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COVID-19 effects on women's home and work life, family violence and mental health from the Women's Health Expert Panel of the American Academy of Nursing

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ABSTRACT

Background: The COVID-19 pandemic exaggerated women's roles in families as primary caretakers and overseers of family health. This is compounded by possible loss of work and resultant loss of health insurance.

Purpose: We examine how pandemic-related factors have altered women's roles and created stressors challenging stress adaptation and typical coping strategies, including how registered nurses have faced unique challenges.

Family Violence and Pandemic-Related Mental Health Challenges: Enforced stay-athome orders exaggerated by work-from-home has amplified family violence worldwide. Besides COVID-19 protective measures increasing greater contact with abusers, they limited women's access to help or support. Pandemic-related issues increased anxiety, anger, stress, agitation and withdrawal for women, children, and registered nurses.

Discussion: More evidence about pandemic-related impacts on women's home and work lives, especially the scope of stressors and emotional/mental health manifestations is urgently needed. Policies to support interventions to improve mental health resilience are paramount.

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Our aim as American Academy of Nursing (AAN) Women's Health Expert Panel members is to promote awareness of COVID-19 pandemic factors impinging on women's health as underpinnings for research, practice, and policy change efforts. In this commentary, we examined how pandemic-related factors have altered women's roles and work, negatively affected mental health, exaggerated family violence, and created stressors challenging stress adaptation and typical coping strategies. We include a discussion of the added stressors and complications for women RNs who have challenges at work compounded by the issues many women face at home as well. Finally, we link the stressors to 2 AAN policy priorities (promote innovation and sustainability; reduce patient, provider, and system burden) to policy recommendations to alleviate the stressors discussed in this paper.

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Pandemic-Related Changes to Women's Roles and Family Stressors

The COVID-19 pandemic has exaggerated many normally occurring inequities experienced by women, such as excess responsibilities as primary caretakers for young, old and infirm family members, overseers of family health care and jugglers of family demands inside while working outside the home. Pandemic-related job loss from layoffs, job setting changes, and access (or lack of) to health care have amplified economic and health-related stressors for women.

Outside Employment

The pandemic has created a recession-type climate with a sharp rise in unemployment, reduction in working hours and/or temporary furloughing, especially affecting women. Pre-pandemic estimates demonstrated nearly half of US workers were women and 70% of mothers with children under age 18 were in the labor force. Yet, an income gap persisting for decades still shows women earn only 81% of what men do (Henry J. Kaiser Family Foundation, 2018). During most recessions male employment is hit hardest, but this pandemic has had more impact on women. This is largely a function of the industries in which women work, the shift to working from home and women's competing roles as family caregivers, especially the sudden back to home care for children due to school and childcare closures. During the pandemic, paid employment has been preserved in certain critical sectors such as health care, pharmacies or grocery stores and in sectors where telecommuting is possible. However, disproportionate numbers of women work in frontline service positions such as in restaurants, retail and hospitality positions where on-site work is mandatory and for which the pandemic invoked widespread lay-offs. With proportionately more women occupying lower-wage and frontline positions, many experienced limited flexibilities in adjusting to pandemic-driven events. Lack of pre-pandemic or loss of health insurance benefits associated with deferred work has limited women's access to health care (Wenham et al., 2020).

Informal and Formal Caregiving

Given the shift to more home-schooling of children, coupled with adjustments to accomplish paid work outside of or at home (telecommuting), there is an excess toll on women, particularly those who are single parents. In households with children under the age of 18 years, 21% are headed only by a mother, while only 4% are headed by only a father (Alon et al., 2020). Pandemic-related stressors multiplied as women prepared for and adjusted to working from home while providing more childcare and supporting home schooling compounded by extra work of disinfecting environments and implementing protective tasks (Wenham, et al., 2020). Employer expectations for remote working has often been implemented with little awareness or concern for women and their childcare, school support responsibilities (Gausman & Langer, 2020; Wenham, et al., 2020).

Women make up the majority of informal caregivers for adults in need. In pre-pandemic times, many informal caregivers reported high stress levels, often termed "caregiver burden," and some reported significant mental health and economic pressures from their unpaid caregiver roles (Bell & Folkerth, 2016; Gausman & Langer, 2020). The COVID-19 extra care demands (e.g., environmental disinfection, distancing) have resulted in increased reports of caregiver burden (Sheth, et al., 2021). In their employment and formal or informal caregiving roles, disproportionate numbers of women are exposed to and become infected by COVID-19. Worldwide, an estimated 70% of the health workforce is made up of women who are frontline health workers (nurses, midwives and community health workers), including a majority of health facility service-staff (cleaners, laundry, catering). In the US, women hold 78% of all hospital jobs, 70% of pharmacy jobs and 51% of grocery store positions. Consequently, women are more likely than men to be working in positions with more exposure to the COVID-19 virus. Evidence from Italy and Spain showed that 66% and 72% of health workers infected were women as compared with 34% and 28% of men respectively (Thibaut & van Wijngaarden-Cremers, 2020). Disproportionately, women as caregivers in home or agency employment have been in close, prolonged contact with high-risk or already COVID-19 infected individuals and exposed to environments with marginal resources and poor adherence to safety regulations, including inadequate availability of protective equipment that is suitable for women. Together formal and informal caregiving roles positioned women to spread the disease to and from work and home and forced many to engage in time-consuming and stressful protective behaviors, such as isolating from family or complex disinfecting rituals at home. Many confronted death and dying patients on a scale unimaginable prior to the pandemic and the demands of family life often afforded little time for recovery from the stressors of working with critically ill patients.

Women as Registered Nurses

Registered nurses (RNs) caring for people with COVID-19 have high numbers of stressors. They report dealing with unusually high numbers of deaths, supporting people without access to their families while dying, practicing without adequate personal protective equipment, experiencing abuse from communities by pandemic deniers or anti-vaccine groups, and worrying about transmitting infection to their families.

Among the pandemic consequences of limiting elective surgeries and other revenue-generating services for hospitals while diverting staff and other resources to care for critical and dying patients has been the furloughing of nurses. This has exacerbated burnout and exhaustion among RNs around the world, has been superimposed on preexisting hospital nursing shortages with resultant poor RN-to-patient ratios and longer working hours (International Council of Nurses, 2021; Lasater, et al., 2020). Rates of depression, anxiety, posttraumatic stress disorder, and death among nurses threaten to intensify nursing shortages, with the International Council of Nurses (ICN) signaling global shortages exceeding 10 million by 2030, possibly escalating to 14 million (ICN, 2021). Urgently needed are practices and policies that will avert a RN shortage and promote a mentally healthy nursing workforce.

A study of moral distress and mental health among nurses practicing in hospital intensive care units, emergency departments, and floating across units revealed that sources of work-related stress, moral distress, and mental health problems were interrelated (Lake et al, 2021). Moral distress occurs when an individual is unable to take morally justifiable actions or is unable to achieve an ethical outcome, resulting in compromised moral integrity and emotional distress (Hamric 2014). Sources of stress most commonly experienced included caring for patients who must experience hospitalization without family presence, caring for COVID-19 patients who present transmission risk to one's family/household, caring for patients who die during a hospitalization without family and/or clergy present, being asked to provide and continue aggressive and potentially futile treatments when one believes it is not in the best interest of the patient, experiencing poor communication between members of the care team that adversely affects patient care, and being assigned an unsafe number of patients to simultaneously care for without consideration of acuity level for patients assigned. Each of these was also associated with distress. Among those most strongly related to moral distress were number of patients with COVID-19 nurses had cared for in the past week, leadership communication, and accessibility of PPE/supplies and necessity of work-arounds. The best predictor of mental health over 4 months following the peak of COVID-19 was moral distress. Findings suggest the importance of transparent leadership communication, preparation of nurses in ethics in their educational programs, and support in learning self-care approaches, access to counseling as needed, and wellness programs. Clearly communicated policies related to crisis standards of care are required from leadership to insure nurses understand these (Lake et al, 2021).

With these work stressors, it is no wonder that over 50% of RNs indicated feeling overwhelmed (American Nurses Association, 2021). The emotional/behavioral toll is known to last as long as 3 years after an outbreak or disaster (Panchal et al., 2021). As well, RNs who are women are likely to confront exaggerated home care responsibilities, such as childcare and support for schooling activities. Together these stressors contribute to fatigue, mental health issues, and coping difficulties.

Protecting and strengthening resilience, the ability to bounce back from a stressful experience or respond positively in the face of adversity, is paramount. Cognitive-behavioral interventions indicate positive coping skills can be learned, such as engaging the support of others and cognitive restructuring. Possible benefits of resilience training for professionals exposed to intensive, emotionally charged work environments require multimodal approaches such as incorporating exercise, written exposure therapy, event-triggered counseling sessions, and mindfulness-based stress reduction (Mealer, 2017; Rushton et al., 2016). It is imperative to design programs that reduce barriers and encourage attendance after work, especially for women RNs with childcare, work-home life balance, and time issues (Rushton et al., 2021).

Family Violence

Abuse from intimate partners, domestic abuse, and abuse from children disproportionately affect women (Bradbury-Jones & Isham, 2020). Partly attributable to COVID-19 enforced stay-at-home orders and compounded by work-from-home or loss of employment, the COVID-19 pandemic has amplified family violence worldwide (International Women's Health Coalition, 2020). Family violence refers to threatening or other violent behaviors, encompassing physical, sexual, psychological, or economic threats (Peterman et al., 2020). In the US and Australia after launch of the pandemic, calls to intimate partner violence hotlines and internet searches related to domestic abuse support services increased in the wake of reduced access to services, including shelters (Van Gelder et al., 2020; Bosman, 2020; Mazza et al., 2020, Kagi, 2020; Poate, 2020). Similar dynamics were reported for China, Brazil, Italy, France and the U.K. (Usher et al., 2020; Davies & Batha, 2020; Kelly & Morgan, 2020). COVID-19 "stay-home" protective measures forced more contact with actual or potential abusers and limited women's access to help or support, especially among those economically dependent upon their abusers (Lauve-Moon & Ferreira, 2017). A potentially hidden and less prominent form of abuse is violence from children. Internationally, about 1 in 10 parents is said to experience child-to-adult violence that is not necessarily restricted to older adult parents (Lee, 2020). During the pandemic, child or adolescent to parent violence reportedly has risen by 69%. This highlights a need for appropriate interventions for all forms of family or domestic violence at a time when such resources are sparse (Condry & Miles, 2020).

Pandemic-Related Worries, Stressors and Mental Health Challenges

The COVID-19 pandemic has had profound impact on the mental health of women across the lifespan. Compounded by role stress and for some women, family violence, direct pandemic-related fears have magnified stress and worries for women. Taylor and colleagues (2020a, 2020b, 2020c, 2020d) described a COVID stress syndrome, characterized by central worry about the dangers of COVID-19. Worries were associated with behaviors such as social avoidance, panic buying, and coping difficulties and with excessive worry, compulsive information checking, reassurance seeking, and high concern for protective gear. Those who believed COVID-19 dangers were exaggerated are thought to have disregard for preventive measures such as social distancing, hand hygiene, wearing masks, and vaccination; such disregard for preventive behaviors add to feelings of threat in women with high concern for COVID-19 dangers. Although women had higher total stress scores than men on the COVID stress scale, no other gender-specific analyses were evident. In an early 2020 poll using the Amazon Mechanical Turk platform ($n = 1015$, 54% women, average age 39 years), participants indicated exposure to and rated "stressfulness" for several COVID stressors over the past week, their coping strategies (including substance use, active coping, self-distraction, behavioral disengagement, humor), and their adherence to CDC guidelines. Rated more negatively by women than men were the stressors of risk of self or loved ones becoming infected; reading or hearing talk about severity and contagiousness of COVID; uncertainty regarding length of quarantine and/or social distancing. Women also rated more negatively: changes in daily personal routines (cooking, cleaning, exercise-relaxation, hobbies, attending work, earning money); changes in social routines (being with friends/loved ones); experiencing personal or religious ritual cancellations; and increased contact with close others causing conflict and co-worrying. They felt more negatively about needing to find the "silver lining"; losing current job opportunities that result in loss of training, education, or delay of graduation; changes to the national/global economy; and difficulty in accessing resources for daily life. Coping strategies reported by more women than men included distraction, seeking emotional social support, and religious support. Interestingly, women were more likely than men to want to adhere to CDC guidelines for social distancing, cleaning and handwashing, and engaging in person-to-person transmission protections (Park, et al., 2020). These observations, coupled with evidence that women make the majority of health care decisions for those close to them, make women the essential group to target for pandemic education and population-wide health programs, for example, vaccination adoption.

Pandemic-related observations worldwide for women are heightened anxiety, anger, stress, agitation and withdrawal have heightened (WHO, 2020), impairing overall mental health. In a study of the impact of COVID-19 on mental health of 1210 participants in China, female gender, student status, specific physical symptoms of myalgia, dizziness, coryza and poor self-rated health status were significantly associated with higher levels of stress, anxiety, and depression. Pandemic psychological impact was rated moderate or severe by 53.8%, 16.5% reported moderate to severe depressive symptoms, 28.8% moderate to severe anxiety symptoms, and 8.1% moderate to severe stress levels. (Wang, Wang & Yang, 2020). In the U.K. before the pandemic, about 10% of people reported anxiety-related disorders (Jia et al., 2020) and associated lower quality of life with self-isolation (Brenes, 2007). Shortly after the first case of COVID-19, a study with 932 adults over 18 years old (63.3% women) who were practicing self-isolation and social distancing, revealed that 36.8% reported poor mental health (judged by scores on the Beck Depression and Beck Anxiety Inventories and Edinburgh Mental Well-being Scale). Those with poor mental health were more likely to be women, younger, and single, separated, divorced, or widowed (Smith et al., 2020). In a large cohort from the UK, clinically significant levels of mental distress increased from 19% to 27% after lockdown occurred. Increases in General Health Questionnaire scores were greatest among 18–24-year-old and 25–34-year-old groups, women, and people living with young children, and those employed before the pandemic (Pierce et al., 2020).

Older Women

For older adults, pandemic-related quarantine or social distancing has exacerbated loneliness, interfered with daily routines, decreased sensory stimulation that helps orient to reality, worsened inactivity, and possibly created more likelihood of drug misuse and not filling prescriptions, raising concern for mental health. Surprisingly, early pandemic evidence showed older women had greater emotional and mental health resilience. Analysis by the Henry J. Kaiser Family Foundation (Panchal et al., 2021) indicated that in August, 2020, more people reported anxiety or depression than before the pandemic (11%), but fewer adults 65 years and older (24%) reported these symptoms compared to younger adults (40%). Rates among older adults were higher for women (28% for women compared to 20% for men) as well as those declaring Hispanic origin, low incomes, and living alone. Women's Health Initiative participants queried about their experiences during the COVID-19 pandemic (mean age 83, SD = 4.5 years) reported higher levels of loneliness from pre- to intra-pandemic. Those reporting increased loneliness were older, experiencing stressful life events including bereavement and social disruption, and had a history of vascular disease or depression. Those experiencing a decrease in loneliness were

more likely to be Black, engaged in physical activity more often, were optimistic, and had higher purpose in life. Women reporting greater loneliness also reported higher perceived stress, depressive and anxiety symptoms (Goveas et al, 2022). A majority of the Women's Health Initiative (WHI) participants (75%) reported very good or good levels of well-being despite also reporting being very concerned about the pandemic (51%), experiencing disruptions in living arrangements (7%), and changes in medication access (10%). They also reported reduced physical activity levels which were more common in urban vs. rural areas (55% vs. 44%). The vast majority reported using face masks (93%), testing for COVID (20%) and 3.5% of these tested positive (VoPham et al., 2022).

A subset of the WHI cohort enrolled in the Women's Health Initiative Strong and Healthy intervention trial (WHISH) that delivers physical activity recommendations reported their physical activity level and priorities before and during the pandemic. Although 89% perceived their health as good, very good, or excellent, 90% reported moderate to extreme concern about the pandemic. Over half (55%) reduced their physical activity levels, but 27% reported no change and 18% increased physical activity. Women reported their priorities as staying in touch with family and friends (21%) and taking care of one's body (20%). Staying active was the most frequently selected priority related to physical well-being ($n = 33\%$) (Wegner et al., 2021).

Perinatal Period

For women in the perinatal period, COVID-19 has shown significant effects on depression and anxiety, especially in the context of decreased access to diagnosis and psychological or pharmacological treatment (Pfefferbaum, 2020). Pre-pandemic perinatal period evidence showed depression and anxiety to affect 1 in 7 women and convey increased risk of preterm delivery, reduced mother-infant bonding, and delays in cognitive/emotional development of the infant (American College of Obstetricians and Gynecologists, 2018). With the COVID-19 pandemic in Italy, a cross-sectional study of 100 pregnant women showed increased rates of depression and anxiety over pre-pandemic data (Saccone, 2020). Another study of before and after COVID-19 onset with the enforced physical distancing/isolation measures in pregnant ($n = 520$) and postpartum ($n = 380$) women showed more depression and anxiety and less physical activity. Such evidence supports a heightened need for mood disorder assessment and potential treatment with continued health behavior coaching to promote maternal mental health in perinatal women (Davenport, 2020).

Children and Adolescents

For children and adolescents, there are scarce gender-specific data pertaining to impact of the pandemic on mental health. Instead, combined gender data vary by developmental age, current educational status, having special needs or preexisting mental health conditions, being economically disadvantaged, and child/parent quarantines due to infection or fear of infection (Singh et al., 2020). Young children (age 3–6 years) were more likely to have symptoms of clinginess and fear of family members being infected than older children (age 6–18 years) (Viner et al., 2020). Children and adolescents with special needs varied in their response to lockdown often based on their individual conditions. For example, children with autism were thought to show an increase in behavioral problems and acts of self-harm (Singh et al., 2020), while those with obsessive compulsive disorders may be among those most affected by the pandemic. Their obsessions and compulsions related to contamination, hoarding, and somatic preoccupation may lead to heightened distress (American Psychological Association [APA], 2020).

Older adolescents and youth were reported to have anxiety regarding cancellation of examinations, exchange programs, and academic events (Lee, 2020). In times of distress, panic buying can occur (Arafat, 2020) and in concert, there has been a rise in hoarding behavior among teenagers (Oosterhoff et al., 2020). Increased use of the internet and social media has been observed with concern for whether a longer-range effect might be compulsive use (a kind of addiction). Risks to certain types of internet use include being bullied or abused. During stay-at-home or lockdown orders, teens have little opportunity to report violence, abuse and harm if they are in abusive homes (Singh et al., 2020). These observations imply the need for parental awareness, education, and support as well as increased screening by health care providers.

For women (adolescents through older age), social networks have long been central to resilience but are a resource highly affected by the pandemic (Allen et al., 2020). In the context of intersecting inequalities (e.g., lack of affordable housing, low wage employment, inadequate health care coverage), especially for vulnerable under-advantaged groups, research, practice and policy engagement that promotes ethno-racial-congruent, system-wide, community-based programs is warranted.

Seen from this brief commentary on emotional health, few specific conclusions about women's and girls' pandemic-related mental health are empirically evident. It appears that women are more likely than men to report mood problems; in the perinatal period women are especially vulnerable and older women are less at risk of mood disorders than younger women. Pandemic isolation effects on female children remain unclear and warrant intensive longitudinal scrutiny. Knowing more about the impact of COVID-19 on age-related sex and gender sub-groups would illuminate those most at risk to develop mood disorders and guide clinicians toward early identification and treatment. Increased need for mental health and substance use services will likely persist long term, even as new cases and deaths due to COVID-19 subside (Panchal et al., 2021).

Table 1 – AAN Policy Priorities and COVID-19 Effects on Women's Home and Work Life, family Violence and Mental Health

Topics	Policy Priority #2 Promote Innovation and Sustainability	Policy Priority #3 Reduce Patient, Provider, and System Burden
Pandemic-Related Changes to Women's Roles and Family Stressors *We recommend designing policies which directly reduce barriers associated with caretaking, and support unemployment and employment and childcare benefits and resources.* *We recommend government and other non-profit agencies prioritize funding for research addressing pandemic-related impacts on women's home and work, and sexual and reproductive health lives.*		Policy Recommendations: 1. Encourage government subsidies to replace pay for women who provide child care or serve as informal or formal caregivers 2. Suspend work requirements for government assistance programs until school and daycare centers reopen and for those serving as unpaid caregivers for family members who are COVID-19 infected 3. Remove requirement to be actively seeking work to obtain unemployment insurance 4. Extend unemployment benefits to workers who voluntarily leave employment to provide childcare and caregiving to loved ones 5. Extend tenure clocks for junior faculty in response to the COVID-19 pandemic; address sex disparities during the pandemic as more women than men are responsible for childcare that may not allow them to conduct research and scholarship 6. Intersecting inequalities and access to resources such as child-care collaboratives, affordable housing, low wage employment, inadequate health care coverage, and supportive services due to lack of funding
Nurses And Moral Distress *We recommend developing policies addressing the effects of moral distress on the individual nurse and downstream effects on the nursing workforce.*		Policy Recommendations: 1. Advocate that policymakers take urgent action to ensure the physical and mental well-being and health of nurses and other health care workers, with emphasis on building resilience 2. Policymakers to provide support for clinicians while developing policy initiatives to address nurse workforce shortages 3. Incorporate into professional nursing education and training the importance of creating a professional moral compass: a. Learning about information on ethics from professional organizations or institutional ethics resources b. Recognition of symptoms of moral distress c. Resources to access when recognize symptoms of moral distress
Building Resilience and Adaptation to Disasters *We recommend developing resiliency training programs for health care professionals.*	Policy Recommendations: 1. Conduct of research aimed at: a. Identifying effective strategies that promote work-life balance b. Clinician well-being focused on not only the demands of health careers and the workplace, but also the broader social context in which the work takes place c. Examining why nurses are not comfortable accessing and using employed assistance services 2. Impact of COVID on the care of pregnant women	Policy Recommendations: 1. Emphasis on building social networks during times of crises through the use of alternative media (virtual technology) to support sharing of experiences 2. Advocate for support of and development of infrastructure system-wide programs at the community level; with special attention given to under-resourced groups of women

(*continued*)

Table 1 – (*Continued*)

Topics	Policy Priority #2 Promote Innovation and Sustainability	Policy Priority #3 Reduce Patient, Provider, and System Burden
	across the different trimesters	
Family Violence *We recommend developing or strengthening policies to increase abused individuals' access to resources that get them to safer environments.*	Policy Recommendations: 1. Increase online educational resources that detail "how to get help", "how to get to safety", and "how to develop social networks that can help you cope" 2. Collect data on numbers of calls to hotlines and local authorities to support policy development for increasing resources	Policy Recommendations: 1. Emphasize the need to increase, not decrease domestic and intimate partner violence help during the pandemic 2. Prioritize violence prevention and use research evidence to determine causes and risk factors of violence 3. Train police and other local authorities about ways to protect individuals who request abuse intervention 4. Raise awareness in all health care providers and school professionals that will increase identification of abuse, refer abused individuals to available resources, and assure safety 5. Increase the numbers of hotlines available to provide emergency assistance to women and other abused individuals; have these operational 24/7 6. Increase media attention about domestic violence and intimate partner violence 7. Advertise on television, radio, and billboards what resources are available for abused individuals and how to access 8. Support legislation that provides funding to shelters 9. Support organizations that resource refuge accommodation; increase creation of temporary shelter homes
Pandemic-Related Worries, Stresssors, And Mental Health Challenges *We recommend a purposeful and concerted effort by health care providers, researchers, and policymakers to develop and fund easy access, sex and age specific mental health and substance use services for women.*	Policy Recommendations: 1. Create inclusive approaches in which health care workers such as nurse practitioners, school nurses, pediatricians, general physicians, school staff and other groups receive basic mental health care training such that they are able to identify mental health needs and provide appropriate resource referrals 2. Address professional and practice requirements to allow telehealth delivery of mental health care that observes the necessary privacy	Policy Recommendations: 1. Integrate into current policies and/or create policies that tailor systems support for women and girls across the life space 2. Promote health policies that bolster mental health care, including promoting an increase in the workforce and reducing barriers to access (affordable care, alternative modes of care delivery, and an increased numbers of providers) 3. Ensure adequate fund allocation and monitoring with policy implementation to increase access to mental health care resources 4. Identify and fund resources to help support children, adolescents, and young adults' emotional wellbeing 5. Develop policies and resources to assist women with their increased caregiving responsibilities, stay-at-home orders, and economic burden

Key Points for Research, Practice and Policy

There is urgent need for expanded evidence about pandemic-related impacts on women's home and work lives, particularly the scope of stressors and emotional/mental health consequences. The complexity of work stressors intersecting with women's childcare and school support for children at home is poorly understood and needs research, education, and policy support; this is particularly crucial for women working as RNs in a stressed health care system. Attention must be paid to increased family violence and need for bolstering women's access to resources, safe environments, and mental health assistance. Data are needed that are disaggregated by sex/gender to better target interventions to improve health care practices and determine resource needs. As evidence emerges, rapid translation into community and health systems programs supported by relevant policy substantiation and reinforcement is crucial to promote social networks and

educational skill development programs that support women's roles. To address these challenges, we propose research, practice, and policy recommendations (see Table 1), which if implemented, hold promise for securing optimal health and health care for women.

Disclaimer

Uniformed Services University of the Health Sciences: The opinions and assertions expressed herein are those of the author (Kotas-Polston) and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.

Author Contributions

Judith A. Berg: Conceptualization, Writing of Original Draft, Review & Editing; Nancy Fugate Woods, Conceptualization, Writing of Original Draft, Review & Editing; Joan Shaver: Conceptualization, Writing of Original Draft, and led Review & Editing efforts; Elizabeth Kostas-Polston: Conceptualization, Creation of table, Writing of Original Draft, Review & Editing.

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