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Views about Women's Mental Health: Study in a Squatter Settlement of Karachi

Pages with reference to book, From 139 To 142

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Abstract

Objective: Mental health of women is globally receiving particular attention. This study assessed community's view on certain aspects of women's mental health prior to introducing an intervention.

Setting: The study was conducted in an urban squatter settlement located in District West of Karachi in 1997 where the Aga Khan University has set up a Primary Health Care program in partnership with the communities. **Methods:** Using convenient sampling, door to door household survey was conducted by medical students.

Results: Two hundred and eighty one residents were interviewed. Respondents were asked to list contributory factors which lead to mental distress in women. Two hundred and ten (75%) were able to list certain factors. The factors listed were; low family income (40%), dispute amongst spouses (30%), verbal abuse by in-laws (25%) and too many children (5%). When asked what women in the community did while they were mentally distressed 35% respondents reported that women talked to their husbands and 18% said counselling from a health provider was sought. Main channels of social support desired were; revenue generation (67%), membership of a women's group (11%) and training of local community women in counselling skills (10%).

Conclusion: Signs of awareness about mental health issues are present even in marginalized communities of Pakistan. In order to improve the mental health of women interventions should primarily focus on raising family income (OPMA 49:139, 1999).

Introduction

The often cited definition of health coined in 1978 stresses the importance of mental, physical and social well being as opposed to the mere absence of disease¹.

WHO in its report on health trends and emerging issues in the 1990s and the 21st century identified mental illness in adults as one of the eight diseases which deserve particular attention especially in context of increasing urbanization².

Busenberg³ has reported that globally there are 500 million mentally ill people and their number is likely to increase. By 2015 Karachi will be the 7th largest city in the world with a population of 20 million with approximately 40% of its population residing in slums^{4,5}. Reliable data for psychiatric morbidity is meager. Studies^{6,7} report prevalence ranging from of 12% - 38% for Karachi. In a study⁸ in the mountain villages of northern areas of Pakistan a conservative estimate of psychiatric disorders of 48% in women and 16% in men was reported. Married women are more likely to suffer because they go through stresses of family breakdown especially in an urban environment, household work, marital problems, child bearing and child rearing⁹. Mental health of women particularly in poor urban areas, however, has received little attention¹⁰. Despite WHO's advocacy to incorporate programs on mental health in Primary Health Care (PHC), training of health personnel and delivery of health care have failed to attend to mental health problems particularly those of women". As a result, majority of psychiatrically ill patients receive therapy from non-psychiatric physicians, social support groups and immediate family members all over the world^{12,13}.

Social support involves exchange of expressions and is characterized by sympathy, empathy, understanding, affection, advice and material or financial aid¹⁴. Existence of such social support groups and organizations in developed countries is not surprising¹⁵⁻¹⁸. Little is however known about the existence of such channels in Pakistan.

This study in an urban squatter settlement of Karachi explored community's views about certain aspects of women's mental health particularly contributory factors towards mental distress, existing channels of social support and possibilities of community-based interventions within the existing community-based PHC program set up by the Aga Khan University (AKU).

Material and Methods

Setting of the Study

This study was conducted in Sultanabad, an urban squatter settlement located in District West of Karachi, where the Community Health Sciences Department (CHS) of AKU has set up a PHC program in partnership with local community based organizations to improve the health of mothers and children. According to the baseline census of CHS conducted in 1996, approximately 12,000 people mostly (58%) Pushto speaking are living amidst poor housing and sanitary conditions. Urdu is readily understood. Of those above the age of fifteen years approximately 70% are currently married. Majority (70%) of the households have a joint family system, the women moving in to live with their in-laws after marriage. Amongst the married women 90% are housewives, 79% are illiterate with an average of 4.4 pregnancies during their reproductive years. Only 50% men are literate with 20% having no source of income.

Sampling Strategy and interview Characteristics

A team of five medical students supervised by the author conducted household interviews in August 1997. Convenient sampling was done. With an average of completing ten questionnaires per day, it was estimated that approximately 300 residents could be interviewed within the time allocated for data collection by the undergraduate medical curriculum. The questionnaire was administered in Urdu and pretesting done in an adjoining community.

That this survey was aimed to identify some determinants of The entire catchment area of Sultanabad was divided into five field zones with defined geographical boundaries. Starting from first household on the right the students knocked at each door and attempted to interview.

Consent was obtained before administering the questionnaire. The volunteers and students briefly explained mental distress amongst women and recommend suitable and appropriate community-based interventions.

The students were instructed to interview only one woman (preferably married with children) per household. In case more than one woman resided within a household and both were consenting the one first encountered was interviewed.

Study variables

Open ended questions were asked to understand contributory factors for mental distress and existing and desired channels of social support. A structured close ended question was posed to specifically ask about existence of formal channels like clubs, organizations, social and local recreational groups etc.

Data entry and analysis

Data entry and basic frequencies were generated on a computer software package (Epi-Info, 6.04).

Results

Characteristics of the respondents

Of the 300 residents approached, 281 (93%) responded, of which 66% were women. The majority of

the residents (30%) were between 25-34 years with 116 (41%) being illiterate (Table 1).

**Table 1. Demographic profile of respondents.
n=281 (185 women, 96 men).**

Age	Frequency	%
18-24 years	53	18.9
25-34 years	84	29.9
35-44 years	77	27.4
45-54 years	35	12.5
55-64 years	14	5.0
65 and above	18	6.4
Level of education		
*illiterate	116	41.3
primary	66	23.5
secondary	62	22.1
higher secondary	25	8.9
graduate	10	3.6
others	2	0.8
Marital status		
Married	223	79.4
Widowed	16	5.7
Single	33	11.7
Divorced	5	1.8
Separated	4	1.4
Time since resident:		
<1 year	16	5.7
1-5 years	21	7.5
5-10 years	32	11.4
>10 years	212	75.5
No. of previous child deaths:		
None	216	77.1
1 or more	65	32.9

*Not able to read and write a simple letter.

Respondents were married (79%) and the monthly income of 136 (48%) of these was between Rupees 2,500-5,000. Of the 185 women interviewed, 148 (80%) were housewives and 21 (11%) had a domestic source of income (Table 2).

**Table 2. Socio-economic profile of respondents.
n=281 (185 women, 96 men)**

Monthly income	Frequency	%
<Rs.2500	28	10.0
Rs.2500-<5000	136	48.4
Rs.5000-<10000	81	28.8
Rs.10000-<15000	20	7.1
>Rs.15000	16	5.7
Household structure:		
*Kacha	4	1.4
**Pakka	213	75.8
Semi-pakka	48	17.1
Tin roof	16	5.7
Employment status (male):		
Unemployed	17	18.7
Daily wages	8	7.3
Employed	69	71.9
Other	2	2.1
Employment status (female):		
Housewife	148	79.6
Housewife with domestic source of income	21	11.3
Working outside	14	7.5
Others	2	1.5

*Kacha: house roof and walls not built in concrete

**Pakka: house roof and walls built in concrete.

Contributory factors for women's mental distress

Contributory factors towards a poor mental status of the mother were listed by 210 (75%). The four identified factors were low family income by 84 (40%), dispute amongst spouses by 63 (30%), verbal

abuse by in-laws by 52 (25%) and having too many children by 11(5%).

Existing social support

Formal channels of social support as listed above were non-existent. The interviewers asked the respondents to list measures a mother took while in mental distress. Many informal means of social support were listed by the respondents (Table 3).

Table 3. Current measures of social support taken by mentally distressed mothers.

Response	%
Talk to husband	35
Go to a health care provider	18
Talk to friends	16
Talk to religious leaders	4
Talk to sister	3
Do nothing	24

The responses that got the three highest scores were; “talk to husband” (35 %), “do nothing” (24%) and “seek help from a health care provider” (18%).

Desired forms of social support

Expressing their choice of social support channels for women, 188 (67%) respondents opted for measures to generate income for community women, 30 (11%) membership in a women’s support group, 29 (10%) training of local community women in counseling skills and 27 (9%) consulting a health provider. Seven (3%) did not give their opinion.

Discussion

There is considerable interest and information about the reproductive health status of women in developing countries. Except some hospital-based studies, a parallel interest and a data base on women’s mental health status is lacking¹⁹. This is one of the few studies that assesses the perception of a community prior to embarking on an intervention.

Within the socio-cultural context of developing countries it is easier to talk and seek treatment for physical illness relative to psychological ailments²⁰. In this study, however, respondents reported discussing mental health issues with spouses and health care providers. They also expressed their desired means of social support for tackling mental health issues. The contributory factors listed by study participants have also been documented in other studies^{1,20-22}. These include absence of support provided by social relationships, internal dynamics of the family but most importantly insufficient money and unemployment. In a Brazilian study it was demonstrated that the lower the household income, the less educated the mother the higher was the chance of mental disturbance²⁰. Although a

survey of this kind tends to select the more cooperative and communicative respondents nevertheless we conclude that signs of awareness about mental health are present even in disadvantaged and marginalized communities of Pakistan.

In this regard, the Department of CHS which currently offers basic PHC services like immunization, family planning and antenatal care is now also considering to address broader issues of socio-economic development. Efforts are underway to link Sultanabad with non governmental organizations which offers microenterpreneur credit schemes and train women to supplement family income.

Moreover, the Department of Family Medicine and Psychiatry at AKU are together exploring the low cost, community-based initiative of lay co-counseling. This technique involves training of local women in counseling of those mentally distressed. Lady Health Workers (LHWs) appointed by the government and volunteers of the existing AKU-PHC program at Sultanabad could be trained in this regard. These efforts can be supported by a psychiatrist when required.

A follow up intervention study to assess the impact of these culturally appropriate, socially acceptable and mutually desirable interventions will be conducted so that the benefits to mental health can be understood and similar efforts be carried out on a larger scale.

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