

Using a gender lens to monitor mental health

Natalia Diaz-Granados¹, Donna E. Stewart^{1,2}

¹ University Health Network Women's Health Program, Toronto, Canada

² Department of Psychiatry, University of Toronto, Toronto, Canada

Mental health remains on the forefront of the public health agenda since mental disorders affect approximately 450 million people worldwide (World Health Organization, 2004) and account for 12% of the global burden of disease (World Bank 2004). It is well established that gender differences exist along the spectrum of mental health with depression projected to be the highest cause for disability in 2020 for women (World Bank 2003). Additionally, women are more likely to experience depression and anxiety (Lewinsohn et al. 1998; Pigott 1999; Bijl et al. 2002; Kessler 2003; Stewart 2005); dysthymic disorders (Riolo et al. 2005); seasonal affective disorders (Chotai et al. 2004; Lee 1998), eating disorders (Robergeau et al. 2006), panic disorders and phobias (Weissman et al. 1997; Bijl et al. 2002); have a higher incidence of attempted suicide and are more likely than men to suffer from more than one mental illness, a condition associated with increased severity of mental illness and disability (World Health Organization 2004). Likewise, men have higher rates of completed suicide (Moscicki 1994) and higher prevalence of alcohol and substance abuse (Grant et al. 2004; Brady et al. 1993). The patterns of mental health service access and utilization also differ between men and women: the latter make greater use of services, receive more treatment/prescription medication (e.g. psychotropic drugs) and have higher rates of hospitalization (Salmon et al. 2006). Moreover, important gender differences persist in the determinants of mental well-being and resiliency (World Health Organization 2000a), including employment type (i.e. informal/formal) and status, family status, care giving roles, education and health-related behaviours (World Health Organization 2000b; Walters 2004; Rieker & Bird 2005).

While both sexes would benefit from mental health system improvement, women's unique roles in reproduction, the family and society, and their often lower status, necessitate special considerations for their mental health. In 1995, the

United Nations Beijing Platform for Action stated that “*Women have the right to the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and wellbeing ...*” (United Nations 1995) and more recently an International Consensus Statement on Women's Mental Health was ratified by over 120 member countries at the 2005 World Psychiatric Association Congress in Cairo (Stewart 2006). Likewise, men's mental health, a commonly neglected issue, remains a vital and timely issue that warrants more attention.

These gender disparities in mental health highlight the need to include gender equity measures in the process of planning, implementing and evaluating mental health programs at national, state and municipal levels. These gender-sensitive mental health indicators should be able to capture gender-related changes over time within a well defined health information framework that encompasses health status, determinants of health and health systems such as the one proposed by the World Health Organization Kobe Centre (2005). These indicators should feed into a user-friendly action-oriented strategy that results in higher quality service delivery, more accessibility and targeted care. Setting up a core set of gender-sensitive mental health indicators allows for regular monitoring of programs and international, national and regional comparisons that could guide stakeholders in funding-related decisions and planning of future strategies that incorporates gender specific treatment interventions.

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Currently, the monitoring and evaluation of most mental health programs do not examine gender equity (NMHWG 2005; European Union 2004; European Union 2002) and are aimed towards health care providers and administrators, evaluating components of health systems at an individual level. Advocating for a gender-sensitive national mental health surveillance program that includes health system indicators as well as community indicators would not only ensure that

appropriate care reaches those at higher risk (i.e., refugees, immigrants, single-parent mothers, women who experience intimate partner violence), but it would also promote the use and planning of community programs aimed at increasing mental well-being. Therefore, a gender lens must be used in order to reduce mental illness and improve the mental well-being of a population in order to ensure that appropriate care reaches those who need it most.

References

- Brady KT, Grice DE, Dustan L, Randall C (1993). Gender differences in substance use disorders. *Am J Psychiatry* 150: 1707–11.
- Chotai J, Smedh K, Johansson C, Nilsson LG, Adolfsson R (2004). An epidemiological study on gender differences in self-reported seasonal changes in mood and behaviour in a general population of northern Sweden. *Nord J Psychiatry* 58: 429–37.
- European Union (2004). The State of Mental Health in the European Union. European Commission: Health and Consumer Protection Director-General.
- European Union (2002). Commission of the European Communities and the National Research and Development Centre for Welfare and Health STAKES. Establishment of a set of mental health indicators for European Union: Final Report. URL: http://europa.eu.int/comm/health/ph_projects/1998/monitoring/fp_monitoring_1998_frep_09_en.pdf
- Bijl RV, De Graaf R, Ravelli A, Smit F, Vollebergh WA; Netherlands Mental Health Survey and Incidence Study (2002). Gender and age-specific first incidence of DSM-III-R psychiatric disorders in the general population: Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS) *Soc Psychiatry Psychiatr Epidemiol* 37(8): 372–9.
- Grant BF, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP (2004). Co-occurrence of 12-Month Alcohol and Drug Use Disorders and Personality Disorders in the United States: Results From the National Epidemiologic Survey on Alcohol and Related Conditions *Arch Gen Psychiatry* 61: 361–8.
- Kessler RC (2003). Epidemiology of women and depression. *J Affect Disord* 74: 5–13.
- Lee TM, Chan CC (1998). Vulnerability by sex to seasonal affective disorder. *Percept Mot Skills* 87(3 Pt 1): 1120–2.
- Lewinsohn PM, Gotlib IH, Lewinsohn M, Seeley JR, Allen NB (1998). Gender differences in anxiety disorders and anxiety symptoms in adolescents. *J Abnorm Psychol* 107: 109–17.
- Moscicki EK (1994). Gender differences in completed and attempted suicides. *Ann Epidemiol* 4: 152–8.
- NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005). Key Performance Indicators for Australian Public Mental Health Services. ISC Discussion Paper No.6 Australian Government Department of Health and Ageing, Canberra.
- Pigott TA (1999). Gender differences in the epidemiology and treatment of anxiety disorders. *J Clin Psychiatry* 60 (Suppl)18: 4–15.
- Rieker PP, Bird CE (2005). Rethinking gender differences in health: why we need to integrate social and biological perspectives. *J Gerontol B Psychol Sci Soc Sci Spec* 2: 40–7.
- Riolo SA, Nguyen TA, Greden JF, King CA (2005). Prevalence of Depression by Race/Ethnicity: Findings From the National Health and Nutrition Examination Survey III. *Am J Public Health* 95(6): 998–1000.
- Robergeau K, Joseph J, Silber TJ (2006). Hospitalization of children and adolescents for eating disorders in the State of New York. *J Adolesc Health* 39: 806–10.
- Salmon A, Poole N, Morrow M, Greaves L, Ingram R, Pederson A (2006). Integrating Sex and Gender in Mental Health and Addictions Policy: Considerations and Recommendations for Federal Policy Development. Vancouver, BC. British Columbia Centre of Excellence for Women's Health.
- Stewart DE (2006). The International Consensus Statement on Women's Mental Health and the WPA Consensus Statement on Interpersonal Violence Against Women. *World Psychiatry* 5: 61–64.
- Stewart DE (2005). Depression during pregnancy. *Canadian Family Physician*. 51: 1061–3.
- United Nations (1995). The Beijing platform for action. Report of the Fourth World Conference on Women. New York: United Nations.
- Walters V (2004). The Social Context of Women's Health. *BMC Womens Health*. 4 (Suppl 1): S2.
- Weissman MM, Bland RC, Canino GJ, et al. (1997). The cross-national epidemiology of panic disorder. *Arch Gen Psychiatry* 54: 305–9.
- World Bank (2004). Mental Health and the Global Development Agenda: What Role for the World Bank? World Bank: Health, Nutrition and Population. URL: <http://siteresources.worldbank.org/INTMH/Resources/Rachel-MentalHealth.pdf>
- World Bank (2003). Mental Health. URL: [http://wbIn0018.worldbank.org/HDNet/HDdocs.nsf/0/7f80b2aaacc89c3885256a42005e2d69/\\$FILE/AAG%20Mental%20Health%20110703.pdf](http://wbIn0018.worldbank.org/HDNet/HDdocs.nsf/0/7f80b2aaacc89c3885256a42005e2d69/$FILE/AAG%20Mental%20Health%20110703.pdf)
- World Health Organization Kobe Centre (2005). Report of the Consultative Meeting to Finalize a Gender-Sensitive Core Set of Leading Health Indicators. Kobe: WHO Kobe Centre.
- World Health Organization (2000a). Fact sheet No. 248: Women and mental health. 2000. URL: <http://www.who.int/media-centre/factsheets/fs248/en/print.html>
- World Health Organization (2000b). Fact sheet No. 252: Women, ageing and health. 2000. URL: <http://www.who.int/media-centre/factsheets/fs252/en/print.html>

Address for Correspondence
Natalia Diaz-Granados, MSc
University Health Network
Women's Health Program
200 Elizabeth Street, EN 7-234
Toronto, Ontario M5G 2C4
Tel.: +416 340 4800 ext 6783
e-mail: natalia.diaz-granados@utoronto.ca