

# ***The Interface Between Mental Health and Reproductive Health of Women Among the Urban Poor in Delhi***

**Ranendra Kumar Das and Veena Das**

## **EXECUTIVE SUMMARY**

This study looked at the intersection of reproductive health and mental health of women among the urban poor in Delhi, India. It is part of a larger study that seeks to understand how differences in experiences of migration, clustering of low-income, middle-income, or upper-income households in a locality, type of practitioner markets, as well as other neighbourhood characteristics influence household decision-making with regard to health.

Recent work has shown that while there are no consistent gender differences in low-prevalence and severe mental disorders such as schizophrenia and bipolar disorder, gender differences appear to be significant factor in common mental disorders such as depression and anxiety. We tried to see whether reproductive health, defined not in terms of clinically defined conditions such as pregnancy and postnatal depression, but in terms of the cumulative experience of pregnancy, miscarriages; and child mortality, could provide a lens to see women's overall life experiences that impact on mental health.

Our larger study is located in seven neighbourhoods in Delhi, four of which have large clusters of low-income families. For purposes of indexing mental health at the community level, we have complete responses from 789 individuals to the SCL-90-R questionnaire that is widely acknowledged to have cross-cultural validity. A detailed women's health questionnaire was administered to a sub-sample of married women. In addition, we conducted one hundred ethnographic interviews with a sub-sample of the married women who had responded to the women's health questionnaire. The ethnographic interviews were semi-structured but used an amplificatory technique of interview allowing women to structure their own emplotment of stories relating to relations in both the natal family and the conjugal family.

The relation between poverty and common mental disorders has been found in several studies, and our study confirmed these findings. In addition there were specific factors that were important – so mental distress decreased with age. Women who were engaged in earning activities even in poor households suffered less. The mental distress increased if women had faced harassment in their conjugal families. Adverse reproductive experiences strongly affected the mental health of women and these experiences were not necessarily of the immediate past. We find a close association of the state of physical health and mental health. Physical illness significantly burden have pointed out that co-morbidity is associated with mental illness the combination they consider is that of psychiatric morbidities. None of the studies we have seen try to correlate physical and psychiatric co-morbidity in a systematic way.

We tried to construct a picture of domesticity through the ethnographic interviews. We find that state definitions of reproductive choices in terms of limiting families had been internalised even in the poorest neighbourhoods but instead of leading to systematic health care these simply resulted in widespread use of abortions and terminal contraceptive methods to control the size of the family.

Our interviews also revealed that women were most vulnerable to harassment in spaces in which there was a desire for the new – for college education, for marrying by choice, and for commodities. While images from the media have introduced new desires there were very few opportunities for bringing these to fruition. Hence first generation female college students, those living in families where the husband had temporarily migrated to earn money, and families who felt they were unable to maintain the status appropriate to their caste or neighbourhood

standards, made women much more vulnerable than those who were living in relatively homogenous neighbourhoods in terms of income and assets. This is not to suggest that these desires are suspect but to show the high costs of aspiring to set new norms for the domestic.

Domestic violence was more pervasive in low-income neighbourhoods than in middle-income or high-income neighbourhoods but women had a stake in maintaining relations even with husbands who were beating them. This does not mean that women accepted this as a sign of love – they would have liked community participation in resolving this problem. There was great suspicion of the State especially as experienced in the figure of the policeman, which was why state intervention was not welcomed as solution. Communities themselves had notions of unacceptable violence but the men who brutally beat their wives were more likely to be the ones who had reputations of violence even against men – hence local leaders were afraid to intervene in these cases. One of the most protective factors for women was the strong interest of the natal family to continue to provide support after a woman's marriage.