affect changes in health care policy.

Next we will explore the methodological links between research data and the needs of community coalitions. Key to this area is a critique from Maya Goldenberg’s (2006) work that focuses on evidence-based medicine (EBM), and identifies the limitations of an evidenced-based research approach if it fails to utilize a feminist lens. Although limitations come from arenas other than feminist ones, a feminist lens focuses particularly on women’s experiences as epistemically valid whereas other critiques of EBM focus more broadly on an epistemic and meta-analysis of necessary and sufficient conditions for evidence efficacy from randomized controlled trials more broadly (Cartwright 2011, Worrall 2007). Although some of this work overlaps with feminist concerns about what counts as evidence, Goldenberg’s analysis, together with details from the feminist evidence-based practice of Jessica Gregg, helped to focus the range of what counts as significant evidence in EBM, and pointed to the necessity of including both qualitative and participatory research in order to maximize the success of quantitative research with regards to women specifically. These kinds of studies have laid the conceptual groundwork for key relationships such as that which emerged in 2003 between the National Women’s Law Center and Oregon Health and Science University’s Center for Women’s Health. This cooperative relationship ended up in a fully realized national focus on women’s health in the context of a broad spectrum and policy and health, in the form of national and state-by-state Report Cards on women’s health.

moved toward an analysis of gender relations, which required the categories of “men” and “masculinity” to be understood as necessary parts of women’s lives that contributed to and played out the logic of domination.
In addition to quantitative analysis, the National Report Card on Women’s Health identifies the policy dimensions of health, which is a qualitative assessment. And armed with knowledge from the Oregon State Report Card, an outreach program unique to Oregon--PATH (Policy Advisory Towards Health) for women--has been able to broaden the scope of scientific theory, methodology, and research in Oregon. This has resulted in solid, pragmatic links between community coalitions and legislators.

We will explore how positive outcomes in the Oregon State legislature have enabled joint efforts between research and policy, lab and street experience, and expert and common knowledge. This has become possible by finally looking at the kind of feminist evidenced-based research that not only attends to women’s everyday experiences, but that incorporates gendered relationships as a necessary category of research analysis in addition to the research and medical sex categories of male/female. Feminist EBM complements traditional EBM in some ways, specifically with regards to a shared goal to avoid individual medical practices and treatments that are “often not based on what might generally be judged as the currently best available evidence (Worrall 984).” However, traditional EBM does not sufficiently take up the concerns of the bias of a male status quo. The suggestion is that a feminist analysis forms the basis for the kind of successful legislative outcomes experienced in Oregon--outcomes that can and do improve women’s health.

**Feminist Analysis and Feminist Philosophy of Science**

First- and second-wave feminism tried to incorporate the lost women of history. These women had achieved success in everyday life, academia, and public life, and yet they remained invisible in the public record. Their work and contributions disappeared because they did not
serve the particular epistemology of their respective ages. Although these women had been involved in the public realm across the spectrum, including labor management, medical research, child and social welfare policy, and new academic disciplines of psychology and sociology, their contributions were not valued as equal to some men’s contributions, because the women’s contributions did not ally with the underlying logic of what counted. The additive enterprise of Women’s Herstory made the contributions of these women visible, but not lasting, because additive endeavors do not change the underlying and exclusive logic.

As early as the turn of the twentieth century, when American philosophers such as John Dewey championed women’s rights by challenging foundational beliefs and recognizing the socially constructed nature of this underlying and exclusive knowledge base, logical positivism fought back. However, by the 1980s, logical positivism gave way to process philosophy, a resurgence of Pragmatism, and Feminist Philosophy, all of which tied truth directly to particular contexts and for the purposes of this paper, to the contexts of women’s reported experiences.

In the 1980s and 1990s, second- and third-wave feminist efforts changed women’s lives by deepening a focused conceptual, theoretical, and methodological analysis of exclusive strategic frameworks and deconstructed zones of women’s marginalization. Standards of evidence were challenged. Assumptions of what counted as evidence were exposed and were found to stem from whatever axioms were taken as foundational. Many philosophers and

---


feminists articulated ways in which human paths to knowledge are created, not discovered or revealed.\textsuperscript{11} Foundational beliefs and the presumptive notions of objectivity and the neutrality of knowledge, particularly in the sciences and technology, were challenged, and these challenges forced a shift in focus from the “view from nowhere”\textsuperscript{12} to a subjective dimension of objective evidence. In doing so, much of feminist medical and scientific research reflects an effort to integrate qualitative and participatory research methods into the tradition of quantitative analysis that allowed women’s reports about their own health to be taken seriously.\textsuperscript{13} Specifically feminist claims both challenged the notion that women’s subjectively reported experiences about their own health were less true scientifically because they were less reliable as well as challenged the explanations of those reports within a traditional framework that considered women’s bodies as men’s bodies with hormones.

Philosophers of science and women in science studies in the late 1990s and early 2000s succeeded in articulating a different version of what counts as evidence, as traditional conceptual scientific tools were put to the test. There was a demand that scientific methods of investigation incorporate an analysis of powerful background beliefs. Feminist philosophers of science and science studies took up post-colonialist tools of the oppressed, developed within the social sciences and humanities, to create some consensus in feminist theory and activism. This


\textsuperscript{13} This effort is not necessarily a wholesale challenge to the scientific method, but, to some purists, it may have seemed to be. (Leckenby and Nagy Hesse-Biber 2007).
consensus allowed efforts to make persistent criticisms of absolute truth: to make visible the value (qualitative) dimension of factual (quantitative) claims; to link dominant discourses with domination; to coordinate social, cultural, and political issues with logical analysis; to realign theory with practice; to resist the turn to underlying truth and instead emphasize concrete experience; to provide room to analyze what has been left out when we use the notion of “objective”; and to provide room to analyze the process of identifying what exactly are the problem(s) to be solved. One of the main criticisms resulting from this consensus found that randomized control trials are prioritized in the internationally recognized hierarchy of evidence. Figure 1 indicates the difficulty and prevention of qualitative research from reaching above a level III in the hierarchy.

Viewing Evidence-Based Medicine (EBM) through a Feminist Lens

Evidence-based medicine was originally developed to confront the inconsistencies among research sources, data collection, and interpretation, as well as the variability of treatment recommendations and medical practice. Proper science requires systematization in medicine. Evidence from randomized controlled trials is favored as having special epistemic weight, and “best practices,” “clinical pathways,” and “care maps” are developed to ensure efficiency and more effective treatments (Kirkham et al. 2007). EBM’s innovators state, “The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” and “more thoughtful identification and compassionate use of individual patients’ predicaments, rights, and preferences” by means of “clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research” (Sackett et al. 1996). EBM requires a standardization of care that systematically finds, appraises, and uses contemporaneous research findings as the basis for
clinical decisions (Straus and McAlister 2000). The hope is that disparities in treatment and outcome for a particular health issue will decrease when the best available treatment is applied in each similar circumstance. Among the potential critiques of this methodology is a feminist critique: It may be difficult to apply an EBM standard of care to different bodies and different life circumstances unless gendered relational experiences count as evidence, when the model of a healthy body is male and subjective experiences are less valued.

Granted, some of the treatment disparity difficulties are considered universal to the practice of medicine: the shortage of coherent, consistent scientific evidence; difficulties in applying evidence to the care of individual patients; and barriers to the practice of high-quality medicine. But Nancy Cartwright claims that randomized controlled trials (RCT) that provide the evidential basis for EBM is logically flawed more generally. The weakness she finds is in calling EBM the gold standard because “it works somewhere”. She claims that EBM entails self-validating cause-effect relationships that mislead treatment results. Efficacy claims occur in ideal circumstances that both do not exist and do not serve all purposes. “For policy and practice we do not need to know ‘it works somewhere’. We need evidence for ‘it-will-work-for-us’ claims: the treatment will produce the desired outcome in our situation as implemented there (1401).” Although Cartwright’s focus on cultural and social perspectives compliments feminist concerns, the concerns universal to medicine from a feminist point of view in fact entail the “it works somewhere” to mean where men are, i.e., where men work and under what conditions they work, and tangentially if at all to mean where women work and under what conditions they work (Messner 2008).

In addition to the limitations of RCT’s necessary conditions, John Worrall (2007) voices the limitations of RCT’s sufficient conditions. He argues that although RTCs lie at the top of the
“evidence hierarchy” their potential to cover known and unknown confounders is not sufficient. “[A]lthough many commentators often seem to make the claim (and although many medical investigators unquestioningly following the ‘approved’ methodology may believe it), no one seriously thinking about the issues can hold that randomization is a sufficient condition for there to be no difference between the two groups that may turn out to be relevant (1004).” So, even though these critics of EBM suggest broad logical flaws in the premise that the best available treatment will result when applied in each similar circumstance, which feminist would agree with, they do not specifically take up the gendered issues that feminist critics of EBM do, i.e., that efficacious medical treatments for women will follow from RCTs that include only men for example (Greaves 2011; Correa-De-Auaujo 2006; Johnson & Repta. 2011; Sandberg 2013). Reflections unique to EBM entail questions of the perpetuation or worsening of health disparities across race, class, and gender, particularly when men’s bodies are considered the standard against which health is predominantly measured (Straus and McAlister 2000).

Feminist criticism of EBM is based on the downside of set standards. Maya Goldenberg, in a 2005 article, “Evidence-Based Ethics? On Evidence-Based Practice and the ‘Empirical Turn’ from Normative Bioethics,” suggests that EBM as the standard of care serves to increase certainty and seems to be able to adjudicate among competing claims. But, she states, EBM fails as the pursuit of truth, since it relies on the notion that any claim can stand or fall in light of the evidence, which assumes a “givenness” of evidence as “facts” about the world. Her criticism reflects the feminist sensibility that facts do not stand as true independently of the particular context in which they are selected. This claim is not unique to a feminist claim. Yet, elsewhere, Goldenberg states,
“EBM’s ability to guide health care decision-making by appealing to “the evidence” as the bottom line is attractive to many because it proposes to rationalise this complex social process. Yet it does so through the positivistic elimination of culture, contexts, and the subjects of knowledge production from consideration, a move that permits the use of evidence as a political instrument where power interests can be obscured by seemingly neutral technical resolve . . . Positivistic empiricists have regarded evidence in this way: any bias that enters scientific inquiry in the context of discovery is eradicated in the purifying process of the context of justification. The evidence left standing after scientific inquiry is assumed to be “facts” about the world and therefore warrants the title scientific evidence” (2006).

Thinking and seeing through Goldenberg’s lens reminds us that since our observations are influenced by our background beliefs and assumptions, we must always be cautious of having adopted extra-empirical criteria for what counts. What counts may be “. . . subject to the whims, preferences, biases, and social agendas of the researching scientists” (2006).

Consequently, feminists question whose lives we model research around and what differences need to be taken into account to ensure that the theory can adjust beyond the status quo to encourage fair practice and outcomes. “If observation is theory-laden, then it cannot serve as an independent constraint on theories, thus permitting subjective elements to constrain theory choice. Similarly, if observations acquire evidential relevance only in the context of a set of assumptions, a relevance that changes with a suitable change in assumptions, then it is not clear what protects theory choice from subjective elements hidden in one’s background assumptions” (Goldenberg 2006). The feminist focus is not only specific to individual bias; rather its focus is
also on the status quo bias against women’s bodies as different from men’s only because of estrogen and uteri.

If researchers assume that one theory fits all, then the working assumptions are that the differences among race, class, and gender are insignificant. Feminist insights indicate that empirical evidence does not increase certainty, because subjective elements that inescapably enter all forms of human inquiry bias our understanding of things. Standards of evidence require social models of scientific practice, not rigid adherence to objectivist models that “emancipate us from scarcity, ignorance, and error.” If, as Goldenberg continues,

“The configuration of policy considerations and clinical standards into questions of evidence conveniently transform normative questions into technical ones. [. . . then . . .] Political issues are not resolved, . . . but merely disguised in technocratic consideration and language. Thus the goals of medicine and other normative considerations lie just below the surface of these evidentiary questions, and evidence becomes an instrument of, rather than a substitute for, politics” (Goldenberg 2006).14

And yet, EBM has often and clearly identified practices that may cause disparities. For example, the Cochrane Collaboration performed systematic reviews and published summaries of evidence that showed routine use of episiotomies was more harmful than policies that restrict their use.15 And another report showed that continuous fetal heart monitoring did not provide added benefit (Thacker, Stroup, and Chang 2001). There has been a push for the incorporation of qualitative research, participatory-based research, and postpositivist-based research into EBM.


15 Routine use of episiotomies compared to restricted use leads to more posterior perineal trauma, more suturing, and more complications. There are no benefits with regard to pain and severe vaginal or perineal trauma (Carroli and Belizan 2001).
And, feminist EBM requires the incorporation of these research dimensions and demand that considerations beyond reproductive issues such as the following be addressed. All of these rely on using gender and race as specific categories of analysis: including women in RCTs (Coakley et al. 2012; Jagsi 2009); applying RCT treatments different from those in the study (Cartwright); recognizing the gendered construction of diagnosis interpretation of medical signs in women patients (Malterud 1999); and improving the use and safety of medications in women through sex/gender and race/ethnicity analysis (Correa-De-Araujo 2005; Manteuffel 2014). These requirements are among several in relation to women’s everyday lives, and have the potential to identify and challenge the criteria of what counts as evidence, what are the working assumptions in research methods and methodology, and what may have been left out or unintentionally ignored.

**An Example of Feminist Evidence-Based Practice**

In 2010, Jessica Gregg used EBM combined with a community-based participatory research (CBPR) approach to evaluate Oregon’s Vietnamese American and Latina communities. Her in-depth interviews showed that Oregon’s Vietnamese American women’s culturally associated beliefs do influence their behavior with regard to cervical cancer screening, but that those beliefs do not influence behavior in a linear way (2010). That is to say that discrete cultural attitudes or a lack of access do not easily explain the low rate of Pap smears. Even though it is suggested that cervical cancer is almost entirely preventable with regular Pap screening, and disparities in morbidity and mortality from this disease are primarily attributable to disparities in the rate of screening (Taylor et al. 2004), Gregg states, “An isolated belief will not necessarily cause an individual to act one way or another with regard to obtaining procedures or accepting
technologies. However, whether or not individuals consider procedures to be necessary or useful will largely depend on their cultural values and priorities” (2010).

If researchers and practitioners measure success only by the rate of screenings for preventive care, the culturally specific prevention practices do not count as evidence. In fact, Gregg identifies that some of these women do not consider Pap smears as a part of their own prevention practices. Gregg did in-depth interviews of women while using a community-based participatory research design that allied with the Asian Family Center at Oregon’s Immigrant and Refugee Organization and Oregon Health and Science University; community advisory boards emerged as part of the research design. In the interviews, the women indicated that preventive care was a high priority. One woman washed with soap at home since she could not do so at work, given time constraints. Another avoided certain foods in order to eliminate discharge (a sign of health imbalance). What Gregg found was that whether a woman sought gynecological exams depended on an assessment of “her increased risk and inability to practice adequate prevention” (Gregg, 2010). The woman who could not wash with soap at work went for yearly Pap smears. Others went if they thought they were out of balance, but they went only once because they sensed that their own preventive measures were adequate. And another woman, who said she would go for a gynecological exam infrequently (once every four years), explained that she would just keep herself clean, believing “that her own actions could help prevent gynecological disease.”

Gregg concludes, “The implication, then, is that the more closely Vietnamese American women hold culturally associated beliefs around the efficacy of their efforts to prevent disease, the more important easily accessible care becomes” (2010). Offering access or increasing access
at a low cost or for free does not necessarily raise the screening rate. These findings contrast with standard measures of how to reduce disparities in health care.

Oregon’s Latina community also shows a low rate of screening. In 2009, Gregg explored that community to determine exactly “what individuals believe that the Pap smear will discover or what uses they attribute to the procedure.” She found that some beliefs entail a fear of discovering other diseases or conditions, and that other beliefs associate getting the procedure with promiscuity and lack of faithfulness. Some women were prevented from getting the procedure if their husbands did not accompany them. Again, access and cost were not necessarily primary factors.

Feminist scientists (those working in research centers and concerned with health disparities) including Gregg have pushed for the incorporation of qualitative research, participatory-based research, and postpositivist-based research, which rely on many feminist/humanist principles, in conjunction with EBM. And in fact the evidence offered by these scientists has had a direct effect on community health policy. For example, Oregon’s Multnomah County Health Department now funds a Community Capacitation (empowerment training) Center that uses popular education materials (Rios-Campos 2008), based on Brazilian Paulo Friere’s (1976) adult literacy principles, to teach culturally specific health promotion to community health workers from within their own community.16

The origins of feminist participatory research stem from the efforts of reformist movements like that of Friere, which intended to re-frame adult education. These alternative

16 See website for County Community Capacitation Center at http://web.multco.us/health/community-capacitation-center
approaches are a major focus of feminist science studies and science as a feminist.\textsuperscript{17}

“Participatory Research is not merely to describe and interpret social reality, but to radically change it” (Maguire [1987] 2008). Women whose lives are affected must inform research and subsequent policy.

If we look at current trends, it is impossible to predict how the social reality of health care may change. And access and cost are only two of the factors that will impact women’s health outcomes. If “EBM is superimposed upon current medical practice, repeating and reinforcing existing biases against women, both in research and in treatment, then the methods of EBM potentially disenfranchise women, both in defining ‘the best evidence’ and in developing guidelines” (Rogers 2004).

A National and State-by-State Report Card on Women’s Health

A feminist lens can bring EBM issues to the forefront of policymakers’ minds, far beyond the traditional feminine subject of reproduction issues. Some of the research and policy

\textsuperscript{17} Various activities incorporate the objective and assumptions of participatory research: (a) investigation, (b) education, and (c) action. The process of investigation is collective, where both researcher and participants articulate issues in what is called “problem posing.” During these activities, both researcher and participants seek the development of critical consciousness toward an improvement of the lives of those involved in the research process and a transformation of fundamental societal structures and relationships. The process of education assists people to further develop skills in collecting, analyzing, and utilizing information by increasing a critical understanding of social problems, understanding the social problems’ underlying causes, and envisioning the possibilities for overcoming the social problems. And the process of action is a collective process to rehumanize subjects of investigation by not treating people as objects to be counted, surveyed, predicted, and controlled, which can cause ordinary people to relinquish their capacity to make real choices and cut off meaningful decision making.
questions have been: What are women’s key causes of death? What are women’s chronic conditions? What medical conditions are women getting and not getting screened and treated for? What women get Medicaid, and what are the methods to expand enrollment? What are the gendered/raced/community aspects of access to services? What are the screenings and treatment coverage mandates?

These are the questions, among many others, addressed in Michelle Berlin’s study, *Making the Grade on Women’s Health: A National and State-by-State Report Card* (http://hrc.nwlc.org). The evidence from the report card is different than the kinds of evidence gathered to date because it is about women’s bodies specifically. And the methodology of the National Report Card is unique in its focus on the particular policy indicators that have to date been absent with regards to examining the health outcomes of women.

*Making the Grade on Women’s Health: A National and State-by-State Report Card* was initiated and co-authored by the National Women’s Law Center (NWLC) in 2001. This report measures the status of women’s health and related policies for the U.S. as a whole, as well as for all fifty states and the District of Columbia. It evaluates 34 health status indicators and 68 health policy indicators and assesses progress in reaching key benchmarks and policy objectives related to the status of women’s health. The National and State-by-State Report Cards include class, gender, and race in their evidence-based focus and compares health status with policy status; this helps to ensure a broader range of what counts as significant evidence.

Berlin has based much of her work on the data collected and catalogued in her extensive study of the report cards, and in 2003 Oregon Health Sciences University’s Center for Women’s Health was designated as one of only 21 U.S. Department of Health Services’ National Center’s of Excellence in Women’s Health (CoE). The information in the National and State-by-State
Report Cards is essential towards ensuring pragmatic links between community coalitions and legislators.

Berlin explains some of the methodology of the Report Card:

“Policies were selected based on whether they addressed and could have significant positive impact on critical women’s health issues reflected in the status indicators; whether they were measurable and comparable across states; and whether they were adopted by at least one state. The Advisory Committee worked with experts to select policies for inclusion and set appropriate classification criteria. States were rated on policy indicators as “meets policy,” “limited,” “weak,” and “no policy/harmful policy” according to the extent that the policies in each are adequately protects women’s health. The category of “no policy/harmful policy” was included to recognize that states can adopt policies that are at least as harmful as having no policy at all. . . . Health status indicators were included in the Report Card if they had a significant impact on women’s quality of life, functioning, and well-being and if they affected a large number of women or a specific population and/or age group. Additional criteria included whether the indicator (a) could be affected through intervention, prevention, or improvement; (b) was measurable; (c) was commonly used or existed with a consensus on use; or (d) addressed an emerging important issue” (1777-8) (Wisdom, Berlin, and Lapidusa 2005).

The current benchmarks were drawn primarily from Healthy People 2010; the grades indicate how close states are to meeting benchmarks and take into account if they still have time to achieve benchmarks; and the ranks illustrate how states compare to other states. A satisfactory grade (S) indicates that the state met the benchmark; subsequent grades are listed as Satisfactory
Minus (S -); Unsatisfactory (U); and Fail (F). National Health Performance findings were Unsatisfactory in the 5th Report Card in the series, which came out in 2010.

Nationally, only three benchmarks were met: Women receiving mammograms, Colorectal screenings, and Annual dental visits. In contrast, 23 benchmarks were missed. At the State Performance Health Status level, the only health status indicators met by all states were Annual Dental Visits and Colorectal Cancer Screenings. The health status indicators missed by all states were: Health Insurance, Poverty, Obesity, Wage Gap, Pap Smears, Eating Five Fruits and Vegetables a Day, Diabetes, Infant Mortality, Chlamydia and Life Expectancy. And, of course, health status varies by state, with the top-ranked states being Vermont, Massachusetts and Hawaii, and the bottom-ranked Mississippi, Louisiana, and Arkansas.

With regard to policies to improve women’s health at the State Performance level, the leading states were California, New Jersey, and Massachusetts. The last states on policies to improve women’s health were Mississippi, Idaho, and South Dakota. The policies met by all states were Medicaid Coverage for Breast and Cervical Cancer Treatment and Nutrition Education for Food Stamp Recipients. The policy goals met by very few states were Abortion Clinic Access Protected (no states) and Gender Rating in All Group Health Insurance (one state).

This work continues to be spurred by behavioral and social science research on the causes and solutions to health and disabilities disparities in the U.S. population (Smedley and Hussein 2010). This research points to the need for further research on health disparities between, on the

---

18 See Figure 2: “Health Status Varies by State” and Figure 3: “2010 Overall State Grades.” from, “Women’s Health: Where are We” By Michelle Berlin, MD, MPH Vice Chair, OHSU Dept. of Obstetrics and Gynecology. Cultural Competency: Women’s Health Week, 2013.
one hand, women’s racial and ethnic populations, women’s lower socioeconomic classes, and rural women residents and, on the other hand, the overall U.S. female population. Reducing health gaps among groups is a particular public health concern.

The mere existence of a National and State-by-State Report Card on women’s health is a result of a feminist sensibility that became more visible throughout the 1970s’, 1980s’, and 1990s’ feminist movements. Before policies were changed to allow the inclusion of women in a broader range of research and longitudinal studies, women’s bodies were seen as odd variations of men’s bodies. The recognition that diseases may exhibit differently in women’s bodies has fostered contemporary research results showing differences across a broad spectrum of conditions and diseases from AIDS (Rosser, 1994) to heart disease.19

One striking example of these differences can be seen in the development of the angiogram. This diagnostic tool was developed studying only men’s bodies, where heart disease manifests primarily through clogged arteries. As a result, women who complained of chest pain and whose angiograms were clear were rerouted toward another cause of their pain; women were less often diagnosed as suffering from heart disease, and continued to die from it. What we now know is that heart disease in most women manifests not only in compromised large blood vessels, but also in the smaller vessels (Grady 2006). This has gone some distance toward

correcting the erroneous conclusions regarding the number of women who are killed by heart
disease. It wasn’t until evidence-based medical protocols synthesized data that did not only use a
male body model superimposed on the female body that researchers recognized the
inconsistencies could be traced.

Because EBM takes advantage of both qualitative and quantitative understanding of
disease variables in relation to local understandings and values, it has the strong potential to
broaden the social perspectives of policymakers. In particular, the qualitative dimension of EBM
in the *National Report Card* reflects a particularly feminist lens since it zeroes in on the policies
that are and *are not* in place. With an emphasis on social and cultural perspectives, we can
measure governments’ commitment to women’s health by looking at existing policy. Are there
policies in place at the state level that address for example, challenges in female veterans’ health
(Resnick 2012), differences in depression (Nemeth 2013; Swenson 2010); sex specific risks of
cardiovascular disease and cognitive decline (Miller 2013); racial health disparities (Rogers
2004b; Krieger 1987; Schwartz 2001); and sex based differences in drug activity (Rabin 2013;
Whitley 2009; Correa-De-Araujo 2005; Manteuffel 2014) to focus on just a few?

**Linking Feminist Theory to Feminist Practice: The State of Oregon’s Use of the National
and State-by-State Report Card**

In Oregon, researchers and practitioners have been successful in linking their research to
legislative actions through PATH (Policy Advisory Towards Health) *for women*, the National
Report Card’s outreach program in Oregon. PATH *for women* is a program coordinated between
Oregon Health and Science University’s (OHSU) Center for Women’s Health and Oregon’s
Portland State University (PSU) undergraduate Department of Women, Gender & Sexuality

PATH for women seeks to address the critical need for broad-based information that is both current and evidence-based to empower policymakers and the public to support decisions that ensure the best possible health outcomes for all women in our region. The program tracks indicators of women's health and serves as an independent source of data and analysis for policy makers, advocates, and the general public. PATH for women works directly with private entities, as well as state, regional, and national legislators and staff to assure that stakeholders are knowledgeable about key and emerging women’s health issues, emphasizing those best addressed by changes in health policy legislation. It also creates public and private partnerships to educate health professionals and diverse communities about the key and emerging issues and interventions available to develop and maintain a healthy community. And finally, it conducts specific evidence-based analyses and translates the research of key issues that specifically impact the efficiency, cost, and outcomes of health care for women.\(^{20}\)

It is well recognized that most of the health care burden in the United States stems from chronic illness, and that most of this may be related to lifestyle and behavioral factors (Smedley and Hussein 2010). If we look at Report Card results and Oregon legislation, it is possible to correlate grades with subsequent policy actions that can lead to improved health outcomes, as Berlin’s research suggests.

Using the initial report cards (2001–2004), PATH for women provided analyses and technical assistance to every Oregon legislator in the 2005 session, which addressed the coverage of breast and cervical cancer screening mandates. This resulted in a decision to permanently

\(^{20}\) See Oregon Health and Sciences University PATH for women: http://www.ohsu.edu/xd/health/services/women/about-us/policy-and-advocacy/path-for-women.cfm
require insurers within Oregon to offer full coverage for breast and cervical cancer screening. In addition, the Oregon state legislature established the mandates that require that insurance companies offering policies in Oregon must provide coverage for breast and cervical cancer screening exams. This coverage was formerly subject to the “sunset” provision, requiring re-approval every six years, but is now part of permanent law.

The qualitative dimensions of the Report Card, specifically the various policy indicators, then led to the formation of the Oregon Summit for Women’s Health Policy, held in 2006. The Summit addressed three key topics: healthy aging; mental health; and care before, during, and after pregnancy. Key issues in these vital areas were identified; workgroup participants suggested avenues to remedy the concerns raised; and the findings guided the establishment of current law that requires the Oregon Health Authority to do outreach training and informational materials concerning maternal mental health.21

In the 2009 legislative session the Cancer Prevention and Treatment Bill passed and increased the number of women screened by the Oregon Breast and Cervical Cancer Program. This was a direct result of Report Card data.22 In addition, the HPV Vaccine Bill

21 https://docs.google.com/a/pdx.edu/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcndod2F8Z3g6NW
M5Y2U3YWU1NDQxYTE1NA

22 Senate Bill 433 passed expanding the eligibility for women for treatment of breast and cervical cancer if they are diagnosed through a health care provider outside of the Oregon Breast and Cervical Cancer Program (OBCCP). The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide presumptive Medicaid eligibility to women diagnosed with breast or cervical cancer and, as a result, access to federally-funded lifesaving medical treatment. Up until this point, the Department of Health Services policy allowed only women who were diagnosed through an OBCCP provider to obtain treatment for breast or cervical cancer. There are additional women who meet the income and age requirements of this program, but if they are diagnosed through a
passed, which requires that state-regulated health insurance programs cover Gardasil for female beneficiaries, and seeks to ensure that any new insurance programs include coverage.\textsuperscript{23}

As in many other states, the leading causes of death for women in Oregon are heart disease, cancer, and stroke, with marked disparities across race and class.\textsuperscript{24} The most recent 2010 report card, the fifth in a series, included an analysis of differences in care and access by race and ethnicity. It also highlighted two major developments that have a significant bearing on women’s health—the enactment of national health care reform legislation (the Patient Protection and Affordable Care Act) and the creation of Healthy People 2020, which establishes a new framework and new goals for national health.\textsuperscript{25}

The Oregon Women’s Health and Wellness Alliance (OWHWA) have long used Oregon State Report Card data to help steer legislation. Started in 1993, this bipartisan group of non-OBCCP provider, they are not eligible for treatment. This bill expands eligibility for screenings and out-of-coverage treatment. Data from PATH for women’s report card contributed to this work.

\textsuperscript{23} Gardasil is a human papillomavirus (HPV) vaccine that protects against about 70\% of the HPV strains that are linked to cervical cancer.

\textsuperscript{24} The Oregon 2010 Report Card data show that the women’s coronary heart disease death rate (per 100,000) for white women is 78.7; for black women, 92.3; for American Indian women/Alaskan Native women, 55.8; for Asian and Pacific Islander women, 43.3; for Hispanic women, 46.7; for non-Hispanic white women, 79.2; and non-Hispanic black women, 94.9 (Berlin et al. 2010). As to health status in general, racial and ethnic health disparities in Oregon reflect nationwide statistics. Recent Oregon Behavioral Risk Factor Surveillance System and Pregnancy Risk Assessment and Monitoring Survey data report that in comparison to white women, women of color are significantly less likely to have health insurance; less likely to report exercise or physical activity in the past thirty days; more likely to have been diagnosed with diabetes; more likely to be current smokers; more likely to report having experienced physical violence in the past year; and less likely to get prenatal care in the first trimester (US Department of Health and Human Services 2004).

\textsuperscript{25} See National Women’s Law Center: http://www nwlc.org/resource/making-grade-womens-health-2010-webinar
legislators, health care personnel, state and local agency staff, and citizen advocates is dedicated
to three main areas: promoting the health, safety, and economic well-being of women;
coordinating interested parties from across the state; and helping to identify key legislative
agenda issues for the Oregon Legislative Session. PATH for women has provided technical
information drawn from issues highlighted in the 2010 Oregon Report Card to the Alliance and
to legislative members who wanted to more effectively identify and communicate key areas for
women’s health policy development. This has provided the needed on-the-ground dissemination
to aid in informed legislative consideration and community decision-making.26

For example, during the State of Oregon’s 2011 legislative session, after two years of
working on recommendations by the Maternal Mental Health Task Force, House Bill 2235
passed and now requires the Oregon Health Authority to provide educational and outreach
training and informational materials concerning maternal mental health to health care providers
serving pregnant, postpartum, and postpregnancy patients.27

Bills from the 2011 and 2013 legislative sessions include areas covered by the Report
Card (increasing slots in the Breast and Cervical Cancer Program28 and providing coverage for

26 https://sites.google.com/site/orwhwa/2013-successes/fact-sheets

27 https://docs.google.com/a/pdx.edu/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6NW
M5Y2U3YWU1NDQxYTE1NA

28 See,
https://docs.google.com/a/pdx.edu/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6YW
UwMDkxOTFmZWYyYTBk
prenatal and reproductive care\(^{29}\) as well as in areas beyond the Report Card data. These include providing for and coordinating Sexual Assault Response Teams to victims of sexual assault, which involves integrating law enforcement with medical and social services;\(^ {30}\) prohibiting shackling--the restraint of pregnant women inmates;\(^ {31}\) requiring coverage for dense breast screenings;\(^ {32}\) and expanding access to primary and mental health care in underserved areas.\(^ {33}\)

Oregon and Washington consistently have some of the highest incidence rates of breast and cervical cancer in the nation. Three hundred women per year receive treatment for breast and cervical cancer through Oregon’s Division of Medical Assistance Program’s (DMAP) breast and cervical cancer treatment program. As an indication of a marked benefit to legislative action, an

\(^{29}\) See, 
https://docs.google.com/a/pdx.edu/viewer?\text{a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6MmEyZjk1MWRlOTQ0NTNiMw}

\(^{30}\) See, 
https://docs.google.com/a/pdx.edu/viewer?\text{a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6MzMzMDhiMzhlNzA5MzNIZQ and,}
https://docs.google.com/a/pdx.edu/viewer?\text{a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6Njk0MWVIzkyMDBzWZI5NA}


\(^{32}\) See, 
https://docs.google.com/a/pdx.edu/viewer?\text{a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcdnod2F8Z3g6MTM4MDAxNTkwZmZiMDVj}

\(^{33}\) See, 
additional 156 women will be served by expanding eligibility of this program.\textsuperscript{34} While this is a small quantity, it is still a measurable improvement. It is difficult, as Berlin states, “to relate a current or recently enacted policy to health outcomes that may have developed slowly over years” (Wisdom 1783). Yet Berlin’s study “still conceptualize[s] current state policy as a valid measure of the state’s efforts to address gender inequalities by enacting policies that benefit underrepresented populations” (1783) and larger measurable improvements can be the material of a subsequent article. This article relates to setting up these kinds of successes.

**Conclusion**

*PATH for women* has used the findings in Oregon’s Report Card to provide legislative policymakers and community partners with data critical to women’s health and health care. This has improved critical benchmarks in health and has supported the development of effective policies and programs. The importance of criteria for indicator selection and benchmarks is vital, as is the timely review and update of data that bridges a knowledge gap between research and direct service outreach. This OHSU/PSU partnership continues to advance women’s health policy research and identifies high priority women’s health indicators in Oregon. Oregon health planners, health advocates, grant applicants, researchers, and legislators have used the Report Card data broadly.

Evidence-based research that is planned, performed and distributed with feminist perspectives, premises, and methodologies also provides support for the policy efforts and

\textsuperscript{34} See,

[https://docs.google.com/a/pdx.edu/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcndod2F8Z3g6YWUwMDkxOTFmZWYyYTBk](https://docs.google.com/a/pdx.edu/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvcndod2F8Z3g6YWUwMDkxOTFmZWYyYTBk) and

legislative decision-making of service community organizations. Linking this type of medical research to policy in the legislative process facilitates the enactment of laws that sustain positive changes in women’s lives. Report Card data has helped preserve funding for public health issues affecting women, and has supported the efforts on behalf of women around disease, domestic violence, sexual assault, and human trafficking issues, as well as around economic and employment issues. These efforts also meet feminist goals for improving women’s health and reducing gender disparities by race and class.

Methodological questions are front and center in research that is focused on disparities in health care. PATH for women has helped bridge the knowledge gap between research labs and direct service organizations. In so doing, grassroots organizations have been encouraged to focus on requesting, designing, and funding research on women’s health. This stands in stark contrast to the traditional model, wherein large funding agencies have been relied upon to accommodate these needs—a top-down approach that often overlooks essential information. PATH for women has used a feminist lens where there is a need for sensitivity to the gendered differences that cause ill health. The researchers are extremely careful not to “superimpose [EBM] upon current medical practice, repeating and reinforcing existing biases against women, both in research and in treatment” (2004a). Revision of the evidence hierarchy has been recognized as a needed dimension.

Gregg uses EBM and CBPR research in Latina and Vietnamese communities. This work requires thinking in terms of independent variables, not only additive linear causality. These qualitative variables are not treated as contaminated by confounding; rather they offer meaningful data that contributes to the understanding of high cervical cancer mortality rates
among these populations. This work broadens the scope of scientific theory, methodology, and research.

Legislative action has been shown to support positive health outcomes for women. The effectiveness of the legislation can be monitored. Instead of showing that the lack of policy disadvantages women, we can show how policy can reduce disparities. And as stated earlier, coordinating policy indicator variables with health indicator variables produces a powerful means for understanding which health indicators need further policy support.
References


Ithaca: Cornell University Press.


Gregg, Jessica. 2009. “Beliefs about Pap Smears among Mexican Immigrants.”


Longino, Helen. (1993) 1999. “Subjects, Power and Knowledge: Description and

Prescription in Feminist Philosophies of Science.” Pp. 264–79 in _Feminism and Science_


Malterud, Kirsti. 1999. “The (Gendered) Construction of Diagnosis Interpretation of


Manteuffel, Marie et al. 2014. “Influence of Patient Sex and Gender on Medication Use,

Adherence, and Prescribing Alignment with Guidelines. _Journal of Women’s Health_.

Vol. 23, No. 2.


Science Constructed on Male Model Systems Is a Threat to Women Workers’ Health.”


Miller, Virginia et al. 2013. “Sex-Specific Risk of Cardiovascular Disease and Cognitive


Figure 1.

Hierarchy of Evidence

Ia. Evidence obtained from meta-analysis of randomised controlled trials.

Ib. Evidence obtained from at least one randomised controlled trial.

IIa. Evidence obtained from at least one well designed controlled study without randomisation.

IIb. Evidence obtained from at least one other type of well-designed quasi experimental study.

III. Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.

IV. Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

Fig. 1 by P.G. Shekelle, S.H. Woolf, M. Eccles, and J. Grimshaw. “Developing Guidelines.”

Health Status Varies by State

- **Top-Ranked**: Vermont, Massachusetts, Hawaii
- **Bottom-Ranked**: Mississippi, Louisiana, Arkansas

<table>
<thead>
<tr>
<th>Status Indicator</th>
<th>Best (%)</th>
<th>Worst (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease Death Rate (per 100,000 women)</td>
<td>60.9 (HI)</td>
<td>174.8 (DC)</td>
</tr>
<tr>
<td>Obesity (%)</td>
<td>19.4 (CO)</td>
<td>36.8 (MS)</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>5 (AK)</td>
<td>12.9 (WV)</td>
</tr>
</tbody>
</table>

“Data from The National Women’s Law Center and Oregon Health & Science University Center for Women’s Health, *Making the Grade on Women’s Health: A National and State by State Report Card* (2010), available at: hrc.nwlc.org”
Figure 3.

“Data from The National Women’s Law Center and Oregon Health & Science University Center for Women’s Health, *Making the Grade on Women’s Health: A National and State by State Report Card* (2010), available at: hrc.nwlc.org”