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Statement submitted by International Association for Women's Mental Health, a non-governmental organization in consultative status with the Economic and Social Council*

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

* The present statement is issued without formal editing.

Statement

Current biomedical and human rights literature supports, as stated in our International Consensus for Women's Mental Health, (Stewart 2006) that the enjoyment of women's rights is contingent upon enjoyment of sound mental health and access to significant services and opportunities for the promotion, prevention and recuperation of health, including action upon the social determinants involved.

Women's mental health is closely inter-related with a woman's overall health and survival along the entire life cycle and across the different areas of development, which have biological, social and psychological contributing factors. Prominent among these is education. Education including a basic primary education is related to women's mental health as well as health overall and the improved health and survival of a woman's family. (See reasoning behind Millennium Development Goals related to primary education for all).

High prevalence rates of mental disorders, such as depression and anxiety are in part an expression of central nervous system harm resulting from the disproportionate exposure of women to chronic stressors and violence. Unfortunately, in addition, mental health services do not receive the same financing or programmatic priority as other health services in most parts of the world. (World Health Organization, 2008).

Depression is a mental disorder that impairs the person's energy and ability to enjoy life. It affects the functioning of the brain, and thus has adverse consequences on all bodily functions, and results in cognitive as well as behavioural and emotional problems. These lead to impaired functioning in all spheres, increases abuse and may be compounded by suicidal ideation. Sadly, suicide, mostly related to depressive symptoms, is one of the leading causes of death for women in reproductive age. (Teti et al, 2014)

Experts agree, based on large epidemiological studies, that the excess depression that affects women (with a ratio of about 2:1 in comparison with men) is related to traditional roles of women in patriarchal settings (Seedat et al 2009) and to the disproportionate exposure of women to violence, especially in the household. (Campbell, 2002)

While women suffer from all forms of violence, as described in the 2002 World Health Organization Report on Violence, the high prevalence rates of intimate partner abuse point to an unfair and hazardous dynamic in the relationship between men and women. Patriarchal paradigms and the need to control a woman's body and her behaviour, supported by the differential in power and physical strength between men and women, result in physical and mental lesions, including death by homicide and suicide, high social costs, the intergenerational perpetuation of poverty and abuse and inhumane suffering for millions of women. Clearly, this situation deprives women of the opportunities to benefit from educational and labour opportunities, endangers their lives and well-being and clearly impairs their ability to learn about their fundamental human rights and exercise them.

There has been extensive research about the magnitude and possible risk and protective factors of intimate partner violence. We know that the prevalence varies within and among countries and that rural residence, low education, low socioeconomic status, unemployment, the use of alcohol by the aggressor and the

victim and young age predispose to violence. It is more difficult to describe protective factors. For instance, education up to 12 years is known to contribute overall to a woman's health and mental health but is not clearly protective of harm from intimate partner violence in some countries in the Americas (Kishor and Johnson, 2004; Bott et al, 2012). Other factors such as community attitudes towards violence and community conflicts need to be considered as well (World Health Organization 2013 report on global and regional estimates of prevalence of violence against women).

United Nations Women has guidelines for protective legislation. However, current research shows that these are not followed, in aspects as basic as the naming style, and when nominally embraced by a country, they are not implemented. (Ortiz Barreda and Vives cases 2013). This fact illustrates the low priority that the protection of the life, integrity and well-being of women have for many states.

Likewise, the World Health Organization has issued guidelines for the health sector response, based on evidence. (World Health Organization, 2013). Effective mechanism to insure incorporation of these into the health programs of each individual country are clearly needed, together with a worldwide robust effort to provide training to the health personnel expected to deliver the care. In terms of the number of people affected, this is a high public health priority. The sluggish response bears witness to the disenfranchisement of women in certain settings.

From a global standpoint, the plight of refugee/displaced women and children illustrates how millions of women are uprooted and exposed to violence and deprivation, due to circumstances lying outside of their control. The psychological consequences reflect the total disruption of everyday life and the relinquishing of significant life projects. This issue needs to be addressed by countries in conflict as well as in post conflict situations.

Another challenge faced by the global community relates to sexual and reproductive issues. The interface between sexual and reproductive health and psychological well-being has long been the preoccupation of legislators and practitioners: it goes well beyond the role of hormones and neurotransmitters in sustaining the mental health of women. The most pressing issue is the impact of childbearing on the life of a woman: how and when she chooses to become pregnant or not, the type and acceptability of health services to insure that her choices can be implemented without risking her life, the difficulties she has in accessing and using modern contraception and the availability of abortion. The legal and societal penalization of sexual activity on the woman's terms (and not those prescribed by the community or the partner) encompasses these controversial issues that are not adequately addressed in large parts of the world.

The impact of the social determinants of health on promotion of mental health and prevention of disease interventions are progressively better understood. (Sen and Ostlin, 2007). Stress at work, inequity in access to health care, the multiple roles and burdens of women, and the demands of globalization all may have a role in determining how much a woman realizes her right to health. (Rondon 2013) The role of the central nervous system and the manner in which environmental stimuli may transform both the function and the structure of the brain are becoming clearer thanks to research supported by technological advances in neuroimaging.

Research on the etiology, course and management of mental disorders in women, and probably more important, on the way the nervous system responds to life experiences and to the factors that shape the resilience of women to difficult life circumstances is urgently needed and constitutes a challenge to academia and international organizations. In particular, research is needed on providing adequate access to evidence based interventions for early intervention and treatment of depression and other mental ill health among women and girls, including in the perinatal period, and support for recovery.

Empowerment of women is a complex issue that involves consciousness raising to modify the social construction of gender, which subordinates women. Becoming the owner of her own life, in an ecological context encompassing the individual and societal roles that women may want to perform, requires energy and clear vision. These are not possible if the person suffers from unattended depression or is exposed to verbal, physical or sexual abuse. It is impossible to gain enough agency to play a significant role in one's destiny in a context of discrimination or poverty, if one's life is endangered by the need for a back-alley abortion, or even worse, by the knowledge that young healthy women die at childbirth from preventable causes.

There is a significant gender imbalance in the access of women to well-being and autonomy. Furthermore, these gender imbalances permeate most health systems, so that women die from preventable causes in the course of a physiological event such as childbearing and suffer from untreated depression, a chronic condition for which inexpensive and effective treatment exists. Addressing these unfair differences (how gender determines who gets sick, who gets recognized as being ill and who gets treated, whose illnesses are subject to more research and whose needs shape health policies and programs) is a crucial challenge, the response to which lies in different levels of the global community. It is not possible to attain gender equality until these issues are resolved.