Chapter 3
Social and Societal Context of Women's Mental Health, What Women Want, What They Get: Gap Analysis in Pakistan of Mental Health Services, Polices and Research

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Introduction

It's no bed of roses! Pakistan is a country with a predominantly Muslim population, which has divisions based on religious sects, class and ethnicity (some prefer to call themselves 'nations') residing in urban, rural and mountainous areas of Pakistan. The rural areas can be further demarcated according to different ecological zones of the country—dry and arid, desert, riverine, coastal, to name some important regions. Pakistani society is deeply stratified. There are the rich and the very rich, the poor and the very poor, and the middle class with some variations within it. It embodies a pluralism that is held together by a constitution that acknowledges equality of all citizens but endorses some discriminatory laws that impact women negatively (Bari & Pal, 2000). It has conflicting ideologies—with capitalism as the primary development paradigm, but systematically and consistently critiqued by socialist-oriented individuals and groups. Whereas constitutionally there is right to life, to education, and medical care, ground realities present a different picture. State expenditure on the social sector remains abysmally low, the military and debt servicing consume most of the budget. On the one hand, Pakistan is a nuclear country and has

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developed a nuclear programme as a deterrent to India's nuclear power; on the other hand, poverty continues to be a major challenge.

In recent years violence in Pakistan has rapidly expanded to include brutal killings by the Taliban, which also include bomb blasts at shrines, mosques and shopping areas. The impact of such violence and growing insurgency on the mental state of the ordinary people has also been documented. Khalily (2011) found very high prevalence of psychological distress and post-traumatic stress disorder (PTSD) among those people who have lost a dear one in the Swat Valley of Khyber Pakhtoonkhwa. There are other militant and extremist religious groups that target different ethnic groups, gender and minorities, in various forms of violence, including burning down whole villages. Criminal gangs also operate with impunity killing at will; and the state is also accused of extra-judicial killings and abductions (HRCP, 2012).

Women face violence and discrimination on a daily basis. Several traditions such as *karo-kari* (honour killing), *watta satta* (exchange marriages) and *vani* (child marriages) are part of the Pakistani culture, and the Pakistani society also seems to condone the traditions of dowry and dowry killing (Niaz, 2004; Perveen, 2013). Many women face humiliation; physical, sexual, verbal and emotional violence at the hands of their husband and in-laws, predominantly the mother-in-law; poverty and household debts compound the problems (Niaz, 2004). For some women no respite is available from the drudgery of everyday life, no social support is available, and there are few opportunities for recreation, especially for those women who are at the lowest rung of the social stratum.

Moreover, many women are deprived of education, training and work opportunities (Bari & Pal, 2000), and it must be noted that these women also per force need to work after marriage and into their old age. Educated or not, women in general have a subordinate position and are not made part of the household decision-making process and tend to have no control over their life (Ali et al., 2011). How women deal with the stresses they experience, what resources are available, and what they can access are determined by their social context shaped by their class and social category. For example, a woman in a rich feudal group may face more social barriers to have access to health care resources compared to an urban middle class woman who is less controlled by her kith and kin. Although the cost of care may not be an issue for some, it plays a major role in the life of most women, because Pakistan does not have a national health service that provides free care to all. Women's practical needs are abound and compounded by not being met by various factors, their strategic interests[1] are ignored.[2] It is therefore not surprising that women in Pakistan are found to be more depressed than men (Mirza & Jenkins, 2004); married women attempt suicide because of the stresses of marriage (Khan &

[1] Strategic interests refer to women's decision-making—decision about when to marry, whom to marry, when to have a child, how many children to be in a family; to pursue their interests; to pursue employment. In short, what is the extent of women's control over their lives.

[2] The distinction between women's practical needs and strategic interests is well established in the feminist literature. This distinction is also to be found in many gender training manuals. See references to Molyneux and Moser in Wieringa (1994).

Reza, 1998) or that young, educated married and unmarried women in a northern area of Pakistan were more vulnerable to psychiatric morbidity and more likely to attempt suicide (Khan, Ahmed, & Khan, 2009).

The stresses women experience are linked to their social position, and access to resources available are also linked to their social position, as the society does not have a universal health system for all. Juxtaposed with this reality is the growth of health services, policies and research. Whether these developments are meaningful to the distressed woman is explored in this chapter.

Evolution of Mental Health Care in Pakistan

Realities, Needs, Challenges! Historically, the first mention of mental health service provision in the Indo-Pak subcontinent is found in the colonial era with the enforcement of the first Indian Lunacy Act in 1858. This led to the establishment of asylums all over India. This Act was replaced by the Indian Lunacy Act 1912 raising the asylums status from merely being a place of confinement, for dangerous persons or those with severe mental disorders, to a place where patients would be brought for advice and treatment (Munogee, 2007). At the time of independence in 1947 Pakistan inherited the Indian Lunacy Act 1912 and three asylum-like hospitals in very poor conditions and with no mental health professionals and very poor conditions (Gadit, 2007a). Pakistan is amongst the 60 % of countries globally that have a mental health policy (WHO, 2005), however, it has evidently not been translated into practice (Gadit, 2007b; Irfan, 2010). The mental health policy was first formulated in 1997 with emphasis on advocacy, promotion, prevention, treatment, rehabilitation and inter-sectoral collaboration. Subsequently, a national mental health plan and a national health programme were formulated in 1986 and implemented in 2001(Irfan, 2010). The mental health policy and the mental health plan were revised in 2003 (WHO, 2009). The mental health ordinance was enacted in 2001, replacing the outdated Lunacy act of 1912; however it lacks the clarity of specific roles for government sectors and non-governmental organizations pertaining to the effectiveness in actions and programmes for mental health (Gadit, 2007a, 2007b).

In spite of all these policy developments, mental health is not integrated into national health policies or the health system and services in Pakistan. The word ‘mental health’ appeared only once in the National Health Policy 2001. It is placed under the heading ‘third year plan of the public sector development programmes’ (Annexure III, pp. 18–19) stating that there are 275 programmes available on the theme and 310 are required, and a gap of 35 still persists. The National Health Policy 2001 was revised as National Health Policy 2009, ZERO DRAFT and again mental health is mentioned once, but introduced with an additional jargon of ‘Psychological rehabilitation’. Annexure III of the document placed it under the heading of Essential Service Delivery Packages (ESDP) being offered to the citizens in the Rural Health Centers (p. 30). It is not meant for Basic Health Units that

are by and large located all over Pakistan, and in some areas issues of violence and security are now a grave concern.

Pakistan has a public health sector that is meant to be free but is riddled with problems; there is a wide gap between the needs and the resources available to address mental health issues. Over the years psychiatric units have been established in the major Government teaching hospitals and later many small private psychiatric hospitals were opened throughout the country. However, majority of these are located in large cities (Gadit, 2007a) and inaccessible to a vast majority of the population living in small cities and rural areas.

According to WHO-AIMS report (2005) out of the total health care budget only 0.4 % is allocated to mental health; there are 342 psychiatrists and 478 psychologists. Only about 24 beds are allocated for psychiatric services per million population, and only 2–3 health professionals including psychologists and social workers are available per million population (Saxena, Sharan, Garrido, & Saraceno, 2006). Moreover, the utilization of mental health services is poor with a preference to seek help from non-professional faith and traditional healers due to the stigma attached to the mental illness (Ansari et al., 2008). The situation is worse for women with mental health issues.

Health and education are perennial low priorities for Pakistan. The private sector is active in both these sectors and functions with minimal, if any, regulations. Issues of quality and cost of service are left to the provider. It is a *Lassie-faire* arrangement.[3] There is considerable philanthropy in Pakistan (Bonbright & Azfar, 2000), and some free health and education services are also available, but no universal health coverage is provided by the State, and high levels of 'out of pocket payments' for health care exists. Furthermore, quality of care remains questionable and there are no established standards or monitoring of quality of care.

This responsibility is left to the discretion of health care institutions/providers. None of these efforts, however, reflect awareness of the sociocultural conditions which shape women's life and also impact their access to services and/or resources that would ameliorate their mental conditions.

Mental Health Research in Pakistan

Science and Evidence! Scholarly and grey literature was searched using three electronic databases, CINAHL, PubMed and Science Direct. Studies published between January 1995 and August 2010 were accessed. The search primarily focused on anxiety and depressive disorders and the keywords used in various combinations included

[3] Laissez-faire (French: "allow to do"), policy of minimum governmental interference in the economic affairs of individuals and society. The origin of the term is uncertain, but folklore suggests that it is derived from the answer Jean-Baptiste Colbert, controller general of finance under King Louis XIV of France, received when he asked industrialists what the government could do to help business: "Leave us alone." (http://www.britannica.com/EBchecked/topic/328028/laissez-faire)

Pakistan; women; mental health; female; mother; anxiety; depression; stress; violence and suicide. Psychiatric illnesses and disorders such as schizophrenia, bipolar disorders, seizure disorders, obsessive–compulsive disorders were excluded from the search. The total number of studies retrieved after removing duplications was 116 and out of these 76 were finally reviewed.

The review found four major mental health problems being studied, i.e. depression, anxiety, suicide/suicidal ideation/emotional stress and violence; seven different methodologies used to understand women's health (surveys, case control studies, quasi-experimental studies, observational studies, narrative analysis, interview analysis and descriptive case series) and four major strands of research studies:

1. Studies estimating prevalence of psychological conditions (anxiety, depression or suicidal ideation)
2. Studies examining relationship/association between different mental health problems and socio-demographic factors with specific women's health outcomes
3. Understanding women's coping strategies during mental and psychological problems and illnesses

Intervention studies seeking reduction in different clinical conditions (such as depression and anxiety) by the use of counselling techniques with women and care providers for women's better health outcome. Anxiety and depression are two most prominent clinical conditions (Gulamani, Shaikh, & Chagani, 2013) followed by suicidal ideation and emotional stress (Khan et al., 2009; Khan & Ali Hyder, 2006; Khan & Reza, 1998). Studies on domestic violence (Ayub et al., 2009; Karmaliani et al., 2011), violence during pregnancy and other illnesses (Ali, Israr, Ali, Janjua et al., 2009; Karmaliani et al., 2009) and marital rape (Ali et al., 2009) are commons forms of violence inflicted upon women (Ali, Mogren, & Krantz, 2013). Majority of the studies on mental health in women have focused on adult women or reproductive age women, particularly married women. Furthermore, studies have concentrated on a specific age group, phase of reproductive life or marital status of women. To put it differently, categories used for women were adult women, mothers, pregnant women, married women, pregnancy, reproductive age, reproductive health, and reproductive, sexual rights.

Though depression and anxiety prevails among all ages, the reproductive phase is the most concentrated area of mental health research. Antenatal care (Ali et al., 2012), prenatal depression (Zahidie, Kazi, Fatmi, Bhatti, & Dureshahwar, 2011), postnatal depression (Husain et al., 2011), postpartum depression (Gulamani et al., 2013) and perinatal period (Zahidie & Jamali, 2013) are some important reference points the literature uses to link mental disorders with pregnancy. It is interesting to observe that no single study was found examining psychological problems or psychiatric illnesses among young girls or young/unmarried women living with parents.

Marriage and pregnancy are two major events that significantly affect women's level of anxiety and depression (Ali et al., 2012). Gender inequality and disadvantage in form of taboos (e.g., secondary infertility) and discriminatory social norms (preference for son) increases the level of stress and emotional distress. Moreover, lack of social support, low opportunities to vent negative feeling and lack of involvement in

decision-making are other major risk factors; low socio economic condition and household debt also puts women on the verge of sickness (Rahman & Creed, 2007; Zahidie et al., 2011). Mentally ill women are more stigmatized, and being alone with problems and unable to access health care facilities, they suffer from worse clinical (development of psychological disorder) and social outcomes (Ayub et al., 2009).

Two studies focused on understanding socio-economic and demographic factors that put women into different mental disorders (Ali & Zuberi, 2012; Qadir, Khan, Medhin, & Prince, 2011). Few studies also showed what social practices make women vulnerable or protective of the level of anxiety and depression women experience. For instance, livelihood practices (e.g., fishing community), locality (urban/rural), family type (nuclear/extended) and family dynamics may increase or decrease the level of anxiety and depression (Naeem et al., 2008). At least two studies (Mumford et al., 2000; Qadir et al., 2011) have established that the socio-economic status is not a significant protective factor of women as commonly perceived. However, level of education may positively impact women's psychological health and well-being.

Studies also mentioned how women cope with mental and psychological disorders, especially those women who are ill, either due to depression and anxiety or because of being affected by any form of violence. Women have primarily been repressing their emotions if violence is imposed upon them or whenever they are going through severe depressive condition (Zakar, Zakar, & Kramer, 2012). Increased involvement in religious activity, positive distraction through mingling with family members and neighbours also enable them to survive with their mental conditions (Zakar, Zakar, Hornberg, & Kraemer, 2012). Interaction with family members and neighbours especially strengthens their coping mechanism (Khan, 2012; Rafique, 2010). Additionally, alternative medicine or indigenous healing practices are also an important space for women to deal with their mental and psychological suffering (Saeed, Gater, Hussain, & Mubbashar, 2000). This is especially done in the rural context of Pakistan where treatment from illnesses is sought from faith healers than a physician.

Another set of studies that were found were intervention studies (Ali, Ali, Azam, Khuwaja et al., 2010) that go beyond knowledge generation process and address women's mental health problems as they face them. These studies include interventions such as supportive and cognitive behavioural counselling by minimally trained community health workers, economic skills development, women's empowerment programmes, microcredit programmes and counselling husbands (Ali et al., 2010; Karmaliani et al., 2011; Rahman et al., 2012). The focus of these interventions is primarily on those women who are anxious, depressed or abused by their husbands.

The studies reviewed have mostly measured the prevalence of mental health problems and their impact but have failed to answer how and also why women suffer from psychological and psychiatric disorders and illnesses. This means that what goes into women's social contexts is less explored and examined for an adequate understanding of women's mental health. Surveys, case control studies and use of few qualitative tools like interviews, observations, and focus group

discussions have proved inadequate to answer these questions. Other methodological traditions, preferably from social sciences that have the capacity to go beyond questionnaires and screening tools could be used to explore women's other phases of life to see what is happening to them in the larger social context. Further, lack of operational studies conducted in this area indicates that intervention studies are the least tried methods for dealing with mental disorders.

To conclude, research on women's mental health in Pakistan is dominated by the positivist framework (Guba, 1994) which assumes that only scientific knowledge can reveal the truth about reality (pp. 109–110). It thus tends to focus more on the clinical aspects of care and ignores the social and contextual problems which require a different paradigm of understanding. A major gap in all the research literature is the absence of application of the findings to programmes and policies that could benefit women with mental health problems. Research thus appears isolated and disconnected with measures that could benefit women.

Women's Understanding of Mental Health

Quality of Life Matters! This section is an account of how urban and rural poor women from two provinces of Pakistan (Sindh and Baluchistan) understand mental health. These findings are from two studies: One was part of a multi-country study on women's empowerment titled 'Women's empowerment in Muslim Contexts'. A participatory action research approach was taken which facilitated women to be the analysts of their own lives. Its framework of inquiry included facilitating women to discuss what they understood by health, and with the help of a picture they discussed what makes women happy and unhappy. They also deliberated over what constitutes mental health (Aziz, Shams, & Khan, 2011). In Pakistan, the study was conducted in Sindh in 2007–2008. The second study was a part of a large quasi experimental design conducted under an 'Early Childhood Development Project' in three districts of Baluchistan in 2012. Information was collected on women's mental health through focus groups discussions and in-depth interviews. A semi-structured guide was used to explore women's understanding of health and mental health, symptoms and effect of mental health problems on women's life, attitude towards women with mental health issues, coping mechanism and availability of social support and mental health services.

A multi-voice narrative is used to present how women interpret mental health. It is a well-recognized part of narrative research, and instead of including statements of different women, several voices are collated to present an overview of what women say (Heikkinen, n.d.).

Sindh, historically the cradle of an ancient civilization, is still governed by feudalism which means small number of families ruling the life of large number of people who work on their lands. Education has made inroads in Sindh and there is a growing middle class, but the poor, whether in urban or rural settings, are governed more by their sociocultural norms rather than formal laws of the country.

Baluchistan is a rugged and sparsely populated province of Pakistan, and here tribalism governs the life of women and men, especially the poor.

Women's understanding of the state of mental well-being was reflected in their use of the word or contentment or *sukoon*. The following understanding is drawn from both urban and rural sites of a study on women's empowerment in Sindh (Aziz et al., 2011).

> Mental contentment (pursukoon) is mental health; to be able to listen attentively, and be in a state of wellbeing (khushgawariyat) … if there is mental health, there will be decision making; if our mental wellbeing is good, we shall be able to make right decisions.

There were interactions with women's groups around different stages of life and their experiences in those stages. In these discussions again, the word *sukoon* (contentment) was frequently used.

> If there is '*sukoon*' in the home there will be no illness and people will be healthy …
>
> when I am happy my mind gets '*sukoon*', I am fresh and I feel like working … .
>
> 'When I went out, to visit mother and grandmother' I felt *sukoon*. … 'when I got married I got sukoon, when I was an adolescent I was worried' … '*jawani*' (youth, pre-marital part of life) was without worries, there was *sukoon*, after marriage there were restrictions' … Children are a source of happiness, and when they become adult then '*sukoon*' comes'.
>
> Contentment '*Sukoon*' … it is a gift of God; it gives happiness; there will be no mental tension, and when this happens there will be health … . you get *sukoon* by remembering God; if there is nobody in the house, woman will have *sukoon* … if people are not contended (not *pursukoon*) then their heart and mind will not be happy and will not work
>
> We labour before marriage and after marriage; there are children now, but no *sukoon*.
>
> There is no *sukoon* in any stage of life.

Women in Baluchistan, though coming from a very different, background had similar understanding.

> Mental health is mental contentment (*sukoon*) … . If our mind is healthy and is content, then we can think well; worries and too much of thinking effects mental health; any thought which causes worry impacts mental health;
>
> Many women linked self-governance and empowerment with mental health.
>
> If there is self-governance there will be '*sukoon*' … 'if our mind is healthy and our mind has '*sukoon*', then we can think well.
>
> When she is self-governed (*khudmukhtar*) she will be mentally OK … . If she is mentally worried, she will not be able to be self-governed; if she is mentally ok, then she will be able to be self-governed; if her mind is okay then she can become self-governed.
>
> One of the women also de-linked self-governance with being worried.
>
> … if I am mentally worried and I am self-governed, and if I wish to go to Sukkhar then I will be able to go.

This same approach of asking women about mental health was also taken with a group of all illiterate rural women living in a remote village. Interestingly, there was not much variation in the understanding of mental health by illiterate women in a village, and educated, working women in a rural setting. Both groups were from the same district in Sindh, Pakistan.

> If health is good then we will travel and we will enjoy it … everything will feel good; there will be no backache, no headache, no heartache … if there is no health, then even people will not be liked.

On the other hand, participants in both provinces described a mentally unhealthy woman as one who also has lots of physical complaints, is easily irritable, gets angry on little things, is not happy, complains of lack of sleep, has lost interest and is unable to take care of the family.

> One who is not mentally happy, will not talk much; will not be attentive, 'after we have spoken with her and ask her, she will ask what we had said' … if mind is not ok, then heart also will not be happy and nobody would be liked … A woman who is not mentally well, will be weak, will sleep, tie a bandage on her head, will not listen to anybody.

Interestingly women's perception of their identity, self-image, status and role defined by the society also defined the wider concept of health. Fulfilment of the expectations of the family and successfully performing household chores are considered an important characteristic of a healthy woman.

> (A woman) who can look after her children, can also perform household chores is healthy … A healthy woman does all her work on time, takes good care of her husband, her home, if she is not healthy then she cannot take care of her husband her home or anything … A (healthy woman) has no mental tension, is contended (pursukoon), can look after her children, if health is not good she cannot do anything correctly.

Poverty and economic hardship came out as the main causes of mental health problems in rural areas from both provinces.

> Husbands do not work, so wives fight with them and take stress … If there is money then there will be happiness, then human beings will be liked, if there is no happiness nothing will be liked. What society says will not be liked, and [the person] would be ill and be isolated.

Strained relationship with husband, negative attitude of the in-laws, domestic violence and lack of social support were other risk factors identified by the study participants. Some women were not allowed to interact with their own family members due to the restrictions imposed by the husband.

> … due to home environment (women) suffer from mental illness, husband does not take care, attitudes are not good … If a woman is not mentally well and fights with her husband, then it can result in physical violence by the husband … Some husbands are strict and all the distress leads to sickness in the women … Some men do not allow women to meet their siblings and family and this also leads to mental illness in women.

Women expressed that no attention is paid to mental health of women in their home and community; no medical services are available in the community and neighbourhood; services are available only in big cities and majority of the people visit religious faith healer (*Maulvi*) for such ailments. Coping strategy advised and used by participants is mostly 'praying' (faith in God'). Some of the participants reported that sharing the issue with husband or with someone helps her if she has trusting relationship.

> There are no government health services in our area, (private) doctors are there but they do not take care of the patients … We do not go to doctor for the treatment we prefer religious person (*Maulvi*) … we take treatment from '*Maulvi*', who gives '*taweez*' (sacred words written on small piece of paper, wrapped in a cloth and worn as a locket) … If a woman recites Holy Quran she will get better.

Discussion and Framework for Advancing Mental Health of Women

From Awareness to Action! The domain of mental health is not entirely dormant in Pakistan. There is a mental health ordinance which provides legal cover to some mental health issues. Mental health is mentioned in some policy documents, no matter in how cursory a manner. A spattering of services is available, but their effectiveness is not systematically monitored as they are not an integral part of the public health surveys.[4] Research on mental health is also being undertaken, but how it links with policies and programmes is difficult to ascertain. While this indifference prevails, there are women, especially of poor communities, who carry a burden of mental stress and can identify what is needed to ensure their mental well-being. This raises the question: what is the relationship between research, policies and programmes with what women are saying about mental health. The answer is: there seems to be no relationship, and this absence of relevance between services, research and policies to women's understanding of health are the gaps between these three domains (of research, service and policies) and women. These gaps raise several questions. Namely, why is mental health not a priority like reproductive health? Why are the obvious stressors on women's life not on the agenda of policy makers? Why has mental health not been mainstreamed in the Primary Health Care system of Pakistan? Why is the impact of violence and anarchy on the lives of the vulnerable not addressed by researchers as well as health providers?

Mental well-being is not simply the absence of mental disorder; it is a state of mind inextricably linked with daily life. The Commission on Social Determinants of Health (CSDH) report (2008) unequivocally recommends that daily lives of women have to improve as it will lead to better health outcomes in a generation (Marmot, Friel, Bell, Houweling, & Taylor, 2008). If women's daily life is to improve then it is understandable to say their mental well-being should improve. It seems a monumental task to mainstream mental health in the health sector, and especially within the Primary Health Care (PHC) programmes that alone reach out to communities and subscribe to community participation as advocated by the PHC Declaration of 1978.

There is a global struggle to keep social determinants of health afloat. WHO in 1948 gave the world a definition of health, and it was: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). Thirty years later, in 1978, WHO gathered its state

[4] Pakistan has two major surveys that take place on a regular basis: (1) Pakistan Demographic and health Survey, 2013, provides no information on mental health and (2) Pakistan Social and Living Standards Measurement Survey. Both do not provide any data that could help monitor the mental health of women.

members to a conference and the PHC Declaration of the conference reiterated the WHO definition of health. Thus, physical, mental and social well-being remained the central feature for understanding health. Thirty years later, 2008, WHO-CSDH issued its report, which again stressed on issues of equity and addressing the conditions in life that lead to poor health outcomes. Its first recommendation 'Improve Daily Living Conditions' poses a challenge to all public health professionals. While better off regions of the world (Europe, Australia, Canada, Japan) have shown success in addressing the social determinants of health, developing countries, barring some examples, like that of Sri Lanka, have not been able to demonstrate improvements in the well-being of their population, especially the marginalized, the poor and disenfranchised. What has persisted in the developing world is the clinical model of health, and the challenges emanating from this model persist. This struggle is not unlike the women's struggle against patriarchy and hegemonic masculinities. However, women's movements offer a model of persistence and determination which could be emulated by health professionals conceptually driven by the meaning of health as well-being.

If the field of mental health has lagged behind in developing preventive and promotive programmes, and finding a place within Primary Health Care and the larger health systems and policies, this neglect cannot justify a continuation of this indifference. There is a growing number of people and institutions who recognize the social determinants of mental health and the need to address them. The need of the day is to bring together those determined to take forward the well-being model, whether from the perspective of physical, mental or social well-being.

A framework for mental health within the larger rubric of social determinants of health could help guide the advocacy work needed for women's mental health. A framework evolved in the process of the research project, women's empowerment in Muslim contexts, and was constructed to capture the research design as it was being implemented. It was thus not an adoption or adaptation of any available framework of women's empowerment. The framework is based on four sets of concepts:

1. Three levels for analyzing the context (WEMC, 2008) of women's well-being (Fig. 3.1):
   (a) Micro-level—women at the household level.
   (b) Meso-level, which consists of the socio cultural environment that governs women's lives and includes the customary practices that are often more powerful than the laws of the country.
   (c) Macro-level—this is where policies are made.
2. Identification of mental health issues and their social determinants.
3. Factors that facilitate women's empowerment and factors that impede women's empowerment.
4. Participatory approach for facilitating women's empowerment for challenging the social determinants of health.

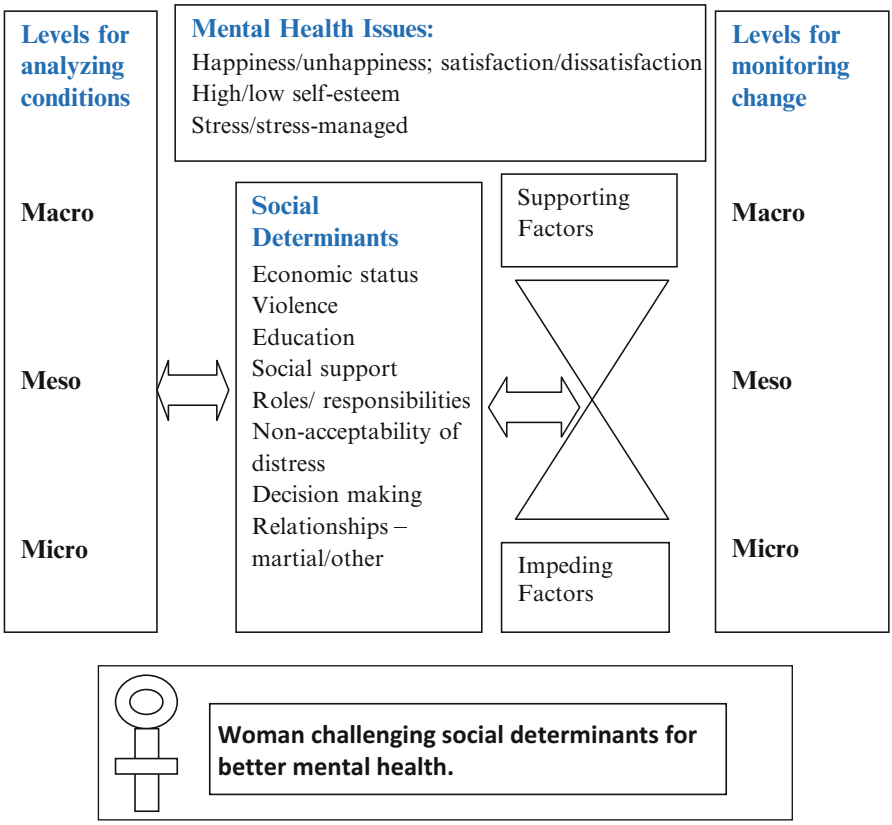

Fig. 3.1 This framework can be used for developing programs and research questions for an integrated approach to women's mental wellbeing

Conclusion

What Needs to Be Done? Pakistan is caught in an impasse—what women say they need for their mental well-being is not on the radar of mental health researchers, service providers and policy makers. To overcome this situation mental health researchers need to get attuned to the issues being raised by women. Sociocultural and political barriers (from non-responsiveness of the state to politics of everyday life) in the society are the major obstructs in women's well-being. Psychological morbidities, from which majority of the women suffer, are actually the result of the nature of day-to-day living conditions. Studies from this perspective would be significant for answering the questions pertaining to improvements in women's mental health in Pakistan. If women's assessment of the causes of their mental health is to be taken seriously, then women would need to become partners in exercises of understanding and action. Women who suffer the pain and burden of poor mental

health, and who bear the brunt of psychological disorders most, need to get priority in becoming partners in the diagnosis and treatment of their own health. Mental health researchers could also consider building alliances with the many NGOs in Pakistan who work at the community level. The NGOs have integrated gender equality into their programmes. They recognize the social barriers that women face because of their social position, but they are not linked with the mental health professionals to address women's mental well-being. This partnership is likely to immensely contribute to supporting interventions for women's rights and to understand and remove the psychological barriers to women's development. This partnership between mental health researchers, NGOs and women living with poor mental health would provide a large enough base to shape policies and programmes for mental health. Three recommendations can be drawn from this conclusion:

1. Mental health research to integrate the principles of participatory action research by inducting women-research-subjects as equal partners in advocacy for removing the factors that construct poor mental health.
2. Mental health researchers to forge partnership with NGOs working at the community level with women, so that mental well-being becomes integrated in efforts for realizing women's rights.
3. Mental health researchers and NGOs to expand the voices of women to policy makers and service providers.

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Response #1

Fatema Hasan

Trapped in my being
Life!
O life of mine!
I have no grievance against you
None, whatsoever
There's nothing that hasn't changed
Nothing that I've not acquired.
Why is it then that I don't feel happy
A feeling of distress haunts me
A briery, prickly notion makes me restless
I feel something is amiss in my life
A smoldering fire, I apprehend
Will flare up into a conflagration
My home and hearth
My peaceful existence

Would come to an end.
I am a bulwark of defense
around my near and dear ones
I'm at ease with my environ
Satisfied with my children, my husband, my family
Content with their going and coming time schedule
Their presence on breakfast table or evening tea
I've no gripe against in-laws
No grouse against kith and kin
Nothing, indeed, that might create tension
Cause distress.
My home is a paradise incarnate
A refuge and a shelter
Peacefulness, placidity is my own creation …
I always thought my life was a sheltered haven
Harmony and restful quietude is the norm
In my day to day life … but
For some days
I have been feeling a thorn prick my heart
A burning itch, as it were, getting sharp
An itch that perhaps
might, for a moment, be bearable for me.
Was it an insufferable dream or an illusion?
I felt I have wings—self-grown,
I am flying somewhere, far away, above and high, embraced by the space,
Leaving this daily life behind …
I am happy, God knows why I am feeling so.
Then it was
That all of a sudden
A beckoning call, a cry from below
Made me wake up, pull me down …
Down into a chasm, a gorge of dejection
I fell down and down
I got entangled—finally losing myself.
No longer am I a distinct 'self' now.
No longer do I have any relationship with any one
No affinity at all.
In a house I am, but
The house is not my own.
I have nothing … indeed, nothing at all.
Why and wherefore did it happen?
Indeed, I don't know.
I don't know at all.
****

Response #2

Anis Haroon

(Translated by Kausar S. Khan, Ghazala Rafique, Sohail Bawani)
Listen to my needs
When ill, I cannot go to a doctor
either there is no money, or husband has no time.
When a cow is stricken, treatment is rapid
Is cow more valuable than me?
Yes. It is, for it provides milk;
but I also give milk to children
I bear the weight all household work.
I also need attention
I am not noisy, so nobody listens.
If I speak,
I am called impatient, petulant, and short of reason
My tired body needs rest
My mind needs peace
My heart has desires.
Why this restriction on my mobility and movements?
Why this violence on me?
Violence destroys homes,
destroys mental tranquility
Would somebody ask me what I wish?
Without health there is nothing,
no happiness without respect
I carry the weight of body and heart
They say my home is heaven
Yes. It is heaven, but for my husband and children
I made it so with hard work and sacrifices.
I want to be part of this heaven
How is this to be?
It is possible only if I'm accepted as equal
And my pain and suffering are addressed
I need few words of respect and love;
Acknowledgement of my importance
I need also to feel
that I am an equal being;
part of decisions made.
I am not a servant, nor a soul-less body
My mind thinks, and my heart has a rhythm
I need recreation too
I want to share what my heart says, with those who are mine

See what it is to understand me as an equal being
This home would really be heaven
For you and also me.

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