ISSUE BRIEF | September 2022

Click here for more publications

IMHO Keshav Desiraju INDIA MENTAL HEALTH OBSERVATORY

Impact of Poverty Reduction Programs on Suicide, Mental Health and Well-being

AUTHORS
Sayali Mahashur and Tanya Nicole Fernandes

ACKNOWLEDGMENTS
Prepared with inputs from Arjun Kapoor and Amiti Varma

SUPPORTED BY
THAKUR FOUNDATION

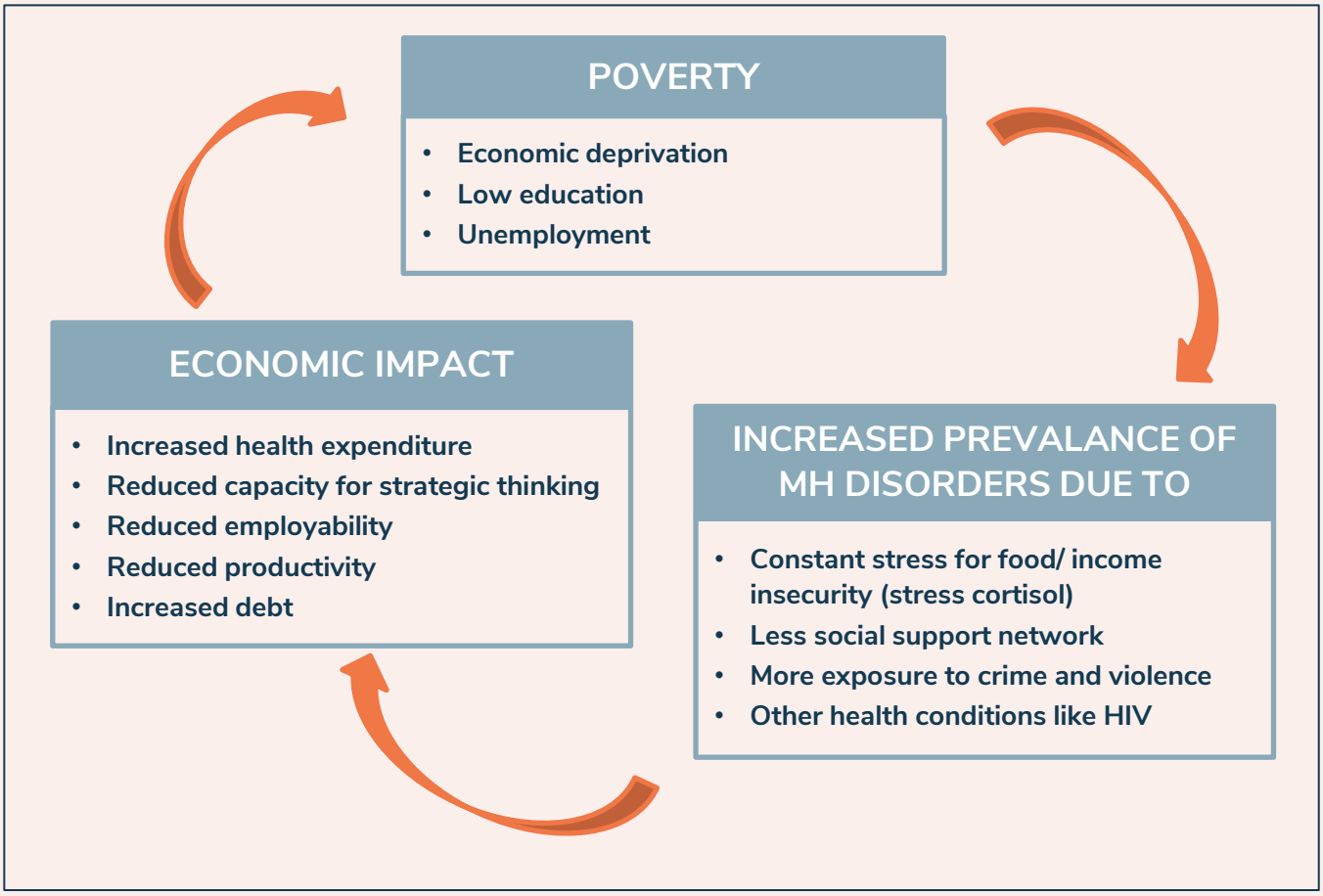
Introduction

Social, economic, and environmental inequalities are contributing factors that affect mental health and suicide. Research has shown a strong relationship between poverty and mental health. Poverty is usually characterised by prolonged periods of economic deprivation, food insecurity, poor social capital and vulnerability to violence and discrimination that have detrimental impact on mental health and well-being.[1]

In India, adopting such an approach has become increasingly urgent given the prevalence of distress among individuals experiencing poverty, marginalisation, debt, or unemployment. A closer look at the suicide rate in the country is an indication of this growing concern. The National Crime Record Bureau (NCRB) publishes data on deaths by suicide in the country. In 2021, 164,033 deaths by suicides were reported, 7% higher as compared to 2020. 7% of the reported suicides were due to poverty, unemployment, and indebtedness. [2] This is likely to be an underestimate as Rakhi Dandona and colleagues writing in The Lancet Public Health, put the number of suicides in India at ~230,000 annually from 1992-2016. [3] Another marker of distress is the prevalence of mental health conditions among the general population. In India, a case-control study in Delhi found that persons living with a severe mental illness were at higher risk of poverty due to stigma associated with their mental health conditions. [4] While more research is required in the Indian context, it is fair to assume that this issue is ubiquitous given that 197.3 million people are estimated to be living with a mental health condition in the country. [5]

The National Mental Health Policy, 2014 recognizes the inextricable link between poverty and mental illness as a negative vicious cycle that entraps many people, in some cases even leading to an intergenerational transfer of financial insecurity. Social isolation because of poor material support and inaccessible social resources or networks may lead to missed economic opportunities. Conversely, the social drift theory posits that people living with mental health conditions gradually 'drift' into poverty during the course of their lives due to reduced economic productivity, stigma and discrimination, and increased health expenditure towards to the treatment of their conditions. Figure 1 illustrates the negative cycle of poverty, mental ill health and economic instability and their reinforcing nature. [6]

Figure 1: Vicious cycle of poverty and mental ill health (adapted from World Economic Forum[1])



1. World Economic Forum. This is why mental health should be a political priority [Internet]. World Economic Forum. [cited 2022 Sep 6]. Available from: https://www.weforum.org/agenda/2021/01/poverty-mental-health-covid-intervention/

Therefore, interventions and policies that directly attenuate the effects of poverty may be promising approaches to improve overall mental health outcomes and reduce suicide risk. Anti-poverty measures have been implemented in varying forms and contexts to generate income and employment, encourage investments in education and healthcare and improve the overall quality of life of beneficiaries. Some common programmes include cash transfers which provide households with direct cash payments and microfinance schemes that disburse small loans to individuals outside the formal banking system. In this brief, we examine the impact of these poverty-reduction interventions on suicide, mental health and well-being by reviewing studies conducted on such programmes.

Cash transfers – life saving financial instruments

Cash transfer programmes are typically administered by governments to provide low-income households with direct cash payments. For this brief, we reviewed 10 studies from low and middle-income countries (LMIC) including Brazil, Indonesia, Mali, Kenya, India, Malawi, South Africa, India, and Zambia.

The studies covered both conditional as well as unconditional cash transfers that were either one-time payments or long-term transfers paid out in intervals. The period of studies included were from 2011 to 2020. In most cases, target population consisted of the poorest in the society.

Table 1: Descriptive review of literature on cash transfers

S No.	Name of the Paper	Author	Year of Publication
1	The Role of Cash Transfers in Preventing Suicides in Low- and Middle-Income Countries	Lukas Hensel	May-20
2	Effect of the Brazilian cash transfer programme on suicide rates: a longitudinal analysis of the Brazilian municipalities	Alves, Machado and Barreto	Nov-18
3	Can cash transfers prevent suicides? Experimental evidence from Indonesia	Cornelius Christian and Christopher Roth	2016
4	Discussion paper – The Impacts of Cash transfers on Mental Health and Investments: Experimental Evidence from Mali	Melissa Hidrobo, Naureen Karachiwalla and Shalini Roy	Dec-20
5	Cash transfers, maternal depression and emotional well-being: Quasi experimental evidence from India's Janani Suraksha Yojana programme	Powell-Jackson, Pereira et al.	2016
6	Government of Malawi's unconditional cash transfer improves youth mental health	Angeles et al.	2019
7	The Comparative Impact of Cash Transfers and Psychotherapy on Psychological and Economic Well-being	Johannes Haushofer et al.	2020
8	The effect of cash transfers on mental health: Opening the black box – A study from South Africa	Julius Ohrnberger, Laura Anselmi, Eleonora Fichera, and Matt Sutton	2020
9	Does alleviating poverty affect mothers' depressive symptoms? A quasi-experimental investigation of Mexico's Oportunidades programme	Emily J Ozer, Lia CH Fernald, Ann Weber, Emily P Flynn and Tyler J VanderWeele	2011
10	Does money buy happiness? Evidence from an unconditional cash transfer in Zambia	Luisa Natalia, Sudhanshu Handa, Amber Peterman, David Seidenfeld, Gelson Tembod	2018

The largest cash transfer programme in the world has been Brazil's Bolsa Família Programme (BFP). Launched in 2004, it reached 46 million Brazilians in over a decade. BFP was targeted towards extremely poor households, especially women. These households received a monthly benefit of USD 15-20 subject to fulfilment of certain health and education requirements like pre- and postnatal care, growth monitoring, immunization, and participation in nutrition education seminars. [7] A recent evaluation of BFP found an astounding 61% decrease in the risk of suicide among BFP beneficiaries compared to non-beneficiaries, showing that poverty alleviation improves socio-economic statuses and lowers suicide risk. The study proposes cash transfers provide financial stability and enable households to access health and social services. Findings from a longitudinal study on the BFP in 2018 revealed that municipalities with higher BFP coverage for longer duration significantly lowered suicide rates compared to the counterparts, specifically among women. [8]

In Indonesia, the Program Keluarga Harapan (PKH) was launched in 2007 as a conditional cash transfer programme with an objective to improve educational and health outcomes through the provision of cash transfers. On average PKH eligible households received between USD 60-220 every year (approximately 12% of their expenditure prior to PKH) The cash transfers were conditional upon fulfillment of certain criterion like prenatal check-ups, post-natal care for newborn and compulsory school attendance.[9] PKH was intended for households living in extreme poverty. At the time of its inception, these were below 80% of the poverty line. A study by Christian & Roth (2016) found that PKH reduced suicides by a probability of 15% in targeted sub-districts. The decrease in suicides was associated with the positive improvements in agriculture productivity as a result of the increased household income. [10] Similar results were also reported in Kenya, where suicide reports dropped by 18% among cash transfer recipients which were attributed to lowered stress due to curtailed agricultural losses. [11]

In addition to suicide reduction, cash transfers were also found to positively impact mental health outcomes. In Mali, the unconditional national cash transfer programme, (*Filets Sociaux*) was introduced in 2014 to reduce food insecurity. Cash transfers were initiated to households based on level of food insecurity, agricultural productivity, household size and composition, labour & employment. The result of a randomized control trial pointed to a decrease in generalised anxiety, worry for one's family, economic and food security as well as improvement in self-esteem, implying that cash transfers play a role in improving psychological well-being. [12] In Malawi, the Social Cash Transfer Programme saw a decrease of depression symptoms in youth (15-19) years, particularly among young girls. The benefits reduced dependency on hard informal labour and provided necessary social support to families. [13] In South Africa, a study on the Child Support Grant targeted to households with children in an eligible age group, found a statistically significant positive association between the cash transfers and improvements in mental health. [14] A parallel evaluation done in Zambia on similar grant for children showed an improvement in happiness among women beneficiaries associated with an increase in well-being of their children. [15] Within India, under the National Health Mission, Janani Suraksha Yojana (JSY) was started in 2005. [16] The programme provides a one-time cash payment to pregnant women if they deliver in a health facility. In Uttar Pradesh, women were provided INR 1400 in rural areas and INR 1000 in urban settings. Evidence from a quasi-experimental study showed an 8.5% reduction in maternal depression and a 36% drop in moderate depression likely to be associated with reduced debt for institutional deliveries. [17] A note-worthy finding in India given the high estimated prevalence of postpartum depression. [18]

Overall, cash transfers were found to not only reduce the incidence of suicide substantially but also improve overall health and well-being of beneficiaries particularly women, adolescents, and children.

Microfinance – the mixed impact of microloans on well-being and suicide

Another financial instrument is microfinance which refers to the provision of small "micro" loans to individuals or groups (mainly women) who do not have access to the tradition banking system. Such credit is usually used as capital for income generation activities and starting small businesses.

We reviewed 9 studies on the impact of microfinance initiatives on mental health and suicide, between 1998 to 2012. The research findings from these studies were ambivalent. In this section, we explore some of these findings and the reasons for the ambiguity in the results.

Table 2. Descriptive review of literature on microfinance

S No.	Name of the Paper	Author	Year of Publication
1	Participation in Microfinance Program and Women's mental health in South Asia: A modified systematic Review	Farhana Madhani, Susan M Jack, Catherine Tompkins, Anita Fisher	2015
2	Micro-Credit and Emotional Well-Being: Experience of Poor Rural Women from Matlab, Bangladesh	Ahmed SM, Chowdhury A, Bhuniya A	2001
3	Participation in Micro-Finance Programmes and Women's Mental Health in South Asia: A Modified Systematic Review.	Madhani F, Tompkins C, Jack S Fisher	2015
4	Can microcredit help improve the health of poor women? Some findings from a cross-sectional study in Kerala, India..	Mohindra K, Haddad S, Narayana D	2008
5	The Impact of Access to Microfinance on Mental Health.	Prince J	2014
6	Making Microfinance More Effective.	Karlan D, Mann R, Kedall J, Pande R, Suri T Zinman J	
7	India's micro-finance suicide epidemic.	Biswas S	2010
8	Does Microfinance Cause or Reduce Suicides? Policy Recommendations for Reducing Borrower Stress	Ashta A, Khan S, Otto PE	2011
9	Small individual loans and mental health: a randomized controlled trial among South African adults.	Fernald LC, Hamad R, Karlan D, Ozer EJ, Zinman J	2008

A study from Bangladesh in 2001 analyzed the emotional effects of credit support on women from poorer households and their response to stress. The study showed no significant difference in 'emotional stress' among women in the programme compared to non-recipients. Extreme difficulty in making financial ends meet was the most significant stressor for the women in the study. However, the prevalence of emotional stress was high among both micro-finance members and non-members. Although their material status had improved, there was a steady rise in emotional stress with involvement in micro-finance from the first year onward, peaking at three years and then declining. This initial emotional stress was attributed to the anxiety experienced on the receipt of the loan where women were viewed as breaking away from traditional patriarchal gendered structures, which in turn impacted their familial relationships and roles. [19] Another paper from the same study in Bangladesh found that with increased participation in the programme, there was significant positive effect on indicators related to empowerment where women were more involved in family decisions and had more physical mobility. [20]

In India, a 2008 study of self-help groups (SHG) in Kerala that facilitate micro-lending among members showed that early participation in SHGs were affiliated with less reported emotional stress. [21] Another evaluation from Rajasthan where microfinance loans were granted to the impoverished population in one of the poorest districts of India, Udaipur, reported that outstanding loans from microfinance schemes have a negative impact on mental health that was associated with increased stress and poor life satisfaction. [22] These negative results were associated with increased indebtedness and defaulting on payments. In South Africa, another study on micro-credit where people experiencing extreme poverty who were earlier rejected a loan were given access to micro-credit, showed mixed findings on their impact on stress and depressive symptoms. [23]

Evidence on the relationship between microfinance and suicide is limited. In India, a sudden spate in suicides in the state of Andhra Pradesh were speculated to be linked with outstanding micro-finance loan payments. A study by Ashta et al. in 2010 found that there was a significant positive association between suicide rates among men and microfinance which could be at attributed to divorce pressures as a result of large debt and changing gender roles in households where women are the primary borrowers. [24] Reports have also indicated that pressures from private microcredit firms may have in fact led to suicides in some states. [25]

As has been already observed, the impact of microfinance on mental health and suicide is unclear and limited. In many cases, this may be due to constraints in the studies conducted. Most studies that do report negative associations have stated that the stressors associated with debt and loan repayments may be responsible for the poor mental health outcomes. In a study conducted in West Bengal in 2008 with Village Financial Services, a microfinance institute based in eastern India, researchers found that by merely changing the payment schedule of microloans from a weekly to monthly basis, clients reported significantly less feelings of worry, anxiety, and tension. [26] Modifying the terms of microlending therefore could address some of the stress and worry associated with loan repayment.

.

Conclusion

Our review is focused on cash transfers and microfinance programmes for prevention of suicide and better mental health outcomes especially in the poorer population. There are, however, myriad financial inclusion interventions beyond cash transfers and microfinance programmes. Asset transfer interventions are another example of financial inclusion programmes, where households are provided a 'productive asset' that generates income which is later deposited in a savings account. The Targeting Hard Core Poor program (THP) run by the non-profit Bandhan in West Bengal is one such intervention that showed improvements in beneficiary's mental health with increased levels of self-reported happiness. [27] Similarly, existing government-run poverty alleviation programmes such as the National Rural Employment Guarantee Scheme (NREGS) have some psychological benefits particularly for the reduction in depressive symptoms among rural women. [28] In-depth qualitative research is required to understand the multiple intricate pathways through which such interventions influence and impact mental health, well-being, and suicide risk.

From our review, we conclude the positive benefits of cash transfers on mental health and suicide are indisputable. In many cases, the magnitude of impact of cash transfers on reducing suicide rates is significant, including when compared to other mental health interventions given that a large part of mental health conditions in low-and-middle-income countries in India are a result of poverty. This firmly supports the social determinants and intersectoral approach to improving mental health and reducing suicide rates. In contrast, while microfinance initiatives have improved the economic position of many households, they have also increased the emotional stress to beneficiaries in some cases due to the stress related to the repayments. However, findings from our review also suggest that stressors can be decreased dramatically by curtailing predatory lending and easing repayment conditions.

Thus, we conclude that direct cash transfer payments are a life-saving instrument that has the potential to prevent suicides and improve mental and well-being. A cash transfer trial was conducted in Chennai, Tamil Nadu, India during the peak of COVID pandemic in 2020-2021 in partnership with SCARF, India (Schizophrenia Research Foundation), the results of which are awaited. Further research specific to the Indian context will help policymakers take informed decisions towards the implementation of such programmes to improve the health and quality of life for individuals and communities. [29] In the Indian context, though, budgetary deficits and administrative bottlenecks seem to be the main argument against direct cash transfers to households. The reluctance stems from concerns around the paucity of funds with state and district level institutions and their lack of ability to monitor the transfer of such funds. While the debate has evolved over the years, the key problems persist [30] Further, reliable data on population socio-economic demographics and prevalence of mental health disorders and suicide risk will have to collected to determine the target populations for such programmes.

References

1. World Health Organisation. Social Determinants of Mental Health. In: Social Determinants of Mental Health [Internet]. [cited 2022 Apr 25]. Available from: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf
2. National Crimes Records Bureau. Accidental Deaths & Suicides in India 2020 [Internet]. 2020 [cited 2021 Dec 9]. Available from: https://ncrb.gov.in/sites/default/files/ADSI_2020_FULL_REPORT.pdf
3. Dandona R, Kumar GA, Dhaliwal RS, Naghavi M, Vos T, Shukla DK, et al. Gender differentials and state variations in suicide deaths in India: the Global Burden of Disease Study 1990–2016. Lancet Public Health. 2018 Oct 1;3(10):e478–89.
4. Trani JF, Bakhshi P, Kuhlberg J, Narayanan SS, Venkataraman H, Mishra NN, et al. Mental illness, poverty and stigma in India: a case–control study. BMJ Open. 2015 Feb 21;5(2):e006355.
5. Sagar R, Dandona R, Gururaj G, Dhaliwal RS, Singh A, Ferrari A, et al. The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990–2017. Lancet Psychiatry. 2020 Feb 1;7(2):148–61.
6. Fox JW. Social class, mental illness, and social mobility: the social selection-drift hypothesis for serious mental illness. J Health Soc Behav. 1990 Dec;31(4):344–53.
7. Machado D, Williamson E, Pescarini J, Rodrigues L, Alves FJO, Araújo L, et al. The Impact of a National Cash Transfer Programme on Reducing Suicide: A Study Using the 100 Million Brazilian Cohort [Internet]. Rochester, NY: Social Science Research Network; 2021 Jan [cited 2021 Dec 7]. Report No.: ID 3766234. Available from: https://papers.ssrn.com/abstract=3766234
8. Alves FJO, Machado DB, Barreto ML. Effect of the Brazilian cash transfer programme on suicide rates: a longitudinal analysis of the Brazilian municipalities. Soc Psychiatry Psychiatr Epidemiol. 2019 May 1;54(5):599–606.
9. Nazara S, Rahayu SK. Program Keluarga Harapan (PKH): Indonesian Conditional Cash Transfer Programme. Cent Incl Growth. 2013 Oct;6.
10. Christian C, Roth C. Can Cash Transfers Prevent Suicides? Experimental Evidence from Indonesia. SSRN Electron J. 2016 Jan 1;
11. Haushofer J, Shapiro J. Policy Brief: Impacts of Unconditional Cash Transfers∗ [Internet]. 2013 [cited 2022 May 27]. Available from: https://www.semanticscholar.org/paper/Policy-Brief%3A-Impacts-of-Unconditional-Cash-Haushofer-Shapiro/97cf4b53ac004073a6e459cf7bc96fc30edc9f82
12. Hidrobo M, Karachiwalla N, Roy S. The impacts of cash transfers on mental health and investments: Experimental evidence from Mali [Internet]. 0 ed. Washington, DC: International Food Policy Research Institute; 2020 [cited 2021 Dec 9]. Available from: https://ebrary.ifpri.org/digital/collection/p15738coll2/id/134223

References

13. Angeles G, de Hoop J, Handa S, Kilburn K, Milazzo A, Peterman A. Government of Malawi's unconditional cash transfer improves youth mental health. Soc Sci Med. 2019 Mar 1;225:108–19.

14. Ohrnberger J, Anselmi L, Fichera E, Sutton M. The effect of cash transfers on mental health: Opening the black box – A study from South Africa. Soc Sci Med. 2020 Sep 1;260:113181.

15. Natali L, Handa S, Peterman A, Seidenfeld D, Tembo G. Does money buy happiness? Evidence from an unconditional cash transfer in Zambia. SSM - Popul Health. 2018 Apr 1;4:225–35.

16. Janani Suraksha Yojana :: National Health Mission [Internet]. [cited 2021 Dec 10]. Available from: https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309

17. Powell-Jackson T, Pereira SK, Dutt V, Tougher S, Haldar K, Kumar P. Cash transfers, maternal depression and emotional well-being: Quasi-experimental evidence from India's Janani Suraksha Yojana programme. Soc Sci Med 1982. 2016 Aug;162:210–8.

18. Upadhyay RP, Chowdhury R, Aslyeh Salehi, Sarkar K, Singh SK, Sinha B, et al. Postpartum depression in India: a systematic review and meta-analysis. Bull World Health Organ. 2017 Oct 1;95(10):706-717C.

19. Ahmed SM, Chowdhury A, Bhuiya A. Micro-Credit and Emotional Well-Being: Experience of Poor Rural Women from Matlab, Bangladesh. World Dev. 2001 Nov 1;29:1957–66.

20. Madhani F, Tompkins C, Jack S, Fisher A. Participation in Micro-Finance Programmes and Women's Mental Health in South Asia: A Modified Systematic Review. J Dev Stud. 2015 Aug 14;51:1–16.

21. Mohindra K, Haddad S, Narayana D. Can microcredit help improve the health of poor women? Some findings from a cross-sectional study in Kerala, India. Int J Equity Health. 2008 Jan 10;7:2.

22. Prince J. The Impact of Access to Microfinance on Mental Health. undefined [Internet]. 2014 [cited 2022 May 26]; Available from: https://www.semanticscholar.org/paper/The-Impact-of-Access-to-Microfinance-on-Mental-Prince/480c306a34092b0bb9b31b43b59e6c843b7cf4d8

23. Fernald LC, Hamad R, Karlan D, Ozer EJ, Zinman J. Small individual loans and mental health: a randomized controlled trial among South African adults. BMC Public Health. 2008 Dec 16;8:409.

24. Ashta A, Khan S, Otto PE. Does Microfinance Cause or Reduce Suicides? Policy Recommendations for Reducing Borrower Stress [Internet]. Rochester, NY: Social Science Research Network; 2011 Mar [cited 2022 May 26]. Report No.: 1715442. Available from: https://papers.ssrn.com/abstract=1715442

References

25. Biswas S. India's micro-finance suicide epidemic. BBC News [Internet]. 2010 Dec 16 [cited 2022 May 27]; Available from: https://www.bbc.com/news/world-south-asia-11997571

26. Karlan D, Mann R, Kendall J, Pande R, Suri T, Zinman J. Making Microfinance More Effective. Harvard Business Review [Internet]. 2016 Oct 5 [cited 2022 May 27]; Available from: https://hbr.org/2016/10/making-microfinance-more-effective

27. Banerjee A, Duflo E, Chattopadhyay R, Shapiro J. The Long term Impacts of a " Graduation " Program : Evidence from West Bengal [Internet]. 2016 [cited 2022 May 27]. Available from: https://www.semanticscholar.org/paper/The-Long-term-Impacts-of-a-%E2%80%9C-Graduation-%E2%80%9D-Program-%3A-Banerjee-Duflo/18fd1175767b8de37db202d9482bdbe54b66e748

28. Tsaneva M, Balakrishnan U. The Effect of a Workfare Programme on Psychological Wellbeing in India. J Dev Stud. 2019 Dec 2;55(12):2593–609.

29. Rao G, Schilbach F, Carney K, Ho L, Karandikar A, Ramanathan S, et al. Cash transfers and psychological support to address mental health impacts of Covid-19 in India | The Abdul Latif Jameel Poverty Action Lab [Internet]. The Abdul Latif Jameel Poverty Action Lab (J-PAL). 2020 [cited 2022 May 27]. Available from: https://www.povertyactionlab.org/evaluation/cash-transfers-and-psychological-support-address-mental-health-impacts-covid-19-india

30. India and Cash Transfers - India's Universal Basic Income: Bedeviled by the Details [Internet]. Carnegie India. [cited 2022 Sep 7]. Available from: https://carnegieindia.org/2018/02/14/india-and-cash-transfers-pub-75503