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APPLYING COMMUNITY PARTICIPATORY METHODS TO MEET WOMEN'S MENTAL HEALTH NEEDS IN KARACHI, PAKISTAN

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ABSTRACT

Poor mental health is a global epidemic with women affected more often compared to men. Compromised mental health jeopardizes women's health and functioning and also the health and wellbeing of their children. To promote women's mental health, principles of community participatory methods were used to design and implement a mental health program, which was predicated on empirical research, sensitive to community culture and needs, and delivered by Lady Health Workers in an urban slum area of Karachi, Pakistan. The sequential steps of community participation, program development, implementation and strategies for sustainability are described.
Key words: Women, Mental Health, Community Participatory Methods, Sustainability

INTRODUCTION

Women's Mental Health: A Global Crisis

The World Health Organization's Ottawa Charter for Health Promotion (1986) posited health as multidimensional and put forward a social model that

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defined health as including social, personal, and physical capacities. Health cannot be fragmented or reduced to a single causal factor and women's mental health is no exception. Good mental health is intrinsically important, conferring a subjective sense of emotional well being on the individual woman and extrinsically important, representing a significant resource to the broader community in which she lives and works. Gender theory holds Public policy including economic, socio-cultural and environmental factors, community stressors and life events, personal behavior and skills, and availability and access to health services, as important determinant of women's mental health status.

Present global statistics document that women's health and wellbeing are more affected by poverty, illiteracy, and unemployment compared to men. For women in South Asian countries such as Pakistan, the statistics are appreciably worse (UN, 2009). Pakistan reports one of the highest rates for psychiatric morbidity in the world. Hussain (2000) reported 66 % of the women were depressed in his study of community-dwelling women in Pakistan. Married women in Pakistan are at greater risk for depression compared to single women (Fikree, 1999; Khan, 1998). Compounding the depression among Pakistani women is the high prevalence of partner violence (Karmaliani et al., 2008). Studies have validated that more severe the abuse, the greater the negative impact on a women's physical and mental health (Laserman et al., 1996).

Poor mental health among women is a global epidemic yet effective programs remain limited. Committed to learning from an impoverished community and involving residents in deriving strategies for better mental health among women, an international, multidisciplinary team of nurses and psychologists from the Schools of Nursing at Aga Khan University (AKU) in Karachi, Pakistan and Texas Woman's University in Houston, Texas and the Department of Psychiatry at AKU approached a community of need to form a partnership for better mental health. The purpose of this paper is to describe the process in implementing mental health intervention for women in a resource poor community of Karachi.

Applying Community Participatory Methods

A community participatory method is a collaborative process involving professionals and community representatives. A community participatory method engages community members, uses local knowledge in the understanding of health problems and the design of interventions, and invests community members

in the processes and products of research (Faridi, 2007; Israel, 1998; Jones, 2007; Minkler, 2003). The following steps describe the actions taken to implement a community based participatory plan to improve women's mental health in Karachi, Pakistan.

Step 1. Involving the Community in Designing a Program for Better Mental Health

To discuss the high burden of depression and partner violence on women's mental health, especially among poor women, and associated compromised functioning of their children, the research team requested focus group and key informant meetings with community leaders, agency directors, and economically disadvantaged mothers. The meetings were always scheduled in the community at a time and place convenient to the participants. To maximize inclusiveness, community designated lay leaders, such as the community clinic advisory board chairperson, the community-appointed spokes person(s), and the community-based governing organization chairperson(s) were requested to suggest invitees for focus group meetings. Learning the organizational structure of the community was crucial in contacting appropriate lay leaders to establish community participatory meetings.

The purpose of each focus group was to share our concerns about maternal depression, partner violence, and child functioning and the goal of offering a mental health program to mothers to improve maternal mental health and child functioning. We asked the focus group attendees to share their perceptions of the importance of maternal depression, partner violence, and child functioning, as well as their recommendations for a culturally acceptable community program. Considering, community residents spoke several different languages, we always asked about the preferred language from the group. If translations were needed, we stopped the focus group every 3-5 minutes to translate to keep everyone equally informed. We always had one team member fluent in all languages spoken by the focus group participants.

In addition to focus group meetings, we scheduled talks with key informants. Focus groups worked well when many people were involved, such as community based-organizations (i.e., clinics, programs, civic associations). However, when we contacted nongovernment organizations (NGOs) frequently only one or two staff members directed, implemented, and managed a total program. Therefore, key informants tended to be the entire NGO staff. The key

informant meetings with NGO's followed the same protocol as focus group gatherings. We always asked the informants their perceptions of the importance of maternal depression, partner violence, and child functioning, as well as acceptable, culturally sensitive community programs. We continued the focus group and key informant meetings until we stopped receiving new information. All informants agreed on the prevalence of maternal depression and partner violence and the importance of better mental health for women, but the informants differed on the design of the program.

Our team had proposed an empirically tested individual counseling program (Ali, 2000, 2003). The community participants had reservations about a one-on-one approach. The community participants felt the male members of the household would not agree to their women participating, feeling the woman had been identified as having problems and therefore casting a negative impression of their household. Our team decided to pause and learn more about the cultures of the community so we could better propose the type of mental health program which would be culturally acceptable.

Step 2. Measures to Ensure Sustainability

Karachi, Pakistan is a megacity of over 20 million persons. Much of the population lives in multiethnic, economically deprived, densely populated settlements of 15,000 to 30,000 families. Bilal Colony, the community with which our team works, is one such inner city congested community of 25,000 families. The residents of Bilal Colony are an ethnic mix of many nationalities, cultural groups, and regional alliances. Many residents are migrants who moved south from the Northern tribal governed regions of Pakistan and along the Afghanistan border. The populations were displaced due to tribal disputes, lack of employment, and war. Other residents migrated to Karachi and settled in Bilal Colony from India and Bangladesh. Ethnic-specific clusters of families who migrated from the same geographic area or who speak the same language tend to cluster and form neighborhoods governed by traditional mores and values. Most residents live in extended households of up to 15 persons. For many families median monthly income is less than the equivalent of $50 US dollars. Unemployment and underemployment is appreciable with many men and most women unable to secure employment. Many children do not attend school and adults without literacy skills are common.

Community leaders and residents readily identified the need for mental health programs but were concerned about the stigmatization of women attending a "mental health" program. Discussing the stigma issue of a mental health program, community residents recommended we first address the lack of an adult literacy program. The women leaders of the community felt the male household heads would be very likely to permit their wives to attend adult literacy classes. The women further advised that after male trust was established, the mental health program could be introduced with more success. The idea of adult literacy classes for women to include literacy and mental health skills of problem solving and conflict resolution was positively received by the adult literacy teachers and community leadership.

The teachers used a "Life Skills Curriculum" to teach literacy that included effective communication, safe parenting, and healthy hygiene. The teachers were very excited to add a mental health component following the literacy class. However, in Karachi the community based adult literacy programs for women were in short supply with many more communities requesting adult literacy programs than the government could fund. Our community had no adult literacy programs for women although the community had requested an adult literacy program for many years.

To meet the community need of adult literacy for women and a mental health program, our team began a year long process to secure an adult literacy program for the community. Following a one year effort of multiple meetings and completion of numerous forms, the adult literacy request was granted. Three adult literacy programs were established in the community. We proposed to incorporate key elements of the empirically tested counseling model with a "group" mental health program that focused on problem solving and conflict resolution (Ali, 2003). We proposed to add a 1-hour mental health session, once a week for 8 weeks, to the daily 1-hour adult literacy class. All interested women would be invited both the adult literacy and mental health sessions. Additionally, we proposed to hire community health workers to teach the mental health program content. The community agreed and welcomed the adult literacy and mental health combination programs. The community was accustomed to Community Health Workers and respected their knowledge and presence in the community. The community felt offering a mental health program in conjunction with adult literacy classes for women would ensure acceptability and sustainability of the mental health initiative.

Step 3: Program and Personnel to meet Community Acceptability

In Pakistan, community health workers are termed Lady Health Workers (LHW). The Pakistani government, to offer a minimum level of affordable primary health care to communities of need, initiated the LHW role and training in 1994. Lady Health Workers deliver basic health care in the home in both rural and urban economically deprived communities of Pakistan. The Lady Health Worker is an integral part of the Pakistan National Program for Family Planning and Primary Health Care in Pakistan and is a crucial component of the health care delivery system for the country. An estimated 96,000 LHWs and their supervisors have been trained and deployed in the 135 districts that compose Pakistan.

The job description of LHWs initially included health education and basic preventive services for family planning, maternal and child health, improved nutrition, better hygiene and sanitation, and child immunization. Today the role also includes more comprehensive program management as well as offering mental health services of problem solving, empathetic listening and psychological support (Ministry of Health Government of Pakistan, Internal assessment of Lady Health Workers' Programme, 2007).

Using principles of community participatory research to improve women's mental health, our research team of nurses, psychologists, and LHWs understood that to follow the traditional LHW model of offering individual mental health services in the woman's home would not provide privacy. Additionally, the community leaders advised such mental health problem solving would be unsafe if the woman chose to discuss issues of domestic violence or family relationships. The community leaders appreciated the high need for mental health services and requested we offer a mental health program to as many women as possible through the male accepted format of adult literacy classes. Therefore, being attentive to community input and sustainability, a mental health program suitable to small groups of women attending adult literacy classes was selected.

Step 4: Blending Intervention with Community Need

Group counseling is well recognized in the literature, as a cost effective approach to promote mental health in resource deprived communities (Bass et al., 2006). Previous research in Pakistan demonstrated effectiveness when LHW's

offered basic mental health services of empathetic listening, guided referral, and interactive problem solving to economically deprived women (Ali, 2003). Incorporating tested components from Ali (2003) LHWs familiar with the multiple cultures of the community were prepared using the training manual as set forth by Ali, 2003). The small group format would enable the mental health program to be sensitive to community participatory recommendations, cultural sensitivity and women's safety. Additionally, we would be able to offer a mental health program to more women than a one-on-one approach would allow.

Twelve hours of training was offered to the LHWs. Training focused on empathetic listening, supportive communication skills, and systematic problem solving. Empathetic listening was taught with role-play and open discussions. To teach the skill of reflective listening, the group enacted scripted dialogues. For example, one LHW took the role of empathetic listener and another LHW that of a mother with depressive symptoms, such as problems sleeping. The LHW read the mother's script:" I am fed up with my life. I work round the clock and yet no one is happy with me. I am not appreciated. Even when I go to bed I cannot sleep". The LHW replies (using reflective techniques), "You are upset and unhappy. Despite your best efforts you are not appreciated by others. It is very frustrating not to be able to sleep."

To teach systematic problem solving we enacted common life situations. For example, women often discussed their frustration with the father's lack of involvement with the children. The LHW were taught how to use positive statements and positive reinforcement to confront the common parenting problem of lack of a father's time with the children. The LHW would respond to women, "When your husband is home waiting for dinner to be prepared and the children are playing, I suggest you say, "The children enjoy playing with you. I would appreciate you playing with the children for 20 minutes while I prepare dinner". If the husband plays with the children, the LHW would suggest the mother offer praise and positive comments. If the husband did not play with the youngsters, the LHW would recommend the mother say nothing and try again the next day.

Lady Health Workers were selected from community residents by using screening interviews that focused on their communication skills. Other important attributes of the LHWs considered for employment were their willingness to work with women, their concerns and attentiveness towards women issues, and their ability to encourage women's participation during the mental health sessions. The team psychologist trained the Lady Health Workers.

Training was completed during a weekly 3-hour session for four weeks. Additionally, the LHW's were offered information on how-to offer supportive dialogue and problem-solving techniques in small group settings with emphasis on the importance of group dynamics and confidentiality. For example, to ensure group participation the LHWs learned how to create an atmosphere of respect during the mental health sessions. If the women were shy or appeared reluctant to participate, the LHW was instructed in strategies to encourage the shy woman to share a recent life experience or ask her to relate an event of general interest, such as a recipe or household event.

The LHWs suggested that at the end of every mental health session the women be provided with handy tips on cooking or protecting family hygiene through preparation of clean water. The LHWs felt these tips resulted in successful maintenance of the women's interest during the sessions.

At the conclusion of the mental health training the LHW's were offered a four- hour session on confidentiality and ethics. The training was guided by Yalom's principles of group cohesiveness, which according to Yalom are important processes to produce change (Yalom, 1995). To ensure confidentiality, the trainer stressed the importance of group guidelines that included, respecting each woman's information, agreement not to disclose or discuss any information shared in-group sessions at home or in the neighborhood.

Additional information was discussed during the 4-hour session on how to maintain a positive regard for the comments of others and the difference between offering empathy and sympathy. It was emphasized throughout the training session strategies to offer support from the group members on problems discussed by individual women. Strategies for maintaining respect for the problems shared by each woman were also stressed. The goal was for the LHWs to be a facilitator to enable the group to assist individual women in solving problems of daily living. In order to ensure trust and maximize group cohesiveness, training for the LHWs also stressed the importance of communicating to each woman in each session and the equal rights of each group member.

Challenges and Opportunities Realized When Using Community Participatory Methods

As we applied methods of community participation toward program development many challenges and opportunities were realized. For example, the LHWs were as economically improvised and resource deficient as the women who participated in the mental health groups. However, as we quickly learned, the LHWs had developed skills to maximize economic resources and community services to maintain health and wellbeing. The LHW also understood the culture of the community and how best to offer coping skills within a culturally sensitive context.

Realizing the importance of keeping the LHWs for program success and sustainability, we offered ample encouragement, patience, and reinforcement of training information to the LHWs. For example, one LHW was married with 4 children. Her husband, a laborer, was not willing to help with household tasks or child care. Overwhelmed with personal life stressors, the LHW lacked self-assurance regarding her ability to effectively discuss communication skills to the women in the mental health program. The LHW had been chosen because of her commitment to the community residents and her determination to improve the mental health of women in her community. The team decided extra support would be necessary for this LHW and therefore offered extra training time and personal encouragement.

As the team developed trust with the women of the community additional interventions were identified by the community to optimize the women's mental health. For example, the women discussed lack of employment opportunities and the need for skill building to increase the probability that women could obtain and retain a job. The community residents and leadership corps consistently requested a program to build economic self-sufficiency of the women.

Applying principles of community participatory methods, our team worked with community women to develop an economic skill-building training program based on empowerment of women model by Schall and Becker (n.d) .Presently our team is testing the group mental health program for women, developed from community participation, and described in this paper contrasted to economic skill building as designed and described by Hirani et al. (2010a). Both programs were derived from community participation methods and

designed to be culturally sensitive and sustainable (Karmaliani, 2009). Both programs are offered through the adult literacy programs established by the government.

To test the differential effectiveness of the group format mental health program compared to group economic skill building compared to a wait-list control group, a three-arm randomized clinical trial, approved by the Ethical Review Committee of Aga Khan University, is underway with initial results reported (Hirani et al., 2010b). Attention to community need and involvement of community residents has focused our team toward the comparison of potentially sustainable programs to improve the mental health of women in Pakistan, which we feel has global application and sustainability.

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