

Addressing Depression among Women through Action on the Social Determinants of Health in Pakistan: A Literature Review

by

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Abstract

Depressive disorders constitute a substantial proportion of the global disease burden. These disorders are a major public health concern for both developed and developing countries, with particularly high prevalence observed in Pakistan, especially among women. Despite recognition of the social determinants (SDH) of depression to address mental health globally, Pakistan is lagging behind with poorly implemented mental health policies. This literature review examines the association of the SDH and depression among women in Pakistan. This review confirms a high prevalence of depression among women linked to SDH including poverty, illiteracy, unemployment, lack of social support and housing, inadequate health care access and poor mental health facilities with stigma attached to mental disorders. The findings also reveal a need for a comprehensive mental health policy to integrate mental health services into primary health care and to target mental health care towards underprivileged and marginalised women. A key component of an integrated approach to address the SDH associated with the growing burden of depression amongst women in Pakistan is a focus on mental health literacy among underprivileged and marginalized women.

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Introduction

Pakistan is a low middle-income country with an annual GDP growth rate of 4.4% (The World Bank, 2015). Pakistan is also the sixth most populous country in the world with a population exceeding 195 million people, 66% of whom live in rural areas (Masud, 2011). By 2025, the population is expected to increase to 210 million (Babar et al., 2013). About 33% of Pakistan's population lives below the poverty line (Hameed, 2008) and the country has the second lowest headcount poverty rate after Sri Lanka in the region of South Asia (The World Bank, 2015). The rate of poverty was considerably lower in the 1970s and 1980s when compared to the rates of 1990s. Additionally, the poverty rate increased from 26.6% in 1993 to 32.2% in 1999 (Asian Development Bank, 2002). This rise in poverty rate is attributable, in part to corruption, political instability, poor governance, and poor economic and education policies implemented in Pakistan (Asian Development Bank, 2002).

Pakistan has four provinces: Punjab, Sindh, Khyber Pakhtunkhwa (formerly North Western Frontier Province) and Baluchistan. According to 2014 estimates, the ratio of males to females is 1.06 in Pakistan (IndexMundi, 2015). About 33.3% of the population are under the age of 15 and 9.4% of the population are over the age of 55 (IndexMundi, 2015). The life expectancy at birth for males and females is 65 and 69 years, respectively (IndexMundi, 2015). The literacy rate for men is 68.6% and for women is 40.3% in 2009. (Index Mundi, 2015). With a growing population, access to healthcare is one of the biggest challenges for the population in terms of resources, affordability, and availability of services.

Pakistan is in the middle of an epidemiological transition with a change in disease pattern, where disease burden is shifting from communicable to non-communicable diseases (NCDs) (Babar et al., 2013). This has increased strain on the health system of the country with added cost infliction on society. Psychiatric illnesses are a form of NCDs. According to World Health Organization (WHO), depression affects approximately 350 million people worldwide, across all ages and communities (WHO, 2015). In Pakistan, the overall prevalence of depression is 34% and is higher among women, ranging between 30-66% (Mirza & Jenkins, 2004; Zainab, Fatmi, Kazi, 2012). The focus of this paper is to understand the factors associated with the higher prevalence of depression among women in Pakistan and to provide recommendations to address the contributing factors.

Background

Depression is a common mental disorder, characterized by feeling of sadness, and loss of interest. Depression is both a major determinant of suicide rate and a major contributor to the global burden of NCDs (Qasim, 2012). The *Global Burden of Disease and Risk Factors* report of 2006 claims that neuropsychiatric disorders contributes 37% of all healthy life years lost due to disease (these include unipolar depression, bipolar disorder, schizophrenia, epilepsy, alcohol and drug use disorders, dementias, anxiety disorders and mental retardation) (Lopez, Mathers, & Ezzati, 2006). The high prevalence of depression not only causes a huge burden on the health system but also causes the loss of quality of life for the affected individuals and their families, loss of productivity and a high risk of unemployment (Henderson, Henderson, Lavikainen, & McDaid, 2004). In Pakistan, 10-16% of the country's population suffer from some form of mental illness (Gadit, 2007). Major mental disorders in Pakistan include depression (6% of all mental

disorders), schizophrenia (1.5% of all mental disorders), and epilepsy (1-2% of all mental disorders) (Gadit, 2004). In Pakistan, the extrapolation of prevalence rates of depression yields about 8,437,406 out of the 157,935,000-population (Muhammad Gadit & Mugford, 2007). A systemic review on the prevalence of anxiety and depression was conducted by Mirza & Jenkins (2004) showed that the overall mean prevalence in the community population was around 34% with the point prevalence for women is 29-66% and 10-33% for men. In a community based study that was conducted among adult women belonging to a fisherman community in Karachi showed the point prevalence of depression of 7.5% (Nisar, Billoo, & Gadit, 2004). The Mini International Neuropsychiatric Interview, which was supplemented by ICD-10 was used in this study to diagnose depression (Nisar, et al., 2004). The prevalence of depression in Pakistan's provinces based on other comprehensive local clinic based studies were: Sindh: 16% urban, 12% rural, Punjab: 8% urban, 9% rural, Baluchistan: 4% urban, 2.5% rural, Khyber Pakhtunkhwa: 5% urban, 3% rural (Gadit & Khalid, 2002). In these studies, high rates of prevalence is geared towards urban population because many of the studies were carried out in urban centers because of the available psychiatric setups (Gadit & Khalid, 2002). However, few studies were carried out on population level, but many were clinic based (Muhammad Gadit & Magford, 2007). Therefore, there is an identified need for more population based studies in Pakistan. In addition, there is not a single study that could show the province wide differences in the prevalence of depression among men and women (Gadit & Magford, 2007). However, studies conducted on the prevalence of depression show consistent results of higher rates among women in variable settings (Saeed et al., 2000; Qasim, 2012).

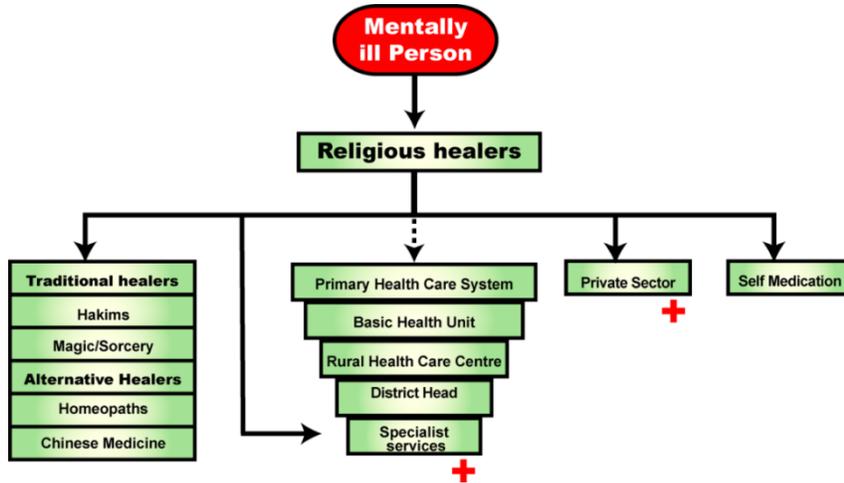
Given the burden of mental disorders on individual women with the negative implications for children and families, women's mental health is an emerging global health issue. The symptoms of depression often begin at an early age and affect the quality of life, economic activity, learning, social and cultural life. In addition, it affects people's ability to participate in their communities (Henderson et al., 2004). These symptoms are often recurring making depression the leading cause of disability in terms of total years lost worldwide (World Federation of Mental Health, 2012). According to WHO estimation, depression will rank as the second cause of "disease burden" in the world by the year 2020 (WHO, 2001). It is also projected to be the largest contributor to the overall disease burden by the year 2030 (WHO, 2008). Depression impacts quality of life more than most physical conditions, and in some cases chronic depression can lead to suicide or suicide attempts (Hernandas et al., 2004). Around 15% of people with chronic depression commit suicide, while 56% attempt suicide (Hernandas et al., 2004).

The prevalence of depression is expected to continue to rise in the low- and middle-income countries, because of the rapid increase in population growth, urbanization, and adverse social, economic, and environmental factors (Holden, 2000). Pakistan is a lower middle income country where poverty, illiteracy, malnutrition, gender biasness, divorce, corruption, and increased stress levels among the population are common (Jalaluddin,& Jalaluddin, 2012). Due to these issues, depression is the second most common cause of disability in Pakistan (Ali & Zuberi, 2012). Depression is more prevalent in Pakistani women because of unique personal, interpersonal, socio-cultural and healthcare services issues such as early marriage, high fertility rate, low employment, low literacy level; poverty; limited budget allocation for health particularly

for mental health, few mental healthcare service providers; stigma associated with mental illness; and accessing mental health care services (Gadit, 2007; Mirza & Jenkins, 2004). These issues pose significant threats for the physical and mental conditions of women.

In Pakistan, women with depression are often reluctant to seek formal health care services not only because it is neither available nor accessible but also due to the stigma attached to it. The reasons behind such stigma are illiteracy, indifference, intolerance and ignorance towards mental disorders, which are rooted in the social fabric of the society (Syed, Hussein, & Yousafzai, 2007). Due to such rooted causes, seeking mental health services is not the first or immediate option for women in Pakistan (Syed et al., 2007). Moreover, many people in Pakistan believe that mental disorders are due to the evil eye, black magic and demonic possession (Nisar, Billoo, & Gadit, 2004). For many Pakistani women, a more favorable alternative is to seek psychological treatment from religious leaders and faith healers (Fig.1)(Gilani, Gilani, Kasi & Khan, 2005). Thus, the influence of these social, environmental, and cultural conditions can pose as contributing factors towards the high prevalence of depression among women in the country.

Figure 1: The Mode of Seeking Help for Mental Health Illnesses in Pakistan



Source: Gilani, A. I., Gilani, U. I., Kasi, P. M., & Khan, M. M. (2005). Psychiatric Health Laws in Pakistan: From Lunacy to Mental Health. *PLoS Medicine*, 2(11), e317. <http://doi.org/10.1371/journal.pmed.0020317>

As mental disorders are shaped to a greater extent by the social, physical and economic environment in which people live, these social, physical and economic conditions could potentially prevail as important determinants of depression among women in Pakistan. In Pakistan, little attention has been given to understand and address the SDH to improve the mental health of the population. A significant gap also exists between the need for treatment of mental disorders and the resources available to women in Pakistan (Afridi, 2008). Further, there is a lack of explorative, and epidemiological data to understand the extent of the problem and plan strategies and policies to address those issues in order to reduce the burden of mental disorders particularly depression among women in Pakistan (Afridi, 2008).

Purpose

The purpose of this capstone is to: a) contribute towards an understanding of the association of SDH and depression among women in Pakistan through a literature

review; b) to describe policy initiatives and services in Pakistan for women to address the social determinants of depression; and c) to recommend strategies to tackle these SDHs.

Methods

This literature review examines the association between SDH and depression among women in Pakistan. The key research question was ‘How is SDH associated with high prevalence of depression among adult women in Pakistan?’ A literature review was conducted through electronic search using databases that include Medline, CINAHL, PsycINFO, and Global Health. A search through Google Scholar was also conducted for articles that might be missed. Grey literature was also reviewed for relevant information.

Key search terms were depression, depressive disorders, prevalence, risk factors, social determinants of health, mental health, women, Pakistan and South Asia. Exclusion criteria includes articles without abstract, non-full text articles, non-English language articles published before 2000 and lack of relevance to the objectives of the study. The scholarly search brought to light a significant lack of academic articles relating to addressing social determinants of depression among women in Pakistan. The search retrieved about 140 articles of relevancy. After applying inclusion and exclusion criteria, 29 articles were selected for this paper. The reference lists from relevant studies were also checked in order to identify further pertinent studies. Below is the eligibility criterion for conducting the literature search.

Inclusion Criteria	Exclusion Criteria
Full text articles available in English language	Non-full text articles
Articles published between 2000-2015	Articles published before 2000
Articles with full abstract	Articles without abstract
Articles relevant to research question	Lack of relevance to research question

Results

Association of SDH and depression

People’s health is influenced by the social and economic factors in which they live and work. These factors are apparent in their working and living conditions which influence their health in both positive and negative ways (Canadian Public Health Association (CPHA), n.d). SDH have a considerable impact on the predisposition of individuals, especially women to various physical and mental conditions. “SDH are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole” (Raphael, 2007, p.19). Social determinants such as education, income, social support networks, culture, and access to health care influence a wide range of health risks and health behaviours. According to the Commission on Social Determinants of Health (CSDH) of the WHO, SDH focus on the “causes of the causes—the fundamental global and national structures of social hierarchy and the socially determined conditions, these create in which people grow, live, work, and age” (Marmot et al., 2008, p.42). SDH lead to health inequities—“the unfair and avoidable differences in health status” (Liang et al., 2012, p.1). Therefore, it is important to understand SDH in order to reduce the health inequities among and between different populations.

However, little attention has been allotted to address SDH in relation to mental health issues, including depression despite the recognition that SDH are clearly implicated in mental health.

Mental health is a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2014). Hence, mental health is not just influenced by individual factors but also by the, social, cultural, and economic factors that are affecting the lives of the individuals. The dynamic interactions of individual, social, and environmental factors have significant impact on an individual’s mental health and productivity. Pakistani women face hardship, discrimination, and violence at each stage of their lives. Living in these difficult circumstances affects their physical and mental health. The psychological consequences of violence and discrimination are more brutal than physical effects (Niaz, 2004). The experience of violence and discrimination jeopardize women’s autonomy, social stability and drains their emotional strength and self-esteem — increases their vulnerability to variety of mental health problem such as depression. The aetiology of depression is multifactorial that includes biological, psychological and social factors. Thus, there is no one identifiable factor that can determine the cause of depression. The onset of depression among Pakistani women is influenced by the adverse life events and other social and environmental factors that increase women’s susceptibility to depression. Table 1 illustrates determinants of depression at individual, social, and environmental level among women in Pakistan.

Table 1: Determinants of depression

Level	Adverse factors	Protective factors
Individual attributes	Low self-esteem Difficulties in communicating Substance use, Medical illness	↔ Self-esteem, confidence ↔ Communication skills ↔ Physical health, fitness
Social circumstances	Family conflict, neglect Exposure to violence/abuse Low income and poverty Unemployment, work stress	↔ Social support of family & friends ↔ Physical safety and security ↔ Economic security ↔ Satisfaction and success at work
Environmental factors	Poor access to basic services Injustice and discrimination Social and gender inequalities	↔ Equality if access to basic services ↔ Social justice ↔ Social and gender equality

Adopted from: World Health Organization. (2012). Risks to mental health: An overview of vulnerabilities and risk factors. *Geneva: WHO*.

Depression is a complex phenomenon and it is an interplay of many social, economic and environmental factors such as social conditions and social relations. The majority of depression in Pakistani women has been associated with a set of issues including poverty (Mirza & Jenkins, 2004), low levels of education (Husain, Gater, Tomenson, & Creed, 2004), unemployment (Patel & Kleinman, 2003), poor housing conditions (Husain, Creed, & Tomenson, 2000), early marriages, living in extended families (Dodani & Zuberi, 2000), large number of children (Husain et al., 2000), physical and verbal abuse by husband and in-laws (Naeem et al., 2004), and inaccessible and unaffordable mental health services (Gadit, 2004). These social conditions and stressful life events would appear to pose significant threats to the overall physical and mental health of women. Therefore, it is imperative to focus on addressing protective factors to avert the adverse circumstances that lead to depression.

Several studies indicating that the high prevalence of depression among Pakistani women is associated with social, economic and environmental conditions in

which they live. A cross-sectional study conducted in Karachi, Pakistan on the risk factors for depression among married women belonging to high and low socioeconomic status (SES) showed that the prevalence of depression among married women from both low and high SES groups is around 66% (Zainab, Fatmi, & Kazi, 2012). However, the factors associated with depression among married women in both the groups varied (Zainab et al, 2012). Among the low SES group, social relations such as poor relationships with husband, in laws and children were significantly associated with depression among married women, while among the high SES group, social conditions and household work is associated with depression (Zainab et al., 2012). Another study conducted by Qadir and his colleagues (2013) on the association of marital relationship and perceived social support with mental health of women from the city of Rawalpindi, Pakistan showed that the satisfaction with married life decreases the risk of depression while social support had the buffering effect on marital relations which influenced the mental health of the women (Qadir, Khalid, Haqqani, Zill-e-Huma, & Medhin, 2013). Further, having a low educational level is significantly associated with high risk of developing depression and anxiety, where as living in a nuclear family system had a protective effect against mental health problems in this study (Qadir et al., 2013). However, previous studies have reported both living in nuclear and extended family as being the risk factors for mental disorders (Mumford et al, 2000). Further research is required to clarify this ambiguity (Mumford et al, 2000). In Pakistani society, socioeconomic conditions appear to be strong determinants of mental health for women.

Poverty has been suggested to have a strong relationship with mental health. Stress, anxiety, and depression are frequently reported conditions that are linked to poverty (Patel & Kleinman, 2003). Poverty is a condition when a person cannot meet the

basic necessities of life such as food, clothing and shelter (Tariq, Idrees, Abid & Samin, 2014). The World Bank definition of poverty recognized by the government of Pakistan is an individual income below \$1.25 per day. Around 54% of the population is poor in Pakistan (Tariq et al., 2014). Living in poverty has both direct (people cannot access health care services) and indirect effects on mental health of the individual (people lack knowledge and awareness about health related issues) (Hafeez, 2014). According to the United Nations report in 1997, out of 1.3 billion people who live under poverty worldwide, 70% are women (Institute for Women's Policy Research, 2010). Out of world's total income, women only contribute to 10% of that income (Institute for Women's Policy Research, 2010). It is also alarming that women who live in low- and middle-income countries like Pakistan with no or low literacy are financially dependent on their family members. This financial dependence makes women insecure, and more susceptible to poor mental health. Consequently, in Pakistan, women disproportionately suffer from the adverse effects of poverty because of low literacy levels, lack of awareness, lack of employment opportunities and inaccessibility of healthcare services.

Scope of Mental Health Services

The process of deinstitutionalization has changed the focus of mental health services from mental asylums to teaching hospitals and community based services to reach out to mentally ill patients at their doorstep. However, the accessibility of these services in low- and middle income countries like Pakistan is out of reach for the majority of the population (Afridi, 2008). Even though rapid improvements have been made in the delivery of mental health services in Pakistan in the last few decades, the situation is not adequate in terms of trained staff, patient care and services (Afridi, 2008). In Pakistan,

mental health services are provided through 3 channels: government, the private sector and through traditional healers. The delivery of mental health service in urban areas of Pakistan takes place at the tertiary level (hospital) in both government and private hospitals (Karim et al., 2004). Whereas in rural areas, people seek mental health treatment from religious and traditional healers (Karim et al., 2004).

Mental health resources in Pakistan are inadequate and depression is burdening the country's scarce resources. The total health care expenditure of the country is below 1% of the Gross National Product (GNP) out of which only 0.4% is allocated to mental health (Zainab et al., 2012). There are inadequate mental healthcare facilities to serve the mental health needs of the population, which are particularly on the rise. For example, there are 5 government mental health hospitals for a total of 1.9 beds per 100,000 population and are integrated with mental health outpatient facilities (WHO, 2009). However, the number of beds has increased by 4% in the last five years, which still cannot sustain the increasing burden imposed by a growing population (WHO, 2009). Overall, the country has just 400 psychiatrists and 50 psychiatric nurses (Qasim, 2012). In addition, only 5 psychiatrists per hospital exist for the population of over 195 million (Qasim, 2012). Though, there are both public and private hospitals that are equipped with psychiatric units. Still, the health care system of the country is riddled with innumerable issues with lack of resources, trained healthcare professionals, and increasing healthcare cost. There is not a single mental health care provider in any rural area of Pakistan, where about 60% of the population is living (Tassawar, 2014). Moreover, the majority of public and private hospitals is situated in large cities, making it inaccessible for the rest of the population living in rural areas. Therefore,

depression remains undiagnosed and untreated in rural parts of Pakistan where the majority of the population resides.

Out of all the mental health expenditures, 11% of the expenditure is dedicated to mental hospitals (WHO, 2009). This expenditure is lower than other low and middle-income countries (WHO, 2009). In terms of affordability of psychotropic medicines, only 5% of the population has free access to it (WHO, 2009). The social insurance plan does not cover mental disorders (WHO, 2009). Thus, for over 60% of the poor population, the out of pocket expense of mental health treatment puts extra financial burden on their scarce resources.

Gender inequalities are very prevalent in the patriarchal society of Pakistan. Gender gaps are widespread in education, nutrition, healthcare and employment (Rizvi, Khan, & Shaikh, 2014). The gender inequalities in the healthcare system have direct effects on the healthcare seeking behaviours among women (Rizvi et al., 2014). Lack of female healthcare providers in primary health care setting is an important determinant of poor mental health among women (Rizvi et al., 2014). There is no female psychiatrist in the Baluchistan province that is the largest province by area in the country (Afridi, 2008). Hence, the response of country's healthcare system to women's physical and psychological need is distressing that result in undesirable health outcomes.

Mental Health Policy

In 1986, a National Mental Health Policy (NMHP) was formulated in Pakistan as part of the general health policy for the country. NMHP replaced the Lunacy Act of 1912 with a new Mental Health Ordinance in 2001 but was not implemented until 2001 (Irfan,

2011). The aim of the NMHP was to work towards uptake of the biopsychosocial model, integration of mental health at all levels of healthcare and the promotion of the public health approach in the delivery of healthcare (Irfan, 2011). The first mental health policy was formulated in 1997 and revised in 2003 addresses the issues of advocacy, promotion, prevention, treatment, rehabilitation and inter-sectoral collaboration (WHO, 2008; Irfan, 2011). It emphasizes the training of primary care-providers, enhances the capacity of teaching psychiatric hospitals, and provides detoxification centers (Irfan, 2011). It also entails crisis intervention and counselling services along with upgrading of mental hospitals. In addition, the revised policy includes components such as the comprehensive delivery of care in mental hospitals and quality improvement (WHO, 2008). However, the meager budget of 0.4% allocated to mental health from the total health care expenditures and the continued negligence exhibited by the government and the health department results in failure to accomplish the set targets (Irfan, 2011). Furthermore, the government has not taken any step forward to provide mental health services in the basic and secondary level health units. The healthcare system of country was decentralized in 2001. Provincial Health Departments are now responsible for planning and resource allocation for healthcare delivery including mental health services at the provincial level (Zaidi et al., 2013). But, unfortunately, there is not much have been done in that area that can be counted on. A national mental health authority was formed twice in the country to provide advice to the government on mental health policies and legislation. Due to political instability, lack of will, corruption and bias in the health system and lack of commitment among stakeholders resulted in poor implementation of mental health ordinance (Jalaluddin & Jalaluddin, 2012).

Programs to address mental health issues

Many national and international non-governmental organizations in collaboration with public sectors are working together to meet the mental health needs of the vulnerable population in Pakistan. These non-governmental organizations provide care to mentally ill patients either with no cost or at subsidized rates. Below is a description of such programs that are working towards reducing stigma attached to mental disorders and providing treatment and rehabilitation services to patients with mental disorders.

Pakistan Mental Health Association (PMHA)

PMHA is a non-profit non-commercial organization established in 1965 for public service and awareness of mental health (PMHA,n.d). This organization runs free mental health clinics in Karachi and provides psychiatric consultations, counselling, psychotherapy and medications free of cost to slums dwellers. Further, this organization provides a platform to undergraduate and postgraduate medical students from different medical colleges for clinical training in mental health. Moreover, it works at a grass root level to achieve its vision and mission of promoting awareness of mental health through outreach activities in small towns and rural areas of Pakistan to raise awareness regarding mental health disorders and treatment through interactive activities in the community.

Karwan-e-Hayat

Karawan-e-Hayat is a non-profit welfare organization established in 1983 (Karwan-e-Hayat, n.d). It is the only mental health non-governmental organization that provides both inpatient and outpatient services. It provides treatment and rehabilitative

services in 3 facilities of Karachi to over 80% of the population free of cost. Since its establishment, this organization is also working towards raising public awareness about mental health and behavioral change in the society. In addition, psychiatrists, nurses, psychologists, occupational therapist and nurses are trained in these facilities to gain experience and competency in mental health.

Carefor Health

Carefor Health is a non-profit organization in Pakistan that works with low-income people with mental illness to provide counselling and rehabilitative services. In addition, it collaborates with organizations that provide mental health care to organizations providing jobs, training, and housing to people who recovered from mental illness. By doing so, its aim is to make adults with mental illness a part of mainstream society and reduce stigma surrounding mental illness. This organization is a good initiative to support the transition of mentally ill people from rehab into society by developing a network of organizations that support this effort. This organization is doing exemplary work in Pakistan by identifying youth, adults, and women with mental illness and provides treatment and rehabilitative services with the help of supporting organizations such as Basic Needs and Aman foundation (Care for health, n.d). Further, Carefor Health provides vocational training and employment opportunities to both men and women who have recovered from mental illness in the reputable organizations. Moreover, this organization is working diligently to reduce stigma surrounding mental illness and helping people with mental illness to re-establish their lives.

BasicNeeds

BasicNeeds is an international non-governmental organization working in 12 countries globally, including Pakistan to improve the lives of people with mental disorders. Their main goal is to integrate “the BasicNeeds Model”, (Fig. 2), into Pakistan’s mental health care system by working across the system with individuals, communities, local and national government and international organizations to achieve basic human rights for people with mental illness (BasicNeeds, n.d.).



Figure 2: The BasicNeedsModels

Source:BasicNeeds. (n.d). *Our approach*. Retrieved from <http://www.basicneeds.org/>

The BasicNeeds model consists of five key components: capacity building, community mental health, livelihoods, collaboration, and research (BasicNeeds, n.d.). *Capacity building* aims to increase training in diagnosing and treating mental illness, as well as to better understand the needs of individuals with mental disorder (BasicNeeds,

n.d.). Collaborating with government and other local NGOs is important for creating changes in the system (BasicNeeds, n.d.). The *community mental health* component aims to promote accessible services and treatment (BasicNeeds, n.d.). *Livelihoods* aim to help underprivileged people recover and integrate them into the community through “regaining the ability to work” (BasicNeeds, n.d.). Lastly, *research* is a key in gathering evidence for improving mental health of the population (BasicNeeds, n.d.). The model has been implemented in three districts of Karachi in 2013 in collaboration with local partners Health and Nutrition Development Society (HANDS), Karwan-e-Hayaat and Sindh Graduates Association (SGA) to deliver BasicNeeds’ community based mental health services and provides job opportunities for program participants. The goal of BasicNeeds is to empower individuals and their families and connects communities with government and other organizations to advocate for public policies that enable people with mental illness to live and work successfully in their community. Further, it provides people with mental illness the access to integrated mental health care, social, and economic services in the communities of Pakistan.

Interventions to address SDH

Additionally, there are non-governmental organizations and other government sectors in Pakistan working on addressing SDH by working on women’s literacy, provision of financial services for low-income women, and shelter homes. These services are for general women but these strategies may have the potential to reduce depression in vulnerable women as well. Below are the details of such organizations working towards addressing SDH among women in Pakistan.

Kashf Foundation

Kashf foundation is Pakistan's premier wealth management company for low-income households established in 1999 (Kashf Foundation, 2015). The aim of this organization is to provide high quality affordable housing to low-income household, especially women. This organization empowers women by building their entrepreneurship skills through access to business loans, providing financial education training to develop their financial management skills and providing micro-insurance services to minimize family level contingencies. By doing so, this organization helps women to improve the economic status of their families. Moreover, this organization also conducts training sessions for clients, their husband, and adolescent boys on "gender justice" to raise awareness about gender discrimination and gender norms in relation to women's involvement in the economy and their access to financial services. These workshops are very crucial in the patriarchal society of Pakistan where women are under the influence of men and do not get the equal rights and opportunities as of men. Thus, women suffer from the lifelong physical, mental, and financial stress, which in turn leads to mental disorders such as anxiety and depression.

Sindh Education Foundation (SEF)

The SEF is a semi-autonomous organization established in 1992 to educate and empower children and communities from remote and underserved areas of Sindh province by providing access to educational facilities to bring social change (Sindh Education Foundation (SEF), 2012). This organization is the largest educational foundation in Pakistan with over 2,000 schools and educational centers in the underserved parts of Sindh province with the financial support of the Department of

Education & Literacy, Government of Sindh (SEF, 2012). To ensure the quality of education in the schools, this foundation conducts quantitative and qualitative research (SEF, 2012). Further, it identifies improvement areas and monitors the impact of the intervention for improving educational intervention at the grassroots level.

One of the program that has been implemented by SEF in the year 2000 is “Women Literacy and Empowerment Program” with the aim “to promote literacy as an enabling learning skill for human wellbeing and gender equality in disadvantaged communities” (SEF, 2012). The program “works on the philosophy of building alliances with women so as to empower them with decision making autonomy to effectively manage their own lives and discuss and resolve the issues that mutually affect them at the community level” (SEF, 2006-2007). The foundation has built the Women’s Literacy and Empowerment Centers (WLECs) to provide basic literacy skills to women in the community. 42 WLECs in addition to 2 vocational centers have been established in Karachi and Sehwan under SEF. Further, this program provides awareness regarding health issues and nutrition across the centers. The aim of this is to enhance understanding of health issues particularly maternal health and early childhood care to benefit not only their children but also their household and the community as whole. Additionally, the centers work on many fundamental areas of the Millennium Development Goals such as primary health services, early childhood education, women economic empowerment, and women support services such as childcare and counselling. Dealing with such issues is very important as Pakistan is still lagging behind in achieving the 8 goals of MDGs (United Nations Development Programme, 2013). These MDGs link directly with mental health as their focus is on issues such as poverty, education, women empowerment, and maternal and child health. These are the

important determinants of mental health and thus needs to be addressed in order to improve the overall physical and mental health of the population. As SEF only serves the underserved population of Sindh province, it is very important that these programs should be expanded in other provinces so that the women and children of those provinces can be benefited from these services.

Shelter Homes for Domestic Violence Survivors

There are some government and non-government based Shelter homes available across the country such as DarulAman, PANAHA, and Mukhtar Mai Women's Shelter Home to provide shelter to women who are victim of domestic violence, sexual abuse, assault, and exploitation. These shelter homes provide immediate shelter, legal aid, psychological counselling, and rehabilitation, access to the media and the justice system for women who have been subjected to violence. DarulAman, which is a government based organization built to impart vocational and skill training for the destitute women to enable them to generate income for themselves. These kinds of shelter homes needs extra funding from the government to further meet the needs of destitute women and to improve the quality of services they offer in these facilities. Furthermore, these facilities should be open to other deprived women who are mentally ill or depressed so that they can get help from these facilities and make them self-reliant and self sufficient to meet their basic necessities of life.

A range of social, financial, and educational programs can address women's mental health needs. Microfinance programs that have been implemented in South Africa and India to tackle poverty among disadvantaged groups have shown a positive impact on the mental health of women(WHO, 214). Government of Pakistan should

expand these kinds of programs across the country to empower people (especially women) and help them to find their way out poverty. WHO (2014) also recommends that a key intervention to improve women's quality of life and their biopsychosocial health is through women economic empowerment. Thus, government of Pakistan should implement programs that support women's economic empowerment in collaboration with other non-government and private sectors.

Discussion

Mental health crises are highly prevalent in Pakistan with women disproportionately suffering from a higher prevalence of depression. Many studies have shown the close association of depression among women with low socioeconomic conditions, low literacy rates, lack of social support and relationship problems. Women in Pakistan unduly suffer from the brunt of depression due to socio-cultural and economic problems. Women in Pakistan are expected to marry and have babies at an early age and raise a family. Further, women face harsh family circumstance because of the subordinate status entitled to them. Moreover, women are financially dependent on husband and family member and do not receive the due respect and support from husband and in-laws. Due to these factors, women do not seek help for mental illness and thus most of the time depression remains undiagnosed and untreated. In addition, lack of awareness and stigma surrounding mental illness becomes a hurdle for women to seek formal health care services. Other factors causing high prevalence of depression among women are poverty, gender discrimination, social injustice, and shortage of mental health care providers at community level.

The existing scarcity of human resources in mental health services, lack of political will, indifferent attitude of public and private sector towards mental health issues, and low priority from international donor agencies makes a grim situation for mental health promotion and services in Pakistan. Mental health services are confined to large cities of the country with negligible presence in rural areas. Lack of public awareness about mental health, gender discrimination, social stigmas, and myths associated with psychological disorders jeopardizes the health seeking behaviour of the disadvantaged population, particularly women. Albeit, there are certain NGOs working diligently to improve the mental health of the population in Pakistan. However, these are meager in terms of catering to the needs of vulnerable population living in remote or rural areas of Pakistan. These programs could be expanded to improve the mental health of women across the country. Thus, it is a crucial time for government of Pakistan to call for a joint action to take steps to address the factors contributing to growing burden of depression among Pakistani women.

Recommendations

Given the current scenario of mental disorders, particularly depression among women in Pakistan, it is essential to take action at each stage of life to reduce the risk of those mental disorders that are linked with social inequalities to improve population mental health. Good mental health will not only make one happy, but also help individuals to cope up with the daily stresses of life and gives an individual a sense of well-being and inner strength. Dealing with SDH is essential in promoting mental health, because health is a fundamental human right for everyone regardless of creed, color, race, religion, social, economic and political conditions. Therefore, it is of utmost

importance that mental health promoters should use a critical lens in planning and implementing programs in Pakistan, understanding SDH and taking actions that are culturally sensitive and appropriate. Also, there is a need to make structural changes in the social and economic conditions to improve gender relations as well as women's status and their mental wellbeing in the society of Pakistan.

This paper strongly recommends to promote mental health and reduce the prevalence of depression with a strong focus on the promotion of mental health literacy as it is vital in enhancing awareness and reduce stigma attached to mental disorder. Further, it will help to recognize symptoms of mental disorder at an early stage and enable them to seek treatment for it.

Promotion of mental health literacy

Promotion of mental health literacy is an integral component to improve the mental wellbeing of the population. Sohail (2005) investigated the level of mental health literacy in Pakistan indicating that there is a high need of mental health as people are unable to recognize the symptoms of mental disorders and treat them as physical disorders. It is recommended that government should launch mental health awareness campaigns in collaboration with other private and non-governmental organizations to educate public regarding mental health through print, electronic and social media with special focus on targeting uneducated and rural population. Because the rural population of Pakistan have more misconceptions about mental disorders and have a low literacy rate (Sohail, 2005). Government should expand school mental health programs in rural areas across the country to improve mental health literacy among rural population with the aim to increase awareness of mental health among children, teachers and the community and to train school teacher on mental health principles so that they pass on

this knowledge to their students, identify common mental health problems in their students, provide support in this respect and increase community awareness of mental health needs and services in general. Such program had been implemented in rural Rawalpindi in Pakistan and has shown positive outcome in improving mental health awareness in school children and community (Rahman et al., 1998). These programs have the potential to identify mental health problems at an early stage and seek appropriate treatment. Further Interventions should be directed to develop and disseminate information on gender specific mental health issues across the life span in both rural and urban areas and in ways that are culturally competent to enhance understanding of mental health issues, address stigma and help reduce health disparities.

Another intervention that could be implemented to promote mental health literacy is the training of primary health care workers. For this purpose, government should collaborate with mental health professionals to train primary health care workers and Lady Health Workers (LHWs) in mental health. In Pakistan LHWs plays a crucial role in providing door-to-door services to meet the health needs of the rural and slum population. The training of these LHWs in mental health could play a key role in improving mental health by identifying and refer individuals particularly women with mental disorders at an early stage. Further, LHWs could provide counseling services and stress coping techniques for women suffering from mental disorder in the communities. Through this intervention, women will be more encouraged to share their issues with LHWs and will be treated in their own culturally sensitive environment. In addition, to promote mental health literacy, educational workshops should be conducted for diverse populations to change the beliefs and perception of public regarding mental

disorder. Enhancing mental health literacy should be considered to be an important preventive measure in reducing high prevalence of depression, as awareness will enhance understanding of positive mental health among public. Further, people will make informed decisions in regards to seeking mental health treatment, which in turn will reduce stigma attached to mental illness.

Following are the additional recommendations that could be implemented to prevent the factors that are contributing to high prevalence of depression among women in Pakistan.

Promote Gender Equality

In the patriarchal society of Pakistan, women are discriminated, abused and restricted at home —prevent them to get education, employment and to seek healthcare services. In Pakistan, over 70% of the population lives in rural and semi rural areas with low literacy rate and basic facilities available. However, women living in urban areas have better access to education and employment and are not bound by many of the restrictions faced by rural women. Government of Pakistan (2012) also reports that women living in rural areas lack the basic needs particular health care needs and educational facilities. Further, women are culturally recognized as inferior to men and thus suffer from poverty due to gender inequalities, patriarchal control, discrimination, lack of job opportunities and limited access to inheritance and income. It is the reason that Pakistani women suffer from the psychosocial stress throughout their lifetime from childhood to adolescence, middle age and old age. Although, the status of women is changing with the passage of time in the male dominated society of Pakistan. Women are getting education, working in male dominated disciplines and have been able to raise voices for their rights. Further, they have been able to make support groups and

network to advocate issues and fight for their rights. Pakistan has significant number of females in judiciary, education, medical, business, politics and other fields of life. But, there is still a lot that needs to be done at in the area of gender discrimination as well as gender mainstreaming through the women empowerment at every level. There are non-governmental organizations such as Blue Veins and Aurat Foundation that are working to empower women and improving their position so that their role in social, political and economic development is recognized. Further, these organizations are working to eradicate gender discrimination in the society and promote equal participation of women in social, economic, civil, cultural and political life. Additionally, these organizations promote rights of women regarding their health and create enabling environments to exercise their rights (Blue Veins, 2006-2014; Aurat Foundation, 2013). I believe that these kinds of programs should be encouraged and implemented across the country, particularly targeting women of rural areas where they considered inferior as of men and cannot exercise their rights.

Integration of Mental Health in Primary Health Care(PHC)

Accessibility, availability and affordability of mental health services are the leading issues in Pakistan. PHC in Pakistan only addresses the physical conditions with complete separation from mental health (Irfan, 2013). This is in contrast to Declaration of Alma-Ata, which reaffirmed the WHO definition of health including mental health as an integral part and urged member countries to integrate the notion of primary health care in their health systems (Irfan, 2013). In Pakistan, there is an urgent need of integrating mental health into primary and community based mental healthcare services to combat the high prevalence of mental disorders. I highly recommend that government of Pakistan should invest in providing accessible and affordable mental healthcare treatment to

disadvantaged population. This could be achieved through integration of mental health into primary healthcare. As WHO also recommends the integration of mental health at all healthcare levels, especially PHC. The integration of mental health into primary health care is a fundamental process that would help to provide faster and easier access to mental health service to a large number of the population (Budosan, 2011). Further, it will also help to reduce stigma surrounding mental illness in Pakistan (WHO, 2008). To integrate mental health into primary health, government should focus on the training of primary health care workers in mental health with assistance of mental healthcare professionals. Emphasis should be given to empower female healthcare providers and train them in mental health so that culturally sensitive care will be provided across the country. This will enhance their knowledge, capacity, and skills in mental health which will help them to treat and manage people with mental disorders efficiently. Data from other countries illustrates that with training and support; primary health care workers can detect and treat a range of mental disorders such as depression and anxiety (National Collaborating Centre for Mental Health & National Institute for Clinical Excellence, 2004).

Several countries across the world have successfully integrated mental health into primary health care settings. This encompasses both high and low- and middle-income countries e.g. UK, Canada, Argentina, South Africa, and India (WHO, 2014). For example, in India mental health services are integrated into primary-care centers. The community and schoolteachers refer the patients. All the patients are provided psycho-education (education on mental disorders) along with treatment and monitoring (WHO, 2014). Moreover, in 1970 a community based intervention project “The comprehensive Rural Health Project (CRHP) was implemented in western Maharashtra, India to integrate mental health into primary health care, with a strong focus on women (WHO, 2014). The

project seeks to address the social and economic determinants of health and to take action to improve knowledge about mental health issues and reduce stigma attached to mental disorders(WHO, 2014). In addition, the project seeks to take action to help with income generation, agriculture and environmental programs, education and referral services. Moreover, the project interventions help to build capacity, self-esteem and improve self-perception of women from the community with the help of trained volunteers(WHO, 2014). The evaluation of the interventions showed positive impact on women's lifestyle and family relationship which results in improved mental health. This kind of program can be translated into the Pakistani context as both the countries share similar culture, traditions and ethnicities (WHO, 2014).

Pakistan is facing high inflation and the gap between the rich and the poor is widening. Thus, disadvantaged people are trapped into the many physical, social, and economic problems, which limit their ability to seek treatment. In Pakistan, integration of mental health services into primary care can create better outcomes. It will not only make services available at the doorsteps of the disadvantaged group but will also avoid the indirect costs associated with seeking specialist care in distant locations (Irfan, 2013). Further, it also minimizes discrimination and removes the risk of human-rights violation that occurs in psychiatric hospitals.

Implementation of Mental Health Policy

Controlling growing mental health crises in Pakistan is a challenge for the government and the international organizations because poor mental health leads to violation of human rights and discrimination in society. There is need of a comprehensive plan that should approach the issues of mental health through multidisciplinary approach. The main objectives of such a plan should include mental

health promotion, prevention, treatment, rehabilitation, care and recovery from mental disorders. A report by WHO (2014) suggested that the National mental health policies should not only address mental disorders, but should also identify and address broader issues which promote mental health such as mental health promotion into policies and programs in governmental and non-governmental organizations. It is imperative to include sectors such as education, labour, justice, environment, housing and welfare in development of mental health promotion activities (WHO, 2014). Additionally, it is recommend that the government collaborate with non-governmental organizations to implement cost effective mental health programs in schools and communities that would help identify and refer individuals with depression at an early stage to deal effectively with the growing burden of depression.

The government of Pakistan should keep mental health legislation on the top most priority and should establish psychological council bodies and legislation for mental health (Tassawar, 2014). Because, high prevalence of mental disorders appears to have a huge impact on economy of the country (Irfan, 2013). Therefore, it is recommended that the government focus their attention on investing in planning and implementation of effective mental health programs that can serve the mental health needs of vulnerable populations. The government should focus their attention on advocacy and promotion to reduce the stigma surrounding mental illness. Moreover, it is recommended that the government should invest in research. A lack of local research on mental health and SDH is a significant hindrance in the national planning and allocation of resources. The focus of research should include epidemiological research, mental health policy, health system research, economic evaluation of models of mental health care, development and validation of research instruments, evaluation of intersectoral linkages and clinical

research (Mubbashar & Saeed, 2001). Moreover, there is not a single qualitative study conducted on the determinants of depression among women in Pakistan. I would encourage that researchers should carry out qualitative studies to get the rich and detailed description of the causes of depression among women so that intervention could be design according to the needs of women. The government should also build a separate body for the purpose of monitoring and evaluation of mental health policies. This will help to recognize the strengths and weaknesses of the plans that are in place. Further, the results of evaluation can be used to improve current policies.

In conclusion, this literature review has summarized the association of depression and SDH among Pakistani women. The results of this review demonstrate that depression is growing at an alarming rate in Pakistan particularly among women because of the failure of recognizing and addressing the contributing factors. Further, lack of mental healthcare professionals, inaccessibility and affordability of mental healthcare services, gender discrimination and stigma attached to depression is another challenge for the women in Pakistan to seek mental health services. As the literature has shown, mental health system of Pakistan fails to consider the bigger context influencing health outcomes among women. I hope the results and recommendations summarized in this paper will be used to foster greater responsibility among government and policy makers to develop more responsive and effective programs for women with focus on underlying factors of marginalization and discrimination of social and health issues, and recognize and incorporate the social, cultural, and economic context in planning mental health intervention.

Critical Reflection

I wanted to do a capstone that discusses the importance of addressing social determinants of health among women with depression. So I choose a topic that created a deeper understanding of the association of social determinants of health and depression in Pakistan. Writing this capstone paper had been a challenging yet rewarding experience for me. I struggled with narrowing my focus of research and come with such recommendations that could be implemented in a country with limited resources. I believe that with the help of my supervisor Malcolm Steinberg and Dr Elliot. Goldner, I was able to strengthen the findings and recommendations of my paper so that It could create an impact on the readers.

Completing this capstone paper has been a very valuable experience for me. I learned that taking a collaborative approach is crucial in improving the mental health of the population. Further, it is important to take the grass root level approach to understand the factors contributing to poor mental health. Overall, I feel that this experience has broadened my awareness and knowledge regarding mental health issues among women in Pakistan and how to critically evaluate perceptions surrounding the problem and then come up with the practical solutions.

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