Contextualizing mental health: gendered experiences in a Mumbai slum

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Gendered experiences in a Mumbai slum

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Abstract

Despite decades of priority, urban mental health programmes in developing countries remain in their infancy. To serve low-income communities, research needs to consider the impact of common life experience in slums, including poverty, bad living conditions, unemployment, and crowding. Our study in the Malavani slum of Mumbai examines afflictions of the city affecting the emotional well-being and mental health of women and men with respect to gender. This is a topic for which mental health studies have been lacking, and for which psychiatric assumptions based on middle-class clinical experience may be most tenuous. This study employs ethnographic methods to show how environmental and social contexts interact in shaping local experience with reference to common mental health problems. Focussing on the social and environmental context of the mental health of communities, rather than psychiatric disorders affecting individuals, findings are broadly applicable and sorely needed to guide the development of locally appropriate community mental health programmes. Identified afflictions affecting mental health include not only access to health care, but also sanitation, addictions, criminality, domestic violence, and the so-called bar-girl culture. Although effective clinical interventions are required for mental health services to treat psychiatric disorders, they cannot directly affect the conditions of urban slums that impair mental health.

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Introduction

In Mumbai, India's largest city with an estimated population of 16,360,000 (Census of India, 2001), 60% of the people live in dilapidated areas, communities whose residents routinely contend with serious economic hardships and constricted opportunities. The Indian government refers to such an area as "slum", a label which is intended to identify communities in need of support, but may paradoxically and unintentionally fix identities in ways that deny, rather than afford, opportunities for urban development. Characterising a community as a slum may identify it with chaos and squalor. It may also mark the people who reside there as dirty and chaotic, inappropriately confusing their disadvantaged status with an unshakable feature of their identity—a mark of stigma and a source of shame.

Some social commentators in India, however, have suggested an alternative to this middle-class interpretation of slum, noting that they are not just hotbeds of problems, but also places where millions of rural poor have flooded into cities to take advantage of opportunities for work, higher income, education, healthcare facilities, and entertainment. Cities rely on the labour of these slum residents to work the factories, drive the taxis and rickshaws, and to work as servants to care for the families of the middle class. Recognising they provide economic opportunity and opposing the wave of slum demolition for urban renewal in Mumbai in the late 1980s, critics of the mainstream view argued that although we need to improve the conditions in the slums, we nevertheless need more slums (Aiyar, 1988).

Similar accounts that emphasize either positive or negative features of slums have been reported from many parts of the world (Lloyd, 1979; Gilbert & Gugler, 1994). The concept of "slum" itself is vague and ambiguous. The Penguin Dictionary of Geography defines a slum as "a rundown settlement or part of a settlement, usually in or near an urban area and characterized by dilapidated buildings or shacks, the poverty of its inhabitants, squalor, the presence of refuse and overpopulation" (Clark, 1998). Outsiders commonly have low regard for slums, considering them to be dirty, dangerous places where uneducated, criminal, and alcoholic people reside.

Among research efforts to serve development interests in the mid-1990s, Harpham (1994) and Harpham & Blue (1995) put "mental health" on the agenda of urban health studies. Based on a broad review of the literature, they emphasised the role of social factors contributing to urban mental health problems through increased stressors, such as overcrowding, pollution, and limited social supports resulting from breakdown of extended families and disrupted traditional networks. Over the past decade, recognition of the need to examine the impact of poverty on mental health has received increased attention, acknowledging the effects of bad living conditions, unemployment, crowding and congestion on both physical and mental health (WHO, 2001; Desjarlais et al., 1995).

Social roles defined by gender influence this vulnerability, and a gender-focussed analysis and study of mental health in slum communities can be expected to clarify how women and men experience physical and social environments affecting their emotional life. These effects are mediated by gender in various ways, for instance, as devaluation of women's needs and abilities, unequal social status, marital stress, housing conditions, and both gender-based and other life events (Abas & Broadhead, 1997; Davar, 1999; Chakraborty, 1990).

In this article, we present findings from a study which contextualizes common mental health problems in an urban slum of Mumbai. By focusing on conditions of a slum

community, we address a segment of the urban population for which mental health studies are lacking, and for which the assumptions from middle-class clinical experience may be most tenuous. What are the links that men and women in this community see between their well-being or distress and the urban environment? How do concepts of mental health problems relate to these environmental and social afflictions of life in the slum? By investigating such questions in a particular locality, this research aims to contribute to the growing interest in the community contexts of mental health with reference to population health and mental health promotion (WHO, 2002; Friedman & Starfield, 2003; Kickbusch, 2003; Kindig & Stoddart, 2003).

Main features of life in Malavani

The area called Malavani, situated 35 kms north of central Mumbai in a Western suburb, is a representative slum. Its population is approximately 150,000, and the residential area includes two distinctive types of settlements: recognized (or legalized) areas and illegal settlements, which we refer to as sanctioned and unsanctioned slums, respectively. The infrastructure for all of Malavani, by and large, is very poor, lacking basic amenities such as clean water and satisfactory sanitation, and the worst conditions are in the unsanctioned slums (Figure 1). Historically, this community has been identified with criminal elements, and this identity makes it a culturally undesirable place to live.

[Insert Figure 1 about here]

Methods

The bulk of this study was carried out from 2000 to 2001; but it actually continues up to now. Various ethnographic methods were used. Participant observation at the outset was especially important to clarify the nature of life and culture in this slum, and the routines of behaviour and interactions in the course of daily life. Community-based fieldwork included in-depth interviews with key informants and residents of the community, focus group discussions, other informal group discussions, and participatory methods. The agenda for the interviews and focus groups was developed from consultation with community action facilitators working in Malavani and from discussion with staff of the primary health centre serving the community. Interviews with long-term residents were conducted in selected, representative sections of Malavani.

Among the 28 in-depth interviews, 10 were with men and 18 with women. The women were mainly housewives from different parts of Malavani slum (sanctioned and unsanctioned), four were community health workers, and three women were socially active in the area. Men were from various social, religious, and occupational groups, including some with government jobs, unemployed young men, and community leaders. Six focus groups were organized to ensure representation of both sexes in sanctioned and unsanctioned areas. Most of these adults had lived in their respective communities for 5 to 15 years. Focus group discussions (FGDs) were conducted with men and women, one each in sanctioned and unsanctioned areas, and a third focus group in each area was conducted with adolescent boys and girls who were born and raised in Malavani. Older focus group participants and interview respondents provided a historical account, from the origins of the community to the present, highlighting significant developments and changes in the community life of Malavani.

The research team consisted of a community social worker and medical doctors (including the first author and resident trainees in psychiatry). In addition to the interviews and FGDs,

information about the history of settlement, population data and socio-economic status was collected from official records of primary health centre and health posts, and from records of the Mumbai Municipal Corporation. In the following sections, which include illustrative narrative accounts of community life, pseudonyms have been used to protect the identity of respondents.

A specific agenda guided interviews with individual respondents and FGDs. This agenda considered stressful and supportive features of community life with particular attention to gender context. To begin with, general aspects of life in the community were discussed, considering problems and concerns with respect to infrastructure and basic amenities, general environment and facilities. Many issues such as unequal distribution of basic amenities, demolition of unsanctioned housing, homelessness, criminality and negative social labelling were elaborated. Various aspects of men's and women's roles with respect to jobs, unemployment, social interactions in the community were examined. Common themes—including addictions, domestic violence and marital problems—emerged spontaneously in the course of these discussions. Women's FGDs emphasized the pressure on women to earn, domestic violence and the impact on them of alcoholism among men. In the privacy of individual interviews, women reported personal accounts of marital problems and victimisation. Men's FGDs emphasized a lack of opportunity, joblessness and environmental problems.

Main Causes of common mental health problems

Various environmental and infra-structural problems that affect everyone in Malavani are summarised in Table 1, which indicates the experience and mental health implications of these problems for the community population. Based on widely held ideas about Malvani, migration into this community itself commonly generated feelings of demoralisation and

hopelessness. Water, electricity and toilet facilities were scarce, even in the government sanctioned plots, but worse in unsanctioned areas where stealing water and electricity with illegal connections is very common. The cost of electricity, water, and the use of toilets is a heavy burden for many Malavani residents. FGDs elaborated the unequal distribution of basic amenities and how this led to hostility and conflicts. Because it is official government policy to clear unsanctioned slums every six to eight months, many residents live with a persisting threat of demolition and homelessness. Criminal violence is also a major concern. Petty crimes appeared to be associated with the expansion of Malavani and the proliferation of the unsanctioned slums, unemployment, and addictions and problem use of alcohol and drugs.

[Table I about here]

In the interviews and FGDs, men and women identified various interrelated social afflictions affecting the mental health of both sexes in different ways. Tables II and III summarize these problems, including economic insecurity, problem use of alcohol and drugs, violence, strained marital relations, and so forth.

[Tables II and III about here]

Economic insecurity

Unemployment and underemployment of men is regarded as a major problem (Table II). Because finding work may often require a bribe, money is required to make money. Hoping to

find work in day labour, men congregate in areas where they are most likely to get such work, such as at the Malad railway station. They take whatever diverse small jobs may be available, such as helping to paint a house, construction, carpentry, and labor with contractors. Other men make a living self-employed as hawkers selling small items, driving rickshaws, working in grocery shops, or selling betel and tobacco (*pan* and *bidis*).

Some men who cannot get such work settle into a pattern of unemployment, which becomes troublesome for them and their families. After repeated unsuccessful efforts seeking work, the men may develop a sense of helplessness and become accustomed to sitting idly.

Sumantai, a female resident community worker with the research group, explained the emotional turmoil resulting from unemployment that affected her husband's mental health as follows:

> *He brought us to Mumbai to earn a livelihood as we were facing problems in our village from drought. Many men moved out to Mumbai with their families. We came and settled in Malavani with others. He soon got frustrated here, as he was not able to earn despite trying hard. Initially he stopped socialising with other people from the village due to shame, and he complained of "tension." Slowly, he started drinking alcohol because of feeling tense. When I started working as a domestic servant, he initially hated to survive on my income. He used to become hostile and leave the house for the whole day, spending his time with other unemployed (bekar) individuals in the community, returning home very late. Today after 10-12 years of being in Malavani he is an alcoholic. He doesn't even try to earn or to look for a job.*

Some men appear unconcerned about unemployment, comfortably accepting their wives working and providing the family income. When asked about this pattern, a man explained, "It is quite normal in the city like this where women are working, because men don't get jobs. So what? Even children are working and earning. Looking after and taking care of the family

is a women's job; she needs to help her husband in difficult times." More typically, however, men and women in FGDs discussed repugnant effects of unemployment. They referred to some examples of men staying with other women for sexual enjoyment while harassing their working wives for money and to maintain the household.

Regardless of what men might think of their unemployment, it took a toll on the mental and emotional state of their wives and children. One woman described her irritation and helplessness with her husband, explaining that she had been trying to find a job for him, but no matter what turned up, he refused it on one pretext or another. The distinction between whether he could not or would not find work became difficult to make. "Poverty is a problem", she explained, "but it creates more tension for women. These men always say they can't work, but they don't even try. When we try to arrange for a job they immediately decline the offer. Now these men have got the idea of keeping bar-girls so they don't have to work."

Because many men either have no jobs or cannot earn enough, about 60% of the women in both sanctioned and unsanctioned slum areas are working at paying jobs. Jobs available to these working women are typically menial, often positions as domestic servants, minding children in a kindergarten (*balwadi*), or as labourers at construction sites. Some sell fruits, vegetables, or cooked snacks, either circulating on foot or sitting in a market. Younger women with some education may work as salesgirls in the city, even in the better shops. Some stitch clothes, embroider, or work as packers in the shops. We encountered some women who had taken up their husband's work as hawkers, selling various items or providing services on the footpath. Some women pursued unexpected occupations inconsistent with gender-based expectations, such as the woman in Figure 2 working as a cobbler. Still other women found jobs as bar-girls, selling drinks and dancing for men, and for many of them, this entailed at least part-time work as prostitutes.

[Figure 2 about here]

Their ability to work and earn when men cannot is a distinctive feature of the urban experience of Malavani women. Nevertheless, their capacity to earn money outside the home does not necessarily bring the right to manage this money in the home. Even among those women who do manage their earnings, it is often with limited autonomy. Women who are earning are expected to give this money to their husbands or fathers. Consequently, even if they are earning enough, they may still lack sufficient funds to purchase essential household supplies.

Addictive and problem use of alcohol and drugs

Dependence on alcohol and tobacco—smoked and chewed—is very common among men in Malavani (Table II). Many respondents identified this as the root cause of various social problems, especially criminality and domestic violence, which are rampant in the community. According to FGD estimates, alcoholism is a problem affecting 60-70% of the male population, and if additional drugs like cannabis are counted, problem drug use affects 75-85%. According to most of the male respondents from focus groups and in individual interviews, addiction to brown sugar (preparation of heroin that is smoked) is now less of a problem than ten years ago. It has decreased as a result of growing public awareness of its effects and because of its cost. Alcohol is distilled locally in hutments, called *hatbhatti*, is readily available. We also met a few women who sell liquor to regular consumers. Alcohol may be sold on credit (*udhari*) as the person drinks. At some point the drinkers are required to pay, or they will get no more, or they may be threatened if the don't pay. As the pressure

builds, these men may get the money from their wives, from pick pocketing, other petty crime, or from begging if they must. Both women and men attributed much of the violence and antisocial behaviour in the community to alcoholic men.

Male and female participants in FGDs explained that alcohol and drug use is an expression of frustration by men to unemployment and financial insecurity. Women with alcoholic husbands and children also blamed the addiction-prone environment in Malavani. One woman respondent who lost her husband due to alcoholism, and who also had an alcoholic son, explained, “The community definitely plays a role. All drugs are easily available, and people openly consume drugs here. Living in this place is itself a tension.”

A 41 year-old male addict explained in detail how as a very young boy he began drinking and then deteriorated socially. He emphasized peer pressure and the addictive surroundings of Malavani among the main reasons for his becoming addicted:

> *I became an addict because of Malavani. In other places I would not have done that. I came to Malavani at age 11 with my mother from Bihar. As my mother went outside to earn daily, I started smoking cigarettes and occasionally drinking alcohol with bad friends. Everybody was so open about drinking and smoking. Nobody objected, since people have accepted these habits as routine. They introduced me to brown sugar, which first came to Malavani in the 1980s. I was not aware of the ill effects of this drug until I was totally addicted to it. When my consumption increased, there was no money left, so I started pick pocketing and carried on with petty theft. My mother left me and went back to Bihar. I was all alone, tense and frustrated. No support and no one to turn to—no money. Now I am dying without food and medicine.*

FGDs elaborated conditions that show how the atmosphere in Malvani is conducive to drug addiction. The drugs are available in the community because so many people sell these drugs to earn easy money. Many women respondents regarded alcoholics as emotionally

disturbed and uncontrollable. When asked, they did not regard dependence on alcohol and drugs as a mental health problem. They typically consider it more of a social problem affecting irresponsible and unemployed (*bekar*) people. They explained that addiction of any sort started as a habit to deal with tension, and it becomes a problem under the influence of bad people in the community. They also linked the condition with tension from unemployment and poverty. Women addicts were mainly identified as bar-girls who either smoke, drink alcohol or take opium. Such women were considered "bad". "These women are bad characters who are spoiling the young generation by hooking them. They should be thrown out of the community."

Degenerate and Diverse Character of Men

An elderly Muslim faith healer gave a scathing account that summarized the overall impact of widespread unemployment, addictions, infidelity and domestic violence on the character of Malavani men:

> *The men of Malavani are frustrated and characterless people. They don't work, they don't earn, and they sit the whole day on their beds. If women earn because the husband doesn't have a job, that is okay since there is no choice. But the man should at least value her contribution. These men are big tensions for the women. They are not faithful; they abandon them for other women. Sometimes they are married twice, and they expect the wife who is earning to take care of the other woman. They beat them badly and humiliate them every day. They even harass their wives for the money they want to give to other women and bar-girls. Today they even keep bar-girls for easy money, or they ask their wives to be bar-girls.*

Although such derisive views were widespread, they were not uniform, and we also heard positive accounts. One woman related her story in an FGD of how her life was transformed from a hell (*narak*) to heaven (*swarag*) when her husband renounced alcohol and committed himself to the principles of Buddhism. Her husband became a responsible wage-earner, looked after the children and spent time with the family. “It was more than I could have asked for.” Some religious groups and community organizations have targeted alcohol problems and family values as a target for community intervention.

Violence

Violence is a pervasive experience in Malavani with distinctive effects on men and women. Various types of violent conflict are also distinctive—that is, fighting between individuals, between different colonies and gangs, or between different ethnic or religious groups. In view of scant resources, it is understandable that quarrels among these groups often develop over practical concerns, such as where to leave garbage, get water, and rights to use toilets (where available) and areas for defecation. The quarrels that are a part of daily life may escalate and lead to violence. They may also become a focus of gang fights. Many of these conflicts arise from long-term antagonisms, land disputes, or in response to larger events that lead to mob violence. Community tensions also exist between residents of the sanctioned and the unsanctioned slum colonies, arising from the unequal distribution of basic amenities; one group may try to appropriate electricity, water, and even the toilets of another. Communal tensions between Hindus and Muslims, usually dormant, may suddenly ignite over seemingly trivial disputes or political issues. As in other sections of Mumbai, some of our informants advised that such communal conflict is a product of the last decade, and that there was very little communal discord in Malavani before the riots of 1992-93, following the destruction of the Babri Masjid in Ayodhya on 6 December 1992.

Domestic violence is a common daily experience. Husbands beat their wives, and mothers in turn beat their children. The women we spoke with suggested that 60 to 70 per cent of all women in Malavani routinely endure some degree of domestic violence. Nearly all the women in our focus groups reported having been beaten at one time or another, and according to them, nearly every household had its own story of drunkards and domestic violence. When discussing the frequency and the consequences of such experiences, they described a pattern of domestic violence, humiliation and frustration, and their accounts of these household stories suggested that it seemed to them that suicide was the only alternative to the misery of such conditions.

The wide extent of domestic violence that was widely reported by men and women respondents was also supported by evidence from clinical experience in the PHC. We saw wounds and fractures that many patients accounted for from physical abuse. Most respondents in the focus groups regarded such violence as a part of normal life, especially when men are unemployed, drinking or have more than one wife. Some people suggested that this happens rarely in educated families, or when the men are in good spirits, have acceptable jobs and enough money.

As they became more reliant on the earnings of their women, men seem to give greater priority to controlling them. One man, for example, who earned nothing in the past 18 years, continued to live with his wife and beat her regularly and severely. He said that his wife was responsible for the beating because she provoked him by speaking arrogantly and not doing her housework properly. He explained, “She has to be kept under control. She thinks too much of herself because she is earnings these pennies for us.”

In the focus group discussions, many women agreed that physical abuse resulted when men became accustomed to sitting idly without responsibilities. Some women argued that living far away from their cultural roots, these men were uninhibited about responding to

every impulse. There was no moderating influence of elders to whom they must answer or who might challenge their conscience and admonish them for unruly behaviour. Others mentioned that men are influenced by their peers who also abuse their wives and families. Several women reported that men were highly suspicious of their wives and daughters, not wanting them to speak to other men, or even to other women, because these men feared their women might be talking about them and plotting against them. Some men kept detailed accounts of their women's time outside the house for marketing or anything else, including visits to the doctor.

Women from the sanctioned colonies and from the better-off Muslim families were more likely to be tolerant of domestic violence. As one of them explained in an FGD, a woman who gets everything she needs from her husband should not mind if he beats her. She told us, “There is no insult, if your own man beats you. It is his right to do so, our men also have various tensions of running a family, earning money. Where else will he remove his frustrations?”

Several also acknowledged that women must tolerate at least that much to forestall abandonment and to discourage their husbands from taking additional wives.

Women who did not share this view felt there was little they could do about it; there was no way out and no chance for social justice. So long as they were compelled to live with the men who beat them, the legal system could not help. Occasionally a local women’s group might try to help, but at best with mixed results. They explained that women who tried to help others might themselves be at risk, and they become targets of abuse from their own husbands.

Accounts were not uniformly hopeless, however, and we heard of some successful interventions. Socially aware and active women had formed a local group to protest wife beating and to prevent men from deserting their wives. They had approached local leaders for

help, and police when needed, and they persuaded alcoholic husbands to get treatment. One of the women within the group was also working with the research team.

Strained marital relations

In the FGDs, women recounted a steady flow of stories about marriage and married life. They attributed many of their tribulations in Malavani to changing features of the culture, a more open society and loss of traditional family values, which were all attributed to the influence of city life. Although some women from the sanctioned colonies enjoyed a relatively better lifestyle, their stories were also filled with pathos, despair, humiliation, and struggle for survival.

One woman told us that she didn't know whether the man who brought her as child from North India to Malavani was her father or not. He had sold her as a young girl, 11 or 12 years old, into marriage and disappeared, which led her to question whether it could really have been her father who did that. She described her experience as a new way of pushing young girls into prostitution, sanctioned under the guise of marriage to make it legitimate. She explained how many poor young girls are brought from different parts of the country to become bar-girls or to be sold into prostitution. Sometimes they come with marriage proposals, or they are purchased from their relatives, and some are simply kidnapped. The weight of resentment from such harsh treatment was clear as these women recounted their personal histories.

Some women felt badly cheated, especially those who had been brought to Malavani from a village in another part of the country. These rural women did not have any inkling of what was in store for them. Life in the city that awaited them was far different from what they had heard about Mumbai, and perhaps seen in films—a city that was supposed to be a wonderful and exciting place. They expected modern amenities and relief from the drudgery of the farm work they had endured in their villages. One of these women explained her disappointment

after living ten years in Malavani: “The slum is more troublesome for women in every way. You are not secure in a place like this, not physically or otherwise. Thank god I don’t have a daughter. If I did, I would not have stayed. I would have gone back to UP (Uttar Pradesh).”

Although many older women resented the ordeals they routinely endured and their inferior status, they lacked confidence in their ability to do anything about it. They explained that it was necessary to submit to such violence and to accept a system controlled by men. Others felt that education and economic autonomy provided some hope of a way out. This view was expressed mainly by younger women in the focus groups. Those who were earning or going to college were most likely to argue that women need to speak up and claim more than they were offered. In today’s world, they said, the capacities of women are in no way different from those of men. Most of them agreed, however, that men do not want them to be independent or to gain power. The president of the local women’s group (*mahila mandal*) told us: “I cannot take too many decisions about what I cook in the house. I cannot go anywhere without asking my husband. In our slum it will be discussed if I don’t tell my husband. People will criticise and say I am on the wrong path. Men may become suspicious about our activities.”

Most women in Malavani are illiterate or have no more than some primary education. Very few, according to the PHC records, have reached beyond the 8th standard. As some women explained, there was no question of schooling for those girls who were overtly exploited, inasmuch as no one typically indicated any interest in their welfare. Some families allowed their daughters to pursue advanced education, but they feared that the girls would become more vulnerable, rather than resilient, to threats of exploitation. They were concerned that “urban ways”, as reflected in Hindi films, might lure girls into recklessness and irresponsible relationships with boys that could too easily spoil their lives. We heard stories of girls who had run off with boys, and it was clearly understood that these girls had been

exploited. Few girls had the opportunity to go to high school or college; instead, they were encouraged or compelled to marry. In focus group discussions, adolescents agreed that education was less of a priority for girls than for boys. Moreover, girls were expected to assist their mothers in housework and child care, not to do homework for school and prepare for examinations.

Inter-religious and inter-caste marriages are matters of increasing concern for women. Many examples indicated the problems resulting from romance and mixed marriages, including cases of attempted suicide. Marital relations typically became strained as the romance faded, and when the boy's parents in the joint family began to treat the girl harshly and disdainfully. There were stories of families evicting the daughter-in-law, and leaving her to fend for herself. Such women were seen as particularly vulnerable to exploitation. Because they needed job and income to provide an alternative to homelessness and destitution, they were likely to become bar-girls or prostitutes.

Vocabulary and syntax of mental health problems

Among the various terms that are used to characterise the stressors and distress of life in this slum community, narrative accounts emphasized the concept of tension; this term was most pervasive and important. Tension refers to a broad range of subjective distress, which may coincide with common psychiatric disorders (anxiety and depression) but goes well beyond that. Even when people suffering from tension do not meet formal criteria for a diagnosis, the impact of tension may nevertheless be severe, and it may lead to suicidal and addictive behaviours. The taxonomy of tension is specified by its various sources: "husband tension, children tension, financial tension, in-law tension, work tension, water tension, and so forth." Tension is the language through which the people articulated and commonly summarize the emotional impact of the environmental and the social experience of the slums.

Discussion

Our findings demonstrate the substantial impact of environmental and social setting on health status, consistent with many urban health studies. MacIntyre and colleagues (1993) explained how environmental conditions and the availability of inexpensive healthy foods, quality of health services, differences in crime rates and a less hostile environment affect mortality rates. In another region, studies of social conflict and criminal violence have also demonstrated their impact on health and well-being in four Latin American countries (Moser 1996). Simply put, the places where people live have a sizeable impact on overall health and well-being, and it is important to know which factors are particularly significant in that regard. Our study demonstrates that people themselves identify similar links between localized afflictions and common mental health problems.

Consideration of gender helps to explain the links between various social conditions and mental health, and our findings show how particular features of gender and culture affect mental health in the Malavani community. Many studies have already demonstrated the high rates of common mental disorders, especially depression, for women (Dennerstein et al, 1993; Makosky, 1982; Pearlin & Johnson, 1977; Belle, 1990). Research is notable for sex differences, with higher rates of these disorders affecting women in India and worldwide (Brown & Harris, 1978; Davar, 1995; Ponnudurai & Jaykar, 1980; Konadaram, 1983; Broadhead & Abas, 1998; Stark & Flitcraft, 1991; Koss, 1990; Leidig, 1992; Gilmartin, 1990). Our ethnographic findings indicate the substantial role of gender differences in education, employment opportunities, household and community entitlements, and particular forms of victimisation. Although such conditions render both men and women vulnerable, it is often in different ways. The mental health problems that result are typically experienced and communicated as various stressor-specific forms of tension.

Approaches to mental health policy and planning for community mental health benefit from attention to priorities defined with reference to local socio-cultural contexts. A focus on the context of these "tensions" is required to promote mental health with reference to local stressors and supports, and to complement curative mental health services for psychiatric disorders (WHO, 1984). Community development that aims to foster mental health should acknowledge gender-specific needs of women and men, and endeavour to provide more opportunities; ensure adequate infrastructure; and prevent exploitation, victimisation and domestic violence.

As a mental health study, our approach is somewhat unusual, insofar as it is concerned with non-specific mental health issues (e.g., emotional distress, subjective quality of life of poor people living in deprived conditions) and the role of poor hygiene and sanitation, population density, hutment demolition, homelessness, violence and crime—rather than rates and determinants of psychiatric disorders per se. Our concern with population mental health, however, requires such an approach to address the interests of illness prevention and health promotion, just as psychiatric epidemiological studies are required to address the interests of curative medicine and psychiatry (WHO, 2002). Our findings and our approach also show how paradigms for population health may be extended to mental health (Friedman & Starfield, 2003; Kindig & Stoddart, 2003).

Complimentary approaches to mental health research are needed to address interdisciplinary academic interests and practical needs for mental health planning. Psychiatric epidemiology is required to specify the burden of mental disorders. Ethnographic studies like this one explain afflictions and their influence on emotional experience and mental health in particular contexts. Cultural epidemiology explains how mental health problems are configured with reference to local categories and narratives of experience, meaning and behaviour (Weiss, 1997; Weiss, 2001). The formulation and development of

informed global, national, and local priorities for mental health require guidance from a complementary mix of these research orientations (Weiss et al., 2001).

New public health initiatives of the nineteenth century brought about substantial decline in deaths from infectious diseases through sanitary reform, and we now need to consider how analogous population-based measures may be adapted to promote mental health. Consider, for example, the paradigm of infectious diarrhoeal diseases; without attention to hygiene and sanitation, antibiotics can make only a limited contribution to improving population health. Similarly, although antidepressants have an important role to play in treating patients with clinical depression, they cannot directly improve difficult living conditions or tame hostile social environments that produce depression and impair mental health in other ways. Findings from this study are currently guiding a community mental health programme for Malavani, and we hope that the example of this research may also be useful in formulating local strategies for other programmes as well.

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Table I. Impact of urban afflictions affecting everyone

Problems	Experience	Implications for mental health
Migration and displacement to slum	•Decline in social status •Restricted opportunities •Broken social and cultural ties	•Hopelessness, disappointment, and demoralisation •Addictions
Poor infrastructure and bad living conditions	•Routine hassles and hardships •Compromised living styles	•Deterioration in quality of life •Adjustment problems with emotional distress
Unequal distribution of basic amenities	•Perceived injustice •Rivalry, disharmony, and conflict	•Instability, •Hostility and violence •Criminality
Demolition of housing and homelessness	•Persistent insecurity, instability •Feeling of discrimination •Social Instability	•Emotional distress •Depression •Anger and hostility
Communal and ethnic disharmony	•Poor interpersonal and social relationships, •Community violence	•Aggression and violence •Depression

Source: Field research (2000-2001)

Table II. Impact of urban afflictions mainly affecting men

Problems	Experience	Implications for mental health
Economic insecurity	•Unemployment and underemployment •Lack of family income •Lack of meaning and purpose •Apprehension about future	•Insecurity and lack of motivation •Learned helplessness •Criminality •Frustration, aggression •Domestic violence
Substance abuse and dependence	•Economic hardships •Stressful lifestyles •Disturbed social relationships	•Rejection, hostility •Antisocial behaviour •Domestic violence •Depression
Violence	•Interpersonal and social conflicts •Gang violence	•Hostility and aggression •Deterioration in quality of life
Polygamy and extramarital relations	•Disregard for marital and family responsibilities •Disruption in cultural values •Diminished social standing	•Emotional distress •Alienated social networks •Marital discord and disrupted family life

Source: Field research (2000-2001)

Table III: Impact of urban afflictions mainly affecting women

Problems	Experience	Implications for mental health
Employment of women	•Dual responsibilities of home and work •Substandard jobs and pay •Sexual exploitation	•Fatigue and weakness •Low self-esteem from menial position •Depression, emotional distress
Polygamy and infidelity	•Marital disharmony •Abandonment •Exploitation of women •Domestic violence	•Emotional distress, worthlessness, depression •Deliberate self-harm and suicide
Domestic violence	•Family disharmony •Marital disharmony •Humiliation of women	•Shame, Helplessness, humiliation •Depression •Deliberate self-harm and suicide
Inter-religious and inter-caste marriages	•In-law and household conflict •Exploitation •Abandonment •Homelessness	•Devaluation, loss of self esteem •Deliberate self-harm and suicide
Alcoholic husbands	•Domestic violence •Economic hardship •Marital discord	•Anger and hostility •Devaluation, diminished self-esteem •Depression and suicide

Source: Field research (2000-2001)

Figure 1. Streets in unsanctioned colony of Malavani during a lull in monsoon rains.

Figure 2. Woman working with her husband as cobbler.