Course: Women and Health (877)
Semester: Spring, 2022

ASSIGNMENT No.1

Q.1 What are the current approaches to women and health? How health and development is interrelated? Discuss it in detail with examples.

In most societies, women have lower social status than men, producing unequal power relations. For this reason, women and girls can be particularly vulnerable to human rights abuses and suffer poor health outcomes as a result. Arguably, women need special attention when framing an agenda for global health due to the fact that women are biologically different from men and therefore have different needs throughout their lifespan (Sankaran, 2010).

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) is the principal international human rights treaty addressing the rights of women. In 1997 the United Nations Economic and Social Council (ECOSOC) adopted a resolution calling on all specialized agencies of the UN to mainstream a gender perspective into all their policies and programes. Numerous other conferences and declarations have resulted in the reaffirmation of women's rights and needs in the health sector (Sankaran, 2010).

A gender-based approach is established on the recognition of the differences between men and women. Policies that support women's empowerment serve to alleviate inequitable gender roles (Rosenfield, Min, & Bardfield, 2010). Despite much effort toward creating gender equality, women remain vulnerable, with many women still not able to experience enjoyment of their fundamental human rights. Recognition of the importance of women's rights is central to any discussion of the MDGs, as innumerable studies have demonstrated that gender equality is a precondition for sustainable growth and poverty reduction.

Go to:

MILLENNIUM DEVELOPMENT GOALS

For the MDGs to effectively redress the inequalities experienced by women and ensure a healthier future, a gender-based approach must be considered for each of these goals. A gendered approach means not only examining biological differences but also the socially constructed expectations that differentiate the roles and attributes of men and women (Correa-de-Araujo, 2006; Pinn, 2003). Increasingly, policymakers and nongovernment organizations have determined that the health and well-being of communities and societies is dependent on the welfare, education, and empowerment of women.

Goal 1: Eradicate Extreme Poverty and Hunger

In some regions, such as Asia and Oceania, the percentage of impoverished people in the region has more than halved since 1990, surpassing the WHO target for 2015 (UN, 2006). Unfortunately, those who still live in disadvantaged areas are more likely to report fair or poor health as compared with those from more affluent areas (Patel & Burke, 2009).

Across all ages of women, the highest mortality and disability rates are found in Africa (WHO, 2009). The improvement of women's health and well-being hinges on a detailed understanding of the social determinants

of health and their interaction. While socioeconomic status plays a large role in health and well-being, social networks and individual factors are also important.

It is ICOWHI's aim to lobby for funding to strategically address poverty and hunger through supporting sustainable and culturally appropriate strategies, and to reduce the disparities between developed and developing countries. Applying a structured framework to define, address, and improve women's health outcomes ensures implemented strategies remain both effectual and sustainable. In addition, increasing the profile of women's health issues in public debate and discourse is critical to affect change and enable health policy that recognizes the discrete needs of women and children.

In order to address social determinants of health and achieve gender equality, the following factors need to be considered (Marmot, 2005):

- Preventing people from falling into long-term disadvantage
- Addressing the social and psychological environmental effects of health
- Ensuring a good environment in early childhood
- Addressing the impact of paid and unpaid work on health and well-being
- Addressing the problems of unemployment and job insecurity
- Promoting friendship, social relations, strong supportive networks, and social cohesion
- Addressing the dangers of social exclusion
- Addressing the effects of alcohol and other drugs
- Ensuring access to supplies of healthy food
- Ensuring access to healthier transport systems.

Goal 2: Achieve Universal Primary Education

Globally, despite a net increase in enrollments, a gender gap persists in education attainment. In many countries, educating girls is widely perceived as being of less value than educating boys (UN, 2010). It is estimated that one in every five primary school age girls are unenrolled, compared with one in every six boys (Lavin, 1992). Education directly benefits women and their children, and it is strongly associated with good health and is an important predictor of well-being (Grown, Gupta, & Pande, 2005; Lavin, 1992). In all countries with reliable data, child mortality rates are highest in households where the education of the mother is lowest (WHO, 2009). In addition, literacy plays a distinct role in determining a population's level of disease and mortality by affecting accessibility to health-related literature and information (Wilson, 1992). In 1996 there were approximately 597 million illiterate women in the world, as compared with 352 million men.

The ICOWHI seeks to promote education initiatives because of the positive correlation between education and health outcomes. Education not only needs to be addressed at the primary level, but at secondary and tertiary levels as well. Raising education rates at a primary and secondary level will have positive flow on effects for women in terms of employment, health, and minimizing social disadvantage. Secondary education is associated

with a higher age of marriage, low fertility and mortality, enhanced maternal care, and reduced risk of contracting HIV/AIDS (Grown et al., 2005). In addition, each additional year of secondary school education reduces the probability of public welfare dependency in adulthood by 35% (Lavin, 1992), exemplifying the correlation among education, social disadvantage, and health outcomes. The ICOWHI plans to support women in educational endeavors to promote empowerment and positively affect gender inequality in the educational sphere. We need to advocate for doctorally prepared graduates who can provide leadership and direction for research.

Strategies to ensure that these goals are met include the following; reducing the costs of education, providing scholarships, ensuring schools are girl friendly, educating men on the benefits of educated women, and reducing the physical barriers in accessing education such as issues surrounding transportation (Grown et al., 2005). Not only does accessibility need to be improved, but content and structure also need to be addressed. This can occur via teacher training and curriculum reform and by addressing institutionalized gender bias that exist within schools (Grown et al., 2005).

Through supporting higher-degree education and research in developing countries, ICOWHI is well placed to support initiatives to promote women's health issues.

Goal 3: Promote Gender Equality and Empower Women

Gender inequality also pervades labor markets and the political landscape. It is deeply rooted in entrenched attitudes, societal institutions, market forces, political values, and ideas (Kettel, 1996). Since 1990, there has been a steady global increase of women in nonagricultural wage employment. The WHO estimates that women remain at a disadvantage in securing paid jobs, however, due to pervading sociocultural attitudes, minimal options for balancing work and family responsibilities, and challenges in birth control (UN, 2006).

In the health profession, women make up the majority of health workers in most settings but are often excluded from positions of responsibility and authority. The WHO describes the current situation as a paradox, as women are the backbone of formal and informal health care: however, they are often excluded from these services or have limited access (WHO, 2009). Similarly, these factors contribute to the underrepresentation of women in politics and business (Terjesen, Sealy, & Singh, 2009). While the percentage of parliamentary seats held by women has increased from 12% to 19% since 1990, progress is slow and there is still much advancement to be made (UN, 2010). Some countries have implemented mandatory or voluntary measures to increase the number of women in politics, which partially may account for such increases.

It is the ICOWHI's aim to support such legal, political, and business changes, which positively assert gender equality and promote fair and equitable workplace policies. The ICOWHI intends to facilitate increased female participation in decision-making positions not only in the governance of health but other policy area as well.

Goal 4: Reduce Child Mortality

Mortality rates for children under the age of 5 have decreased globally, with the rate dropping 28% (UN, 2010). Unfortunately, the number of children who die every year from preventable disease significantly exceeds the

goal set for 2015 and remains at 87 deaths per 1,000 live births. Pneumonia, diarrhea, malaria, and AIDS account for 43% of all deaths in children under 5 worldwide in 2008 (UN, 2010). The leading risk factors for child mortality include malnutrition (under nutrition), unsafe water, poor sanitation and hygiene, suboptimal breastfeeding, and indoor smoke from solid fuels (WHO, 2009). The under-5 mortality rate is highest in developing areas with low household wealth and poor maternal education rates. Similarly, a link between maternal education level and child vaccination has been identified. This further exemplifies the critical link between poor levels of education, social disadvantage, and adverse health outcomes.

Every year around nine million children under 5 years, including 4.3 million girls, die from conditions that largely are preventable and treatable (WHO, 2009). It is therefore crucial to promote the provision of early childhood education to all mothers, including programs regarding breastfeeding, nutrition, and child vaccination and targeting women in low socioeconomic and impoverished areas. As a result of the positive correlation between education and health outcomes, it is ICOWHI's goal to target women for education initiatives. Improved and wider access to education paired with the provision of basic health services and vaccination will likely have a cost-effective and dramatic effect in reducing child mortality.

Improving child mortality is closely linked to advancing maternal health, as it will reduce those who die at birth and ensure health development in the early stages of the child's life (Shaw, 2006). It is therefore vital that these goals are addressed codependently, rather than separately.

Goal 5: Improve Maternal Health

When a mother dies, it impacts negatively on the health, education, nutrition, and economic status of her orphaned children and the community, and it also leads to a welfare loss that may take generations to overcome (Alban & Andersen, 2007). More than half a million women continue to die every year in pregnancy and childbirth due to entirely preventable reasons, 99% of whom live in the developing world (Grown et al., 2005). In developed countries, there are, on average, nine maternal deaths per 100,000 live births; however, for disadvantaged developing countries this figure is 1,000 or more per 100,000 live births (WHO, 2009). Maternal mortality remains highest in sub-Saharan Africa and Southern Asia. Despite a global increase in the number of births attended by skilled health care personnel, ratios of maternal mortality in these areas have changed very little since 1990. Significantly, wealthy and urban mothers are three to six times more likely than rural and poor mothers to deliver with health personnel present. In sub-Saharan Africa, where approximately half of the world's maternal death occurs, only 46% of births occur with the assistance of a skilled health professional, an increase of merely 4% since 1990 (UN, 2006).

Regular use of antenatal services prior to delivery also has been shown to improve maternal and neonatal health outcomes. Lack of access to antenatal and postnatal care services is commonly associated with social isolation, a lack of recognition of the importance of gestational care, or lack of resources such as transport (Womens Health Outcomes Framework, 2002). Given that the two main causes of maternal mortality in developing regions are hemorrhage and hypertension (UN, 2010), providing skilled health care prior to and at delivery is

pivotal to minimizing maternal mortality. In some areas of Asia and Africa, less than half the women giving birth are attended to by skilled health personnel (UN, 2010). The ICOWHI seeks to support universal education and health strategies that aim to increase the proportion of births attended by skilled health personnel, particularly for women in remote and rural areas. In addition to providing care at delivery, it is important to make available adequate reproductive health services, postpartum care, and family planning. While no single answer can address the multiple causes of maternal deaths, the ICOWHI intends to lobby for increased funding for health care interventions that reduce maternal death rates. The ICOWHI also intends to make these interventions more widely available, particularly in rural and impoverished areas.

Q.2 Discuss the general mental disorders that are prevalent in women. What is the feminist view of mental health discuss?

Gender is correlated with the prevalence of certain mental disorders, including depression, anxiety and somatic complaints.[1] For example, women are more likely to be diagnosed with major depression, while men are more likely to be diagnosed with substance abuse and antisocial personality disorder.[1] There are no marked gender differences in the diagnosis rates of disorders like schizophrenia, borderline personality disorder, and bipolar disorder.[1][2] Men are at risk to suffer from post-traumatic stress disorder (PTSD) due to past violent experiences such as accidents, wars and witnessing death, and women are diagnosed with PTSD at higher rates due to experiences with sexual assault, rape and child sexual abuse.[3] Nonbinary or genderqueer identification describes people who do not identify as either male or female.[4] People who identify as nonbinary or gender queer show increased risk for depression, anxiety and post-traumatic stress disorder.[5] People who identify as transgender demonstrate increased risk for depression, anxiety, and post-traumatic stress disorder.[6]

Sigmund Freud postulated that women were more prone to neurosis because they experienced aggression towards the self, which stemmed from developmental issues. Freud's postulation is countered by the idea that societal factors, such as gender roles, may play a major role in the development of mental illness. When considering gender and mental illness, one must look to both biology and social/cultural factors to explain areas in which men and women are more likely to develop different mental illnesses. A patriarchal society, gender roles, personal identity, social media, and exposure to other mental health risk factors have adverse effects on the psychological perceptions of both men and women.

Gender-specific risk factors

Gender-specific risk factors increase the likelihood of getting a particular mental disorder based on one's gender. Some gender-specific risk factors that disproportionately affect women are income inequality, low social ranking, unrelenting child care, gender-based violence, and socioeconomic disadvantages.

Anxiety

Women experience a higher rate of General Anxiety Disorder (GAD) than men. Women are around 15% more likely to experience comorbidities with GAD than men. Anxiety disorders in women are more likely to be

comorbid with other anxiety disorders, bulimia, or depression. Women are two and a half times more likely to experience Panic Disorder (PD) than men. Women are also twice as likely to develop specific phobias. Additionally, Social Anxiety Disorder (SAD) occurs among women more frequently than men. Obsessive-compulsive Disorder (OCD) is present among women and men at similar rates, though women tend to have a later onset of symptoms. With OCD, men are more likely to experience more aggressive, sexual-religious, and social impairments while women are more likely to experience fear of contamination.

Gender is not a significant factor in predicting the effectiveness of pharmacological interventions or cognitive behavioral therapy in treating GAD.

Depression

Major depressive disorder is twice as common in women compared to men. This increased rate is partially related to women's increased likelihood to experience sexual violence, poverty, and higher workloads. Depression in women is more likely to be comorbid with anxiety disorders, substance abuse disorders, and eating disorders. Men are less likely to seek treatment for or discuss their experiences with depression. Men are more likely to have depressive symptoms relating to aggression than women. Women are more likely to attempt suicide than men however, more men die from suicide due to the different methods used. In 2019, the suicide rate in the United States was 3.7 times higher for men than women.

The presence of a gender bias results in an increased diagnosis of depression in women than men.

Postpartum depression

Men and women experience postpartum depression. Maternal postpartum depression affects around 15% of women in the United States. Postpartum depression is under-diagnosed. Women experiencing PPD have trouble seeking treatment due to the difficulties of accessing therapy and not being able to take some psychiatric medications due to breastfeeding. Around 8-10% of American fathers experience paternal postpartum depression (PPPD). Risk factors for PPPD include a history of depression, poverty, and hormonal changes

Eating disorders[

Women constitute 85-95% of people with anorexia nervosa and bulimia and 65% of those with a binge-eating disorder. Factors that contribute to the gender disproportionality of eating disorders are perceptions surrounding "thinness" in relation to success and sexual attractiveness and social pressures from mass media that are largely targeted towards women. Between males and females, the symptoms experienced by those with eating disorders are very similar such as a distorted body image

Contrary to the stereotype of eating disorders' association with females, men also experience eating disorders. However, gender bias, stigma, and shame lead men to be underreported, underdiagnosed, and undertreated for eating disorders. It has been found that clinicians are not well-trained and lack sufficient resources to treat men with eating disorders. Men with eating disorders are likely to experience muscle dysmorphia.

Q.3 Describe reproductive rights in detail. What is meant by reproductive justice?

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:[2]

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.

Women's reproductive rights may include some or all of the following: abortion-rights movements; 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. Reproductive rights may also include the right to receive education about sexually transmitted infections and other aspects of sexuality, right to menstrual health and protection from practices such as female genital mutilation (FGM).

Reproductive rights began to develop as a subset of human rights at the United Nation's 1968 International Conference on Human Rights. 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." 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. 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.

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.

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.

Reproductive rights are a subset of sexual and reproductive health and rights.

Human rights have been used as a framework to analyze and gauge abuses, especially for coercive or oppressive governmental policies. The framing of reproductive (human) rights and population control programs are split along race and class lines, with white, western women predominately focused on abortion access (especially during the second wave feminism of the 1970-1980s), silencing women of color in the Global South or marginalized women in the Global North (black and indigenous women, prisoners, welfare recipients) who were subjected to forced sterilization or contraceptive usage campaigns. The hemisphere divide has also been framed as Global North feminists advocating for women's bodily autonomy and political rights, while Global South women advocate for basic needs through poverty reduction and equality in the economy.

This divide between first world versus third world women established as feminists focused on women's issues (from the first world largely promoting sexual liberation) versus women focused on political issues (from the third world often opposing dictatorships and policies).[34] In Latin America, this is complicated as feminists tend to align with first world ideals of feminism (sexual/reproductive rights, violence against women, domestic violence) and reject religious institutions such as the Catholic Church and Evangelicals, which attempt to control women's reproduction. On the other side, human rights advocates are often aligned with religious institutions that are specifically combating political violence, instead of focusing on issues of individual bodily autonomy. The debate regarding whether women should have complete autonomous control over their bodies has been espoused by the United Nations and individual countries, but many of those same countries fail to implement these human rights for their female citizens. This shortfall may be partly due to the delay of including women-specific issues in the human rights framework. However, multiple human rights documents and declarations specifically proclaim reproductive rights of women, including the ability to make their own reproductive healthcare decisions regarding family planning, including: the UN Declaration of Human Rights (1948), The Convention on the Elimination of All Forms of Discrimination Against Women (1979), the U.N.'s Millennium Development Goals, and the new Sustainable Development Goals, which are focused on integrating universal reproductive healthcare access into national family planning programs. Unfortunately, the 2007 Declaration on the Rights of Indigenous Peoples, did not address indigenous women's reproductive or maternal healthcare rights or access.

Since most existing legally binding international human rights instruments do not explicitly mention sexual and reproductive rights, a broad coalition of NGOs, civil servants, and experts working in international organizations have been promoting a reinterpretation of those instruments to link the realization of the already internationally recognized human rights with the realization of reproductive rights. An example of this linkage is provided by the 1994 Cairo Programme of Action:

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These 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. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community.

Similarly, Amnesty International has argued that the realisation of reproductive rights is linked with the realisation of a series of recognised human rights, including the right to health, the right to freedom from discrimination, the right to privacy, and the right not to be subjected to torture or ill-treatment. The World Health Organization states that:

Sexual and reproductive health and rights encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, including contraceptive services, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and sexual and reproductive health needs of adolescents. Universal access to sexual and reproductive health is essential not only to achieve sustainable development but also to ensure that this new framework speaks to the needs and aspirations of people around the world and leads to realisation of their health and human rights.

However, not all states have accepted the inclusion of reproductive rights in the body of internationally recognized human rights. At the Cairo Conference, several states made formal reservations either to the concept of reproductive rights or to its specific content. Ecuador, for instance, stated that:

With regard to the Programme of Action of the Cairo International Conference on Population and Development and in accordance with the provisions of the Constitution and laws of Ecuador and the norms of international law, the delegation of Ecuador reaffirms, inter alia, the following principles embodied in its Constitution: the inviolability of life, the protection of children from the moment of conception, freedom of conscience and religion, the protection of the family as the fundamental unit of society, responsible paternity, the right of parents to bring up their children and the formulation of population and development plans by the Government in accordance with the principles of respect for sovereignty. Accordingly, the delegation of Ecuador enters a reservation with respect to all terms such as "regulation of fertility", "interruption of pregnancy", "reproductive health", "reproductive rights" and "unwanted children", which in one way or another, within the context of the Programme of Action, could involve abortion.

Q.4 To be old, female and poor is a triple jeopardy. Comment and discuss this statement in detail.

Perceptions of stigma associated with mental health status are prevalent among racialized populations such as Black youth (Williams and Mohammed, 2009; Khenti, 2013; Black Health Alliance, 2015). The impact of intersecting systems of oppression, such as race, gender, and age on this population, exacerbates their experiences of mental health stigma (Kranke et al., 2012; Jackson-Best, 2017). Due to the historical intersectional locations of these systems of oppression within the axes of marginality, the stigma associated with mental illness poses a critical problem within Black communities (Matthews et al., 2006; Roberts et al., 2008). As depicted in Hollywood movies such as A Beautiful Mind, and as documented in scholarly publications, mental illness among White men is often associated with brilliance, while mental illness among Black people is characterized as pathological and an unequivocal sign of weakness (Danquah, 1998). The stigma and oppression caused by the negative perception of mental illness does not bode well for Black families, especially for many Black women who are the backbones of their families. Thus, it is not surprising that there is a disproportionate number of Black youth at the intersection of race and gender who suffer in silence with mental illness and the associated stigma.

This article seeks to examine reports on how the mental health stigma, when it intersects with race and gender, further compounds, complicates, and shapes the mental health experiences of Caribbean and Black female youth of Caribbean descent in Canada. The article engenders a discussion that strengthens the focus on mental health stigma campaigns and education addressing the mental health of young Black women in Canada. To mitigate the paucity of research available in Canada on the topic, insights into concepts and existing discussions on women's mental health throughout this paper will include references to literature from the U.S., U.K., and professional experiential knowledge, and personal insights from conversations with young Black women of Caribbean descent.

For the purpose of this discussion the term Caribbean refers to Black individuals born in the Caribbean and living in Canada, as well as individuals born in Canada whose parents are of Caribbean heritage. The terms young adults and youth are used interchangeably throughout this discussion to refer to young people aged 18–25 years of age (Government of Canada, 2018). The focus on age includes references to youth and young women which is reflective of a given phase on the age continuum. Similarly, focus on the concept of gender which encapsulates either of the sexes, notwithstanding those who are gender neutral, includes reference to the term “female” (and “gender”), and to specific mention of young Black women of Caribbean descent. We also use several ethno-specific terms in our discussion (e.g., Afro-Canadians, African-American, Afro-Caribbean, Black) to refer to Black populations. Black is used as a blanket term to refer to people of African origin or who self-identify as Black. Guided by the lens of intersectionality, this article draws on contemporary examples and on scholarly and gray literature to examine and discuss the high prevalence of mental health stigma in the Canadian Black and Caribbean community, and to discuss the effects of the complexities of race, age, and gender on their experiences with mental illness.

Stigma has been identified as a barrier to accessing mental health services and/or supports for youth populations in general. Various types of stigma that affect the experiences of individuals with mental illness have been identified in discussions on mental health. For example, Clement et al. (2015) outlined six categories of stigma: (1) stigma that is anticipated, whereby the impacted individual expects to be treated or perceived unfairly, (2) stigma that is based on the experience of unfair treatment and unjust perception, (3) stigma that is internalized based on stereotypical views of one's self, (4) perceived stigma by an individual based on the stigmatizing attitudes and behaviors that others direct toward individuals with mental illness, (5) the endorsement of stigma that results from an individual's negative perception toward others with mental illness, and (6) stigma that is present when an individual seeks or receives treatment as a result of mental illness (11–12). Other discussions have made reference to intersectional stigma that occurs when concrete and identifiable social, economic, and political power allows the identification of differences, the construction of stereotypes, the separation of labeled persons into distinct categories, and the disapproval, rejection, exclusion, and discrimination against the persons so characterized (Parker and Aggelton, 2003; Campbell and Deacon, 2006). These different forms of stigma can

no doubt further compound the challenges associated with experiences of mental illness, especially for members of groups that are already oppressed.

Stigma, for this discussion, is understood as the product "of devaluing, labeling, and stereotyping that are manifested in the loss of status, unfair and unjust treatment. Discussions on stigma that are conceptualized as a "cut into the skin to symbolize the threat or danger of the stigmatized person" will also be incorporated throughout this article. Social psychologists often view stigma as a "mark", "separating individuals from one another based on a socially conferred judgement that some persons or groups are tainted as less than". Furthermore, the social construction of stigma results in social rejection, devaluation, and discrimination. Experiences of stigma have a deleterious effect on the mental health of members of marginalized populations, and this effect is more pronounced among racialized populations such as Black adults and youth. Double stigma (Garry, 2005) refers to members of racialized groups who already suffer from the burden of mental illness, combined with prejudice and discrimination because of their group affiliation. This area is also under-researched in Canada, as are the social and structural inequalities that have resulted from stigmatization. Overall, more needs to be done to better understand the resulting challenges of mental illness within Black communities in Canada and to address the added complexities of race, gender, and age on their mental health experiences.

This discussion begins with a brief introduction about the issue of mental health in Canada among racialized populations, with specific example about the connotation of mental health when it comes to Black people. Specific terms or concepts are highlighted in the introduction, to explain the context in which they are used throughout this discussion. An overview of key considerations within an intersectionality framework is provided, followed by a synopsis of Caribbean women in Canada with noted gaps in Canadian literature on mental health concerns in this population. This discussion also includes an overview of mental health in the Black community in Canada as well as insights on what is known about Black young women's health in a Canadian context. The discussion concludes with a summary and highlights areas for future research on the mental health of young Black women from Caribbean descent in Canada.

Intersectionality is a concept that emerged during the era of "second wave feminism" and highlights the mutually constitutive forces of gender, sex, race, class, and disability. Intersectionality, applied in this context, considers the impact of race, gender, age, and other social categories on the experience of stigma among young Black women with mental health issues. The intersection of these categories within the different social, cultural, historical, and economic contexts and their impact on the experience of stigma among young Black women are also of concern within the scope of intersectionality. Lorde (1984) argued that women of color are disempowered when aspects of their identity and experiences are examined in isolation from one another. Bowleg (2012) highlighted three key tenets of intersectionality that make it an ideal perspective from which to explore reports of the experiences of young Black women with mental health concerns. These are: (1) "social identities are not independent and unidimensional but multiple and intersecting, (2) individuals from

multiple historically oppressed and marginalized groups are the focal and starting point, and (3) multiple social identities at the micro level (gender, race, disability, sexual orientation etc.) intersect with macro level structural factors (racism, poverty, sexism, ageism, ableism) to produce health disparities" (1270). Intersectionality emphasizes the socially constructed nature of gender and other social categories, and takes the wide range of different experiences, identities, and social relations affecting members of different groups in society which will not fit into one category of analysis.

As such, "this framework highlights the complexity that arises when the subject of analysis includes multiple dimensions of social life and analytical categories" (McCall, 2005, p. 72). Intersectionality has become an all-inclusive framework for theorizing injustice. Using intersectionality theory can highlight the salience of disability, race, age, and other social categories that affect both behavior and access to resources. Intersectionality is an important framework for the examination of experiences of mental health concerns among young Black women and the influences of the associated stigma on their help-seeking behavior .Intersectionality examines how "multiple systems of oppression simultaneously corroborate and subjugate to conceal deliberate, marginalizing ideological maneuvers that define otherness" (Few, 2007, p. 454). Crenshaw (1989, 1991) developed the concept of intersectionality as a tool to convey "the various ways in which race and gender interact to shape the multiple dimensions of Black women's experiences" (Crenshaw, 1991, p. 1244).

Hankivsky and Cormier (2009) posited that intersectionality strives to explain and interpret multiple and intersecting systems of oppression and privilege. For example, Black Caribbean women, and particularly young Black Caribbean women in Canada, may not only experience exclusion from appropriate health-care research but also may be hesitant to accept or seek help for mental health problems for fear of being further stigmatized. It has also been asserted that when young Black women "…do seek healthcare services for their health and mental health, they are often not taken seriously or their complaints are ignored" (Women's Health in Women's Hands (WHIWH), 2007, p. 5). A 2016 report from Women's Health in Women's Hands pointed out that immigrant women's status or country of origin may also play a significant role in their experiences of mental health stigma and subsequent help-seeking processes. The use of an intersectionality lens, then, will serve to disrupt linear thinking that prioritizes any one category of social identity over others. Hankivsky and Cormier (2009) asserted that it provides an understanding of what is created and experienced at the intersection of two or more axes of oppression (for example, race, ethnicity, class, and gender); it is precisely at this basis of intersection that a completely new status is formed, one that is more than simply the sum of its individual parts (Crenshaw, 1991). It is with this intersectionality lens that this discussion on the mental health of Caribbean women in Canada in a broader sense, and more specifically on young Black women of Caribbean descent in Canada, unfolds.

Q.5 Write notes on the following:

a) Son Preference: Causes and Effects

For centuries, son preference has led to postnatal discrimination against girls; this has resulted in practices ranging from infanticide to neglect of health care and nutrition, often ending in premature mortality. But in the 1980s, ultrasound technology started to become available for diagnostic purposes in many Asian countries, and the opportunity to use the new technology for sex selection was soon exploited. In countries where there is a combination of son preference, a small-family culture and easy access to sex-selective technologies, very serious and unprecedented sex-ratio imbalances have emerged. These imbalances are already affecting the reproductive age groups in a number of countries, most notably China, South Korea and parts of India.

The sex ratio at birth (SRB) is defined as the number of boys born to every 100 girls, and is remarkably consistent in human populations at around 105 male births to every 100 female births. South Korea was the first country to report a very high SRB, because the widespread uptake of sex-selective technology in South Korea preceded that of other Asian countries. The SRB started to rise in South Korea in the mid-1980s, and by 1992 the SRB was reported to be as high as 125 in some cities.

China soon followed. Here, the situation is complicated by the one-child policy, which has undoubtedly contributed to the steady increase in the reported SRB from 106 in 1979, to 111 in 1990, 117 in 2001 and 121 in 2005. Because of China's huge population, these ratios translate into very large numbers of excess males. In 2005 it was estimated that 1.1 million excess males were born across the country, and that the number of males under the age of 20 years exceeded the number of females by around 32 million.

In India there are also marked regional differences in SRB. Incompleteness of birth registration makes the SRB difficult to calculate accurately, but using the closely related ratio of boys to girls under the age of six years, it is found that there are distinct regional differences across the country. Several states in the north and west such as Punjab, Delhi and Gujarat have sex ratios as high as 125, but in the south and east, several states such as Kerala and Andhra Pradesh have sex ratios of around 105.

A consistent pattern in all three countries is the marked trend related to birth order and the influence of the sex of the preceding child. If the first child is a girl, couples will often use sex-selective abortion to ensure a boy in the second pregnancy, especially in areas where low fertility is the norm. A large study in India showed that for second births with one preceding girl the SRB is 132, and for third births with two previous girls it is 139, whereas sex ratios are normal where the previous child was a boy.[6] In China this effect is even more dramatic, especially in areas where the rural population are allowed a second child only after the birth of a girl, as is the case in some central provinces. The SRB across the country for first-order births is 108, for second-order births it is 143 and for the (albeit rare) third-order births it is 157.

Prenatal determination of sex became accessible only in the mid-1980s, and later than that in rural areas; therefore, the large cohorts of surplus young men have only now started to reach reproductive age. Because of this, the consequences of this male surplus in the reproductive age group are still largely speculative. However, there is no disputing that over the next 20 years in large parts of China and India there will be a 10%–20% excess of young men. These men will be unable to marry, in societies where marriage is regarded as virtually

universal, and where social status and acceptance depend, in large part, on being married and creating a new family.[7] When there is a shortage of women in the marriage market, women have the opportunity to "marry up," inevitably leaving the least desirable men with no marriage prospects.[8] The result is that most of these men who are unable to marry are poor, uneducated peasants. In China these men are referred to as "guang gun," meaning "bare branches," signifying their inability to bear fruit. In China, 94% of all unmarried people aged 28–49 are male, and 97% of them have not completed high school.

A number of assumptions have been made about the effects of the male surplus on these men who are unable to marry. First, it has been assumed that the lack of opportunity to fulfill traditional expectations of marrying and having children will result in low self-esteem and increased susceptibility to a range of psychologic difficulties. It has also been assumed that a combination of psychologic vulnerability and sexual frustration may lead to aggression and violence in these men. There is good empirical support for this prediction: cross-cultural evidence shows that the overwhelming majority of violent crime is perpetrated by young, unmarried, low-status males. In China and parts of India the sheer numbers of unmated men are a further cause for concern. Because they may lack a stake in the existing social order, it is feared that they will become bound together in an outcast culture, turning to antisocial behaviour and organized crime, thereby threatening societal stability and security.[9] But as yet there is limited evidence for these hypotheses. Our own ongoing research in this area in China suggests that most of these men do indeed have low self-esteem, are inclined to depression and tend to be withdrawn. But there is no evidence that they are prone to aggression or violence, nor are reports of crime and disorder any higher in areas where there are known to be excess men. This may be because there is not yet a large enough critical mass of unmated men to have an impact, or because the assumptions about male aggression do not apply in this context.

It is also thought that large numbers of excess men will lead to an expansion of the sex industry. The sex industry has expanded in India and China in the last decade.[12,13] However, the part played by a high sex ratio in this expansion is impossible to isolate; there is no evidence that numbers of sex workers are greater in areas with high sex ratios. The recent rise in numbers of sex workers in China has been attributed more to increased socioeconomic inequality, greater mobility and a relaxation in sexual attitudes than an increase in the sex ratio.

There may also be positive aspects of this easy access to sex selection. First, access to prenatal sex determination probably results in an increase in the proportion of wanted births, leading to less discrimination against girls and lower female mortality. India, South Korea and China have all reported reductions in differential mortality in the last decade. Second, it has been argued that an imbalance in the sex ratio could be a means to help to reduce growth in the population. Third, as numbers of women in society fall, they become more highly valued and their social status increases. Not only will this benefit the women's self-esteem, mental health and well-being, but the improved status of women should result in reduced son preference, with fewer sex-selective abortions and an ultimate rebalancing of the sex ratio.

b) Safe Motherhood

The goal of the National Safe Motherhood Program is to reduce maternal and neonatal morbidity and mortality and to improve the maternal and neonatal health through preventive and promotive activities as well as by addressing avoidable factors that cause death during pregnancy, childbirth and postpartum period. Evidences suggest that three delays are important factors behind the maternal and new born.

Benefits:

Women and children can benefit from following services:

1. Birth Preparedness Package and MNH Activities at Community Level

(Birth preparedness and complication readiness (preparedness of money, health facilities for the delivery, transport and blood donors).

· Key ANC/PNC services (Iron, Td, Albendazole, etc), self-care (food, rest, no smoking and no drinking alcohol, including pregnancy and post-partum period), essential new born care, identification and prompt care seeking for danger signs during pregnancy, delivery, post-partum and newborn period

2. Rural Ultrasound Program

3. Aama and the New born Program

The Government of Nepal introduced demand side intervention in maternal health with the aim of improving institutional delivery. The Maternity Incentive Scheme was first such intervention, launched in 2005 and designed to share the cost of transportation to health facility. In 2009, in addition to transport incentive user fees were removed from all types of delivery care, known as the Aama Programme. In 2012, a separate demand side intervention called 4 ANC incentives programme (introduced in 2009) was merged with Aama Programme. In FY 2073/74, the free new born care programme (introduced in FY 2072/73) has been merged to the Aama programme. Aama programme in its current form is known as the Aama and New born programme and has the following provisions:

Mother and newborn can directly benefit from the following services:

Transport incentive for institutional delivery: A cash payment is made to women immediately following institutional delivery: NPR. 1,500 in mountain, NPR. 1,000 in hill and NPR. 500 in Terai districts.

Incentive for 4 ANC visits: A cash payment of NRs. 400 is made to women on completion of four ANC visits at the 4, 6, 8 and 9 months of pregnancy institutional delivery and post-natal care.

Free institutional delivery services: A payment to the health facility for the provision of free delivery care. For normal delivery, health facilities with less than 25 beds receive NPR. 1,000;, while health facilities with 25 or more beds receive NPR. 1,500. For complicated deliveries health facilities receive NPR. 3,000; for C-Sections (surgery) NPR. 7,000. Ten complications i.e. APH requiring blood transfusion, PPH requiring blood transfusion or MRP or exploration, severe pre-eclampsia, eclampsia, MRP for retained placenta, puerperal sepsis, instrumental delivery, and management of abortion complications requiring blood transfusion and admission longer than 24 hours with IV antibiotics for sepsis are included as complicated deliveries. Anti-D

administration for RH negative is reimbursed NPR.5000. Laparotomy for perforation due to abortion, indicated or emergency CS, laparotomy for ectopic pregnancy and ruptured uterus is reimbursed NPR. 7000.

Incentives to health workers for deliveries: A cash payment of NPR. 300 are made to health worker attending all forms of deliveries viz: normal, complicated and caesarian section. This is to be arranged form the health facility reimbursement.

Free sick new born care: A payment to the health facility for the provision of free sick new born care. Health facilities are reimbursed for a set package of care cost viz: 'Package 0' no cost, 'Package A' NPR.1000, 'Package B' NPR. 2000 and 'Package C' NPR. 5000. Health facility can claim as high as combination of A+B+C NPR.8000, depending on medicines, diagnostic and treatment services provided.

Incentives to health worker for sick new born care: A cash payment of NPR. 300 are made to health worker providing all forms of service packaged. This is to be arranged form the health facility reimbursement.

Reproductive Health Morbidity Prevention and management Program

Management of Pelvic Organ Prolapse

Cervical cancer screening and prevention training

Obstetric Fistula management

Emergency Referral Fund

Nyano Jhola Programme