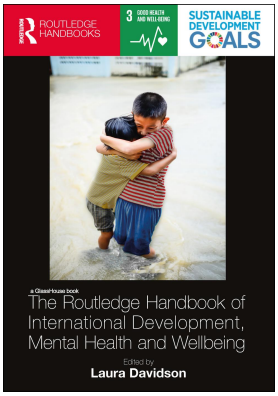

The Routledge Handbook of International Development, Mental Health and Wellbeing

Laura Davidson

Addressing Mental Health From a Gender Perspective

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9780429397844-8
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Published online on: 25 Jun 2019

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ADDRESSING MENTAL HEALTH FROM A GENDER PERSPECTIVE

Challenges and opportunities in meeting SDG3

Carol Vlassoff ⋆

Introduction

This chapter explores the relationship between gender and mental health and the importance of this relationship for meeting Sustainable Development Goal 3 (SDG3). The overall goal of ensuring health and wellbeing for all throughout the life cycle includes the targets of promoting mental health and wellbeing, of strengthening prevention and treatment of substance abuse, and of reducing the suicide mortality rate.[1] This chapter will argue that incorporating a gender approach into the promotion of mental health and wellbeing is essential in the attainment of SDG3, particularly in lower and middle-income countries (LMICs).

Gender refers to 'socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women'.[2] Gender affects people's control over the circumstances influencing their lives and health, including their social status and treatment by society, and their ability to shape or alter these conditions. At birth, men and women are entitled to enjoy their human rights and to be fulfilled and healthy. However, the roles attributed to them are often rooted in unequal power relationships, with women subordinated. Such inequalities can have negative consequences for women's lives, health and wellbeing. Unequal gender relations are prevalent in most societies to some degree, but they are particularly prominent in LMICs where cultural factors often reinforce male-female hierarchies. People of the lesbian, bisexual, gay, and transgender (LBGT) community also face widespread discrimination globally, and are at risk of

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1 United Nations, Department of Social and Economic Affairs, Sustainable Development Goal 3. Available at: https://sustainabledevelopment.un.org/sdg3.

2 WHO (2017), Gender, Women and Health: What Do We Mean by Sex and Gender? Available at: www.legal-tools.org/doc/a33dc3/pdf/.

mental illness because of their repeated exposure to psychosocial stressors, including anti-LBGT attitudes, stigmatisation, and violence.[3]

A considerable amount of epidemiological literature has focused on biological gender differences in mental conditions, but most of the research on sex and gender differences in mental disorders is from high-income countries (HICs). Common mental disorders (CMDs) in LMICs have begun to be investigated only recently, and little is known about how specific risk factors vary by gender, as well as by other demographic and socioeconomic factors. The remainder of this chapter will therefore focus on what is known about gender and mental health issues in LMICs, in terms of challenges and opportunities to address them. Whilst taking a gender-sensitive approach, it will concentrate on women, as a companion chapter in this book deals with male mental health concerns.[4] It should be noted that this chapter does not discuss biomedical interventions for medical disorders, such as medicines and psychiatric therapies, although research and practice are increasingly recognising that men and women often respond differently to medical treatments and thus that gender influences should also be considered when prescribing treatment.[5]

A prevailing gap in the literature on gender differences in mental health in LMICs has been the failure to include perspectives of LBGT populations (with the exception of the HIV literature and specific LBGT journals). The relative lack of attention to LBGT issues in this chapter is due to the paucity of studies available from LMICs.

Sex differences in the burden of mental disorders

It is widely accepted that men and women have similar rates of severe mental disorders, but that they have different patterns of CMDs.[6] Women suffer more from depression, ranked by the WHO as the leading contributor to disability globally.[7] Anxiety disorders, such as post-traumatic stress disorder (PTSD), are also reported more frequently amongst women, as well as panic disorders and phobias (from which women suffer up to three times more than men).[8] Women have more comorbidity and concomitant increased disability (compared to the disability resultant from a single illness).[9] Older women are reported to suffer disproportionately from mental disorders, including dementia, depression, and organic brain syndromes.[10] By contrast,

3 See Willging, C. E., Salvador, M., & Kano, M. A. (2006), Brief Reports: Unequal Treatment: Mental Health Care for Sexual and Gender Minority Groups in a Rural State, *Psychiatric Services*, 57(6): 867–870.

4 See Chapter 9 of this book by Svend Aage Madsen on men's mental health.

5 See, *e.g.*, Fitzgerald, P. & Dinan, T. G. (2011), 'Biological Sex Differences Relevant to Mental Health', in D. Kohan (ed.), *Oxford Textbook on Women and Mental Health* (Oxford: Oxford University Press), Chapter 5, and Farr, S. L., Dietz, P. M., Williams, J.R., *et al.* (2011), Depression, Screening and Treatment among Nonpregnant Women of Reproductive Age in the United States, 1990–2010, *Preventing Chronic Disease* [online], 8(A): 122. Available at: www.ncbi.nlm.nih.gov/pubmed/22005615.

6 WHO (undated), Gender and Women's Mental Health: Gender Disparities and Mental Health: The Facts. Available at: www.who.int/mental_health/resources/gender/en/.

7 WHO (2017), Common Mental Disorders, Global Health Estimates. Available at: apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf.

8 Kadri, N. & Alami, K. M. (2009), 'Depression and anxiety among women', in P. S. Chandra, H. Herrman, J. Fisher, *et al.* (2009), *Contemporary Topics in Women's Mental Health: Global Perspectives* (Chichester: John Wiley & Sons), pp.37–64.

9 *Ibid.*

10 Whilst older age is associated with increased risk of mental disorders, there is evidence that gender differences remain, even after controlling for age. However, more in-depth, disorder-specific, longitudinal

men are described as suffering more from alcohol dependence, antisocial personality disorder, and substance use disorders.[11]

Accepted wisdom as to sex differences in the prevalence of mental disorders has been challenged by Hill and Needham,[12] who note that national studies of overall psychopathology have been limited to a narrow range of conditions, and that there has been no comprehensive test of male-female differences across all known mental health conditions. They also question the tendency to group women and men into a simple dichotomous category of affective disorders (traditionally considered to be more common in women) and behaviour disorders (considered to be more common in men), due to a lack of consistent evidence that women and men respond to stress in different ways. They argue that an overemphasis on 'gendered responsivity' distorts the fact that negative emotions and risky behaviour (such as substance abuse and antisocial behaviour) are associated with stress for both sexes. The implications of their argument for the present analysis is that more attention should be paid to understanding the different stressors affecting the susceptibility and responses of both sexes, rather than to quantifying which sex suffers more or less from different mental disorders.

Gender-related stressors for women in LMICs

This section highlights the main gender-related stressors that particularly affect women's mental health.

Common perinatal and postnatal disorders

Maternal health concerns dominate most of the literature on women's mental health, especially disorders during the perinatal period. Stressors related to this period are both physical and socially derived. In HICs it is estimated that about 10% of pregnant women, and 13% of post-partum women, experience some type of mental disorder—mainly depression or anxiety,[13] but also psychosis. In a systematic review of research on non-psychotic common perinatal mental disorders (CPMD), Fisher *et al*. found them to be even more prevalent in LMICs, where about one in six pregnant women and one in five postpartum women experience a CPMD.[14] This finding, as the authors note, counters the widely held supposition that women's mental health in LMICs is protected by culturally appropriate social support mechanisms. For example, the network of female relatives in extended family situations in South Asian countries was thought to provide women with much greater support than that received by women in nuclear families without other adult females to help care for them and their infants.

research is needed in both HICS and LMIC to confirm these differences over the lifespan, and the influence of factors such as pre-existing conditions and frequency of symptoms.

11 Steel, Z., Marnane, C., Iranpour, C., *et al*. (2014), The Global Prevalence of Common Mental Disorders: A Systematic Review and Meta-analysis 1980–2013, *International Journal of Epidemiology*, 43(2): 476–493.

12 Hill, T. D. & Needham, B. L. (2013), Rethinking Gender and Mental Health: A Critical Analysis of Three Propositions, *Social Science & Medicine*, 92: 83–91.

13 Fisher, J., Cabral de Mello, M., Patel, V., *et al*. (2012), Prevalence and Determinants of Common Perinatal Mental Disorders in Women in Low- and Lower-middle-income Countries: A Systematic Review, *Bulletin of the World Health Organization* [online], 90: 139–149H. Available at: www.who.int/bulletin/volumes/90/2/11-091850.pdf.

14 *Ibid.*, p.5.

Gender plays an important role in how women respond to perinatal stressors in both HICs and LMICs. Domestic abuse and lack of partner support for a pregnancy increase women's stress and the probability of CPMDs. In societies with male sex progeny preference, women may be blamed for bearing a female child and may even feel guilty for doing so. In South Asia, for example, women often admit to feeling 'unfulfilled' if they do not produce a son.[15] In the modern context of Asia's declining fertility, most couples will be content with a small family if they have at least one son, and will forgo having daughters entirely.[16] In India, the widespread availability of sex selective technologies (amniocentesis and ultrasound) in the 1970s and of legal abortion (since 1971) have had the combined effect of allowing couples to determine the sex composition of their families. Sex selection in favour of males has continued, particularly in South Asia, North Africa, and the Middle East, despite economic growth and development in other spheres of society.[17]

Importantly, where women have access to better education and employment opportunities, risk of CPMDs is lower.[18] This is also the case where women have access to reproductive health services and a supportive family environment.[19] CPMDs have deleterious effects not only upon mothers themselves, but also on the mental health and wellbeing of their children. Due to the stigmatisation associated with mental illness, women suffering from CPMDs are less likely to participate in essential preventive health care,[20] and because infants are dependent on their mothers for their survival and wellbeing, their development is compromised if a mother is insensitive or unresponsive to their needs.[21] In LMICs, maternal depression is associated with higher rates of neonatal malnutrition and stunting, diarrhoeal and infectious illnesses, hospital admissions, lower birth weight and incomplete compliance with immunisation schedules.[22] Whilst research on the impact of men's mental health during the perinatal period on childcare is lacking,[23] the burden on mothers is likely to be disproportionately greater. More research concerning women's (and men's) mental health in the perinatal period in LMICs is needed to increase understanding and properly address the issues in culturally and gender-sensitive ways.

Violence and victimisation

Domestic violence (by which is meant in this chapter 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm')[24] is a common hidden problem

15 This issue is discussed in detail in C. Vlassoff (2013), *Gender Equality and Inequality in Rural India. Blessed with a Son* (New York: Palgrave Macmillan).

16 Seth, S. (2010), Skewed Sex Ratio at Birth in India, *Journal of Biosocial Science*, 43(1): 83–97; Vlassoff (2013), *op. cit.*, nt.15.

17 See, *e.g.*, Hesketh, T., Li Lu, M. D., & Wei Xing, Z. (2011), The Consequences of Son Preference and Sex-selective Abortion in China and other Asian Countries, *Canadian Medical Association Journal*, 183(12): 1374–1377.

18 Fisher *et al.* (2012), *op. cit.*, nt.13.

19 *Ibid.*

20 Fisher, J., Tran, T., Buoi, L. T., *et al.* (2010), Perinatal Mental Disorders and Health Care Use in Northern Viet Nam, *Bulletin of the World Health Organization* [online], 88(10): 737–745. Available at: www.scielosp.org/scielo.php?pid=S0042-96862010001000010&script=sci_arttext&tlng=pt.

21 See also further Chapter 11 of this book by Cornelius Ani and Olayinka Omigbodun.

22 Stewart, R. C., Umar, E., Kauye, F., *et al.* (2008), Maternal Common Mental Disorder and Infant Growth – A Cross-sectional Study from Malawi, *Maternal and Child Nutrition*, 4(3): 209–219.

23 See further on this Chapter 9 of this book by Svend Aage Madsen.

24 Hegarty, K. (2011), Domestic Violence: The Hidden Epidemic Associated with Mental Illness, *The British Journal of Psychiatry,* 198(3): 169–170.

for women globally, and a major cause of mental ill health.[25] Injurious physical and mental health sequelae of intimate partner violence (IPV) include injury and death, chronic pain, gastrointestinal and gynaecological problems, depression, and PTSD.[26] Many women also suffer rape and violence during pregnancy, causing harm to both mothers and children. Although it varies significantly between countries, about 30% of women experience physical or sexual IPV during their lifetime globally.[27] In LMICs, the prevalence of physical IPV against women varies from 14% in Cambodia to 71% in Ethiopia.[28] Men also experience IPV, but it is less prevalent and severe.[29] To date, most research in this area has focused on physical and sexual violence,[30] leaving the area of emotional and mental anguish (unrelated to physical abuse) largely undocumented.

Gender-based violence (GBV) against women is widely condoned in many LMICs where patriarchal values are the norm.[31] A recent analysis examined approval for 'wife-beating' under five different circumstances.[32] The first was where a wife goes out without telling her husband. The second related to a wife who neglects the children. The third category was a wife who argues with her husband, and the fourth, where a wife refuses to have sexual intercourse with him. The fifth and final category was where a wife burns the family's food. This survey was carried out amongst 53,538 men and 439,614 women in a sample of households from 39 countries, including 23 LMICs. The questions assessed attitudes only concerning physical abuse, and did not investigate attitudes about sexual or emotional violence toward women. Approval by women of physical chastisement in relation to any one or more of the five categories varied from 2% in Argentina to 90% in Afghanistan. Only one-third of the countries provided data from men's perspectives. For those countries which included men's attitudes, approval varied from 5% in Belarus to 75% in the Central African Republic.[33] Africa and South Asia were the regions where physical chastisement was most accepted, whereas Europe, Latin America, and the Caribbean were the least accepting. Acceptance was more prevalent amongst those with low household income, those of rural residence, and the less educated, as well as (perhaps surprisingly) amongst younger adults (the latter finding being consistent with prior evidence). In the countries with high acceptance of physical chastisement, women were more likely to justify it than men, but in the countries with low acceptance, the opposite was true. The authors noted that those countries with higher approval tend to be also higher in gender inequality, and hence men in such countries are better educated, and have greater access to employment and other opportunities than women. The authors concluded that policies are needed urgently to improve gender equality and women's economic status and education in the countries where acceptance of physical chastisement is most widespread, and that interventions need to be orientated to those most approving of IPV

25 *Ibid.*

26 Campbell, J. C. (2002), Health Consequences of Intimate Partner Violence, *The Lancet*, 359(9314): 1331–1336.

27 Devries, K. M., Mak, J. Y., Garcia-Moreno, C., *et al.* (2013), The Global Prevalence of Intimate Partner Violence against Women, *Science*, 340 (6140): 1527–1528.

28 Tran, T. D., Nguyen, H., & Fisher, J. (2016), Attitudes towards Intimate Partner Violence against Women among Women and Men in 39 Low- and Middle-income Countries, *PLoS ONE* [online], 11(11): 1–14 e0167438. Available at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0167438.

29 *Ibid.*, p.2.

30 *Ibid.*

31 Carter, J. (2015), Patriarchy and Violence against Women and Girls, *The Lancet* [online], 385(9978): e40-e41. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62217-0/fulltext.

32 Tran *et al.* (2016), *op. cit.*, nt.28, p.3.

33 *Ibid.*, p.4.

(such as women, youth, those living in rural areas, and the poor). Given the consequences of these problematic attitudes, the authors conclude that changing accepting attitudes toward violence against women should be national priorities within the context of the SDGs. In terms of the mental health implications from this study, it would appear that female victims of IPV are most at risk of mental health problems because they lack social support and tend to blame themselves for causing the violence.[34]

IPV against women is strongly associated with suicide attempts. Based on analysis of a large 2000–2003 World Health Organization (WHO) study of women aged 15 to 49 in 13 sites, including seven LMICs, Devries *et al*. found that IPV, physical violence from non-partners, divorce, separation, widowhood, childhood sexual abuse, and having a mother who experienced IPV were the most consistent predictors for suicide attempts.[35] The study recommended that health workers in LMICs should receive training to recognise and respond to the consequences of violence in order to reduce the health burden associated with suicidal behaviour.

Poly-victimisation means exposure to a variety of forms of aggression, including maltreatment, vandalism, physical assault, peer, sibling and cyber victimisation, and witnessing family or community violence. Gender differences in the rates and effects of victimisation and poly-victimisation, particularly amongst children and adolescents, are receiving growing attention in HICs. The types of victimisation appear to vary by sex, with females more subject to sexual abuse, whereas males are subjected to more physical abuse.[36] Evidence of long-term mental health consequences for children who experience victimisation remains insufficient, and more research is needed to elucidate the effect of gender and age on the nature of the victimisation and their relation to psychiatric outcomes.

In LMICs, there has been limited investigation of the association between experiences of violence (including poly-victimisation) amongst children and adolescents.[37] A recent study amongst adolescent girls and boys in Vietnam,[38] however, found different effects on health-related quality of life by sex: female adolescents suffered worse effects than males on all outcomes, except for disability. However, for those who experienced poly-victimisation, both girls and boys suffered equally ill-effects, including lower levels of self-esteem and increased levels of anxiety, depression and pain.

Social and economic stressors

Socioeconomic status, including education, employment, and income, has been widely shown to affect mental health, especially that of women. In a study based on the WHO's World Health Surveys (2002–2003), the analysis of data from 53 countries including 29 LMICs found depression to be higher in women. This gender association increased according to the economic development

34 *Ibid*., pp.11–12.

35 Devries, K., Watts, C., Mieko, Y., *et al*. (2011), Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women, *Social Science and Medicine*, 73(1): 79–86.

36 See Gershon, A., Minor, K., & Hayward, C. (2008), Gender, Victimization, and Psychiatric Outcomes, *Psychological Medicine*, 38(10): 1377–1391.

37 Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007), Poly-victimization: A Neglected Component in Child Victimization, *Child Abuse & Neglect*, 31: 7–26.

38 Le, M. T. H., Holton, S., Nguyen, H. T., *et al*. (2016), Victimisation, Poly-victimisation and Health-related Quality of Life among High School Students in Vietnam: a Cross-sectional Survey, *Health and Quality of Life Outcomes* [online], 14(1): 155. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5097374/.

of countries.[39] It was suggested that women in HICs may be more likely to report symptoms of depression, or that changes in traditional gender roles, including assuming multiple roles, may partly explain this finding.

There is, in fact, some evidence that changing gender roles are narrowing the widely reported differences in CMDs between men and women. Cohort analysis of part of the epidemiological data from subsequent WHO World Mental Health Surveys found that female-male differences in major depression, intermittent explosive disorder, and substance disorders were smaller amongst younger cohorts than older ones.[40] These differences were considered to be partly related to changes in conventional female roles, whereby younger women had more access to equalising opportunities, such as employment, birth control and resources that protect against traditional stressors, such as financial dependence.

The link between poverty and the prevalence of mental health disorders has been widely discussed in the research literature,[41] both at country and individual levels. These associations at the country level are still being debated, partly because the studies have used different indicators of poverty and mental health.[42] At the individual level, associations between being female, poverty and CMDs are strong, but the underlying reasons for this require further study, especially in LMICs. For example, in low income communities in Karachi, Pakistan, it was observed that financial worries were more important stressors for males, whereas family concerns were more important amongst females.[43] Gender roles were thought to explain this difference, men having primary responsibility for providing for their families, and women, for the management of relationship issues. The authors observed that low income or low education may increase vulnerability to social challenges that, in turn, are linked to distress. Further, poor women are more likely to live in crowded conditions, to have fewer occupational opportunities, and to suffer from chronic illnesses, all of which are known risk factors for CMDs.[44]

Multimorbidity

Globally, multimorbidity (suffering from two or more chronic physical or mental illnesses simultaneously) is associated with other adverse physical and mental health outcomes, including

39 Rai, D., Zitko, P., Jones, K., *et al.* (2013), Country- and Individual-level Socioeconomic Determinants of Depression: Multilevel Cross-national Comparison, *British Journal of Psychiatry*, 202(3): 195–203.

40 Seedat, S., Scott, K. M., Angermeyer, M. C., *et al.* (2009), Cross-national Associations between Gender and Mental Disorders in the World Health Organization World Mental Health Surveys, *Archives of General Psychiatry*, 66(7): 785–795.

41 See, *e.g.,* Lund, C., Breen, A., Fisher, A. J., *et al.* (2010), Poverty and Common Mental Disorders in Low And Middle Income Countries: A Systematic Review, *Social Science & Medicine*, 71(3): 512–528, which reviewed 115 community and facility-based studies in LMICs that strongly suggested that poorer people have poorer mental health. However, data from LMICs remain more limited than that from HICs.

42 For example, in Patel, V. & Kleinman, A. (2003), Poverty and Common Mental Disorders in Developing Countries, *Bulletin of the World Health Organization* [online], 81(8): 609–615. Available at: www.who.int/bulletin/volumes/81/8/Patel0803.pdf. Table 1 reviews a variety of different measures for poverty, as well as different measures of psychiatric morbidity.

43 Kidwai, R. (2014), Demographic factors, Social Problems and Material Amenities as Predictors of Psychological Distress: A Cross-sectional Study in Karachi, Pakistan, *Social Psychiatry and Psychiatric Epidemiology*, 49(1): 27–39.

44 Patel, V., Kirkwood, B. R., Pednekar, S., *et al.* (2006), Risk Factors for Common Mental Disorders In Women. Population-based Longitudinal Study, *British Journal of Psychiatry*, 189: 547–555.

depression.[45] It has been found to be significantly higher in females in several HICs,[46] and in a few LMICs where studies have been carried out.[47] Whilst previously thought to be more prevalent in the ageing population, recent research has shown that multimorbidity also affects younger people.[48] The links between multimorbidity, gender, and mental disorders plainly require further investigation.

Gender, coping and care-seeking

Many studies of gender differences in the use of health services, especially in HICs, have found that women consult services more than men. Possible explanations have included differences in socialisation, knowledge, sensitivity to symptoms because women are more likely to be in care-giving roles, and health status. Studies on gender and care-seeking for general health problems in LMICs agree that women are more frequent users of rural health clinics than men,[49] but findings suggest that women attend clinics more for others, especially their children, than for themselves.[50] For their own problems, women tend to first consult traditional healers, partly because they have less available cash to pay for formal services, and healers are more likely to accept payment in kind.[51] Healers are also more accessible and tend to provide explanations within cultural frameworks of daily experiences that women understand.[52] Moreover, perhaps in part due to the focus of the Millennium Development Goals (MDGs) on maternal health, LMIC

45 Mercer, S. W., Gunn, J., Wyke, S., & Guthrie, B. (2012), Managing Patients with Mental and Physical Multimorbidity, *British Medical Journal* [online], 345: e5559. Available at: www.bmj.com/content/350/bmj.h176.

46 See, for example, Agborsangaya, C. B., Lau, D., Lahtinen, M., *et al.* (2012), Multimorbidity Prevalence and Patterns across Socioeconomic Determinants: A Cross-sectional Survey, *BMC Public Health* [online], 12: 201. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-201; and Marengoni, A., Angleman, S., Melis, R., *et al.* (2011), Aging with Multimorbidity: A Systematic Review of the Literature, *Ageing Research Reviews*, 10(4): 430–439.

47 See, for example, Arokiasamy, P., Uttamacharya, U., Jain, K., *et al.* (2015), The Impact of Multimorbidity on Adult Physical and Mental Health in Low- and Middle-income Countries: What Does the Study on Global Ageing and Adult Health (SAGE) Reveal?, *BMC Medicine* [online], 13: 178. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4524360/; and Alaba, O. & Chola, L. (2013), The Social Determinants of Multimorbidity in South Africa, *International Journal for Equity in Health* [online], 12: 63. Available at: equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-63.

48 See, for example, Arokiasamy, P., Uttamacharya, U., Jain, K., *et al.* (2015), The Impact of Multimorbidity on Adult Physical and Mental Health in Low- and Middle-income Countries: What Does the Study on Global Ageing and Adult Health (SAGE) Reveal?, *BMC Medicine* [online], 13: 178. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4524360/. See also Taylor, A. W., Price, K., Gill, T. K., *et al.* (2010), Multimorbidity—Not Just an Older Person's Issue. Results from an Australian Biomedical Study, *BMC Public Health* [online], 10: 718. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-10-718.

49 See, *e.g.*, Yamasaki-Nakagawa, M., Ozasa, K., Yamada, N., *et al.* (2001), Gender Difference in Delays to Diagnosis and Health Care Seeking Behaviour in a Rural Area of Nepal, *The International Journal of Tuberculosis and Lung Disease*, 5(1): 24–31; and Allotey, P. & Gyapong, M. (2005), *The Gender Agenda in the Control of Tropical Diseases: A Review of Current Evidence. Special Topics No. 4* (Geneva: UNICEF, UNDP, World Bank, WHO Special Programme for Research and Training in Tropical Diseases (TDR/WHO)).

50 Vlassoff, C. (2008), 'Gender in Health and Illness', in K. Heggenhougen & S. R. Quah (eds) (2008), *The International Encyclopedia of Public Health* (1st edn) (Boston: Elselvier), pp.26–35.

51 Allotey, P. (1995), *The Burden of Illness in Pregnancy in Rural Ghana: a Study of Maternal Morbidity and Interventions in Northern Ghana* (thesis; Perth: University of Western Australia).

52 Allotey & Gyapong (2005), *op. cit.*, nt.49, p.49.

health services pay more attention to maternal-child health, rather than to women's health issues outside of the reproductive age.[53] Further, gender stereotyping identifies females as prone to emotional problems, and men to alcohol problems, thus hindering accurate treatment. A lack of sufficient numbers of female personnel may further inhibit women from using medical services for themselves.

Compared to HICs, there is relatively little knowledge on health-seeking behaviour for those with CMDs in LMICS. However, a recent analysis of sex differences in utilisation of mental health services from 62 LMICs using WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS) found that women used fewer mental health services than men.[54] The authors attributed this difference primarily to gender-based factors, such as women's lack of decision-making power and financial resources, a lack of free time to seek care, and restrictions on their mobility outside the domestic sphere. They also mentioned the possibility that women use more services from traditional healers (as noted above, in relation to general health issues), but that the hypothesis required substantiation.

Some studies in LMICs have found that, because of stigma attached to mental disorders, women tend to report their psychological stress in terms of physical ailments (somatisation). In Indian studies, for example, women often describe poor mental health as gynaecological concerns.[55] Women may hesitate to report culturally deviant behaviour, such as alcohol or drug abuse, especially in societies where substance use is more prevalent and accepted amongst males. Failure to talk about these concerns with health professionals impedes rapid and accurate diagnosis, appropriate treatment, and referral.

Studies on client-provider relations in LMICs have found that women who attend health services are often the subject of blame and are treated as inferior. For example, they may be blamed for reporting late, or for not taking their children for regular immunisations.[56] This exacerbates their reluctance to access health care for themselves, even when other access barriers, such as transportation and economic constraints, are absent. There is some evidence that women sometimes use the opportunity of bringing their children to health facilities to have themselves examined as well, but this is an issue that has received little research attention.[57] Insensitive treatment by health personnel can also be a problem for women in HICs, but more options for restitution are available to them. In mental health consultations, however, men appear to be more affected than women by negative treatment. A recent systematic review of 144 studies from both HICs and LMICs found that stigma had a disproportionate effect on men's help-seeking behaviour, perhaps due to the disconnect between men being typified as

53 For a discussion of this issue, see Vlassoff (2008), *op. cit.*, nt.50.

54 Paula de los Angeles, C., Watkins, W., McBain, L. R., *et al.* (2014), Use of Mental Health Services by Women in Low And Middle Income Countries, *Journal of Public Mental Health*, 13(4): 211–223.

55 See, for example, Maitra, S., Brault, M. A., Schensul, S. L., *et al.* (2015), An Approach to Mental Health in Low- and Middle-income Countries: A Case Example from Urban India, *International Journal of Mental Health*, 44(3): 215–230; and Parkar, S. R., Nagarsekar, B., & Weiss, M. G. (2009), Explaining Suicide in an Urban Slum of Mumbai, India: A Sociocultural Autopsy, *Crisis*, 30(4): 192–201.

56 See, *e.g.*, Percival, V., Richards, E., MacLean, T., & Theobald, S. (2014), Health Systems and Gender in Post-conflict Contexts: Building Back Better?, *Conflict and Health*, 20(8): 19. Available at: conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-8-19. See also WHO (2010), Gender, Women and Primary Health Care Renewal: A Discussion Paper. Available at: apps.who.int/iris/bitstream/10665/44430/1/9789241564038_eng.pdf.

57 See Vlassoff, C. & Bonilla, E. (1994), Gender-related differences in the impact of tropical diseases on women: what do we know?, *Journal of Biosocial Science*, 26: 37–53.

strong and stoical, as opposed to dependent on others by seeking care.[58] In general, it can safely be said that both women and men suffer from gender-related constraints in consulting health professionals for psychological problems.

In terms of coping with mental disorders, emotional and logistical support, such as help with medication and adherence from family, community members and health workers, has been found to play an important buffering role. For example, a study of adherence to treatment for schizophrenia in the United States found that most patients with supportive families remained in treatment longer and had better outcomes than those without such support.[59] Evidence from LMICs on this subject is limited, and there is even less information on gender differences with respect to coping with mental disorders. However, there is growing evidence that spousal and family support are important in their prevention.[60] Providing support for family members or others affected by mental illness can be stressful for care-givers who often lack guidance on appropriate care practices. Hence, it is important that public health programmes provide assistance and counselling to them as well as to patients.

Gender and the response of health systems

The integration of gender into health policies and programmes is a necessary first step in improving the gender-sensitivity of health services. However, its translation into practical guidelines for implementation in LMIC health care settings remains a challenge, due partly to the inexperience of the health sector in this area, and partly to the lack of appreciation as to how traditional gender norms may affect health. In addition, the hierarchy in the health system itself, where men are viewed as decision-makers and women mainly as subordinates, reproduces itself at all levels of the services.[61] Hence, nurses and others may treat lower-level staff and patients in a condescending way, and this pattern is perpetuated in health worker-client interactions, especially with respect to poor women where gender inequality, race and social class often intersect.

Gender inequalities in the health services have also been found to influence the quality of data produced, and the reporting of data and trends.[62] Most women and men experiencing

58 Clement, S., Schauman, O., Graham, T., *et al.* (2014), What is the Impact of Mental Health-related Stigma on Help-seeking? A Systematic Review of Quantitative and Qualitative Studies, *Psychological Medicine*, 45(1): 11–27.

59 Glick, I. D., Stekoll, A. H., & Hays, S. (2011), The Role of the Family and Improvement in Treatment Maintenance, Adherence, and Outcome for Schizophrenia, *Journal of Clinical Psychopharmacology*, 31(1): 82–85.

60 See, *e.g.*, Qadir, F., Khalid, A., Haqqani, S., *et al.* (2013), The Association of Marital Relationship and Perceived Social Support with Mental Health of Women in Pakistan, *BMC Public Health* [online], 13: 150. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1150. See also Fisher, J., Cabral de Mello, M., Patel, V., *et al.* (2012), Prevalence and Determinants of Common Perinatal Mental Disorders in Women in Low- and Lower-middle-income Countries: A Systematic Review, *Bulletin of the World Health Organization* [online], 90: 139–149H. Available at: www.who.int/bulletin/volumes/90/2/11-091850/en/.

61 See, *e.g.*, Vlassoff (2008), *op. cit.*, nt.50; Glick *et al.* (2011), *op. cit.*, nt.59; Percival *et al.* (2014), *op. cit.*, nt.56, 19, and WHO (2010), Gender, Women and Primary Health Care Renewal: A Discussion Paper. Available at: apps.who.int/iris/bitstream/10665/44430/1/9789241564038_eng.pdf.

62 Morgan, R., George, A., Ssali, S., *et al.* (2016), How to Do (or Not to Do) Gender Analysis in Health Systems Research, *Health Policy and Planning*, 31(8): 1069–1078.

emotional distress and/or psychological disorders are never identified, for several reasons. These include the stigma attached to mental illness, the tendency to ignore its signs and symptoms, on the part of both the sufferer and society, and the failure of health systems to recognise these symptoms. Disorders triggered by violence are under-diagnosed because women hesitate to disclose their victimisation unless directly questioned about it by their providers. In many LMICs, hospital statistics are used for general surveillance purposes, such as where it is generalised to the whole population because of the lack of vital registration data. However, inferences from hospital data may be erroneous because they are based on a selective sample, and may miss out women disproportionately because of their greater economic and social constraints in seeking mental health care.[63]

Gender stereotypes affect providers' perceptions of clients' health needs and the way they counsel them.[64] Women are more likely than men to be diagnosed with depression, whilst depression in men is more often ignored.[65] Thus, women are more often treated with psychotropic drugs and they are less likely to be diagnosed as suffering from alcohol abuse. Male providers tend to be more authoritative than female providers, give less time to patients, and are less likely to engage in two-way dialogue with them.[66] This lack of sensitive communication between health workers and female patients makes it difficult for women to disclose psychological and emotional distress; a health issue that is often stigmatised. When women do disclose their problems, many health workers tend to either over-treat or under-treat women.[67]

Acute shortages of trained mental health professionals are widely reported in LMIC studies.[68] Where such facilities, trained professionals and treatments are unavailable, the specific needs of men, women and LBGT populations remain largely unaddressed. Health workers in LMICs are often unequipped to counsel clients on sensitive health issues because they lack training in how to deal with often stigmatised matters such as domestic abuse, unwanted pregnancies, HIV and

63 *Ibid.*

64 A large body of literature articulates the oppression and discrimination that women have faced at the hands of psychiatric practice from the earliest days of the field's history (Burgess, R. A. (2016), 'Dangerous Discourses? Silencing Women within "Global Mental Health" Practice', in J. Jasmine Gideon (ed.), *Handbook on Gender and Health* (Cheltenham: Edward Elgar Publishing), Chapter 5, pp.79–97; L. Appignanesi (2011), *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (London: Hachette); Ussher, J. M. (2010), Diagnosing difficult women and pathologising femininity: gender bias in psychiatric nosology, *Feminism & Psychology*, 23(1): 63–39). Since early psychiatric thinking was dominated by male practitioners (such as Philippe Pinel and Sigmund Freud), women's concerns were categorised according to gendered perceptions of females whose emotional stresses were seen as hysterical or perverse. For more on this subject see Hirshbein, L. (2010), Sex and Gender in Psychiatry: A View from History, *Journal of Medical Humanities*, 31(2): 155–170.

65 Percival *et al*. (2014), *op. cit.*, nt.56, p.19. Available at: conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-8-19.

66 Jefferson, L., Bloor, K., Birks, Y., *et al*. (2013), Effect of Physicians' Gender on Communication and Consultation Length: A Systematic Review and Meta-analysis, *Journal of Health Services Research and Policy*, 18(4): 242–248; and WHO (2010), *op. cit.*, nt.56.

67 WHO (2010), *op. cit.*, nt.56.

68 Baron, E. C., Hanlon, C., Mall, S., *et al*. (2016), Maternal Mental Health in Primary Care in Five Low- and Middle-income Countries: A Situational Analysis, *BMC Health Services Research* [online], 16(1): 53. Available at: bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1291-z. See also Chapter 2 of this book by Lawrence O. Gostin and Laura Davidson; and Bruckner, T. A., Scheffler, R. M., Shen, G., *et al*. (2011), The Mental Health Workforce Gap in Low- and Middle-income Countries: A Needs-based Approach, *Bulletin of the World Health Organization* [online], 89(3): 184–194. Available at: www.who.int/bulletin/volumes/89/3/10-082784/en/.

mental health. Similarly, many health professionals are either unsympathetic to, or find it difficult to address, sexual issues with people with minority sexual orientations, especially in settings where LBGT populations are severely stigmatised. Such weaknesses in the health services inadvertently contribute to the worsening of health problems, as well as the spread of infections. For example, people at risk of sexually transmitted infections, such as men who have sexual intercourse with men, may avoid health facilities when they view them as unresponsive to their needs.

Promising gender-related interventions in LMICS

According to the WHO, three main factors are helpful in preventing the development of mental health problems, especially depression: autonomy (described as the ability to exercise some control in the face of severe events), access and control over some material resources, and support from family, friends, or health providers.[69] With these factors as a guide, this section reviews a number of interventions that have shown at least some success in LMICs in preventing and treating CMDs, especially amongst women.

Interventions to increase autonomy vis-à-vis *severe events*

Several well-established interventions are available for women in the areas of maternal mental health, domestic violence, and substance misuse in HICs. However, less is known about interventions to assist women in LMICs in coping with their mental health. Few psychological interventions for survivors of GBV in LMICs have been rigorously evaluated, as Dawson *et al*. observe.[70] Further, as noted earlier, the assumption that women are protected by traditional cultural practices in the perinatal period impedes attention to this problem.

In most LMICs it is difficult to provide dedicated GBV services because of a combination of resource constraints and stigma.[71] Ideally, these services would be delivered as part of the general health programmes that provide psychological help for survivors of GBV without specifically highlighting it. This would ensure that the situation was not exacerbated either by stigmatising the person further in the community, or by causing further intimate partner GBV should it be discovered that women attended services. A feasibility randomised control trial of one such intervention in Kenya, 'PM+' (Problem Management Plus), demonstrated promising results and the potential for further research on the approach.[72] The intervention was conducted by trained community health workers (CHWs) amongst women living in poor peri-urban villages in Nairobi, and used problem-solving counselling to address symptoms of CMD, such as depression, anxiety and stress. However, it did not specifically select for women affected by GBV. The results were reduced PTSD symptoms amongst women affected by adversity, including GBV. The study also suggested that the generic screening approach was effective in reaching those suffering from GBV, and that non-specialised CHWs could be trained to deliver the intervention successfully.

69 WHO (2017), *op. cit.*, nt.7.

70 Dawson, K. S., Schafer, A., Anjuri, D., *et al*. (2016), Feasibility Trial of a Scalable Psychological Intervention for Women affected by Urban Adversity and Gender-based Violence in Nairobi, *BMC Psychiatry* [online], 16: 410. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5116169/.

71 *Ibid*.

72 *Ibid*.

Childhood and adolescence are crucial phases for nurturing healthy mental and physical development.[73] Evidence, mainly from HICs, indicates that comprehensive mental health promotion interventions, in collaboration with families, schools and communities, can lead to many positive outcomes in mental health, social functioning, school and work performance, and healthy behaviours.[74] However, even though LMICs are home to 90% of the world's young people, empowerment-oriented interventions for adolescents and their effects by gender and socioeconomic status are relatively unexplored.[75] Several studies report gender differences for interventions provided in political conflict situations, but findings are inconsistent. A study of classroom-based interventions (CBI) in conflict-affected rural Nepal reported significant reductions in psychological difficulties and aggression amongst males, with improved pro-social behaviour only amongst females.[76] A CBI designed to alleviate post-conflict distress amongst youth in the West Bank and Gaza, Palestine, found that both sexes responded positively in terms of maintaining hope, but that boys experienced greater benefits than girls in relation to enhancing belief in personal responsibility and control.[77] A later study of an intervention for Palestinian children in Gaza using recovery techniques also found more impact upon males in reducing clinically significant PTSD, whilst only those girls who had low post-conflict trauma ('peritraumatic dissociation') benefited.[78] As the authors noted, this result contradicts the belief that psychological and social help is more attuned to female needs than to those of men. A systematic review of school and community-based mental health promotion interventions for youth in LMIC settings found mixed results, mainly positive, but some negative mental health outcomes. An intervention encouraging students to write about their experiences to help them cope with PTSD led to significantly increased depression symptoms subsequent to the intervention.[79] Findings regarding gender and age differences in response to the various interventions were also unclear, two studies reporting positive impacts for girls, whilst another found a positive impact only for boys, and younger children (especially males) seemed to benefit more from the interventions than older adolescents.[80] The lack of consistency in findings across these interventions highlights the necessity of further

73 For an in-depth consideration of this issue, see Chapter 11 of this book by Cornelius Ani and Olayinka Omigbodun.

74 See, *e.g.*, Barry, M., Clarke, A., Jenkins, R., & Patel, V. (2013), A Systematic Review of the Effectiveness of Mental Health Promotion Interventions for Young People in Low and Middle Income Countries, *BMC Public Health* [online], 13(1): 835. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-835. See also Salam, R. A., Das, J. K., Lassi, Z. S., & Bhutta, Z. A. (2016), Adolescent Health Interventions: Conclusions, Evidence Gaps, and Research Priorities, *Journal of Adolescent Health*, 59(4): S88–S92.

75 Salam *et al.* (2016), *ibid.*

76 Jordans, M. J. D., Komproe, I. H., Tol, W. A., *et al.* (2010), Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial, *Journal of Child Psychology and Psychiatry*, 51(7): 818–826.

77 Khamis, V., Macy, R., & Coignez, V. (2004), *The Impact Of The Classroom/Community/Camp-based Intervention (CBI) Program On Palestinian Children* (New York: Save the Children and USAID). Available at: citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.510.9759&rep=rep1&type=pdf.

78 Qouta, S. R., Palosaari, E., Diab, M., & Punamaki, R. (2012), Intervention Effectiveness among War-affected Children: A Cluster Randomized Controlled Trial on Improving Mental Health, *Journal of Traumatic Stress*, 25(3): 288–298.

79 Barry, M., Clarke, A., Jenkins, R., & Patel, V. (2013), A Systematic Review of the Effectiveness of Mental Health Promotion Interventions for Young People in Low and Middle Income Countries, *BMC Public Health* [online], 13(1): 835. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-835.

80 As the authors note, this finding is consistent with research from HICs which emphasises the importance of reaching children when they are young to sustain their resilience and strengthen coping abilities.

investigation into mental health promotion programmes for youth which allow for a more in-depth analysis of the differential impacts of demographic factors such as sex and age.

There are very few studies of promising, empowerment-focused interventions for LBGT populations, with the exception of some related to HIV and AIDS. However, a study of the Pehchan programme in India which uses a rights-based approach to help communities and systems provide HIV, health, legal, and social services to transgender communities found significant improvement in both demand and access to services nationwide, as well as in 'self-efficacy' and 'collective identity'—a model to respond to the unique health needs of transgender communities.[81] Such programmes do not seem to have been extended to mental health, but they could have similar benefits for people in mental distress, given their frequent marginalisation from society.

Interventions focusing on control over resources

In recent years there has been growing interest in the impact of special financing initiatives on mental health and wellbeing, especially for orphans and young people affected by HIV in Africa.[82] Cash may be provided to beneficiary households, sometimes contingent upon the fulfilment of certain conditions ('conditional' cash transfers), or unconditionally, to improve the welfare of the participating households and to encourage desired changes in behaviour related to economic activities, nutrition, education, and health. Results generally show positive outcomes with respect to cash transfers. For example, in an evaluative report on (mostly unconditional) cash transfers to households in eight African countries (using a rigorous scientific mixed-methods approach with both qualitative and quantitative research methods including control households, positive outcomes were found.[83] These included increased school enrolment of both girls and boys (especially secondary enrolment), improved educational attainment, and reduced illness from diarrhoea amongst children. In five countries (Kenya, Malawi, South Africa, Zimbabwe, and Zambia) the transfer evaluation also contained a module dedicated specifically to adolescents (with face-to-face interviews) which included some questions on mental health. Results showed that programme participants had later sexual debut, made greater use of condoms, had fewer sexual partners, and had lower pregnancy rates. There is very little discussion of mental health in the report, although a separate paper by Handa *et al.* on the Kenyan study[84] noted that by lifting homes out of severe poverty, these programmes may improve mental health and increase hope

81 Shaikh, S., Mburu, G., Arumugam, V., *et al.* (2016), Empowering Communities and Strengthening Systems to improve Transgender Health: Outcomes from the Pehchan Programme in India, *Journal of the International AIDS Society* [online], 19(3) (Suppl 2): 20809. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4949313/.

82 See, for example, Ssewamala, F. M. & Ismayilova, L. (2009), Integrating Children's Savings Accounts in the Care and Support of Orphaned Adolescents in Rural Uganda, *Social Service Review*, 83(3): 453–472; and Ssewamala, F. M., Karimi, L., Chang-Keun, H., & Ismayilova, L. (2010), Social Capital, Savings, and Educational Performance of Orphaned Adolescents in Sub-Saharan Africa, *Children and Youth Services Review*, 32(12): 1704–1710.

83 B. Davis, S. Handa, N. Hypher, *et al.* (eds) (2016), *From Evidence to Action. The Story of Cash Transfers and Impact Evaluation in Sub-Saharan Africa* (Rome/New York/Oxford: Food and Agriculture Organization/UNICEF/Oxford University Press).

84 Handa, S., Halpern, C. T., Pettifor, A., & Thirumurthy, H. (2014), The Government of Kenya's Cash Transfer Program Reduces the Risk of Sexual Debut among Young People Age 15–25, *PLoS ONE* [online], 9(1): p.e85473. Available at: journals.plos.org/plosone/article?id=10.1371/journal.pone.0085473.

for the future.[85] However, it is apparent that future evaluations of these initiatives are needed to explore these mechanisms in relation to mental health.

Cash transfer schemes appear to be especially effective when combined with gender and HIV training, such as the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) programme to empower women in the face of HIV, using a combination of microfinance, gender/HIV-awareness training, referred to as 'Sisters for Life', in combination with community mobilisation. In a cluster randomised trial in South Africa, significant positive effects in household economic wellbeing, social capital, and women's empowerment, as well as in reducing IPV, were reported. However, two other risk factors for HIV—the rate of unprotected sexual intercourse with a non-spousal partner and HIV incidence—were not reduced in all cohorts.[86] Findings regarding gender differences in youth-oriented cash incentive programmes were inconsistent: in Kenya, only young men received significant benefits from the programme, whereas amongst Ugandan orphans, girls benefited more than boys in terms of self-esteem. However, the reasons for these differences were not explored, and hence it is difficult to understand the specific pathways involved. More research clearly is required on this, including how access to financial resources affects not only self-esteem, but also mental health.

Interventions focusing on support from family, friends, or health providers

In HICs, social support has been identified as a contributor to resilience and the reduction of depression in the face of severe events and circumstances,[87] especially amongst women.[88] There is still limited evidence of the impact of successful social support interventions on resilience and mental health in LMICs, and more analysis is required regarding type and stage of intervention (whether preventive, using support/resilience/coping strategies, or providing treatment), population, and age and gender specific targets (such as of children, women, men, and LBGT groups). The robustness of the findings regarding outcomes in studies to date is unclear—some rely on self-reporting, which may skew the results, and other studies are randomised control trials. The majority of studies have focused on maternal mental health and on HIV-affected individuals where the positive effects of social support seems well documented. Evidence of the impact of family and community-based interventions on the rehabilitation of patients with mental illness

85 The authors also noted that young women participating in the cash transfer programme entered into sexual relations later than male participants and non-participants. The authors hypothesised that the cash transfer programmes may reduce women's dependence on males, and reduce unwanted sexual relationships and unprotected sex.

86 Pronyk, P. M., Hargreaves, J. R., Kim, J. C., *et al.* (2006), Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in Rural South Africa: A Cluster Randomised Trial, *The Lancet*, 368(9551): 1973–1983.

87 See, *e.g.*, Thoits, P. A. (2011), Mechanisms Linking Social Ties and Support to Physical and Mental Health, *Journal of Health and Social Behavior*, 52(2): 145–161; and Maulik, P. K., Eaton, W. W., & Bradshaw, C. P. (2011), The Effect of Social Networks and Social Support on Mental Health Services Use, Following a Life Event, among the Baltimore Epidemiologic Catchment Area Cohort, *Journal of Behavioral and Health Services Research*, 38(1): 29–50.

88 Taft, A. J., Small, R., Hegarty, K. L., *et al.* (2011), MOthers' AdvocateS in The Community (MOSAIC)—Non-professional Mentor Support to Reduce Intimate Partner Violence and Depression in Mothers: A Cluster Randomised Trial in Primary Care, *BMC Public Health* [online], 11: 178. Available at: bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-178.

remains weak, with only modestly optimistic results for interventions such as family education, crisis interventions, counselling, and skills training with psychosocial support.[89]

However, there is growing evidence from South Asia that social support significantly reduces the risk of depression and increases resilience in women. In a study of urban Indian women living in a Mumbai slum, those who received social and emotional support from friends and family reported significantly fewer days with depression, even after adjusting for husbands' recent violence and alcohol abuse.[90] Similarly, in Pakistan, higher perceived social support from family, friends, and significant others amongst married women reduced the likelihood of depression and anxiety, and was positively associated with the resolution of marital problems. Neither study described in detail the type of social support received, but community support played a key role, whereas that of family members was less clear. In India, the presence of family members in the home did not affect the degree of depression women reported whereas, in Pakistan, living in a nuclear family increased the risk of CMD symptoms. In South Asia, studies have found that the presence of in-laws in the household often reduces women's freedom and exacerbates their abuse and suffering.[91]

Burgess discusses the impact of the Movement for Global Mental Health (MGMH),[92] a community-based approach often recommended for LMICs, initiated in 2007 within the South African mental health care service. It implements primary mental health care in district hospitals, supported by higher levels of care involving partnerships with stakeholders across multiple sectors. Despite efforts of service providers to offer gender-sensitive treatment—viewing female clients as autonomous and learning about the broader socioeconomic constraints of their daily realities—the services were unable to offer sufficient support for the many issues underlying their distress. Based on the challenges identified in the South African experience, Burgess recommends a community health competency approach using a participatory framework involving dialogue between service providers, researchers, and communities. These competencies include enhancing the ability of community members to identify and refer serious cases of mental disorder and to respond to others in a culturally appropriate manner. The researchers also recommend helping communities develop (or expand existing) skills to address mental difficulties. The importance of safe social spaces and dialogue on challenging issues amongst mental health professionals and local mental health service sectors was emphasised. Finally, the study suggested the development of partnerships with others with experience in tackling similar problems in other global or local contexts. Such partnerships could connect women in need of support to existing resources, such as income-generating activities or skills training, to create opportunities to mitigate wider social problems that impact upon women's experiences of mental distress.

LBGT youths are known to be at risk of compromised health, both physical and emotional.[93] Most research has focused on negative factors associated with such risks, especially in adolescence and young adulthood, including adverse reactions of parents around the time of their child's

89 Weinmann, S. & Koesters M. (2016), Mental Health Service Provision in Low and Middle-income Countries: Recent Developments, *Current Opinion in Psychiatry*, 29(4): 270–275.

90 Dasgupta, A., Battala, M., Saggurti, N., *et al.* (2013), Local Social Support Mitigates Depression among Women Contending with Spousal Violence and Husband's Risky Drinking in Mumbai Slum Communities, *Journal of Affective Disorders*, 145(1): 126–129.

91 Raj, A., Sabarwal, S., Decker, M. R., *et al.* (2011), Abuse from In-laws During Pregnancy and Postpartum: Qualitative and Quantitative Findings from Low-income Mothers of Infants In Mumbai, India, *Maternal and Child Health Journal*, 15(6): 700–712; Parkar, S. R., Nagarsekar, B., & Weiss, M. G. (2009), Explaining Suicide in an Urban Slum of Mumbai, India: a Sociocultural Autopsy, *Crisis*, 30(4): 192–201.

92 Burgess (2016), *op. cit.*, nt.64.

93 Ryan, C., Stephen, T., Russell, S. T., *et al.* (2010), Family Acceptance in Adolescence and the Health of LBGT Young Adults, *Journal of Child and Adolescent Psychiatric Nursing*, 23(4): 205–213.

disclosure of sexual identity.[94] A few studies that have examined the association between parental reactions to sexuality disclosure and the youths' mental health found, perhaps unsurprisingly, that LGBT youths who experienced more rejecting responses to disclosure report poorer psychological adjustment.[95]

Rosario, Schrimshaw, and Hunter (2009) examined substance use amongst LGB youth to consider whether or not there was a connection between misuse and how the young people perceived the reactions of family members and others to their LGB identity. They found that the number of perceived negative reactions was associated with more substance use, although accepting reactions did not directly reduce it. Another study of the relationship between family rejection in adolescence showed clear associations between parental rejection during adolescence and illegal drug use, risky sexual behaviour, depression, and attempted suicide amongst young LGB adults.[96] Nonetheless, it has also been found that family relationships improve after parents become sensitised to the needs and wellbeing of their LGBT children.[97] Whilst the reasons for this were not specifically investigated, D'Augelli *et al*. hypothesised that parents with outwardly LGB children may have suspected their sexual orientation before their children disclosed it to them, and disparaging comments may have elicited disclosure from their LGB child.[98] However, children whose parents were aware of their sexual orientation were less fearful about parent's future reactions, and indicated that they had more parental support than those who had not told their parents. Similarly, an in-depth study of young LBGT adults concerning family acceptance during their adolescence found clear links between family acceptance in adolescence and health status in young adulthood. Participants who had low family acceptance as adolescents were more than three times as likely to report both suicidal ideation and suicide attempts, compared to those reporting high levels of family acceptance. Females reported more suicidal ideation and attempts than males.[99]

Conclusions and recommendations

In this chapter it has been repeatedly observed that global attention to gender issues relating to health is inadequate. This is particularly the case in LMICs (which frequently have cultural practices adverse to women) because of the paucity of research and the absence of data. This results in lack of knowledge about the experience of mental health and illness by gender (and other characteristics), and in how services are provided. As referred to earlier in the chapter, there are often differential perceptions and assumed interventions for male and female clients, leading to

94 Weinmann & Koesters (2016), *op. cit*., nt.89; D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2005), Parents' Awareness of Lesbian, Gay, and Bisexual Youths' Sexual Orientation, *Journal of Marriage and the Family*, 67(2): 474–482.

95 See, *e.g.*, Elizur, Y. & Ziv, M. (2001), Family Support and Acceptance, Gay Male Identity Formation, and Psychological Adjustment: A Path Model, *Family Process*, 40(2): 125–144; D'Augelli, A. R. (2001), Mental Health Problems among Lesbian, Gay, and Bisexual Youths Ages 14 to 21, *Clinical Child Psychology and Psychiatry*, 7(3): 433–456.

96 Rosario, M., Schrimshaw, E. W., & Hunter, J. (2009), Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: critical role of disclosure reactions, *Psychology of Addictive Behavior*, 23(1): 175–184; Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009), Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay and Bisexual Young Adults, *Pediatrics*, 123(1): 346–352.

97 Ryan *et al*. (2010), *op. cit.*, nt.93; D'Augelli (2001), *op. cit.*, nt.95.

98 D'Augelli (2005), *op. cit.*, nt.94.

99 Ryan, C., Stephen, T., Russell, S. T., *et al*. (2010), Family Acceptance in Adolescence and the Health of LBGT Young Adults, *Journal of Child and Adolescent Psychiatric Nursing*, 23(4): 205–213.

different treatments which are not necessarily individually or gender appropriate, or indeed optimal. As evidenced by many of the studies referred to in this chapter, whilst more recently there has been increasing international attention paid to the mental health needs of LMIC populations, it is essential to avoid the automatic replication of Western psychiatric models of treatment in the developing world. Such models frequently are not only culturally inappropriate, but also not necessarily effective in improving outcomes. It is therefore important that in expanding women's mental health services and promoting their mental health in LMICs, new models are explored. Such models must ensure that at all stages of an intervention, women, men, and LBGT communities are active partners in terms of being consulted as advisors or participants, and that their authentic experiences are recognised from a holistic perspective, including their health concerns, within the context of their own lives and experiences.[100]

In this chapter several constraints in addressing gender issues holistically in both HICs and LMICs have been considered; constraints which may seem overwhelming in terms of fulfilling SDG3 which requires the promotion of mental health and wellbeing for all. However, in identifying interventions with the potential for the greatest impact, two main entry points seem most promising in LMICs: addressing and reducing depression amongst women (which could have a major impact on disability worldwide), and school and community-based programmes for children and adolescents.

Focusing on depression, an important first step would be increasing the gender-sensitivity of health services. Affirmative gains in health status have been observed where gender-sensitive services are provided, using a participatory and problem-solving approach that explores the experiences of mental difficulties within the realities of clients' lives.[101] This would entail a new approach to the capacity-building of health personnel at all levels of health services in LMICs.[102] In line with gender mainstreaming programmes globally, training would need to be rolled out over a period of time under the leadership of experienced gender trainers responsible for overseeing the process. Many trainers are available within government and academic institutions and non-governmental organisations (NGOs) in LMICs who could be seconded for this purpose. This training would necessarily consider the factors identified by the WHO as important for preventing mental disorders,[103] especially those promoting empowerment and social support. Increasing access to material resources, such as via employment and income, is also necessary, but this may be a longer-term goal as it extends beyond the mandate of the health sector alone. However, further exploration and validation of income-generating and skills training programmes with the active engagement of clients, cash transfers for vulnerable people in special circumstances (such as children's savings plans for orphans resulting from HIV), and economic support for survivors of traumatic events is required to determine their influence on mental health.

Training should raise awareness amongst health workers concerning periods in the lifecycle when people are most vulnerable to depression, such as the stressors associated with maternal mental health, adolescence, and ageing, when the importance of paying special attention to client

100 Taft *et al.* (2011), *op. cit.*, nt.88.

101 Dawson *et al.* (2016), *op. cit.*, nt.70. For a new approach to improving gender sensitivity in health systems, see Vlassoff, C. & St. John, R. (2019), A human rights-based framework to assess gender equality in health systems: the example of Zika virus in the Americas, *Global Health Action*, 11(3). Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC6427496/.

102 For more on the need to capacity-build human resources, see Chapter 2 of this book by Lawrence O. Gostin and Laura Davidson.

103 WHO (2017), *op. cit.*, nt.2.

need is elevated. Addressing possible GBV in a sensitive way, perhaps using a problem-based approach to allow it to emerge within discussions of general health challenges, also seems a promising intervention that can be used by CHWs. Health workers can collaborate with NGOs, community groups, leaders, and clients themselves as partners in untangling and responding to the stressors of daily life for those in the community. This consultative and participatory approach should also help strengthen social support mechanisms, as care-givers are often left alone to struggle with the challenges they face in providing help to loved ones with mental health problems. The potential for expanding the community competency framework in LMICs, discussed by Burgess and outlined above,[104] deserves further testing and evaluation as a holistic response to clients with mental health challenges, including both their physical treatment needs and their broader environmental concerns.

Youth is the second recommended entry point for accelerating progress toward the achievement of SDG3. Although school and community-based programmes require further evaluation in LMICs, they offer key opportunities for reaching children and adolescents with information on health risks, prevention and empowerment strategies, and can assist with stigma reduction which is a barrier to help-seeking. Training in counselling on adolescent sexuality and preparation for marriage with an emphasis on gender equality would be likely to prove useful for teachers, health workers and family members to help reduce potential stressors for young people.

Due to the lack of evidence of efficacious interventions, evaluative research should accompany the testing and scaling up of the interventions suggested here. Throughout this process, the involvement of those from LMICs is essential, including research capacity-building where necessary. This will ensure that both programmes and their evaluations can be developed and led by LMIC professionals and those affected themselves, thus enabling their authentic contributions to the achievement of health and wellbeing for all.

104 Burgess (2016), *op. cit.*, nt.64.