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Women, poverty and common mental disorders in four restructuring societies

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Abstract

Background: Poverty and female gender have been found to be associated with depression and anxiety in developed countries. The rationale behind this paper was to bring together five epidemiological data sets from four low to middle income countries to examine whether key economic and development indicators such as income and poor education, and female gender, were associated with common mental disorders.

Method: The paper is based on five datasets: three based on primary care attenders in Goa, India; Harare, Zimbabwe and Santiago, Chile; and two based on community samples in Pelotas, Brazil and Olinda, Brazil. All five studies estimated prevalence of common mental disorders along with variables to measure economic deprivation and education.

Findings: In all five studies, female gender, low education and poverty were strongly associated with common mental disorders. When income was divided into tertiles, with the lowest tertile as a reference value, there was a significant trend for reduced morbidity for the lower two tertiles.

Discussion: These findings have considerable implications since the rapid economic changes in all four societies have been associated with rising income disparity and economic inequality. Examples of population based prevention strategies based on increasing the proportion of those who complete schooling and on high-risk strategies such as providing loan facilities to the impoverished are potential outcomes of these findings. Development agencies who focus on women as a priority group have failed to recognize their unique vulnerability to common mental disorders and need to reorient their priorities accordingly.

Keywords: Mental health; Women; Poverty; Cross-cultural; India; Zimbabwe; Chile; Brazil

Introduction

Common mental disorders (CMD) was a term coined by Goldberg and Huxley (1992, pp. 7–8) to

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Table 1
Methodology of studies[a]

Setting	Olinda	Pelotas	Harare	Goa	Santiago
Investigator	AL	ML	VP,CT	VP	RA
Population	community	community	PHC	PHC	PHC
Design	survey	survey	case-control	survey	survey
Sample	621	1277	199 cases,197 controls	303	4200
Sampling	random	multistage random	systematic	random	systematic
Case criteria	SRQ	SRQ	SSQ	CISR	GHQ/CISR

[a] GHQ = General Health Questionnaire (Goldberg, 1978); SRQ = Self Reporting Questionnaire (Harding et al., 1980); SSQ = Shona Symptom Questionnaire (Patel et al., 1997a); CISR = Revised Clinical Interview Schedule (Lewis et al., 1992).

describe "disorders which are commonly encountered in community settings, and whose occurrence signals a breakdown in normal functioning". CMD, also referred to as non-psychotic mental disorders or neurotic disorders, manifest with a mixture of somatic, anxiety and depressive symptoms. CMD are the third most frequent causes of morbidity in adults (prevalence rates) worldwide (World Health Organization, 1995). They are an important cause of disability and pose a significant public health problem (Ormel et al., 1994). The recent WHO report "Investing in Health Research and Development" predicts that depression will be the single most important cause of disability by the year 2020 in the developing world (World Health Organization, 1995). The warning of a mounting crisis of unmet needs for the countless millions with such disorders have been building up over the past 20 years. Evidence of a high prevalence of CMD has been generated from a range of settings in low and middle income countries such as rural Lesotho, primary health clinics in Santiago and the urban general practices of India (Shamasundar et al., 1986; Hollifield et al., 1990; Araya et al., 1994). These studies reveal prevalence figures of CMD exceeding 30% in community samples and approaching 50% in primary care samples.

The WHO Multinational study of the prevalence, nature and determinants of CMD in general medical care settings was conducted in 14 countries (Ustun et al., 1995b). The startling finding of this study was that, despite the use of standardized methods in all centres, there were enormous variations in most variables. Indeed, the only similarities across centres were the general observations of the ubiquity of CMD, the comorbidity of anxiety and depression, and the association of CMD and disability even after adjustment for physical disease severity. On the other hand, specific variables showed substantial variations; thus the prevalence rates of CMD ranged from 7 to 52% of primary care attenders; physician recognition of CMD varied from 5% to nearly 60% and the association of key variables such as gender, physical ill-health and education with CMD were in opposite directions in different centres. These findings demonstrate the need for locally relevant studies with locally validated methodologies whose aim is to identify local needs and inform local health services (Patel and Winston, 1994).

Female gender, social, economic and interpersonal factors remain the most consistently demonstrated risk factors for CMD in industrialised societies. There is growing evidence of an association between socioeconomic deprivation as represented by unemployment (Warr, 1987; Bartley, 1994; Gunnell et al., 1995), low income (Eaton and Ritter, 1988; Power et al., 1991) and lower social class (Brown and Harris, 1978; Meltzer et al., 1995), with suicide rates (Platt and Kreitman, 1990) and psychological disorder. There is consistent evidence of an association between economic deprivation as measured by social class, income and employment, in developed countries and CMD (e.g. Bartley, 1994). A recent household survey from the United Kingdom demonstrated a strong association between CMD and low household income and not saving from income (Weich et al., 1997). Similarly, many studies from these settings have demonstrated a greater risk for women to suffer CMD (Jenkins, 1985).

Most epidemiological studies of CMD in low-income countries have concentrated on prevalence rate estimations, rarely examining the role of risk factors. The aim of this paper is to bring together data collected by the authors in five separate studies conducted in four low and middle income countries in different stages of economic development to examine two hypotheses: first, that female gender is associated with CMD and, second, that poverty is associated with CMD. The rationale for these hypotheses was that these risk factors had been demonstrated in some studies from industrialised societies. If similar associations were demonstrated in low and middle income countries, the implications would be of great importance since they would reflect not only the universal nature of these risk factors, but also have a bearing on the impact of the dramatic economic changes in these countries on the increased morbidity of CMD. These studies were conducted by the authors in their own countries, using methodologies that were sensitive and valid for the local setting. Thus, this paper is not based on a multi-