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Research Article

Social capital and depression among migrant hypertensive patients in primary care

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Abstract

This study was to investigate prevalence of depression among migrant hypertensive patients in primary care and to examine hypertensive patients' social capital and its relationship with the prevalence of depression. An on-site–based cross-sectional study was performed in Shenzhen, China. A total of 830 migrant hypertensive patients completed the survey by using systematic sampling design. A questionnaire including information of depressive symptoms and social capital was administered by face-to-face interview surveys. We found that the prevalence of depression was 11.0% among migrant hypertensive patients in primary care. Social ties (odds ratio = 1.197, 95% confidence interval: 1.034, 1.387) and trust (odds ratio = 2.061, 95% confidence interval: 1.342, 3.165) were statistically significant associated with the prevalence of depression. Our study shows that the prevalence of depression is high among migrant hypertensive patients in primary care. It also suggests an inverse association between social capital and depression among migrant hypertensive patients. Although causal pathways between social capital and depression cannot be established by the present study, it is plausible to design and implement social interventions to improve mental health of migrant hypertensive patients in primary care. J Am Soc Hypertens 2018;■(■):1–6. © 2018 American Heart Association. All rights reserved.

Keywords: Depression; hypertension; primary care; social capital.

Introduction

China has been experiencing the largest internal migration since its opening-up policy, and this population was up to 221 million in 2010.[1] Internal migrants refer to those who leave their officially registered residence to the new place for living.[2,3] The internal migrants are usually rural-to-urban and have lower economic status. The internal migrants usually face limited access to local social welfare such as housing, children's education, and health services.[4] Substantial evidence from both developed and developing countries have shown that migration is associated with increased occurrence of mental problems like depression.[5] The impact of migration on health is exerted mainly through changing social structures and networks that are associated with alterations in social capital.

Depression is a significant contributor to the global burden of disease. It is estimated that there is a 7% of lifetime risk for depression.[6] It will be likely to increase 5.7% of global burden of disease by 2020 and become the second one after ischemic heart disease.[7] Hypertensive patients usually have experiences of lower quality of life, role impairment and somatic symptoms, and so forth, all of

Ethics approval and consent to participate: This study was approved by the Ethical Committee of Shenzhen University General Hospital, Shenzhen University. Written informed consent was obtained from the respondents.

Availability of data and material: The data set supporting the results of this article is included within the article.

Conflict of interest: None.

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which are widely recognized as the risk factors for psychological distress, especially depression.[8,9] Primary care has been placed by the Chinese government as the cornerstone for coping with the challenges aroused by hypertension. The co-occurrence and the impact of psychosocial issues on hypertension are challenging in diagnosis and management. To understand prevalence of depression among hypertensive patients attending primary care facilities is important for health care providers' service provision. However, the information is left unclear, especially for the migrants.

Social capital refers to features of social organizations, such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit. Numerous studies have shown a general positive relationship between social capital and mental health,[10] which motive social scientists and policy makers to intercept social capital into mental health policies. The UK Department of Health has explicitly cited developing social capital as an important feature of mental health promotion.[11] However, the relationship between social capital and mental health is usually relevant to dimensions of social capital and population investigated. In addition, the studies in the developing world are not well researched.

This study aims to investigate the prevalence of depression among migrant hypertensive patients attending primary care facilities. It also examines hypertensive patients' social capital and its relationship with the prevalence of depression.

Methods

Context of the Study

Shenzhen is one of the most populous metropolitan areas located in the Pearl River Delta region of southern China. It is China's first special economic zone holding subprovincial administrative status. It is divided into 10 district-level jurisdictions.[12] The total area of Shenzhen is 1997.3 square kilometers. According to the statistics for 2016, Shenzhen's population is around 11.4 million with about 69% being migrants. Migrants in Shenzhen are normally from rural areas for better paid jobs. They are generally less skilled and minimally educated and hence tend to have lower incomes than their local counterparts. The prevalence of hypertension in Shenzhen has been increasing in the past decade arriving at about 20% in 2016.[13] Shenzhen offers an interesting case study to examine the social capital and mental health of hypertensive patients attending primary care facilities.

Sample and Procedures

This was a cross-sectional study conducted in Shenzhen, China. Community health centers (ie, primary care facilities) were selected as study settings by using multistage cluster random sampling methods. First, one of the ten districts in Shenzhen was selected using simple random sampling methods, that is, Longhua District (including six subdistricts). In the second stage, the list of community health centers for each subdistrict was obtained from Health Bureau of Longhua District. Two community health centers were randomly drawn from each subdistrict deploying a simply random sampling method. At last, a total of twelve community health centers were selected.

The survey was on-site based. The sampling frame was primary care users' population based. Using a systematic sampling design, every fifth care user was selected. The inclusion criteria included individuals (1) aged ≥18 years, (2) with the ability to communicate and give informed consent, and (3) who had been living in Shenzhen for more than 6 months. The selected primary care users were asked whether they had hypertension diagnosed by health care professionals. A measurement of blood pressure was also administered. The selected respondents should either have (1) had hypertension diagnosed by health care professionals or (2) had an elevated blood pressure (≥140/90 mmHg) measurement. One hundred hypertensive patients were approached for each community health center (1200 in total). Extensively trained interviewers performed face-to-face interview surveys between March and September 2017. The respondents were assured of the anonymity and confidentiality of the survey, and informed consent was obtained before the surveys commenced. At last, 1046 respondents completed the survey with the response rate of 87.2%. Among the respondents, 830 were migrants and were included in the analysis of this study.

Variables

The 5-item World Health Organization Well-Being Index (WHO-5) is a questionnaire that measures wellness and can discriminate between individuals with and without mental disorders. It comprises five items with each item indicating the degree of positive well-being during the past 2 weeks on six points (ranging from 0-none of the time to 5-all of the time). The WHO-5 items are as follows: (1) I have felt cheerful and in good spirits, (2) I have felt calm and relaxed, (3) I have felt active and vigorous, (4) I woke up feeling fresh and rested, and (5) my daily life has been filled with things that interest me. Total raw score is calculated by adding the scores for each item, with higher scores indicating the optimal well-being. For comparison with previous studies, we translated raw score to a percentage scale from 0 to 100 through multiplying the raw score by 4. Both international and national studies have shown that WHO-5 had enough discriminatory validity as a screening tool for the detection of depression.[14] The cutoff score for depression is defined as a score less than 50.

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