

## Abstract

*This article examines the concept of women's mental health articulated as a human right in international documents and the current public health concern regarding the contribution of depressive and related anxiety disorders—which disproportionately affect women—to the global health burden. There is a growing awareness, supported by health research and accepted in recent international documents such as the Beijing Platform for Action, that gender inequalities and rights violations such as economic dependence, lack of decision-making power, conflicting gender roles, disproportionate domestic responsibilities, and violence are closely linked to mental health problems of women. The article argues that governments and international agencies, as well as women's health and rights advocates, must place more emphasis on women's mental health and its relationship to underlying gender discrimination and rights violations.*

*Cet article examine le concept de santé mentale des femmes exprimé comme droit fondamental dans les documents internationaux et la préoccupation actuelle de santé publique concernant la contribution des troubles de dépression et d'anxiété - qui affectent de façon disproportionnée les femmes - à la charge de la santé globale. Il existe une conscience grandissante, soutenue par la recherche et acceptée dans les documents internationaux récents (Plate-forme d'Action de Beijing), que les inégalités entre les sexes et les violations de droits telles que la dépendance économique, le manque de prise de décision, la contradiction des rôles entre les hommes et les femmes, la disproportion des responsabilités domestiques et la violence, sont fortement liées aux problèmes de santé mentale des femmes. L'article affirme que les gouvernements et les agences internationales, de même que les défenseurs de la santé et des droits des femmes, doivent mettre davantage l'accent sur la santé mentale des femmes et sa relation à la discrimination sous-jacente entre les sexes et aux violations de droits.*

*En este artículo se examina el concepto de la salud mental de la mujer declarado como un derecho humano en documentos internacionales y la preocupación actual por parte de las entidades de salud pública en cuanto a la contribución a la carga mundial sobre la salud debida a desórdenes depresivos y de ansiedad relacionados, que afectan a la mujer de manera desproporcionada. Hay una creciente conciencia, impulsada por la investigación en salud y reconocida en documentos internacionales recientes tales como la Plataforma de Acción de Beijing, en que las desigualdades de género y las violación de los derechos tales como la dependencia económica, falta de poder en la toma de decisiones, papeles conflictivos de los géneros, responsabilidades domésticas desproporcionadas y la violencia, se encuentran íntimamente ligados a los problemas de salud mental de la mujer. En el artículo se argumenta que los gobiernos y las agencias internacionales, así como los defensores de la salud y de los derechos de la mujer, deben poner mayor énfasis en la salud mental de la mujer y en su relación con la discriminación latente de género y la violación de los derechos.*

# EVALUATING THE ROLE OF GENDER INEQUALITIES AND RIGHTS VIOLATIONS IN WOMEN'S MENTAL HEALTH

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**T**he right to mental health has been articulated in a multitude of international human rights treaties and consensus documents. For example, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."<sup>1</sup> The right to mental health is also articulated implicitly in Article 25 of the Universal Declaration of Human Rights (UDHR): "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."<sup>2</sup>

The right to mental health care for women in particular can also be drawn from Article 12 of the Convention on the Elimination of Discrimination Against Women (Women's Convention): "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."<sup>3</sup>

Nevertheless, although these treaties have set forth the right to mental health in general terms, they do not explicate what this right encompasses, nor do they address the specific ways in which social, cultural, and economic conditions interact with gender inequalities to produce gender differen-

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tials in mental health. For guidance as to what this right means and what its gender-specific dimensions are, we can turn to two sources that provide interpretations of treaties: (1) General Recommendations and General Comments submitted by committees that monitor the implementation of treaties and (2) international consensus documents.

Article 12 of the Women's Convention makes no specific reference to mental health or to its underlying dimensions. A 1999 General Recommendation on Health made by the Committee on the Elimination of Discrimination Against Women (CEDAW), however, states that an analysis of the right to health for women must address not only access to and quality of health care, but also the underlying gender-specific socioeconomic conditions that impact health. It discusses the effect of gender inequalities and violence on women's physical and mental health, as well as gender differentials in psychological conditions. It states that governments must report on factors that impinge on women's health needs, such as:

[s]ocio-economic factors that vary for women in general and some groups of women in particular. For example, unequal power relationships between women and men in the home and workplace may negatively affect women's nutrition and health. They may also be exposed to different forms of violence, which can affect their health. Girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability. . . .<sup>4</sup>

The General Recommendation also highlights gender differences in psychological conditions:

Psychosocial factors that vary between women and men include depression in general and post-partum depression in particular as well as other psychological conditions, such as those that lead to eating disorders such as anorexia and bulimia.<sup>5</sup>

Similarly, the recently issued General Comment on health by the Committee on Economic, Social and Cultural

Rights (CESCR) further clarifies the meaning of Article 12 of the ICESCR. The Comment highlights the need to take into account underlying socioeconomic determinants of health such as poverty, discrimination, and domestic violence and other practices harmful to women:

More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. . . . A gender-based approach recognises that biological and socio-cultural factors play a significant role in influencing the health of men and women. . . . A major goal should be reducing women's health risks . . . and protecting women from domestic violence. . . . [It is also important] to shield women from the impact of harmful traditional practices.<sup>6</sup>

The right to mental health for women has been addressed more explicitly in international consensus documents, which, while not legally binding, provide important interpretations of the commitments contained in the treaties. For example, Paragraph 91 of the Beijing Platform for Action expands on Article 12 of the ICESCR to state:

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.<sup>7</sup>

In 1999 the Commission on the Status of Women issued a set of conclusions on women and health that "acknowledges that the realization by women of their right to enjoyment of the highest attainable standard of physical and mental health is an integral part of the full realization by them of all human rights" and "acknowledges the link between women's physical and mental health throughout the life cycle, the level of national development . . . including . . . women's status and degree of empowerment in soci-

ety, employment, work, poverty, illiteracy, aging, race, ethnicity, [and] violence in all its forms, particularly harmful attitudes and traditional or customary practices. . . .”<sup>8</sup>

As the above sources indicate, the right to mental health is understood by the international community to be closely interrelated with other human rights. Indeed, the right to mental health is a prerequisite to the enjoyment of other rights, such as the right to education and work. Conversely, the enjoyment of other rights, or their violation, will have an impact on the enjoyment of the right to mental health. Domestic violence, for example, is likely to impair a woman’s capacity to fully enjoy her right to mental health, as may restrictions on her mobility, e.g., in communities where forced seclusion occurs.

### **Mental Disabilities and the Global Health Burden**

Although the right to mental health has been accepted in principle by the international human rights community and governments around the world, the issue remains neglected and receives low priority and investment, especially in countries with resource shortages. In addition, despite widespread agreement that women’s health must be understood to encompass more than reproductive health, health and human rights advocates have been slow to address other health issues, particularly the mental health concerns of women.

Yet recent work indicates that mental health problems currently constitute a significant portion of the global health burden.<sup>9</sup> If health policies and programs continue to neglect these needs, this figure is expected to rise even more.<sup>10</sup> In particular, recent World Health Organization (WHO) statistics show that mental health problems account for 11.5% of disability-adjusted life years (DALYs) lost, compared to 10.7% for infectious and non-infectious respiratory diseases, 10.3% for cardiovascular diseases, 8.1% for maternal and perinatal conditions, 6.1% for STDs/HIV, and 5.8% for cancer.<sup>11</sup> Depression, in particular, ranks as the fourth most serious disease worldwide, and, if current trends continue, is expected to rise to second place by the year 2020.<sup>12</sup>

Moreover, significant gender differences in the global prevalence of mental health problems have been found. In

particular, symptoms of depression and anxiety, as well as unspecified psychiatric disorders and psychological distress, are more prevalent among women, whereas substance disorders are more prevalent among men.<sup>13</sup> The DALY data reflect these differences; depressive disorders account for close to 30% of disability due to mental disorders among women, but only 12.6% among men.<sup>14</sup> This gender difference remains constant across diverse societies and social contexts.<sup>15</sup>

Recent WHO statistics show that depressive disorders currently constitute the third leading cause of disease burden for women of all ages.<sup>16</sup> Moreover, for women of reproductive age (15–44), although various maternal conditions worldwide constitute three out of the ten leading causes of disease burden, depression has currently become the major leading cause in both developing and industrialized regions.<sup>17</sup>

Although they have biological components, depressive and related anxiety disorders in women are often also closely linked to social and structural inequalities arising from gender discrimination and violations of women's human rights, such as violence. This linkage between gender inequalities, rights violations, and mental health is clearly articulated in Paragraph 100 of the Beijing Platform, which states: "Mental disorders related to marginalization, powerlessness and poverty, along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women."<sup>18</sup>

The relationship between gender inequalities and negative mental health consequences—particularly depression and anxiety—has been amply documented by health research. Poverty, economic dependence, unemployment, low levels of education, marriage, disproportionate domestic and child care responsibilities, low levels of decision-making power, inequality in the home, and gender-based violence have all been shown to have a negative impact on mental health.<sup>19</sup> In particular, because of the severe impact of gender-based violence on women's human rights and well-being, its effects have been well-documented world-

wide, more so than any other form of gender inequality or rights violation. In fact, it has been suggested that a significant portion of women's psychological distress can be attributed to their experiences of gender-based violence.<sup>20</sup>

### **Research on Gender Inequalities, Violence, and Mental Health**

Public health highlights the relationship between individuals' health status and the social, physical, economic, and political environments in which they live. Lynn Freedman has argued convincingly for using health research to demonstrate the link between health and rights.<sup>21</sup> She states that not only can we study particular health phenomena to understand how they are socially produced; we can also study particular human rights phenomena to understand their implications for health.<sup>22</sup> In the case of women and mental health, this translates concretely into investigating the effect of gender discrimination and rights violations such as forced or early marriages, disproportionate domestic responsibilities, and violence on women's mental well-being. Thus, in Freedman's words, "not only do public health tools help us to identify and describe health issues as socially constructed human rights issues, they also begin to tell us what to do about them."<sup>23</sup>

### **The Role of Gender Inequalities**

Studies in industrialized countries so far confirm that gender inequalities and rights violations are closely linked to women's disproportionate experiences of depression, psychological distress, and related anxiety disorders.

Marital status, for example, has been associated with women's negative mental health outcomes; studies conducted to date suggest that marriage is associated with increased risk for depressive disorders and psychological distress for women because it increases the stresses and expectations on women with regard to domestic labor, child care, and other caretaking duties.<sup>24</sup> Similar associations have been found for poverty and unemployment, as well as for disproportionate responsibilities for household labor and child care.<sup>25</sup>

Although role conflicts and overload from multiple roles (i.e., wife/partner, mother/caretaker, paid worker) have also been cited as precursors to women's experiences of psychological distress, the relationship is less clear. On the one hand, some studies indicate that multiple roles enhance psychological well-being. For example, it has been suggested that paid work in particular provides women with financial autonomy, higher status, and increased social contacts.<sup>26</sup> Others find, on the other hand, that multiple roles are associated with increased levels of psychological distress because they result in role overload and conflict (e.g., the problems experienced by a mother working for pay when her child care arrangement breaks down and her husband does not share child-care responsibilities).<sup>27</sup>

It is highly likely that the context surrounding women's multiple roles determines whether they bring greater benefits or greater costs. For example, the balance of costs and benefits of employment for a working mother will depend on: (a) access to good-quality child care, (b) her husband's willingness to share child-care and other household responsibilities, and/or (c) flexible workplace policies, such as extended maternity/paternity leave.<sup>28</sup> Multiple roles may enhance a woman's psychological well-being when she is able to optimize her resources within the context of these roles (e.g., by sharing household responsibilities and child care equally with her husband). Psychological distress is likely to occur when lack of free choice, powerlessness, and unequal role responsibilities constrain a woman's life.

### **The Role of Gender-Based Violence**

The impact of gender-based violence merits special attention for several reasons. First, gender-based violence is one of the most extreme forms of gender inequality and constitutes an egregious human rights violation against women. Severe and ongoing gender-based violence has been documented in almost every country in the world.<sup>29</sup> After concerted advocacy efforts by women's human rights groups, gender-based violence was accepted as a human rights violation by world governments at the 1993 World Conference on Human Rights in Vienna, and it was clearly



delineated in the subsequently adopted Declaration on the Elimination of Violence Against Women.<sup>30</sup>

Second, violence has repeatedly been shown to have a severe impact on all aspects of women's health, including mental health. Studies show that women who are subjected to domestic and other forms of violence suffer from significantly higher rates of anxiety, major depression, suicidal tendencies, nightmares, hypervigilance, dissociation, somatization, lowered self-esteem, alcoholism, and other similar psychological disturbances associated with post-traumatic stress.<sup>31</sup> In addition, battered women are four to five times more likely to require psychiatric treatment than non-battered women and five times more likely to attempt suicide.<sup>32</sup> Interviews with women in psychiatric institutions also show that about 60–70% have experienced some form of physical, psychological, or sexual violence before being institutionalized, suggesting that violence against women is one of the major contributors to severe mental disorders.<sup>33</sup>

Third, the effects of other gender inequalities are severely compounded by emotional, physical, sexual, and other types of violence, and it is likely that violence cuts across and exists in conjunction with other types of gender inequality. For example, studies have shown a link between low levels of female decision-making power in the home and domestic violence.<sup>34</sup>

Finally, gender-based violence in and of itself contributes to the global burden of disease. The World Bank estimates that the consequences of domestic violence and rape account for approximately 5% of the global burden of disease in developing countries and 19% in industrialized countries for women during the reproductive years.<sup>35</sup>

### **North-South Differentials in Research and Documentation**

Unfortunately, most of the research cited above has been undertaken in industrialized countries, with the majority conducted in the United States. While similar results have been found in developing countries, they are less numerous and less well-documented.

Yet, to the extent that research has been undertaken on the issue, results seem to mirror the findings in industrialized countries.<sup>36</sup> In Thailand, married women have reported higher rates of psychological distress than unmarried women.<sup>37</sup> In Pakistan, suicide attempts have been found to be higher among married women than any other demographic group, leading the authors of one study to conclude that marriage is a significant source of stress for women in that country.<sup>38</sup> In India, linkages between depression, early marriage, and cultural devaluation of women have also been hypothesized.<sup>39</sup> Similarly, cultural constraints on female roles have been associated with depression in India.<sup>40</sup> Poverty and female gender have been found to be associated with depression and anxiety in India, Zimbabwe, Chile, Brazil, and Kenya.<sup>41</sup> In Brazil, the role of housewife has been shown to be a risk factor for psychiatric morbidity.<sup>42</sup> In India, mothers not working for pay have been found to have higher rates of anxiety than mothers working for pay.<sup>43</sup> Also in India, marriage has been shown to be a significant predictor of distress for women but not for men.<sup>44</sup> In Nicaragua, emotional distress has been linked to husbands' control over women's everyday activities (such as visiting friends, working outside the home, and use of contraceptives) and to physical and psychological abuse.<sup>45</sup> Finally, in Turkey, when asked if they feared they would be killed by their husbands if they had an extramarital affair, women who answered yes reported significantly higher rates of psychological distress than women who answered no.<sup>46</sup>

Although domestic violence has been documented in almost every country in the world, data on the relationship between violence and mental health outcomes in developing countries is also fragmentary.<sup>47</sup> Nevertheless, some studies indicate that physical, sexual, and emotional violence have negative effects on women's mental health similar to those documented in industrialized countries. For example, linkages have been found between rape and psychological disorders in Bangladesh and between wife-beating and depression, psychological distress, or suicide in China, Oceania, South America, Nicaragua, and Turkey.<sup>48</sup> Further, low income, illiteracy, young age at mar-

riage, and severity of physical abuse have been found to be significant predictors of anxiety and depression in women in Pakistan.<sup>49</sup> Similarly, in India, where more women commit suicide than men (unlike in Europe and North America), risk factors for female suicide included being suspected by the husband of having an extramarital relationship, having an unsatisfactory or conflict-prone marriage, and lacking children.<sup>50</sup>

Another area of concern is the effect of armed conflict, civil strife, and violent regimes on the mental health of women, including refugee and internally displaced women, although there are only a few existing studies that address this important issue. Depression, anxiety, and psychological distress have been found to constitute major health problems in women who have been subjected to sexual, physical, and psychological violence by opposition forces in situations of armed conflict (e.g., in Rwanda, Bosnia, and Kosovo), in women who have been subjected to violence or extreme oppression by violent regimes (e.g., the Taliban in Afghanistan), and in refugee women (e.g., Afghani women in refugee camps in Pakistan).<sup>51</sup>

### **Implications for Policy and Action**

It is clear that women suffer disproportionately from depression and related anxiety disorders, which are likely in turn to be related to stressors arising from social and structural gender discrimination and rights violations. Indeed, research conducted to date supports the view that women's mental health is closely linked to factors such as economic dependence and differential poverty, lack of decision-making power, gender role conflicts, disproportionate household responsibilities, and—last but not least—violence.

Although international women's health and rights advocates and policymakers have begun to address this linkage, financial and substantive priorities have been placed to date on components of women's health narrowly related to reproductive issues such as maternal/child health and family planning. Policies and services have focused mostly on eliminating barriers to physical health, the apparent assumption being that once physical health is achieved,

mental health will follow.

Yet it has been extensively documented that impairments to mental health can impair physical health (e.g., via stress and lowered immunity to disease) and vice versa, and that mental, physical, sexual, and reproductive health are all dynamically linked to each other.<sup>52</sup> Many studies have demonstrated significant relationships among components of women's reproductive, physical, and mental health. For example, changes in the reproductive cycle or childbirth can cause depression; major psychological problems of adolescents are often related to sexuality, pregnancy, and abortion; and depressive symptoms can be related to gynecological morbidity such as vaginal discharge.<sup>53</sup> Relationships have also been found between reproductive health and rights violations such as violence. For example, high-risk behavior for HIV/STD transmission in adolescents can often be related to childhood sexual abuse; abuse by a partner often persists during pregnancy and may contribute to maternal/perinatal complications.<sup>54</sup>

Thus, women's health must be viewed from a comprehensive framework that includes mental health. This framework has been clearly articulated in the gender-specific Cairo and Beijing documents, which define the right to health for women as "the right to the enjoyment of the highest attainable standard of physical and mental health" (Cairo Programme of Action) and as "a state of complete physical, mental and social well-being" that "involves [women's] emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology" (Beijing Platform for Action).<sup>55</sup>

Several interrelated steps should be taken to fulfill the goal of improved mental health for women. First, given the dearth of documentation on the mental health consequences of gender inequalities and violence in the developing world, more research needs to be undertaken in developing countries. One problem with drawing conclusions about developing country contexts from studies undertaken in the United States and in other industrialized countries is that such studies are very specific to the particular social

and cultural contexts of the industrialized world. Consequently, more research needs to be carried out that takes into account the different types of gender inequalities and violence that are particular to different cultural contexts. For example, further documentation is needed on the role of country or region-specific factors such as forced or early marriage, forced seclusion, lack of permission to work or attend school, and harmful and violent practices rooted in cultural norms regarding gender and sexuality (e.g., female genital mutilation, honor crimes, and dowry-related violence). Although the harmful impact of these factors on women's mental health should be self-evident to any rational observer, documentation often has a positive influence on the willingness of governments to implement changes in policy and service delivery.

Second, mental health problems, especially depression and anxiety, and the links among gender inequalities and health, both mental and physical (including sexual and reproductive health), must be more explicitly addressed by women's health and rights advocates. Mental health advocates, sexual and reproductive health advocates, and women's rights activists must learn to work together more closely. In particular, violence and its mental health consequences must be understood to constitute a major point of interface for women's rights and health advocates.

Third, governments and international agencies must recognize that women have differential health needs related to gender inequalities and rights violations. Accordingly, they must reform existing legislation and mental health care policies and integrate mental health services into primary and reproductive health care systems, taking care to address specific factors that affect women's mental health, as outlined in the Cairo and Beijing documents. For example, primary and community health care providers could receive training on mental health issues and counseling techniques so as to be able to take into consideration gender violence and its mental health consequences during client intake and treatment.

Fourth, it is important to keep in mind that mental health service delivery is a stopgap measure that should

occur simultaneously with primary prevention efforts aiming to eradicate gender inequalities and violence as risk factors for women's psychological distress. Such preventive efforts could encompass the design and implementation of gender-sensitive educational curricula, community-based awareness-raising campaigns, and changes in the legal and law enforcement systems.

Fortunately, there has been an increase, albeit slow, in the number of effective initiatives geared towards addressing these gaps. For example, the NGO Committee on Mental Health, a committee of nongovernmental experts formed in 1997 at the United Nations to provide input to the UN on mental health and to advocate for policy changes on mental health at the UN/international agency level, has recently advocated successfully for governments and international agencies such as the World Health Organization (WHO) to accept the importance of women's mental health issues as an emerging point of focus for the next decade. Prior to the NGO Committee's efforts, there were few documents explicitly emphasizing the right to mental health and mental health services for women.<sup>56</sup> In 1999, however, a landmark resolution titled "Women and Mental Health, with Emphasis on Special Groups" was passed during the 43rd session of the Commission on the Status of Women.<sup>57</sup> The resolution affirms that "one of the major barriers for women to the achievement of the highest attainable standard of health was gender-based inequality" and urges governments, donors, and relevant UN bodies, especially WHO, to address the mental health needs of women and girls with programs and services.

Similarly, the outcome document of the five-year review of the Beijing Platform for Action reaffirms the commitments made in the Platform to improve women's mental health. In particular, Paragraph 103(h) of the document mandates that governments should:

promote women's and girls' well-being, integrate mental health services into primary health-care systems, develop gender-sensitive supportive programmes and train health workers to recognize gender-based violence and care for girls and women of all ages who have experienced any form of violence.<sup>58</sup>

In response, international agencies such as WHO are beginning to address global mental health concerns, including gender differences in mental health and the role played by gender inequalities and violence.<sup>59</sup> On November 12, 1999, the Director-General of WHO, Dr. Gro Harlem Brundtland, initiated a new project called Global Strategies for Mental Health, which aims to improve coverage and quality of psychiatric care services throughout the world.<sup>60</sup> WHO has also affirmed its commitment to create a training manual for national governments and NGOs that will provide primary health care workers with the appropriate skills necessary to assist women and girls experiencing psychological problems as a result of trauma, discrimination, exploitation, abuse, and oppression.

Mental health is relevant to all 12 areas of critical concern in the Beijing Platform for Action, especially health, violence, armed conflict, poverty, the girl-child, education and training, and human rights.<sup>61</sup> Clearly, the eradication of gender inequalities and violations must be a priority. The recognition that gender inequalities and violence are closely linked to negative mental health outcomes is only the first step.

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