POVERTY AND THE PREVALENCE OF MENTAL HEALTH DISORDERS IN NIGERIA

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ABSTRACT

This study is aimed at associating poverty, relative economic factors (in terms of low income and low education) to common mental health disorders. The review revealed that, poverty is pervasive and increasing in Nigeria; that mental health disorders are increasing as cost of living increases; and corruption is perceived as the cause of poverty in Nigeria. Primary and secondary preventive strategies were recommended to reduce the number of people who will suffer full-blown mental health disorder. The study concluded by requesting psychiatrist to empathize and counsel poor people to think and act in positive ways in order to be healthy holistically.

Keywords: Nigeria, Poverty, mental health disorder.

INTRODUCTION

The projection of poverty in Nigeria is bleak affecting the health status of the masses. The NEEDS document (2005) explains this succinctly using three scenarios (A, B, C). (See table 1). According to the NEEDS document in scenario A: Nigeria maintains the average growth performance recorded between 1999 and 2002 (about 3.5 percent) through 2030. Assuming that per capita income was $300 in 2000, it would increase by just $23 by 2015 and by just $48 in 2030. This will make Nigerians one of the poorest in the world. Under this scenario, poverty worsens, engulfing as much as 80 percent of the population by 2030.

The document went further in Scenario B, that growth rise to the average level of late 1980s (5 percent). This level of growth is sufficient to prevent poverty from worsening, the government accepts here that it is not strong enough to reduce it. By 2030 the incidence of poverty remains at a staggering 70 percent, while per capita income increased to $416 in 2015 and $576 in 2030, still leaving the average Nigerian very poor.

In Scenario C, according to the NEEDS 2005, Nigeria fundamentally changes its strategy and achieves an average annual rate of growth is adequate to meet the millennium development goal of cutting the incidence of poverty by half by 2015. Under this scenario, the government predicts that the percentage of people living below the poverty line could fall to less than 20 percent. The doubts entertained here is that of corruption.

Ewhrudjakpor (2008a) in its analysis of poverty and its alleviation, the Nigerian experience, situates poverty holistically, thus:

> *Poverty is a generic term which affects morality, knowledge economy, politics and character. Here the interest is on poverty as experienced by individuals and population to share in a country's wealth. Poverty of an individuals economy means, to be persistently and unchangeably lacking in basic necessities of life (food, shelter, clean water, clothing, medicine,education, knowledge, electricity). P.341.*

On the other hand, (Morakinyo, 2002) defines mental health as:

> *a state of wholesome well, being, relative rather than absolute, accompanied by (i) a degree of happiness and satisfaction under conditions acknowledged by the generality of the other members of the community as normally justifying the degree of happiness and satisfaction felt by the individual and (ii) a state of harmonious, mutually acceptable and satisfaction relationship between the individual and the society.*

While, mental health disorder is;

> *Illness due to social economic, political psychological, genetic, physical, chemical, and or other biological disturbances and manifesting with psychological and or behavioural phenomena together with impairment in functioning (social, occupationally or otherwise), and in which psychological or psychosocial methods are important as curative agents* (Morakinyo, 2002).

Table 1: Implications of Alternative growth Scenario for key development Indicators, 2000, 2015 and 2030.

Scenario	Indicator	Assumed GDP growth	2000 (Actual)	2015	2030
A	Per capita income Incidence. of poverty	3.6 3.6	$300 70 %	$328 75	$352 80 %
B	Per capita income Incidence of poverty	5.0 5.0	$300 70 %	$416 70 %	$576 70 %
C	Per capita income Incidence of poverty	7.0 7.0	$300 7.0%	$556 35%	$1,031 17%

The plan for prosperity must address a striking paradox: about two-thirds of the Nigerian people are poor, despite living in a country with vast potential wealth (Ewhrudjakor 2008b). Although revenues from crude oil have been increasing over the past decades, our people have been falling deeper into poverty. By 1999, about 70 percent of the population had income of less than US $1 a day – and the proportion has risen since then (See table 2). Poverty levels vary across the country.

Why are so many of our people poor? Poverty is dynamic and has many dimensions (see table 2). People may move in and out of poverty as a result of natural disasters or health problems, lack of access to credit, or the lack of natural resources. Poor people are more likely to live in rural areas, be less educated and have larger families than the rest of the population.

Table 2: Dimensions of Poverty in Nigeria in 1995, 1999 and 2001

POVERTY DIMENSIONS AND INDICATORS	1995	1999	2001
INCOME			
Population below US$1 per day (%)	70.2		
Population below minimum level of dietary energy consumption (%)	13		7
SERVICES			
Schooling			
Primary school enrolment (female %)	47.8	45.9	
Primary school enrolment (male %)	52.2	54.1	87.8
Youth Literacy (%age 1524)	81.1		
Health			
Access to essential drugs (5 of total population)			10
Access to physicians (per 100,000 people)		<30*	
Nigerians living with HIV/AIDS (millions)		>5	
Prevalence to HIV, female (% ages 15-24)			
Incidence of tuberculosis (per 100,000 people)			5.8
Under 5 mortality rate (per 1,000)	187		305
Infant mortality rate (per 1,000 live births)	112		183
Immunization, measles (% of children under 12 months)	44		110
Immunization, full (% total children)		17	40
Maternal mortality (modeled estimate, per 100,000 live births)	1100	704*	
Clean water			
Access to safe drinking water (% of population)			50
Access to safe drinking water (% of urban population)		80	
Access to safe drinking water % of rural population)			40
Access to improved water source (% of population0			62
Access to improved sanitation (% population)			54
EMPOWERMENT			
Proportion of seats held by women in national parliament (%)			3
GENERAL			
Proportion (millions)	111.3		125
Average annual growth in GDP		2.9	2.9

Source: World bank. *baseline data upon which reform projections are based
Source: National Economic Empowerment and Development Strategy (NEEDS) 2004.

Poverty has many causes, all of which reinforce one another. In Nigeria one source of poverty is the lack of basic social services such as clean water, education and health care. Another is lack of supportive networks of friends and family. Lack of income is another cause of poverty. The World Health Organization has described poverty as the greatest cause of suffering on earth. This article considers the direct effects of relative poverty on the development of emotional, behavioural and psychiatric problems.

Early identification of mental health disorders and treatment is of vital importance. A mentally healthy person is simply someone who is able to think logically and rationally and who copes effectively in stressful situations. Emotional stability and the ability to adjust to new situations that arise over the life course is also part of mental health. Poverty readily comes to mind. Researchers have asked whether poverty or socio-economic conditions can result to mental health disorders. But there is no dispute about the fact that poverty sustains mental health disorder and that mental health breeds poverty. People who have mental illness might have trouble handling such things as: daily activities, family responsibilities, social relationships, work and school responsibilities. One can have trouble with an area or all of them, to a greater or lesser degree when experiencing a mental illness. It's important to remember that; mental illness is a "medical illness". This study reviews studies on this debate whether poverty causes mental health disorder or whether mental health disorder breeds poverty.

There has been an upsurge in the number of Nigerians suffering from mental illness considering the decreasing rate of standard of living as cost of living increases. In 1993, the Federal Ministry of Health and Social Services reported 20% of the country's population suffered from one type or another of mental disorder (Morakinyo, 2002). Moreover there has been frequency of reports in the media showing the poor mental health status of Nigerians and their political leaders (Eke, 2004; Ogundele, 2007; Enakoko, 2008,

Williams, 2008). In fact these made (Lawani, 2008) reviewed the situation in his article. The Nigerian society as a psychiatric patient lamenting the commonlity of mental health disorders personifying Nigeria.

Lawani (2008) reports that the report by Nigerians antigraft Czar, Mrs. Waziri, about the complicity of developed countries in the siphoning of Nigerians resources leaves much to be desired. Nigerian leaders accumulate wealth that is more than sufficient for them in the course of their lifetime and that of their future generation. This is a reflection of poor judgement, symptomatic of mental illness, which is manifestation of grandiose delusion.

Without primary check, and rehabilitation the consequences of mental illness for the individual and society are staggering: social stigma, unemployment, homelessness, inappropriate incarceration, neglect and suicide. The economic, psychological and social cost of untreated mental illness cannot be quantified due to dearth of records and under reporting of people living with mental illness in Nigeria.

In making choices for health funding in low-income countries, policy makers and donor agencies are guided by epidemiological evidence that indicates the burden of disease on the poor. There is a large body of evidence from industrialized countries demonstrating an association between poverty and risk for common mental disorders. This paper reviews the evidence from developing countries and explores the processes that may explain the poverty mental illness continuum.

Common mental disorders are depressive and anxiety disorders that are classified in ICD-10 as: “neurotic, stress-related, psychosomatic disorders” and “mood disorders”. The public health negative impact of mental and behavioural disorders is shown by the fact that they are among the most significant causes of morbidity in primary care arrangements and produce considerable damage to self and society. From an epidemiological perspective, poverty here

means low socio- economic status (measured by only level of education and income). Characterized by unemployment and low levels of education it is against this background that this review is made. Binitie (1999) reports that the indices for position mental health include inner satisfaction, hopeful aspect, financial solvency in order to maintain a decent life, support systems which include family relations and friends, sexual satisfaction, capacity to manage tension and social pressures and offspring to continue the work into the future. Those who belong to the lower socio-economic class are under great pressure to attempt to succeed through illegitimate means that is through deviance, such deviance may include crime, drug addiction resulting to mental illness or suicide by those who cannot cope with the pressure (Merton, 1957).

In Nigeria, there have been calls in the media for political leaders to be subjected to psychiatric testing before they are put in position of authority. (Olugbile, 2006; Abati, 2008). This is because, the mental health state of these public office holders is deemed to be poor and are adduced to be ineptly corrupt, which is the source of mass poverty in Nigeria. This has placed majority of Nigerians under chronic stress, which has negatively affected their mental health status. The association between poverty and mental health can be situated within the cultural or behavioural models of the unequal distribution of economic facilities and income. According to the 'culture of poverty' view of Lewis (1959), human existence in any given environment involves a process of biological and social adaptation which gives rise to the elaborate structure of norms and behaviours. In that sense, poverty brings along with it a lack of opportunity, reduced availability and accessibility to resources and a greater likelihood of experiencing difficult events. Poverty acting through economic stressors such as unemployment and lack of affordable housing, is more likely to precede mental illness such as depression and anxiety, thus making it an important risk factor for mental illness.

METHODOLOGY

This study used the research technique of content analysis that is relying solely on secondary data obtained from journals, newspapers, magazines, annual reports from the state and the federal government of Nigeria, international and non governmental organizations. The explanatory models of persons suffering from common mental disorders have been described in a number of studies, in all of which poverty and socioeconomic problems have been cited as some of the most important factors causing emotional and behavioral abnormalities. While individual perceptions of illness are not evidence of a causal association.

RESULTS AND DISCUSSION

The findings of this study revealed that: poverty is pervasive and increasing in Nigeria; mental health disorders are increasing as cost of living increases; corruption is perceived as the cause of poverty in Nigeria. The studies reviewed permit a logical relationship of poverty and mental health disorders. This study showed that high cost of living conditions such as poor housing, which is associated with low economic conditions, remained significantly associated with mental health disorders against the background of low level of education. The determinants of economic conditions on mental health disorders is to some extent unclear due to children of rich parents who use hard drugs and develop varied forms of Schizophrenia (Ewhrudjakpor 2008a). While some studies (Sturm and Gresenz, 2002; Sareceno and Barbui, 1997) in developed societies have shown an independent association of low income with depression particularly among women, these findings have also confirmed by studies (Majoroh and Ewhrudjakpor, 2004; Adomakoh, 1975) showing low association, if any, between income inequality and mental health disorders. One study (Ormel, et. al. 1994) showed a higher risk for disorders among persons in the upper income group if their economic and social status dips.

The association between health and socio-economic conditions has been studied widely. It assumed that there is a link between poverty and mental health disorders but this goes with the propositions thus: People with low incomes are more likely to suffer from poor mental health disorders; People with mental health disorder are more likely to stay poor for a long time.

Both of these statements appear to be true. People with mental illness tend to come from the lower socio-economic classes. This might be interpreted as suggesting that being of low socio-economic class predisposes one to developing mental illness. However, if thesocial class of the father, rather than the individual is examined, there is a much more normal distribution. This suggest that schizophrenia does not have a predilection to strike at low socio-economic classes but that those with the disease tend to remain within the range of mental illness. It was concluded that poverty may be a contributory factor (Narayan, et. al. 2000).

Having mental illness has a number of adverse effects on ability to earn. It is more difficult to study and to achieve qualifications. It is more difficult to hold down a responsible job. A person with mental illness may need to take time out occasionally, when the illness needs more intense treatments, whether this means time in hospital or not. Employers like reliability and do not take kindly to employees who frequently take time off. This applies whether the problem is mental or physical illness. Mental illness carries a heavy social stigma and employers are also worried about what the sufferer may do when still working but unwell. It is not only in highly responsible jobs that people with mental health problems face discrimination. Employers like reliability in the work force at all levels and surveys have shown a reluctance to take on any one with a disability at any level, especially a mental disability. They may suffer disparaging remarks at work. There is a lack of sympathy empathy and understanding. (Ewhrudjakpor, 2009b). Just because two things are associated, does not mean that one causes

the other. It is not fair to assume that because the mentally ill are more likely to face poverty, that poverty causes mental illness. It is necessary to look at the evidence (Aruya, et.al. 2003). Mental illness is multifactorial and the tendency to descend the social scale complicates the preposition of post hoc ergo propter hoc. Poverty and unemployment increase the duration of episodes of common mental disorders but not the likelihood of their on set (Agabi, 2008) Financial strain is a better predictor of future psychiatric morbidity than either of these more objective risk factors though the nature of this risk factors and its relation with poverty and unemployment remain unclear. (Williams, 2008).

Like mortality and physical morbidity, common mental disorders are associated with a poor standard of living, independent of occupational social class. These findings support the view that recent widening of inequalities in material standards of living in Nigeria pose a substantial threat to health (Ogundel, 2007; Olugbuler, 2006;Agabi, 2008, Abati, 2008). There is limited evidence of an association between income inequality and poor health in Nigeria. As regions with the highest income inequality are also the most urban, these findings may be attributable to characteristics of cities rather than income inequality (Ewhrudjakpor, 2009b).

There seems to be doubt that people with mental illness are more likely to live in poverty. They are more likely to slide down the social scale. They are less likely to find employment of any sort and they are very likely to face discrimination in all fields of the job market. People with poor mental health are more likely to suffer from poor physical health. They are more likely to smoke and abuse drugs or alcohol. They may also fall foul of the criminal justice system.

The aetiology of mental illness is multifactorial with genetics; upbringing and substance abuse all being possible confounding factors (Ewhrudjakpor, 2009b). A child brought up in financial hardship may also be deprived of affection, but not necessarily. One

factor that is difficult to quantify but does tend to be a recurrent theme in causes of mental illness is stress. Living in poverty with poor living conditions or even being homeless and struggling financially, is certainly a very severe stress. On balance, it seems likely that living in poverty does predispose people to mental illness (Sturm, et. al, 2002; Aruya, et. al, 2003; Adeyemi, 2007).

The psychological impact of living in poverty is mediated by shame, stigma and the humiliation of poverty. Interviews with relatives of young women in rural Japan (Narayan, et.al. 2000) who had committed suicide and with survivors of suicide attempts reveal that hopelessness is a sure experience, it is associated with spouse and family abuse, forced marriages, limited educational and work prospects, stigma for failing to produce a son, and the migration of husbands to urban areas for employment. Illiteracy or poor education is a consistent risk factor for common mental disorders.

Some studies. (Orumel, et.al, 1994; World Health Report, 2001; World Development Report 2000/2002; Aruya, et. al. 2003) have also demonstrated a dose-response relationship between educational level and the risk of such mental health disorders. Reverse causality is unlikely to be a factor, since primary education occurs in early childhood when mental disorders are uncommon. The relationship between low educational level and mental health disorders may be confounded or explained by a number of pathways: these include malnutrition, which impairs intellectual development.

Apart from the possible role of biological factors, which may explain why there is a consistent sex difference in risks for common mental health disorders in all societies, it is plausible that gender factors - the considerable stresses faced by women - may also play a role. In many developing societies, women bear the brunt of the adversites associated with poverty: less access to school, physical abuse from husbands, forced marriage, sexual trafficking, fewer job opportunities and, in some societies, limitation of their participation in activities outside the home.

Poverty is likely to be associated with malnutrition, lack of access to clean water, living in polluted environments, inadequate housing, frequent accidents and other risk factors associated with poor physical health. There is evidence demonstrating the co morbidity between physical illness and common mental disorders, and this association may partly account for the association between poverty and mental disorders. Mental and physical health problems lead to increased health care costs and worsening poverty. Most studies (Adomakoh, 1975; Narayan, et. al. 2000 Sturm; et.al. 2002, Arruya, et .al 2003; Eke, 2004; Ewhrudjakpor, 2008a, 2009b; 2009b) showed an association between the risk of common mental health disorders and low levels of education; other studies (Saraceno, et.al. 1997; World Development Report, 2000/2001; Morakinyo, 2008 Agabi; 2008), also showed a relationship with other indicators of poverty such as poor housing or low income. These findings suggest that the association between poverty and common mental disorders is a universal one, occurring in all societies irrespective of their levels of development (Ormel et.al. 1994).

Whereas it is plausible to speculate that the relationships can be best interpreted in the context of poverty being a risk factor for common mental disorders, reverse causality can be a consideration because common mental health disorders are known to produce disability and increase health care costs. Further, depressed individuals may exaggerate the adversity of current circumstances (Adomakoh, 1975; Majoroh and Ewhrudjakpor 2004). Some studies (World Health Report, 2001) took precautions against this by enquiring about household income from informants who were not depressed. However it is more likely that poverty and common mental health disorders associates with each other in vulnerable individuals, trapped in a vicious cycle of poverty and mental illness. A similar relationship has been shown to exist between poverty and infectious diseases such as tuberculosis and leprosy. Rather than actual income, factors such as insecurity, homelessness, joblessness,

communal neglect, hopelessness as a result of less education may facilitate the risk of suffering from mental health disorders. The most important implication of these findings is to place common mental health disorders alongside other diseases associated with poverty which, on account of this association, attract attention from health policy-makers and Philanthropic donors. The global mental health agitations must play a larger role in public health activities focusing on global mental health disorders. To do this effectively, political leaders and governments will need to confront global poverty, its relation to political and economic developments and its consequences for mental health disorders.

CONCLUSION

This study aimed at assessing the relationship between poverty and prevalence of mental disorders in Nigeria. Poverty here was defined as an individual's economy which must be persistent and unchangeably lacking in basic necessities of life. On the other hand, mental health is a state of wholesome well being relative rather than absolute, accompanied by an individual's and societal happiness and satisfaction. It includes the person's social, psychological and mental well being, in order to relate normally and well with others in society. A deviation from happiness and satisfaction to self and others, qualifies for mental illness.

Literature reviewed as basis of content analysis show that poverty like mental illness is on the increase in Nigeria. This is despite the federal and state governments' poverty alleviation policies and programmes such as NEEDS, 2005. Indicators of poverty in Nigeria are damaging socially, psychologically and physically to the extent of causing mental health abnormalities. This is situated in the behavioural models as in (Lewis, 1959) 'culture of poverty' in the final analysis, absolute economic poverty does precipate mental illness.

This review shows that evidence on mechanisms of the relationship between poverty and mental health disorders can be used to consider a number of primary and secondary preventive strategies. Evidence to support the efficacy of interventions in this field is weak (Enakoko, 2004; Olugbule, 2006; Ogundele, 2007; Lawani, 2008).

From a public health perspective the key to secondary prevention is to strengthen the treatment of common mental health disorders in primary health care centers (through poorly equipped) spread all over Nigeria. This review has demonstrated the efficacy and cost-effectiveness of psychological and pharmacological interventions for common mental health disorders in developing countries need to be adopted by health policy-makers in Nigeria. Primary health care workers need training to recognize and effectively treat common mental health disorders. Just as clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so too, must we challenge the despair of psychiatrists who argue that if their patients are poor they must be depressed and there is little they can do about it. Psychiatrists should continue to empathize and counsel poor people to think and act in positive ways in order to be healthy holistically.

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