Unit 1

A - Women and health care policies Global and national

A draft framework for designing national health policies with an integrated gender perspective

1. Background

Over the last two decades, women's issues have moved rapidly up the policy agenda of international organisations and national governments. During the eighties there was a major increase in policies designed to prevent women from being marginalised from the mainstream of economic and social life. Though these policies did lead to significant improvements in women's lives, their overall status in society remained very much the same. In recognition of this continuing discrimination the focus on women alone is now shifting towards a broader concern with gender relations. In health care and in other areas of public policy, the emphasis is now on identifying and removing the gender inequalities that prevent women (and sometimes men) from realising their potential.

This shift towards a gender perspective was an important step forward. However it has not yet delivered the expected results and two main reasons for this can be identified. First, there has been considerable confusion about the terms being used. What do we mean by 'gender' and why is it different from 'sex'? And how is the 'gender' approach different from one that focuses only on women? These are important issues that need to be properly understood by all those involved in the implementation of 'gender sensitive' health policies. Second, there has been a lag in the development and dissemination of appropriate techniques for the incorporation of gender issues into policy process. If gender equity is to be a major goal in the development of a health service with gender equality in health as the final objective, those involved need to be properly informed about the most effective means by which this can be achieved.

This paper provides an introduction to some of these conceptual and technical issues underlying the development of gender sensitive health policies. It begins with a clarification of the relationship between gender, health and health care and then moves on to present an introductory framework for the mainstreaming of gender issues in the health sector itself. It concludes with some brief observations about gender equity and equality and its overall significance in the public policy debate.

2. Sex, gender and health: clarifying the concepts

Despite its increasing use there is still considerable confusion surrounding the term ‘gender’. It is not simply a more modern word for ‘sex’. Rather it is a term used to distinguish those features of males and females that are socially constructed from those that are biologically determined. Thus men and women are differentiated by social (or gender) characteristics on the one hand and by biological (or sex) characteristics on the other. This means that gender issues are not just of concern to women. Men’s health too is affected by gender divisions in both positive and negative ways. These differences in ‘maleness’ and ‘femaleness’ are reflected in the patterns of health and illness found among men and women around the world.

Women in most countries tend to live longer than men of the same social status as themselves though the size of this gap between male and female life expectancy varies significantly. Yet at the same time women report more sickness and distress than men do. There are also marked variations in the rates of particular health problems between men and women. Men are more likely to die prematurely from heart disease for example, while women are more likely to suffer from autoimmune diseases or musculoskeletal disorders and also from anxiety and depression. Any attempt to explain these differences has to make sense of the impact of both biological and social influences on well being.

2.1 Biological influences on health and illness

Both biomedical and common-sense accounts of the differences between men and women have traditionally focused on their reproductive biology. This approach is clearly important since the structure and functioning of their reproductive systems can lead to particular health problems for both women and men. Only men have to worry about cancer of the prostate for example, while only women can develop cancer of the cervix. However women’s capacity to conceive and give birth means that they have reproductive health care needs additional to those of men both in sickness and in health. Unless they are able to control their fertility and to give birth safely, women can determine little else about their lives so that access to quality reproductive care is a crucial determinant of their health.

The truth of this claim is evident if we look again at male and female patterns of life expectancy. Women’s greater longevity is generally accepted to be biological in origin. Far from being the weaker sex it appears that a number of biological factors combine to give them the potential for greater life expectancy than men. However this biological potential for longer life may be significantly reduced if they are the objects of discriminatory practices such as a failure by society to provide effective and appropriate health services. In these circumstances the gap between male and female life expectancy will be much smaller. Indeed in some societies it may be men who

live longer. It is here then, that the biological meets up with the social and it is these social or gender differences that are potentially amenable to change.

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2.3 The impact of gender inequalities on women's health

Economic inequalities mean that in many countries women have difficulty in acquiring the basic necessities for a healthy life. Of course the degree of their deprivation will vary depending on the community in which they live but the 'feminisation' of poverty remains a constant theme. 'Cultural devaluation' is also important though is difficult to measure or even to define. Because they belong to a group that is seen by society to be less worthwhile, many women find it difficult to develop positive mental health. This process begins in childhood with girls in many cultures being less valued than boys and continues into later life where 'caring work' is given lower status and less rewards. These gender inequalities are further reinforced by women's lack of power and the obstacles they face in trying to effect social change.

At the same time, the nature of female labour itself may affect women's health. Household work can be exhausting and debilitating especially if it is done with inadequate resources and combined (as it is for many women) with pregnancy and subsistence agriculture. It can also damage mental health when it is given little recognition and is carried out in isolation. For some women, domestic life and labour may also carry the threat of violence since the home is the arena in which they are most likely to be abused. Even in the context of paid work, 'female' jobs often pose particular hazards that receive little attention.

3. Gender bias in medical practice

This section will summarise the ways in which both the generation of knowledge in health care and also the delivery of services demonstrates gender bias. The status of medicine as a science has not rendered it immune from wider social and economic forces as the evidence below demonstrates.

3.2 Gender bias in the delivery of health care

Similar concerns have been raised about gender bias in access to medical care and in the quality of care received. There is considerable evidence to show that women experience gender-related constraints on their access to health services and that this affects the poorest women in particular. The obstacles they face include lack of culturally appropriate care, inadequate resources, lack of transport, absence of alternative care for their families and sometimes the refusal of their husband to give permission. Of course limited public expenditure on health care will affect men as well as women but in conditions of scarcity it is often the females in the family whose needs are given the least priority.

If they do gain access to health care, there is also evidence that the quality of care women receive is inferior to that of men. Too many women report that their experiences are distressing and demeaning. Medical knowledge is too often presented as inevitably superior, giving women little opportunity to speak for themselves or to participate actively in decision making about their own bodies. These problems are reflected particularly in the context of reproductive services where dehumanising and insensitive treatment can affect women's willingness to return.

Previous sections have clarified some of the concepts relating to gender and health, and explored the empirical evidence relating to gender differences in health status and the gender bias in health care resources. These form the basis for the next two sections where a framework will be outlined for mainstreaming sex and gender issues in all aspects of health care. Section four examines the area of health -related research while section five examines the delivery of health care itself.

4.1 Measuring women's health

One of the most basic problems facing many policy makers is lack of specific information on the situation of women. The failure to separate women from men in national and regional statistics can make it difficult to plan effectively to meet the particular needs of either group. It is essential therefore that data is collected about both sex and gender differences in health status and that the results are clearly presented for easy use. The conceptual framework for this data collection process must be appropriate to the setting in which it is being used and must also recognise the diversity of women's experiences over the lifespan.

Older women and young girls for example, may have particular health problems, making it essential that factors such as their nutritional status, or their access to health care are routinely monitored. This will require the development of appropriate indicators for measuring different aspects of their health and quality of life. Other groups of women whose vulnerability may require special attention include those who

are refugees or migrants, those who are bringing up children alone and those who are coping with chronic disease or long term disabilities.

In many developing countries, the lack of data on women's health reflects in part the very limited nature of the vital registration system, which affects both sexes. However this is often compounded by a failure on the part of the relevant authorities to recognise the importance of gender issues and a lack of understanding of the complex social pressures that may render women's health problems invisible. In the case of maternal mortality for instance, a wide range of religious, cultural and social factors can contribute to serious under-reporting. New methods have now been developed for identifying those cases that are missed and these need to be used routinely by those responsible for monitoring community health.

Similar problems are evident in relation to the identification and measurement of domestic violence. This represents a huge public health problem which has not yet been adequately documented. If this knowledge gap is to be filled individual countries need to move forward with the development of ethical and culturally appropriate methods for the collection of relevant data in their own particular settings. This can be facilitated by cooperation with international organisations such as WHO who have already developed a range of resources for work in this area.

Gaps in the availability of information on women's lives are now beginning to be filled, providing new sources of accessible data. For instance, the recent development by UNDP of a number of new gender -related indicators, offers important tools with which individual countries can assess the levels of gender equality in their own society. However there is still a need for national governments and international agencies to work together to develop more specific health related measures combining both biomedical and socio-economic data to monitor the changing state of women's and men's health around the world.

4.4 Getting the whole picture

Finally it is essential that strategies to improve the health of women (or men) are grounded in a rigorous analysis of the whole range of reproductive and productive activities undertaken across the lifespan. In the case of women this is especially problematic because of the invisibility of so many of their activities. Femaleness can no longer be equated with motherhood and the scope of health research needs to shift accordingly. Hence planners need to acquire much more information on the risks women face both in the home and in the workplace and a combination of biomedical and social research will be needed to make that possible.

Until recently, few researchers had examined the risks associated with domestic work. This is now beginning to change as new techniques are being developed to explore the 'black box' of the family. This has revealed a number of hazards that are especially dangerous for the poorest women. Analysis of the relationship between patterns of energy consumption and the volume of household work for instance suggests that some women's responsibilities impose long term damage on their health. A range of environmental risks have also been identified including lung damage caused by pollution from cooking stoves as well as a range of unregulated but toxic substances.

Women's work outside the home also needs much more attention from both researchers and policy makers. Though male workers die more often than females from work-related causes there are many parts of the world in which women's work related disease and disability is rapidly increasing. Evidence is only now beginning to emerge that traditionally 'female' jobs such as nursing and clerical work can pose both physical and psychological risks. The millions of women now taking on traditionally 'male ' jobs may also be facing serious risks especially if they are forced to combine heavy physical labour with domestic work and with reproduction.

If these issues are to be taken seriously, occupational health researchers need to develop greater gender sensitivity in their methods of investigation Their findings need to reflect both the different jobs done by women and men and also the biological and social differences that mediate the impact of waged work on health and well-being. Only then will regulatory bodies have accurate information on which to base health and safety at work policies that can benefit men and women equally.

We have identified a number of strategies that can be adopted to ensure that health reset carried our under the auspices of local, national and international organisations is gender sensitive, and provides an appropriate base for policy making. However it is also important to recognise that a great deal of information on gender issues is already available. Hence is essential that health planners and policy makers use the most up to date and gender sensitive resources as the basis for developing their services.

5. Mainstreaming gender in health service delivery

The mainstreaming of gender concerns into the planning, delivery and monitoring and evaluation of health services is a complex process. Lack of awareness or 'gender blindness' on the part of policy makers and planners frequently leads to gender bias and to the prioritisation of male interests in decision making. If this is to be avoided those involved need to have not only a clear understanding of the relevant issues but also the political will to reduce the inequalities between men and women.

This does not, of course, mean that both sexes should be treated in exactly the same way. Despite their commonalities, men and women will also have their own particular needs. Hence adherence to the principle of equity is required to ensure that these different needs are met, with equality in health as the desired outcome. Nor does it mean that all women (or all men) should receive the same treatment. Their varying circumstances will mean that here too a range of strategies will be needed if equality is to be achieved between women and between men.

5.1 Identifying gender concerns in the policy environment

If the goal of developing gender-sensitive policies is to be achieved, this needs to be built explicitly into the original objective of the programme in a way that can be used later for evaluation purposes. This will require a preliminary analysis of the context in which the policy will be operating and a clear understanding of the gender issues involved. This may be a relatively simple operation comparing the numbers of males and females in the target population and assessing the gender patterns in current service use. However the analysis will usually need to be taken a stage further to make sense of the gender relations between individuals and groups being counted.

The questions to be asked will vary depending on the type of policy being developed but in most health care contexts they should include some of the following

do gender differences in daily life expose women and men to different kinds of health risks?

how are existing gender differences in the use of services to be explained?

can any differences be observed in the quality of care women and men currently receive?

who currently controls access to health related resources and do the allocation criteria take into account the different needs of men and women?

These broader contextual issues may sometimes be difficult to map but unless they are woven into the implementation process at all stages the resulting policies will not be sensitive to women or men in their approach and inequitable in their effects. This can be illustrated by reference to some of the gender-related problems that have arisen in the process of health sector reform.

5.3 Putting gender issues into the planning process

If gender inequalities in health and health care are to be properly identified and tackled women themselves will need to be more involved in the design, implementation and evaluation of services. Because of the relative absence of women from most of the important arenas of decision making, special care may have to be taken to ensure that their views are heard. The most appropriate forms of consultation will vary with the circumstances but may include either discussion with representative groups or direct consultation with potential users.

If the planning process is to be as participatory as possible and the goal of greater equality is to be realised in practice there must be a serious commitment to these aims at the highest levels of government. This is best demonstrated through the creation of a national or regional policy framework within which both the planning process itself and delivery of services can be located. Though there is no single model for such a framework, a range of options already exist in countries with varying political and legal structures. Experience shows that little is likely to be achieved unless responsibility for the achievement of greater gender equality (both in health and elsewhere) is clearly allocated and the goal itself is given a high priority.

5.6 Monitoring and evaluation

Finally it is essential that all policies include gender issues in their strategy for monitoring and evaluation. This will enable service providers to measure the differential impact of the policy on men and women in their roles as both users and workers. The results will then provide the basis to plan any changes needed to promote greater gender equity and equality in health. And most importantly the lessons learned can be more widely disseminated to help those at an earlier stage of innovation. Again these monitoring and evaluation strategies need to be culturally sensitive and designed to reflect (and hopefully change) existing patterns of gender relations. However a range of practical tools are now available as a starting point for this work.

6. Putting gender equity and equality in health into a broader perspective

This paper has concentrated on the differences between men and women, exploring the impact of sex and gender on health and health care. It has identified existing gender inequalities in health care and mapped out some of the methods by which they can be tackled. However this can only be a starting point if the ultimate goal is to move towards gender equality in health on a community, a national or a global scale.

Health care is only one of the influences on health itself. Hence if gender inequalities in health are to be tackled successfully the strategy also needs to include a range of other public policies in areas as diverse as education, law and order, agriculture,

transport, social security and the legal system. In each of these areas gender equity needs to be a specific goal and targeted interventions need to be introduced to tackle traditional patterns of gender disadvantage. Only then will the root causes of gender inequalities in health be challenged.

In the development of macro economic policy for example, attention needs to be paid to the informal sector, to unpaid labour and to the 'care economy' so that the implications of any decisions for women's work receive appropriate attention. Similarly, legislation is required to create a 'level playing field' through the control of gender discrimination in access to social and economic resources. Looking at more specific areas of public policy, targeted interventions that can reduce gender inequalities in health include the development of an integrated policy to meet women's practical energy needs, female literacy programmes, special subsidies to meet the transport needs of rural women, strategies to increase women's management of water resources, and more provision of credit for women especially in the agricultural sector.

Finally it is essential that all policy makers recognise that gender inequalities are by no means the only determinant of health. As we have seen, the health of both sexes is also profoundly affected by issues such as class, race and socio-economic status. Thus policies to improve the health of women (or men) must also take factors such as these into account. Gender equity in health is an important goal but it is only one amongst many and broader issues of discrimination and disadvantage will have also have to be addressed if progress is to be made towards the achievement of gender equality and equal health for all.

B - Health care services and women's access

Structure of health care system:

The healthcare infrastructure in India consists of primary, secondary, and tertiary health care. The healthcare at these levels is provided by both public and private health care providers. But nowadays there is an increasing role of private healthcare providers in providing care to the care seekers. At the primary level of health care, we include community health centers (CHCs), Primary health centers (PHCs), and subcenters (SCs). While the sub-district hospitals come under the category of secondary health care and the tertiary level of health care includes the district hospitals and medical colleges. With a population of 1.21 billion, India stands at the second position among the most populous countries in the world, after China. India comprises 7 union territories and 29 states. These states and union territories are further sub-divided into districts and blocks. Thus, provision of health care to such a huge population is the biggest challenge faced by Indian government since after the independence. The

provision of health care needs some sound planning and management and also some policies with a strong implementation and management by the government bodies with private health care providers.

Structure of Health Care System in India Source:

While states are responsible for the functioning of the health care delivery system, Centre also has a responsibility towards the state's health care system in the form of policy making, planning, assisting and providing adequate funds to various provincial health authorities to implement national programs. While national level health care system is guided by the Union Ministry of Health and Family Welfare (MoHFW), there is a state department of Health and Family Welfare in each state, headed by a state minister. Each regional set-up covers 3-5 districts and works under the authority delegated by the state directorate of health services. Middle-level management of health services is the district level structure and it is a link between the state and regional structure on one hand and on the other hand is the peripheral structure such as Primary Health Care (PHC) and Sub-Centre (SC).

- **Role of Centre and state in health care system:** The most important challenge government faces in the health care delivery system is the distribution of responsibilities between states and the center. The central funding for any state is 36 percent of all public health expenditures and in some states, it is over 50 percent. In addition to funds provided by the central government, the planning commission also provided some additional central assistance to some states for undertaking further improvements in the health care system and infrastructure. The Centre has a responsibility to correct the uneven development and provide more resources to the states where vulnerabilities are more. Almost all the states have started introducing user charges for treatment in government hospitals from the people above the poverty line and use that fund so collected to improve the existing infrastructure and quality of health care in the respective institutions

Rural Healthcare System: The existing health care inequalities in the availability of India's healthcare are supposed to be as large as India's own population. When we talk about the health care, the whole population is divided into 2 parts. One is urban population and the second is rural population. The urban population lives in urban areas and they have somewhat better quality access to healthcare facilities such as district and sub-district hospitals because they are generally found nearby in the urban areas. However, the majority of the population lives in rural areas under the below the poverty line and have limited access to health care services and facilities. One of the bottlenecks in Indian healthcare system is that most of the population of India still relies on cultural remedies and traditional practices of healthcare. Rural health is a state subject and every state is trying to raise the standard of living of its people. To improve the health status of its people is one of the basic duties of a state. Today, India faces maternal mortality at a large scale and most of them happened in rural India. Thus, the child health is also influenced in rural areas of the country. Healthcare is the right of every citizen, but the lack of adequate infrastructure and unavailability of healthcare services and non-qualified health workers make India more vulnerable to health consequences. At the primary level of rural health care, we include Community Health Centres (CHC's), Primary Health Centres (PHC's) and Sub-centres (SC's). The healthcare system in rural India runs as a three-tier system based on the following population norms: in plain areas, every sub-centre covers a population of 5000 and in hilly or tribal areas it covers only a

population of 3000. Likewise, the primary health centers and community health centers also covered a definite proportion of the population. A primary health center covers 30,000 population in plain areas against the 20,000 of the population in hilly or tribal areas. According to the area, community health centers (CHC's) also have a different population norm. In plain areas, a CHC covers a population of 1,20,000 while in hilly areas this proportion of the population is limited only to 80,000.

- **Secondary Healthcare:** Secondary health care refers to the second tier of three tier structure of the Indian healthcare system in which patients refer from the primary healthcare to the specialist in better hospitals for treatment. In India, secondary healthcare includes district hospitals and community health centers at the block level Secondary health care also takes care of the primary health care needs of the urban population. The rural-urban migration leads to more urban population and this inevitably leads to over-crowding in the district hospitals and also to underutilization of the specialized services at the district hospitals. During the ninth five-year plan, it was an identified priority to boost the secondary health care system. As health is a state subject thus, every state tries to strengthen secondary health care in the state. In addition to the fund's states get from the central government or state plan, some states have taken the loan to build up district hospitals which are equipped with specialized machines and services.

Tertiary Health Care in India: The third level of Indian health care system is called as tertiary health care. At the tertiary health care, specialized preventive care is given to the patients usually on referral from primary and secondary health care centers. Tertiary health care includes medical colleges and advanced medical research institutes. Tertiary care has played a key role in achieving universal health care. Though it is required at the last stage of treatment or we can say that, only in 1 percent of cases, it plays an important role in calculating the healthcare system structure as a whole. As tertiary health care centers support primary and secondary health care, it is very necessary for effective care at the primary health care centers (PHCs and CHCs). The high cost of health care seeker in most of the health care system is due to the high expenses involved in tertiary health care centers. Tertiary health care center is a healthcare center within which medical education and research take place. While primary and secondary health care centers in the country are inadequate, tertiary care is even more inadequate because of the high expenses of installation and high expenses of seeking care in these health care centers.

Women's access to health care: Women in developing countries are frequently confronted with a myrias of socio-cultural factors which negatively impinge upon physical well-being and accessibility to appropriate health care services. Institutional, economic, and educational barriers effect and lowers their standard of living when compared to their male counterparts.

Women must become agents of change to improve their situation. Factors such as access to income, legal rights, social status, and education may prove far more important in determining women's access to health care than technology distribution and governmental strategies.

Unit 2

Defining reproductive health and reproductive rights issues and statistics

REPRODUCTIVE HEALTH :- Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life.[1] UN agencies claim sexual and reproductive health includes physical, as well as psychological well-being vis-a-vis sexuality.[2]

Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant.

Individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health.

REPRODUCTIVE RIGHT ISSUES AND STATISTICS :-

Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health that vary amongst countries around the world.[1] The World Health Organization defines reproductive rights as follows:Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[2]Women's reproductive rights may include some or all of the following: the right to legal and safe abortion; the right to birth control; freedom from coerced sterilization and contraception; the right to access good-quality reproductive healthcare; and the right to education and access in order to make free and informed reproductive choices.[3] Reproductive rights may also include the right to receive education about sexually transmitted infections and other aspects of sexuality, right to menstrual health[4][5] and protection from practices such as female genital mutilation (FGM).[1][3][6][7]Reproductive rights began to develop as a subset of human rights at the United Nation's 1968 International Conference on Human Rights.[6] The resulting non binding Proclamation of Tehran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children."[6][8] Women's sexual, gynecological, and mental health issues were not a priority of the United Nations until its Decade of Women (1975-1985) brought them to the forefront.[9] States, though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these rights have already been recognized in hard law, that is, in legally binding international human rights instruments, others have been mentioned only in non binding recommendations and, therefore, have at best the status of soft law in international law, while a further group is yet to be accepted by the international community and therefore remains at the level of advocacy.[10]Issues related to reproductive rights are some of the most vigorously contested rights' issues worldwide, regardless of the population's socioeconomic level, religion or culture.[11]The issue of reproductive rights is frequently presented as being of vital importance in discussions and articles by population concern organizations such as Population Matters.[12]Reproductive rights are a subset of sexual and reproductive health and rights

Data and Statistics

CDC's Division of Reproductive Health (DRH) monitors maternal and infant mortality, the most serious reproductive health complications. In addition, attention is focused on gathering data to better understand the extent of maternal and infant morbidity, adverse behaviors during pregnancy, and long-term consequences of pregnancy.

Public health surveillance is the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in public health practice. The public health approach to problem solving includes using surveillance data to identify problems and assess the effectiveness of interventions. Without accurate and timely data, public health programs suffer. This glossary is available of commonly used terms in public health surveillance and epidemiology.The major surveillance systems in the division include the Pregnancy Risk Assessment Monitoring System (PRAMS), the National ART Surveillance

System (NASS), and the Pregnancy Mortality Surveillance System (PMSS). CDC also collaborated with organizations to develop the Sudden Unexpected Infant Death (SUID) Case Registry, which seeks to improve population-based SUID surveillance in grantee states. Reports are generated from these systems on a routine ongoing basis. DRH also monitors teen pregnancy and the number and characteristics of women obtaining legal induced abortions in the United States. Point-in-time surveys are conducted to assess reproductive health in developing countries. DRH researchers sometimes analyze secondary data on such topics as ectopic pregnancy and hysterectomy.

Women HIV/AIDS & STD

HIV stands for human immunodeficiency virus. It harms your immune system by destroying the white blood cells that fight infection. AIDS stands for acquired immunodeficiency syndrome. It is the final stage of infection with HIV. Not everyone with HIV develops AIDS.
HIV often spreads through unprotected sex with a person who has HIV. Women can get it more easily during vaginal sex than men can. HIV may also spread by sharing drug needles or through contact with the blood of a person who has HIV.

About one in four people in the United States who have HIV are women. Women who have HIV/AIDS have some different problems from men, such as

- Complications such as repeated vaginal yeast infections, severe pelvic inflammatory disease (PID), and a higher risk of cervical cancer
- Different, sometimes more severe, side effects from the drugs that treat HIV/AIDS
- Drug interactions between some HIV/AIDS medicines and hormonal birth control
- The risk of giving HIV to their baby while pregnant or during childbirth
- Women often don't get diagnosed until they are in the later in the stages of HIV infection. This means that they may be more at risk of infections.

There is no cure, but there are many medicines to fight both HIV infection and the infections and cancers that come with it. People who get early treatment can live with the disease for a long time.

STDs and HIV.

People who have an STD may be at an increased risk of getting HIV. One reason is the behaviors that put someone at risk for one infection (not using condoms, multiple partners, anonymous partners) often put them at risk for other infections. Also, because STDs and HIV tend to be linked, when someone gets an STD it suggests they got it from someone who may be at risk for other STDs and HIV. Finally, a sore or inflammation from an STD may allow infection with HIV that would have been stopped by intact skin.

STDs can increase the risk of spreading HIV.

Persons with HIV are more likely to shed HIV when they have urethritis or a genital ulcer.[4, 5] When a person with HIV gets another STD such as gonorrhea or syphilis, it suggests that they were having sex without using condoms. If so, they may have spread HIV to their partners.

Some STDs are more closely linked to HIV than others.

In the US, both syphilis and HIV are highly concentrated epidemics among men who have sex with men (MSM).[6, 7] In 2018, MSM accounted for 77.6% of all primary and secondary syphilis cases among males in which sex of sex partner was known.[8] In Florida, in 2010, among all persons diagnosed with infectious syphilis 42% were also HIV infected.[9] Men who get syphilis are at very high risk of being diagnosed with HIV in the future; among HIV-uninfected men who got syphilis in Florida in 2003, 22% were newly diagnosed with HIV by 2011.[2] HIV is more closely linked to gonorrhea than chlamydia (which is particularly common among young women).[10] Herpes is also commonly associated with HIV; a meta-analysis found persons infected with HSV-2 are at 3-fold increased risk for acquiring HIV infection.[11, 12]

Some activities can put people at increased risk for both STDs and HIV.

- Having anal, vaginal, or oral sex without a condom;
- Having multiple sex partners;
- Having anonymous sex partners;
- Having sex while under the influence of drugs or alcohol can lower inhibitions and result in greater sexual risk taking.

Does treating STDs prevent HIV?

Not by itself. Given the close link between STDs and HIV in many studies, it seems obvious that treating STDs should reduce the risk of HIV. However, studies that have lowered the risk of STDs in communities have not necessarily lowered the risk of HIV. Risk of HIV was lowered in one community trial, but not in 3 others.

- In Mwanza (Tanzania), improved STD treatment lowered 2-year HIV incidence by 40% in the intervention towns (1.2%) compared to other towns (1.9%).[13]
- In Rakai (Uganda), a more intensive intervention (mass treatment and improved STD control) was done, leading to lower rates of syphilis and

trichomoniasis, but the incidence of HIV was the same in intervention and comparison towns (1.5% per year).[14]

- A third community trial found no difference in HIV incidence when behavioral plus STD control interventions were compared to usual services (Incidence rate ratio = 1.00), despite lower rates of syphilis (rate ratio 0.52) and gonorrhea (rate ratio 0.25).[15]
- A fourth community trial found HIV incidence was slightly higher in communities that received a combination of interventions including improved STD treatment when compared to control communities (incidence rate ratio 1.27, not statistically significant).[16]

Treating individuals for STDs has also not necessarily lowered their risk of acquiring HIV.

- One study found there was slightly lower risk of HIV seroconversion among female sex workers who had monthly exams for STD (5.3%) compared to sex workers who were examined when they had symptoms (7.6%, P=0.5); their rates of infection were lower for trichomonas (14% vs 7% P=0.07) but not for gonorrhea, chlamydia, or genital ulcers.[17]
- A second trial in female sex workers found a slightly higher incidence of HIV among women who received monthly treatment with azithromycin (4%) compared to women who did not (3.2%, P=0.5) despite major differences in the incidence of infection with gonorrhea (relative risk RR 0.46), chlamydia (RR 0.38), and trichomoniasis (RR 0.56).[18]

Three placebo-controlled trials have assessed the benefit to individuals from treatment with acyclovir to suppress genital herpes ulcers:

- One enrolled female sex workers who were infected with HSV but not HIV; it found no impact on HIV incidence in the acyclovir group (4.29%) compared to the placebo group (4.25%), though it also found no difference in reported episodes of genital ulceration or in measured HSV shedding.[19]
- A second study of HIV acquisition among persons infected with HSV-2 included women and men who have sex with men; HIV incidence was similar in the acyclovir group (3.9%) and the placebo group (3.3%) despite a 47% reduction in observed genital ulcers in the acyclovir group.[20]
- The third study looked at the effect of acyclovir on HIV transmission from heterosexuals infected with both HIV and HSV-2 to their HIV-uninfected

partners; after removing 29% of new infections that were apparently acquired from an outside partner, the incidence was similar in the acyclovir group (1.8%) and the placebo group (1.9%, P=0.69) despite major reductions in genital ulcer disease (risk ratio 0.39).[21]

Screening for STDs can help assess a person's risk for getting HIV. Treatment of STDs is important to prevent the complications of those infections, and to prevent transmission to partners, but it should not be expected to prevent spread of HIV.

What can people do to reduce their risk of getting STDs and HIV?

The only 100% effective way to avoid STDs is to not have vaginal, anal, or oral sex. If people are sexually active, they can do the following things to lower their chances of getting STDs and HIV:

- Choose less risky sexual behaviors;
- Use a new condom for every act of vaginal, anal, and oral sex throughout the *entire* sex act (from start to finish);
- Reduce the number of people with whom they have sex;
- Limit or eliminate drug and alcohol use before and during sex;
- Have an honest and open talk with their healthcare provider and ask whether they should be tested for STDs and HIV.
- Talk with their healthcare provider and find out if either pre-exposure prophylaxis, or PrEP, or post-exposure prophylaxis, or PEP, is a good option for them to prevent HIV infection.

If someone already has HIV, and subsequently gets an STD, does that put their sex partner(s) at an increased risk for getting HIV?

It can. HIV-negative sex partners are at greater risk of getting HIV from someone who is HIV-positive and acquires another STD. The HIV-negative sex partners of persons who are HIV-positive are less likely to get HIV if:

- HIV-positive persons use antiretroviral therapy (ART). ART reduces the amount of virus (viral load) in blood and body fluids. ART can keep HIV-positive persons healthy for many years, and greatly reduce the chance of transmitting HIV to sex partners if taken consistently.

- Sex partners take PrEP after discussing this option with his/her healthcare provider and determining whether it is appropriate.
- Choose less risky sex activities.
- Use a new condom for every act of vaginal, anal, and oral sex throughout the *entire* sex act (from start to finish).

Will treating someone for STDs prevent them from getting HIV?

No. It's not enough. Screening for STDs can help assess a person's risk for getting HIV. Treatment of STDs is important to prevent the complications of those infections, and to prevent transmission to partners, but it should not be expected to prevent spread of HIV.

If someone HIV-positive is diagnosed with an STD, they should receive counseling about risk reduction and how to protect their sex partner(s) from getting re-infected with the same STD or getting HIV.

UNIT 3

Unit 3

Women's health and household

Women's health- Being a man or a woman has a significant impact on health, as a result of both biological and gender-related differences. The health of women and girls is of particular concern because, in many societies, they are disadvantaged by discrimination rooted in sociocultural factors. For example, women and girls face increased vulnerability to HIV/AIDS.

Some of the sociocultural factors that prevent women and girls to benefit from quality health services and attaining the best possible level of health include:

unequal power relationships between men and women;

social norms that decrease education and paid employment opportunities;

an exclusive focus on women's reproductive roles; and

potential or actual experience of physical, sexual and emotional violence.

While poverty is an important barrier to positive health outcomes for both men and women, poverty tends to yield a higher burden on women and girls' health due to, for example, feeding practices (malnutrition) and use of unsafe cooking fuels (COPD).

Definitions and scope

Women's experience of health and disease differ from those of men, due to unique biological, social and behavioral conditions. Biological differences vary from phenotypes to the cellular biology, and manifest unique risks for the development of ill health.[1] The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[2] Women's health is an example of population health, the health of a specific defined population.[3]

Women's health has been described as "a patchwork quilt with gaps".[4] Although many of the issues around women's health relate to their reproductive health, including maternal and child health, genital health and breast health, and endocrine (hormonal) health, including menstruation, birth control and menopause, a broader understanding of women's health to include all aspects of the health of women has been urged, replacing "Women's Health" with "The Health of Women".[5] The WHO considers that an undue emphasis on reproductive health has been a major barrier to ensuring access to good quality health care for all women.[1] Conditions that affect both men and women, such as cardiovascular disease, osteoporosis, also manifest differently in women.[6] Women's health issues also include medical situations in which women face problems not directly related to their biology, such as gender-differentiated access to medical treatment and other socioeconomic factors.[6] Women's health is of particular concern due to widespread discrimination against women in the world, leaving them disadvantaged.[1]

A number of health and medical research advocates, such as the Society for Women's Health Research in the United States, support this broader definition, rather than merely issues specific to human female anatomy to include areas where biological sex differences between women and men exist. Women also need health care more and access the health care system more than do men. While part of this is due to their reproductive and sexual health needs, they also have more chronic non-reproductive health issues such as cardiovascular disease, cancer, mental illness, diabetes and osteoporosis.[7] Another important perspective is realising that events across the entire life cycle (or life-course), from in utero to aging effect the growth, development and health of women. The life-course perspective is one of the key strategies of the World Health Organization.[8][9][10]

Global perspective

Main article: Global health

Gender differences in susceptibility and symptoms of disease and response to treatment in many areas of health are particularly true when viewed from a global perspective.[11][12] Much of the available information comes from developed countries, yet there are marked differences between developed and developing countries in terms of women's roles and health.[13] The global viewpoint is defined as the "area for study, research and practice that places a priority on improving health and achieving health equity for all people worldwide".[14][15][16] In 2015 the World Health Organization identified the top ten issues in women's health as being cancer, reproductive health, maternal health, human immunodeficiency virus (HIV), sexually transmitted infections, violence, mental health, non communicable diseases, youth and aging.[17]

Women's health and household- In most households, women are the managers of their families' health care needs, Among mothers, about three-quarters report that they are the ones who usually take charge of health care responsibilities such as choosing their children's provider (79%), taking them to appointments (77%), and following through with recommended care (77%), compared to approximately a fifth of fathers who report they take care of these tasks. These rates have not changed significantly over the past decade. There are some variations between groups of women by marital status and education level Mothers and fathers differ somewhat on their assessment of their involvement in children's health care. While fathers are more likely to report that their partners take care of their children's health needs than themselves, they are also more likely than mothers to report that it is a joint responsibility

There is a dearth of evidence available on the occupational health hazards that may be encountered by women working in traditionally female jobs. In this overview, demographic data on the distribution of women in major employment areas are given and particular hazards such as stress and a variety of chemical and physical agents are discussed. Stress is considered in relation both to the nature of women's work and to the dual role of employment at home and in the paid workplace. Ergonomics, infections, and injuries on the job are considered. A review of this Forum is provided.

The protection of women exposed to ionizing radiation in the workplace has been intensively examined in recent years but no data concerning women workers themselves have been used. The emphasis has been on the possible exposure of the embryo/fetus, with no concern directed to the potential radiation induction of breast and thyroid cancer in the woman nor to the effect on the woman of adverse pregnancy outcome, which can also result from irradiation of the male germ cells. The recent risk estimates developed by the United Nations Scientific Committee on the Effects of Atomic Radiation from observations of biological effects on populations with nonoccupational exposure to ionizing radiation are presented. Surveys of average annual doses for occupationally exposed populations in hospitals show marked variation in radiation exposure from one country to another and for different medical specialties. Radiation exposure in brachytherapy and nuclear technology has been considerably higher than for X-ray technology. The improvements in radiation protection are a continuous process. The employment of both men and women in hospital and industrial settings where there is radiation

exposure will have to be evaluated more realistically in terms of the risk to the workers themselves and their reproductive integrity.

The toxicity of lead has been known for approximately 2000 years, but the issue of women exposed to lead in the workplace has received relatively little attention until recent years. The major thesis of this paper is that the fetus represents an organism which is sensitive to lead and that the fetus is exposed to lead through the mother by the fact that lead crosses the placental barrier. Fetal exposure to lead is, in the author's opinion, the critical issue involved in assessing occupational exposure to lead among women of childbearing age. Multiple studies have demonstrated that concentrations of lead in the mother's blood are comparable to concentrations of lead in umbilical cord blood at birth. Many investigators consider the demonstrated effects of lead upon the hematopoietic system to be the earliest effect associated with lead exposure. Control strategies which prevent significant alterations in the heme synthetic pathway of the mother should prevent such changes in the fetus and thus protect against the more serious adverse effects of fetal lead exposure.

Unit 4

Women and mental health

Women and men are different not only in their obvious physical attributes, but also in their psychological makeup. There are actual differences in the way women's and men's brains are structured and “wired” and in the way they process information and react to events and stimuli. Women and men differ in the way they communicate, deal in relationships, express their feelings, and react to stress. Thus, the gender differences are based in physical, physiological, and psychological attributes. There are psychological theories that present a gender sensitive viewpoint called as alpha bias, and there are others that are gender neutral representing beta bias. Alpha bias proposes that men and women are different and opposite, and in beta bias differences between men and women are ignored. Alpha bias is seen in psychodynamic theories and therapies where according to Freudian viewpoint, male anatomy and masculinity is the most desired and cherished goal and female anatomy and femininity are seen as a deviation. In contrast, the cognitive theories, behavioral theories, and humanistic-existential theories have beta bias.[1] Alpha bias could be rooted more in the social conditioning and power structure in the societies.

Gender roles have been culturally prescribed through the prehistoric cultures to the more civilized societies. In hunter-gatherer societies, women were generally the gatherers of plant foods, small animal foods, fish, and learned to use dairy products while men hunted meat from large animals. In more recent history, the gender roles of women have changed greatly. Traditionally, middle-class women are typically involved in domestic tasks emphasizing child care. For poorer women, economic necessity compels them to seek employment outside the home. The occupations that are available to them are; however, lower in pay than those available to men leading to exploitation. Gradually, there has been a

change in the availability of employment to more respectable office jobs where more education is demanded. Thus, although, larger sections of women from all socioeconomic classes are employed outside the home; this neither relieves them from their domestic duties nor does this change their social position significantly. For centuries, the differences between men and women have been socially defined and distorted through a lens of sexism in which men assumed superiority over women and maintained it through domination. This has led to underestimating the role a woman plays in the dyad of human existence.

It is necessary to understand and accept that women and men differ in biological attributes, needs, and vulnerabilities.

MENTAL HEALTH AND MENTAL DISORDERS

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism, mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience. On the other hand, a mental disorder or mental illness is an involuntary psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture.

Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness has received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.[2]

Analysis of mental health indices and data reveals that the patterns of psychiatric disorder and psychological distress among women are different from those seen among men. Symptoms of depression, anxiety, and unspecified psychological distress are 2–3 times more common among women than among men; whereas addictions, substance use disorders and psychopathic personality disorders are more common among men. The World Health Organization report[2] lays out these facts effectively. It has further been suggested that observed gender differences in the prevalence rates originate from women and men's different average standings on latent internalizing and externalizing liability dimensions with women having a higher mean level of internalizing while men showing a higher mean level of externalizing.[3]

WOMEN'S MENTAL HEALTH: THE FACTS (WORLD HEALTH ORGANIZATION REPORT, 2001)[2]

Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men

Leading mental health problems of the elderly are depression, organic brain syndromes, and dementias. A majority are women

An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children

Lifetime prevalence rate of violence against women ranges from 16% to 50%

At least one in five women suffers rape or attempted rape in their lifetime.

COMMON MENTAL DISORDERS

Gender differences occur particularly in the rates of common mental disorders (CMDs)-depression, anxiety, and somatic complaints wherein women predominate. Unipolar depression, which is predicted to be the second leading cause of global disability burden by 2020, is twice as common in women. Furthermore, the lifetime risk of anxiety disorders (e.g., generalized anxiety disorder) is 2–3 times higher in females as compared to males.[4]

Moreover, depression is not only the most common women's mental health problem, but may be more persistent in women than men.[5] Although depressive symptoms in men and women have generally been found to be similar overall, women are more likely to present with atypical or “reverse vegetative” symptoms such as increased appetite and weight gain. In case of anxiety disorders, females have greater severity of symptoms, have more often comorbid depression and complicated course.[4]

As across the world, studies in India have shown that CMD such as depression and anxiety are strongly associated to female gender besides poverty. Both community-based studies and studies of treatment seekers indicate that women are, on average, 2–3 times, at greater risk to be affected by CMD.[6] In light of this convincing evidence that CMD are more common in women, the next most intriguing question is what makes females apparently more vulnerable. Hormonal factors related to the reproductive cycle may play a role in women's increased vulnerability to depression.[7] Another answer

may be that the factors independently associated with the risk for CMD are factors indicative of gender disadvantage. These factors include excessive partner alcohol use, sexual, and physical violence by the husband, being widowed or separated, having low autonomy in decision making, and having low levels of support from one's family.[8,9,10] Furthermore, stressful life events are closely associated with the occurrence of depression in vulnerable individuals. During their lifetimes, females are faced with various life stressors including childbirth and maternal roles, caring and nurturing the old and sick of the family. In addition, women are less empowered due to lesser opportunities of education and respectable employment. Moreover, even those who are financially secure fear to cross social lines and therefore too are apparently vulnerable.

SEVERE MENTAL ILLNESS

Although severe mental disorders such as schizophrenia and bipolar disorders are less prevalent than CMD, the chronic course and associated disability make these disorders severe. In addition, the stigma associated with these illnesses has a major impact not only on the sufferer but also on the families. Also, the families are burdened with the care of these patients for almost their entire lives in a great number of cases. Needless to say, the emotional and financial strain on the caregivers may be overwhelming.

There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect <2% of the population.[11] Gender differences have been reported, however, in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course of these disorders, social adjustment, and long-term outcome. The clinical features of bipolar disorder differ between men and women; women have more frequent episodes of depression, more commonly have “rapid cycling” and a seasonal pattern of mood disturbances.[12] Large cross-cultural studies in schizophrenia have shown that “female gender” is associated with a better course and outcome of schizophrenia in the developing countries. Furthermore, females have a later age of onset of schizophrenia as compared to that in males.

Although female gender is associated with a favorable outcome, social consequences such as abandonment by marital families, homelessness, vulnerability to sexual abuse, and exposure to HIV; and other infections contribute to the difficulties of rehabilitation of women. The prevalence rates for sexual and physical abuse of women with severe mental illnesses are twice those observed in the general population of women. In India, the absence of any clear policies for the welfare of severely ill women, and the social stigma further compounds the problem.[6] Stigma has been reported to be more toward ill women than men and also, women caregivers become the target of stigma.[13,14]

Suicide

Studies of suicide and deliberate self-harm have revealed a universally common trend of more female attempters and more male completers of suicide. However, in contrast to the data from many other countries, except China, which records the highest female suicide rate, women outnumber men in completed suicides in India, although the gap between them is narrow.[15] Biswas et al.[16] found that girls from nuclear families and women married at a very young age to be at a higher risk for attempted suicide and self-harm. The suicide rate by age for India reveals that the suicide rates peak for both men and women between the age 18 and 29 while in the age group 10–17, the rate for the female exceeded the male figure.

In his seminal studies, Emile Durkheim had vividly demonstrated over a century ago, that sociocultural factors are significant determinants of suicide behavior and perhaps these impact men and women differently. In an Indian study, the 1-year incidence of attempted suicide was 0.8%, and seven of these women (37%) had baseline CMDs. CMD, exposure to violence, and recent hunger were the strongest predictors of the incident attempted suicide cases.[17] A large degree of attempts is as a response to failures in life, difficulties in interpersonal relationships, and dowry-related harassment.[16] The precipitants for suicide, according to Indian government statistics, among women compared to men are as follows: Dowry disputes (2.9% versus 0.2%); love affairs (15.4% versus 10.9%); illegitimate pregnancies (10.3 versus 8.2); and quarrels with spouse or parents-in-law (10.3% versus 8.2%). The common causes for suicide in India are disturbed interpersonal relationships followed by psychiatric disorders and physical illnesses.[15] Spousal violence has been found to be specifically associated as an independent risk factor for attempted suicide in women.[18]

Violence and abuse

According to an eye-opening United Nations report, around two-third of married women in India were victims of domestic violence and one incident of violence translated into women losing 7 working days in the country. Furthermore, as many as 70% of married women between the ages of 15 and 49 years are victims of beating, rape or coerced sex.[19] The common forms of violence against Indian women include female feticide (selective abortion based on the fetus gender or sex selection of child), domestic violence, dowry death or harassment, mental and physical torture, sexual trafficking, and public humiliation. The reproductive roles of women, such as their expected role of bearing children, the consequences of infertility, and the failure to produce a male child have been linked to wife-battering and female suicide.[20,21]

Sexual coercion is a serious and prevalent concern among female Indian psychiatric patients. Sexual coercion was reported by 30% of the 146 women in an Indian study. The most commonly reported experience was sexual intercourse involving threatened or actual physical force (reported by 14% of

women), and the most commonly identified perpetrator was the woman's husband or intimate partner (15%), or a person in a position of authority in their community (10%).[22]

The consequences of gender-based violence are devastating including life-long emotional distress, mental health issues including posttraumatic stress disorder and poor reproductive health. Common mental health problems experienced by abused women include depression, anxiety, posttraumatic stress, insomnia, and alcohol use disorders, as well as a range of somatic and psychological complaints. Battered women are much more likely to require psychiatric treatment and are much more likely to attempt suicide than nonbattered women.[23] The cross-sectional data from a recent study, in India showed an association between violence and a range of self-reported gynecological complaints, low body mass index, depressive disorder, and attempted suicide.[18] In summary, women are subjected to an alarming amount of violence in childhood and adulthood, and the effects of this violence are often profound and long-term.

REPRODUCTIVE HEALTH

Mood and behavioral changes have been observed to be associated with menstrual cycle since ancient times. The symptoms such as irritability, restlessness, anxiety, tension, migraine, sleep disturbances, sadness, dysphoria, and the lack of concentration occur more frequently during the premenstrual and menstrual phase. A premenstrual dysphoric disorder consisting of extremely distressing emotional and behavioral symptoms is closely linked to the luteal phase of the menstrual cycle.

Mental disturbances frequently occur during late pregnancy and in the postpartum period. Postpartum blues is the most common and least severe postpartum illness affecting between 50% and 80% of new mothers,[24] whereas postpartum depression constitutes a major depressive episode with an onset within 6 weeks postpartum in a majority of cases. In India, depression occurs as frequently during late pregnancy and after delivery as in developed countries, but there are cultural differences in risk factors. In a study in rural Tamil Nadu,[25] the incidence of postpartum depression was 11%. Low income, birth of a daughter when a son was desired, relationship difficulties with mother-in-law and parents, adverse life events during pregnancy and lack of physical help are all risk factors for the onset of postpartum depression. In addition, the postpartum period carries the potential for exacerbation of psychiatric symptoms in women with the preexisting mental illness. Similarly, a recent systematic review[26] on nonpsychotic common perinatal disorders (CPMD) among women from low and middle income countries estimated that about one in six pregnant women and one in five women who have recently given birth experience a CPMD. The risk is highest among the most socially and economically disadvantaged women. The other important risk factors include gender-based factors such as the bias against female babies; role restrictions regarding housework and infant care; and excessive unpaid workloads; especially in multi-generational households in which a daughter-in-law has little autonomy,

and gender-based violence.[26] Also, menopause is a time of change for women not only in their endocrine and reproductive systems, but also their social and psychological circumstances. It has long been known that menopause is accompanied by depression and other mental disturbances.

Reproductive health factors, particularly gynecological complaints such as vaginal discharge and dyspareunia are independently associated with the risk for CMD. More importantly, gynecological symptoms may actually be somatic equivalents of CMD in women in Asian cultures.[8]

SUBSTANCE USE

Although there are variations between countries, rates of substance abuse – particularly abuse of alcohol, tranquillizers, and analgesics – are increasing around the world.[5] Women are more likely to attribute their drinking to a traumatic event or a stressor and women who abuse alcohol or drugs are more likely to have been sexually or physically abused than other women.[27] Significantly more major depression and anxiety disorders are found in females with alcoholism. Thus, the profile of women with substance use problems differs from that in male abusers. However, despite increasing rates, services to assist women are limited.[5]

WOMAN - A LIFE CYCLE OF VULNERABILITIES

As mentioned earlier, in many of the disorders, social factors and gender specific factors determine the prevalence and course in female sufferers. In fact, the numbers are meaningless without considering the sociocultural factors. Thus, depression, anxiety, somatic symptoms, and high rates of comorbidities are significantly related to interconnected and co-occurring risk factors such as gender based roles, stressors, and negative life experiences and events.

Gender determines the differential power and control that men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility, and exposure to specific mental health risks. A strong inverse relationship exists between social position and physical and mental health outcomes. Hence, the effect of the biological vulnerability is increased by the social disadvantages that women have. Pressures are created by their multiple roles and the unremitting responsibility of caring of others. In addition, gender specific risk factors such as gender discrimination and associated factors of poverty, hunger, malnutrition, overwork, domestic violence, and sexual abuse combine to account for women's poor mental health. There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. In addition, severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression.

Furthermore, the expectation about what constitutes illness is gender biased. Thus, the somatic complaints that form the most prominent presentation of CMD may not be taken into account by the care providers. A gender bias more often than not ensures that the symptoms are taken less seriously than they are for men. The impact of mental health problems also shows a gender differential. For example, whereas women are required to be the primary care givers if their husbands were mentally ill, it is themselves who still need to carry on with the role of care giving to the family despite their problems.

The sociopolitical scene in South-East Asia including India in the mildest of terms is bleaker when compared to the Western world.[6,28] Wrath of dowry practices, a firm patriarchal family system with the woman having little say, lesser opportunities for education, and employment add to the plight of women. Women's mental health tends to suffer as they are faced with stressors and are ill-equipped to cope with the same.

Furthermore, when a woman becomes mentally ill, services are sought infrequently and late. Rather she is blamed for the illness. The mentally ill woman may be socially ostracized and abandoned by her husband and her own family. Hence, being a “woman” and being “mentally ill” is a dual curse. Even though some authors feel that marriage protects against psychological breakdown, it is not always true. Several studies show that there is greater distress in married women as compared to married men. The birth of a child, abortion or miscarriage, economic stresses, and major career changes are some of the stressful events in married life; many of these are gender specific.[29]

The responsibility of care for the mentally ill women is often left to her own family than to husband or his family. In a study, of women with schizophrenia and broken marriages, Thara et al.[13,14] found that the stigma of being separated/divorced is often felt more acutely by families and patients than the stigma of having a mental illness. Feelings of disruption, loss, guilt, frustration, grief, and fear about the future of their daughter make the caregivers miserable.

SERVICE PROVISION AND UTILIZATION

Psychiatric epidemiological data cite a ratio of one woman for every three men attending public health psychiatric outpatients’ clinics in urban India. Indian state officials view this as “under-utilization” by suffering women, attributing it to the greater stigma attached to women's mental illness that restricts help-seeking in public health facilities and/or to the lower importance accorded to women's health generally.[30]

Gender heightens the discrepancy between prevalence and utilization. This low attendance is partly explained by the lack of availability of resources for women in the hospital settings. The mental hospitals appear to cater primarily to men in distress, and there is sex-based discrimination in the availability of beds. The male:female ratio for the allotment of beds in government mental hospitals with only service was 73%:27% while those with service, research, and training was 66%:34%.[20]

WHAT NEEDS TO BE DONE?

It is therefore, amply clear that women's mental health cannot be considered in isolation from social, political, and economic issues. A woman's health must incorporate mental and physical health across the life cycle and should reach beyond the narrow perspective of reproductive and maternal health, which is often the focus of our policies.

In the discussion of the determinants of poor mental health of women, the focus needs to be shifted from individual and “lifestyle” risk factors to the recognition of the broader, social, economic, and legal factors that affect women's lives. It is essential to recognize how the sociocultural, economic, legal, infrastructural, and environmental factors that affect women's mental health are configured in the given community setting.

If the efforts to promote women's mental health focus solely on the reduction of individual “lifestyle” risk factors, they may neglect the very factors that bring that lifestyle into being. Moreover, if the individual factors are focused in isolation, ignoring the sociocultural factors, there is an additional risk of placing the responsibility of change on the women alone. However, the truth is that largely the change is beyond their control and lies in the bigger social change. Inadvertently, the failure to change and improvise the mental health may be misattributed to the women.

Education, training, and interventions targeting the social and physical environment are crucial for addressing women's mental health. Identification of significant persons in government departments and other relevant groups in the community, to obtain and document data indicating the extent of women's problems and the burden associated with women's mental problems and the development of policies to protect and promote women's mental health are extremely crucial.

Interventions at various levels aiming at both individual women and women as a large section of the society are essential. These should be implemented at primary care delivery as well on legal and judicial

fronts. The primary care providers must be aware of the major mental health problems affecting women, routinely enquire about common mental health problems, provide the most appropriate intervention and support and provide education to the community on issues related to the mental health of women. Women are increasingly joining the workforce, and there is great potential to intervene at this level too.

There are many reasons why women are reluctant to report incidents of assault and abuse to police. These include: A belief that the incident is a “normal” part of life; feeling responsible for the violent incident; intimidation by the partner; fear of reprisal; financial dependence; continuing love or affection for the partner; inability to respond as a result of the psychological and emotional trauma arising from repeated abuse; and intimidation by the whole legal process. Barriers to an effective criminal justice response also relate to the attitudes and beliefs of those people working within the criminal justice system. Taking into account the above, it is imperative to improve the criminal justice response to violence against women. The initiative of Government of India asking citizens to report any incident of domestic violence that they might have witnessed is commendable and may go a long way to provide security to the women.

The more fundamental need is the woman/girl's education. Being educated provides awareness of rights and resources, the capability to fight exploitation and injustice. Education will also lead to better chances of economic independence, which is so crucial.

It is essential to develop and adopt strategies that will improve the social status of women, remove gender disparities, provide economic and political power, increase awareness of their rights, and so on. Although much depends upon the policy makers and planners, but women must also learn to speak for themselves. Women must act as social activists to fight against the social evils, which are responsible for their woes. Women's anti-alcohol movement in Andhra Pradesh where they destroyed the liquor shops to fight drunkenness of their husbands is a historical landmark. Similar movements to fight prostitution, sexual abuse, and domestic violence could be historical leading steps.

In summary, concerted efforts at social, political, economic, and legal levels can bring change in the lives of Indian women and contribute to the improvement of the mental health of these women.

Women and disability causes and management

Women with disabilities may need specialty care to address their individual needs. In addition, they need the same general health care as women without disabilities, and they may also need additional

care to address their specific needs. However, research has shown that many women with disabilities may not receive regular health screenings within recommended guidelines.3

This section of our website has tools and health information for women with disabilities.

Breast Cancer Screening: The Right To Know

Breast cancer is a major public health concern for all women, including women with disabilities. Women who have disabilities are just as likely as women without disabilities to have ever received a mammogram. However, they are significantly less likely to have been screened within the recommended guidelines. CDC has developed a family of health promotion materials (e.g., posters, MP3 files, low-tech fliers, print advertisements, and tip sheets) to increase awareness of breast cancer among women with physical disabilities and encourage these women to get screened. Materials share the tagline “Breast Cancer Screening: The Right To Know” and feature four women with physical disabilities who have survived breast cancer.

Breast Cancer Screening: The Right To Know »

Cervical Cancer Screening

Cervical cancer is the easiest female cancer to prevent, with regular screening tests and follow-up. It also is highly curable when found and treated early. All women are at risk for cervical cancer, including women with disabilities. It occurs most often in women over age 30. It is important to get tested for cervical cancer because 6 out of 10 cervical cancers occur in women who have never received a Pap test or have not been tested in the past five years. Learn more about cervical cancer screening.

Cervical Cancer Screening »

Center for Research on Women with Disabilities (CROWD)

CROWD promotes, develops, and disseminates information to improve the health and expand the life choices of women with disabilities. The site provides information on sexuality, reproductive health, self-esteem, stress management, and more.

CROWD »external icon

WomensHealth.gov

The federal government's source for women's health information.

WomensHealth.gov »external icon

Women's Health Information from CDC

CDC's website on women's health: working to promote and protect the health, safety, and quality of life of women at every stage of life.

Women's Health Information »

Healthy Living

People with disabilities need health care and health programs for the same reasons anyone else does—to stay well, active, and a part of the community.

Having a disability does not mean a person can't be healthy. Being healthy means the same thing for all of us—getting and staying in good physical, mental, and emotional health so we can lead full, active lives. That means having the tools and information to make healthy choices and knowing how to prevent illness.

Learn more about healthy living »

Intimate Partner Violence

About 1 in 4 women have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. Research has shown that women with a disability are more likely to experience intimate partner violence (IPV) than those without a disability. In fact, researchers found that, compared to women without a disability, women with a disability were significantly more likely to

report experiencing each form of IPV measured, which includes rape, sexual violence other than rape, physical violence, stalking, psychological aggression, and control of reproductive or sexual healthu.4

Violence and women's health

Violence occurs in about 35 per cent of women globally in their lifetime1. In a study done in India, on about 10000 women, 26 per cent reported having experienced physical violence from spouses during their lifetime2. The prevalence could be as high as 45 per cent as indicated by data from Uttar Pradesh3. Latest figures from the National Crime Records Bureau4 show that a crime was recorded against women every three minutes. Every hour, at least two women are sexually assaulted and every six hours, a young married woman is beaten to death, burnt or driven to suicide. It is appalling to learn that 28.4 per cent of pregnant women suffer domestic violence5. As a result of violence, women suffer social isolation, unemployment, income loss, poor self-care and fail to provide childcare, which is a grave concern. Multi-Country Study on Women's Health and Domestic Violence Against Women by the World Health Organization (WHO) reported that 40 and 60 per cent of women surveyed in Bangladesh, Ethiopia, Peru, Samoa, Thailand and Tanzania revealed that they had been physically and/or sexually abused by their close partners6.

United Nations defines ‘violence against women’ as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”7 The role of health professionals in providing care for the survivors can be better understood and addressed from the perspective of the WHO definition of ‘health’, which defines it as ‘an individual's state of physical, mental and social well-being’8.

Physical health: Intimate partner violence with sexual violence is associated with high risk of pregnancy, sexually transmitted diseases (STDs) and HIV infection9. Hence, there is a need to sensitize the doctors who will be able to immediately initiate prophylaxis for pregnancy, STDs and post-HIV exposure in survivors. Other symptoms which need to be addressed, include wounds, lacerations, cuts, bruises, contusions, menstrual disorders, vaginal discharge, dizziness, severe sexual dysfunction, and memory loss.

There should be a structured protocol for comprehensive assessment to provide holistic support in suspected cases, particularly in women presenting with physical injuries to general hospitals. Sometimes hospital admission for appropriate assessment in suspected violence may be required. District hospitals should have a full time, qualified, forensic medical professional and his/her availability could be possibly extended to Taluk hospitals. It should become a routine practice to compulsorily report all cases of

violence against women and provide care to them. A detailed structured assessment of the survivors is to be incorporated in undergraduate curriculum and training.

Mental health: In a survey, 40 per cent of the survivors had poor mental health10. Violence leads to mental disorders such as depression, post-traumatic stress disorder (PTSD), anxiety disorders, self-harm and sleep disorders9. Chronic violence of increased severity is associated with severe depressive disorders. In a study of female psychiatric outpatients with history of intimate partner violence, 14 per cent were identified as having PTSD11. In another study on urban women, 22.3 per cent of them had suicidal thoughts and 3.4 per cent had attempted suicide12. The presenting physical symptoms may have psychological origin, i.e., somatoform disorders, where survivors seek cure of their imperceptible emotional distress through physical complaints. These include headache, back pain, neck pain, joint pains or stomach cramps. Psychologically, there is prevailing mistrust, loss of confidence, guilt, shame and feelings of helplessness with particular reference to intimate partner violence.

All such patients presenting with a history of violence should undergo a standardized and simplified mental health screening, to exclude depression, PTSD and suicide risk. Some may need referral for a specialist mental health assessment. As a minimum standard, psychosocial support and counselling should be accessible and commenced early. This could be made a part of undergraduate training where students would learn to detect, counsel and refer the severely unwell survivors to specialists. There is a pressing need to develop guidelines for all cases of violence disclosed by women. Early detection, counselling and other psychological support in the long term is likely to significantly reduce psychiatric morbidity and mortality.

Social well-being: Social and economic costs of intimate partner and sexual violence have serious implications throughout our society13. A survey showed that only 25 per cent survivors sought help to end violence, whereas 33 per cent never told anyone14. The survivors hardly ever approached the police, yet felt secure in seeking physical health care in hospital settings. More often survivors return to perpetrators as they believe there is no other place to reside, which leads to further exposure to violence and it becomes a vicious circle. Women with disabilities (such as hearing, visually, speech and intellectual disabled) are highly vulnerable to sexual assault15. They may not be able to defend themselves during the crime and also post that fight for justice.

All district hospitals should have a woman and child welfare section with a medical social worker from the Social Welfare Department to assist survivors and also in crisis. Basic issues such as, transportation, food and also clothing are not generally addressed. All survivors should be given legal information including free legal aid. Non-governmental organizations (NGOs) working with women and children

should be supported since these can contribute in providing holistic care. Community education and sensitization regarding women's rights, awareness on domestic violence act needs to be spread across all district hospitals. There is an urgent need to educate the public to stop victimizing or blaming the survivors. Family members may go through emotional distress and may not accept the survivor. Hence, there is a need to have family therapy to enable the family to cope and support the survivor.

Comprehensive care for survivors (CCS): Health and Family Welfare department of all states should work in liaison with judiciary, women and child welfare department, social welfare department, police department and NGOs to provide comprehensive care for survivors. All the sensitive issues rising out of the violence including crisis intervention, physical and mental care, legal aid, socio-economic support, temporary shelter, child custody, re-integration into society, confidence building, counselling, psychosocial support, family therapy, sexual counselling, vocational rehabilitation and follow up care should be delivered under one roof.

A supportive sensitive system needs to be developed, in which the survivor is assisted by a recovered survivor in educating, sensitizing, supporting, counselling, lodging the complaint, physical examination, fighting for justice, rehabilitation and re-integrating into society15. Improved socio-economic status, better education and also increased access to social support system possibly are protective factors against spousal physical violence and mental health issues2. There are innumerable challenges from political will to educating the society in implementing the comprehensive care programme. To address such complex issues, pilot projects need to be done in a few districts across the country. All sectors including education, health, legal, and judicial must work in liaison to address the issue16. There is an urgent need to train the health personnel, police department, judiciary, women and child welfare department and all other people involved in providing care.

The WHO indicates that it is necessary to recognize victims of intimate partner violence, sexual violence, or their suicidal behaviour. The individual cases of violence to women often first come to attention with health care providers. The psycho-social care is generally not available13 and this leaves a large gap in terms of much required comprehensive care7. Recent WHO guidelines emphasize role for physicians and other health professionals, as key gatekeepers in efforts to monitor, identify, treat, and intervene1.

In conclusion, violence against women creates a sense of insecurity and fear in the community. The complex issue can be tackled by providing comprehensive care pro-actively. A multi-dimensional and multi-agency team including access to psychosocial support is to be made available to deliver holistic care under one roof in district hospital setting. Also implementing primary prevention programmes such

as life skills training programme, gender sensitization and sex education in all schools and colleges will go a long way.

Counselling women and stress management

Counselling women - All women who are experiencing or have experienced domestic abuse will need emotional support of some kind, but their needs will vary. All women need to be listened to with respect and without being judged when they choose to talk about their experiences.

They want to be believed – and to feel they have been understood. Mutual support from other women who have had similarly abusive experiences can be very valuable: it will help you to feel less isolated and to recognise that none of the abuse you experienced was your fault.

You will get this kind of support if you go into a refuge or if you use a Women's Aid outreach service, join a support group or attend the Freedom Programme

Some women may benefit from more formal counselling or psychotherapy – though not usually while they are still living with their abuser or immediately after escaping from the violence, when physical safety and practical issues are likely to be of greater concern.

If you decide you would like some counselling, the following information may help you:

Counselling is a two-way relationship, in which the counsellor listens to whatever you want to say, in confidence and without making judgements.

Counsellors are not supposed to give advice, but they may ask questions or challenge you in ways which may help you to look more carefully at some of the assumptions you may have taken for granted.

Usually you will have regular sessions, for an hour or slightly less, each week or every two weeks. Psychotherapy tends to be more intensive than counselling, and may continue for a longer period of time, as issues are explored in more depth. Some practitioners, however, use these terms interchangeably.

The aim of counselling is to help you understand yourself better and come to terms with what has happened to you.

Good counselling will help you to break away from past abusive relationships and work towards living in a way which is more satisfactory and fulfilling for you. It can also help you to build up your self esteem.

However, counselling is not for everyone – and you have to decide whether it is right for you and whether this is the right time for it.

Stress management - It may seem that there's nothing you can do about your stress level. The bills aren't going to stop coming, there will never be more hours in the day for all your errands, and your career or family responsibilities will always be demanding. But you have a lot more control than you might think. In fact, the simple realization that you're in control of your life is the foundation of stress management.

Managing stress is all about taking charge: taking charge of your thoughts, your emotions, your schedule, your environment, and the way you deal with problems. The ultimate goal is a balanced life, with time for work, relationships, relaxation, and fun – plus the resilience to hold up under pressure and meet challenges head on.

Identify the sources of stress in your life

Stress management starts with identifying the sources of stress in your life. This isn't as easy as it sounds. Your true sources of stress aren't always obvious, and it's all too easy to overlook your own stress-inducing thoughts, feelings, and behaviors. Sure, you may know that you're constantly worried about work deadlines. But maybe it's your procrastination, rather than the actual job demands, that leads to deadline stress.

To identify your true sources of stress, look closely at your habits, attitude, and excuses:

Do you explain away stress as temporary ("I just have a million things going on right now") even though you can't remember the last time you took a breather?

Do you define stress as an integral part of your work or home life ("Things are always crazy around here") or as a part of your personality ("I have a lot of nervous energy, that's all").

Do you blame your stress on other people or outside events, or view it as entirely normal and unexceptional?

Until you accept responsibility for the role you play in creating or maintaining it, your stress level will remain outside your control.

Start a stress journal

A stress journal can help you identify the regular stressors in your life and the way you deal with them. Each time you feel stressed, keep track of it in your journal. As you keep a daily log, you will begin to see patterns and common themes. Write down:

What caused your stress (make a guess if you're unsure).

How you felt, both physically and emotionally.

How you acted in response.

What you did to make yourself feel better.

Look at how you currently cope with stress

Think about the ways you currently manage and cope with stress in your life. Your stress journal can help you identify them. Are your coping strategies healthy or unhealthy, helpful or unproductive? Unfortunately, many people cope with stress in ways that compound the problem.

Unhealthy ways of coping with stress

These coping strategies may temporarily reduce stress, but they cause more damage in the long run:

- Smoking
- Drinking too much
- Overeating or undereating
- Zoning out for hours in front of the TV or computer
- Withdrawing from friends, family, and activities
- Using pills or drugs to relax
- Sleeping too much
- Procrastinating
- Filling up every minute of the day to avoid facing problems
- Taking out your stress on others (lashing out, angry outbursts, physical violence)

Learning healthier ways to manage stress

If your methods of coping with stress aren't contributing to your greater emotional and physical health, it's time to find healthier ones. There are many healthy ways to manage and cope with stress, but they all require change. You can either change the situation or change your reaction. When deciding which option to choose, it's helpful to think of the four As: avoid, alter, adapt, or accept.

Since everyone has a unique response to stress, there is no "one size fits all" solution to managing it. No single method works for everyone or in every situation, so experiment with different techniques and strategies. Focus on what makes you feel calm and in control.

Dealing with Stressful Situations: The Four A's

Change the situation:

Avoid the stressor.

Alter the stressor

Change your reaction:

Adapt to the stressor.

Accept the stressor.

Stress management strategy #1: Avoid unnecessary stress

Not all stress can be avoided, and it's not healthy to avoid a situation that needs to be addressed. You may be surprised, however, by the number of stressors in your life that you can eliminate.

Learn how to say "no" – Know your limits and stick to them. Whether in your personal or professional life, refuse to accept added responsibilities when you're close to reaching them. Taking on more than you can handle is a surefire recipe for stress.

Avoid people who stress you out – If someone consistently causes stress in your life and you can't turn the relationship around, limit the amount of time you spend with that person or end the relationship entirely.

Take control of your environment – If the evening news makes you anxious, turn the TV off. If traffic's got you tense, take a longer but less-traveled route. If going to the market is an unpleasant chore, do your grocery shopping online.

Avoid hot-button topics – If you get upset over religion or politics, cross them off your conversation list. If you repeatedly argue about the same subject with the same people, stop bringing it up or excuse yourself when it's the topic of discussion.

Pare down your to-do list – Analyze your schedule, responsibilities, and daily tasks. If you've got too much on your plate, distinguish between the "shoulds" and the "musts." Drop tasks that aren't truly necessary to the bottom of the list or eliminate them entirely.

Stress management strategy #2: Alter the situation

If you can't avoid a stressful situation, try to alter it. Figure out what you can do to change things so the problem doesn't present itself in the future. Often, this involves changing the way you communicate and operate in your daily life.

Express your feelings instead of bottling them up. If something or someone is bothering you, communicate your concerns in an open and respectful way. If you don't voice your feelings, resentment will build and the situation will likely remain the same.

Be willing to compromise. When you ask someone to change their behavior, be willing to do the same. If you both are willing to bend at least a little, you'll have a good chance of finding a happy middle ground.

Be more assertive. Don't take a backseat in your own life. Deal with problems head on, doing your best to anticipate and prevent them. If you've got an exam to study for and your chatty roommate just got home, say up front that you only have five minutes to talk.

Manage your time better. Poor time management can cause a lot of stress. When you're stretched too thin and running behind, it's hard to stay calm and focused. But if you plan ahead and make sure you don't overextend yourself, you can alter the amount of stress you're under.

Stress management strategy #3: Adapt to the stressor

If you can't change the stressor, change yourself. You can adapt to stressful situations and regain your sense of control by changing your expectations and attitude.

Reframe problems. Try to view stressful situations from a more positive perspective. Rather than fuming about a traffic jam, look at it as an opportunity to pause and regroup, listen to your favorite radio station, or enjoy some alone time.

Look at the big picture. Take perspective of the stressful situation. Ask yourself how important it will be in the long run. Will it matter in a month? A year? Is it really worth getting upset over? If the answer is no, focus your time and energy elsewhere.

Adjust your standards. Perfectionism is a major source of avoidable stress. Stop setting yourself up for failure by demanding perfection. Set reasonable standards for yourself and others, and learn to be okay with “good enough.”

Focus on the positive. When stress is getting you down, take a moment to reflect on all the things you appreciate in your life, including your own positive qualities and gifts. This simple strategy can help you keep things in perspective.

Adjusting Your Attitude

How you think can have a profound effect on your emotional and physical well-being. Each time you think a negative thought about yourself, your body reacts as if it were in the throes of a tension-filled situation. If you see good things about yourself, you are more likely to feel good; the reverse is also true. Eliminate words such as "always," "never," "should," and "must." These are telltale marks of self-defeating thoughts.

Stress management strategy #4: Accept the things you can’t change

Some sources of stress are unavoidable. You can’t prevent or change stressors such as the death of a loved one, a serious illness, or a national recession. In such cases, the best way to cope with stress is to accept things as they are. Acceptance may be difficult, but in the long run, it’s easier than railing against a situation you can’t change.

Don’t try to control the uncontrollable. Many things in life are beyond our control— particularly the behavior of other people. Rather than stressing out over them, focus on the things you can control such as the way you choose to react to problems.

Look for the upside. As the saying goes, “What doesn’t kill us makes us stronger.” When facing major challenges, try to look at them as opportunities for personal growth. If your own poor choices contributed to a stressful situation, reflect on them and learn from your mistakes.

Share your feelings. Talk to a trusted friend or make an appointment with a therapist. Expressing what you're going through can be very cathartic, even if there's nothing you can do to alter the stressful situation.

Learn to forgive. Accept the fact that we live in an imperfect world and that people make mistakes. Let go of anger and resentments. Free yourself from negative energy by forgiving and moving on.

Stress management strategy #5: Make time for fun and relaxation

Beyond a take-charge approach and a positive attitude, you can reduce stress in your life by nurturing yourself. If you regularly make time for fun and relaxation, you'll be in a better place to handle life's stressors when they inevitably come.

Healthy ways to relax and recharge

Go for a walk.

Spend time in nature.

Call a good friend.

Sweat out tension with a good workout.

Write in your journal.

Take a long bath.

Light scented candles

Savor a warm cup of coffee or tea.

Play with a pet.

Work in your garden.

Get a massage.

Curl up with a good book.

Listen to music.

Watch a comedy

Don't get so caught up in the hustle and bustle of life that you forget to take care of your own needs. Nurturing yourself is a necessity, not a luxury.

Set aside relaxation time. Include rest and relaxation in your daily schedule. Don't allow other obligations to encroach. This is your time to take a break from all responsibilities and recharge your batteries.

Connect with others. Spend time with positive people who enhance your life. A strong support system will buffer you from the negative effects of stress.

Do something you enjoy every day. Make time for leisure activities that bring you joy, whether it be stargazing, playing the piano, or working on your bike.

Keep your sense of humor. This includes the ability to laugh at yourself. The act of laughing helps your body fight stress in a number of ways.

Learn the relaxation response

You can control your stress levels with relaxation techniques that evoke the body's relaxation response, a state of restfulness that is the opposite of the stress response. Regularly practicing these techniques will build your physical and emotional resilience, heal your body, and boost your overall feelings of joy and equanimity.

Stress management strategy #6: Adopt a healthy lifestyle

You can increase your resistance to stress by strengthening your physical health.

Exercise regularly. Physical activity plays a key role in reducing and preventing the effects of stress. Make time for at least 30 minutes of exercise, three times per week. Nothing beats aerobic exercise for releasing pent-up stress and tension.

Eat a healthy diet. Well-nourished bodies are better prepared to cope with stress, so be mindful of what you eat. Start your day right with breakfast, and keep your energy up and your mind clear with balanced, nutritious meals throughout the day.

Reduce caffeine and sugar. The temporary "highs" caffeine and sugar provide often end in with a crash in mood and energy. By reducing the amount of coffee, soft drinks, chocolate, and sugar snacks in your diet, you'll feel more relaxed and you'll sleep better.

Avoid alcohol, cigarettes, and drugs. Self-medicating with alcohol or drugs may provide an easy escape from stress, but the relief is only temporary. Don't avoid or mask the issue at hand; deal with problems head on and with a clear mind.

Get enough sleep. Adequate sleep fuels your mind, as well as your body. Feeling tired will increase your stress because it may cause you to think irrationally.