Poverty, gender and mental health promotion in a global society

The powerful influence of a range of social and economic factors on mental health has been documented in virtually all epidemiological investigations of mental disorders. These risk factors are similar to the various indicators used to measure ‘human development’. This concept was first operationalised by the United Nations Development Program in its first ‘Human Development Report’ released in 1990. That report opened with the lines:

“The real wealth of nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives. This simple but powerful truth is too often forgotten in the pursuit of material and financial wealth”.

Mental health is an implicit component of this concept, for there is good evidence that poor mental health will compromise longevity, general health, and creativity. Thus, the factors which influence human development will be those which also influence mental health; causality is not likely to be simple or unidirectional for both human development and mental health are broad constructs. It is likely that a dynamic relationship exists between specific aspects of human development, such as poverty, and specific aspects of mental health, such as self-esteem (Patel, 2001). The indicators used to measure human development are varied, and show great variation between countries. In the Human Development Reports, countries are ranked according to an overall Human Development Index (HDI) which is computed on the basis of a number of variables. Another measure, which is of relevance to this paper, is the Gender-related Development Index (GDI), which is a composite measure reflecting gender inequalities in human development. Of the 173 countries for whom HDI were computed in the 2002 report, 53 were ranked as being in the high HDI category, 84 in the middle HDI category, and 36 in the low HDI category. A scan of the list of countries shows that all the countries of Western Europe, North America and Australia/New Zealand are in the high HDI category, whereas most of the rest of the world falls in the middle and low categories. The use of HDI shows that there is a huge diversity between countries which have traditionally been lumped together as ‘developing’. These diversities are further reflected in the frequency of a range of adverse social and economic factors which influence mental health, such as crime rates, physical health indicators, political commitment to public health and social welfare, and the experience of severe civil disturbances such as those caused by conflict and disasters. Disparities are evident both between major geographical regions, and within geographical regions; indeed, human development reports for specific countries reveal enormous disparities even within the same country. Political commitment to public health and social welfare also show a similar pattern of disparity; sadly, some of the poorest countries in the world continue to spend more on the military than they do on education and health. The number of internally displaced peoples and refugees are alarming; again, the numbers are consistently higher in countries with low HDI, demonstrating that poor countries bear the lion’s share of the burden of war and displacement. However, it is reassuring that for the vast majority of countries, including those in the low HDI category, there has been a steady, if slow, improvement in HDI over the past two decades.

In this paper, I will focus on two key macro-issues which profoundly influence all aspects of human development, viz., poverty and gender, with the aim to demonstrate how these elements are related to mental health and mental disorders. The paper will also consider the impact of globalisation on poverty and gender in the context of their influence on mental health, and the strategies for action for mental health promotion.

Poverty and mental health

There are no unitary or cross-culturally valid indicators to measure poverty. Instead, definitions vary depending on the social, cultural and political system in a particular region and country, and according to who might be the user of the data on poverty. Poor people’s definitions of poverty, as described on the basis of interviews in a number of developing countries, reveals that poverty is a ‘multidimensional social phenomenon’ (Narayan, Patel, Schafft, Rademacher and Koch-Schulte, 2000). Thus, lack of what is perceived to be necessary for material well-being, particularly food but also housing and land is a key defining feature. Exclusion from social and political forums, absence of basic infrastructure in their communities, literacy and lack of assets (as opposed to income) are also viewed as important. Poverty, from an epidemiological perspective, means low socio-economic status (measured by social or income class), unemployment and low levels of education. As might be expected, poverty is much more common in developing countries; in

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addition to absolute poverty, relative poverty or inequality also tends to be more common in developing countries. A recent review of community studies from low and middle income countries found that most studies showed an association between low education and the risk for depression; many studies also showed a relationship between other indicators of low socio-economic status such as poor housing or low income with the risk for depression (Patel and Kleinman, 2003). Persons who are depressed often cite economic difficulties as the cause of their ill-health. The relationship between poverty and poor mental health may be mediated by a number of factors including the humiliation and insecurity of living in poverty (Narayan, Chambers, Shah and Petesch, 2000), the greater burden of physical health problems in the poor, and poor access to appropriate health care. Irrespective of the average per capita income of a society, persons who are at the bottom end of the social hierarchy are at a greater risk to suffer these disorders than those who are at the upper end, an effect which seems to be more pronounced in more unequal as well as poorer societies. Thus overcoming poverty might contribute to the promotion of mental health but it is unlikely to be enough; a more equitable distribution of resources remains important.

A variety of social phenomena associated with rapid urbanisation by globalisation may be detrimental to mental health through increasing stress or reducing natural protective factors. Examples of such phenomena include squallid living conditions in urban areas for migrants, and the breakdown of families as sources of social support. The suicide of farmers in parts of India since the mid-1990s, provides another illustration of the impact of globalisation and ensuing financial insecurity on mental health. The seasonal monsoon has consistently failed in some regions of India leading to low harvests and lower incomes for farmers. The ones who have suffered the most have been the poorest subsistence farmers who were not credit-worthy enough to get bank loans and had to borrow money from loan-sharks. With their crops failing year after year, the farmers were faced with the stark choice of selling whatever few assets they still had or become bonded labour to the moneylender until the debt was repaid. Globalisation and the inroads of multinational companies has led to new competition for small-scale farmers whose goods are no longer competitively priced. This adds, directly or indirectly, to numerous other problems such as sub-standard quality of seeds and the lack of cooperative supports from banks. The result of this stress has been more than 1000 suicides in recent years (Sundar, 1999).

Depressive and anxiety disorders are disabling and can prevent sufferers from carrying out their tasks at home and in employment. Depressive and anxiety disorders have adverse economic implications for the individual, their families and society. Thus, it is likely that poverty and poor mental health interact with one another, setting up in vulnerable individuals, a vicious cycle of poverty and mental illness. Socio-economic determinants play an important influence on other mental disorders, such as the economic burden placed by alcohol and substance abuse and severe mental disorders; almost always, the poor face a disproportionately higher fraction of the burden.

Gender and mental health

Whereas sex is a term used to distinguish men and women on the basis of their biological characteristics, gender refers to the distinguishing features which are socially constructed. Gender influences the control men and women have over the determinants of their health, including their economic position and social status, access to resources and treatment in society. Gender can be conceptualised as a powerful social determinant of health which interacts with other determinants such as age, family structure, income, education and social support and with a variety of behavioural determinants (WHO, 2000). The role of gender in public health in developing countries has been acknowledged and ‘mainstreamed’; gender is a core component of major health programmes targeted at child and adolescent health, reproductive health and primary health care. The promotion of gender equality and the empowerment of women is the third of the Millenium Development Goals (MDG) formulated at the Millenium Summit of 2000 which set the strategic direction for the World Bank, UN institutions, and development and donor agencies. The role of gender in mental health is universal, but as with poverty, its impact is likely to be significantly greater in developing countries because gender is a much less recognised determinant in these countries; indeed, the Human Development Report’s Gender Development Index league tables show that low and middle income countries tend to have lower GDI than high income countries (United Nations Development Programme, 2002).

One method of examining the role of gender on mental disorders is to consider those disorders with significant, cross-cultural sex differences, for example, Depression, Alcohol Use Disorders (AUD) and Eating Disorders. The female excess for Depression has been demonstrated in most community based studies in all the regions of the world (WHO, 2000). Stresses in life are known to make a person more likely to become depressed and the greater exposure to stressors may partly explain the female excess in the risk for Depression. The social gradient in health is heavily gendered and women are disproportionately affected by the burden of poverty which, in turn, may influence their vulnerability for Depression. Women are far more likely to be victims of violence in their homes; women who experienced physical violence by an intimate partner are significantly more likely to suffer Depression, abuse drugs or attempt suicide (Asbury, 2001; WHO, 2002). Gender based factors such as heavy workloads, humiliating and entrapping life events related to marital relationships and the preference for boy children in some cultures have all been shown to be associated with a higher risk for depression (Broadhead and Abas, 1998; Patel, Rodrigues and De Souza, 2002). The male excess for AUD has been demonstrated in every community study from every region, although the gaps are the greatest in developing countries. The wide sex differences in alcohol abuse in Latin American countries and the Caribbean has been attributed to a number of gender factors (Pyne, Claeson and Correia, 2002). Drinking and drunkenness are more often perceived to be consistent with gendered notions of
masculinity and thus, men who conform more closely to cultural norms are more likely to drink. In many cultures (but perhaps most well recognised in Latin American cultures), the role of machismo, i.e. the importance of male sexuality, is central in shaping alcohol consumption.

The evidence that gender may play a role in eating disorders stems from the fact that there are enormous sex differences (females outnumbering men) and that cultures which have been relatively immune to the media-driven creation of the ideal body image for women have very low rates of these disorders. Recently, a study from Fiji has demonstrated that the introduction of television in a media-naïve non-Westernised population is associated with a rise in attitudes favouring thinner body image and self-induced vomiting in girls (Becker, Burwell, Gilman, Herzog and Hamburg, 2002), adding weight to the theory that the emphasis on women’s thinness by the media and fashion industries is now leading to a rise in disordered eating in non-Western cultures as globalisation leads to increasing homogenisation of media imagery across the world with Western imagery being the predominant force.

Gender also influences other aspects of mental disorders, such as impact, burden and stigma, and this is evident for those disorders which do not have significant sex differences such as schizophrenia and bipolar disorder. Social responses to mental illness more clearly show a gendered difference, with greater stigma and rejection being evident in the event of a woman suffering from mental illness. Because of the different expectations and evaluations of men’s and women’s behaviour, mental illness in women may attract a greater amount of shame and dishonour and has a greater impact on family life due to the woman’s role in running the domestic activities of the household. These differences may lead to a suppression of the acknowledgement of the experience of mental disorders in women and men. Whereas a mentally ill man may get married, mentally ill women are often left alone. Married mentally ill women are more likely to be sent back to their parental homes, deserted or divorced (Davar, 1999). Gender also influences suicidal behaviour; the higher rates of male suicide in some countries is partly due to the acceptability for men to carry guns and gendered differences in social roles and expectations when faced with adversity. On the other hand, rapid social change with its impact on interpersonal networks and social identity, has been attributed as one the major causes for the rise in suicide rates, especially in rural women in China (Phillips, Liu and Zhang, 1999).

Implications for mental health promotion

One of the central challenges faced by mental health promotion in contexts where infrastructure is poorly developed, where human and material resources are scarce, and where human rights practices cannot be taken for granted is that many of the social changes necessary for improved mental health are far more wide-reaching than generally considered within the ambit of mental health promotion practice. The impact of the changes in terms of narrow and proximate mental health gains is also hard to measure, especially in the short term. In addition, for a range of reasons, some of which have to do with a lack of resources and capacity in developing countries, far less research has been conducted in these contexts than in wealthier countries. It is likely, therefore, that there will be little specific evidence, in particular based on controlled trials, which demonstrates the impact of social and economic development policies and programmes on the promotion of mental health. The evidence that does exist includes narrative and case study material of specific programmes and evidence from the domain of physical health promotion which may be extrapolated to mental health. These programmes focus on three major areas of action: advocacy, empowerment and social support. Empowerment is the process by which groups of persons in the community who have been traditionally disadvantaged in ways which compromise their health, can overcome these barriers and can exercise all the rights that are due to them, with a view to leading a full, equal life in the best of health. In the context of poverty and gender, empowerment can be conceptualised as a core mental health promotion activity in developing countries. Examples of such empowerment activities are considered below.

Economic empowerment

In many developing countries, indebtedness to loan-sharks is a consistent source of stress and worry. These vulnerabilities arise because of the failure of the formal banking sector to extend short term loans to the poorest in the community, who often lack the literacy or ‘credit-worthiness’ which are essential for accessing loans. Radical community banks and loan facilities such as those run by SEWA in India and the Grameen Bank in Bangladesh have been involved in setting up such loan facilities in areas where they do not exist. Provision of such loans may reduce mental illness by removing the key cause of stress: the threat posed by the informal moneylender. Some evidence of the ability of such banks to promote mental health is available. The Bangladesh Rural Advancement Committee (BRAC) is the world’s largest NGO in terms of the scale and diversity of its interventions. Its activities span health care provision, education and rural development programmes. The latter programmes are implemented at the level of individual villages, through Village Organizations (VO) comprising of the poorest members of the community. The primary activities are raising

![Figure 1](https://example.com/figure1.png)

**Recommendations**

- Raise awareness about the association of poverty and gender with mental health amongst public health policy makers, donors and mental health workers.
- Advocate for sustainable and equitable economic development to ensure that economic policies do not inadvertently lead to greater inequalities and marginalisation of people.
- Advocate for eliminating gender discrimination and violence in society.
- Improve access for health care and social welfare of persons living in poverty.
- Enable community programmes which aim to empower women and the poor.
- Evaluate the impact of globalisation on mental health, in particular, where globalisation influences the livelihood or lifestyles of people.

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consciousness and awareness and compulsory savings. Once established, VO members can access credit for income generation schemes. BRAC has carried out evaluations of its programmes in a number of different settings. Data used for evaluation include baseline surveys, seasonal surveys, ethnographic surveys and demographic surveillance. These data show that BRAC members have better nutritional status, better child survival, higher educational achievement, lower rates of domestic violence and improved ‘well-being’ and psychological health (Chowdhury and Bhuiya, 2001).

Equitable economic development

The epidemiological evidence clearly demonstrates the greater risk for common mental disorders for persons living in socio-economically disadvantaged situations. These findings suggest that economic development, which improved the lives of the poor, would lead to an improvement in mental health. A study on the impact of economic development on mental health was conducted in a rapidly industrialising region of Sumatra, Indonesia (Bahar, Henderson and Mackinnon, 1992). The study was able to access data on the change in development levels of each village; the rates of mental disorder were lowest in persons living in those villages which had shown the greatest improvements in living standards and socio-economic development in the previous three years. Community development programmes which include health sector reforms such as decentralisation, participation of local community leaders and empowerment of the marginalised, are being implemented across the developing world as a way of promoting health and preventing disease amongst the poor. Many of these programmes are being led by social ‘entrepreneurs’ and community based non-governmental organisations. In all these models, health is seen as a fundamental part of development and vice versa, i.e. health cannot be assured unless overall development is achieved.

Empowerment of women

Although the link between domestic violence and mental health problems has been firmly established in numerous studies, there have been no systematic evaluations of the mental health impact of violence reduction programmes being implemented in many developing countries. Such programmes work at several different levels, including sensitisation of health workers so that they are confident and comfortable when asking about abuse, integration of education about violence into existing health programmes and communication strategies (such as TV soap operas), enabling legal reforms to ensure the rights of abused women, raising the cost to abusers by imposing a range of legal penalties, provision for the needs of victims and reaching out to male perpetrators (Heise, Ellsberg and Gottemoeller, 1999). Approaches which focus on strengthening intimate relationships, one of the most common contexts for violence, include parenting training, mentoring and marriage counselling; some of these, such as the Stepping Stones programme have been shown to help men to communicate and give them new respect for women, in qualitative evaluations in African and Asian settings (cited in Heise et al., 1999).

Many programmes have been demonstrated to be effective in the reduction of the primary outcomes of reduction in violence and, given the linkages between domestic violence and common mental disorders in women, it is likely that such programmes will have a powerful impact on mental health promotion as well.

In conclusion, although there is considerable variation between, and within, countries in indicators of poverty and gender, there is a clear association between these macro-socio-factors and mental health. Programmes aimed at empowering women and the poor, and policies which ensure gender equality and equity in economic development are likely to play the greatest role in promoting mental health.

References


