

BINDURA UNIVERSITY OF SCIENCE EDUCATION



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**Socio-Economic Factors contributing to Depression among Healthcare Workers at
Sanyati Baptist Mission Hospitals.**

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**A Dissertation Submitted in Partial Fulfillment of the Requirements of the Bachelor of
Science Honors in Safety Health and Environmental Management Degree.
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DECLARATION

I Chikanara Scenara (B220090B), declare that this dissertation titled, “Socio-Economic Factors contributing to Depression among Healthcare Workers at Sanyati Baptist Mission Hospitals,” is my original work and all sources cited are listed in a comprehensive list of references.

Student Signature



Date 30/05/25

Supervisor Approval

This research project meet faculty standard for submission, having been verified for compliance with all relevant faculty guidelines.

Signature of supervisor

Date 30 JUNE 225



Signature of faculty chairperson

30 JUNE 2025

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DEDICATION

I devote this study to treasured family Mrs Chikanara, my sibling in appreciation for their continuous support during my academic endeavours. Not forgotten my late Brother (Mr. Lazarus Kavhayi).

ABSTRACT

Depression among healthcare workers poses a significant challenge, particularly in resource-constrained settings such as Sanyati Baptist Mission Hospitals in Zimbabwe. This study examines the socioeconomic factors contributing to depression among healthcare workers at Sanyati Baptist Mission hospitals. Data was collected through structured questionnaires and key informant interviews with healthcare workers. Both descriptive and inferential statistics were analysed using IBM SPSS to identify common socioeconomic stressors associated with depressive symptoms. The findings indicate a notable prevalence of depression among healthcare workers at Sanyati Baptist Mission Hospital, largely attributed to inadequate remuneration, higher living costs and high workloads, loss of loved ones, divorce and lack of social support systems. Financial strain was the dominant factor contributing to depression, with low wages and economic instability exacerbating stress and a hopelessness feeling. Unavailability of mental health resources and counselling services further deepened the risk of depression, as did increased workloads. The study also highlighted lack of awareness and societal stigma as major factors in underreporting of depression cases and the need for urgent targeted interventions including improved compensation, enhanced access to mental health support and the establishment of robust employee assistance programmes. The study conclude that comprehensive policy and institutional reforms are necessary to support mental health of healthcare workers to significantly reduce the risk of depression. In addition, addressing the socio-economic determinants is important to mitigate depression, improve the healthcare workers well-being and ensure the delivery of quality patient care in rural Zimbabwean hospitals.

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List of acronyms

OPD	: Out Patient's Department
DEHO	: District Environmental Health Officer
DMO	: District Medical Officer
IBM SPSS	: Statistical Package for Social Sciences
WHO	: World Health Organization.

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Depression is a common and debilitating mental illness that affects people worldwide, regardless of their occupational (Broadhead *et al.*,2001). The World Health Organization, estimates that approximately 300 million people suffer from depression (WHO,2015). According to WHO (2023), 31,4% of the healthcare workers in Africa reported having symptoms of depression in 2023, while the combined prevalence of depression among sub-Saharan Africa healthcare workers is estimated to be 24%. In Zimbabwe, 45.8% of healthcare workers are reported to have symptoms of mental health disorders including depression by 2019 (Mugari, 2024). These statistics show prevalence in mental health issues which were reported and documented while a lot of mental health cases in Zimbabwe and Africa go unreported and undocumented due to various factors including lack of awareness, stigma, and social norms (Mudzonga,2022).

Healthcare workers, are particularly vulnerable to depression because of the particular demands and difficulties associated with their line of work, which includes caring for and supporting patients (Shabani *et al.*,2024). Furthermore, during the COVID-19 pandemic, healthcare workers were found to be at high risk of psychological distress; this trend is still unclear in the post-pandemic environment (AlFahhad,2018). The ongoing pressure of regular epidemic prevention and control has overshadowed the mental well-being of these workers (AlFahhand,2018).

Zimbabwe's economic landscape, characterized by high inflation rate and currency instability, has further compounded the issue, resulting in limited job opportunities (Shabani *et al.*,2024). Health care workers often struggle with financial difficulties due to low wages and rising cost of living (Nyandoro & Mudzonga,2022; Phiri *et al.*,2020). The economic hardships can lead to increased stress, anxiety, and hopelessness, all of which are risk factors of depression (WHO,2023). In Zimbabwe, many healthcare workers live below the poverty line and receive poor remuneration (Nyandoro & Mudzonga,2022). The poor wages make it difficult for workers to meet their basic needs, as a result they are financially strained, in debt and living a low quality life (Duke,1978). The constant struggle to make ends meet and the financial stress associated with it contribute to frustration, despair and depression (Nyandoro,2018a). Limited access to counselling services, employee assistance programs, and mental health resources

leaves healthcare workers, without necessary support to cope with work related stressors and personal changes (Mudzonga, 2022; Muposha, 2023). Lack of supportive work environment can contribute to feelings of isolation and contribute to the onset of depressive symptoms (Mudzonga,2022).

Sanyati Baptist Hospital, in the Sanyati district of Zimbabwe, is no exception to various challenges the health sector and the country at large is facing (Nhapi,2019). Understanding the socio-economic factors that contributing to depression among healthcare workers is essential for creating effective support systems and intervention (Nhapi,2019). In Zimbabwe, socio-economic factors that contribute to depression including in healthcare workers, reflecting the challenging economic conditions and work ecosystem in the country (Nhapi,2019; Sibanda *et al.*,2015). High inflation rates, increased cost of living, poor remuneration and higher workloads have a substantially impact the mental health and well-being of health care workers leading to increased rates of depression (Mungai,2016; Viseu *et al.*,2018a).

Sanyati Baptist hospitals offer a wide range of general medical and surgical services with a focus on areas like maternal/child health, HIV/AIDS treatment, and community health outreach. The hospitals are important referral centres for the surrounding rural communities and play a vital role in improving healthcare access and outcomes in this region of Zimbabwe (Duke,1978). For over 60 years, the hospitals are an important part of the country's broader healthcare infrastructure, particularly in underserved rural areas, with the hospitals' faith-based approach and community engagement also making them an important social institution in the region (Mudzonga,2022). Although being critical in providing health care, the hospitals have overlooked the provision of mental healthcare services to their catchment areas (Mudzonga,2022), hence a research into socio economic factors leading to depression will go a long way in understanding depression and establishing a mental health unit at the hospitals for the community and health workers. The research is also essential in addressing some, if not all, of the factors that can lead to depression to both the community and healthcare workers as Sanyati Baptist is a mission hospital with deep roots in the community.

1.2 STATEMENT OF THE PROBLEM

Depression among healthcare workers has become a serious problem, especially in areas with limited resources like Sanyati Baptist Mission Hospitals. Healthcare workers frequently deal with a variety of socioeconomic difficulties that can exacerbate mental health conditions, despite their crucial role in providing care. There are no certified mental health professionals at the hospital, despite the fact that a number of mental health conditions, such as depression, anxiety, bipolar disorder, post-traumatic stress disorder, and phobias (Nyashanu *et al.*,2020). Rising levels of depression among healthcare workers at Sanyati Baptist Mission Hospital present a pressing concern that could compromise the delivery of quality care (Mungai,2016) The implications are far-reaching, as depression can lead to decreased motivation (Broadhead *et al.*, 2001), concentration difficulties (Mungai,2016), reduced empathy, and burnout (Machisa & Shamu,2022), all of which hinder the delivery of patient-centred care and compromise healthcare outcomes. Therefore, it's critical to identify socioeconomic factors that contribute to depression in healthcare workers in order to lower the risk of depression and enhance the standard of care.

1.3 AIM

To explore the socio-economic factors contributing to depression among healthcare workers at Sanyati Baptist Mission Hospitals.

1.4 OBJECTIVES

1. To determine the key socio-economic factors contributing to depression among healthcare workers at Sanyati Baptist Hospitals.
2. To examine the relationship between key contributing socio economic factors and risk of depression among healthcare workers at Sanyati Baptist Mission Hospitals.

1.5 RESEARCH QUESTIONS

1. What are the key socio economic factors contributing to depression among healthcare professionals at Sanyati Baptist Hospitals?
2. Is there any relationship between key contributing socio-economic factors and risk of depression among healthcare workers at Sanyati Baptist Mission Hospitals?

1.6 JUSTIFICATION OF THE STUDY

This study, is crucial for the mental health of healthcare workers because it examines depression among those employed at Sanyati Baptist Mission Hospitals. This study aims to support healthcare professional's mental health in order to enhance their work environment, job satisfactory, and ultimately the quality of care they provide to the patients. Long-term cost-effectiveness and resource optimization are also achieved by addressing these problems, in addition to fulfilling ethical commitments to healthcare providers and constructing easily accessible mental healthcare facilities in development countries. In addition, the findings of this study can help better understanding the mental health of healthcare workers and could be relevant to similar healthcare settings in Zimbabwe and other parts of Africa that deals with similar issues. Gain advantages for the workforce and other stakeholders.

CHAPTER 2: LITERATURE REVIEW

2.1 PREVALENCE OF DEPRESSION AND MENTAL HEALTH IN AFRICA

Depression is a severe mental illness characterized by a variety of physical and mental symptoms, including a sense of worthlessness, diminished interest in once-enjoyed activities, and persistent sadness. Healthcare workers are among those from a variety of backgrounds who are affected (Mungai, 2016; WHO,2015).

People of all ages, genders, and socioeconomic background are impacted by the urgent global concern of depression and mental health. Depression affects more than 264 million people worldwide and is one of the main causes of disability (WHO,2023). Globally people, communities, and healthcare system face major challenges as a result of the recent rise in the prevalence of depression (Whisman et al.,2021).

The issue of depression and mental health is a complex nature of mental health disorders like depression is one of the main causes of their high prevalence. Numerous biological, psychological, and socioeconomic factors can interact in complex ways to cause mental health disorders(WHO,2020). Chronic stress (Sibanda et al.,2015), traumatic life events (Mungai,2016), Chemical imbalances in the brain (Folb et al.,2015), genetic predispositions (Charlson et al.,2014) and environmental factors can all lead to the onset and worsening of mental health issues (Whisman et al.,2021).

Depression and other mental health conditions can have a major influence on a person's capacity to perform well in a variety of sphere of life, including relationships, employment, and general well-being (Mugari, 2024.This can result in a lower quality of life (Broadhead et al.,2001), strained interpersonal relationship (Charlson et at.,2014), and decreased productivity. Additionally, a vicious cycle of escalating health problems is created when mental health disorders coexist with other physical health conditions like diabetes, chronic pain, and cardiovascular diseases(AlFahhand,2018). Healthcare workers frequently deal with particular difficulties and stressors in their line of work, the prevalence of depression is especially high among them (Folb et al.,2015).

Healthcare workers who work in environments with limited resources, like mission hospitals, are even more susceptible to the adverse effects of socio-economic factors that can lead to depression (Folb *et al.*, 2015). Mission hospitals, like the Sanyati Baptist Mission Hospitals, operate in environments where resources are limited, and healthcare workers frequently encounter challenging circumstances. These settings are often located in remote or rural areas, where access to basic amenities, social support systems, and mental health services may be scarce (Gold,2015). The socioeconomic condition that are common in these setting can increase the likelihood that healthcare workers will experience depression, which could jeopardize both their personal health and the standard of care they offer patients

In Africa, depression and mental health issues are major public health concerns, and Zimbabwe is no exception. The evidence that is currently available presents a troubling picture, despite the fact that precise data on prevalence of these conditions can be challenging to obtain for variety of reasons including stigma, a lack of funding for research, and insufficient mental health services (He et al.,2022). The world health Organization estimates that by 2017, about 5% of Africans aged fifteen and older suffered from depression(WHO,2023). However, because of underdiagnoses and underreporting, this number might not accurately reflect the true scope of the issue. Studies have shown that the prevalence of depression varies greatly in Zimbabwe, with estimates ranging from 4.5% to 25.8% and a pooled prevalence of 13.2%. Approximately 18% of Zimbabwean adults between the ages of 18 and 49 report having symptoms of anxiety or depression (WHO,2023)

Increased stress and susceptibility to metal health problems can be caused by socioeconomic difficulties, including poverty, unemployment, lack of access to healthcare, and other socioeconomic determents(WHO,2023).For both those directly impacted and those who care for them, conflicts ,political unrest, and the HIV/AIDS pandemic have been associated with a higher risk of depression (Ward et al.,2013) Furthermore, cultural beliefs and stigma surrounding mental health disorders in some African societies may perpetuate reluctance to seek professional help, leading to under diagnosis and inadequate treatment (Ward et al., 2013).

2.2. SOCIETAL STIGMA ON DEPRESSION

In Africa, societal stigma toward depression continues to be a major obstacle to getting the help and support they need (Broadhead et al.,2001; Mugari,2024; Ward et al.,2013). This stigma is deeply rooted in cultural beliefs, misconceptions, and a lack of knowledge about mental health issues are the main causes of this stigma (Maunganidze, 2016).

In many African societies, depression is often viewed through the lens of traditional and cultural beliefs, which can perpetuate stigma and discrimination especially to the male members of society who perceived to be always strong (Maunganidze.,2016). These beliefs can lead to the perception that depression is caused by personal feelings or moral deficiencies, rather than being recognized as medical conditions that require professional treatment and support (Maunganidze.,2016; Mugari.,2014). Furthermore, the stigma surrounding depression in Africa is exacerbated by lack of awareness and education about the nature and prevalence of mental disorder (WHO,2020).

2.3 FACTORS LEADING TO DEPRESSION

A complex web of interrelated factors, broadly classified as biological, psychological, and environmental /social determinants, frequently contribute to the development of depression (Shadrina et al., 2018). These factors can interact and compound one another, increasing an individual's vulnerability to experiencing depressive episodes (WHO ,2015). It is crucial to understand these underlying contributors to develop effective prevention and intervention strategies.

2.3.1 BIOLOGICAL FACTORS

One of the most researched topic in psychiatric research is the complex interplay between biological factors and depression, which reveals a complex interplay of physiological, neurochemical, and genetic components that contribute to the development of this common mental health condition (Shadrina et al., 2018). Numerous studies have shown that people who have a family history of depression or other mood disorders are much more likely to experience similar condition themselves. In fact, some research indicates that about 40% of vulnerability to major depressive disorder may be due to genetic factors (Shadrina et al.,2018) This genetic predisposition operates through various mechanisms, including the inheritance of genes that influence neurotransmitter function, stress response system, and neural circuit development, all of which can affect an individual's susceptibility to depressive episodes (Liu et al., 2018).

The role of neurotransmitter systems in depression has been a cornerstone of biological psychiatry since the mid-20th century. The monoamine hypothesis of depression, which focuses on the function of key neurotransmitters like serotonin, dopamine, and norepinephrine, has significantly advanced our understanding of mood regulation and led to the development of various antidepressant medications (WHO,2015). These chemical messengers play crucial roles in multiple aspects of psychological functions, including mood, motivation, pleasure, and emotional processing (Liu *et al* ,2018). Disruptions in these neurotransmitter systems can manifest in various ways, from altered neurotransmitter production and release to changes in receptor sensitivity and reuptake mechanics, ultimately contributing to the complex symptomatology of depression (Alves et al.,2017).

Recent advances in neuroscience that go beyond traditional neurotransmitter theories. Research has revealed the significance of neuroplasticity, neurogenesis, and structural changes in the brain are important in the development and maintenance of depressive disorder (Alves *et al.*,2017). According to Alves et al. (2017), these structural and functional changes that affect cognitive function, stress response, and emotional processing may make the classic symptoms of depression worse. Additionally, the role of inflammation and immune system dysfunctions has emerged as an important area of study, with evidence suggesting that inflammatory processes can influence neurotransmitter function and neural circuit activity, potentially contributing to the development of depressive symptoms (Chang et al.,2020).

2.3.2 PSYCHOLOGICAL FACTORS

The intricate relationship between psychological factors and depression is a crucial part of understanding mental health because it highlights how individual differences in personality, cognitive processes, and emotional processing can significantly affect a person's vulnerability to depressive disorder (Chang *et al.*,2020). Certain cognitive styles and psychological traits have been repeatedly shown in research to either predispose or protect against depression (Ward *et al.*, 2013,). A higher risk of getting depression has been closely associated with personality traits like neuroticism, which is defined by a propensity to feel unpleasant emotions more intensely and frequently (Gold,2015). The maintenance of emotional well-being is also frequently more difficult for people who are perfectionist or who have high levels of self-criticism since these characteristics can result in enduring feelings of failure and inadequacy, even in the face of apparent accomplishment (Chang et al.,2020;Shadrina et al.,2025).

The role of cognitive patterns and thought processes in depression has been extensively studied through the lens of cognitive psychology and behavioural theories. Negative cognitive schemas, which are deeply ingrained patterns of thinking about oneself, the world, and the future, can significantly impact how individuals interpret and respond to life events (Gold, 2015). These cognitive distortions often manifest as automatic negative thoughts, catastrophizing, overgeneralization, and black-and-white thinking. When these maladaptive thought patterns become habitual, they create a self-reinforcing cycle where negative interpretations of events lead to low mood, which in turn confirms and strengthens the negative beliefs (Gold, 2015). This cognitive vulnerability can be particularly problematic when individuals face life stressors or challenges, as it can impair their ability to develop and implement effective problem solving strategies (Ford et al., 2016).

Coping mechanisms and emotional regulation strategies play a crucial role in determining how individuals manage stress and negative emotions, ultimately influencing their susceptibility to depression (Marazziti et al., 2021). People who rely heavily on avoidant coping strategies, such as denial, substance use, or behavioural disengagement, often experience more significant psychological distress compared to those who employ more adaptive coping mechanisms (Liu et al. 2018). Effective emotional regulation involves the ability to identify, understand, and modulate emotional response appropriately. When these skills are underdeveloped or impaired, individuals may struggle to process and manage difficult emotions, leading to increased vulnerability to depressive symptoms (Chang et al., 2020). The development of healthy coping strategies and emotional regulation skills is often a key focus in therapeutic interventions for depression.

It is impossible to ignore how early experience and trauma affect psychological development and the results that follow in terms of mental health. Childhood trauma can have significant impacts on a person's psychological development and mold their perceptions of themselves and their relationships with others. This includes sexual abuse, emotional neglect, physical abuse and exposure to domestic violence (Guan et al., 2022). These adverse childhood experiences can lead to the formation of maladaptive core beliefs and attachment patterns that persist into adulthood, creating vulnerability to depression and other mental health challenges (Machisa & Shamu, 2022). The psychological impact of trauma often manifests through disrupted emotional regulation, difficulty forming and maintaining healthy relationships, and persistent feelings of worthlessness or shame (Machisa & Shamu, 2020).

2.3.3 ENVIRONMENTAL AND SOCIAL ECONOMIC FACTORS

The significant influence of social and environmental factors on mental, especially in the onset and progression of depression is crucial for depression studies. These outside factors show the deep interaction between people and their social settings by generating a complex web of situations that can either prevent or trigger depressive episodes (Machisa & Shamu ,2020). Through a variety of pathways ; such as physiological stress responds ,altered cognitive processing , and disrupted social support systems , the cumulative ,effect of multiple environment stressors from acute life events to chronic ongoing challenges can have a significant impact on psychological well-being (Marazziti et al.,2021).This knowledge highlights how crucial it is to take into account the larger social and environmental context when analysing mental outcomes.

Major life events and transitions represent significant environmental triggers that can precipitate depressive episodes, even in individuals who may not have previously experienced mental health challenges (Shabani *et al.*,2024). These events, often termed “psychological earthquakes,” (Sultana et al.,2023), can fundamentally disrupt an individual’s sense of stability and security. The death of a loved one, divorce or relationship breakdown, jobless, or serious illness can challenge existing coping mechanics and overwhelm psychological resources (Charlson et al.,2015). The impact of these events is often compounded by their ripple effects across various life domains –for instance financial hardship following job loss might lead to housing insecurity, relationship strain and reduced access to healthcare, creating a cascade of stressors that can overwhelm individual’s capacity for resilience.

Chronic stress,particularly in the context of moden society,represents a pervasive environmtal factors factors that significantly influence mental health outcomes.The sustained pressure of work-related demads,family responsibilites,finacial constraints,and other ongoing challenges can create a state of persistent physiological and pyschological arousal that taxes both physical and mental resources(Marazziti et al.,2021).This chronic activation of stress responses systems can lead to allostatic load,affecting various biological systems and increasing vulnerability to depression(Viseu et al.,2018a).The moden worplace,with its emphasis on productivity,constant connectivity,and work-life integration,can create particuraly challenging condition that contribute to chronic stress.Similarly,ongoing family confics,caregiving responsibilities or persistent financial instability can create sustained pressure thr erodes psychological well-birng over time (Gold,2015).

The social environment, including the quality and extent of interpersonal relationship and support networks, plays a fundamental role in depressing outcomes. Social isolation and loneliness have emerged as significant risk factors for depression, particularly in contemporary society where traditional community structures have often been eroded by urbanization, technological change, and shifting social patterns (Nyandoro, 2018a). The absence of meaningful social connections can deprive individuals of emotional support, practical assistance, and opportunities for positive social interaction, all of which serve as protective factors against depression (Nyandoro, 2018a). Furthermore, the quality of existing relationships can significantly impact health with toxic relationships, whether in family, romantic, or professional contexts, can create chronic stress and emotional trauma that contribute to depressive symptoms (Maposha, 2023).

Socioeconomic factors and systemic inequalities represent crucial environmental determinants of mental health that operate at both individual and community levels. Poverty, in particular, creates a complex web of challenges that can significantly impact psychological well-being (Nyandoro & Gold, 2015; Phiri et al., 2020). Limited access to resources, including healthcare, education, and stable housing, can create chronic stress and reduce opportunities for positive life experience (Phiri et al., 2020). Additionally, living in economically disadvantaged areas often exposes individuals to higher levels of environmental stressors, such as crime, pollution, and inadequate infrastructure (Nyandoro & Gold, 2015; Phiri et al., 2020). Discrimination, whether on the basis of sexual orientation, gender, race, ethnicity, or other characteristics, can cause trauma and chronic stress that have a major negative influence on mental health outcomes (Gold, 2015; Marazziti et al., 2021). These systemic inequalities often intersect and compound each other, creating particularly challenging circumstances for vulnerable populations.

CHAPTER 3: METHODOLOGY

3.1 STUDY AREA DESCRIPTION

The study was carried out in ward 11 of at Sanyati Baptist Mission hospital with geographic coordinates, latitude of -17.5791296 and longitude of 29.30716, Sanyati District in Mashonaland West province of Zimbabwe (Figure 3.1). Sanyati Mission Baptist hospital is deep routed in the Sanyati growth point community that include Baptist Mission Church and an Orphanage.

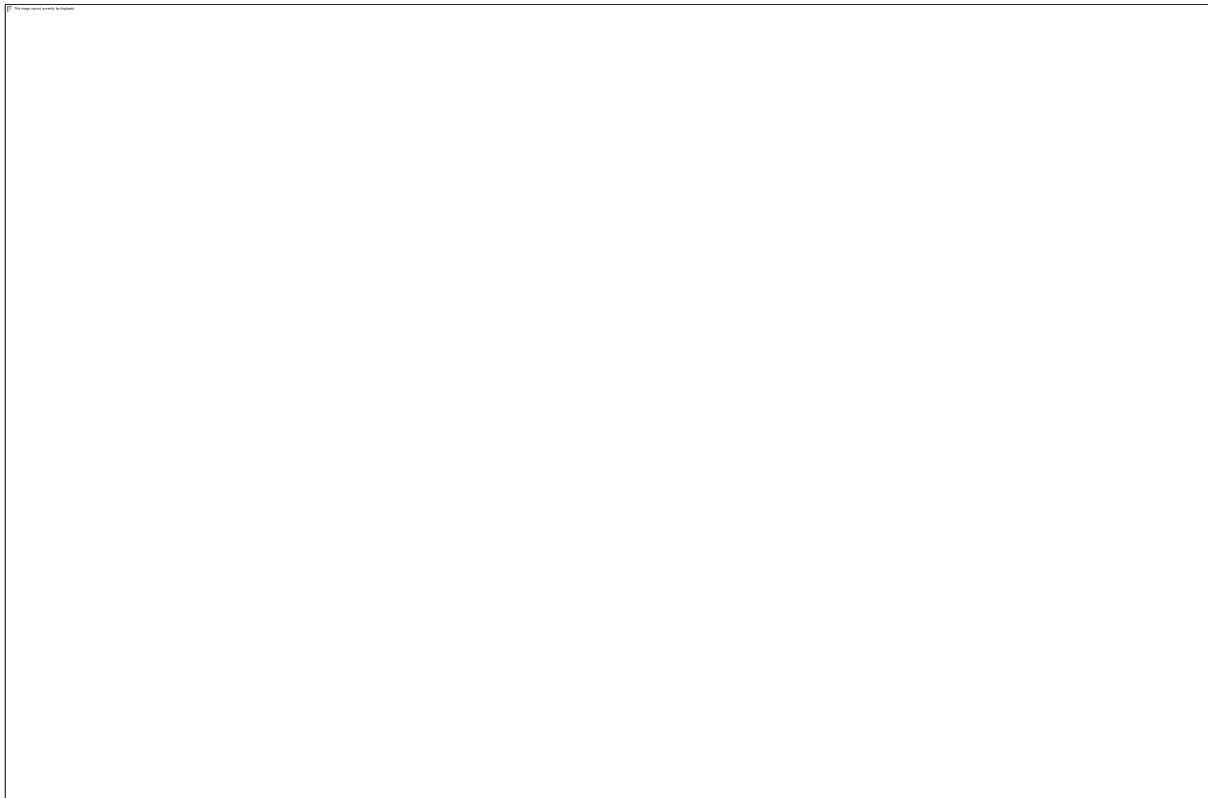


Figure 3.1 Sanyati Baptist Location Map

RESEARCH DESIGN

A qualitative research design was employed for this study for both key informants and individuals. A qualitative research design is an approach that seeks to deeply understand human experiences, behaviours, and social phenomena by collecting and analysing non-numerical data such as questionnaires to determine the prevalence of depression and socio economic factors leading to depression in healthcare workers. In this research, qualitative data such as individual economic status, job security, housing satisfaction, indicators of depression in the last fortnight, and socio economic factors leading to depression were collected. Questionnaires were used in this study as they are important tools in allowing standardized, efficient, and systematic data collection from large groups (Appendix 2, Appendix 3). This makes it possible to identify patterns and relationships between factors such as income, job role, and work environment with depressive symptoms. Their anonymity encourages honest responses about sensitive issues, and the quantitative data collected enable researchers to conduct analyses that reveal direct and indirect contributors to depression. Ultimately, findings from questionnaire-based studies support evidence-based policymaking and the development of targeted mental health interventions for healthcare staff.

3.2 STUDY POPULATION

The population for the study comprised of hospital administration, chaplaincy, doctors, nurses, nurse aides, laboratory technicians, pharmacists, cooks, maintenance staff, ambulance technicians, sanitary staff, morticians, therapists, social workers and volunteers and the population size was 196. The population was distributed in the following departments; 5 in the outpatient's department, 8 laboratory department, 15 maternity department, 8 school of nursing, 7 maintenance department, 10 laundry department, 7 Family child health, 4 central suppliers' sterile department, 6 mortuary department, 81 medical wards, 5 kitchens, 4 health information department, 5 dental departments, 3 x-ray, 5 pharmacy department, 12 administration department, 11 doctor's consultation. However, some healthcare workers overlapped different departments.

3.3 SAMPLE SIZE

The sample was calculated using Thrusfield (2007) formula.

$$n = \frac{z^2 \times p \times (1 - p)}{e^2}$$

The sample size, n, z, p, and e in this formula represent the proportional expected prevalence of conditions, the Z-score that corresponds to the desired confidence interval (for example, 1.96 for 95% confidence interval), and the desired precision or margin of error, respectively. For this study a 95% confidence interval and a 5% margin of error were used to estimate the prevalence of depression, with an expected prevalence rate of 60%.

$$\begin{aligned} n &= \frac{1.96^2 \times 0.6 \times (1 - 0.6)}{0.05^2} \\ &= 40 \end{aligned}$$

Therefore, n = 40 (which is 20% of the population)

The sample size consists of 40 participants

3.4 SAMPLING PROCEDURE

For sampling purposes, some departments were merged to form a single department based on the leadership of the departments as some departments in the study population are headed by a common head of department. Stratified random sampling methods was employed to select participants, where the following departments; Casualty, Maternity, Medical & Surgical, Outpatients, Laboratory, Pharmacy, Administration, Maintenance, Mortuary, and Laundry were considered as strata and participants were randomly selected from each stratum. Sampled participants in each department were based on the number of healthcare workers in each department with higher samples selected from departments with more healthcare workers. The sampled respondents were 2 in casualty, 3 in Maternity, 10 in Medical & Surgical, 3 in Outpatients, 1 in Laboratory, 2 in Pharmacy, 2 in Administration, 3 in Maintenance, 2 in Mortuary, and 2 in Laundry. All heads of departments were purposively sampled as key informants. Sampling involved both males and females to avoid gender inequality.

3.5 DATA COLLECTION

Data were collected through questionnaires where sampled healthcare workers were administered a questionnaire to collect both qualitative and quantitative data. A questionnaire incorporating both closed-ended and Likert-scale items was created and structured into four distinct sections that is demographic information, socio- economic factors, depression prevalence knowledge, and depression assessment (Appendix 2, Appendix 3). The questionnaire was distributed across all the departments.

3.6 DATA ANALYSIS

Data from questionnaire and from key informant interviews were tabulated in Microsoft Excel 2013 including demographics, income status, knowledge of depression, and socio economic factors leading to depression. Descriptive statistics including percentages of males to females, occupation, marital status, educational level, and number of dependencies were ran using IBM Statistical Package for Social Sciences (SPSS) version 23. Socio- Economic factors that influence depression in healthcare workers were identified from the respondents' questionnaire together with their severity rating. The data was then analysed using the general count test in SPSS to determine the number of respondents who mentioned a certain severity.

To test the relationship between key contributing socio economic factors and risk of depression among healthcare workers at Sanyati Baptist Mission Hospitals, a non-parametric analysis of variance Kruskal Wallis 'H' test was used in SPSS to test if there is a significant relationship between a socio economic factor and a depression assessment factor, while a Jonckheere Terpstra test for Ordered Alternatives was used in SPSS to identify the exact group of people that is affected by a factor.

3.7 ETHICAL CONSIDERATIONS

Data security and confidentiality were guaranteed, with special attention paid to safeguarding participants who share their experiences with depression. Informed consent was obtained from all participants, and community engagement was given priority to ensure culturally sensitive implementation. Since depression research is a very sensitive health research, robust security measures were implemented to ensure that all communications are encrypted and that any personal data and information collected is stored securely to ensure privacy and confidentiality.

CHAPTER 4: RESULTS

4.1 DESCRIPTIVE COMPOSITION OF RESPONDENTS

Thirty health general health care workers and 10 key informants were administered with questionnaires. The gender distribution of the thirty healthcare workers was 43,3% female(n=13) and 56,7% males(n=17), 46.67% were nurses (n=14), 16.67% were General hands (n =5), 6.67% were environmental health specialists (n=2), and all other occupation categories including chaplain, cook, dental therapist, health informant, laboratory microscopist, nurse aide, PC, pharmacist and rehab technician all had one responded (n=1) and contributed 3.33% of the respondents each (Figure 4.1). The gender distribution for key informants was 60% males (n=6) and 40 % females (n=4).

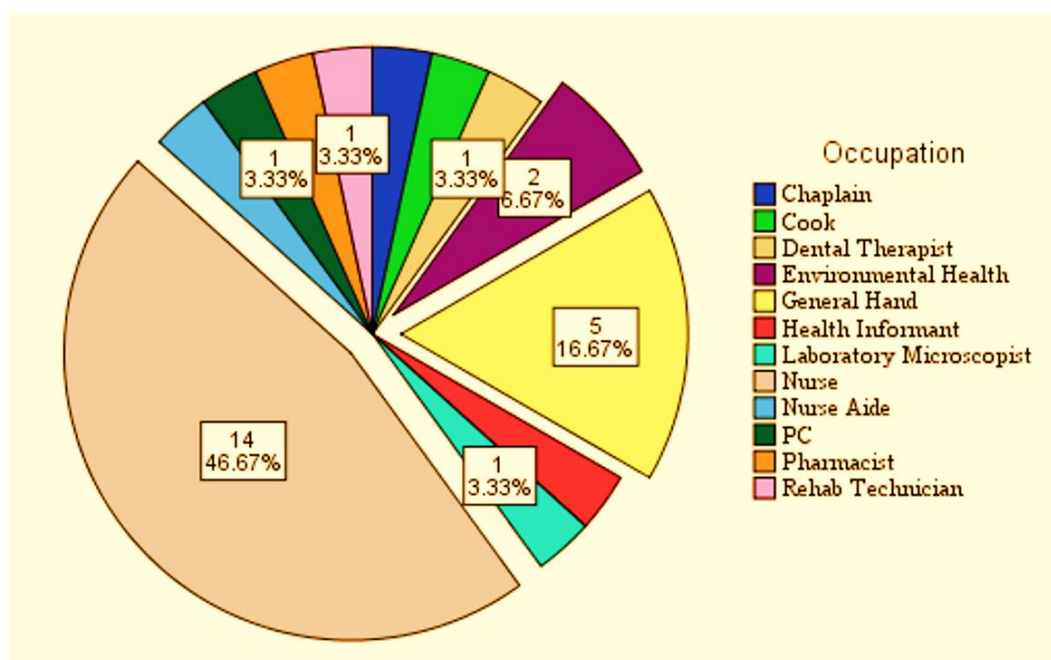


Figure 4.1: Respondents' occupation (%)

In terms of marriage status, 73.3% of the healthcare workers were married (n=22), while 13.4% were single (n=4), 3.3% were divorced (n=1), and 10% widowed (n=3) indicating that personal relationships play a crucial role in their mental well-being. The high percentage of married individuals could suggest a support system that might mitigate feelings of depression, although the data indicates that married respondents also reported feeling down more frequently (Figure 4.2).

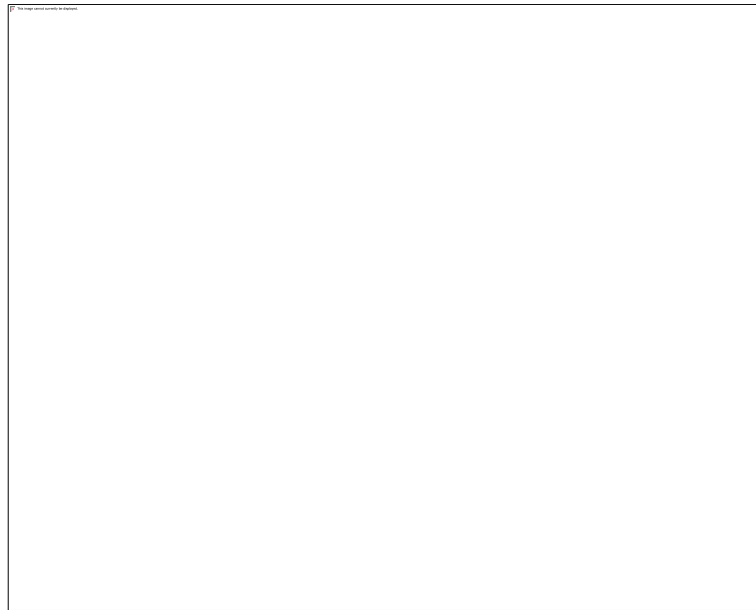


Figure 4.2: Respondents' marital status

The highest percentage of health care workers have diplomas (36.7%), while only 10% had bachelor's degrees (n=3), 33.3% had national certificate (n=10) and 20% had high school education (n=6) (Figure 4.3).

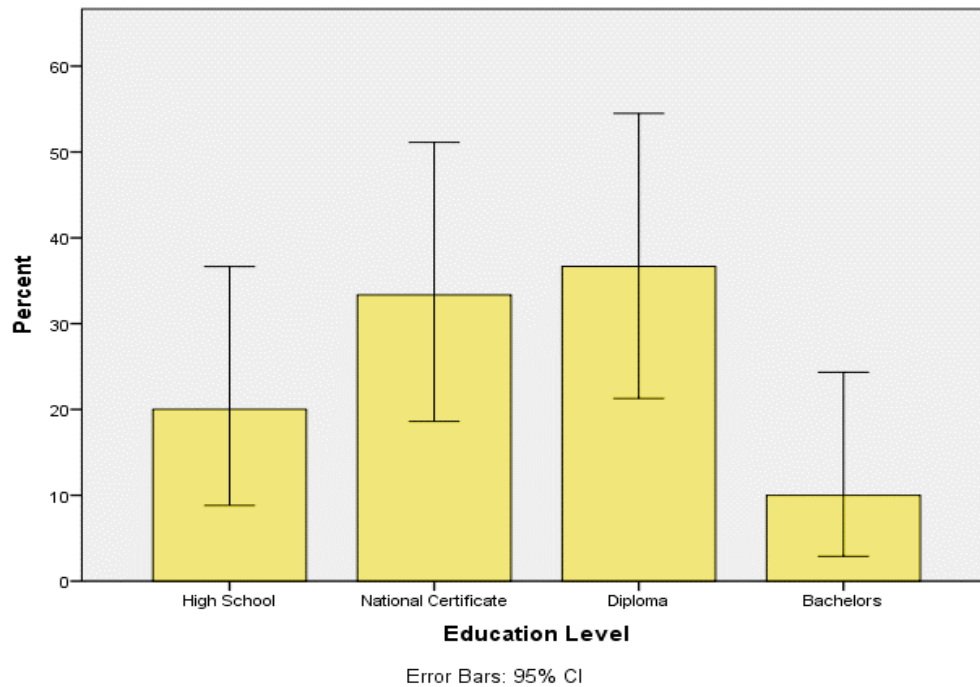


Figure 4.3: Respondents' Educational Level $\pm$ 95% Confidence Interval

Males had more number of dependencies (mean = 6) compared to female health workers (mean = 4) while those with the least education level including high school (mean = 6), national certificate (mean = 4) and diploma level (mean = 5) had higher number of dependencies compared to degree holders (mean = 3.6) (Figure 4.4).

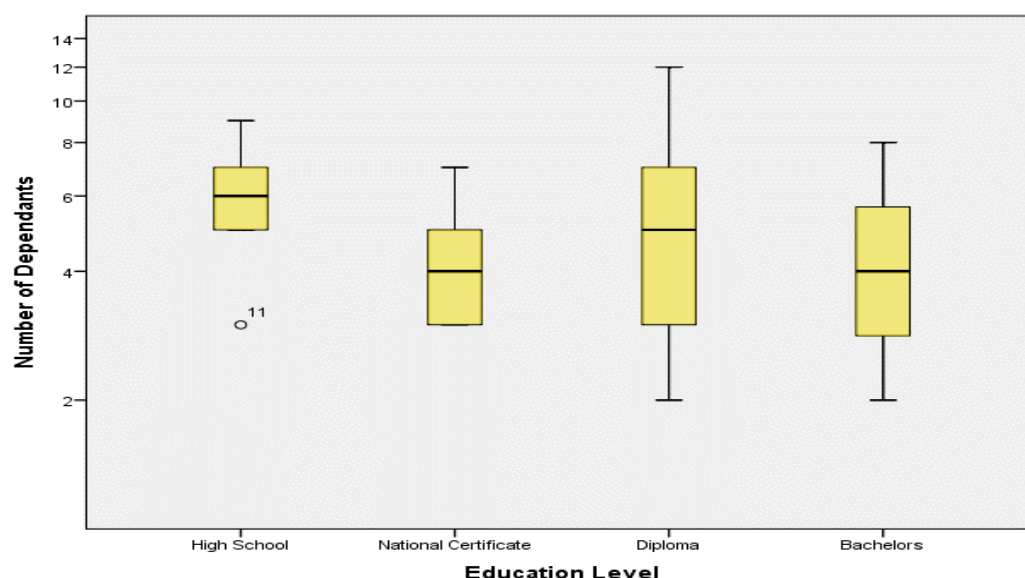


Figure 4.4: Respondents' number of dependants against educational level

4.2 SOCIO-ECONOMIC FACTORS CONTRIBUTING TO DEPRESSION

Respondents identified twenty-two socio economic factors as factors leading to depression in terms of severity (Table 4.1). Most respondents identified Low income & high expenditure, no income, lack of financial services, lack of investment and loss of a loved one as extremely severe factors contributing to depression (Table 4.1). Inflation, currency instability, and exposures to viruses were identified as very severe factors that lead to depression, while low income & low expenditure, high workload & poor remuneration were identified as moderately severe factors leading to depression (Table 4.1). The majority of respondents identified unstable income, job insecurity, unemployment, abuse, infidelity, religion, societal norms, societal values, intimate relationships, family & extended family relationships, and loss of property as not severe factors leading to depression.

Table 4.1: Depression-Related Socioeconomic Factors and Their intensity (The severity selected by the majority of respondents for each factor is shown in green, and the second-most respondents are shown in blue.

Socio Economic Factor	Number of respondents per Severity Rating. 0= No effect, 1 = Not severe, 2 = Slightly severe, 3 = Moderately Severe 4 = Very severe, 5 = Extremely Severe						
	0	1	2	3	4	5	Average Severity Score
Inflation	0	1	3	7	11	8	3.73
Low income and high expenditure	0	1	2	6	10	11	3.93
Low income low expenditure	0	4	3	11	7	5	4.03
Unstable income	0	10	1	5	6	8	3.03
No income	0	9	2	4	5	10	3.16
Currency instability	2	5	2	7	8	6	3.23
Job insecurity	3	8	6	3	7	5	2.53
High work load and poor Remuneration	0	4	2	11	6	7	3.2
Unemployment	2	11	4	0	4	10	2.9
Lack of financial savings	0	4	4	6	5	11	3.5
Lack of investments	1	3	2	9	5	10	3.26
Exposure to pandemics, viruses and bacteria	0	3	7	5	10	5	3.23
Abuse (Physical = P, Emotional = E, Specify)	0	12	6	2	8	2	2.4
Infidelity	0	13	8	3	5	1	2.1
Religion	3	15	6	1	5	0	1.67
Societal norms	3	12	8	3	2	2	1.83
Societal values	2	11	8	3	2	2	1.8
Intimate relationships	4	12	3	6	4	1	1.9
Family relationships	3	9	5	6	5	2	2.23
Extended family relationships	2	9	6	3	6	4	2.46
Loss of a loved one	0	8	2	6	5	9	3.16
Loss of property	1	8	2	6	6	7	2.97

Low income & high expenditure (mean = 3.93), Low income & low expenditure (mean = 4.03), inflation (mean = 3.73) had an averaged severity score of 4 (to the nearest whole number) as they were identified as very severe socio- economic factors leading to depression (Table 4.1), while abuse (mean = 2.4), infidelity (mean = 2.1), religion (mean = 1.67), societal norms (mean = 1.83), societal values (mean = 1.8), family relationship (mean = 2.23), and extended family relationship (mean = 2.46) had an averaged severity score or 2 (to the nearest whole number) identified as slightly severe in leading to depression (Table 4.1). The socio-economic factors

leading to depression, as shown in Table 4.1, reveal that low income and high expenditure scored the highest in terms of perceived severity. This indicates that financial challenges are a primary concern for healthcare workers, potentially leading to feelings of hopelessness and depression. Conversely, factors such as infidelity and societal norms were rated as less severe, suggesting that while they may influence mental health, they do not have the same immediate impact as financial issues.

4.3: RELATIONSHIP BETWEEN KEY CONTRIBUTING SOCIO-ECONOMIC FACTORS AND RISK OF DEPRESSION

Different socioeconomic demographics were tested across depression assessment factors to determine their influence using a Kruskal Wallis ‘H’ test and a Jonckheere-Terpstra test for ordered alternatives. Marriage status showed a statistically significant influence on the feeling-down depression factor (p-value = 0.035) (Table 4.2), with those married showing signs of feeling down for more than half of the days and several days in the previous two weeks compared to those single, divorced, and widowed (Figure 4.5).

Independent-Samples Jonckheere-Terpstra Test for Ordered Alternatives



Figure 4.5: Jonckheere-Terpstra Test for Ordered Alternatives in Independent Samples Marital status's impact on the assessment of depression symptoms during the previous two Weeks.

Educational level has a statistically significant influence to sleeping trouble (p value = 0.019) (Table 4.2) as respondents with higher educational levels (bachelor's degree) had trouble sleeping nearly every day in the previous 2 weeks, while those with high school and national certificate education did not have trouble sleeping (Figure 4.6a). These findings suggest that individuals with less education might face greater financial pressures and responsibilities, potentially contributing to increased stress and risk of depression.

Table 4.2: Kruskal Wallis (H') test results on the demographics influence on depression assessment factors in the previous 2 weeks.

Factor	Little interest in things	Feeling Down	Sleep trouble	Feeling tired	Poor Appetite	Feeling bad	Trouble Concentrating	Moving slowly	Thoughts of death or self-injure
Marriage Status	0.126	0.035*	0.327	0.257	0.711	0.673	0.528	0.447	0.729
Educational Level	0.681	0.157	0.019*	0.02*	0.047*	0.019*	0.115	0.191	0.246
Monthly Income	0.123	0.2	0.795	0.856	0.544	0.546	0.02*	0.901	0.55
Gender	0.664	0.642	0.357	0.173	0.281	0.091	0.55	0.102	0.688
Household Economic Status	0.038*	0.024*	0.317	0.341	0.945	0.112	0.033*	0.557	0.557

Educational level also influenced the feeling of tiredness (P value = 0.02) as respondents with higher educational levels, diplomas and degrees, showed more tiredness on half of the days and almost every day in the last 2 weeks respectively (Figure 4.6b).

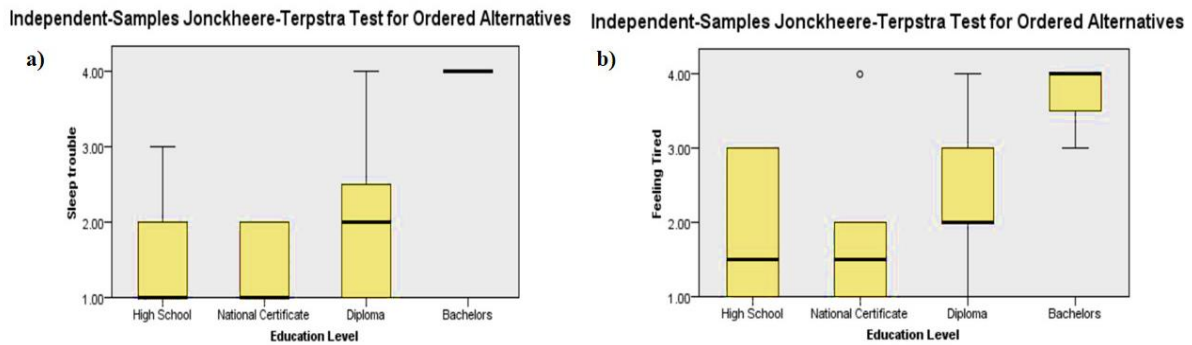


Figure 4.6: Separate Samples Test for Ordered Alternatives by Jonckheere-Terpstra The impact of education attainment on depression assessment during the previous two weeks in relation to sleep difficulties (a) and figure (b) feeling tired.

Poor appetite was also influenced by the educational status (p value = 0.047) (Table 4.2) as those with higher educational levels showed poor appetite in the past two weeks compared to those with high school and national certificate education (Figure 4.7a). Higher educated individuals (diplomas and Bachelor's degrees) felt bad for more than half of the days in the past two week (Figure 4.7b) as educational level was statistically significant in the influencing a bad feeling (p -value = 0.019) (Table 4.2).

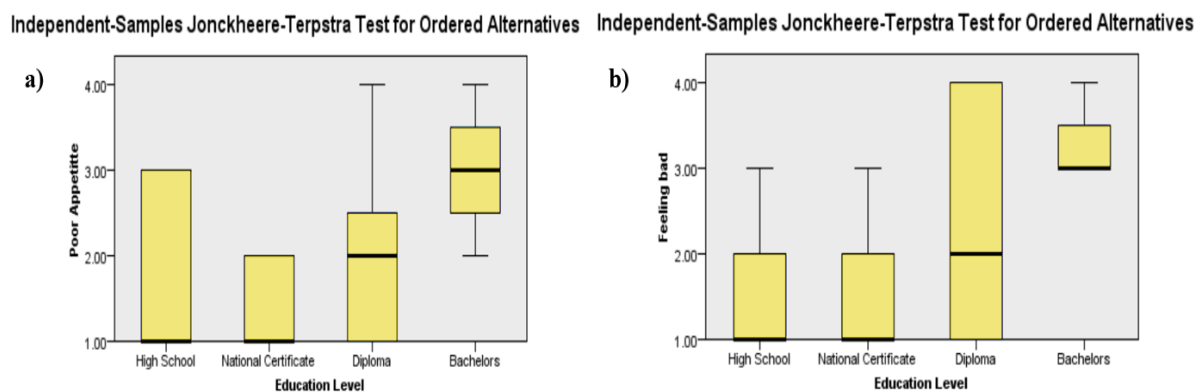


Figure 4.7: Independent Samples Jonckheere Terpstra Test for Ordered Alternatives Effect of educational level on **poor appetite (a)** and **feeling bad (b)** depression assessments in the past two weeks. (1= not at all, 2 = several days, 3= more than half of the days, 4 = nearly Every day).

Monthly income was statistically significant in influencing concentration at work (p value = 0.02) (Table 4.2) with those earning between US\$ 501 – 1000 having trouble concentrating at work for more than half of the days of the past two week while those earning less than US\$ 500 had trouble concentrating for several days and less (Figure 4.8).

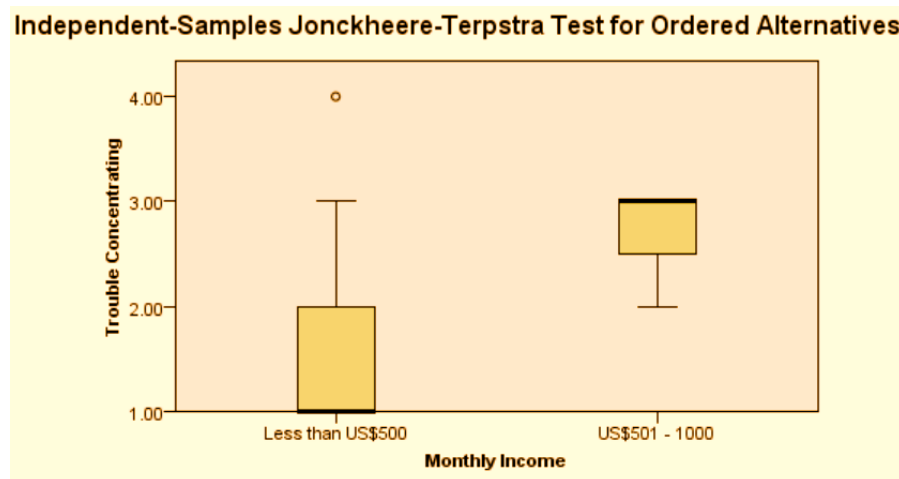


Figure 4.8: Jonckheere-Terpstra Test for Ordered Alternatives in Independent Samples Monthly Income's Impact on trouble concentration focusing for the last two weeks on depression assessment (1= not at all, 2 = several days, 3 = more than half of the days, four = almost every day)

Gender had no statistically significant influence on any depression assessment factors (Table 4.2). Household economic status had a statistically influence on respondents having a little interest on things (p value = 0.038) (Table 4.2) as respondents with very low and low household economic statuses showed lack of interest in things for more than half of the days and several days respectively compared to respondents with moderate and high economic household statuses (Figure 4.9a). In addition, household economic status had an influence on feeling down (p value = 0.024) and trouble concentrating (p value = 0.033) (Table 4.2). Respondents with very low household economic status felt low nearly every day, while those with low and moderate household economic status did not feel low at all, conversely respondents with high household economic status felt low for several days a week (Figure 4.9b). Household economic status also influenced concentration at work (p value = 0.033) as respondents from very low and low household economic status had trouble concentrating for several days a week while respondents with a moderate and higher household economic status did not lose concentration at all for the past two weeks (Figure 4.9c)

Independent-Samples Jonckheere-Terpstra Test for Ordered Alternatives

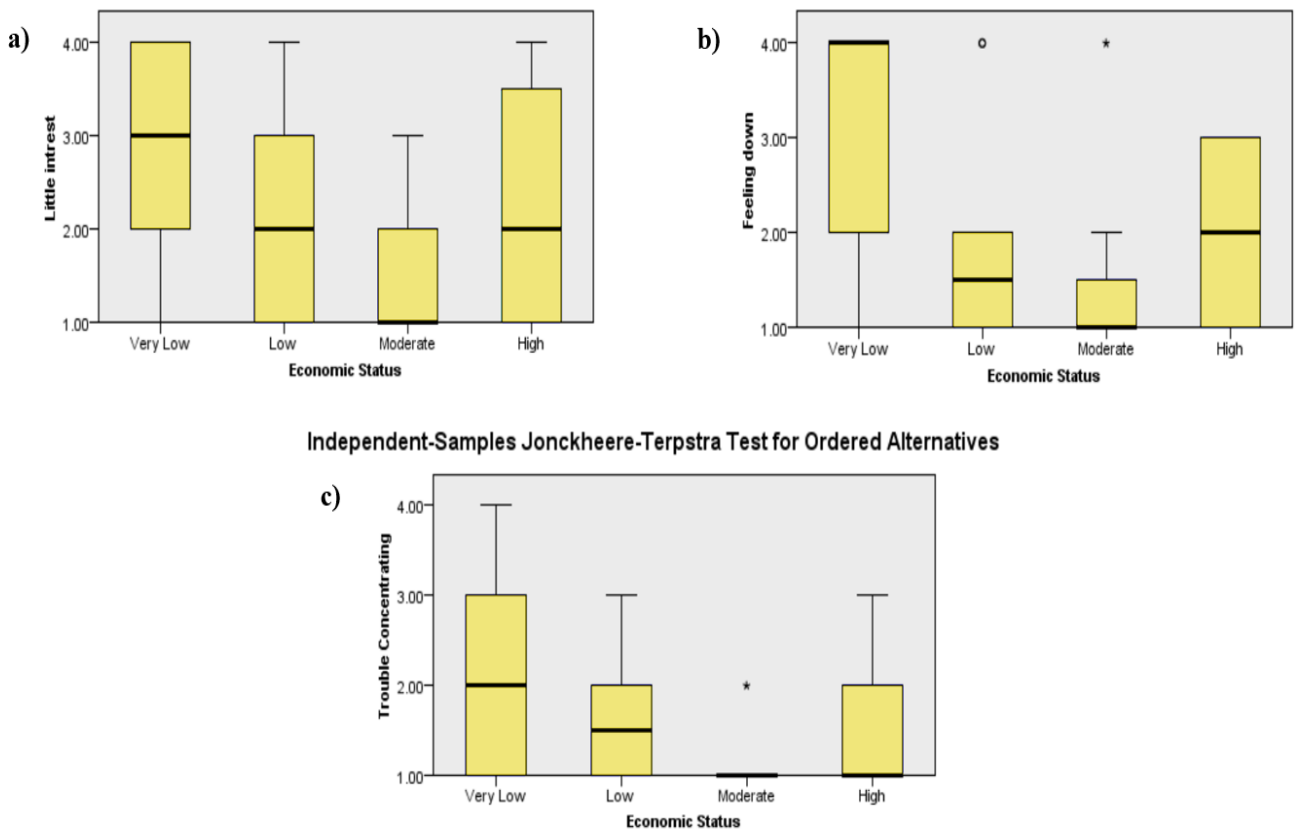


Figure 4.9 (a), (b), (c): Independent Samples Jonckheere-Terpstra Test for Ordered Alternatives Impacts of household economic status on depression assessment during the previous two weeks: low interest (a), depression (b,) and difficulty focusing(c). (1 = not at all, 2= several days, 3 = more than half of the days, 4 = almost every day)

CHAPTER 5: DISCUSSION

5.1 SOCIO ECONOMIC FACTORS LEADING TO DEPRESSION

The results identify a range of socio-economic factors-such as low income, high expenditure, inflation, currency instability, and lack of financial savings or investments-as being perceived by healthcare workers as severe contributors to depression. Notably, low income and high expenditure, as well as inflation, were rated as among the most severe factors. This aligns with extensive literature indicating that economic challenges like poverty, unemployment, and financial stress are both causes and consequences of mental health disorders (AlFahhand,2018). Systematic reviews and meta-analyses consistently show a robust association between financial hardship and increased risk of depression, with financial stress exerting a stronger effect among populations with lower income or wealth.

The study's emphasis on income-related stressors is supported by literature demonstrating that both absolute income and income inequality are significant predictors of depressive symptoms (Marazziti et al., 2021). Mechanisms include increased exposure to neighbourhood adversity (AlFahhand,2018)), reduced access to health services (Duke, 2020), and heightened feelings of financial insecurity (Gold,2015), and shame among low-income individuals (Folb et al.,2015). Studies have found that populations in areas of higher income inequality have a 1.19 times greater risk of depression than those in more equal societies (Viseu et al.,2028a). The material deprivation and lack of investment in low-income areas exacerbate these mental health risks.

The results showed educational level significantly influencing several depression assessment factors, including sleep trouble, tiredness, poor appetite, and feelings of worthlessness, with higher education sometimes associated with increased reporting of these symptoms (Chang et al.,2020).However, larger population-based studies, such as the NHANES analysis, generally show a negative association between educational attainment and depressive symptoms-higher education correlates with a lower prevalence of depression after adjusting for covariates (Li et al.,2022).This protective effect of education is mediated by factors such as improved employment opportunities, higher income, and better health literacy. However, the relationship can be complex and may be moderated by race, marital status, and family economic factors (Sultana *et al.*, 2022). The study also found out that educational level influences sleep trouble which is echoed in the literature, which documents that low socio-economic status is associated

with poorer sleep quality and continuity. Mediating factors include unhealthy behaviours, chronic stress, and limited access to healthcare (Marazziti *et al.*, 2021).

The results show that marital status significantly influences feelings of depression, with married individuals reporting more frequent feelings of being down compared to single, divorced, or widowed respondents. This is nuanced in the literature, while some studies suggest marriage is protective against depression, others find that marital strain or specific subgroups (such as married women) may experience higher rates of depressive symptoms (Sultana *et al.*, 2022). Separation or divorce is consistently associated with higher rates of major depression.

The research demonstrates that lower household economic status is associated with greater lack of interest in activities, more frequent feelings of being down, and trouble concentrating. This is consistent with the broader literature, which finds that financial hardship is more strongly associated with current depression than with prior history, and that the impact is particularly pronounced in late adulthood and middle age disorders (Marazziti *et al.*, 2021). Policies aimed at reducing economic inequalities and improving living standards are recommended as effective strategies to mitigate the burden of depression.

Interestingly, the results show no statistically significant influence of gender on depression assessment factors among healthcare workers. This contrasts with broader epidemiological findings, which consistently show that women are more likely to develop depression than men, though men may experience different symptom profiles and are at higher risk for depression-related suicide (Li *et al.*, 2022). The absence of a gender effect in this sample may reflect occupational or contextual factors specific to the healthcare workforce. At the same time, high workload and poor remuneration were identified as moderately severe contributors to depression, while job insecurity and unemployment were rated as less severe by most respondents. This somewhat contrasts with literature that identifies job insecurity and unemployment as significant risk factors for depression, especially during economic downturns or public health crises (Sultana *et al.*, 2022). The discrepancy may be due to the relative job stability of healthcare workers compared to other sectors.

The study strengthens the central role of socio-economic factors particularly income, education and household economic status in shaping the risk and experience of depression among healthcare workers. This is consistent with other researches that bring out the importance of balancing economic inequalities, better working conditions and provision of targeted mental health support to vulnerable groups (Shabani *et al.*, 2024). Marital status and lack of gender

differences effects suggest that interventions should be context specific and sensitive to unique challenges faced by healthcare professionals.

5.2 Relationship between key contributing socio-economic factors and risk of depression

The results identify a range of socio-economic factors-such as low income, high expenditure, inflation, currency instability, and lack of financial savings or investments-as being perceived by healthcare workers as severe contributors to depression. Notably, low income and high expenditure, as well as inflation, were rated as among the most severe factors. This aligns with extensive literature indicating that economic challenges like poverty, unemployment, and financial stress are both causes and consequences of mental health disorder (He *et al.*, 2022). Systematic reviews and meta-analyses consistently show a robust association between financial hardship and increased risk of depression, with financial stress exerting a stronger effect among populations with lower income or wealth (Marazziti *et al.*,2021)

There is evidence that both absolute income and income inequality are significant predictors of depressive symptoms, which support this study's focus on income-related stressors (Nhapi,2019). Mechanisms include increased exposure to neighbourhood adversity (He *et al.*,2022; Viseu *et al.*,2018a), reduced access to health services, and heightened feelings of financial insecurity (Marazziti *et al.*,2021) and shame among low-income individuals (Guan *et al.*,2022). Studies have found that populations in areas of higher income inequality have a 1.19 times greater risk of depression than those in more equal societies (Guan *et al.*,2022 Viseu *et al.*,2018a). The material deprivation and lack of investment in low-income areas exacerbate these mental health risks.

The results showed educational level significantly influencing several depression assessment factors, including sleep trouble, tiredness, poor appetite, and feelings of worthlessness, with higher education sometimes associated with increased reporting of these symptoms. However, larger population-based studies, such as the NHANES analysis, generally show a negative association between educational attainment and depressive symptoms-higher education correlates with a lower prevalence of depression after adjusting for covariates (Li *et al.*,2022; Guan *et al.*,2022). This protective effect of education is mediated by factors such as improved employment opportunities, higher income, and better health literacy. However, the relationship can be complex and may be moderated by race, marital status, and family economic factors (Guan *et al.*, 2022). The study also found out that educational level influences sleep trouble which is echoed in the literature, which documents that low socio-economic status is associated

with poorer sleep quality and continuity (Li et al.,2022). Mediating factors include unhealthy behaviours, chronic stress, and limited access to healthcare (Marazziti et al.,2021)

The results show that marital status significantly influences feelings of depression, with married individuals reporting more frequent feelings of being down compared to single, divorced, or widowed respondents. This is nuanced in the literature, while some studies suggest marriage is protective against depression, others find that marital strain or specific subgroups (such as married women) may experience higher rates of depressive symptoms (Sultana et al., 2023) Separation or divorce is consistently associated with higher rates of major depression (Viseu et al.,2018a).

The research demonstrates that lower household economic status is associated with greater lack of interest in activities, more frequent feelings of being down, and trouble concentrating. This is consistent with the broader literature, which finds that financial hardship is more strongly associated with current depression than with prior history, and that the impact is particularly pronounced in late adulthood and middle age (Ward et al.,2013). Policies aimed at reducing economic inequalities and improving living standards are recommended as effective strategies to mitigate the burden of depression.

It's interesting to note that the findings indicate that gender has no statistically significant impact on the variables used to assess depression in healthcare workers. This stands in contrast to more general epidemiological findings that consistently demonstrate that women are more likely than men to experience depression, even though men may have different symptoms profile and be more likely to commit suicide (Phiri et al.,2020). The absence of a gender effect in this sample may reflect occupational or contextual factors specific to the healthcare workforce. At the same time, high workload and poor remuneration were identified as moderately severe contributors to depression, while job insecurity and unemployment were rated as less severe by most respondents. This somewhat contrasts with literature that identifies job insecurity and unemployment as significant risk factors for depression, especially during economic downturns or public health crises. The discrepancy may be due to the relative job stability of healthcare workers compared to other sectors.

The study strengthens the central role of socio-economic factors particularly income, education and household economic status in shaping the risk and experience of depression among healthcare workers. This is consistent with other researches that bring out the importance of balancing economic inequalities, better working conditions and provision of targeted mental

health support to vulnerable groups (Viseu et al.,2018a). Marital status and lack of gender differences effects suggest that interventions should be context specific and sensitive to unique challenges faced by healthcare professionals Marazziti et al.,2021).

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS;

ECONOMIC FACTORS IMPACTING METAL HEALTH:

- Low income, high expenditures, inflation, and currency instability are viewed as some of the most significant social-economic stressors leading to depression, particularly among healthcare workers at Sanyati Baptist Hospital. Additionally, a lack of financial saving and investments has been identified as considerable factor contributing to depressive symptoms.
- Educational Level Influences Depression Symptoms - Higher educational attainment (diploma and bachelor's degree) is associated with increased reporting of sleep trouble, tiredness, poor appetite, and feelings of worthlessness among respondents.
- Socio-Economic and Social Factors such as infidelity, abuse, societal norms, and family relationships were had a low severe relationship with a risk factor of depression, though they may still play a role.

6.2 RECOMMENDATIONS

- Develop targeted interventions to improve the financial well-being of healthcare workers, such as salary reviews, hardship allowances, and access to affordable financial services.
- Establish workplace mental health programs focusing on stress management, financial planning, and resilience training for healthcare workers.
- Healthcare professionals from low-income and low-household economic status backgrounds should receive priority support because they are more likely to experience depression.
- Given larger epidemiological trends, continuous monitoring is advised to guarantee gender-sensitive approach in mental health intervention, even though gender was not significant in this study.

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APPENDIX 1: RESEARCH PERMISSION LETTER

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APPENDIX 2: HOSPITAL STAFF QUESTIONNAIRE



RESEARCH QUESTIONNAIRE FOR HOSPITAL STAFF MEMBERS

Good Day, I am Chikanara Scenara, a student at Bindura University of Science Education doing a research on the topic “**Questionnaire on Socio-Economic factors contributing to Depression among healthcare workers at Sanyati Baptist Mission Hospitals.**” May you kindly spare your time to answer the following questions on depression. Your answers will be treated with confidentiality and privacy, and will go a long way in helping to develop strategies to fight depression.

Section A: Demographic Information

1. Enumerator Name _____ Enumerator Code _____
2. Date of Interview (Dd/Mm /Yy)
3. /___/___/2025
4. Age: _____
5. Gender: ☐ Male ☐ Female
6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
7. Number of dependents: _____
8. Occupation: ☐ Nurse ☐ Doctor ☐ Pharmacist ☐ Other (please specify): _____
9. Years of experience in healthcare: _____
10. Highest level of education: ☐ High School ☐ National certificates ☐ Diploma ☐ Bachelor's ☐ Master's ☐ Doctorate

Section B: Socio-Economic Factors

11. What is your current monthly income US\$? ☐ Less than \$500
☐ \$501 - \$1000 ☐ \$1001 - \$1500 ☐ \$1501 - \$2000 ☐ More than \$2000
12. How would you rate your household's economic status? ☐ Very low ☐ Low ☐ Middle ☐ High ☐ Very high
13. Do you have any outstanding debts or loans? ☐ Yes ☐ No
14. If yes, what is the total amount of your outstanding debts/loans?

☐ Less than \$1000 ☐ \$1001 - \$5000 ☐ \$5001 - \$10,000 ☐ More than \$10,000

15. How would you rate your job security?

☐ Very insecure ☐ Insecure ☐ Somewhat secure ☐ Secure ☐ Very secure

16. How satisfied are you with your current housing conditions?

☐ Very dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐ Very satisfied

17. Do you have access to affordable healthcare for yourself and your family?

☐ Yes ☐ No

18. How would you rate your work-life balance?

☐ Very poor ☐ Poor ☐ Average ☐ Good ☐ Excellent

19. How often do you experience financial stress due to low income or high expenses?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

20. Do you have any additional sources of income besides your primary job?

☐ Yes ☐ No

21. If yes, what is the approximate monthly income from these additional sources?

☐ Less than \$200 ☐ \$201 - \$500 ☐ \$501 - \$1000 ☐ More than \$1000

Section C: Depression Assessment

22. Over the last 2 weeks, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

b. Feeling down, depressed, or hopeless:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

c. Trouble falling or staying asleep, or sleeping too much:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

d. Feeling tired or having little energy:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

e. Poor appetite or overeating:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

f. Feeling bad about yourself or that you are a failure or have let yourself or your family down:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

g. Trouble concentrating on things, such as reading the newspaper or watching television:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

h. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

i. Thoughts that you would be better off dead or of hurting yourself in some way:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

J. What do you think are the main causes of depression in healthcare workers?

Factor	Tick	Rate the factors in terms of severity 1= Not severe, 2= Slightly severe, 3=Moderately Severe 4 = Very severe, 5 = Extremely Severe					Comments
		1	2	3	4	5	
Inflation							
Low income and high expenditure							
Low income low expenditure							
Unstable income							
No income							
Currency instability							
Job insecurity							
High work load and poor Remuneration							
Unemployment							
Lack of financial savings							
Lack of investments							
Exposure to pandemics, viruses and bacteria							
Abuse (Physical = P, Emotional = E, Specify)							
Infidelity							
Religion							
Societal norms							
Societal values							
Intimate relationships							
Family relationships							
Extended family relationships							
Loss of a loved one							
Loss of property							
Others (Please specify)							

23. Have you ever been diagnosed with depression by a healthcare professional? ☐ Yes ☐ No

24. If yes, are you currently receiving treatment for depression? ☐ Yes ☐ No

25. What do you think can be done to reduce depression among healthcare workers?

Thank you for your participation! Your responses will be kept confidential and will be used for research purposes only.

APPENDIX 3: KEY INFORMANT QUESTIONNAIRE



KEY INFORMANT QUESTIONNAIRE

Good Day, I am Chikanara Scenara, a student at Bindura University of Science Education doing a research on the topic “**Socio-Economic factors contributing to Depression among healthcare workers at Sanyati Baptist Mission Hospitals.**” May you kindly spare your time to answer the following questions on depression. Your answers will be treated with confidentiality and privacy, and will go a long way in helping to develop strategies to fight depression.

Section A: Demographic Information

1. Enumerator Name _____ Enumerator Code _____
2. Date of Interview _____ (Dd/Mm /Yy) /___/___/2025
3. Department _____
4. Age: _____
5. Gender: ☐ Male ☐ Female
6. Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
7. Number of dependents: _____
8. Occupation: Nurse ☐ Doctor ☐ Pharmacist ☐ Nurse Aide ☐
- Other (please specify): _____
9. Years of experience in healthcare: _____
10. Highest level of education: High School ☐ Diploma ☐ Bachelor's ☐ Master's ☐ Doctorate ☐
11. Which hospital department do you lead _____

Section B: Depression Prevalence Knowledge

12. How many healthcare workers fall under your department?
Less than 25 ☐ 25-50 ☐ 50-75 ☐ 75-100 ☐ Over 100 ☐

13. How many non-healthcare workers fall under your department?

Less than 25 ☐ 25-50 ☐ 50-75 ☐ 75-100 ☐ Over 100 ☐

14. In the past year, did any of workers in your department exhibit any signs of mental health disorder.

Yes ☐ No ☐

15. If yes, what signs does were exhibited?

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16. How many workers exhibited signs of mental health disorders?

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17 Of those workers how many workers exhibited signs of depression?

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18. Did any of the workers seek any medical or psychological treatment on depression or any other mental health?

Yes ☐ No ☐

If yes, specify how many workers and the mental health disorder?

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19. Do you think the hospital need a mental health division for staff and patients? Explain your answer.

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Section C: Depression Assessment

22. What do you think are the main causes of depression in healthcare workers?

Factor	Tick	Rate the factors in terms of severity 1= Not severe, 2= Slightly severe, 3=Moderately Severe 4 = Very severe, 5 = Extremely Severe					Comments
		1	2	3	4	5	
Inflation							
Low income and high expenditure							
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Lack of financial savings							
Lack of investments							
Exposure to pandemics, viruses and bacteria							
Abuse (Physical = P, Emotional = E, Specify)							
Infidelity							
Religion							
Societal norms							
Societal values							
Intimate relationships							
Family relationships							
Extended family relationships							
Loss of a loved one							
Loss of property							
Others (Please specify)							

23. What do you think can be done to reduce depression among healthcare workers?

Thank you for your participation!