

Nursing Education on Women's Health Care in Australia, Japan, South Korea, and Thailand

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Only within the last 3 decades have a select number of countries addressed issues surrounding the all-inclusive health and well-being of women. This factor has had a major influence on nursing education within these countries and the subsequent development of curricula. Because the preparation of nurses is pivotal in shaping a society's health care agenda, this article compares and contrasts demographic characteristics, curricular frameworks, the role of the nurse, quality control of nursing curricula, and the focus of nursing courses related to women's health care among the countries of Australia, Japan, South Korea, and Thailand. Recommendations based on infant mortality rates, life expectancy, leading causes of death, and country-based health care issues are provided to inform and guide the future focus of nursing education courses on women's health care within these countries.

Keywords: *nursing education; women's health; international*

Over the past century, the well-being of women in many countries has received minimal recognition by health care providers and governmental policy makers. The majority of research, health care delivery, and economic support have

focused on illnesses that tend to afflict the male gender, with the exception of female reproductive health. Even with cardiovascular disease, which affects as many women as men, the knowledge and science that guide health care practices have been based on the study of White males (Robertson-Malt et al., 1999). It has been only within the last 25 years that a limited number of countries have begun to recognize and address health care issues that are specific to women (Evangelista, Kagawa-Singer, & Dracup, 2001). This change in perspective has occurred as a result of the greater participation of women in positions of political and financial power and an increase in the professionalization of nursing (a predominantly female profession). Yet, as a result of socioeconomic inequity and inaccessibility to medical treatment in some countries, the well-being of women remains dismal at best. One only needs to watch the worldwide evening news or read a news-based journal to obtain a flavor of what many women face regarding their status (Bennett, 2002). An example of this low status was the plight and oppression of women in Afghanistan under the regime of the Taliban.

As reflected during the 13th International Council on Women's Health Issues, held in Seoul, Korea, June 26-29, 2002, great variation exists around the world regarding how women's health care issues are perceived and addressed. Some countries have made great strides by attempting to gain scientific knowledge about the specific health care needs of

TABLE 1
Comparison of Birth Rate, Infant Mortality, Leading Causes of Death, and Life Expectancy
for Women from Australia, Japan, South Korea, and Thailand

	<i>Australia</i>	<i>Japan</i>	<i>South Korea</i>	<i>Thailand</i>
Birth rate (per 1,000 population)	12.86	10.04	14.85	12.5
Infant mortality rate (per 1,000 live births)	4.97	3.88	7.71	6.2
Leading causes of death among women	Cancer	Cancer	Cancer	Cancer
	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease	Cardiovascular Disease
	Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease	Cerebrovascular Disease
	Chronic Lung Disease	Pneumonia	Diabetes Mellitus	Pulmonary Diseases
	Accidents	Accidents		Accidents
Life expectancy for women (in years)	83	84	79	75

SOURCE: Central Intelligence Agency (2002); The International Nursing Foundation of Japan (2000); World Health Organization Statistics (1999).

NOTE: The ordering of the leading causes of death is only for comparison across countries and is not based on which cause of death is highest or lowest.

TABLE 2
Land Mass, Population, and Population Density for Australia, Japan, South Korea, and Thailand

	<i>Australia</i>	<i>Japan</i>	<i>South Korea</i>	<i>Thailand</i>
Land Mass (in square kilometers)	7,686,850	377,835	98,480	514,000
Population	19,357,594	126,771,662	47,904,370	61,797,751
Population density (in square kilometers)	2.5	336	486	120

SOURCE: Central Intelligence Agency (2002).

women. Other countries have focused solely on the delivery of care but have conducted little scientific research on health problems that are unique to women. Because of socioeconomic factors and the educational preparation of health care providers, other countries remain amiss in moving ahead with the development and implementation of both research and health care delivery that specifically focus on the unique needs of women.

For countries to change how health care is provided for women, alterations need to occur not only in the delivery system but also in the educational systems that prepare the care providers. To address the many unique needs of women, a holistic and comprehensive approach to health care delivery is needed. Because nurses make up the largest percentage of all health care providers and are major contributors to the health care delivery system in every country, an examination needs to occur regarding how women's health care is taught within schools of nursing. As a first step in this endeavor, the authors have focused on comparing health demographics, leading causes of death, and current health care issues within the countries of Australia, Japan, South Korea, and Thailand. In addition, a comparison has been made among the countries regarding the type of women's health care content being taught within schools of nursing. Finally, recommendations are provided that focus on content that should be considered when developing courses on women's health.

WOMEN'S HEALTH

For the purpose of this article, the authors have defined women's health as the spiritual, emotional, cultural, and physical well-being of women. This well-being is influenced by the social, political, cultural, and economic context within which the women reside (Women's Health Office, 2003).

Comparison of Countries

To fully understand issues surrounding women's health within a specific country, one needs to examine such aspects as population density, birth rate, infant mortality rate, life expectancy, leading causes of death, and concerns regarding the general health of the populace (See Tables 1 & 2). It is within these contexts that one can better comprehend the present and future needs of women's health care based on country of origin.

As noted in Tables 1 and 2, population density and infant mortality rates vary. The population densities of Japan, South Korea, and Thailand are high compared to those of Australia. This can be attributed to the large landmass that exists in Australia. In comparison to the other countries, Japan has both the lowest infant mortality rate and birth rate. In fact, the Japanese are not replacing themselves at an adequate rate. The average number of persons per household in 2000 was 2.69 compared to 2.82 in 1995 (Japanese Ministry of Public Management, Home Affairs, Ports & Telecommunications,

TABLE 3
Comparison of Health Care Issues of Women in
Australia, Japan, South Korea, and Thailand

<i>Women's Health Care Issues</i>	
Australia	<ol style="list-style-type: none"> 1. Aging population 2. Increase in chronic illnesses 3. Need for culturally competent health care 4. Inequity between health care delivery and outcomes of rural and urban populations 5. Poor health outcomes of indigenous Australians
Japan	<ol style="list-style-type: none"> 1. Increase in chronic illnesses 2. Movement toward a markedly elderly population 3. Increase in infectious diseases, such as TB and AIDS
South Korea	<ol style="list-style-type: none"> 1. Movement toward a markedly elderly population 2. Increase in chronic illnesses 3. Increase in lifestyle illnesses related to smoking
Thailand	<ol style="list-style-type: none"> 1. Prevalence of anemia among pregnant women 2. Accessibility of health care services 3. Lack of continuity of care from the hospital to the community 4. Abuse and violence 5. Increase in AIDS

SOURCE: Health and Development Related Indicators (2003); International Nursing Foundation of Japan (2000).

2000). Japanese women live slightly longer than women in the other countries; therefore, this decline in birth rate will contribute to an increased proportion of aged women within the general Japanese populace.

The leading causes of death are fairly comparable among the countries. Such issues as an increasing elderly population, the increased incidence of chronic illnesses, the emergence of certain infectious diseases, the high cost of health care, and the inaccessibility to health care services appear to affect most of these countries (see Table 3). All of these factors are noteworthy as nursing educational programs related to the health care of women are developed.

Nursing Education Related to Health Care of Women

Given the problems of (a) an increasing elderly population, (b) increases in chronic illnesses, (c) increases of illnesses related to lifestyle, (d) occurrences and reemergence of certain infectious diseases, (e) the presence of inaccessible health care, and (f) cultural diversity within some of the countries, one would assume that nursing education has taken these issues into account when developing and implementing programs and courses related to the health care of women. However, after a review of the content offered in nursing courses within Australia, Japan, South Korea, and Thailand, it is surprising to find that these issues are not always considered by faculties of nursing.

To better understand nursing education related to women's health care within each of these countries, several factors should be examined. These factors include the curricular framework of nursing education programs, the role of nurses within the health care system, the control of quality of nursing curricula, the types of entry-level nursing programs in existence, and the focus of nursing courses that are offered on women's health care (see Tables 4 & 5).

Curricular framework. The curricular framework of schools in Australia, South Korea, and Thailand was found to be fairly consistent. The belief of nurse educators in these countries is that faculty should be nurses who are responsible for developing, planning, and implementing all aspects of the nursing curricula. Thus, nursing curricula are based on a nursing model (holistic care). A nursing program that utilizes non-nurses to teach a course within the curriculum often tries to assign these faculty members to teach courses in the biological and behavioral sciences (i.e., chemistry and psychology). If a non-nurse does teach in a course related to nursing science and/or practice, attempts are made for a nursing faculty member to coteach the course with the non-nurse so that appropriate nursing application of the content takes place.

Japan, however, is quite different in that a large number of the educators in schools of nursing are physicians. Thus, the nursing curriculum structure is strongly impacted by the use of the medical model (dysfunction and disease). In fairness to Japanese schools of nursing, it must be kept in mind that until the late 1990s, a limited number of baccalaureate and masters degree programs in nursing existed (International Nursing Foundation of Japan, 2000). As a result, there has been an insufficient number of nursing faculty prepared at both the baccalaureate and graduate degree levels in nursing. This has led to a heavy reliance on physicians to provide nursing education. Changes are beginning to occur, and the country has begun to implement more baccalaureate and masters degree nursing programs.

Role of the nurse within the health care system. Beliefs about nursing education in each country have a direct effect on the role of the nurse. Australian nurses are involved in both independent and collaborative interdisciplinary practice. Prior to the country's indemnity insurance crisis, a large number of midwives were engaged in independent practice. However, as a result of the insurance issue and continued medical dominance, a number of midwives have been forced out of independent practice into collaborative practice with other members of the health care team (Brodie, 2002). The role of the nurse practitioner is fairly new within the Australian health care system. The development and implementation of this role has provided nurses with an opportunity for more independence in their delivery of health care services. The implementation of the nurse practitioner role, which is still in its infancy, and the related legislation to support this new role

TABLE 4
Comparison of Women's Health Nursing Education for Australia, Japan, South Korea, and Thailand

	<i>Australia</i>	<i>Japan</i>	<i>South Korea</i>	<i>Thailand</i>
Curriculum framework	Nursing Model	Medical Model	Nursing Model	Nursing Model
Role of nurses within the health care system	Collaborative interdisciplinary practice	Implementer of physicians orders	Collaborative interdisciplinary practice	Collaborative interdisciplinary practice
Monitors quality and composition of nursing education	Nursing faculty University administration National nursing and university accrediting agencies State nursing licensing boards	Ministry of Health and Science	Nursing faculty University administration Korean Council for University Education (4-year programs) Ministry of Health & Welfare; Ministry of Education & Human Resources Development National Health Personnel Licensing Examination Board	Nursing faculty University administration Ministry of University Affairs Nursing Council
Entry Programs:				
1. Diploma	No	Yes (2 & 3 year)	No	No
2. Associate	No	Yes	Yes (3 year)	No
3. Baccalaureate	Yes	Yes	Yes	Yes
Focus of women's health content:				
1. Childbearing	Yes	Yes	Yes	Yes
2. Disease and dysfunction	Yes	Yes	Yes	Yes
3. Health promotion/disease prevention	Yes	No	Yes	Yes
4. Health care issues	Yes	No	Yes	Yes

SOURCE: Anders & Kunaviktikul (1999); Daly & Jackson (1999); International Nursing Foundation of Japan (2000); Shin (2001).

TABLE 5
Recommendation on Course Content in Women's Health Courses for Australia, Japan, South Korea, and Thailand

<i>Country Specific Focus Areas of Content on Women's Health Care</i>
Australia
<ul style="list-style-type: none"> • Health care needs of indigenous Australian women • Disparity of health care delivery between rural and urban women
Japan
<ul style="list-style-type: none"> • Disease prevention • Health promotion • Needs of an increasing elderly female population • Tuberculosis • HIV/AIDS
South Korea
<ul style="list-style-type: none"> • Needs of an increasing elderly female population • Health promotion and disease prevention related to diabetes mellitus • Lifestyle illnesses related to smoking
Thailand
<ul style="list-style-type: none"> • Increased prevalence of anemia in pregnant women • Adequate health care delivery to women from the hospital to the community setting • Abuse and violence • HIV/AIDS

has met with resistance from physicians (Pearson & Peels, 2002; Whitecross, 1999).

Australia continues to struggle with the requirement of a master's degree to practice within the advanced practice role (i.e., clinical nurse specialist, nurse practitioner, and midwife). At the present time, there are no incentives or requirements for holding a higher degree. Thus, the vast majority of nurses who engage in course work beyond the baccalaureate degree obtain only a graduate certificate or diploma and not a graduate degree. A graduate certificate is awarded for successful completion of 25% of the course work required for a master's degree, whereas a graduate diploma is granted for successful completion of 50% of the course work required for a master's degree.

In Japan, the role of the nurse is to be the implementer of physicians' orders. Although Japanese nurses hold an independent nursing license, their practice is controlled by what physicians direct them to do. Nurses are encouraged not to question or disagree with the actions or directives given by physicians. Such a practice most likely contributes to the suggested finding that Japanese hospital nurses tend to assess themselves as ineffective communicators (Ito & Lambert, 2002). In addition, a major contributing factor to the less-

than-independent role of nurses in Japan is the fact that of the four countries, the educational level of nurses tends to be at a lower level (Lambert, Lambert, & Ito, in press). Very few nurses currently hold a baccalaureate degree, master's degree, or doctoral degree in nursing. Although some nurses do hold either an associate or baccalaureate degree in nursing, the number of nurses remains much lower than the number of nurses prepared within hospital-based diploma programs (International Nursing Foundation of Japan, 2000).

Nurses prepared at the entry level in South Korea—much like nurses in Australia—are able to engage in collaborative interdisciplinary practice and to control their own domain of nursing care. They work in hospitals, public health centers, industrial settings, nursing homes, birthing centers, and schools. Nurses who are prepared as advanced practice nurses are educated at the postbaccalaureate or postassociate degree level by way of a 1-year, nondegree program at a college or university. The programs focus their preparation in the areas of (a) home care, (b) anesthesia, (c) psychiatric mental health, and (d) public health. These nurses constitute only 5% of all Korean nurses and are legally certified by the Korean government as advanced practice nurses (Lee, 2002). In addition to advanced practice nurses, Korean nurses who have a postbaccalaureate or postassociate degree can also become nurse specialists by attending 1 year of in-service education in a specific clinical arena provided by their specific hospital. Unlike advanced practice nurses, nurse specialists are not certified.

In Thailand, the health care system places an emphasis on health promotion, disease prevention, curative care, and rehabilitation within the scope of nursing practice. Nurses carry out direct and indirect patient care as practitioners within a model of interdisciplinary collaboration. The majority of nurses hold a bachelors degree in nursing, and an increasing number of nurse (particularly in university-based teaching hospitals) hold masters and/or doctoral degrees (Srisuphan, Suxchaya, Nuntabut, & Hatagit, 2002). The role of the nurse has markedly advanced within the Thai health care system over the past 2 decades, with nurses playing a major role along with the other members of the health care team in decreasing the country's infant mortality rate.

Control of quality of nursing curricula. How the quality of nursing programs is controlled varies among the four countries (see Table 4). Within Australia, nursing faculty members, in consultation with clinical colleagues, have major control over the curriculum content and how it is presented. Nurse educators and administrators internally monitor the quality of each nursing program. National and professional nursing and university accrediting agencies and state licensing boards provide external monitoring (Heath, 2002).

The quality and content of Japanese nursing programs are controlled at the national governmental level by the office of the Minister of Health and Science (International Nursing

Foundation of Japan, 2000). Internal assessment of the quality of a specific program is limited and basically nonexistent in many schools. This is an area of concern for both nursing faculty and the Office of the Minister of Health and Science, which currently is examining how the quality of nursing education and the competency of graduates from Japanese schools of nursing should be assessed.

In South Korea, the development, implementation, and internal monitoring of the nursing curricula are controlled by the nursing faculty. Externally, the quality of the programs is controlled through the office of the Minister of Health, accrediting agencies, and the Korean Council for University Education (Kwan, 1997).

Thai nursing faculty have total control over the curriculum. Internal monitoring of the quality and content of nursing programs involves nursing faculty and administrators within each school of nursing as well as the respective university administration and the Ministry of University Affairs. Externally, the Nursing Council controls the quality of nursing programs throughout Thailand (Srisuphan, Suxchaya, Senarantana, et al., 2002).

Types of entry-level nursing programs. Entry-level nursing programs vary within and among the four countries. In Japan, 2- and 3-year diploma programs, 2-year associate degree programs, and 4-year baccalaureate degree programs constitute the entry level into nursing. Japan is fairly new to the world of baccalaureate education in nursing. It was not until 1990 that the Japanese government mandated that within 10 years there be a significant increase in available baccalaureate degree nursing programs. As a result, baccalaureate degree programs in nursing grew from 11 in 1990 to 101 in 2002 (Japanese Nursing Association, verbal communication, August 19, 2002). Unfortunately, the number of qualified faculty with graduate degrees in nursing has not kept pace with this massive growth in college-based programs. This has led to the hiring of more physicians to teach nursing.

In South Korea, the entry-level nursing programs include the 3-year associate degree program and the 4-year baccalaureate degree program. Korea initiated the 4-year baccalaureate program in nursing in 1955. In 1979, all 3-year diploma nursing programs were moved from a hospital setting into a junior college, thus creating the 3-year associate degree programs (Kim, 1998). Unlike Japan, Korea no longer has hospital-based (diploma) nursing programs.

Australia and Thailand hold the distinction of having only the baccalaureate degree in nursing as the entry level into professional nursing. No diploma or associate degree programs for professional nurses exist in either of these countries. Thus, Australia and Thailand have clearly delineated the educational level of the professional nurses versus the nurse prepared at the technical and/or vocational level. This factor has, and will continue to have, an influence on the level and stan-

dard of educational preparation and the role of nurses within the Australian and Thai health care systems. It should be noted that Australia does have a health care provider called the enrolled nurse. However, this provider is not in the realm of a professional nurse, because he/she has only 1 year of education and works under the supervision of a registered nurse. The enrolled nurse holds a certificate and is comparable to the licensed practical or vocational nurse that exists in some other countries (Unruh, 2003).

In Australia, the government mandated a transfer of all nursing education programs from hospital-based programs to the higher education sector. This was carried out from 1984 to the end of 1993 (Daly & Jackson, 1999). Recently, as the result of a national nursing shortage and the desire of some political forces who wanted to use nursing academics as a scapegoat for poor nursing retention and recruitment rates, two national reviews of nursing education ensued (Heath, 2002; Senate Community Affairs Committee [SCAC], 2002). These reviews reaffirmed the fact that nursing education should remain within the university setting and identified factors in the service sector of health care that were contributing to retention and recruitment problems related to nurses.

In Thailand, the first baccalaureate program in nursing was developed in 1956, and by 1978, all hospital-based programs were eliminated and replaced with baccalaureate degree nursing programs. Because of a severe nursing shortage in Thailand in the 1980s, the country developed 2-year nursing programs. These programs were considered technical, and nurses desiring to become professional nurses enrolled for an additional 2 years of study in a baccalaureate program (Anders & Kunaviktikul, 1999). However, these 2-year technical programs were phased out and no longer exist (Srisuphan, Suxchaya, Nuntabut, et al., 2002).

What is unique about Thailand nursing programs is that they come under the jurisdiction of the Ministry of University Affairs, the Ministry of Public Health, private universities, the military, the police department, a city, or the Red Cross. The majority of the nursing programs, however, are under the jurisdiction of the Ministry of University Affairs ($n = 12$), the Ministry of Public Health ($n = 35$), or a private university ($n = 9$) (Anders & Kunaviktikul, 1999).

Focus of nursing courses on women's health care. Although Australia, Japan, South Korea, and Thailand are culturally, linguistically, and spiritually diverse, one will find it interesting that with the exception of Japan, entry-level nursing education on women's health care is fairly similar (see Table 5). The fact that a substantial number of Thai and South Korean nurse leaders and educators received their masters degrees and/or doctoral degrees in nursing from universities in Australia and the United States has some bearing on this factor. When examining undergraduate-level nursing content on women's health care in these countries, one can note that an emphasis is placed on childbearing and new

motherhood within the maternal/child courses, whereas in the adult and gerontology courses, the emphasis on women's health focuses on disease, dysfunction, disease prevention, and health promotion. In Thailand, unlike Australia and South Korea, students can have a focus on midwifery or gynecological nursing at the undergraduate level. With completion of this type of program, the graduates receive a bachelors degree in nursing and midwifery.

South Korea and Thailand offer specialized programs at the masters level in women's health. Within these programs of study, students are prepared in depth about all aspects of women's health care. A strong emphasis is placed on reproductive health, health promotion, and disease prevention. As a result of concerns about existing health care problems related to women and children, the health care system in Thailand has taken a positive stance on improving the quality of life and rights of women. Emphasis has been placed on health problems of women in the workplace and violence against women. As stated in Thailand's Draft Health Act, Article 9, Women's health is specific and complex because of their reproduction system, which influences holistic health of the whole lifecycle of a woman from birth to death. Therefore, women's health should be promoted, protected and ill health prevented appropriately (Draft Health Act in Thailand, 2002).

Unfortunately, at this point in time, Australia does not have any specialized nursing programs at the masters level with a specific holistic approach to women's health other than midwifery. Advanced preparation in women's health continues to flourish predominately within midwifery. However, some primary health care does take place within the curricula of the midwifery programs of study.

At the doctoral level, nursing programs in all four countries prepare nurse researchers who have focused their research on specific aspects of women's health with the intent of creating new knowledge (Chirawatkul, Patanasri, & Koochaiyasit, 2002; Cho, 2002; Daly, et al., 2000; Daly, et al., 1998; Endo, 1998; Jackson, et al., 2000; Jirapaet, 2001; Noji et al., 1997; Shin, 1997, 1998, 1999a, 1999b; Tashior, 2002; Yimyam, 1998). New information has been generated on, but not limited to, such topics as menopause, health seeking behavior, pattern recognition, cardiovascular disease, myocardial infarction, maternal role attainment, depression, health status, lifestyle behaviors, and breastfeeding. It should be noted that although Japan does not focus on health promotion within its nursing curricula, Japanese nurse researchers are focusing some of their studies within this very area of concern (Noji et al., 1997; Tashior, 2002).

Unlike South Korea, Thailand, and Japan, Australia is extremely culturally diverse. A large percentage of the population is made up of individuals who are either foreign-born or the children of immigrants (Central Intelligence Agency, 2002). Thus, many nursing programs in Australia focus a portion of their nursing content on the health care needs of the

culturally diverse members of the population. Particular attention is paid to preparing culturally competent nurses who have an understanding of the role, health care needs, and health-seeking behaviors of women within a specific culture (Carberry, 1998; Davidson et al., in press; Gorman, 1997).

In Japan, the primary focus on women's health at the undergraduate level is on childbearing and new motherhood. In fact, diploma and undergraduate nursing students can take additional courses in midwifery to engage in and be licensed to practice in the area of midwifery with completion of their educational program (International Nursing Foundation of Japan, 2000). This content is presented in maternity courses within the nursing curriculum. Similar to South Korea and Thailand, content related to disease and dysfunction specific to women is presented in adult and gerontology nursing courses. However, unlike the other countries, Japan places little, if any, focus on health promotion and disease prevention as it relates to women. This is not surprising given the fact that the nursing curricula tend to function under a medical model (disease/dysfunction) approach to care. However, a number of hospitals have created women's health care clinics. This hopefully will spark the need for nurses prepared specifically in women's health.

Graduate nursing education in Japan has been somewhat limited. As of 1998, only 31 master's-level and 9 doctoral-level nursing programs existed (International Nursing Foundation of Japan, 2000). By 2002, 53 masters programs and 16 doctoral programs in nursing existed (Japanese Nursing Association, verbal communication, August 19, 2002). To date, no master's-level nursing program specific to the overall health care needs of women has been developed and implemented. Limited research on women's health has been published in refereed journals by nurses who hold graduate degrees in nursing (masters and doctoral). Thus, minimal new nursing knowledge related to the health care needs of Japanese women currently exists. Several Japanese nurse educators, however, have recognized the importance of expanding women's health content for nursing students and have published a textbook on women's health with a holistic approach to care (Yoshizawa & Suzuki, 2001).

Recommendations for Nursing Education Related to Women's Health Care

Although great strides have been made among several of the countries regarding educating nurses about women's health, nurse educators still need to consistently examine the changing health care needs of women and to subsequently develop nursing curricula that prepare nurses to address these needs. No evidence-based nursing research could be located in these countries to support what needs to be carried out to strengthen women's health care education in schools of nursing. However, examining current data on birth rates, infant mortality rates, leading causes of death, life expectancy, and current country-specific health concerns is a starting point for

determining the future focus of nursing curricula related to women's health (See Tables 1 & 3). Awareness of these factors can lead to advocacy by nurses to improve health-related outcomes (Fowler, 1989; Wheeler, 2000).

Recommendations influencing each country. Regardless of cultural, linguistic, or spiritual differences, the women within the countries of Australia, Japan, South Korea, and Thailand have a number of similarities regarding their leading causes of death. Such similarities suggest that women's health courses emphasizing prevention and care relevant to cancer, cardiovascular diseases, and cerebrovascular diseases would be beneficial. All countries except Korea have accidents as a leading cause of death. Thus, course content focusing on aspects of accident prevention would be important.

Course content should include aspects of disease and dysfunction as well as components of health promotion and disease prevention (i.e., exercise, diet, adequate rest, avoiding situations that contribute to the occurrence of accidents, and engaging in activities that can facilitate mental and spiritual health). Culturally congruent education that focuses on healthy habits of daily living should be emphasized. For example, consumption of food products rich in phyto-estrogen (i.e., soy products), a common component of the Japanese diet, has been suggested for use by postmenopausal Japanese women who tend not to take hormonal replacement therapy to contend with the side effects of menopause (Adlercreutz, Hamalainen, Gorbach, & Goldin, 1992; Lock, 1991).

With the exception of Thailand, the epidemiologic data in the other three countries suggest a need to address the health care issues associated with aging. Course content could address such topics as osteoporosis, osteoarthritis, vision changes, depression, urogenital changes, difficult mobility, widowhood, and alterations in bodily appearance and function. Particular emphasis should be made in the women's health curriculum on health promotion activities that are congruent with each country's cultural values and beliefs. For example, in Asian countries, a common activity, for the purpose of transportation, is bike riding. Encouraging women to continue with such a form of exercise, as long as it remains a safe practice, might prove useful. In addition, evidence-based practice research on women's health care could provide cross-cultural evidence on the linkage between health education and practice.

Country-Specific Course Content on Women's Health

Australia. Nursing content related to the need for culturally competent health care, inequity between health care delivery and outcomes of rural and urban Australians, and poor health outcomes of indigenous Australians are pertinent areas of concern. Because of Australia's vast cultural diversity, nursing courses need to focus on the specific health care needs of women who are from various ethnic and cultural

groups. Education should focus on understanding factors that influence disparities in health outcomes between indigenous and other Australian populations, factors such as differential living conditions, access to care, dietary practices, tribal health practices, and compliance with Western plans of health care (Australian Institute of Health and Welfare, 2000).

In addition, the growing divide that is occurring between health delivery and outcomes of rural and urban Australians should not be ignored. The manner in which these differences are influencing the health and well-being of rural Australian women must be considered. For example, providing courses and clinical experiences related to indigenous Australians who are located in remote and rural areas of the country could prove very beneficial to student learning. Nursing students witnessing the difficulties faced by indigenous Australian women could be helpful in bringing about future change in the health care system.

Japan. Nursing content related to an increase in infectious diseases, particularly tuberculosis and AIDS, is an important area to address in courses related to health care for women. Emphasis should be made on course content and clinical experiences that go beyond disease and dysfunction and include health promotion and disease prevention. This is particularly noteworthy when one considers the fact that the life expectancy of Japanese women is longer than most women around the world (see Table 1). For example, providing adequate instruction to students on how to teach female patients about the transmission of tuberculosis and HIV/AIDS and about specific activities that can prevent the spread of these two diseases is important. There is need for nurses with advanced degrees in nursing to shift the approach of nursing education from the medical model to a nursing model of care. This modification will assist in moving the Japanese nursing curricula, as it relates to the health care needs of women, from a disease and dysfunction perspective toward a more holistic approach to care that incorporates health promotion and disease prevention. The Japanese government is working to facilitate such a change by supporting an increase in the number of baccalaureate, masters, and doctoral programs in nursing (Ministry of Education Coordinating Council on Medical and Dental Education, 2001).

The fact that Japan has a very high population density should not be ignored when addressing health promotion and disease prevention. Because of the high population density, any type of airborne infectious disease, such as tuberculosis, can easily spread throughout the population. Although the population density of Japan is estimated to be 336 individuals per square kilometer (see Table 2), the fact that the terrain of the country is very mountainous reduces the actual inhabitable land mass. Because the Japanese actually reside on only 10% of the country's landmass, the true estimated population density is closer to 709 individuals per square kilometer. Such crowding has the potential for making the control of any

infectious disease very difficult. As a result, Japan often resorts to the use of quarantine to prevent a massive spread of infectious diseases.

Thailand. Nursing education, in Thailand, should address prevention of anemia among pregnant women, access to health care services by women, and continuity of care from the hospital to the community. Creating a nurse-managed, community clinic for women with a disease prevention and health promotion approach to care is an example of how nurse educators can provide learning experiences that facilitate both the availability of health care services and the continuity of care from an acute-care setting to a community setting. Health care emphasis should include monitoring and managing the prevalence of anemia in pregnant women, dietary instruction, and provision of iron supplements.

Consistent with the emphasis given on women's rights and their quality of life in Thailand, nursing courses should focus on the changing health care needs of women, issues of abuse and violence, and the prevalence of HIV/AIDS. Nurses need to receive knowledge and skills in the assessment of women's health care needs, factors contributing to abuse and violence, the availability of societal resources for abused women, and the use of preventative measures in the spread of HIV/AIDS (e.g., the use of condoms).

South Korea. Increasing morbidity related to smoking is evident among South Korean females. Establishing smoking cessation clinics for women that are managed by nursing faculty and students can provide educational experience related to illness prevention associated with lifestyle changes. Women should also be provided with the knowledge and skills necessary to create a smoke-free environment in the workplace and the home.

An increase in diabetes mellitus is occurring within the female population of South Korea. Thus, nursing curricula should include content related to managing chronic illnesses, identifying the presence of diabetes mellitus, and preventing diabetes (i.e., appropriate diet, weight control). A nurse-managed diabetic clinic can focus on the control and management of diabetes by women in their workplace and at home.

SUMMARY

Women's health is a multifaceted phenomenon that is embedded within the sociocultural context of one's country. Similarities and differences exist in the health care needs of women around the world. This article attempts to offer some curricular approaches in educating nurses regarding the health care needs of women within the countries of Australia, Japan, South Korea, and Thailand.

The monitoring of population growth, infant mortality, life expectancy, leading causes of death, and current health care concerns is one way to assist in keeping nursing education

related to women's health relevant and current. Women's health care has a bright future as long as all health care professionals maintain a creative and knowledgeable approach to educating the next generation of providers.

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