Review Article

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Intersecting Mental Health and Sexual and Reproductive Health

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Abstract

Mental Health and Sexual and Reproductive Health are well-studied with accolades of literature on each topic; however, their interrelationships have been under-described. Mental Health problems can be result of concurrent or past Sexual and Reproductive Health ill event and vice versa. This article presents intersection between Mental Health and Sexual and Reproductive Health based on available literature. Intersections between Mental Health and Sexual and Reproductive Health and their impacts can be studied through life course perspective and needs prioritized attention in case of Gender Based Violence and for people living with disability. The article highlights the importance to explore other aspects such as emotions, gender and sexuality associated with Mental Health and to study and understand physiological and psychological context between Mental Health and Sexual and Reproductive Health. It also stresses the need of further research on intersection between Mental Health and Sexual and Reproductive Health.

Keywords: Mental Health, Sexual and Reproductive Health, Intersection

Tweetable abstract: To collect evidence and to establish intersection between Mental Health and Sexual and Reproductive Health is crucial.

Introduction

Mental Health and Sexual and Reproductive Health (SRH) forms an integral part of overall health and well-being of an individual. Different phases and changes in sexual and reproductive behavior can play an important role in determining and shaping Mental Health status and vice-versa. However, the concept of the intersection between Mental Health and SRH is only emerging. The study on intersection between Mental Health and SRH has been underrated so far with inadequate and incomprehensive database assessing reproductive and Mental Health [1].

Data from few researches in the past give us some insights about relationship between Mental Health and SRH. About 10-15% of women in developed countries and 20-40 % of women in developing countries experience depression during pregnancy or after childbirth [1]. Research have shown people with serious mental illness tend to have more lifetime sexual partners, limited use of contraception and unplanned pregnancy among women which leads to greater risk of Sexually Transmitted Infections (STIs) including Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) [2].

Furthermore, violence is estimated to occur in between 4% and 8% of pregnancies and physical abuse in pregnancy is reported to cause higher stress [3]. Significantly higher levels of depressive symptoms have been found among women seeking treatment for infertility than in presumed fertile controls [4]. A study in past has shown high prevalence of depressive disorder and higher frequency of psychiatric diagnosis during miscarriage and prevalence of depressive and anxiety disorder among women during menopausal transition [5].

This article explores intersection between Mental Health and SRH especially in regards to puberty, gynecological conditions, Gender Based Violence (GBV) and disability and argues for gender sensitive approach in research which is expected to enhance quality of life through improvement in both Mental Health and SRH status.

Mental Health during life course

SRH and Mental Health are interdependent and interconnected throughout the course of life. During the puberty phase, young people go through lots of physical, mental and psycho-social changes [6] and are susceptible to ranging degrees of mental stress. The mental strain is even higher especially for those who are questioning their own sexuality and gender identity [7]. These physical changes when accompanied with deleterious cultures and traditions can create conducive environment for poor mental and physical health. For instance, menstruation in Nepal is still a topic of stigma and discrimination; and practice of untouchability is abundantly found in Nepal. Girls and women in hilly region of Mid Western and Far Western region of Nepal are sent to cow hut during menstruation and this discriminatory practice is called “Chaupadi” [8]. Whilst following Chaupadi, many women and young girls have been reported to be harassed, raped or killed by bites of snake, other animals or natural disaster. Isolation from family, social exclusion, low self esteem, fear of sexual abuse and assault leads to mental stress and results into trauma and depression [9].

Gynecological conditions affect womens’ physical and Mental Health and wellbeing. Stress due to white vaginal discharge, unintended pregnancies and unsafe abortion leads to onset or reoccurrence of serious mental illness [10]. Perinatal depression is one of the most prevalent and severe complications of pregnancy and childbirth [1]. Miscarriage is strongly linked with depression [4]. These Mental

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Health issues induced during pregnancy or post child birth not only hampers mental, physical and social wellbeing of mother but also child care and overall development of child [11].

Young women are vulnerable towards STIs because of thinner vaginal wall than elder women. Subordination of women, poverty, illiteracy, substance abuse, and dependency for financial security over men makes it difficult for women to insist for safer sex leaving women more prone towards STIs including HIV [1]. Research have shown Mental Health problems such as anxiety disorder, insomnia, depression, acute psychotic disorders, mental retardation and dementia among people living with STIs due to mental stress caused by shame, guilt, oppression, fear of discrimination, sense of isolation and lack of support [12].

Infertility is yet another reproductive issue incurring Mental Health issue. In case of Nepal, infertility is emerging as a public health issue with exact prevalence still unknown [13]. Issues of infertility are of immense shame among both male and female in Nepalese context. Guilt, fear of earlier sexual experience and use of contraceptives, substance abuse, and misdeed of past life is prominent among men and women with infertility and this triggers sadness, mental stress, anxiety and depression in person [14]. Likewise,during post reproductive cycle,menopause labeled as reproductive problems also contributes to fluctuation of emotions and leads to mental tension and anxiety among women [15].

Mental health and Gender Based Violence (GBV)

Gender is a critical determinant of Mental Health. Addictions, substance use disorders and psychopathic personality disorders are more common among men while symptoms of depression, anxiety, and unspecified psychological distress are 2–3 times more common among women [16]. GBV affects physical, mental, reproductive health and also has impact on behavior of person. Women experience violence at home, work place and in public spaces. GBV acts both as contributor and consequences of many SRH issues such as infertility, miscarriage, HIV and AIDS as well as mental health conditions such as anxiety and depression. According to Nepal Demographic and Health Survey (NDHS) 2016, 22% of women in Nepal aged 15-49 years have experienced physical violence, 7% have ever experienced sexual violence and six percent of women who have ever been pregnant have experienced violence during pregnancy. GBV is an outcome of patriarchal society which puts emphasis on control over sexuality of girls and women such as fertility control, mobility control and decision-making power [17] which creates conflict between partners and family members leading to psychological effects and costing emotional wellbeing of women [18].

Mental Health, disability and SRH

People living with disabilities are often denied of SRH information, access to abortion service and other various sexual and reproductive servicesand they are likely to experience physical, emotional, sexual abuse, GBV and are more prone towards HIV and other STIs [19]. Researchers have found disabled people to have poor mental health. They are more likely to have schizophrenia, bipolar affective disorder, anxiety disorders, depression, obsessive-compulsive disorder, dementia and behavioral disorders [20]. Violence against women is prominent among women with psychosocial disabilities. Long-standing history of forced sterilizations, hysterectomies and abortions among women with psychosocial disability is found as institutional measures to manage menstrual hygiene, avoid pregnancies and deal with unwanted pregnancy that are always read as unwanted for women with psychosocial disability [21].

Increased need of research

Most of research intersecting Mental Health and SRH are conducted in developed countries and there is eminent need of research in developing countries [9, 22]. Rigorous and systematic research on linkage of mental health with menopause, Female Genital Mutilation (FGM), linkage with Sexual and Reproductive Health Rights of men and Mental Health, psychological aspects of abortion, social epidemiology of HIV infection and its intersection with mental health in women and Mental Health consequences of gynecological injuries is still inadequate [1].

The findings from study on integration between Mental Health and SRH will contribute to screening and intervening mental and SRH conditions which will improve quality of life across all gender. It not only provides evidence for linkage between SRH but also helps to remove stigma and discrimination associated with it. While studying theintersection between mental health and SRH, it is necessary that we adapt life course approach over cross sectional approach to effectively understand and study emotional distress [23]. Sex and gender perspective is important determinant of health since sex and gender interact to produce differential risks and vulnerability in health, health seeking behavior, access to health service and information. Thus, gender sensitive model in research is essential for intersecting research on Mental Health and SRH to ensure significant improvement in Mental Health, SRH and overall quality of life [24].

Conclusion

The research on linkage between SRH and Mental Health in past has been very minimal and revolves around women's reproductive health issues and often neglects gender and psychological aspect. The need of collecting evidence to establish intersectionality between Mental Health and SRH is a must. Increasing access to SRH services and mainstreaming Mental Health with SRH deems important. This will not only establish relationship between SRH and Mental Health but will contribute to achieve proper quality of life.

Moving beyond biology and looking through lens of gender and rights perspective will help in ensuring better health services and to remove stigma and discrimination attached with SRH and Mental Health. Institutions delivering health services in all levels (primary, secondary and tertiary) needs to be sensitive on issues of SRH and Mental Health. Health institutions furthermore should explore inter-

secting relation between Mental Health and SRH and help to prevent prevalence of Mental Health conditions associated with SRH. The evidence from available researches, recommendations from international conferences and local experiences also argues to focus strongly on adolescent health and interlinking SRH and Mental Health for better health, well being and to achieve gender equality.

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