CHAPTER – II
CONCEPTUAL FRAME WORK

EVOLUTION OF THE CONCEPT OF MENTAL HEALTH FROM MENTAL ILLNESS TO MENTAL HEALTH:

The evolution of the concept of mental health is linked to the larger developments in the understanding of human behavior. Starting from explanations of supernatural causation, we have arrived at understanding the states of mind and mental health from a holistic point of view. Rapid advances in the understanding of the human brain and individual and group behavior open up new possibilities for non-medical and wider psychosocial actions towards promotion of mental health.

The World Health Organization (WHO) constitution defines health as a state of complete physical, mental and social well being not merely the absence of disease or infirmity. However, WHO, in the first thirty years (1948-1978), focused largely on specific illnesses not so much on health (William, 1988). The Alma Ata Conference in 1978 (WHO, 1978) is a landmark in the development of the concept of health. The conference viewed health as an individual’s responsibility rather than a service to be delivered to individuals (William, 1988). The concept of primary health care (PHC) is revolutionary both in terms of conceptual clarity and details included for achieving the goal.

The Alma Ata recommendation includes promotion of mental health as one of the eight components of PHC. This shift in emphasis from illness to health is important, as the term ‘mental’ connotes illness rather than well being. This traces the evolution of concepts of mental illness and mental health, categorization of mental health issues, recent developments in the prevention of mental and psychosocial disorders, current approaches to mental health program development and concludes by outlining the future of mental health care with special reference to India.

The importance of mental health has been known to range from the care of the ill to the promotion of mental health by professionals. Govindaswamy (1970), Indian
psychiatrist, stated, the field of mental health includes three sets of objectives. One of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness, which however are not the same for every individual. The objective for those persons is prevention. The third objective has to do with the upgrading of mental health of normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists in the protection and development at all levels, of human society of secure, affectionate and satisfying human relationships and in the reduction of hostile tensions in persons and groups.

The Indian view of mental health:

Indian psychiatrists have described how mental health has been an important part of Indian philosophy and social thought. Wig (1990) has summarized this as; Indian culture has always attached great significance to spiritual life. The term spiritual is, of course, not identical with the term mental, but both recognize the value of inner mental life and experiences. In India, the term health is usually not confined to physical state; in any Indian definition of health there is always reference to mental harmony and potential for spiritual growth. The present day term mental health is European in concept and origin. There is no exact equivalent of the term mind in Indian languages, because the differentiation of body and mind has never been important in Indian philosophy, as it has been in modern European thought. Thus, when we speak of ‘mental health’ especially positive mental health, not merely the absence of mental disorder, the average Indian will always perceive in it an underlying reference to spiritual development. The holistic approach to health in general and mental health in particular to a large extent, reflects the current concept of mental health.

Indian philosophy attaches great importance to the spiritual dimension of life. The ultimate goal of life is self-realization or realization of one’s inner nature. Material things are regarded as illusions and are hence impermanent. There are repeated references in the religious texts to the need for detachment from material
things and for a search for the spiritual meaning of life (Wig, 1990). A number of Indian mental health professionals have focused on the various aspects of Indian concepts of mental health (Wig, 1990, Neki, 1977).

Four themes can be identified in this area. First, the recognition of the rich knowledge available in classical texts of India. The second set of observations have focused on the cross cultural consideration of dynamics in terms of personality functioning. The third area where contributions have been made is the area of using traditional concepts for therapy. The fourth area has been in relation to the place of family in therapy.

**Understanding mental illness and mental health:**

For the last 500 years, the western approach to deviant or abnormal behavior has been influenced predominantly by religion and science. Till about 17th century, all abnormal behavior was seen as an act of the devil that is against God consequently, the ill were seen as evil and Christianity approved specific sanctions to kill them or punish them. The next phase considered all abnormal behavior as criminal that is anyone whose behavior was socially unacceptable was classified as bad and they their behavior from other angles. With the advent of modern scientific thought, the focus shifted from evil to ill in a way, people are not bad but mad or insane. This shift, however subtle, was significant. The ill were looked after in more humane surroundings. At the turn of 20th century, there were other major developments in mental health. The most significant was the contribution of Sigmund Freud. He presented behavior and mental functions as understandable. He gave the world a new conception of both infancy and adolescence, and characterology, and evolved a system of treatment where the origin of the disease would be revealed. This contribution of Sigmund Freud shifted the focus from the illness to wellness and the isotonic view of behavior to understandability of behavior rooted in childhood experiences and parent child relationships.
Concept of mental health:

Mental health covers an elusive and diffuse field and the term itself encompasses a multiplicity of meaning. Freeman (1975) regards it, “as a valuable rubric to head a chapter and describe an area of research than as a concept”. Schultz (1977) remarks “the concept is difficult, challenging, and complex, full of unknowns and half truth and no doubt some fad and fancy as well”.

The very word “Mental health” is worthy of criticism essence of mental health specifics what person or mind? If the ultimate reference is to the person why the adjective ‘mental’? With finally, the ultimate reference is to the person (Soddy, 1965) and this typifies the lack of relationship between the term and what is in it placed for communication.

For reasons of precise communication some theoreticians opt to do away the very term mental health and in its place prefer such as ‘healthy personality’ (Jourard, 1968), ‘Psychological’ well being (Breadburn, 1969), ‘emotional maturity’ (White, 1977), ‘Soundness as a person’ (Barron, 1977) and of the sort current concept of mental health includes the ingredients of all the above said notions, and is much more rich to trust the psychological communication with the reserve benefits that is boundaries are flexible for inclusion of any possible elements in future.

Definitions of mental health

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.

The World Health Organization defines mental health as “a state of well being in which the individual realize his or her own abilities, can cope with the normal stresses of life, can work productivity and fruitfully, and is able to make a contribution to his or her community”. It was previously stated that there was no one “official” definition of mental health. Cultural differences, subjective assessments,
and competing professional theories all affect how “mental health” is defined.

**Mental health definition:**

“Mental health is the balance between all aspects of life social, physical and spiritual and emotional”. It impacts on how we manage our surrounding and make choice in our lives clearly it is an integral part of overall health.

It is a state of emotional and psychological well being in which an individual is able to use his or her cognitive and emotional capabilities. Functioning in society and meet the ordinary demands of everyday life.

Mental health refers to “A person’s overall emotional and psychological conditions.”

Mental health is for more than the obscene of mental illness and has to do with many aspects of our lives inducing.

1. How we feel about ourselves.
2. How we feel about others.
3. How we are able to meet the demands of life.

According to Medicare (2005) guidance, “only a qualified occupational therapist has the knowledge, training and experience required to evaluate and as necessary, reevaluate a patient’s level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function, and where appropriate, recommend to the physician a plan of treatment.”

Occupational therapists work with the mental health population throughout the life span and across many treatment settings where mental health services and psychiatric rehabilitation are provided (AOTA, 2009). Just as with other clients, the OT facilitates maximum independence in activities of daily living (dressing, grooming, etc.) and instrumental activities of daily living (medication management, grocery shopping, etc.). According to the American Occupational Therapy Association, OT improves functional capacity and quality of life for people with
mental illness in the areas of employment, education, community living, and home and personal care through the use of real life activities in therapy treatments (AOTA, 2005).

War (1987) notes that the term mental health is difficult to specify and that no universally accepted definition is available.

His emphasis on mental health whether individual would be identified as ill or not in medical sense. He views mental health as a on a continuum ranging from very good mental health, through conditions considered moderately healthy; to those widely taken to be indicative of moderate and severe illness he also rejects a “passive contentment” view of mental health, recognizing that healthy people often experience strain or anxiety.

Maintaining mental health involves:

a) Attention to life style:

If we are doing too much or too little in our lives mental health can suffer, we need a good balance between our study and leisure pursuits.

b) Social contact:

Having contact with others whose company we enjoy whether at school work at home or as a member of a club, helps to develop social interaction.

c) Reviewing our lives from time to time:

This involves considering what our aims and goals in life are and whether we are taking steps to achieve those problems can arise when we feel that life is not satisfying and fulfilling.

d) Awareness of how mind body interacts:

Just as our state of mental health can affect our physical health, the reverse is also true if diet, sleep and exercise are neglected and inadequate, not only our bodies with suffer but also our minds.
e) Having people in our lives we trust:

It is important to have someone to go with our problem and worries such as friends, teachers, family members.

f) Awareness of what can go wrong:

Just be conscious of what can go wrong realize what tiredness and irritability if ignored, might lead to more serious stress related problems.

Boehm (1955) conceived mental health as “a condition and level of social functioning which is socially acceptable and personally satisfying”. Minnesinger (1945) contended that “mental health as the adjustment of human beings to the world and to each other with the maximum of effectiveness and happiness”. English (1958) conveyed more of the concept of denoting mental health as “a relatively enduring state wherein the person is well adjusted, has a rest for living, and is attaining self actualization of self realization. It is a positive state and mere absence of mental disorder.

Thus, mental health is the balanced development of the individual personality and emotional attitudes that enables him to live harmoniously with his fellow men. Mental health is not exclusively a matter of the relation between persons; it is also a matter of the relation of the individual towards the community he lives in towards the society of which the community is a part, and towards the social institutions which for a large part guides his life, determines his way of living, working and the way he earns and spends his money, the way he sees happiness, stability and security.

A WHO expert committee on mental health reviewed the various definitions of mental health and observed “mental health is influenced by both biological and social factors. It is not a static condition but subject to variations and fluctuations of degree; is the committee’s conception implies the capacity in an individual to form harmonious relations with others, and to participate in or contribute to change in his social and physical environment. It also implies his ability to achieve a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives in that it
reaches an integrated synthesis rather than denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others.

Mental health refers to the adjustment of human beings to each other and to the world with maximum effectiveness and happiness. The two factors that would affect the mental health are positive attitude and interpersonal relations. Positive attitude towards the life is an individual’s factor for an effective mental health. Persons with positive attitude are most successful and adaptive in various walks of life.

Mental health implies freedom from internal conflict, no consistent tendency to condemn or pity oneself, a good capacity to adjust to situation and people, sensitivity to the emotional needs of others, capacity to deal with other individuals with consideration and courtesy and good control over one’s own emotions without constantly giving into strong feelings of fear, jealously anger and guilt.

**Characteristics of a mentally healthy person:**

A mentally healthy person has three main characteristics:

1) He feels comfortable about himself i.e., he feels reasonably secure and adequate. He neither underestimates nor overestimates his own ability. He accepts his shortcomings life has self respect.

2) The mentally healthy person feels right towards others. This means that he is able to be interested in others and to love them. He has friendship that is satisfying and lasting. He is able to like and trust others. He takes responsibility of his fellow men.

3) The mentally healthy person is able to meet the demands of life. He does something about the problems as they arise. He is able to think for himself and to take his own decisions. He sets reasonable goals for himself. He shoulders his daily responsibilities. He is not bothered over by his own emotions of fear, anger, love or guilt.
Characteristics of mental healthy individuals:

1. A well adjusted person has some awareness of his motives, desires, ambition and feeling. He knows himself and accepts his strength and weakness gracefully. He chooses a task to moderate difficulty to achieve.
2. He has a high degree of self esteem and confidence. Unlike a maladjustment person, he feels adequate and equal to others in facing the challenges and reasonability of daily life.
3. As he is mentally healthy, he will express his emotions in a desirable and controlled manner.
4. He has the capacity to socially adjust with others and get along with them in different situations.
5. His intellectual powers as well developed. He thinks independently and takes appropriate decisions as and when required.
6. He lives in a world of reality and not in a world of fantasy. He does not run away from harsh reality of life.
7. He has the courage for facing failures in his. He learns from his mistake and improves in his functioning.
8. He conforms to the norms of his group and has a sense of belongingness to his group.
9. He sorts cut his problems appropriately and so does not suffer from anxiety frustration or conflicts.
10. He is always punctual for his duties and does not suffer from forget fullness.
11. He is self confident and optimistic.
12. He has an adequate sex adjustment and does not suffer from sex abnormalities.
13. He is well adjusted and happy his profession.
14. He leads a balanced life of work rest and recreation.

Assessing mental health:

The term mental health encompasses a great deal about a single person, including how we feel, how we behave, and how well we function. This single aspect of our person cannot be measured or easily reported but it is possible to obtain a global picture by collecting subjective and objective information in order to delve into
a person true mental health and well being. When identifying mental health wellness and planning interventions, here are a few things to keep in mind when completing a thorough mental health assessment in the nursing profession:

- Is the patient sleeping adequate hours on a regular sleeping cycle?
- Does the patient have a lack of interest in communication with other individuals?
- Is the patient eating and maintaining an adequate nutritional status?
- Is the ability to perform activities of daily living present (bathing, dressing, toileting oneself)?
- Can the patient contribute to society and maintain employment?
- Is the ability to reason present?
- Is safety a recurring issue?
- Does the patient frequently make decisions without regards to their own safety or the safety of others?
- Does the patient exhibit a difficulty with memory or recognizance?

**Physical and Biological Interventions:**

**Psychiatric medication:**

Psychiatric medication is a commonly used intervention and many psychiatric mental health nurses are involved in the administration of medicines, both in oral (e.g., tablet or liquid) form or by intramuscular injection. Nurses will monitor for side effects and response to these medical treatments by using assessments. Nurses will also offer information on medication so that, where possible, the person in care can make an informed choice, using the best evidence available.

**Electroconvulsive therapy:**

Psychiatric mental health nurses are also involved in the administration of the treatment of electroconvulsive therapy and assist with the preparation and recovery from the treatment, which involves an anesthesia. This treatment is only used in a tiny proportion of cases and only after all other possible treatments have been exhausted. Approximately 85% of clients receiving ECT have major depression as the
indication for use, with the remainder having another mental disease such as schizoaffective disorder, mania or schizophrenia.

**Physical care:**

Along with other nurses, psychiatric mental health nurses will intervene in areas of physical need to ensure that people have acceptable levels of personal hygiene, nutrition, sleep etc., as well as tending to any concomitant physical ailments.

**Psychosocial interventions:**

Psychosocial interventions are increasingly delivered by nurses in mental health settings and include psychotherapy interventions such as cognitive behavioral therapy, family therapy and less commonly other interventions such as milieu therapy or psychodynamic approaches. These interventions can be applied to a broad range of problems including psychosis, depression and anxiety. Nurses will work with people over a period of time and use psychological methods to teach the person psychological techniques that they can then use to aid recovery and help manage any future crisis in their mental health. In practice, these interventions will be used often, in conjunction with psychiatric medications. Psychosocial interventions are based on evidence based practice and therefore the techniques tend to follow set guidelines based upon what has been demonstrated to be effective by nursing research. There has been some criticism that evidence based practice is focused primarily on quantitative research and should reflect also a more qualitative research approach that seeks to understand the meaning of people’s experience.

**Spiritual interventions:**

The basis of this approach is to look at mental illness or distress from the perspective of a spiritual crisis. Spiritual interventions focus on developing a sense of meaning, purpose and hope for the person in their current life experience. Spiritual interventions involve listening to the person’s story and facilitating the person to connect to God, a greater power or greater whole, perhaps by using meditation or prayer. This may be a religious or non-religious experience depending on the individual’s own spirituality. Spiritual interventions, along with psychosocial
interventions, emphasize the importance of engagement, however, spiritual interventions focus more on caring and ‘being with’ the person during their time of crisis, rather than intervening and trying and ‘fix’ the problem. Spiritual interventions tend to be based on qualitative reach and share some similarities with the humanistic approach to psychotherapy.

Organization of mental healthcare:

Psychiatric mental health nurses work in a variety of hospital and community settings:

- People generally require an admission to hospital, voluntarily or involuntarily if they are experiencing a crisis that means they are dangerous to themselves or others in some immediate way. However, people may gain admission for a concentrated period of therapy or for respite. Despite changes in mental health policy in many countries that have closed psychiatric hospitals, many nurses continue work in hospitals though patient length of stay has decreased significantly.

- Community nurses in mental health work with people in their own homes (case management) and will often emphasize work on mental health promotion. Psychiatric mental health nurses also work in rehabilitation settings where people are recovering from a crisis episode and the where the aim is social inclusion and a return to living independently in society.

- Psychiatric mental health nurses also work in forensic psychiatry with people who have mental health problems and have committed crimes. Forensic mental health nurses work in adult prisons, young offenders' institutions, medium secure hospitals and high secure hospitals. In addition forensic mental health nurses work with people in the community who have been released from prison or hospital and require ongoing mental health service support.

- People in the older age group who are more prone to dementia tend to be cared for in separate places than younger adults and there are also specialist services for the care of adolescents with mental health problems. Occasionally there have been
efforts to integrate psychiatric units across the age spectrum.

Mental health is a more complex concept than physical health. It is much more difficult to measure though we can usually recognize the extreme cases of mental illness easily. It is difficult to categorize individuals who are normal in other ways but may have a problem in understanding another person viewpoint or being sensitive to the emotional needs of others. Such problems if they were sufficiently serious and persistent would definitely be indicative of poor mental health.

Declaration of Alma Ata on September 12, 1978, identified primary health care as a rational and practical means for developing and industrialized nations to achieve health for all by the year 2000. It was hoped that “attainment of this level of health by people will permit them to live a biologically healthy, socially enriching and economically productive life, irrespective of any national boundaries, racial prejudices economic deprivation and political commitments”. To achieve the goal of the ‘Alma Ata Declaration’, the mental health services were to be integrated with health and social services so as to ensure the community as well being. This declaration did not specifically answer and respond to the question related to mental health and human rights, but it was instrumental in laying down the foundation of subsequent developments in that direction.

The importance of mental health has been known to range from the care of the ill to the promotion of mental health. The field of mental health includes three sets of objective’s one of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness, which however, not the same of every individual. The objective for those persons is prevention. The third objective has to do with the upgrading of mental health of normal persons quite apart from any question of disease or infirmity. This is positive mental health. It consists in the protection and development at all levels, of human society of secure, affectionate and satisfying
human relationships and in the reduction of hostile tensions in persons and groups (Govindaswamy, 1970).

Therefore, mental health covers an elusive and defuse field and thus encompasses a multiplicity of meaning. As Schultz (1977) remarks the concept of mental health is difficulty, challenging and complex. Mental health has attracted comprehensive operation in research and theoretical exposition.

The World Federation for Mental Health, a non-governmental organization, was founded in 1948 conceived mental health in social terms. It linked the mental health of individuals to the well being of communities and nations. Brody (1987) translates the “ability to live with one’s fellows” as the capacity to empathize, to relate and to collaborate with one another. According to the United Nations Universal Declaration of Human Rights the opportunity to be healthy, both mentally and physically, was conceived as a human right in itself. It recognized the interdependence of the “human family” and the legitimacy of the common longings and needs of people everywhere.

**CONCEPT OF STRESS:**

The modern world, which is said to be a world of achievements, is also a world of stress. One finds stress everywhere, whether it be within the family, business organization/enterprise or any other social or economic activity. Right from the time of birth till the last breath drawn, an individual is invariably exposed to various stressful situations.

The word 'stress' is defined by the Oxford Dictionary as "a state of affair involving demand on physical or mental energy". A condition or circumstance (not always adverse), which can disturb the normal physical and mental health of an individual. In medical parlance 'stress' is defined as a perturbation of the body's homeostasis. This demand on mind-body occurs when it tries to cope with incessant changes in life. A 'stress' condition seems 'relative' in nature. Extreme stress conditions, psychologists say, are detrimental to human health but in moderation stress is normal and, in many cases, proves useful. Stress, nonetheless, is synonymous
with negative conditions. Today, with the rapid diversification of human activity, we come face to face with numerous causes of stress and the symptoms of stress and depressions.

The concept of stress was first introduced in the life sciences by Selye in 1956. It is a concept borrowed from the natural sciences. Derived from the Latin world ‘Stringer’, stress was popularly used in the seventeenth century to mean hardship, strain, adversity or affliction. It was used in the eighteenth and nineteenth centuries to denote force, pressure, strain or strong effort with reference to an object or person. In psycho-physiology, stress refers to some stimulus resulting in a detectable strain that cannot be accommodated by the organism and which ultimately results in impaired health or behavior.

In the common parlance, however, the terms ‘stress’ and ‘strain’ are used synonymously in a non-scientific manner.

According to Selye (1956), “any external event or any internal drive which threatens to upset the organism equilibrium is stress”. Lazarus and Folkman (1984) define stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her well-being”.

According to Mason (1975) the stress has been approached in at least four different ways.

- As the stimulus or external force acting on the organism.
- As the response or changes in the physiological functions.
- As the interaction between an external force and the resistance opposed to it, as in biology.
- As a comprehensive phenomenon encompassing all the three.

Psychologists have been studying stress and its impact on psychological and physical health for several decades. Stress is a negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioral changes that are directed either toward altering the stressful event or accommodating
to its effects  (Baum, 1990).

Mason (1975) reviewed literature on stress and concluded that there was confusion and a lack of consensus regarding its definition. The term stress has been approached in at least four different ways. First, as the stimulus or external force acting on the organism; second, as the response or changes in the physiological functions; third, as the interaction between an external force and the resistance opposed to it, as in biology; and finally, as a comprehensive phenomenon encompassing all the three.

Agarwal et al. (1979) believed that the confusion in definition is primarily due to the fact that the same term is used variously by scholars of different disciplines. Thus, in physics, stress is force which acts on a body to produce strain. In physiology, the various changes in the physiological functions in response to evocative agents denote stress (rather than strain). In psychology, stress refers to a particular kind of state of the organism resulting from some interaction between him/her and the environment.

The term stress is used to connote a variety of meanings both by the common man and psychologists. Psychologists of different persuasions have given (a) stimulus-oriented, (b) response-oriented (both physiological and behavioral) definitions of the term and (c) depth psychologists have treated the concept from the etiological and psychodynamic viewpoints. It appears that under these circumstances the essential features of the stress experience have not received the attention they deserve (Asthana, 1983).

**Stimulus-Oriented Approach**

Stress is regarded as an external force which is perceived as threatening. Some view threat itself as stress. According to Selye (1956) any external even or any internal drive which threatens to upset the organism equilibrium is stress.

**Response-Oriented Approach**

The nature of stress, it is claimed, can be understood best in terms of the way people perceive and ascribe meaning to stress-producing situations, the values they
attribute to actions and the way they interact with events. Stress cognition is conceived as pre-conceptual; it is more adjectival than motivational. Psychiatrists have identified four phases in the reaction to stress – the initial phase of anticipatory threat, the impact of stress, the recoil phase and the post-traumatic phase.

The response-oriented approaches describe how stress is reacted to, and how people function under stress. The way it is presumably experienced is inferred from the response made to it. The biologically-oriented approach to stress is also response-oriented, i.e., it views the reactions of the organism as attempts to come to terms with the environment. Psychologists feel secure if they are able to successfully relate the psychological to the physiological processes by establishing concomitant variation in the vicissitudes of the psyche relative to change in the soma. Such a reductionist explanation seems to satisfy the physiologically-oriented psychologists.

**The Psychodynamic Approach**

This approach considers events (both external and internal) which pose a threat to the integrity of the organism leading to the disorganization of personality as stress. Stress presages loss of ego strength and loss of ego support. Stress may be interpersonal (external) or intra-psychic (between own impulses and ego) factors resulting in anxiety.

The socially-oriented psychologists believe that the intra-psychic needs call into play mechanisms of perceptual selection, defense and vigilance. There are wide variations in reactions to stress and the capacity to tolerate it between persons, and in the same individual on different occasions. The most basic fact about stress is that, like feelings, stress is experienced. The feeling of stress is an act in which there is a reference, not a casual relation, to an object that is intended or intentionally presents.

**Positive Role of Stress**

Present-day researchers and practitioners visualize the phenomenon of stress in a new perspective. As Kets de Vries (1979) had noted, each individual needs a moderate amount of stress to be alert and capable of functioning effectively in an organization. It may prove as an asset so long as it is tolerable and helps in creating
healthy competition. Organizational excellence and individual success are achieved through well-managed stresses.

Indian scholars (Pestonjee, 1987; Mathew, 1985), in their conceptual papers agreed with this contention. Mathew has gone to the extent of advocating the particular types of stresses are essential for being a creative manager. However, no empirical work has been done on these lines. An exception is the study titled ‘Organizational Behavior Issues for Managers and Systems Analysts’ (Pestonjee and Singh, 1987). While studying stresses and job satisfaction in the case of managers and system analysts, they noted that managers and system analysts in private organizations scored higher on both stress and satisfaction as compared to their counterparts in public organizations. They explained their findings in the light of the characteristics to private organizations which generate greater stress and, in turn, lead to higher job satisfaction.

Theories of Stress

Fight-or-Flight

One of the earliest contributions to stress research was Walter Cannon’s (1932) description of the fight-or-flight response. Cannon proposed that, when an organism perceives a threat, the body is rapidly aroused and motivated via the sympathetic nervous system and the endocrine system. This concerted physiological response mobilizes the organism to attack the threat or to flee; hence, it is called the fight-or-flight response (Kemeny, 2003).

At one time, fight-or-flight literally referred to fighting or fleeing in response to stressful events such as attack by a predator. Now more commonly fight refers to aggressive responses to stress, whereas flight may be seen in social withdrawal or withdrawal through substance use such as alcohol or drugs.

On the one hand, the fight-or-flight response is adaptive because it enables the organism to respond quickly to threat. On the other hand, it can be harmful because stress disrupts emotional and physiological functioning, and when stress continues unabated, it lays the groundwork for health problems.
Selye’s General Adaptation Syndrome

Another important early contribution to the field of stress is Selye’s (1956) work on the general adaptation syndrome. Although Selye initially intended to explore the effects of sex hormones on physiological functions, he became interested in the stressful impact his interventions seemed to have. Accordingly, he exposed rats to a variety of stressors – such as extreme cold and fatigue – and observed their physiological responses. To his surprise, all stressors, regardless of type, produced essentially the same pattern of physiological responding. In particular, they all led to an enlarged adrenal cortex, shrinking of the thymus and lymph glands and ulceration of the stomach and duodenum. Thus, whereas Cannon’s work explored adrenomedullary responses to stress – specially, catecholamine secretion – Selye’s work more closely explored adrenocortical responses to stress.

From these observations, Selye (1956) developed his concept of the general adaptation syndrome. He argued that, when an organism confronts a stressor, it mobilizes itself for action. The response itself is non-specific with respect to the stressor; that is, regardless of the cause of the threat, the individual will respond with the same physiological pattern of reactions. Over time, with repeated or prolonged exposure to stress, there will be wear and tear on the system.

The general adaptation syndrome consists of three phases. In the first phase, alarm, the organism becomes mobilized to meet the threat. In the second phase, resistance, the organism makes efforts to cope with the threat, as through confrontation. The third phase, exhaustion, occurs if the organism fails to overcome the threat and depletes its physiological resources in the process of trying.

Assessing Stress

Given that stress can produce a variety of responses, what is the best way to measure it? Researchers have used many indicators of stress. These include self-reports of perceived stress, life change and emotional distress; behavioral measures, such as task performance under stress; physiological measures of arousal, such as heart rate and blood pressure; and biochemical markers (or indicators), especially elevated catecholamine and alterations in the
diurnal rhythm of cortisol or cortisol responses to stress (Baum et al., 1982; Dimsdale et al., 1987). In each case, these measures have proven to be useful indicators.

However, each type of measurement has its own associated problems. For example, catecholamine secretion is enhanced by a number of factors other than stress. Self-report measures are subject to a variety of biases, because individuals may want to present themselves in as desirable a light as possible. Behavioral measures are subject to multiple interpretations. For example, performance declines can be due to declining motivation, fatigue, cognitive strain, or other factors. Consequently, stress researchers have called for the use of multiple measures (Baum et al., 1982). With several measures, the possibility of job-training a good model of the stress experience is increased.

Dimensions of Stressful Events

As we have just noted, events themselves are not inherently stressful. Rather, whether they are stressful depends on how they are appraised by an individual. What are some characteristics of potential stressors that make them more likely to be appraised as stressful?

Negative Events

Negative events are more likely to produce stress than are positive events. Many events have the potential to be stressful because they present people with extra work or special problems that may tax or exceed their resources. Shopping for the holidays, planning a party, coping with an unexpected job promotion and getting married are all positive events that draw off substantial time and energy. Nonetheless, these positive experiences are less likely to be reported as stressful than are less likely to be reported stressful than are undesirable events, such as getting a traffic ticket, trying to find a job, coping with a death in the family, or getting divorced. Negative events show a stronger relationship to both psychological distress and physical symptoms than do positive ones (Sarason, Johnson and Siegel, 1978). This may be because negative stressful events have implications for the self-concept producing loss of self-esteem or erosion of a sense of mastery or identity (Thoits, 1986).
There is one exception to this pattern. Among people who hold negative views of themselves, positive life events can have a detrimental effect on health, whereas for people with high self-esteem, positive life events are linked to better health (Brown and McGill, 1989).

Uncontrollable Events

Uncontrollable or unpredictable events are more stressful than controllable or predictable ones. Uncontrollable events are perceived as more stressful than controllable ones. When people feel that they can predict, modify, or terminate an aversive event or feel they have access to someone who can influence it, they experience it as less stressful, even if they actually do nothing about it (Thompson, 1981). For example, unpredictable bursts of noise are experienced as more stressful than are predictable ones (Glass and Singer, 1972).

Feelings of control not only mute the subjective experience of stress but also influence biochemical reactions to it. Believing that one can control a stressor such as noise level (Lundberg and Frankenhaeuser, 1976) or crowding (Singer et al., 1978) is associated with lower catecholamine levels than believes that one has no control over the stressor. Uncontrollable stress has been tied to immunosuppressive effects as well (Borscht et al., 1998; Peter’s et al., 1999).

Ambiguous Events

Ambiguous events are often perceived as more stressful than are clear-cut events. When a potential stressor is ambiguous, a person has no opportunity to take action. He or she must instead devote energy to trying to understand the stressor, which can be a time-consuming, resource-sapping task.

Clear-cut stressors, on the other hand, let the person get on with the job of finding solutions and do not leave him or her stuck at the problem-definition stage. The ability to take confrontation action is usually associated with less distress and better coping (Billings and Moos, 1984).
Overload

Overloaded people are more stressed than are people with fewer tasks to perform (Cohen, 1978; Cohen and Williamson, 1988). People who have too many tasks in their lives report higher levels of stress than do those who have fewer tasks. For example, one of the main sources of work-related stress is job overload, the perception that one is responsible for doing too much in too short a period of time.

CONCEPT OF ANXIETY:

Anxiety has been defined in variety of way such as “a disturbed state” of the body (Johnson, 1951) emotional reactivity. Hardman and Johnson (1952) arousal (Skubic, 1986) nervousness (Ekegami, 1970), neuroticism (Pikunas, 1969 and Kane, 1970) unrealistic and unpleasant state of body and mind In medical, terminology anxiety is defined as apprehension of danger accompanied by restlessness and feelings of oppression in the epigastrium. A variety of psychological reaction such as increased heart rate, rapid shallow berating, sweating, muscles tension and drying of the mouth are associated with Anxiety, fear and Anxiety differs in one important respect. Fear has an obvious cause and once that cause is eliminated, the fear will subside; in contrast anxiety is less clearly linked to specific events or stimuli. Therefore, it tends to be more pervasive and less responses to changes in the environmental (Crooks and Stein, 1988).

Fear is usually defined are rational emotional reaction to danger or the anticipation of danger or harm form a real objective stimulus in the external environment. Moreover the magnitude of the fear is directly proportional to the amount of danger that evokes it. In contrast that may be unknown to others. Moreover, the intensity of the anxiety is after of the objectively measured danger.

A variety of types have been given to anxiety such as trait anxiety, state anxiety manifest anxiety, chronic anxiety specific anxiety etc. Spielberger (1966) was first anxiety theorist to distinguish between state and trait anxiety, Burton (1976) and Martens (1971) also supported these concepts.

As an emotional reaction, anxiety is innate and plays a crucial role in shaping human behavior. Lingis (1976) argues that in all anxious anticipation “there is a sense
of void” which produces a sense of vulnerability (the bases for distress) as well as (a level of exhilaration). Anxiety therefore, is understood not as “a solid core of substance” but as “a current of forces assembling and dissipating itself”. Anxiety has extremely wide dimension as is clear from various definitions given, above. Like any other emotion, anxiety is a psycho-physiological phenomenon on the one end of which lie numerous physiological actions reactions raising the arousal and activation level of the body and on the other, stands, a feeling tone”, a cognitive state having for reaching consequences and effect on human psyche, viewed as a cognitive label, anxiety may occur within various time frames relative to the existence of potentially stressful event.

Anxiety has often been used as synonym for activation and arousal. Although this may not be wholly true but we cannot escape this notion because of the vital physiological changes that occur during anxiety. In psychological literature, anxiety is documented primarily as a psychological state; it nevertheless has such psychological indices associated with it as dry mouth, clam palms, wet forehead, increased, cardio-reaction, reaction faster metabolic activity etc.

Anxiety affects psychological and physiological working of the organisms in numerous ways. For instance, anxious individuals are said to have reduced attention control. During heightened activity (anxiety inclusive) attention cannot remain one pointed it, is distributed to various aspects of the organisms activity which is chaotic and intensive. There is an effect on the individuals judgment, anxiety often results, in narrowing of the field of attention as relevant cues are excluded. Loss of information seems to be processed by those under momentary (state) anxiety or those whose deeper personality system is marked by high levels of trait anxiety (Cratly, 1989). Anxious individuals have also been found to be tensed or highly strung. As a result, their performance in tasks involving precise neuro-muscular coordination is quite low compared to those who are less anxious and perform under tension free state of body and mind. In nut shell, anxiety retards muscular performance.

Cratly (1989) rightly concludes that “anxiety” does not result in a physical vacuum but, is usually a part of complex of feelings that may include low self esteem,
helplessness, depression or aggressive thoughts and behaviors’. The persistent negative feeling associated with anxiety coupled with psychological commotion (an inevitable result of high anxiety syndrome), ultimately makes the individuals fall a prey to psycho-somatic disorders. Logically equanimity between activation arousal and anxiety may be convincing, realistically it is not because anxiety is much more complex phenomenon than general activation arousal physiological state of the body.

There have also been attempts to draw parallels between stress and anxiety. Both may be internal states causing the organic to react to the external threat in their specific ways, simultaneously working out natural coping strategies to maintain homeostasis, and bring about adjustment. The notion of trait and state anxiety is said to be closely related to the notions of stressful events, situational stresses, and so called life stresses. Repeated exposure to stressful situation may have either of two important out comes (Craley, 1989); either the individual becomes better able to handle stress as psycho-physiological adjustment are made thus lowering levels of general trait anxiety, or repeated stresses or a combination of stresses in life and in competition may cumulatively break down in the individuals coping mechanism leading to higher levels of both state and trait anxiety that in turn will impede performance of many kinds including athletic behavior. Stress is event related and specific and is internal psychological condition. Stress is event related and specific and is internal psychological condition. Stress may cause anxiety and anxiety, in turn, lead to strain a bodily and psychological reaction to stress. The ability and the ways people react to stressful situation differ from individual to individual. Some may manifest restlessness of mind and body; others may exhibit tendencies to heighten muscle tone or some unique patterns of muscular activity.

The term stress is part of every language, and has several meaning. Stress is mental and physical condition that results from a perceived threat or dangerous that results from a perceived threat or dangerous that cannot be with reality. If you perceive something to be dangerous or challenging you will experience the bodily responses known as stress.

Stress is often associated with strain, yet the two terms differ in an important way. Stress is your response to a force that upsets your equilisium. Strain is the
adverse effects of stress on an individual’s mind, body and action.

Few people can escape work stress, which is fortunate, because escaping all forms of stress would be undesirable for most of us. An optimum amount of stress for most people and most takes.

The individual makes a cognitive evaluation of whether a given event or situation is a stressor. If you perceive an event to be thrilling or highly challenging it becomes a stressor. The stressor can stem from factors within the individual. For instance if the individual has low self-confidence he or she will experience frequent stress. If the organization expects professional management employees to work 70 hours a week, many organization members will experience stress.

In psychology stress refers to a state of organism resulting from some interaction with the environment. In psychophysiology, stress is stimuli, which imposes detectable strain that cannot be easily accommodated by the bodily and so present itself impaired health or behavior.

Many people think of stress as a simple problem. In reality, however, stress is complex and often misunderstood. To learn how job stress freely works, we must first define it and then describe the process through which it develops.

Stress is an independent variable influencing employee’s satisfaction and performance. Second, it is incumbent on management to improve quality of life of organizational members. As stress is linked to coronary heart disease, a reduction in stress is expected to improve longevity of work force.

Simple total stress is an individual’s reaction to a disturbing factor in the environment. To quote a formal definition, “stress is defined as an adoptive response to an external situation that results in physical psychological and /or behavioral deviations for organizational participant.

The terms personality often figures in discussions on one’s job prospects, achievement and on other similar occasions. In all these events personality is understood in its narrow sense as implying one’s charm, popularity, dress and other
physical attractiveness. Perceiving personality in this narrow sense will not help much in understanding an individual’s behaviors an organization.

Stress in usually thought of in negative terms. It is thought to be caused by something bad. All though there are numerous definitions and much debate about the meaning of job Stress. Inancewich and Mattson define stress simply as the interaction of individual with the environment, but there they go on to give a more detailed working definitions as follows, “an adaptive response, mediated by individual difference and or psychological processes, that is a consequence of any external (environment) action, situation or event that place excessive psychological or physical demands upon a person.

Beehr and Newman define job stress as “a condition arising from the interaction of people and their jobs and characterized by changes within people that face them to deviate from their normal functioning. Taking these two definitions them for the purposes. “Stress” is defined as an adaptive response to an external situation that results in physical, Psychological and behavioral deviations for organization participants.

It is also important to point out what stress is not.

1. Stress is not simply anxiety. Anxiety operates solely in the emotional and psychological sphere, where as stress operates their and also in the physiological sphere. Thus, stress may be accompanied by anxiety, but the two should be equated.

2. Stress is not simple nervous tension. Like anxiety nervous tension may result from stress but the two are not the same. Unconscious people have exhibited stress and some people may keep it “bottled up” and not received it through nervous tension.

3. Stress is not necessarily something damaging, bad or to be avoided. Eustress is not damaging or bed and is something people should seek out rather than avoid. The key, of course, is how the person handles the stress. Stress is in enviousable; distress may be prevented or can be effectively controlled.
Extra organizational stressors include things such as society technological change, the family, economic and financial conditions, race and class, and community conditions. A great effect on people’s life styles and this of course is carried ever into their jobs. The space of modern living has increased stress and decreased personal wellness. This latter concept of wellness has been defined as “a harmonious and productive balance of physical, mental and social well being brought about by the acceptance of one’s personal responsibility for developing and termed to a health promotion program. Because people trend to get caught up in the rush mobile, urbanized, crawdad, on the go lifestyle of today, their wellness in general has determined and the potential for stress on the job has increased.

A pension family has a big impact on personality development. A family situation either a brief crisis, such as a squabble or the illness of a family members, many people have been forced to take a second job (man light) or the spouse has had to enter the work force in order to marks ends meet this under time for recreational and family activities. The overall effect on the employees is more stress on their primary jobs.

**Individual stresses:**

There is also more research and agreement on individual level stresses. Although there are many possible individual stress three areas seem to be more recognized them other. There are going from very narrow to border based unit at analysis. (1) Role stressors including conflict, ambiguity and overload. (2) Personal characteristics, including personality dimensions and Type A behavior patterns. (3) Life and career changes.

**Role characteristics:**

Individual employees have multiple rules (family, work professional community and so on) and these often make conflicting demands and create conflicting expectations. After a recent extensive search of the empirical research it was concluded that “work schedule, work orientation, marriage, children, employment patterns, may all produce pressures to participate extensively in the
work role or family role”.

Role ambiguity results from inadequate information or knowledge to do a job. The ambiguity may be due to inadequate training, poor communication. In any event, the result of role, conflict and ambiguity in stress for the individual and there is a substantial body of research indicating undesirable outcomes for the individual and the organization.

Type A characteristics:

Personality traits such as femininity, extroversion, spontaneity, emotionality tolerance for ambiguity, locus of control, anxiety and the need for achievement have been control, uncovered by research as being particularly relevant to individual stress, most recent attention however has consider on the so called “Type A personality”.

Friedman and Rasenman define the Type A personality person as “an action emotion complex that can be observed in any person who is aggressively involved in a chronic to achieve more and more in less and less time, and it required to do so, against the opposing efforts of other things or others person.

Life and career changes:

Like technological and social change life and /or career changes can be stress producing. Life’s changes may be slow or sudden.

The same can be said for career changes, being suddenly through into a new job with new responsibilities can be very stressful.

Personal characteristics of stress:

Individual difference are variable that allow us to distinguish among people on such basis as gender, race or ethnicity, age, social status, past experience, heredity, intelligence and personality type. These and other individual difference pose special problem for stress research, because these variables seem to be important determinants of how people perceive and react to stressors and the type of stress
outcomes they experience. Specifically, in difficult differences can change or moderate the stressor strain relationship. For example you may have a hypothesis that women perceive stressors differently and response differently from the man. If this is true, they you could say that gender moderate the stressor – strain relationship.

Because of difference in lifestyles, experience and heritage people who are members of ethnic minorities may perceive and respond to stress differently from the whole majority. However, very little research exists on radial differences in job related stress.

CONCEPT OF HIV/ AIDS:

HIV/AIDS is one of the main health and social challenge in the contemporary world. India is experiencing rapid and extensive spread of HIV infection. Indian stands among the countries which have highest number of persons living with HIV/AIDS today. HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006.

HIV is an acronym for the term “Human Immunodeficiency Virus” and can be explained as a virus, which enters into the cells of the body and weakens the body’s ability to fight other disease and infection (Murray, 1999). It is further described by the centre of disease Control and Prevention as the Virus which causes, or results in the onset of AIDS (CDC, 2001).

Murray (1999) describes AIDS as the disease a person with HIV gets. AIDS is an acronym for “Acquired Immune Deficiency Syndrome” (Mbuya, 2000). Acquired means that it is not genetically inherited but it is a result of an environmental factor. Immune Deficiency describes the resulting weakening of the infected person’s immune system, and Syndrome refers to the characteristic of this disease in that it does not present with one specific disease but rather a collection of symptoms.
There are two types of HIV, HIV-1 and HIV-2. In the United States, unless otherwise noted, the term “HIV” primarily refers to HIV-1. Both types of HIV damage a person’s body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of people living with HIV, and may reduce their ability to transmit HIV. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer. Support services are also available to many people with
HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services.

AIDS is the late stage of HIV infection, when a person’s immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of “highly active” combinations of medications that were introduced in the mid 1990s.

No one should become complacent about HIV and AIDS. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments need to be taken daily for the rest of a person’s life, need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Despite major advances in diagnosing and treating HIV infection, in 2007, 35,962 cases of AIDS were diagnosed and 14,110 deaths among people living with HIV were reported in the United States.

**Brief History of HIV/AIDS:**

In 1986, the first known case of HIV was diagnosed by Dr. Suniti Solmon amongst female sex workers in Chennai. Later the year, sex workers began showing signs of this deadly disease. At that time, foreigners in India were traveling in and out of the country. It is thought that these foreigners were the ones responsible for the first infections. By 1887, about 135 more cases came to light. Among these 14 had already progressed to AIDS. Prevalence in high risk groups reached above 5% by 1990. As per UNDP’s 2010 report, India had 2.39 million (23.95 lakh) people living with HIV at the end of 2009, up from 2.27 million (22.7 lakh) in 2008. Adult prevalence also rose from 0.29% in 2008 to 0.31% in 2009.

In 1986, HIV started its epidemic in India, attacking sex workers in Chennai, Tamil Nadu. Setting up HIV screening centers was the first step taken by the government to screen its citizens and the blood bank.
To control the spread of the virus, the Indian government set up the National AIDS Control Programmed in 1987 to co-ordinate national responses such as blood screening and health education.

In 1992, the government set up the National AIDS Control Organization (NACO) to oversee policies and prevention and control programs relating to HIV and AIDS and the National AIDS Control Program (NACP) for HIV prevention. The State AIDS Control Societies (SACS) was set up in 25 societies and 7 union territories to improving blood safety. In 1999, the second phase of the National AIDS Control Program (NACP II) was introduced to decrease the reach of HIV by promoting behavior change. The prevention of mother-to-child transmission program (PMTCT) and the provision of antiretroviral treatment were materialized. In 2007, the third phase of the National AIDS Control Program (NACP III) targeted the high-risk groups, conducted outreach programs, amongst others. It also decentralized the effort to local levels and non-governmental organizations (NGOs) to provide welfare services to the affected.

Modes of Transmission:

The HIV is transmitted through infected blood and body fluids. Sexual transmission is the most common route of transmission.

1. Sexual transmisión (Unsafe sexual practices)
   Heterosexual
   Homosexual
2. Blood contact (Contaminated Blood)
   Blood transfusion
   Intravenous drug use
   Occupation exposure (needle stick)
3. Mother to child transmission (Infected mother to new born)
   In-Uterus
   During delivery
   Breast feeding
The key risk groups are
- High Risk Groups (HRG)
  - Female Sex Workers (FSW)
  - Men who have Sex with Men (MSM)
  - Transgender (TG)
  - Injecting Drug Users (IDU)
- Bridge Populations
  - Truckers
  - Migrants

Routes of Transmission of HIV, India, 2011-12

Estimated Annual New HIV Infections:

New HIV infections have declined by more than 50% over the past decade from 2.7 lakh in 2000 to 1.2 lakh in 2009. Of these, six high prevalence states account for only 39%, while the states of Orissa, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat together account for 41% of new infections.
Stages of Disease:

AIDS is a disease which is caused in slow and gradual process. Theoretically, four stages have been identified in the development of HIV/AIDS infection.

1. **Initial HIV Infection:** In this stage, with the entering of HIV virus in the body, some people come to experience temporary serocon version disease within few weeks which resembles influenza with symptoms like fever, body ache and headache. The immune system in the body produces antibodies which does not destroy the HIV virus. After this, no characteristic develops for months and years together, but during this period a person can spread the HIV infection to others through sex, shared needles, blood transfusion, etc.

**HIV and AIDS Statistics – Worldwide:**

HIV/AIDS remains one of the world's most significant public health challenges, particularly in low- and middle-income countries. As a result of recent advances in access to antiretroviral therapy (ART), HIV-positive people now live longer and healthier lives. In addition, it has been confirmed that ART prevents onward transmission of HIV.

In 2011, there were 34 million people living with HIV. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral (anti-HIV) therapy, which has helped reduce AIDS-related deaths, especially in more recent years.

Worldwide, 2.5 million people became newly infected with HIV in 2011. There were 2.7 million [2.4 million–2.9 million] new HIV infections in 2010. 25 countries have seen a 50% or greater drop in new HIV infections since 2001. In 2011, new infections in children were 43% lower than in 2003, and 24% lower than 2009.

At the end of 2012, close to 10 million people were receiving ART in low- and middle-income countries. However, over 16 million other people who are eligible for ART under new 2013 guidelines do not have access to antiretroviral drugs. There were also 2.1 million adolescents living with HIV in 2012. But progress has been made. In
2011, 56% of pregnant women living with HIV received the most effective drug regimens (as recommended by WHO) to prevent mother-to-child transmission of the virus.

WHO has released a set of normative guidelines and provides support to countries in formulating and implementing policies and programs to improve and scale up HIV prevention, treatment, care and support services for all people in need.

Misconceptions about HIV Contraction:

People are often concerned that HIV can be contracted through common contacts with an HIV infected person, such as shaking hands or sharing glasses or eating utensils sharing the dresses, using the same toilet. These are not risk factors for contracting HIV. There is no evidence that HIV can be spread through these means, and people should not be afraid to be around people who have HIV or to use a glass, eating utensils, or plate that an HIV infected persons has used, or to have other common contacts.

CONCEPT OF TUBERCULOSIS (TB):

TB is an infectious disease caused by *Mycobacterium tuberculosis* (M.tuberculosis) bacilli. TB bacilli mainly affect the lungs, causing lung tuberculosis (pulmonary TB). However, in some cases, other parts of the body may also be affected, leading to extra-pulmonary tuberculosis. Pulmonary TB is more common in HIV infected TB patients compared to in HIV negative TB patients.

TB germs usually spread through the air. When a patient with untreated pulmonary TB coughs, sneezes or talks, they involuntarily throw TB germs into the air in the form of tiny droplets. These tiny droplets, when inhaled by another person, may cause TB. Untreated TB cases spread the infection to others in the community; each infectious patient can infect 10-15 individuals in a year unless they are effectively treated.
TB Infection versus TB Disease:

TB infection: Organism is present but dormant, cannot infect others, person is not sick.

TB disease: Person is sick and can transmit disease to others if in lungs.
10% of individuals with TB infection will develop TB disease
Each individual with active but untreated TB can infect 10-15 people/year.
When does TB Infection Become a Disease.
Most likely to occur in first two years after infection
If person become immune compromised
HIV Cancer Chemotherapy Poorly controlled diabetes Malnutrition.

Pulmonary TB

HIV –infected patients with TB can have:
Cough with expectoration of more than two week’s duration,
Fever Night sweats Weight loss of appetite Chest pain Haemoptysis Anemia

Extra-Pulmonary TB:

A person with extra pulmonary TB may have the following general symptoms:
Weight loss
Loss of appetite
Fever
Night sweats.

Sites and Symptoms of Active Extra Pulmonary TB Disease:
Other symptoms depend on the organ involved:
Lymph node TB: Swelling in the neck or armpit or without discharge
TB meningitis: Headache, fever, drowsiness, confusion, neck rigidity
Spinal TB: Back pain, fever and in some cases, swelling of the backbone
Pericardial TB: Chest pain, Shortness of breath.

How Tuberculosis Spreads:

TB can spread when a patient sneezes or coughs. People in close contact with the patient can become infected when they breathe in these germs (tubercle bacilli).
Stress the importance of taking all family members exposed to the disease (contacts) and who have symptoms of TB to the closest health facility for screening of TB. Prevent TB spreading, by covering the mouth and nose with cloth when coughing sneezing and avoid spitting in public.

**CONCEPT OF DIABETES:**

The mission of the WHO Diabetes Program is to prevent type 2 diabetes and to minimize complications and maximize quality of life for all people with diabetes. Our core functions are to set norms and standards, promote surveillance, encourage prevention, raise awareness and strengthen prevention and control.

The number of people with diabetes has risen from 108 million in 1980 to 422 million in 2014.

The global prevalence of diabetes* among adults over 18 years of age has risen from 4.7% in 1980 to 8.5% in 2014. Diabetes prevalence has been rising more rapidly in middle- and low-income countries.

Diabetes is a major cause of blindness, kidney failure, heart attacks, stroke and lower limb amputation. In 2012, an estimated 1.5 million deaths were directly caused by diabetes and another 2.2 million deaths were attributable to high blood glucose. Almost half of all deaths attributable to high blood glucose occur before the age of 70 years. WHO projects that diabetes will be the 7th leading cause of death in 2030.

Healthy diet, regular physical activity, maintaining a normal body weight and avoiding tobacco use are ways to prevent or delay the onset of type-2 diabetes. Diabetes can be treated and its consequences avoided or delayed with diet, physical activity, medication and regular screening and treatment for complications.

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood sugar. Hyperglycemia, or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body's systems, especially the nerves and blood vessels.
in 2014, 8.5% of adults aged 18 years and older had diabetes. In 2012 diabetes was the direct cause of 1.5 million deaths and high blood glucose was the cause of another 2.2 million deaths.

Type 1 diabetes (previously known as insulin-dependent, juvenile or childhood-onset) is characterized by deficient insulin production and requires daily administration of insulin. The cause of type 1 diabetes is not known and it is not preventable with current knowledge.

Symptoms include excessive excretion of urine (polyuria), thirst (polydipsia), constant hunger, weight loss, vision changes and fatigue. These symptoms may occur suddenly.

Type 2 diabetes (formerly called non-insulin-dependent or adult-onset) results from the body’s ineffective use of insulin. Type 2 diabetes comprises the majority of people with diabetes around the world, and is largely the result of excess body weight and physical inactivity. Symptoms may be similar to those of Type 1 diabetes, but are often less marked. As a result, the disease may be diagnosed several years after onset, once complications have already arisen.

Until recently, this type of diabetes was seen only in adults but it is now also occurring increasingly frequently in children.

Gestational diabetes is hyperglycemia with blood glucose values above normal but below those diagnostic of diabetes, occurring during pregnancy. Women with gestational diabetes are at an increased risk of complications during pregnancy and at delivery. They and their children are also at increased risk of type 2 diabetes in the future. Gestational diabetes is diagnosed through prenatal screening, rather than through reported symptoms. Impaired glucose tolerance (IGT) and impaired fasting glycaemia (IFG) are intermediate conditions in the transition between normality and diabetes. People with IGT or IFG are at high risk of progressing to type-2 diabetes, although this is not inevitable.
What are common consequences of diabetes?

Over time, diabetes can damage the heart, blood vessels, eyes, kidneys, and nerves:

Adults with diabetes have a 2-3-fold increased risk of heart attacks and strokes

Combined with reduced blood flow, neuropathy (nerve damage) in the feet increases the chance of foot ulcers, infection and eventual need for limb amputation.

Diabetic retinopathy is an important cause of blindness, and occurs as a result of long-term accumulated damage to the small blood vessels in the retina. 2.6% of global blindness can be attributed to diabetes.

Diabetes is among the leading causes of kidney failure.

Other costs saving interventions include:

Screening and treatment for retinopathy (which causes blindness); blood lipid control (to regulate cholesterol levels); screening for early signs of diabetes-related kidney disease and treatment.

WHO aims to stimulate and support the adoption of effective measures for the surveillance, prevention and control of diabetes and its complications, particularly in low and middle-income countries To this end, WHO:

- provides scientific guidelines for the prevention of major NCDs including diabetes;
- develops norms and standards for diabetes diagnosis and care;
- builds awareness on the global epidemic of diabetes, marking World Diabetes Day (14 November)
- Conducts surveillance of diabetes and its risk factors.
The “WHO Global report on diabetes” provides an overview of the diabetes burden, the interventions available to prevent and manage diabetes, and recommendations for governments, individuals, the civil society and the private sector.

The WHO “Global strategy on diet, physical activity and health” complements WHO's diabetes work by focusing on population-wide approaches to promote healthy diet and regular physical activity, thereby reducing the growing global problem of overweight people and obesity.

* Defined as fasting blood glucose equal to or higher than mmol/L, or on medication for raised blood glucose, or with a history of diagnosis of diabetes.

** High blood glucose is defined as a distribution of fasting plasma glucose in a population that is higher than the theoretical distribution that would minimize risks to health (derived from epidemiological studies). High blood glucose is a statistical concept, not a clinical or diagnostic category.

**CARE GIVER:**

Family caregivers and friends play a critical role in a loved one’s recovery from stroke, particularly as time spent in hospitals and rehabilitation facilities continues to decrease. Stroke recovery lasts for at least two years after stroke onset, so most of the support during this period comes from informal sources including friends and family members.

Providing care for a stroke patient can be an extremely rewarding experience. At the same time, it can be very stressful and frustrating to be suddenly thrust into the position of caregiver with little or no warning. It is crucial to remember to take care of your own needs in addition to those of the patient.

Also important to note is that stress tends to increase over time if the caregiver’s needs are not met. Some of those needs may include the need for information (especially better understanding of the emotional and behavioral changes of the patient), the need for skills in the physical aspects of care, and the need for support in the “case management” aspects of care. In terms of emotional reactions,
caregivers often feel one or more of the following: anxiety, guilt, depression, frustration, resentment, impatience, and fear. (Fear that a stroke may happen again, fear that the stroke survivor may be unable to accept his or her disabilities, fear that the survivor may require nursing home placement, fear that the caregiver may make mistakes, and fear that families and friends will abandon them.) Coping with these reactions is paramount to a healthy caregiver, and ultimately, to a well-adjusted patient.