FARHANA IRFAN MADHANI

PARTICIPATION IN MICRO-FINANCE PROGRAMS AND WOMEN'S MENTAL HEALTH AND WELL-BEING IN KARACHI, PAKISTAN: AN INTERPRETIVE DESCRIPTION

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

DOCTOR OF PHILOSOPHY (2015) McMaster University

Faculty of Health Sciences-Nursing Hamilton, Ontario

TITLE:	Participation in Micro-Finance Programs and Women's Mental Health and Well-Being in Karachi, Pakistan: An Interpretive Description
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NUMBER OF PAGES:	xix, 332

ABSTRACT

Background. In striving to achieve the UN Millennium Development Goals, Pakistan pledged to focus on eradicating extreme poverty for its population. The association between socio-economic status and health is well established. Micro-finance institutions provide access to credit for poor women where cultural and social constraints limit their opportunities for economic advancement. While involvement in a micro-finance program has been shown to reduce poverty, little is known about how this involvement impacts women's mental health.

Objective. The purpose of this qualitative study was; (a) to gain an understanding of how women conceptualize the meaning of their mental health; (b) to explore the impact of women participation in micro-finance programs on their mental health; (c) to determine how they promote their mental health; and (d) to obtain their recommendations for change to micro-finance institutions.

Methods. Using interpretive description methodology, data were collected and analyzed through interviews with 32 urban-dwelling women who have been micro-finance loan recipients for a period of 1 to 5 years. A total of six micro-finance administrative personnel were also interviewed; five institutional documents were reviewed. Data were analyzed in the source language Urdu, following three main phases of content analysis methods, preparation, organization and reporting.

Results. Women conceptualize mental health as being the presence of peace and the absence of tension. Participants relate this tension to absence of basic resources in their day-to-day living and lack of safety and security around the city. Women recognized

micro-finance programs as being a major inspiration towards their flourishing mental health. Regular practice of religion, being resilient towards adversity and securing family respect through a consistent source of income and repayment of the loans were identified approaches to promoting mental health. In enhancing micro-finance programs further, the women recommended for them to initiate vocational training institutions and to provide opportunities for their children to seek education at affordable cost.

Conclusion. The women participants of this study represented "everyday women" of Pakistan, who thrive through their resilience and courage to mitigate poverty and to achieve peace. Combating obstacles to meet the basic needs, including access to education, would be a useful first step towards mental health promotion for Pakistani women. Financial services of micro-finance, along with provision of vocational skills training, "women-to-women" approach and modifications in policy would assist women to utilize their loan productively. Multiple stakeholders should work collaboratively for the promotion of mental health determinants. As nurses are now moving beyond the traditional roles and counteracting complex issues, this study identifies implications for research, education, and practice.

ACKNOWLEDGEMENTS

The long ride of my thesis has been a challenging and satisfying one, but I would never have been able to complete it without the help of the following people.

I would like to begin with my supervisory team, Dr. Catherine Tompkins, Dr. Susan Jack and Dr. Carolyn Byrne. Your continuous guidance, timely feedback, and encouragement helped me to improve my work. My thesis would have not be completed without your sincere commitment.

I must also extend special gratitude to Dr. Catherine, my supervisor for your undying faith in me to be able to graduate in 2015. Your constant editorial support and positive remarks helped me moving forward. Dr. Susan for your challenging and thought provoking questions and comments. Dr. Carolyn for your humour, encouragement and guidance. My sincere thanks goes to Dr. Anita Fisher, my previous committee member, you were greatly missed and Dr. Judith McFarlane, who challenged me with this powerful topic.

Many thanks to all the participants. I salute your resilience and keeping a positive attitude filled with hope. I appreciate the time you spent and the pain you took to share your stories with me. Without your contribution, this study would not have been possible.

Special thanks to Dr. Asho Ali and Dr. Naghma Rizvi for their feedback on translation of categories and themes. Thanks to friends and colleagues for their supportive text messages along the PhD journey. To Lisa Kabesh for editing the thesis. Immense thanks goes to The Aga Khan University School of Nursing and McMaster University for partial funding of my PhD program.

I would like to thank my parents and siblings, for their prayers for my courage and to Almighty Allah, for giving me perseverance to complete this thesis. My sincere thanks to the Haji family. They have helped me immensely and I cannot thank them enough. From groceries to meals, and for looking after my children and their needs for when I was busy working, without you I would not be able to be where I am, today.

I would like to dedicate this thesis to my husband; Irfan, and my children; Faizaan and Eman. Your unfaltering love has supported me throughout this experience. My earnest gratitude to you all, and the sky is the limit, but for you even space held no boundaries. Thank you Faizaan for your beautiful poem "A Rising Light". Your poem truly reflects the voices of the women of Pakistan.

Ultimately, I could not have done it without any of you!

A Rising Light
Written by Faizaan Madhani

Slowly, a rising light,
Bringing us some might.
From low places we came,
Now we see the height.

No longer just housewives.
No longer do we just clean and bear children.
For now we dare to provide,
Our families, our children, our lives.

It is what we took,
For families, for hope.
A beacon of light so tall,
For now in life, we do more than just cope.

What do we want?
Help is what we want.
Without knowledge money means nothing,
No ill spendings should haunt us.

Now we see our lives changing,
A new picture we're painting.
Our lives are getting better,
Though it may be challenging.

But stress is a dangerous road,
Our lives escalating.
So fast, so tense,
But prayer brings me calm.

We need an audience,
To listen, to console.
Someone who understands,
For our minds to be clear.

Slowly, a rising light,
Bringing us some might.

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AKAM	Aga Khan Agency for Micro-Finance
AKDN	Aga Khan Development Network
AKRSP	Aga Khan Rural Support Program
AKUSONAM	Aga Khan University School of Nursing and Midwifery
BDO	Business Development Officer
BFL	Basic Financial Literacy
BIL	Business Incubation Labs
BRAC	Bangladesh Rural Advancement Committee
CAQDAS	Computer-Aided Qualitative Data Analysis Software
CTS	Conflict Tactics Scale
FMFB	First Micro-Finance Bank
GDP	Gross Domestic Product
GESA	Gender Empowerment and Social Advocacy
HCP	Health Care Practitioners
HIREB	Hamilton Integrated Research Ethics Board
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IPV	Intimate Partner Violence
IMAGE	Interventional trail with Micro-Finance for AIDS and Gender Equity
KF	Kashf Foundations
LHV	Lady Health Visitors
MDGs	Millennium Development Goals
MFB	Micro-Finance Banks
MFI	Micro-Finance Institutions
NGO	Non-Government Organization

MHC	Mental Health Continuum
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NRSP	National Rural Support Program
OR	Odds Ratio
OPP	Orangi Pilot Project
PhD	Doctor of Philosophy
PKR	Pakistani Rupees
PMN	Pakistan Micro-Finance Network
QSR	Qualitative System Research
RCT	Randomized Control Trail
RTI	Research Triangle Institute
SBP	State Bank of Pakistan
SES	Socio-Economic Status
SFE	Systemized Financial Education
SWB	Subjective Well-Being
SWLS	Satisfaction with Life Scale
UNICEF	United Nations Children's Emergency Funds
UN	United Nations
US	United States
WEC	Women Entrepreneur Council
WEI	Women Empowerment Index
WHO	World Health Organization

DECLERATION OF ACADEMIC ACHIEVMENT

I, Farhana Madhani declare this thesis report is my original work and I completed for partial fulfillment of a Doctor in Philosophy of Science in Nursing degree. As a primary investigator for this project, I conducted the study including, the data collection, and analysis and the writing of this thesis report. To the best of my knowledge the content of this thesis does not infringed on anyone's copyright.

The entire thesis process was supported and guided by my supervisor, Dr. Catherine Tompkins, and my committee members, Dr. Susan Jack, and Dr. Carolyn Byrne.

Chapter One: Introduction

It has been more than a decade since 189 world leaders signed the Millennium Declaration (United Nations Development Programme, 2003) which identified the most significant international human challenges, outlined humanitarian responses to those challenges and established key goals for development, governance, human rights, peace and security. The Millennium Development Goals (MDGs) envisioned a world free of extreme poverty and hunger for all women, men, youth and children; improved health of mothers and children; access to primary schooling for all boys and girls; gender equity; reversal of the spread of HIV/AIDS, malaria, and tuberculosis; environmental sustainability; and a global partnership for development (United Nations, 2000). Originating from the United Nations' Millennium Summit, the Millennium Declaration is considered the most important global agreement ever made for international development, encompassing a broad range of global issues (United Nations Development Programme, 2003). In order to establish the context necessary for an understanding of the main research question posed within this thesis, this introduction begins by providing an overview of the economic and political climate of Pakistan, the site of my research into the connection between micro-finance and women's mental health, before moving on to a discussion of the connections between women's mental health and well-being and broader social prosperity.

Pakistan, along with other world leaders, adopted the MDGs in the year 2000, and pledged to focus on eradicating extreme poverty and hunger by halving the proportion of Pakistani people whose income is less than a dollar a day (Pakistan Millennium

Development Goals Report, 2004). The last 13 years have seen the country face serious challenges in meeting many of the MDGs, with domestic issues compounded by a sudden deterioration of the global economy (Commonwealth Foundation, 2013). Although Pakistan is handicapped by many serious political, economic, social and religious challenges, the Government of Pakistan claims to be committed to the ongoing achievement of the MDGs (Pakistan Millennium Development Goals Report, 2010).

Pakistan is a country that is experiencing persistent inflationary pressure and weak performance in the major economic sectors. Over the last decade, the surge in global commodity prices, especially the price of oil, has led to unprecedented inflation within this country. A huge debt owed to foreign institutions and other countries further impacts the situation and has left minimal resources available to be allocated towards domestic development (State Bank of Pakistan, 2012-2013). Far-reaching structural problems, including a poor tax-to-Gross Domestic Product (GDP) ratio, energy and power shortages, a growing water deficit, a drastic increase in population, and low development expenditure in critical sectors are a few of the chronic problems endured by the country (The State of Pakistan's Economy, 2012-2013).

The war on terror has further exacerbated the economic decline. There has been a rise in the incidents of militancy and terrorism, spreading from the tribal areas to all parts of the country, critically affecting Karachi, the largest and most populous city of Pakistan, and undermining development efforts. Individual and institutional resources such as shops, restaurants, cinema theaters, girls' schools, and military training facilities have been destroyed in large numbers on a routine basis. Furthermore, militants have

particularly targeted the wide-scale destruction of public infrastructure, especially girls' schools. From 2001-2007, there was an increase in suicide bombers targeting civilians and uniformed personnel, including law enforcement officers and government officials, all over the country. The rise of sectarianism has led to inter-sectoral violence and killing of people from minority sects of Islam and other religions and the destruction of their places of prayer. Target killings and the kidnapping of health professionals and their families belonging to the minority sects of Islam have also continued to grow, provoking a wide spread sense of insecurity and fear among the general population in Pakistan (Pakistan Millennium Development Goals Report, 2013). According to the Center for Research and Security Studies (2013), there have been high rates of injuries and at least 4,286 people killed in Pakistan due to targeted killings, security operation militant attacks and terrorism during the last eight months of the year 2013 (Bokhari, 2013). These sociopolitical problems not only have led to the loss of precious human lives and infrastructure but have imposed a number of significant costs on individuals, societies, and the state, and have thereby substantially disrupted the economic and social structure of the country.

The blowback of the war on terror not only influenced political, economic, and social sectors of the country, it challenged population health, the delivery of health care and further diverted Pakistan from meeting its MDGs geared towards health. The targeting of health workers by militants, particularly the killing of polio vaccinators all over the country, has been specifically detrimental to public health and development efforts. Pakistan is one of only three countries in the world where polio is still endemic,

despite receiving huge foreign funding to conduct campaigns for countering polio (World Health Organization [WHO], 2010a). The repeated attacks and bomb blasts on polio health workers and police van and security agents guarding health teams during polio vaccination drives have not only seriously hampered the effort to eradicate polio but threaten the country's law and order, violate human rights, and limits basic economic opportunities (Pakistan Millennium Development Goals Report, 2013). According to the annual health report compiled by the Pakistan Medical Association, during the last five years the country has shown gradual improvement on some of the health indicators related to the MDGs, but is still far short of the 2015 target (Health of the Nation, 2014). According to the WHO (2015a; 2015b), children's immunization coverage against six preventable diseases increased to 78% in 2008 and 2009 from 52% in 2001 and 2002, but still has not met the aim of 90% coverage by 2015. Further, among South Asian countries, Pakistan has one of the highest rates of mortality of children under five years with a rate of 86.5 per 1,000 children. Though these figures fell from 117 deaths in 1990 and 1991, it is still short of the MDG target of 52 deaths per 1,000 live births. Similarly, the infant mortality rate dropped from 102 to 70 deaths per 1,000 live births, which still remains behind the MDG target rate of 40 deaths per 1,000 live births. With an MDG target for maternal mortality rate of 123 deaths per 100,000 births by 2015, Pakistan has shown considerable yet insufficient progress, with a rate of 260 deaths per 100,000 births in 2013. Though contraceptive usage has almost tripled and is up to 35.4% since 1990 and 1991, the fertility rate at 3.8% remains considerably higher than the target of 2.1. Pakistan is among the countries where highly infectious bacterial and viral diseases are endemic

(Health of the Nation, 2014). For example, the incidence of tuberculosis is estimated at 231 cases per 100,000 per year, which is rated sixth highest for the burden of tuberculosis among other nations (WHO, 2014). A poor health care delivery system, deficient basic facilities, and lack of awareness lead to the heavy burden of disease. Though most of the diseases are preventable through vaccination, mass awareness, and provision of basic facilities such as water and sanitation, nearly 94 million people (52% of the total population) do not have access to adequate sanitation (UNICEF & WHO, 2012).

Unfortunately, Pakistan falls in the low human development index category due to the lower expenditure on social sectors. The country spends 0.8% of its GDP on health and 1.8% on education, rates that are lower than some of the poorest African countries such as the Congo, which spends 1.2% on health and 6.2% on education (United Nations Development Programme, 2013). While the WHO recommends 6% of GDP as the minimum health budget in any country (Xu et al., 2010), Pakistan spends less than 1% on public health, with only 20% used specifically towards the prevention and treatment of health issues and more than 80% of that budget spent on paying salaries and administrative costs (Health of the Nation, 2014).

Thus, the progress towards meeting the MDGs has been a great challenge for a country like Pakistan with its resources constraints. The resources and expertise assigned for achieving MDGs have had to be redirected to rebuild the country's infrastructure, improving security and to fighting the war against terrorism. Consequently, the goal of achieving the 2015 Pakistan MDGs seems to be more elusive than ever (Pakistan Millennium Development Goals Report, 2013).

Background to the Research Study

Understanding Pakistan's recent political and economic instability is key to an understanding of the relationship between the mental health and well-being of Pakistani women and their involvement with micro-finance programs that this research explores. The issue of women's health has attained higher international visibility in recent decades given that the health of families and especially children is tied to the health of women. The MDGs explicitly highlight women's empowerment as a key strategy for achieving global health through the enablement of women's education, employment, gender equality and the reduction of violence (United Nations, 2000).

My motivation and inspiration in pursuing my PhD thesis concentrating on women's health and related issues is based on my twenty years of experience as a nurse, nurse educator, and researcher in Pakistan. My special interest in women's health, gender inequity, and social disparities began when I started my academic journey as a Baccalaureate Nursing student when I and other students were required to visit the district of Thatta (a rural settlement in Sindh, Pakistan) for a community nursing experience. This helped me gain insight into women's limitations in seeking health care, accessing education, and in making decisions in matters related to themselves. I have worked with families of low socio-economic status (SES) who have limited resources. In this capacity, I was fortunate to collaborate with a Non-Government Organization (NGO) working to establish girls' schools in under privileged areas. With the support of community leaders and the NGO, I was able to pioneer the first school for girls in the village of Noor Mohd Thaeen of the Thatta district as my independent student project. In addition to this, while

teaching the course Culture, Health, and Society to undergraduate nursing students in Karachi at the Aga Khan University School of Nursing and Midwifery (AKUSONAM), I had the opportunity to hear the stories shared by my students about the suffering of women caused by a lack of health care, and about social injustice engendered by cultural or religious arguments. This experience enriched my subject knowledge and made me keen to learn more about how systematic societal factors impacts women's health and well-being. During my Master's of Science in Nursing program at Wisconsin, Madison, a course on Crisis Intervention highlighted women's issues from a Western perspective. This experience gave me an opportunity to compare the disparities, health threats and measures and resources available to women in my country with those available to women in the west.

My interest in women's health grew further when I joined a group of researchers from the Aga Khan University, the University of Alabama at Birmingham, and the Research Triangle Institute International (RTI) to examine a range of socio demographic, psycho-social, nutritional, and clinical factors associated with infectious morbidity and pregnancy outcomes among mothers and children, through National Institutes of Health (NIH) funding. One of the significant outcome of this study was the development of a culturally sensitive screening instrument, which was based on WHO ethical and safety guidelines for research in domestic violence. This experience also provided an opportunity to learn about women's experiences of domestic violence before and during pregnancy. Later, my interest and experience expanded through my role as a co-investigator in a randomized controlled trial (RCT) to examine the effectiveness of two

community-based interventions (counseling and economic skill building) directed at mothers, to promote maternal mental health and child behavioral outcomes. This study addressed primary health issues confronting women worldwide, like depression and violence, and simultaneously suggested strategies to enhance the psychological health of women and their children.

The association between socio-economic status and health is well established. Poor people experience poor health (Marmot, 2007). Women with children disproportionately represent the poor people of the world (WHO, 1995). This knowledge and my own experience motivated me to examine the connection between SES and mental health, especially among economically disadvantaged women. In my research for this thesis, I have debated and raised questions about what constitutes women's mental health in circumstances of unstable socio-economic conditions. What measures improve the socio-economic conditions that influence mental health? How can these measures be implemented? These questions led me into a discussion of micro-finance and associated terms like micro-credit, micro-enterprise, and micro-lending as financial alternatives for low-income populations. Micro-finance assists poor families with meeting basic needs while building assets to reduce vulnerabilities (Reed, 2011). There is an emerging priority among many micro-finance programs to provide financial services to poor women from developing countries where cultural and social constraints limit their opportunities for economic advancement (Holvoet, 2005).

The number of studies addressing the impact of micro-finance on development and livelihood has increased substantially over the last two decades (Vaessen, Leeuw,

Bonilla, Lukach, & Bastiaensen, 2009). Research from developing countries documents the influence of micro-finance programs on poverty alleviation, access to resources, and improved nutrition (Kabeer & Mahmud, 2004; Snow & Buss, 2001), as well as improved immunization coverage and reduced fertility (Schuler, Hashemi, & Riley, 1997). Researchers have begun to explore the association between women's participation in micro-finance programs and their mental health and well-being (Fernald, Hamad, Karlan, Ozer, & Zinman, 2008; Mohindra, Haddad, & Narayana, 2008), feelings of empowerment (Montgomery & Weiss, 2011; Rooyen, Stewart, & De Wet, 2012; Stewart, Rooyen, Dickson, Majoro, & De Wet, 2010), and reports of intimate partner violence (IPV) (Ahmed, 2005; Bates, Schuler, Islam, & Islam, 2004; Dalal, Dahlstrom, & Timpka, 2013; Hadi, 2005; Kim et al., 2007; Koenig, Ahmed, Hossain, & Mozumder, 2003; Naved & Persson, 2005). Although empowerment has been shown to improve mental health (Mayoux, 1998), the evidence is mixed on the impact of micro-finance on women's mental health and well-being. Some studies suggest that micro-finance is associated with an increased control of economic resources among poor women (Hashemi, Schuler, & Riley, 1996) enhanced women's decision-making power (Holvoet, 2005), higher self-esteem (Aruna & Jyothirmayi, 2011), decreased perceived stress (Mohindra et al., 2008), and reports of decreased IPV (Schuler, Hashemi, Riley, & Akhter, 1996). Other studies report that incurring loan debt and coping with increased financial burden may augment psychological stress and increase poor mental health for some poor women (Fernald et al., 2008). Furthermore, involvement in micro-finance may challenge the relational power

imbalance between men and women, thus provoking conflict and violence within the family (Naved & Persson, 2005).

Considering the wide variation in findings related to mental health and well-being and the impact of micro-finance on women, this issue requires careful exploration. Further, while there is increasing recognition of women's mental health and well-being in developing countries, there is little information about women's subjective conceptions of their mental well-being in general and as an outcome of their participation in micro-finance in particular. Experts in women's health studies in the context of micro-finance have urged researchers and policy makers to incorporate women's voices in projects and program planning to understand the complete picture of the impact of micro-finance on women's mental health and well-being (Kabeer, 2001). Understanding first how women define mental health and well-being and then exploring their perceptions of how their participation in micro-finance impacts their mental health are important steps in developing a foundation of knowledge upon which interventions and programs can be developed to promote optimal health among this population of vulnerable women.

Purpose of the Study

Multiple gaps exist in the literature about the experiences of women recipients of micro-finance in Pakistan. One such gap is the lack of empirically-derived information about women's experiences as loan recipients of micro-finance programs, and how these experiences relate to their perceptions of mental health and well-being. This study was initiated to answer this question by presenting a qualitative analysis of the experiences of

urban-dwelling women from Karachi, Pakistan, who have been micro-finance loan recipients for a period of 1 to 5 years.

The purpose of this study was threefold and addresses these gaps in the literature: to gain an understanding of how women conceptualize the meaning of their mental health and well-being in the context of micro-finance, to identify what micro-finance means to these women, and to explore the impact of their participation in micro-finance programs on their mental health and well-being. In addressing these questions, the research responds to several motivations. First, mental health is considered a "western term" (Gill, 2009; Harms, Kizza, Sebunnya, & Jack, 2009, p. 13); however, it is also deemed a socially constructed phenomenon, whereby it is affected by language and culture (Walker, 2006). Through this study, I hope to explore the basic and common understanding of the phenomenon of mental health and well-being in a local Pakistani context. Secondly, the study will explore the similarities and differences in understandings of the phenomenon of mental health and well-being among Pakistani women as compared to the core components of the operational mental health definition, presented by the WHO (2005a) and the elements drawn from psychological and sociological research on the nature of well-being (Keyes, 2002). Finally, in the context of Pakistan's economic, social, and political unrest, the thesis unfolds how political insecurity, growing poverty, frequent acts of violence and terrorism, and poor law and order specific to the city of Karachi influence women's descriptions of mental health and well-being. The knowledge gained from this study will offer a unique insight into how women in Pakistan interpret mental health, and the dissemination of these research

findings can be used in collaborative efforts and a holistic approach towards the promotion of mental health among Pakistani women. Further, I anticipate that the study outcome will inform the measures that could contribute a small but significant step towards the achievement of the MDGs through women's participation in micro-finance.

Significance and Contribution of the Study

This study is significant for its unique approach to the intersection of women's mental health and financial independence, and for its focus on Pakistani women in particular. This is the first empirical independent academic study to the best of my knowledge that attempts to examine the construct of mental health and well-being among loan recipient women of micro-finance in Pakistan. In recent years, there has been much debate regarding the impact of participation in micro-finance programs on health. Karachi, as one of the major hubs of micro-finance and micro-credit activities in Pakistan, is a suitable setting for examining this important notion of women's mental health and well-being (State Bank of Pakistan, 2011).

This study will provide important contributions both to the literature on women's perceptions of mental health and to an understanding of how micro-finance programs and women's mental health are interconnected. First, the study outcome will supplement the body of scientific knowledge about Pakistani women's perceptions and experiences of mental health and well-being in the context of micro-finance. Second, as mental health needs in developing countries largely go unnoticed (Patel, 2007), the study will inform and support micro-finance programs in recognizing women's mental health needs, optimizing the beneficial effects of these programs. Specifically, study outcomes should

support the need for advanced collaborative research among health care practitioners (HCP) including nurses, policy makers, and donor agencies, with the goal of developing interventions to promote positive mental health and well-being outcomes among women receiving micro-finance.

Further, the burden of poor mental health demands the attention of HCPs, particularly nurses, as they play a significant role in health promotion and illness prevention (WHO, 2002), particularly with women. Based on the available data from Pakistan, the prevalence of mental disorders, specifically anxiety and depression, is higher in women than among men (Mirza & Jenkins, 2004). There is an increase in the mental health problem in Pakistan due to growing insurgency and violence in the country (Khalily, 2011). Similarly, self-reported past year and life-time prevalence of physical violence is 56% and 58% respectively (Ali, Asad, Mogren, & Krantz, 2011). The study will increase the depth of knowledge among HCPs, especially nurses as the first level of service providers, to recognize SES as a significant determinant of health and particularly mental health and well-being, as there is "no health without mental health" (WHO, 2007, p.2). The study findings will be a starting point to guide HCPs to recognize a comprehensive definition of mental health, not limited to mental disorders, and learn to be sensitive to women's mental health and well-being. Due to the relationship between poverty and poor mental health (Patel & Kleinman, 2003; Patel, 2007), a critical examination of the impact of micro-finance as a strategy to alleviate poverty on women's mental health is important. It is anticipated that a subjective and context-specific conception of mental health and well-being developed by this study will allow HCPs to

more fully understand women's overall health within this context (Popay, Williams, Thomas, & Gatrell, 2003).

Structure of the Thesis

This thesis is comprised of five chapters: Chapter One, Introduction; Chapter Two, Review of Literature; Chapter Three, Research Methodology; Chapter Four, Results; and Chapter Five, Discussion.

Chapter One introduces the research topic with a brief introduction of the MDGs and Pakistan's limitations in meeting the MDGs. It provides an overview of the studies conducted in the field of micro-finance with respect to the variables of mental health and offers an explanation of the purpose, significance and contribution of the research study.

Chapter Two presents the theoretical scaffolding of thesis, an approach consistent with the research paradigm, interpretive description, which is employed to examine the phenomenon of mental health and well-being and is discussed in detail in Chapter Three (Thorne, 2008). Theoretical scaffolding shapes the study design by establishing the initial scholarly and intellectual positions through empirical and theoretical literature on mental health and well-being in general and in the context of micro-finance in particular. This section encompasses two parts: a literature review and theoretical forestructure (Thorne, 2008). The first component, the literature review, examines conceptual and empirical literature relevant to the research focus and questions, and a summary of the gaps in current knowledge. Details of the inception of micro-finance in South Asia, available studies examining the notion of mental health and studies pertinent to women's participation in micro-finance and their impact on mental health variables will be

discussed. The second part, theoretical forestructure, reviews theoretical perspectives that is relevant and informed the study. The WHO definition of mental health (2005a) and Corey Keyes (2002) multidimensional model of mental health and well-being which provide a conceptual framework will be detailed. Importance of conceptualization and construction of mental health and its understanding and relevance for future interventions are summarized in Chapter Two.

Chapter Three describes the methodology chosen for the study. The chapter will begin with a detailed description of, and the rationale for choosing interpretive description as the qualitative approach to guide all methodological decision-making in this study. Next, the chapter will present the research questions that drove the study, and will, describe the research process in detail, including the study's setting (Karachi), sampling, data collection, and data analysis procedures. Ethical issues identified and addressed within the context of this study will also be described. This chapter will conclude with the details and criteria for the trustworthiness of the study's findings.

The main findings that answer the research questions are reported in Chapter Four. First, the demographics of study participants are discussed. Next, the responses of the research questions are described and incorporates the themes emerging from the data from interview transcripts, field notes, and documents analyzed during the study. This chapter will connect and engage the reader by providing quotations directly from interview data. The chapter advances with a conceptual map developed by examining the relationships among themes that emerged from the data, which provides a description and interpretation of the conceptual understanding of the phenomenon of inquiry.

Chapter Five is devoted to a discussion of the findings in light of existing knowledge specific to mental health and well-being in the context of micro-finance and Keyes operational definition of mental health. The discussion will also engage with how Pakistan's unstable political climate, which results in inconsistent or non-existent employment for women and threats to their personal safety, influences women's mental health. The chapter contains further interpretation of findings by examining the relationships among themes that emerged from the data. Chapter Five also addresses the implications of the findings, specific to the practice goals of interpretive description (Thorne, 2008), to promote the mental health and well-being of Pakistani women. Finally, to guide our practices, future directions in nursing practice, research, and education are presented. This chapter will conclude with an overview of the strengths and limitations of the study.

Chapter Two: Theoretical Scaffolding

Consistent with the interpretive description tradition of qualitative inquiry, this chapter presents the theoretical scaffolding of the study. The theoretical scaffolding served to "prepare the ground" (Thorne, 2008, p. 53) for the investigation by identifying the existing knowledge in the field and recognizing the theoretical underpinnings that informed the research and the conceptual understanding I brought to the study (Thorne, 2008). Although no previous studies had explored the perceptions and experiences of women's mental health and well-being in the context of micro-finance programs, there were extensive studies on this population. Further, there were conceptual and theoretical perspectives pertinent to the understanding of mental health and well-being which were relevant to the inquiry and how I led the study.

The study's theoretical scaffolding has two components: (a) the literature review, and (b) the theoretical forestructure. The literature review is a description of empirical and conceptual literature relevant to the research question and helps substantiate the relevant research questions as posed. The theoretical forestructure, on the other hand, is comprised of theoretical and conceptual perspectives that are relevant and has informed my thinking about the study. Thus, reviewing and considering existing empirical and conceptual literature helped me expand my understanding of the phenomenon (Morrow, 2005).

Literature Review

This review section will begin with an overview of the inception of micro-finance programs in South Asia in general and in Pakistan specifically. The status and

significance of women's participation in micro-finance programs will also be outlined, to understand the relevancy of studying this vital population. The participation of women in micro-finance programs has led me to explore the literature from a range of impact studies focusing on women. In this chapter, I review selected empirical and theoretical literature to provide an overview of what is known about the experiences of women participation in micro-finance programs, and its role in women's mental health and well-being. This chapter will also provide justification for incorporating women's views of their perceptions of mental health and well-being, thereby building an understanding of this phenomenon in the context of micro-finance.

Historical development of micro-finance programs in South Asia. The term micro-finance refers to the provision of financial services in the form of small loans to poor and low-income clients for self-employment projects to generate income (Grameen Bank, 2011). The first micro-finance projects were implemented in Bangladesh during the 1970s by the Nobel Peace Prize winner Muhammad Yunus of Grameen Bank, in response to prevailing poverty conditions among the vast rural population (World Bank, 2006). The Grameen Bank of Bangladesh was one of the first organizations to institutionalize the term micro-finance (Grameen Bank, 2011). Since poor people are not able to access loans from commercial banks because of a lack of collateral or any property for guarantee, micro-finance provides micro-loans for their businesses, charging high interest (Mitra, 2009). The provision of these loans to this vulnerable population is intended to alleviate poverty and to promote social benefits in a sustainable way (International Labour Organization, 2009). Many micro-finance institutions (MFI) go beyond the

provision of credit and offer their clients a combination of services such as savings accounts, life and health insurance, and skills and education training (World Bank, 2006).

The high interest rates charged by the MFIs to its borrowers has been subject to controversial debates (Rosenberg, Gaul, Ford, & Tomilova, 2013). Interest rates associated with micro-finance loans are higher than the usual commercial banking services and range from 2.5% to 4% a month and about 31% to 50% a year (Hasan & Raza, 2011; Rauf & Mahmood, 2009). However, poor people are willing to pay these interest rates because of the added advantage they receive for not requiring collateral (Rosenberg et al., 2013). Micro-finance is considered one of the most effective strategies in fighting poverty, necessary to respond to the urgent needs of those people living on less than US$1 or US$2 per day (World Bank, 2006). Thus, MFIs are able to attract clients in huge numbers and to sustain themselves by recycling funds through re-loaning. The following section details the commencement of micro-finance programs in Pakistan, followed by an overview of the status of women's participation in such programs.

Evolution of micro-finance programs in Pakistan. Micro-finance in Pakistan is not new, but it is relatively young compared to other countries in the region. Initially, micro-finance programs were prioritized by agriculture banks in the 1960s in order to increase financial access to farmers to purchase fertilizers, machinery, and seeds (Hussein & Khan, 2009). This later shifted to non-farm enterprises. The Aga Khan Rural Support Program (AKRSP) in the rural agrarian frontier in the northern areas of Pakistan and the Orangi Pilot Program (OPP) in urban Karachi, a port city and commercial capital of the country, were among the first to initiate micro-finance programs in 1982 and 1987

respectively (Hussein & Khan, 2009). The basic aim of both institutions is poverty alleviation through community development (Hasan & Raza, 2011; Rauf & Mahmood, 2009).

In 1990, the model of AKRSP was implemented in different parts of the country with the establishment of the National Rural Support Program (NRSP). These institutions were general support institutions that provided a wide range of social services, including financial services (Hussein, 2009). During the late 1990s, regulated financial institutions such as commercial banks and leasing companies entered into the micro-finance arena, predominantly based in Pakistan's major urban cities (State Bank of Pakistan, 2006). Financial services that were provided to the poor were often socially driven, were highly subsidized, and little effort was made to recover delinquent loans. To address these shortcomings, NRSP established micro-finance NGOs in 1996; one of these was the Kashf Foundation (Hussein, 2009; Hussein & Khan, 2009). These NGOs were established exclusively as micro-finance institutions, and many of them offered credit primarily to women. These MFIs followed the traditional group-lending model (Jaffer, 1999). In 1998, the Pakistan Micro-Finance Network (PMN) came into existence representing MFIs in the country. Further developments followed in 2000, when the micro-finance bank ordinance changed the dynamics of the sector and the first micro-finance banks (MFB) were established (Hussein, 2009; Hussein & Khan, 2009).

According to the Pakistan Microfinance Network (2014), there are a total of 11 MFBs and 24 MFIs registered with the PMN, the national association of MFIs and MFBs, accounting for 2.53 million micro-borrowers. Currently, 41% of total active micro-

borrowers are accounted for by MFBs and the rest by MFIs. While both offer nearly the same service, their major differences are predominantly in their regulations. MFBs are regulated by the State Bank of Pakistan (SBP) under the MFB ordinance and they are usually restricted to offering micro-credit, savings accounts, life insurance, and rarely health insurance. In contrast, MFIs are registered under various acts, which means that they have no regulatory consistency. Many MFIs supplement their services with family health insurance as well as life insurance for the borrower and also engage in social mobilization and community building activities (Hussein & Khan, 2009; Rankin, 2002). A group lending model has traditionally been a central focus of micro-finance programs for social mobilization and community engagement. The model stipulates joint liability and mandatory attendance at group meetings to harness the community's social capital, broadly defined as a community's network of trust and engagement (Jaffer, 1999). While most of the micro-finance programs in Pakistan rely on group lending arrangements, several MFBs and MFIs are modifying their group lending models and replacing them with individual lending (State Bank of Pakistan, 2011). It is also important to know that in Pakistan, the term micro-finance has been used interchangeably with micro-credit because other services and products have been far less developed than credit. Micro-finance typically refers to micro-credit as well as micro-saving and micro-insurance (Hussein, 2009). In Karachi, there are more than 100 different branches of MFBs and MFIs (Hussein & Khan, 2009). The two micro-finance programs selected for this study, the FMFB and Kashf Foundation, are considered the top two providers of micro-finance

in the country (State Bank of Pakistan, 2011). Details of these programs are provided in the description of the study setting under the methods section in Chapter Three.

Micro-finance programs and women's participation. As micro-finance is considered a tool to reduce poverty, considerable international attention has focused on the growth of MFIs, especially in developing countries, and specifically targeting women (International Labour Organization, 2009). This focus on women is based on the premise that women in poor households are more likely to be credit-constrained, and hence less able to undertake income-generating activities (Swain & Wallentin, 2009). With a combined population of 1.4 billion, South Asia is home to half of the world's poor population (World Bank, 2006). It is in this region where micro-finance activities are most prevalent and are predicted to grow further, particularly among women who represent the majority of micro-finance clients (Khandker, 2005). According to estimates, about 80% of micro-finance clients are female, with the highest percentages in Asia (Reed, 2011). Women have been shown to spend more of their income than men on their households and improving family welfare (Kabeer, 1998). In comparison to men, women were also found to repay their loans, in spite of daily hardship. Thus, "women's success benefits more than one person" (Deshpande & Burjorjee, 2002, p.14).

Among South-Asian countries, Pakistan is no exception. The country faces growing poverty, where almost 40% of the population lives around the poverty line, earning less than US$2 a day (State Bank of Pakistan Annual Report, 2010). Further, the socio-economic indicators with respect to women are the lowest in the region. Pakistan's Human Development Index, which is based on life expectancy, schooling, and income

indices, is 0.504, which places the country slightly above the average of 0.456 for countries in the low human development group. However, the country falls below the average of 0.548 for all countries in South Asia and 145th of the total of 187 counties reported. In terms of the Gender Inequality Index, which reflects women's disadvantage in reproductive health, empowerment, and the labour market, Pakistan's value of 0.573 ranks it 115th out of 146 countries reported (United Nations Human Development Report, 2011). These two indices reflect the inequalities that persist between men and women in the country, particularly in relation to secondary school education (23.5% of women attend secondary school, vs. 46.8% of men) and labour force participation (21.7% of women participate in labour force, vs. 84.9% of men) (Pakistan Bureau of Statistics, 2012). The emergence of micro-finance in Pakistan is an important tool for alleviating poverty and promoting awareness and literacy among women from poor communities, with an overall goal of promoting better health and combating gender inequity (Hussein & Khan, 2009).

According to an estimate, approximately 59% of micro-finance clients are women in varied micro-finance programs in Pakistan (MicroWatch, 2012). This figure has increased over time; however, Pakistan still lags behind its regional peers such as India and Bangladesh, where the percentages are 94 and 91 respectively (World Bank, 2012). Estimates by the PMN currently place Pakistan's potential micro-finance market at close to 27.5 million clients. Its data further show that as of December 2011, the share of women borrowers had increased. Out of the total active borrowers of 2.1 million, 1.2 million were women (State Bank of Pakistan, 2011). However, according to a recent

review of 27 MFIs conducted by the World Bank, 50% to 70% of loans to women clients may actually be used by their male relatives; these figures are higher in urban areas and in NGOs, who lend exclusively to women (World Bank, 2012). Hence, the figure of women loan recipients seems high, while financing is largely directed to male family members.

Micro-finance has been hailed as a "magic bullet" for the global fight against poverty (Kabeer, 2005, p. 4709). The success or failure of a micro-finance program is most often evaluated on the improvement or deterioration of a participant's financial portfolio, including wealth or income, and changes in their assets (Swain & Wallentin, 2009). With the aim to meet MDGs with the support of micro-finance programs, researchers from developing countries have examined the role of micro-finance in women's empowerment, which is considered a marker of mental health (Mayoux, 1998).

Micro-finance and empowerment of women. The literature recognizes the economic and social empowerment of women as a central goal of their participation in micro-finance (WHO, 2005b). A systematic review examining the impact of micro-finance in sub-Saharan Africa suggested that involvement in micro-finance has both positive and negative impacts on women's empowerment (Rooyen et al., 2012; Stewart et al., 2010). The authors claimed that this mixed response could be partly due to the complexity of the concepts of empowerment, and methodological challenges researchers encounter when attempting to measure and analyze it.

One of the largest studies to examine micro-finance and women's empowerment is from Bangladesh by Hashemi and colleagues (1996). This mixed methods study combined ethnographic interviews and observations with survey data from 120

households. Findings suggest strong evidence of empowerment across several indicators such as mobility, decision-making, reduced domestic violence, and improved purchasing power among women loanees of micro-finance programs. Similarly, Kabeer's (2001) mixed methods study of quantitative data from 700 households and qualitative findings from interviews of 50 women reports increased "courage and confidence" and increased "voice" in household decision-making, and reduced "tension, conflict and violence" with participation in micro-finance activities (p.70). Likewise, results of quantitative and qualitative data from a survey by Grameen Bank revealed an increase in "confidence and courage" both within the household and larger community with involvement in micro-finance (Lutfun & Khan, 2007, p. 697).

Women's empowerment was also examined through quantitative studies within some South Asian countries. Using quasi-experimental sampling design, data were collected from 1000 households, including households where women micro-finance members and non-members, from five states in India during 2000 and 2003 (Swain & Wallentin, 2009). Researchers advocate that women's empowerment takes place when they effectively improve the quality of their lives and challenge the gender-based and existing social norms and culture. The variance of mean difference of women's empowerment was significant and higher among women involved in micro-finance programs (0.26) as compared to non-members (0.0.7) (Swain & Wallentin, 2009). A similar outcome was reported from Northeast India in a five-year study period from 2004 to 2009, comparing 300 micro-finance members with 150 non-members. The propensity

score matching showed improved empowerment indicators among members as compared to non-members (Lyngdoh & Pati, 2013).

Similarly, two studies from Bangladesh and a study from India also studied the differences in the level of women's empowerment among those who were involved in micro-finance activities and those who were non-members (Amin et al., 1998; Aruna & Jyothirmayi, 2011; Pitt, Khandker, & Cartwright, 2006). Results revealed that women engaged in micro-finance, compared to non-participants, demonstrated higher scores on autonomy (Amin et al., 1998; Pitt et al., 2006), and authority indices (Amin et al., 1998), as well as on the Women Empowerment Index (WEI) ($p<0.000$) (Aruna & Jyothirmayi, 2011).

A study from South India by Holvoet (2005) used household survey data to examined one particular dimension of empowerment: decision-making. Researchers found that women's membership in a micro-finance program significantly shifts overall decision-making patterns from norm-guided behaviour and male decision-making to more joint and female-led decision-making. Further, intensive skills training, in addition to availing the loan services, and longer duration of membership in micro-finance had an impact on women's decision-making power; however, the duration of membership was not specified. In contrast, a study in India by Mohindra et al. (2008) revealed higher improvement in decision-making if membership in micro-finance was limited to less than two years, as compared to non-membership and membership of more than two years. These variations in results speak to the complexity of measuring decision-making and the absence of a standard approach. Moreover, poor life satisfaction was reported among the

newer members and non-members as compared to women who were members for more than two years.

Studies have shown that with increased economic contribution to the household, rural and urban women from developing countries increased their self-esteem and confidence through their interaction with people outside of the confines of their families (Afrin, Islam, & Ahmed, 2008; Ahmed, Siwar, & Idris, 2011). A Pakistani study of women in139 rural villages and three urban cities reported that although female borrowers of Khushhali bank's micro-finance program had better psychosocial functioning than non-members, these women did not show any further improvement after accessing loans. Interestingly, wives of male bank borrowers scored lower on autonomy indices before receiving the loan, but showed improved scores in autonomy or decision-making power after the household received the loan (Montgomery & Weiss, 2011). The results suggest that access to micro-finance loans empowers women, even if they are not the direct borrower. It also suggests that women who access micro-finance loans may have higher initial psychosocial functioning as opposed to non-members and wives of male borrowers (Montgomery & Weiss, 2011).

The above evidence brings the insight that beyond economic benefits, micro-finance improves women's control over economic resources, alleviates stress related to sources of future income, reduces family conflicts and has a positive impact on women's empowerment and self-confidence. However, Karim's (2008) ethnographic work and that of Pitt et al., (2006) revealed that 97% and 38% of women's loans respectively were controlled by men. In fact, Pitt and colleagues (2006) document that 78% of husbands

reported using the money from their wives' loan to spend on their own income generating projects. These findings lead one to speculate that micro-finance loans may lead to women's disempowerment if they do not retain control of their loans or, if the money coming into the household creates an improved environment, this actually contributes to women's independence and autonomy (Kabeer, 2001).

Methodological issues in studying empowerment. The perspective and meaning of empowerment varies among empirical studies (Swain & Wallentin, 2009). Some studies focus on the gender equality perspective, which challenges the status quo and advocates for increases in decision-making, autonomy and control over economic resources (Kabeer, 2001; Mayoux, 1998). Other researchers explain empowerment from the lens of social capital and community development (Bezboruah & Pillai, 2013). For the most part, empirical studies on micro-finance are based on an over-extended definition of empowerment and so, tend to overestimate its effect on women's empowerment (Goetz & Gupta, 1996). Ali and Hatta (2012) claim that "empowerment is conceptually complex and methodologically challenging to measure and analyze" (p. 112). Its meaning, outcome, and goals are socially, culturally, and politically driven and therefore need a rigorous method for measuring and tracking changes in levels of empowerment (Malhotra, Schuler, & Boender, 2002). Swain and Wallentin (2009) also argue that empowerment has multiple aspects and it cannot be directly observed. Authors further claim that studies suffer from possible bias due to disparity involved in program participation and unobserved households and individual characteristics.

There are variations in how studies that were reviewed defined and measured the dependent variables in relation to empowerment and how control or comparison groups were assigned. Kabeer (2005) claims that intra-household decision-making was a commonly investigated indicator of women's empowerment. For instance, Hashemi et al., (1996) examined women's involvement in major decisions within the family as well as in making large and small purchases. Holvoet (2005), on the other hand, carried out a carefully designed study of the impact of decision-making as a measure of empowerment. She explored four different categories of decision-making, such as women-dominated decision-making, male-dominated decision-making, norm-following decision-making and bargaining over decisions. Swain and Wallentin (2009) measured empowerment as a latent variable using a measurement model. Similarly, Mohindra and colleagues (2008) measured decision-making based on male members' involvement. If there was no male involvement, decision-making was attributed solely to females. This approach might have inadequately captured the complexity of the women's decision-making and exaggerated the findings. Other studies examine women's empowerment by "managerial control" (Goetz & Sen Gupta, 1996, p. 63), increased economic contributions to the households (Lutfun & Khan, 2007), and increase self-esteem and confidence (Pitt & Khandker, 1996). Thus, disparity exists; however, it gives variability and diversity to the phenomenon and therefore demands investigation in a rigorous manner (Pitt et al., 2006).

The issue of assigning participants to a control or comparable group is another challenge to robust empirical studies (Swain & Wallentin, 2009). A study by Montgomery and Weiss (2011) ascertained that "constructing a control group comparable to treatment

group is not straightforward" (p. 89). Comparison groups included: members versus non-members, members with certain duration of involvement in micro-finance, and loanees versus non-loanees. It can be further argued that the placement of micro-finance programs in specific geographic areas and in certain situations may result in bias in empirical studies (Montgomery & Weiss, 2011). For example, a study from India recognized the possibility of contamination since the study was conducted in one small village where the practice among members might spill-over to non-members, thus diluting effects and reducing the ability to detect the differences between members and non-members (Mohindra et al., 2008).

Further, there are significant design challenges in controlling selection bias and the characteristics of women who join credit and saving activities. A recent case study analysis of in-depth individual and focus group interviews with women from Afghanistan suggests that micro-finance is not the sole indicator of women's empowerment specific to gender relations. Both members as well as non-members of micro-finance programs claim that women's individual and family characteristics, such as education level, mobility, and exposure to migration are key indicators in their empowerment and not just participating in micro-finance activities (Echavez, Zand, & Bagaporo, 2012).

In reference to the above discussion, it is crucial to examine the demographic characteristics in relationship to empowerment. Two studies examined the effect of age (Amin, Becker, & Bayes, 1998), education, and SES (Amin et al., 1998; Mohindra et al., 2008) on indicators of mental health, but not in direct relationship to micro-finance. The results suggested that increased age, higher educational levels of women and their

partners, and higher yearly family income had a significant relationship ($p<0.01$) with higher scores on autonomy and authority indices (Amin et al., 1998). However, among women with a high school diploma or more, Mohindra et al. (2008) reported limited women's decision-making power when a male led household decisions (OR=1.23, CI=0.72-2.11). Nevertheless, these women were more satisfied with their lives as compared to women with less or no education. Increased landholdings, a measure of SES, showed a low odds ratio in life dissatisfaction (OR=0.85, CI=0.50-1.44). The same authors also acknowledged that women recruited into their study were either the heads or spouses of the heads of the household. These women may possess greater autonomy because of their senior positions, as compared to younger women living in a similar household, or to women in another comparison group (Hashemi et al., 1996). It is interesting to note that a study from India suggested that women with less than a high school education were less likely to be micro-finance members (Mohindra et al., 2008). This leads to speculation about the characteristics of women who join micro-finance programs.

Empirical studies on women's empowerment in the context of micro-finance were found to be enormous and diverse. Key aspects of the available literature that informed the present investigation claim that access to credit through micro-finance is considered to be an important ingredient of empowerment simply because women are able to fulfill both their social and economic roles for livelihood (Mayoux, 2001), and thus effectively improve their well-being. In the next section of the literature review, in order to provide more context regarding the impact of women's participation in micro-finance program on

their mental health, I provide a synopsis of research literature specific to mental illness and IPV. In the absence of studies explicitly on women's mental health, the existing literature will set the ground and provide insight for the present study, the role micro-finance plays in the promotion of women's mental health, an indispensable component to understanding overall health.

Definitions and Variables in women's mental health. Mental health is considered an integrated aspect of overall health that influences an individual's thoughts, feelings, and behaviours (WHO, 2005a). The WHO (2005a) recognizes mental health as a state of one's ability to realize and cope effectively with the normal stresses of life, to live productively, and to make community "contributions" (p. 2). Globally, mental health disorders are considered the leading cause of disability or "years lived with disability" (Whiteford et al., 2013, p. 1575). This global burden is increasing, and is affecting the quality of life of individuals, especially women (WHO, 2004a).

Gender-based discrimination; low status in society, especially at home; the high burden of work; and exposure to IPV critically impact women's health (WHO, 2008a). Although, women engage in two thirds of the world's working hours, they only earn 10% of the world's total income (United Nations, 2010), and are often financially dependent on their male family members. This may have the effect of leaving them insecure, helpless, and more vulnerable to poor mental health (Thara & Patel, 2001). Likewise, being a victim of violence is related to poor self-esteem and psychosocial health, and negative coping strategies (Bradley, Schwartz, & Kaslow, 2005). Abused women have significantly higher scores of depression and anxiety (Fikree & Bhatti, 1999), mental

stress, nervousness, unhappiness, difficulty in decision-making (Niaz, 2003) and suicidal thoughts (Vachher & Sharma, 2010). The aforementioned attributes are strongly interwoven and greatly influence women's mental health.

Micro-finance and stress and depression. Existing research literature on the effects of participation in micro-finance on mental health is rare and is predominantly in reference to negative rather than positive aspects of mental health, hence reporting outcomes related to perceived emotional stress and depression (Ahmed et al., 2001; Fernald et al., 2008; & Mohindra et al., 2008). A large cross-sectional study from India (Mohindra et al., 2008) reported an overall 90% prevalence rate of emotional stress among women who were micro-finance loanees for more than two years, as well as those who were members for less than two years and those who were non-members. However, when the women's demographic and SES characteristics were controlled, women micro-finance members for more than two years demonstrated significant lower levels of self-reported emotional stress as compared to non-members. Moreover, poor life satisfaction was reported among the newer members and non-members as compared to women who were members for more than two years. These results suggest the duration of women's involvement in micro-finance activities may provide opportunity to adjust to the new role, thus reducing emotional stress and improving life satisfaction.

Ahmed and colleagues (2001) evaluated the emotional stress of Bangladeshi women micro-finance loanees based on one month of their participation in micro-finance. The impact of poverty was reported as the most significant contributor to emotional stress among the women. That is, stress resulted as these women faced extreme difficulty in

making financial ends meet. The prevalence of emotional stress was higher among both poor micro-finance members (42.6%) and non-members (44.3%), than non-members with higher SES (29.4%). Among members, there was a gradual increase in emotional stress with involvement in micro-finance from the first year onward, reaching a peak around three years, and then declining. The prevalence of emotional stress increased when a member first received a loan (63.4%) and then declined (27.3%) after obtaining skills development training. Further, tensions and stress are increased when women first become responsible for contributing to the family income (Ahmed et al., 2001). These findings raise further questions regarding women's participation in micro-finance as an intervention in terms of emotional wellbeing. This notion is rarely addressed in the literature. It is unclear if the development agencies that focus on women as a priority group for micro-finance have recognized the gap between expectations and achievements from program participation, and vulnerability to poor mental health in general and mental disorders in particular (Patel, Araya, de Lima, Ludermir, & Todd, 1999).

When comparing emotional stress with demographic and socio-economic indicators the significant predictors among poor members and poor non-members were: belonging to a household with a small landholding; being over thirty; being divorced, separated or widowed; having more than three living children; having family members with poor health status; household heads having a low level of schooling; or the family encountering an economic crisis (Ahmed et al., 2001; Mohindra et al., 2008). Attainment of high school (Mohindra et al., 2008) and formal schooling of the household head (Ahmed et al., 2001) were associated with less emotional stress.

Ahmed and colleagues (2001) support the notion that women members demonstrate reduced stress with increased duration in micro-finance when they receive skill development training. The women also experience lower levels of social withdrawal and increased satisfying attitudes in response to stressful events, as compared to non-members of similar SES status. It is important to note that although non-members with higher SES have lower emotional stress, these higher SES non-member demonstrated depression like symptoms measures while coping with stressful events when compared to poor members and poor non-members. So while it would appear that greater length and depth of involvement in micro-finance activities may reduce women's emotional stress, and improve coping strategies, the lower level of emotional stress associated with non-members of higher SES also lead us to ask if higher SES could be a possible predictor of positive coping practices.

An empirical study with a randomized design from South Africa revealed mixed effects on mental health among individuals receiving a second chance for small loans (Fernald et al., 2008). Among the sample size of 257 men and women, 53% were micro-finance new applicants who had been previously rejected for a loan and were assigned to the intervention group. Participants were assessed for psychological stress using Cohen's Perceived Stress Scale and symptoms of depression through the Center of Epidemiologic Studies-Depression Scale at 6 and12 months. Regression analysis showed an increase in the level of perceived psychological stress in the combined sample of men and women (OR=0.64, CI=0.04, 1.23), with higher symptoms among men in the treatment group. On the other hand, access to loans was associated with decreased depressive symptoms in

men (OR=-1.18, CI=-2.34,-0.02) but not in women (OR=1.53, CI=0.13, 2.93). Further, among women members, increased duration and involvement in micro-finance activities resulted in greater economic independence and financial security, thereby alleviating the stress and tension related to future income (Fernald et al., 2008).

Similar to previous studies from India and Bangladesh, the South-African study also found increased family income significantly decreased symptoms of depression (OR=-0.88, CI= -1.58, -0.19). However, a larger household size significantly increased the risk of psychological stress (OR=0.11, CI=0.01, 0.21). Further, more than two years of schooling was significantly associated with having lower combined depression and psychological stress symptoms (OR= -1.00, CI= -1.77, -0.22) (Fernald et al., 2008).

A recent unpublished thesis by Prince (2014) analyzed the impact of micro-finance loans, saving plans, and insurance on mental health indicators such as life satisfaction, stress or depression among members of micro-finance. Data were collected between 2002 and 2009 from 12,951 poor participants in the Udaipur district of Rajasthan, India. The demographic data were collected using a self-developed scale entitled, The Adult Module of the Integrated Family Survey. Further, the Satisfaction with Life Scale (SWLS) was used to measure life satisfaction; however, no scale was mentioned to measure stress or depression among the study participants. Results show that access to financial services, such as loans and savings, did not increase stress or depression, and neither did it impact life satisfaction. However, participants with outstanding loans reported an increase in stress by 0.071 units and decreased life satisfaction by 0.11 units. The author recommends MFIs consider incorporating aspects

of mental health in designing their loan programs, though no specific intervention was suggested.

The above section reviewed studies that support the notion that involvement in micro-finance activities increases financial security and, along with access to skills training, improves mental health outcomes over time. SES is recognized as a determinant of mental health status; therefore, "mental health should be included as a measure of success (or failure) when examining the potential tools for poverty alleviation" (Fernald et al., 2008, p. 14). In the developing world, access to small loans has been hailed as a mean for poverty alleviation; yet, micro-finance has been criticized as "usury" and harmful to vulnerable borrowers (Kabeer, 2001, p. 106). The following section will contribute uniquely to the literature by examining the critical mental health issue of IPV and how IPV is related to participation in small loan programs such as micro-finance.

Micro-finance and intimate partner violence. IPV is an explicit manifestation of gender inequality and is increasingly recognized as a significant risk factor for a range of poor physical and mental health outcomes (Kim et al., 2007). Studies that examine the relationship between economic empowerment with IPV are predominantly from Bangladesh (Ahmed, 2005; Bates et al., 2004; Hadi, 2005; Koenig et al., 2003; Naved & Persson, 2005). Violence was measured as mental torture (Hadi, 2005), verbal abuse (Ahmed, 2005; Koenig et al., 2003), physical-only abuse (Hadi, 2005; Koenig et al., 2003; Naved & Persson, 2005), or domestic violence in general (Bates et al., 2004). The Conflict Tactics Scale (CTS) (Bates et al., 2004; Naved & Persson, 2005) and the WHO Violence Against Women Instrument (Bates et al., 2004) were commonly used

instruments to measure exposure to violence in these studies. Other studies documented the nature of the questions, but did not specify the tool used (Ahmed, 2005; Hadi, 2005; Koenig et al., 2003).

The results suggest a mixed range of patterns. Three studies from Bangladesh reported higher prevalence of violence among micro-finance participants (Ahmed, 2005; Koenig et al., 2003; Naved & Persson, 2005). However, other studies reported low odds ratios when violence was measured for the previous year. For example, Bates et al., (2004) reported OR=0.75 (CI=0.56-1.00, $p<0.05$) for all types of violence and Hadi (2005) detailed OR=0.35 ($p<0.01$) for mental torture and OR=0.32 ($p<0.01$) for physical assault. Koenig and colleagues (2003) and Hadi (2005) observed the effect of women's autonomy in relation to subsequent exposure to IPV, with conflicting results. Koenig et al. (2003) reported that higher autonomy index scores were associated with significantly higher rates of exposure to physical violence, but the opposite finding was true in another study in Bangladesh (Hadi, 2005). Among studies that reported increased exposure to violence following participation in micro-finance, logistic regression analysis suggested increased risk of violence in the early years among women members as compared to non-members (Ahmed, 2005; Bates et al., 2004; & Koenig et al., 2003). The violence reached its peak when the loan was obtained and began declining with the introduction of skills development training (Ahmed, 2005). Likewise, increased duration in micro-finance activities was associated with less exposure to violence (Hadi, 2005; Koenig et al., 2003). Hadi (2005) revealed that involvement in economic-generating activities for five years or longer reduced the incidence of violence by two-thirds. Hence, similar to emotional

stress, exposure to IPV among women members increases during the early period of engagement in micro-finance activities. However, these effects may decrease as the length of time involved in the micro-finance program increases (Khandker, 2005).

A recently published cross-sectional study brings more insight into the issue of IPV in the context of women's demographics. This study was carried out in six different divisions of Bangladesh, where government-approved organizations providing micro-finance services are available (Dalal et al., 2013). Out of 4,465 women who answered the IPV questionnaire, 39% of them were members of micro-finance programs. Among the study participants, the overall prevalence of IPV for moderate physical violence was reported at 48%, and 16% each for severe physical and sexual violence. Authors reported that women with micro-finance involvement were three times more exposed to violence compared to non-members. Women within the highest level of wealth index showed a twofold increase in violence associated with program membership. The least educated and poorest groups showed no change in IPV exposure associated with micro-finance. Further, educated program members were less exposed to IPV if they were not involved in day-to-day household decision-making.

Other studies that examined the effects of education on IPV showed a protective association with less violence related to higher educational level (Ahmed, 2005; Bates et al., 2004; Hadi, 2005; & Koenig et al., 2003). Koenig and colleagues (2003) and Naved and Persson, (2005) revealed that women with primary education, as well as the husband's education level and spousal communication, were also protective factors. The association of an increased risk of violence with early period of women's engagement in

micro-finance activities may support the notion that men's inability to economically support their families or the challenge a change in women's roles related to income places women at increased risk of violence and maltreatment (Bates et al., 2004). Further, with an increase in education level, women may become more vocal in challenging their husbands' authority, resulting in violence (Krishnan, 2005; Schuler, Hashemi, & Badal, 1998). Kabeer (1998) also suggests that women's economic contribution and independent decision-making leads to greater conflicts within the household. However, when men learn to accept this new economic role for women (Ahmed, 2005), access to increased family income may help reduce the male's financial burdens and enable the family to attain basic needs, reducing family conflict and violence (Kabeer, 2001). Thus, this new role for women may allow "both cooperative as well as conflictual solutions to emerge" (Kabeer, 2001, p. 80).

Studies from other parts of the world, including India and South Africa, demonstrate fairly similar outcomes as the Bangladeshi studies. One of the major cluster-randomized trials in the history of South Africa is the Intervention trial with Micro-finance for AIDS and Gender Equity (IMAGE) study conducted between 2001 and 2005. The two-year IMAGE study used an integrated approach combining micro-finance, gender and HIV training, and community mobilization (Kim et al., 2007). The IMAGE study combined anti-violence work and curriculum focusing on gender equity enhancing and HIV/AIDS education curriculum within existing micro-finance interventions with 4,000 active clients. Findings are unprecedented: after two years, the risk of past year IPV was reduced by more than half (adjusted risk ratio=0.45; 95%, CI= 0.23, 0.91).

Qualitative data from focus groups revealed that reduction in violence was a result of a range of strategies that encouraged participants to reason, challenge, and question the acceptability of violence, to expect better partner treatment, to dissolve abusive relationships, and to increase community awareness about IPV (Kim et al., 2007). The author concluded that empowering women socio-economically, particularly through micro-finance, contributes significantly in reducing IPV.

The growing empirical literature that considers the relationship between involvement in micro-finance and subsequent exposure to IPV suggests a mixed range of patterns. These mixed findings require cautious interpretation because of intrinsic methodological challenges that may introduce bias into the final results (Kabeer, 2001). For example, almost all of the quantitative studies involved analysis of cross-sectional data that varied in the reference period or the timing of the events. Ahmed (2005) evaluated IPV in the previous four months as compared to Koenig and colleagues (2003) who assessed the similar variable over the previous twelve months, as well as life-time exposure to IPV. Further, there are significant design challenges in controlling selection bias and the characteristics of women who join credit and saving activities. This poses two questions. First, are emotionally anxious, depressed (Kabeer, 1998), and abused women more likely (Mahmud, 2000) or less likely (Steele, Amin & Naved, 2001) to join intervention programs? Second, is participation in such programs associated with stress and violence? All the studies reviewed agreed that increased duration in micro-finance, training and skill development, and educational interventions collectively improved

women's mental health outcomes and equipped them with the necessary skills to resolve conflict and avoid violent situations with more confidence (Ahmed, 2005).

The aforementioned reviewed literature from developing countries, in the context of women's mental health and micro-finance, is limited to women's perspectives on empowerment, their perceived psychological stress and depression, and experiences with IPV. These studies are large and small, qualitative and quantitative, showing both positive and negative findings and experiences with involvement in micro-finance. However, in spite of many methodological constraints, these studies make a significant contribution to the literature related to the impact of micro-finance on women's mental health and well-being and raise important questions that require further investigation. The proposed study will address a critical research gap by presenting a qualitative analysis of how urban-dwelling women from Karachi, Pakistan, who have been micro-finance loan recipients for a period of 1 to 5 years, conceptualize the meaning of mental health and well-being. Further, it will explore what micro-finance means to these women and the impact of their participation in micro-finance programs on their mental well-being.

Theoretical Forestructure

The theoretical forestructure component of this thesis makes two contributions. When I proposed the study, I reviewed Keyes' (2002) multidimensional model of mental health and well-being. I speculated that Keyes model would provide a conceptual framework to recognize the depth and the breadth of the perceptions and experiences of mental health and well-being shared by participants of this study. So the first contribution the forestructure makes is linking Keyes' model of mental well-being with the early

history, theories and traditions of mental health described by Greek philosophers. I will link the Hedonic and Eudaimonic traditions to Keyes multidimensional model of mental health and well-being. The second is marked by the examination of understanding mental health in the context of language and culture. Both components will provide a basis for analysis in the following chapters.

Early history and tradition of mental health. Though the notion of mental health is not new, there has been ongoing discussion around how we understand mental health and mental well-being in the scholarly work (Bury, 2001; Hart, 1985, March, Keating, Punch, & Harden, 2009; Nettleton, 2006; Rogers & Pilgrim, 2007), there has been ongoing discussion around the issue of mental health and mental illness in the scholarly world (Macklin, 1981; WHO, 2005a). In general, mental health is viewed and described from the perspective of mental illness (Gill, 2009), or as a negatively biased condition connoting the absence of disease, rather than the presence of positive attributes (Ryff & Singer, 1996). For instance, the stated mission of the National Institute of Mental Health (NIMH), predominantly focuses on mental illness. Their mission statement is "To understand mind, brain, and behavior, and thereby to reduce the burden of mental illness through research" (NIMH, 2008, p. 1). Indeed, in several decades since NIMH was first established, much has been learned about mental illness and far less is known about mental health (Keyes, 2013). A review of literature found that research publications address negative rather than positive psychological states in a ratio of 17 to one (Diener, Suh, Lucas, & Smith, 1999). Keyes (2005) argues that an absence of mental health should not be viewed as the presence of mental illness because there is no guarantee that an

absence of mental illness will lead to good mental health. Thus, "mental health and mental illness cannot be dichotomized" (Keyes, 2002, p. 208).

From the early theories and research findings in the field of psychology, Marie Jahoda in 1958 revealed that mental health and mental illness are not at opposite ends but correlate with each other, which leads to confusion about their definitions. She interpreted mental health in the context of happiness, quality of life, and a positive sense of well-being (Tengland, 2001). In 1960, Gurin, Veroff and Feld defined subjective well-being as an assessment of an individual's satisfaction and happiness in life (cited in Keyes, 2013). Later, Diener (1984) and Ryff (1989) strengthened theories on subjective well-being and psychological well-being respectively. During the twentieth century, Vaillant (2003) presented the multidimensional phenomenon of positive mental health. Positive personal qualities, social-emotional intelligence, subjective well-being, and resilience and coping were the major concepts of Vaillant's (2003) perspective on mental health. Hence, social scientific scholars have spent more than 40 years moving the promising agenda of mental health forward through studies of subjective well-being (Keyes, 2013).

Although academic discourse on this topic has been recent, the history of subjective well-being grew from ancient Greek philosophers about two millennia ago. Though their theories did not directly target mental health, two of their concepts are being pursued in the current streams of mental health research: the Hedonic and Eudaimonic traditions (Keyes, 2013). The first distinct tradition, presented by Aristippus, a student of Socrates and a member of the Cyrenaic school of hedonism (435 to 356 BC), is *Hedonic*, which refers to feelings of positive emotions. The Hedonic tradition of well-being

typically describes the pursuit of pleasure for its own sake. It encompasses the maximization of positive feelings and minimization of negative feelings. In contrast, Aristotle (385 to 322 BC) put forward the tradition of *Eudaimonia.* He believed that happiness is not limited to positive feelings or emotions but is about developing and creating abilities to become a more fully functioning individual, realizing one's own potential and striving towards excellence and positive functioning. Within the streams of current empirical research, researchers measure individuals' subjective experiences through three components of well-being which encompass Hedonic and Eudaimonic traditions. The Hedonic tradition reflects subjective emotional well-being (Keyes, 2007), whereas the Eudaimonic tradition mirrors subjective psychological (Ryff, 1989) and social well-being (Keyes, 1998). The following section examines both traditions in order to gain a basic understanding of these traditions and from there advances into the three types of well-being which will form the conceptual framework of this thesis.

The Hedonic tradition: feeling good about life. The first component of Hedonic well-being, also called emotional well-being, is the most common approach to understanding and defining well-being. The fourth century Greek philosopher Aristippus, suggested that the goal of life is to experience the maximum amount of pleasure and that "happiness is the totality of one's hedonic moment" (Ryan & Deci, 2001, p. 143). There is consensus that the Hedonic tradition reflects the view that well-being consists of maximizing subjective happiness and pleasure, and minimizing pain (Ryan & Deci, 2001). Hence, in order to maximize Hedonic well-being, people should do what makes them happy. Psychologists who prescribe to the Hedonic perspective evaluate emotional

well-being as subjective well-being (SWB) (Diener & Lucas, 1999; Waterman, 1993). SWB consist of three components: happiness, life satisfaction, and positive affect or interest in life (Keyes, 2007). From this perspective, well-being is defined as a high level of positive affect, a low level of negative affect, and a high degree of satisfaction with one's life (Deci & Ryan, 2008).

Despite the popularity of the Hedonic tradition, it has received some criticism due to its narrow portrayal of well-being. Studies argued that a Hedonic view on well-being fails to account for the complexity of different types of positive feelings (Ryff, 1989; & Watterman, 1993). For instance, conceptualizing happiness as a quantitative difference along a single dimension running from bad to good has been challenged (Diener & Lucas, 1999). It was suggested that life satisfaction and pleasure are generated by different stimuli from those affecting Eudaimonic feelings of personal growth and interest (Kopperud & Vitterso, 2008; Watterman, 1993). This led some psychologists to reflect on the notion of well-being in terms of individual striving and optimal functioning, consistent with the notion of the Eudaimonic tradition (Ryan & Deci, 2001; Ryff 1989; Ryff & Singer, 2008).

The Eudaimonic tradition: functioning well in life. Eudaimonic well-being is more than experiencing positive affect or satisfaction with one's life. It reflects the development of one's true highest potential and meaning in both the individual's psychological well-being and social well-being. (Ryan & Deci, 2001; Ryff & Singer, 2008). According to this tradition, not all desirable outcomes, such as positive feelings, will yield endurable well-being when achieved (Deci & Ryan, 2008). Instead, well-being

is achieved by self-realization through the fulfillment of one's own personal potential (Waterman, 1993). Aristotle advocated that "true happiness is found in the expression of virtue and doing what is worth doing" and not in the Hedonic tradition, which emphasizes the "slavish follow[ing] of desires" (Ryan & Deci, 2001, p. 145). Thus, the Eudaimonic tradition adds a significant perspective to the study of well-being (Deci & Ryan, 2008).

One of the most prominent models within the Eudaimonic tradition is the model of psychological well-being developed by Carol Ryff (Ryff, 1995). This leading researcher on Eudaimonic well-being challenged the Hedonic view by emphasizing the importance of theoretical grounding and basing her perspective on optimal human growth and functioning (Ryff & Singer, 2000). Her conception of Eudaimonic well-being has been informed by the work of developmental, clinical, and humanistic psychologists (e.g. Erikson, Maslow, Rogers, Jung, Jahoda) and reflects optimal psychological functioning as one's highest potential (Ryff, 1989). Ryff (1995) depicts Eudaimonic well-being as distinct from Hedonic or emotional well-being, and presented six multidimensional constructs of psychological well-being: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relations with others, (e) purpose in life, and (f) self-acceptance. Thus, these dimensions of Eudaimonic well-being reflect an additional component of well-being and represent a valuable guide to a more complete and meaningful life that is explicitly concerned with an individual's development and self-realization (Ryan, Huta, & Deci, 2008).

Since well-being is not merely a "private phenomenon" (Keyes, 1998, p. 121), and each individual is embedded in social structures and communities, optimal human

functioning cannot be complete without considering the social aspect of well-being. Following a similar method to that of Ryff (1989), Keyes presented his standpoint of social well-being in 1998 (Keyes, 1998). Inspired by the classical writings of social psychology perspectives, he shared five elements of social well-being that represent a more public experience of individuals' functioning in their social world (Keyes, 1998). These operational dimensions of social well-being include: (a) social integration, (b) social contribution, (c) social coherence, (d) social actualization, and (e) social acceptance. Hence, the conceptualization of social well-being that accounts for the challenges individuals face as members of society represents a distinct component of well-being that, along with emotional and psychological well-being, contributes to a complete understanding of overall well-being (Keyes, 1998).

Distinguishing between Hedonic and Eudaimonic well-being does not come without challenges. Researchers have concluded that wellness is unlikely to be either completely Hedonic or entirely Eudaimonic and is instead much more likely a combination of both or "blended activities" (Deci & Ryan, 2008; Keyes, 2007; Steger, Kashdan, & Oishi, 2008, p.39; Waterman, Schwartz, & Conti, 2008). The following section will focus on the Keyes' definition of mental health and the Mental Health Continuum (MHC) to fully understand the dimensions of mental health, which this thesis has pursued to examine the phenomenon of mental health and well-being within the context of micro-finance.

Keyes' definition of mental health. Keyes (2005) views mental health as a positive phenomenon that is more than the absence of mental illness. The mental health

definition presented by the WHO affirms the conceptualization of mental health from a positive perspective, asserting that it 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" (2005a, p. 2). This definition reflects the multidimensional components of the Hedonic and Eudaimonic traditions of well-being, which Keyes (2005) recognizes as the core components of the WHO definition of mental health. For instance, Keyes (2007) linked "a state of well-being" from the WHO definition of mental health, which constitutes affective (i.e., emotional) well-being with the realization of one's ability to cope effectively with stresses. This coping capacity reflects aspects of optimal functioning (i.e., psychological) well-being, and an individual's contribution towards society and community, which falls under the optimal functioning of social life (i.e., social) well-being. In other words, a combination of an individual's subjective (emotional) and functional (both psychological and social) well-being together forms one's over-all mental health (Keyes, 2002). Appendix 1 details Keyes's (2002) multidimensional model of mental health and well-being.

Based on the aforementioned explanation, this thesis views the WHO definition of mental health components of emotional, psychological, and social well-being as overarching concepts of Hedonic and Eudaimonic traditions as presented by Keyes (2002). Specifically, this study's constitutes the conceptual framework draws from Keyes' indicators of individual's subjective wellbeing, which includes: (a) emotional well-being, (b) psychological well-being, and (c) social well-being, to conceptualize the

subjective perceptions and experiences of women's mental health and well-being among urban-dwelling Pakistani women participating in micro-finance programs.

In view of a comprehensive explanation of mental health and in an effort to empirically assess the nature and incidence of mental health and mental illness, Keyes introduced the notion of a mental health continuum (MHC) in 2002 and recently revised in 2007 (Keyes, 2002; Keyes, 2007). The following section will briefly discuss Keyes' mental health continuum and the meaning and importance of examining the subjective conceptualization of mental health.

The mental health continuum: from languishing to flourishing. For Keyes, mental health and mental illness are not the opposite of each other, nor is mental health merely the absence of mental illness. As a result "the mental health continuum consists of complete and incomplete mental health" (Keyes, 2002, p. 210). Keyes argues that individuals with a high level of subjective well-being are in a complete mental health status and are *flourishing* in life. Individuals with a low level of subjective well-being are with incomplete mental health and are *languishing* in life. Individuals who are *moderately mentally healthy* are neither flourishing, nor languishing in life. Thus, one who languishes may experience profound emptiness, stagnation, or quiet despair, but not necessarily exhibit symptoms of mental illness (Keyes, 2005).

Among reliable instruments, the diagnostic scheme of Keyes' (2002) mental health continuum parallels the scheme used by the American Psychiatric Association to diagnose major mental illnesses. The MHC assesses individuals' emotional, psychological and social well-being through a single questionnaire, so, in terms of the

MHC, to be flourishing in life one must exhibit high levels of well-being from the two ancient traditions, Hedonic and Eudaimonic. Flourishing for Keyes is the combination of both Hedonic and Eudaimonic well-being, (i.e., feeling good and functioning well, respectively). Flourishing individuals are completely mentally healthy because they are not only free of major mental illnesses, but they also fit the diagnostic criteria for the presence of mental health. Similarly, individuals who are languishing in life exhibit a low level on measures of emotional and functional well-being. The purpose of the present study is not to assess and categorize participants along the mental health continuum but rather to understand and recognize the phenomenon of mental health and well-being in its social and cultural context. The discussion to follow will throw light on the notion of creating meaning and understanding the reality of mental health and well-being in the context of language and environment.

Subjective conceptions of mental health and well-being. Understandings of mental health are predominantly determined by the meanings individuals give based on their experiences and feelings (Chambers, 1997; Fernando & Weerackody, 2009). Acknowledgment of these experiences are highly context-sensitive and are influenced by the nature of human conditions, individual worldviews, and cultural factors (Fernando & Weerackody, 2009). Further, race, gender, age, and social background play a significant role in the construction and creation of meaning of mental health and well-being (Gu, 2006). Culture influences different perspectives and dimensions in representing one's reality of worldviews and understandings of one's mental health (Vaingankar et al., 2012). For instance, Kakar (cited in Fernando & Weerackody, 2009), in his exploration of

psychological inquiry and healing traditions, postulates that with regard to mental health, people from India focuses on the search for one's inner feelings, whereas individuals from the West would concentrate on the notion of "freedom" and expanding the dimensions and possibility of choices. Michael T. Walker, in his article "Social Construction of Mental illness" (2006), has referenced Ludwig Wittgenstein (1889-1951), one of the founding fathers of postmodernism, who emphasized that, human experiences of "relationship and communication create vocabularies" which are being socially constructed and based on individual's realities (2006, p. 3). Walker (2006) emphasized the role of language in the social activities of everyday life in representing "the nature of reality and mind" (p. 2). He believes that "language empowers people" and assists in learning truth as opposed to measuring reality in a reductive and objective manner (p. 6). Rogers and Pilgrim (2007), Kirmayer (2007), and Chambers (1997) concur on the notion of recognizing the individual reality of mental health in a local context, taking into consideration the social and cultural factors involved. Individuals have diverse values, goals, and strengths, thereby allowing them to define mental health for themselves, with these definitions accurately reflecting the true picture of one's state of mental health (Diener, Sapyta, & Suh, 1998; Fernando & Weerackody, 2009).

Another essential notion in the explanation of mental health is its newness and uniqueness. Gill (2009) argues that the concept of mental health is primarily a Western construct, where it is widely recognized as an "individual's personal qualities" (p. 13). He further concludes that to assume the Western conceptualization of mental health for

developing nations would be an incorrect step, and urges an exploration of how these concepts are explained and valued in developing nations.

The literature search related to the conceptualization or perceptions of mental health, mental well-being, and positive mental health yield limited results and mostly derive from the Western world. Among these studies, a small proportion of qualitative studies or studies using open-ended questionnaires predominantly involved among children from Scotland and the United Kingdom (Armstrong, Hill, & Secker, 2000; Majumder, O'Reilly, Karim, Vostanis, 2015; Roose & John, 2003; Singletary et al., 2015; Svirydzenka, Bone, & Dogra, 2014); and youth and adolescents from Uganda, Sweden, and Mexico (Harms et al., 2009; Johansson, Brunnberg, & Eriksson; 2007; Wells, Varjas, Cadenhead, Morillas, & Morris, 2011). One involved Albanian immigrant refugees (Dow & Woolley, 2011), and another multiple ethnic groups from Singapore (Vaingankar et al., 2012). Mental health perception was also identified among Pakistani nomads (Choudhry & Bokharey, 2013) and Iranian women were participants in a recently published study (Mirabzadeh et al., 2014). These studies examined the construct of mental health based on the language and cultural and social practices of its population. Along with perceptions of mental health, most of the available studies mainly focus on the factors associated with emotional stress and psychosocial and mental distress rather than on an individual's theoretical conceptions of mental health and well-being (Choudhry & Bokharey, 2013; Mirabzadeh et al., 2014; Wells et al., 2011). However, a study from by Vaingankar and colleagues (2012) developed a conceptual framework of mental health and well-being through focus group discussions among adults belonging to three major ethnicities in

Singapore. The outcome of studies will be shared in Chapter Five in comparison to the findings of the current study.

In pursuing the definition of mental health and well-being, psychologists and psychoanalysts have worked using a "rubric" or set of criteria which covers different perspectives of human psychological functioning, such as feelings of well-being, effective functioning in personal and social lives, an absence of incapacitating symptoms, etc. (Fernando & Weerackody, 2009 p.199). The WHO (2005a) also refers to a broad range of activities related to mental and subjective well-being in its definition of mental health. The study of subjective well-being as a way of accessing the meaning attributed to mental health is a fairly recent development (Fernando & Weerackody, 2009). Learning and measuring subjective conceptions accurately requires assessment of one's own emotional states (happiness and satisfaction), one's psychosocial function (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance), and one's social functioning (social integration, social contribution, social coherence, social actualization, and social acceptance) (Keyes, 2002; Keyes, 2013).

What does all this mean for the mental health researcher? The phenomenon of mental health and well-being is socially constructed and individuals have the expertise, the knowledge and the language to describe and share their reality in their local and social context. Further, there is a need to examine the challenging phenomenon of mental health in the context of positive mental health and well-being to improve mental health interventions. Thus, my starting point is to understand the mental health constructions of Pakistani women, particularly those from disadvantaged backgrounds who are struggling

to make their and their families lives better by seeking loans for economic progress. It is important to focus on these women as their reflections will inform the study and the complex phenomenon of mental health and well-being which, to my knowledge, has received limited research attention in general and in the context of micro-finance in particular.

Chapter Summary

Consistent with the interpretive description tradition of qualitative inquiry, in this chapter I presented the theoretical scaffolding of the study. The literature review detailed an overview of the micro-finance programs in South Asia and in Pakistan. This chapter outlined the significance of women's participation in micro-finance programs through literature from a range of impact studies focusing on women. This overview provided a justification of the inquiry. The theoretical forestructure component detailed the early history, theories and Hedonic and Eudaimonic traditions of mental health described by Greek philosophers. This knowledge was relevant to understand Keyes (2002) multidimensional model of mental health and well-being. The subjective (emotional) and functional (psychological and social) well-being provided the depth and breadth to understand the perceptions and experiences of mental health and well-being shared by participants of this study. This chapter concluded with the significance of examination of understanding mental health in the context of language and culture and its relevancy in future practices.

Chapter Three: Research Methodology

The selection of an appropriate research methodology is the foremost process to inform the research question and to develop knowledge. A qualitative approach is used in this study to describe and interpret women's experiences of engagement in micro-finance programs and its perceived impact on their mental health and well-being. The study works within a paradigm of naturalistic inquiry, and the principles of interpretive description have created the structure for the study and provided direction for all methodological decisions (Thorne, 2008). The purpose of this chapter is to explain my approach to researching the phenomenon of mental health and well-being. I will briefly describe the research method of interpretive description and my reasons for choosing this approach. A description of the setting, the process of participant recruitment, the sample, data collection, and data analysis procedures and processes will follow. Finally, I will describe the strategies used to establish methodological rigour and the ethical considerations to reduce or prevent harm to the study participants.

Study Design

Why interpretive description? Interpretive description is a "noncategorical" methodological research approach for examining a clinical phenomenon with a focus on "human health and illness experiences" (Thorne, Kirkham, & MacDonald-Emes, 1997, p.173). This methodology was created in response to the need to address complex experiential clinical research questions that are difficult to answer using any one existing traditional methodology (Thorne, 2008). Interpretive description is a significant contribution to the field of qualitative research, especially in an applied health field such

as nursing, where it can be used to develop clinical understanding and inform clinical practice.

Consistent with traditional qualitative research methods (e.g., phenomenology, grounded theory and ethnography), interpretive description is grounded in the individual's experiences (Thorne et al., 1997). However, in later years, Thorne (2008) asserted that methods such as the ones listed above evolved within the health sciences from the disciplines of philosophy, sociology and anthropology respectively. These are disciplines which follow the philosophical underpinnings of social sciences and are firmly anchored in theoretical and empirical problems. Thorne, Kirkham, and O'Flynn-Magee (2004a) view nursing as a discipline that demands attention to day-to-day clinical practical concerns. Therefore, knowledge generated from these traditional research methods, which primarily focus on the core nature of human experiences and behaviours, may not efficiently address the practical problems of nursing. Thorne and her colleagues suggest that interpretive description explicitly address research questions and problems that originate from clinical practice and emphasize the practical implications of the research findings (Thorne, 2008; Thorne et al., 2004a). Thus, the interpretive descriptive method emerged as a distinct qualitative approach to offer "a clinical description with an interpretive or explanatory flavor" (Thorne et al., 2004a, p. 3).

Interpretive description's emphasis on the relevance of practical application, finding solutions that work, and the improvement of clinical reasoning and ultimately client care (Thorne et al., 1997) reflects the essentials of a philosophy of pragmatism (Patton, 2002). Further, it is associated with the naturalistic orientation to inquiry and

informed by the key axioms proposed by Lincoln and Guba (1985). The key axioms are as follows: (a) there are multiple complex, constructed realities that are understood through individuals' subjective experiences, (b) the inquirer (researcher) and the object of inquiry (participant) interact and influence one another, so that the knower and known are inseparable, (c) theory must emerge or be grounded in the data rather than using a priori theory, (d) there are human commonalities or "shared realities" and individual variances across these multiple, constructed realities (Thorne et al., 2004a, p. 3), and (e) inquiries are conducted in as naturalistic a context as possible, to "tap human experience in context" and to maintain the respect, comfort, and ethical rights of all participants (Thorne, 2008, p. 203). Thus the aim is to understand how individual experiences are situated in, and influenced by, various contexts of human experiences, to the degree possible (Thorne, 2008). Interpretive description yields constructed truths rather than facts, by virtue of its reliance on interpretation. Furthermore, the hallmark of interpretive description is the generation and extension of knowledge about the clinical phenomena in a way that guides clinicians or, more specifically, provides evidence for their inquiry and practice (Thorne et al., 2004a). Nurses and other applied heath researchers have found that, as a research design, interpretive description provides a logic and philosophical rationale to answer qualitative inquiries (Thorne, Con, McGuinness, McPherson, & Harris, 2004b). This method is reported as "atheoretical" as the intention is to generate knowledge related to clinical problems of health and illness, rather than to generate theory or to theorize (Thorne, 2008, p. 62).

The key feature of interpretive description is theoretical scaffolding "to prepare the ground" for the researcher to investigate the phenomenon through exploring existing literature and identifying theoretical and conceptual ideas (Thorne, 2008, p.53). A priori background knowledge encourages researchers "not to go in blind" but rather to incorporate theoretical knowledge, clinical pattern and their personal perspectives that inform the study (Thorne, 2008, p. 21). Thorne (2008) and her colleagues (Thorne et al., 2004a) asserted that theoretical scaffolding provides an "analytical framework" (Thorne et al., 1997, p. 173) upon which a qualitative study is developed to "generate new insights that shape new inquiry as well as applications of evidence to practice" (Thorne, 2008, p. 35). However, the originators of interpretive description caution the researcher to remain vigilant to avoid premature closure of emerging conceptualization and the production of a "glorified content analysis" (Thorne et al., 2004a, p. 10). Furthermore, since theoretical scaffolding is considered to shape the preliminary analysis, researchers should gradually distance themselves as new meanings about the phenomenon are developed (Thorne et al., 2004a; Thorne, 2008). In this way, the method acknowledges researchers' prior knowledge and allows truth-seeking by deconstructing prior knowledge through inductive data analysis of the phenomenon within its context (Thorne, 2008).

Other features of interpretive description include purposive and theoretical sampling to seek variation in emerging themes and to gather an adequate quantity and variety of data sources. In keeping with this principle, interpretive description encourages data triangulation from multiple sources such as observation, document review, and other collateral data sources to contribute to the trustworthiness of the findings. However,

individual in-depth interviews are the primary data source in interpretive description (Thorne, 2008). Constant comparative methods, a reciprocal approach to data collection and analysis, give direction for further data collection (Patton, 2002).

With regard to analysis, interpretive description employs an inductive process and follows a grounded approach to articulate patterns emerging in relation to the phenomenon of study (Sandelowski, 2000; Thorne et al., 2004a). The aim is to produce findings that move beyond self-evident, initial descriptive claims towards more abstracted interpretations. Thorne (2008) asserted that the purpose of interpretation in interpretive description is to generate an interpretive account of the "associations, relationships and patterns within the phenomenon that has been described" (p. 50) and critical examination within the methodological guidelines that is consistent with the discipline in which the research is situated (Thorne et al., 2004a). Thus, interpretive description extends the creation and construction of realities through describing and interpreting a phenomenon in the context of "qualitative creditability criteria" (Thorne et al., 2004a, p. 8), thus affirming the rigour of qualitative studies (Table 1 summarizes the principles of interpretive description).

Table 1: Summary of Guiding Principles in Interpretive Description

Design Components	Principles
Analytic framework	Relevance to practical application, improvement of clinical reasoning and patient care. Associate with the naturalistic orientation to inquiry. Recognize theoretical scaffolding for background knowledge and disciplinary orientation of inquiry.
Sampling	Purposeful and theoretical sampling to seek variation in themes. Enhance credibility by fostering strong database
Data sources	Data triangulation from multiple data sources. Constant comparative method provides direction for further data sources. Ensure multiple data sources contribute to the trustworthiness of the findings.
Data Analysis	Employ inductive analysis process than deductive. Follow iterative or constant comparative analysis. Allow creative and flexible data analysis approaches from other methods. Repeated immersion in data and asking broad questions. Promote broad-based codes and avoid decontextualization of data. Represent findings through thematic summary or conceptual description.

Note: Adapted from Thorne et al., (1997, 2004a) and Thorne (2008)

Since the present study is a quest to examine the rarely reported and poorly understood phenomenon of Pakistani women's mental health and well-being within the context of engagement in micro-finance, the methodologically robust approach of interpretive description provides a "logical model" (Thorne, 2008, p.17) for this inquiry as per the following explanation.

First, interpretive description is a methodology that assumes multiple realities and constructed truths, created by individual minds in their context (Thorne, 2008). It offers new understanding and meaning by reshaping prior knowledge (Thorne et al. 1997). It aims to understand how individual experiences are influenced by their context (Thorne,

2008). Given that previous research remains primarily limited to the indicators of mental illness or general beliefs about these illnesses, not to how individuals both shape and are shaped by their contexts, interpretive description afforded the methodological tools needed both to examined the theoretical conceptions of mental health and well-being and to describe the specific experiences of women as they relate to their own perceptions of mental health. It is essential to focus attention on the experiences of the women, their mental health challenges, and their coping strategies within the context of the responsibilities of seeking loans and other forms of economic sustenance, along with their traditional role as women in Pakistani society. Here, interpretive description constitutes a method of knowledge development through emerging interpretations of data and ensuring critical questioning of pre-existing beliefs and understanding (Thorne, Hislop, Armstrong, & Oglov, 2008).

Second, while interpretive description has strong links to grounded theory (e.g., purposive and theoretical sampling), phenomenology (e.g., human subjective experiences), and ethnography (e.g., field exposure), a clear and sustained emphasis on human health and illness experiences and persistent attention to "practice knowledge and nursing science" strongly underpins interpretive description (Thorne et al., 1997, p. 173). The method emphasizes finding practical implications of research outcomes that are relevant to human problems or situations, and explicitly addresses solutions that work (Patton, 1999). As mentioned in Chapter Two, mental health is a poorly understood phenomenon in developing nations and is predominantly limited to the absence of a mental disorder. I believe that, through interpretive description, this study will contribute

to our body of knowledge of how women in Pakistan experience their mental health and well-being and what health care practitioners in general, and nursing in particular, can do to make a difference in their lives.

Third, interpretive description supports triangulation of multiple data sources to seek multiple perspectives of the phenomenon. Although many types of data sources can be used, interviews that access participants' rich experiential knowledge to understand the phenomenon are a primary research tool for understanding participants' reality (Thorne, 2008).

Finally, maximum variation is one of the crucial features of interpretive description. Though demographic variables may give some useful direction for preliminary decisions, the notion of maximum variation relevant to "conceptual variables" is determined through inductive analysis of themes (Sandelowski, 1995a; Thorne, 2008, p. 161). For example, the initial literature review provided the framework for my study to seek variation through demographic variables. Thus, women were recruited from two different micro-finance programs, with variation in numbers of loan, skills training, and years engaged in micro-finance programs. The inductive analytic process of interpretive description will formulate relationships among data and theorize outliers that will capture unique and diverse perspectives of the phenomenon under study: women's experiences of their mental health and well-being (Thorne et al., 1997).

The study is strengthened through triangulation of multiple data sources, and the rigorous process of data collection and analysis that guided the understanding of the complex phenomenon of women's mental health and well-being in the context of micro-

finance. The findings will provide evidence to health care practitioners to enhance their clinical practice (Thorne, 2008) and will assist microfinance institutions to modify policies to maximize women's mental well-being and improve the overall impact of participation in micro-finance.

Study Setting

This study was conducted in Karachi, Pakistan. A purposeful sample of urban-dwelling women who were identified as loan recipients of the First Micro-Finance Bank (FMFB) and Kashf Foundation (KF) were invited to participate.

Pakistan is located in South Asia, bordered by India to the east, China to the north-east, Iran to the south-west, and Afghanistan to the west and north. The country covers a total area of 796,095 km and is divided into four provinces: Sindh, Punjab, Balochistan and Khyber Pakhtunkhua (formerly known as the North West Frontier Province) (Qureshi, 2010). In the absence of population census data over the last 15 years, the estimated population is 177 million, 2.5% of the world population (World Bank Report, 2015). Pakistan is the second most densely populated country, after India, in the South Asian region (Véon, Horko, Kneipp & Rogers, 2008). The majority of the population (65%) resides in the rural part of the country, with the remaining 35% living in urban settings. In Pakistan, approximately 24% of the population live below the poverty line, with rates of poverty higher in rural settings. Within this context, the most impoverished families also lack access to basic needs such as education, health, clean drinking water, and sanitation (National Institute of Population Studies, 2013). Pakistan

Bureau of Statistics (2014) estimates that approximately 74% of the population is engaged in the labour force, 53% male and 21% female (>15 years of age).

The city of Karachi is the capital city of Sindh province, located in Southern Pakistan on the coast of the Arabian Sea (Indian Ocean). Karachi is spread over 3,530 sq km, with an estimated population of 18 million (City District Government Karachi, 2007). The city is the tenth largest city in the world by population (United Nations Population Division, 2008) and is expected to be the second largest city by 2020 with 27.5 million people (Butler, 2005). Karachi is among the cities receiving the largest number of migrants from rural settings and northern parts of the country where recent floods and political instability are forcing individuals to relocate (Qureshi, 2010). A large segment of Karachi's population, roughly 40%, lives in poverty. The employment rate fell from 33.43% in 1981 to 27.58% in 1998. Average household monthly incomes is estimated between Pakistani Rupees (PKR) 3,000 and PKR 5,000 (US$30-50) mainly due to the high number of immigrants that remain unemployed or earn their living by doing irregular and low paying jobs (Qureshi, 2010). Approximately 75% of households fall under the category of poor and low-income groups while only 25% constitute the middle and high income strata (Qureshi, 2010). High unemployment and poverty mean that 50% of the population in Karachi live either in squatter settlements or in slums (Hasan & Mohib, 2003). In the province of Sindh, the Labour Force Participation Rate for the age group 10 and above was 45%, 37.66% male and only 7.37% female (Pakistan Bureau of Statistics, 2014).

The following section will detail the two micro-finance institutions selected for this study: the FMFB and KF. Both are considered to be the top two providers of micro-finance in the country (Pakistan Microfinance Network, 2014).

The First Micro-Finance Bank. In Pakistan, the FMFB is the result of the transformation of the micro-finance program of the Aga Khan Rural Support Program (AKRSP), with more than thirty years of experience, into a specialized bank (Hussein, 2009). AKRSP has its foundation in the Aga Khan Development Network (AKDN), established in 1950 as a non-denominational and private development agency that sought to improve living conditions and opportunities in Sub-Saharan Africa, Central and South Asia, and the Middle East. AKDN has mandates ranging from health and education to architecture, environment, culture, micro-finance, rural development, disaster reduction, promoting private-sector enterprise, and revitalizing historic cities (Aga Khan Foundation, 2010). AKDN is a large network that seeks to build sustainable institutions and reduce dependence on external development assistance (Aga Khan Foundation, 2010). The micro-finance sector of AKDN has been brought together as regulated micro-finance institutions under the administration of the Aga Khan Agency for Micro-Finance's (AKAM). AKAM's website states, AKAM works closely with the other AKDN institutions to achieve its underlying objectives to reduce poverty, to reduce the vulnerability of poor population, and to alleviate economic and social exclusion. AKAM aims to improve people's quality of life by helping them to improve their income, become self-reliant, and gain the skills to sustain in financial markets. AKAM has been providing its services in 13 countries across the globe (Aga Khan Agency for Microfinance, 2010).

The FMFB is one of the major initiatives of AKAM, established as a non-listed public limited company under the provisions of the company's ordinance in November 2001 and then licensed as an MFI under the "Microfinance Institutions Ordinance 2001" in January 2002. FMFB formally started operations in February 2002, taking deposits through its first branch in July 2002 (Aga Khan Agency for Microfinance, 2010). According to AKAM, the primary focus of the institution is to lend money to deprived populations with the goal of securing the borrowers' future with dignity and pride, and to reduce poverty by promoting sustained economic development (Aga Khan Agency for Microfinance, 2010).

The bank provides a number of services to its members. FMFB was the first bank to introduce saving accounts along with credit and life insurance services for the impoverished community of the country (First Microfinance Bank of Pakistan, 2012). In addition to saving accounts, FMFB offers a range of loans adapted to meet the needs of the diverse clientele in urban and rural settings. These include start-up and existing business finance loan for individuals, groups, and business groups, and house improvements and health and education finance loan schemes. FMFB provides a life insurance facility to all its borrowers. For instance, in case of death or permanent disability of the borrower, the bank pays off the outstanding loan of the borrower and also gives a sum of PKR10,000 (US$ 100) to the bereaved family. Health insurance for spouses and children is a new initiative of FMFB, along with its additional services such as chequing operations, micro insurance with loan and life coverage and wire transfers (State Bank of Pakistan, 2011).

According to a recent available report, FMFB has disbursed around US$47 million among its 154,706 active borrowers, of which 63% lives in rural areas. Its loan portfolio is concentrated on agriculture and livestock. The majority of the loans are for less than US$500; the average loan size is as small as US$253. The Bank claims to have significantly improved outreaching to female borrowers with women constituting 38% of clients in 2006, up from 8% in 2004. However, these figures have dropped from 35% in 2010 to 33% in 2012. Over the years FMFB has disbursed 400,831 loans to women, amounting to PKR 7 billion (approximately US$ 75 million) (First Microfinance Bank of Pakistan, 2012).

Since the inception of FMFB-Pakistan in July 2002, the network serves all the provinces of the country. Women from Karachi represent 52% of its 33% total female borrowers with the majority receiving loans in solidarity groups against social collateral (First Microfinance Bank of Pakistan, 2012). Of the 11 FMFB branches in the Karachi and Baluchistan regions, women were recruited from three different branches for this study: (1) Garden branch; (2) Karimabad branch; and (3) Mehmood Abad branch.

Kashf Foundation. The second micro-finance institution selected for this study was the Kashf Foundation. Using the Grameen bank model, KF was established in mid-1996 by a community participation specialist working with the United Nations Development Program and the World Bank, Ms. Roshaneh Zafar (Mahmood, 2007). The name Kashf is the Urdu word for “miracle” and “revelation”, and KF emerged as a non-profit institution that aimed to demonstrate that economic empowerment of women can be a key enabling factor in moving Pakistan beyond its social and economic standing

(Mahmood, 2007 p. 2; Shahid, Tarar, Hayat, & Khalid, 2014). The vision of the institution is to provide "financial services for all in a poverty free and gender equitable society" (Shahid et al., 2014, p.2). KF began its journey in 1996 as a non-profit MFI set up under Section 42 of the Companies Ordinance, 1984, and is regulated by the Securities and Exchange Commission of Pakistan (Mahmood, 2007). Over the years, KF has grown and is considered to be one of the largest MFIs in Pakistan. It offers diverse financial and non-financial services to address the needs of impoverished families for mandatory long term development and poverty alleviation (Rauf & Mahmood, 2009). According to the KF Annual Report (2012-2013), KF's economic empowerment program has grown from 913 female clients in June 1999 to 324,139 female clients in June 2013. The foundation has distributed nearly PKR 29.67 billion to over 2.22 million women borrowers to support more than 1.5 million families through its 174 branches across Pakistan. KF claims for every Rupee disbursed in the market as a micro-finance loan, only 25% was provided to women in 1996. This figure has increased to 50% since the inception and success of KF.

KF's primary target is women-headed house-holds in urban and peri-urban areas with a family monthly income between PKR 3,500 to 27,500 (approximately US$ 2/day) per family member and whose members must own or rent a home and are unlikely to relocate and have the capacity to work as micro-entrepreneurs (Mahmood, 2007; Shahid et al., 2014). KF's core product is the *General Loan* through the provision of group collateral loans. Since most borrowers have no credit history or collateral in this program, eligible candidates are brought together into solidarity groups of 25 women, each with a

group leader and four to five sub-group leaders who jointly insure each other against default. Each group is assessed and coached by a KF loan officer prior to and during the loan provision process. Borrowers can use the General Loan to support an established business or start a new one or to support their own micro-enterprise, which may employ male family members. The loan amount ranges from PKR 10,000 to 50,000 (US$165-500), and repayment is typically 12 to 24 instalments over 12 months at an interest rate of 20% per annum. Successive borrowers are entitled to increase their loan amount by up to PKR 4,000 (US$65) per cycle (Mahmood, 2007).

In the last few years, KF has introduced the *Business Sarmaya (investment) Loan* scheme for individual borrowers who demonstrate an enhancement of their existing entrepreneurship and whose needs have evolved beyond the General Loan. Small entrepreneurs also receive advisory support for their business and their loan ranges from PKR 30,000 to 100,000 (US$500 to 1,650) (Kashf Foundation Annual Report, 2005-2006).

KF's credit program is complemented by the provision of ancillary services such as financial education, gender empowerment training, and health education and social theatre performances on social issues (Kashf Foundation Annual Report, 2010-2012). The Foundation has trained 527,376 women under its Basic Financial Literacy (BFL) and Advanced Systemized Financial Education Training (SFE) since 2010 with the aim of promoting planning and budgeting, proper use of loans and increasing confidence in financial transactions. Gender Empowerment and Social Advocacy (GESA) Training is a new initiative aimed at enabling women to become active agents of social and economic

change. KF has trained 93,709 participants since 2011, which includes clients, their husbands, and adolescent boys from the community (Kashf Foundation Annual Report 2010-2012). Further, the Kashf social theater program aims to educate and create awareness among low-income communities, especially among women, about gender discrimination and to promote women's rights as basic human rights. These theaters are usually interactive with themes around social issues and common myths related to women's economic contribution to the household. Performances are held in different cities of Pakistan on a regular basis and attract a large volume of viewers from different SES backgrounds (Mahmood, 2007). According to the KF Annual Report of 2010-2012, nearly 26,000 viewers witnessed 246 performances of the Foundation's social theater programs.

KF is one of the pioneer institutions to introduce life insurance and saving services to provide security to clients and their spouses (State Bank of Pakistan, 2011). The minimum insured amount is PKR 10,000 (US$ 165) and maximum is PKR. 25,000 (US$ 410), with a premium no more than 1.5% of the insured amount. Clients of the General Loan are required to buy this policy at the time the loan is disbursed to cover the outstanding loan at the time of death plus funeral benefits for the family (Mahmood, 2007). Home improvement loans for improving and renovating recipients' living condition are another initiative of the Kashf Foundation (Kashf Foundation Annual Report, 2009-2010). For this study, participants were recruited from only one branch, the Liaquatabad branch.

Sample and Sampling Strategy

Purposeful sampling is typically implemented in qualitative research to involve selecting participants who are capable of providing the richest and the most detailed information about the phenomenon (Aita & Mcllvain, 1999; Creswell, 2007; Patton, 2002). In interpretive description, purposeful and theoretical sampling are foundational principles (Thorne, 2008). Consistent with interpretive description, participants were purposefully selected based on their abilities to provide a useful "angle" (Thorne, 2008, p. 9) on the experiences of participation in a micro-finance program. In the current study, I was interested in learning about women's experiences of engagement in micro-finance programs and the perceived impact that their involvement has, in general, on their mental health and well-being. To garner a rich perspective of participants' experiences, a purposeful sample of two unique data sources was sought and invited to participate: a) urban-dwelling women who are loan recipients from one of the two micro-finance institutions identified; and b) administrative personnel responsible for managing the micro-finance programs.

For the urban-dwelling loan recipients to be considered eligible to participate in the study, they had to

1. had been loan recipients of micro-finance programs for a period of one to five years,
2. had received at least one loan in the last five years,
3. spoke Urdu (the national language of Pakistan),
4. expressed willingness to participate and is available to be interviewed, and

5. provided oral or written consent.

With respect to the primary data source (urban-dwelling women), participants were homogeneous in terms of being loan recipients of micro-finance institutions, although an active effort was made to include a diverse, heterogeneous sample to represent maximum variation across the sample (Patton, 2002; Thorne, 2008). The basic principle behind maximum variation sampling is to obtain a unique and broad angle of vision of the phenomenon, and at the same time seek variation on the themes and concepts that become prominent as the analysis proceeds (Patton, 2002; Sandelowski, 2000). The goal in this project, then, was to obtain a sample that had sufficient heterogeneity to produce an in-depth and comprehensive representation of variations in mental health experiences with involvement in a micro-finance program, while at the same time gathering sufficient substance to formulate some account of the patterns of participation that were shared across cases.

In this study variables represent either basic demographic characteristics, or were those that seemed relevant to the research question and were drawn from the micro-finance literature and impact studies. The demographic parameters include age, education, number of loans, skills training received, and years engaged in a micro-finance program. The rationale for including women during their first five years of participation in a micro-finance program was based on my hypothesis that these women would provide a rich data source from their experience working with micro-finance programs. If years of participation were increased, participants might suffer from recall biases or may have become self-sufficient and no longer be involved in a micro-finance program. In addition,

the context of each of the participating micro-finance institutions is different in terms of mission and services. Recruiting participants from two institutions further maximize the variation within the sample.

While sample size remains a debatable question in the field of qualitative health research, sample size in interpretive description is based on what is known, or on the background literature and the need for further exploration to understand a phenomenon (Thorne, 2008). Since the phenomenon of mental health in the context of micro-finance has not been studied extensively in general, and in the Pakistani context in particular, the small sample size must be small enough "to permit the deep analysis and large enough to give a new and richly textured understanding of the experience" (Sandelowski, 1995a, p. 182). Consistent with the interpretive description method, where sample size varies between five and thirty (Thorne, 2008) and considering the maximum variation sampling strategies, "the largest minimal sample size" of the purposeful sampling strategies was considered (Sandelowski, 1995a, p.181). Hence, the initial goal was set to recruit 20 to 30 participants, with a minimum of 10 participants from each micro-finance institution to ensure equal representation. Thorne (2008), argues that saturation is not a valid goal of interpretive description. As there are infinite variations in relation to participants' experiences in the context of health research, meaningful description of the phenomenon with sufficient depth should be considered when determining the final sample size.

Although I recruited participants and data collection simultaneously from my first two settings (the Garden branch of FMFB and the Liaquatabad of KF) before moving to the other branches of FMFB, settling on numbers of interviews was not an easy decision.

While I was performing concurrent preliminary data analysis during data collection and was in the process of reporting this analysis to my supervisory committee, I carried on with further interviews. When I completed data collection from three settings, the Garden branch, the Karimabad branch of FMFB, and the Liaquatabad of KF, I had 21 interviews. I realized that I had reached the lower limit of my sample size, but I was not ready to end interviewing as my aim was not only for representativeness of the sample but "representativeness of concepts and how concepts vary dimensionally" (Strauss & Corbin, 1998, p. 214). In this study, sufficient depth of description of the phenomenon of mental health, while considering the phenomenal variation (Sandelowski, 1995a) was the key feature.

My committee and I reached a decision that I should move to the last and final study setting. I had an opportunity to recruit women from the Mehmood Abad branch of FMFB, assigned to me by the regional manager of the FMFB. I recognized from the participants' demographic parameters that the majority of my existing participants were in their second and fifth years of loans. Since the Mehmood Abad was a newly established branch of FMFB, opened in early 2012, I sought to recruit participants during the first year of their loan period, not only for demographic differences, but to seek phenomenal variations in mental health perceptions and experiences. Response at the Mehmood Abad branch was encouraging and I interviewed 10 participants from that branch, while completing concurrent preliminary data analysis. As the study proceeded, I was less focused on accessing women with varying years in micro-finance but rather

more attentive and interested in finding new and varied responses to the phenomenon of mental health among my participants.

I had concluded my interviews with the total sample of 31 participants when I received a call from the area manager of the Liaquatabad branch of KF who sought my interest in interviewing one of their clients who is a member of Women Entrepreneurs Council (WEC), representing women of her area or region. Hence, I concluded my data collection with 32 participants and I deemed that they provided a meaningful description of the phenomenon of mental health and well-being and elicited questions for further research consideration (Thorne, 2008).

In this study, purposeful sampling of administrative personnel employed within each of the two micro-finance institutions was also included. The rationale for inclusion of micro-finance personnel was to obtain rich descriptions of the micro-finance programs, context, and the services provided and to elicit information about their experiences and observations in terms of opportunities and challenges women loan recipients' experiences, as well as the support received from the micro-finance institutions. I sought to include the institutional personnel who met the following inclusion criteria:

1. have worked in the program for three or more years;
2. have engaged in at least one of the following activities:

    (a) policy development for loan recipients and

    (b) decision making and monitoring women's loans,

    (c) organizing and conducting skill development or financial literacy education, or

    (d) dealing with day to day loan-related issues among women loan recipients; and

3. spoke Urdu or English (the National and working languages of Pakistan respectively).

Micro-finance personnel, comprising area managers, field staff, team leaders, relationship officers and financial literacy trainers representing both the FMFB and the KF were sampled. I purposively drew the sample to capture expected and emerging variation (Thorne et al., 1997; Thorne, 2008) within the phenomenon of mental health and well-being. This multi-disciplinary group of micro-finance personnel, employed in different roles, supports the "high quality, detailed description of each case, which are useful for documenting uniqueness" by capturing the important theme that cut across cases (Patton, 2002; Patton, 1990, p. 172). Hence, the final sample size of 32 women loan recipients and six micro-finance personnel responsible for day to day activities of issuing and recovering loans, best represented the study aim, demographic and phenomenal variation, generation and verification of themes, data patterns, exploration of relationships and data analysis.

Access to the Field

Due to the complexity of accessing women participants, who were receiving loans from micro-finance institutions, many layers of formal and informal approval was required. During the initial phase of my proposal development, I sought the interest of, and the permission to access participants from, the two selected micro-finance institutions via electronic mails. Based on my initial contact with the head offices, I met the regional managers of both the FMFB and the KF in Karachi. Meeting regional officers was the key feature to access to the community and field sites. I was asked to meet these

administrative staff in person by the head office of selected micro-finance located in Islamabad and Lahore. I presented regional officers with a copy of the Hamilton Integrated Research Ethics Board (HIREB) final approval on my research proposal, along with a brief proposal summary that detailed the study purpose, benefit to participants and institutions, data sources, recruitment strategies, incentives, interview questionnaire, confidentiality, and withdrawal. I was happy with the positive response of the micro-finance regional officers at both settings and received assurance of their support to access participants and a place for interviews.

Recruitment Strategies

The regional officer of the FMFB suggested that I recruit from three different area branches of the FMFB. He recommended the Garden, the Karimabad and the Mehmood Abad branches based on maximum utilization and the high volume of women loan recipients. For the KF, only one area branch, the Liaquatabad was suggested by the regional manager due to its wide catchment area and high volume of loan recipients. I complied with the regional officers' decision for both micro-finance programs.

Recruitment began in mid-August of 2013. According to the plan, the area manager assigned a micro-finance officer to invite women (who met the study eligibility criteria) in groups of 5-8 to visit their area micro-finance office. Women came individually, in pairs, and in groups of 3 to 10, which was a pleasant surprise for me and I felt encouraged. I met these women either one to one or in groups of 3 to 5 depending on the availability of space and seating arrangements. I introduced myself and shared the study purpose, outlined the benefits to the participants and society, and reviewed the

hours of commitment, incentives, confidentiality measures, and procedure for withdrawal from the study, and requested their participation in the study (Appendix 2, script at first contact). I recognized that by being invited by the micro-finance officer, the women, as loan recipients, may have felt forced to visit the micro-finance office for this recruitment process and so assured them that participation in this study would be totally voluntarily and their decision whether or not to be the part of the study would not affect their continuing access to micro-finance services.

I had an over whelming response from potential participants in the recruitment phase. Women who were interested and ready to participate in the study, were screened through a inclusion screening questionnaire (Appendix 3) which sought information related to participants' years of experience with a micro-finance program, number of loans received, exposure to any skill development training from micro-finance programs or elsewhere, and contact details. Inclusion screening questionnaires met two purposes: screening of potential participants and facilitation of the achievement of the maximum variation in sampling. Results from the screening tool determined eligibility. Of the 29 women who reported from the three branches of the FMFB, 27 met the screening criteria and 24 were willing to participate. In contrast, out of 26 women from the KF, only 17 met the screening criteria and 15 women were interested and willing to return for interview. Initially, I recruited two women for piloting the study questionnaire, who were eligible and interested in the study, and were not willing to return for interview. In the end, I recruited a total of 39 women from both institutions, a little beyond the initial plan. I

anticipated an expected last minute drop-off or over all low turnover for interviews, and therefore recruited all those who were eligible and willing to participate.

Verbal consent was sought from participants who were interested and interview locations, dates and times were set up as mutually negotiated with participants. There were women who were comfortable travelling in pairs and groups and wanted to come together and interview in groups. They were once again reminded that interviews would be done individually for confidentiality and to maintain individuality uniqueness. Interviews were therefore planned in such a way that women who wished to travel in groups or pairs did so for individual interviews, and they waited until their group members finished with the interviews before they all traveled back again. A maximum of three interviews were scheduled for each day. Cell phone numbers were exchanged to set up reminders for interview dates and times and to improve the response rate. Women were willing to share their personal or family member's cell phone numbers when they did not have the access to one of their own. Women who had planned to travel in groups shared one of their group member's number if they did not have their own number (Appendix 4, contact sheet and interview schedule).

I employed a similar recruitment strategy for both of the micro-finance institutions, both the three branches of the FMFB (i.e., the Garden, the Karimabad and the Mehmood Abad branches) and the Liaquatabad branch of the KF. The first sites of recruitment and data collection was the Garden branch of the FMFB and the Liaquatabad branch of the KF. I then moved to the Karimabad branch and finally to the Mehmood

Abad branch of the FMFB. Data collection from the Liaquatabad branch of KF continued till the very end of the data collection process.

Micro-finance administrative personnel were also recruited during my frequent visits to the FMFB and the KF by learning the various roles and responsibilities micro-finance personnel played in their institutions. Based on the established criteria, some individuals were suggested by the KF regional and area managers. These personnel were contacted individually during my visits to the KF and verbal consent was obtained after explaining the study purpose, benefit to the participants and society, hours of commitment, confidentiality, and procedure for withdrawal from the study. An interview date and time was set up based on their availability and cell phone numbers were exchanged. The recruitment strategy was kept similar for micro-finance personnel in both institutions. One micro-finance staff member from each of the three branches was recruited among the three branches of FMFB, whereas three micro-finance personnel were recruited from a branch of the KF based on the set criteria.

Project Timeline

The thesis project timeline is enclosed in Appendix 5.

Data Types and Collection Procedures

Consistent with interpretive description, as well as with the concept of trustworthiness in qualitative research, data types represent “multiple angles of vision” (Thorne, 2008, p.78). In addition, multiple data types contribute to a “thick description” of the phenomenon (Morrow, 2005, p. 256). In this study, data were collected through multiple strategies including in-depth, semi-structured individual interviews, documents,

and field notes. The purpose of incorporating various types of data is to seek multiple truths and to maximize the "richness, breadth, and depth of the data gathered" (Morrow, 2005, p.256).

Semi-structured individual interviews. The primary data collection strategy was in-depth, face to face interviews with the study participants. Since the key aim of data collection was to access participants' subjective perceptions and experiences of mental health and well-being, interviews were helpful to discover the what, who, where, and how of the phenomenon (Sandelowski, 2000). The extensive literature review pertinent to women's participation in micro-finance and its impact on their mental health and well-being guided and provided a frame of reference to develop the interview guide. For instance, the questionnaire addressed participants' experiences of mental health and opportunities and challenges in terms of their mental health promotion with their involvement in micro-finance. Furthermore, interviews explored how and in what way different measures of micro-finance programs could or could not be a source of their mental health promotion. Since the subjective opinion of mental health and well-being among women has never been studied in Pakistan, and especially in the context of micro-finance, questions focusing on individual's perceptions and understanding of the term mental health and well-being were also explored (Appendix 6). The interview questionnaire for micro-finance personnel was predominantly focused on various roles of the relevant micro-finance program towards mental health promotion measures, apart from poverty alleviation, among its borrowers. Personnel were also asked to share their

views and experiences in terms of opportunities and challenges women loan recipients come across in receiving and returning loans (Appendix 7).

Prior to the commencement of the study, the consent form, the demographic questionnaire, and the interview guide were translated into Urdu, the National language of Pakistan. This translation was carried out by a person who was considered an expert in both English and Urdu languages and had prior experience in translations. Further modifications in terms of clarity, simplicity and use of day-to-day language were incorporated to promote better understanding among participants, whom I expected to be at a low literacy level.

Interview guides are often piloted before the commencement of data collection. A pilot in qualitative research can be of "greatest potential benefit" to refine research instruments such as semi-structured and informal interviews (Sampson, 2004, p. 399). Creswell (2007) cites the relevancy of pilots in qualitative research to explore feasibility, test the understanding of concepts or questions, reframe questions, assess for biases, suggest additional questions and also suggested they may create an early sense of emerging concepts and themes. Consistent with the literature, I piloted the demographic questionnaire and the interview guide. The first two participants, who were initially recruited from the Garden branch of FMFB and the Liaquatabad branch of KF, were considered for this purpose. Piloting assisted me to incorporate some new demographic questions. It also made me acknowledge the fact that, although participants were unaware of or new to the term "mental health and well-being", their shared experiences reflected their thoughts and insights of their day-to-day experiences of mental health related issues.

As I noticed participants had difficulty in understanding and explaining the term "well-being," I modified my interview guide to use "mental health," but still retained the term "mental well-being" with the objective to explore it with future participants if need arose. The interview guide changed marginally over the course of data collection and analysis to reflect emerging categories and themes. I also adopted flexibility in the sequence of questions to suit the interview pace and the direction of discussion and included more probes, examples, and pauses.

I conducted semi-structured face-to-face interviews consisting of open-ended questions, designed to elicit responses that inform the research questions. Study participants who were loan recipients were offered a choice of interview location, either at the Aga Khan University School of Nursing and Midwifery (my employing institution) where I was assigned an office, or the micro-finance area branch, where participants often came to seek loans or in their homes. The primary reason for offering this choice was the recognition that some participants may feel more comfortable in a place where they can be assured of their safety and confidentiality. Most women chose to be interviewed in their nearest and respective micro-finance branch, whereas very few were interested in being interviewed at their homes. Interviews were arranged at a mutually agreed upon time, taking into consideration the availability of space in the micro-finance branches. No interviews were conducted on Mondays in the Liaquatabad branch of the KF due to spacing issues. Participants were informed of their inclusion in the study at the recruitment phase and were asked to commit one interview of 75-90 minutes. Although some participants travelled in pairs and in groups of three to reach the interview

destination, all interviews were conducted individually and in a separate room. Typically, two interviews were conducted on each day, except thrice when three interviews and once when four interviews were completed in a day. There were days when only one participant reported and she was interviewed while the other scheduled women did not report.

Interviews with micro-finance personnel were also conducted at their respective micro-finance area branch. As some of the micro-finance personnel scheduled most of their time in the field, the interview day and time was planned accordingly. These interviews were carried out individually, in a separate room, and interviews ranged from 40-60 minutes. All the interviews in this study were conducted in Urdu, and were carried out by the primary investigator. Thus, the data was gathered in the context of the naturalistic environment in which participants' experiences of the phenomenon had arisen (Thorne, 2008). All the interviews were audio-taped with an audio recorder with participants' permission. All of the participants agreed to recording; however, some of the loan recipients were concerned about the confidentiality of their data. They were reassured and participants' names were not used during interviews and were instead addressed with "aap" (a respectful way of saying "you" in Urdu).

At the beginning of each interview, study information and consent were reviewed once again and oral or written consent was sought based on participants' preferences (Appendix 8 and Appendix 9). I also made a very brief statement (approximately one minute in length) about my professional nursing affiliation in seeking interviews and explained that I had no direct connection or role in a micro-finance program. Following

the literature, this articulation was important to establish rapport and to gain trust, an essential component in seeking information from study participants (Benner, 1994; Robson, 2002). Participants shared confidential information, which they might be reluctant to share with someone who has an associations with micro-finance, thereby demonstrating confidence. Furthermore, participants were contacted via cell phone, a few days prior to and a day before the interview day, as a reminder and confirmation of the interview date and time. I also utilized these phone calls to ask the women about their personal and family health and employment, and to discuss safety measures while travelling to the interview due to frequent crises within the city. I believed this act was culturally congruent and facilitated the beginning of relationship development which Field and Morse (1985) suggest is important to begin with to move into rich and quality discussions of the phenomenon experienced. I noticed a sense of comfort and relaxation on participants' faces when I met them on the day of interview. They met me enthusiastically and graciously as if they had known me for quite some time.

A demographic questionnaire (Appendix 10) was completed after the consent and prior to the interview. Questions related to loans and employment offered a platform for participants to share their experiences of being loan recipients of micro-finance programs. The interview guide design in interpretive description is more structured than the one implemented in typical qualitative research (Thorne, 2008). I used short interview questions that invited long, spontaneous, and rich answers. Furthermore, I employed a simple semi-structured interview guide that provided flexibility and allow expansion on

the particular areas identified as relevant to the study focus (Gill, Stewart, Treasure, & Chadwick, 2008; Thorne et al., 1997).

I engaged participants with new questions to explore emerging patterns or concepts as the study progressed (Morrow, 2005), such as "How would you have dealt with the situation if you had not received the loan?" "What had helped you to make your choice of what you decided to choose?," and "Tell me what interested you about my study?" As the study progressed, I included questions that were informed by other interviews and evolved as a direction of the inquiry (Thorne, 2009). Further, after consulting with my committee members, I also incorporated questions underlined in the literature, pertinent to the description of mental health. Additional probing was also incorporated for encouragement and further exploration. These probes included exploratory questions and comforting statements or nonverbal supportive social cues with the intention of assisting participants' comfort (Opdenakker, 2006; Sturges & Hanrahan, 2004). These cues were critical to data quality (Miller & Crabtree, 1999) and encouraged me to gain participants' trust and gather the rich description of the phenomenon as the study progressed.

Throughout the interviews, I employed active listening skills, such as reflecting, paraphrasing, and summarizing to strengthen the credibility of findings (Morrow, 2005) and to facilitate the process of interpreting what I was hearing from participants and verifying that I had understood their perspectives (Kvale, 1996). As data collection and analysis occurred concurrently, with each step informing the other in an iterative process (Creswell, 2007), the emerging categories and themes were tested during succeeding

interviews. At the end of each interview or after two interviews, depending upon the situation, I reflected on the interview process, my questioning skills, the depth of the responses, my biases, and concepts to be further explored in future interviews. Specific attention was given to the cues and words to which participants referred while sharing the details of their perceptions and experiences of phenomenon. At the end of the interview all participants were given a small token of appreciation for their participation and time in the form of a small pouch in which they could use to keep their loan book and loan money. A small juice box and a packet of cookies were also given as courtesy and transport fare was reimbursed in the form of cash.

Field notes. In addition to the face-to-face interviews, I audio recorded field notes before and after the interview, whilst waiting for the participants and considering the situation. I deemed field notes vital to elaborate my understanding of participants' experiences and the study context (Hall & Callery, 2001), and they enabled me to review my thoughts and comprehend the situations (Lofland & Lofland, 1995). As I became immersed in data overtime, I realized that field notes helped me to recall each data collection encounter with my participants. I recorded detailed descriptions of the interview settings, observations of the surroundings, and descriptions of the participants and their non-verbal behavior (Creswell, 2007), as well as any issues encountered during the interviews (Thorne, 2008). For instance, my field notes from an interview with a loan recipient state. "She had tears in her eyes while discussing her son's story, it must be heart breaking to see her son like this every day," [Field notes, November 13, 2013] and during another interview I recorded, "They (micro-finance staff) keep coming into the

room to get one thing or the other… women feel threatened and stop sharing their stories" [Field notes, October 9, 2013]. I paid special attention to the ease and difficulty participants experienced in their responses to my questions, noting for example, that a participant "all of a sudden stared at me as I had asked her an unexpected question about her loan." [Field notes, October 19, 2013]. Furthermore, informed by Emerson and colleagues (1995), I clarified participants' non-verbal behaviour rather than relying on my own interpretation. Some of the commonly observed behaviours were avoiding eye contact, looking at the wall while talking, shrugging shoulders, putting head down and unusual smiling. During one interview I noted, "Her irrelevant smile forced me to ask her, what made her to smile… and she responded that many women are not using loan money as they are supposed to use" [Field notes, December 5, 2013]. In another interview, I remarked, "She looked at the wall as she was uncomfortable with my question and does not want me to know or she is trying to ignore me" [Field notes, October 9, 2013]. In addition, I also reflected on my thoughts, observations, and emotions pertaining to the interview in the field notes, which overlapped with my reflective journal. I transferred the field notes from the audio recorder to my laptop and saved them as voice files with the participant number and interview date. Later, I transcribed my notes in a Microsoft Word file (Appendix 11).

I maintained a reflective journal after listening to the recording of each interview. My intentions were to reflect on the interview process, the depth and breadth of the responses, my interviewing skills, the need for the reframing of questions, and areas to be explored in future interviews. I raised many questions in my journal, which was a typical

of my inquisitive mind, not necessarily to seek answers but to understand the world. For instance, I asked "How are her experiences of mental health evolving around her finances and lack of resources," "Why do women seem happy and claim that their mental health has improved, when they pay high interest for their loan, some women receive loans from two programs even, how do they manage to repay their loans?," and "What made her decide to apply for loan when she is in her late 50s and she is not happy with her first loan?" As informed by Thorne (2008), my reflection assisted me in the decision-making process of data gathering and analysis throughout the research process (Appendix 12).

Documents. Another key data type was documents. Documents in qualitative studies count as an important resource for data triangulation, to increase the comprehensiveness, validity (Patton, 2002; Thorne, 2008) and creditability of the study (Bowen, 2009). The decision to use documents was consistent with the use of collateral data sources in interpretive description (Thorne, 2008). My specific reasoning for seeking such text was to access additional angles on the study phenomenon, to corroborate and verify findings from the interviews (Miller & Alvarado, 2005), and to develop insight by examining the similarities and differences between documents and the interview text (Thorne, 2004). At the end of each interview with the administrative personnel from the micro-finance institution, each participant was asked to share copies of the relevant institution's documents that provide information about the background and context of the institution and program (Bowen, 2009). Participants from the KF shared hard copies of their micro-finance institutions' annual reports (2010-2012), and their financial literacy program training manual and workbook. Micro-finance personnel from the FMFB did not

provide any hard copies of their documents and encouraged me to seek reports from their regional branch manager. I sought five institutional annual reports published in last two to four years along with training manuals from the KF. These documents provided supplemental data and directions for the development of additional questions for the participants, to inform the study. For instance, both institutions' annual reports primarily focus on their programs' vision, mission, messages from board members, and activity reports with some statistics. As documents offer "a range of subjective and objective knowledge" (Thorne, 2008, p.83), the KF's document texts echo borrowers' voices in the form of subjective descriptions of their positive experiences with the KF in general and with any specific event or activity. One statement "Kashf's Micro-Plus Approach: Giving Women More Than Micro-credit" was repeated over and over in the report, which caused me to focus my inquiry into the connection between mental health and micro-finance (KF Annual report, 2010-2012, p.13). With the review of documents, I asked the participants who were loan recipients, "How has financial literacy training helped you in general and in the promotion of your mental health?," and "What is the social theatre program and how did you benefit from it?" Furthermore, reviewing documents also shaped my interviews with micro-finance personnel, causing me to inquire, "How has working with KF helped you in your personal life or in general?" and "What role does the gender equity workshop play in your interaction with loan recipients?" Thus, one data source complemented another (Bowen, 2009) and created a more transparent audit trail and analysis (Thorne, 2008). A template of a reporting form designed to assist in summarizing the reviewed documents is included in Appendix 13.

Data Management

With advancements in computer management, qualitative researchers have embraced computer-aided qualitative data analysis software (CAQDAS) to handle rich text-based and a large volume of unstructured data to promote study rigour and methodological transparency (Dainty, Bagilhole, Neale, 2000). Initially I used the NVivo 10 qualitative system research (QSR) to store, organize, code and manage the large amount of qualitative data that was gathered in this study (Qualitative Systems Research, 2010). However, I then shifted to Microsoft Office 2013 due to its easy access and my competency in the software. I used colour coding, tables and matrixes, and flow diagrams to organize, analyze, and to provide a visual representation of data.

All the interviews were recorded on a digital audio recorder and files were then transferred to my personal password-protected laptop as soon as possible after the interview. Digitally recorded interviews were saved as digital sound-encrypted files. All the interview files from the digital recorder were removed once all the data was transcribed; however, data from encrypted files were backed up in a password-protected external device. Transcribed data were saved in a Microsoft Word file to facilitate coding and concept building. Similarly, data from field notes, documents, and reflective journals was also saved in Microsoft Word.

Data Analysis and Interpretation

Data analysis in qualitative research demands “a close engagement with one’s data” and illumination of the complexities of human experiences, actions, and thoughts through insightful and interpretative skills (Bazeley, 2013, p. 4). A hallmark of qualitative

data analysis is the concurrent collection and analysis of data (Creswell 2007; Thorne, 2008). The critical review of the literature and Keyes' (2002) conceptual framework of mental health and well-being suggested in Chapter Two formed the basis for the preliminary analytic framework. The following section details the description of analysis.

Data transcription. For the data analysis in this study, the first step involved the transcription of each interview, conducted in Urdu. All the interview data were transcribed in Roman Urdu, which uses the English alphabets (Sulemani, 2003). The Roman script for Urdu is not an official standard for writing Urdu text, but it is widely used due to the influence of English in the Urdu speaking community (Ahmad, 2009). Further, unlike Urdu script, Roman script for Urdu does not have any standard for spelling. A word can be written in various forms not only by distinct writers but also by the same writer at different occasions (Ahmad, 2009). Since there is no one-to-one mapping between Urdu letters and vowel sounds and the corresponding Roman script for Urdu letters, it is much easier to use.

Data transcribing from the interactional context into a written form is an integral part of qualitative research (Nikander, 2008). Representation of audible data into textual form is an interpretive process (Bailey, 2008) and requires judgment based on methodological assumptions underpinning the study project (Poland, 1995; Wellard & McKenna, 2001). Further, the extent to which non-verbal cues such as silence, body language, and emotional aspects such as crying, laughter, and sighs should be incorporated in the transcribed text is debated (Halcomb & Davidson, 2006; Nikander, 2008). Lambert (1997) claimed that transcription is a multilayered process and is more

than just converting spoken words into text (as cited in Halai, 2007). The transcribed text should be edited by inserting nonverbal cues, pauses, quality of voice, and deleting overlapping sentences, where necessary, to better understand the data in its context (Duranti, 1997; Halai, 2007).

Following the methodological assumption of interpretive description, the early aspect of the data analysis process demands an accurate construction of a "record" of the data text and immersion in "those records" to develop "a sense of the whole beyond the immediate impression" (Thorne, 2008, p. 143). For this project *verbatim transcription* was carried out by the primary investigator to enforce an opportunity to engage in the interview process as well as to recognize and focus on non-verbal cues along with "storyline" (Thorne, 2008, p. 144). This experience of engagement for novice researchers in data transcription is of a vital significant due its scholarly and reflective purposes (Thorne et al., 2004a).

I reproduced word-for-word reproduction the verbal data of women's perceptions and experiences of their mental health with involvement in a micro-finance program. I attempted to ensure that written words were an exact replication of the audio-recorded words in its contextual meaning (Poland, 1995). Further, I asserted that my transcription should capture the conversation and notation, not as a "tidied-up version" (Nikander, 2008, p. 226), but rather as a detailed representation affording transparent view of the phenomenon (Peräkylä, 1997, as cited in Nikander, 2008) of mental health. Poland (1995) also claimed that the "inter-subjective nature of human communication" could easily be lost in transcription, which is an "interpretive activity" (p.292) A *verbatim transcription*

plays a key role in preserving both the form and accuracy in communication. Therefore, in my transcript, not only is there a verbatim account of the words shared by participants in the interview, but I have also added notations and descriptions of non-verbal reactions to the transcript documents. This ensures that the full meaning of the experience is available for analysis. For instance, during one interview, a participant would look up to the ceiling whenever she was referring to the "divine figure of God" or used the term "aus ke" (an Urdu word used to refer to someone or something), rather than simply saying God or Allah [FMFBW5-line 87]. In another interview, it was important to note in the transcript that a participant remained silent for a long period of time in response to the question, "How are you using your loan money?" Similarly, I noted in the transcript that one participant started crying when I asked her about her mental health status [KashfW4-line136]. All these examples refer to situations where verbal and non-verbal notations capture the conversation in a more transparent way and informs the process of analysis. I aimed to establish a detailed enough illustration in the transcription to allow me to understand the content of the interview and the exploration of non-verbal and emotional cues for analysis (Sandelowski, 1994).

During my verbatim transcription, it was noted that many participants integrated key English words into their conversation. Common terms include: tension, fresh, bank, form, and staff. To help my understanding, I chose to retain all the English words and transcribed them under inverted comas to indicate in the transcript that these words were spoken by participants and were not a translation. Further, I carried out the editing process by reading and re-reading the transcribed text along with repeatedly listening to

recorded data to better understand it. I frequently asked myself, "Is my transcript capturing the diverse perspectives of my participants' worldviews of mental health?," and "How perfect and complete should I make my interview transcripts so that the data analysis process is facilitated?" My aim was to convert the data into a text which was easy to write, easy to read, easy to learn, and easy to understand, which Flick (1998) has called "the criteria of manageability, readability, learnability and interpretability" (cited in Halai, 2007, p. 350).

In qualitative research, interviews are important approaches for information gathering. When research demands the translation, the translation is double, involving both converting ideas expressed in one language for one social group to another language in another group (Torop, 2002), as well as entailing the process of cultural decoding (Chen, Boore, & Mullan, 2005; Torop, 2002), thus bringing the source language as close as possible to the target language (Keiichiro, 2001; Wu, 2006).

From transcription to translation. Data translation adds another layer of complexity in this multilayer process of data analysis (Al-Amer, Ramjan, Glew, Darwish, & Solamonson, 2015; Chen & Boore, 2009; Nikander, 2008). For the context of this project, which includes completion of a doctoral dissertation in English, data collection in the source language (in this case Urdu) needed to be translated into English (the target language) by following a method which maintains a high methodological rigour in qualitative research (Birbili, 2000; Lopez, Figueroa, Connor, & Maliski, 2008; Nikandar, 2008; Santos, Black, Sandelowski, 2015). Though there is a scarcity of literature about data translation in qualitative research (MacLean, Meyer, & Estable, 2004; Nikandar,

2008), information is available about translation procedures (Birbili, 2000; Lopez et al., 2008) and the timing of translation (Santos et al., 2015) in cross-language studies for accuracy and methodological rigour.

The general consensus in cross-cultural and cross-language studies is that one aim in the data analysis step is to identify a procedure that recognizes the gap between a participant's initial "a life-as-told" narrative and "a life-as-told-as-translated" narrative that translates the initial narrative from the source to the target language. Finally, the process concludes with "a life-as-interpreted" narrative constructed by the researcher (Santos et al., 2015, p.135).

Among the literature focusing on the translation process, the most commonly used procedure is to conduct data collection in the source language and then to translate the interview into the target language prior to data analysis (Brislin, 1970; Larkin, Dierckx de Casterlé, Schotsmans, 2007; Lopez et al., 2008). Other techniques require adding an additional step to the process by including a translation of the entire text from the target language back to the source language and repeating this process until the target language is acceptably equivalent to the source language (Bracken & Barona, 1991; Chang, Chau, & Holroyd, 1999; McDermott & Palchanes, 1994; Temple, 1997). Qian and colleagues (2006) also discussed the strategy of data coding, categorization and identification of themes in the source language with a subsequent discussion of important themes and the provision of an English summary statement.

Chen (2004) and Twinn (1997) applied two different methods of translation in a single study to evaluate the effectiveness of translation in qualitative data analysis. Chen

(2004) first translated the Chinese text (the source language) into English and then had the translation checked by a bilingual person who spoke both English and Chinese. The next step included content analysis of both the Chinese and English version of the data, resulting in the coding of data into categories and themes. Then, the Chinese categories and themes were translated into English and back translated into Chinese. The final stage included a comparison of the categories and themes that were generated from both the Chinese and English datasets. Both Chen (2004) and Twinn (1997) affirm that they identified similar concepts and categories in their analysis, regardless of using Chinese or English as the medium of analysis. Based on these results, in subsequent studies, Chen and Boore (2007; 2008; 2009) did not translate all of the study data into the target language for analysis in the later studies but analyzed data in the source language and then subsequently translated the emerging categories and themes into English. The authors suggest that in the absence of any standardized procedure for evaluating the influence of translation on the trustworthiness of data in qualitative research, researchers should undertake analysis in the source language. In addition, they recommended using two bilingual translators and an expert panel with language, cultural, subject and methodological expertise to resolve any discrepancies that arise in the translation process and who can address questions of an epistemological or cultural issue.

Santos and colleagues (2015) share two different approaches to the translation and analysis of qualitative data in two international cross-language qualitative studies. In their work, they describe procedures required for the early and late phases of data translation. In the early phase of data translation, the first interview data are collected in the source

language and translated into the target language. Next, the data text from the target language is back translated into the source language. In their studies, data analysis and interpretation then took place in English with refinement through back and forth translation from the target language (English) to the source language (which was Portuguese in these studies), whereas, in the later phase, data translation occurred at the dissemination phase only. Meaning, data collection, analysis, and manuscript writing occurred in the source language followed by manuscript translation into the target language. In the translated manuscript, elements comparing and contrasting findings from both source and target language would be included. Santos and colleagues (2015) conclude by recommending that researchers include the early phase of data translation as this assists in mitigating validity issues in qualitative research by allowing more interaction between researchers and translators.

For this study, I chose to translate study data (collected in the source language of Urdu) into the target language (English) at a stage where the literal, conceptual (Brislin, 1970) and contextual meanings (Chang et al., 1999) are preserved. Data were analyzed in the source language at the level that Torop (2002) refer to as "boundary-crossing between two different languages" (p. 594). My aim was to construct themes and findings that would maintain the original meaning and relevance of the information from the culture where the text was constructed, even after it had been translated (Regmi, Niadoo, & Pilkington, 2010). To minimize the introduction of errors through the translation process (Chen & Boore, 2008) minimal translation in the early phase occurred. Instead, relying on recommendations from the literature, I sought to locate words in the target language with

equivalent explanations in the source language, an extremely complex process, considering the limitation of translating a dialect to a language (Twinn, 1998; Halai, 2007). For instance, the word "Pathan" frequently reported by many participants, does not have an equivalent word in English. The word refers to an ethnicity and refers to persons originating from the Northwest region of Pakistan and the neighboring country of Afghanistan. Since these regions are predominantly mountainous, the word Pathan also refers to "people of the mountain." Since there is a severe lack of infrastructure in this region, the majority of people lack education and are often found doing menial work. Beyond this, the word Pathan carries political and religious extremist overtones and connections with Al-Qaeda and Taliban. In another example, one of my study participants said "auper wale ke" (a word in an Urdu dialect to refer to divine force or figure) [KashfW1-line 27], the English literal meaning of this word would be "belong to someone who lives on upper floor." In another example a participant said "zindagi ke gari aage jati hai" meaning, "life goes on" [FMFBW15-line 187], but the English literal meaning would be "the car of life moves forward." In these and other similar incidents, following Nes, Abma, Jonsson and Deeg (2010), I worked in the source language as long as possible to avoid potential mistranslation, to provide accuracy (Twinn, 1998), and to prevent data distortion through translation (Tsai et al., 2004).

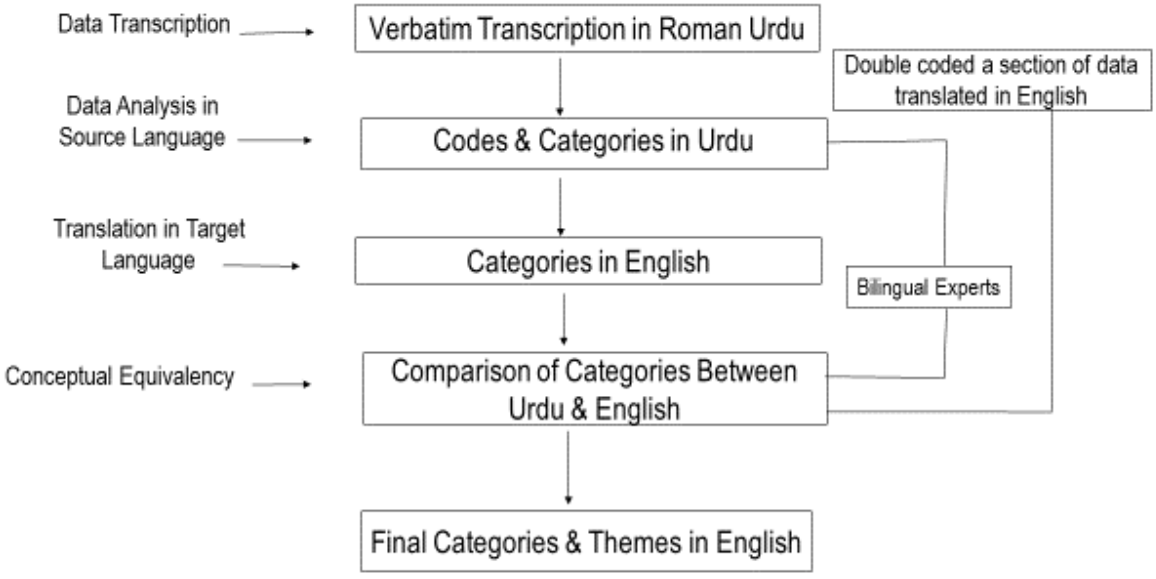
Furthermore, my decision to analyze the data in the source language was also reinforced by Nikander's (2008) recommendation that "overseas students and students with different ethnic backgrounds" should consider "conducting data analysis in their mother tongue" (p. 229), while staying in their own culture and maintaining the scientific

rigor of studies (Squires, 2009). Issues related to study feasibility, such as time to complete the study (Rossman & Rallis, 1998) and available financial resources (Chen & Boore, 2009) also played a supplementary role in influencing my decision to conduct analysis in Urdu.

Rigour in data translation. To achieve methodological rigour in the analytic process, the interview data were transcribed verbatim and then manually coded in Roman Urdu. Next the codes were grouped to create sets of categories. Several categories that characterized (a) perceptions of mental health, (b) mental health experiences with involvement in micro-finance, and (c) strategies to improve mental health, evolved from the data. These categories were then translated into English and related phenomenon were grouped together into themes (Creswell, 2007; Thorne, 2008). To seek rigour in translation, the conceptual equivalence of the translated data is a significant step in the qualitative research analysis process (Squires, 2009). Chang and Chau (1999) and Wong and Poon (2010) asserted that conceptual equivalence is achieved through technical and conceptual accuracy of a participant's text. This requires not only the comparability of the literal meaning of the spoken words by a language proficient but also entails knowledge of participants' culture (Chen et al., 2005). Frey (1970) also commented that the "comparability of interpretation or meaning in qualitative research is often influenced by researchers' knowledge and understanding of intimate language and culture" (cited in Birbili, 2000, p. 2). As mentioned earlier, Urdu is my mother tongue and I am of a similar cultural background as of my participants, so translation was carried out by considering the literal meanings, as well as the meanings of expressions from the source language,

Urdu, into English, the target language (Crystal, 1991). During this process, conceptual equivalence was gained by finding the closet meaning of the participant's statement (Chen & Boore, 2009; Halai, 2007). Special attention was paid to the dialect word or phrase not present in English. In these cases, such words were replaced by suitable English words with the closet meaning and expression to keep the spirit and originality of the original text, thus ensuring "a natural and an easy form of expression" that is comprehensible (Halai, 2007, p. 351). The flow diagram of the translation procedure is shared in Figure 1.

Figure 1: Data Translation Procedure



To promote validation of the translated data that were coded into established categories and to achieve conceptual equivalence, 25% of the analyzed content was

shared with an Urdu speaking academic, with expertise in qualitative research methods, living and working in Karachi, Pakistan. The data shared included quotes and codes in Urdu, and a list of categories in Urdu along with their English translation. Identified discrepancies were reviewed and discussed via electronic mail until agreement on the conceptual meaning was achieved. To refine the translation, I relied on my own knowledge and skills in Urdu, and, as required, consulted several online Urdu-English and English-Urdu dictionaries throughout the analysis process. To promote the dependability of the data, sections of translated text were double coded in English by a member of my doctoral committee.

Data Analysis in Interpretive Description

Data analysis in interpretive description involves transforming the raw data into finding (Sandelowski, 1995b; Sandelowski & Barrosso, 2002) and "constructing an interpretive account of what the themes within the data signify" (Thorne et al., 2004a, p. 8). Interpretive description goes beyond description to abstract interpretation by creating linkages, "an association, relationship and patterns within the phenomenon" under study, through analytic and interpretive process (Hunt, 2009; Thorne, 2008, p. 50). Interpretive description does not give a step-by-step recipe for data analysis; instead it allows the researcher to adapt a flexible approach from other forms of qualitative research methods (Thorne, 2008). Thorne and colleagues (2004a) recognize the researcher's role as crucial in analysis and emphasizes that the researcher drives the interpretation, rather than "data speak[ing]" for themselves, participants representing their stories, or findings emerging inexorably (p.12). Analysis in interpretive description is characterized by a

comprehensive and contextualized perspective of data through creative and flexible approaches, rather than a decontextualization of data into small segments (Thorne, 2008). For instance, engaging in inductive analysis, concurrent data collection and analysis, and iterative or constant comparative analysis are vital features (Thorne et al., 2004a). Similarly, analytic inquiry is enhanced by repeated immersion in the data (Lincoln & Guba, 1985) and asking broad analytical questions such as "What does it mean?" and "What is happening here?" of the data in order to comprehend the findings. This inductive analysis process discourages premature or overly precise coding at the initial coding stage, thus promoting a "broad-based code" to capture the whole view (Thorne, 2008, p.147).

Theoretical scaffolding in interpretive description shapes the preliminary "analytic framework;" however, a gradual departure from this framework is encouraged in the early analytic stage so that alternate models and concepts can be identified, developed, and refined (Thorne et al., 2004a, p.10). Researchers following interpretive description usually represent the finding through a "thematic summary" or "conceptual description" (Thorne, 2008, p. 164) or what Sandelowski and Barroso (2003) call an "interpretive explanation," whereby patterns in the data create thematic linkages, using analytic and interpretive process (p. 908).

In this study, the literature related to women's mental health and their participation in micro-finance programs as well as the application of Corey Keyes' (2002) mental health framework provided the relevant theoretical scaffolding for data analysis. Chapter Two detailed this theoretical scaffolding. As the analysis progressed, the

established themes of the subjective perceptions and experiences of the mental health and well-being among urban-dwelling Pakistani women participating in micro-finance programs were studied in reference to Keyes' mental health framework. The purpose of this step in the analysis was to explain and illuminate how the perceptions and experiences of mental health among the study participants are similar and different from the existing literature. Further, Keyes' (2002) mental health continuum, which identifies mental health state from "languishing to flourishing," was also followed to gain and recognize an understanding of how participants of this study viewed their mental health. This will be addressed in Chapter Five.

Content analysis. In order to answer the research question and to capture the unique experiences of women's mental health in connection with their involvement in micro-finance, I needed an analytical framework to structure and organize the analysis process. Although there are numerous approaches and a range of devices available for analyzing qualitative data, I intended to find one that aligned with the overall philosophy of my selected methodology. Thorne and colleagues (2004a) concur that interpretive description involves navigating within and beyond the theoretical scaffolding from the initial descriptive claim to abstracted interpretation and to a coherent product. The phenomenon of women's mental health in the context of micro-finance following an interpretive description approach was analyzed through content analysis.

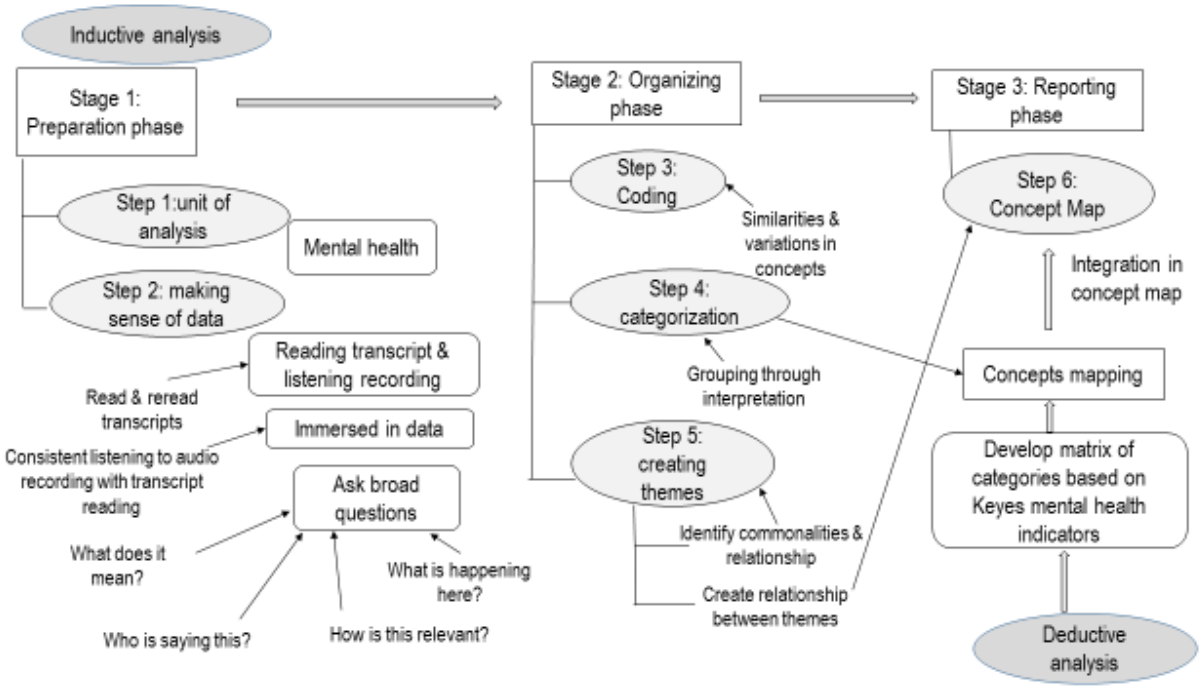
Content analysis is a systematic and objective means of both describing and interpreting qualitative data to enhance the understanding of phenomena of interest (Cavanagh, 1997; Downe-Wamboldt, 1992; Vaismoradi, Turunen, & Bondas, 2013).

Within nursing, content analysis has established a long history due to its flexibility and multifaceted approach, which accommodates various research designs (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Further, inductive and deductive approaches to content analysis allow researchers to move from specific to general or general to specific respectively depending on the purpose of the study (Elo & Kyngäs, 2008; Thorne, 2008). Since women's mental health in the context of micro-finance has not been explored and there is limited knowledge of the phenomenon, the inductive method was followed (Green & Thorogood, 2004). However, theoretical knowledge, clinical patterns, and observation form the basis of the preliminary "analytic framework" such that, study outcomes were constructed moving from deductive to inductive, which is consistent with interpretive description (Thorne, 2008; Thorne et al., 2004a). Thus, the analysis procedures selected for this study were in keeping with the overall philosophy of the methodology and approaches to generate new evidence about the phenomenon (Thorne, 2008).

Content analysis processes represent three main phases: preparation, organization and reporting (Elo & Kyngäs, 2008). During the preparation phase, the demographic data of the participants who were micro-finance borrowers were examined and reported. This data included participants' age, formal and informal education, marital status, number of children, and number of years of involvement with micro-finance and activities for income generation. A description of the study sample to answer the research question is necessary to draw relevant conclusions about the research question from the analysis (Duncan, 1989; & Elo & Kyngäs, 2008). A detailed description of the demographic data

is presented in Chapter 4. Figure 2 provides a visual representation of the content analysis carried out in this study.

Figure 2: Content Analysis



Consistent with qualitative data analysis and content analysis, I sought strategies to immerse myself in the data (Thorne, 2008). During this stage of preparation, I read and reread the interview text. I consistently listened to the audio recording independently and while reading the text. Thorne and colleagues (2004) concur that listening to audio recordings of interview conversations stimulates different insights than reading a written transcript of text. This approach enabled me to obtain a sense of the whole and get close to the stories of my participants who shared their mental health experiences with involvement in a micro-finance program (Boeije, 2002; Burnard, 1991) Since data

collection and analysis is iterative and informs one another, repeated immersion in data encouraged me to ask what, how and why questions. I employed broad analytic questions, such as "What does it mean?," "What is happening?," "Who is saying this?," and "How is this relevant?" Content analysis (Elo & Kyngäs, 2008) in general and interpretive description in particular refers to these questions as "good questions" to make sense of data and to shape the direction of the inquiry to evolve new possibilities (Thorne, 2008, p. 10).

The next step involved organizing the data. During this stage of inductive content analysis, codes were generated from the data by examining transcripts and reading small sections and paragraphs. The codes represent the central phenomenon of interest and the beginning of the conceptualization of the findings. Thorne and colleagues (1997) proposed avoiding coding too meticulously and in too much detail to prevent premature closure during intensive data analysis. Throughout this coding stage, the text data was read through again, similarities and variations in concepts were highlighted with different colours and grouped together accordingly, and many sub-categories were created in the margin. A priori and emergent coding were followed during the initial stage and slowly led to focused or context-based coding to encourage the development of new ideas (Strauss & Corbin, 1990). Codes and their definitions were recorded in a separate file to ensure consistency across the data. Sub-categories were combined and reduced to a small set of categories that were similar in nature.

Cavanagh (1997) asserted that creating categories is a significant step to provide the means of describing the phenomenon, to increase understanding, and to generate

knowledge. As the analysis process proceeded, and consistent with the *interpretive* approach of interpretive description, I further identified the commonalities and dimensions of each category, explored linkages and relationships between categories, and arranged them into major themes. Thorne and colleagues (2004a) claim that interpretive description provides a platform for creating conceptual linkages in the subjective experiences under study to create credible and meaningful knowledge. Formulating categories and constructing themes requires thorough interpretation and decisions as to which categories are to be grouped to conceptualize the phenomenon of interest, women's mental health in the context of micro-finance. Burnard (1991), Polit and Beck (2004), and Elo and Kyngäs (2008) refer to this process as abstraction in inductive content analysis and this is the final stage of organizing data. The overall goal of this process is to target theoretical importance through a conceptual lens, revealing certain nuances, contradictions, and paradoxes. Throughout the analysis, I followed constant comparative analysis, until no new categories emerged and no new insights were identified. In addition, I continued to ask "What does it mean?," "What is happening here?," and "What am I learning here?" This exercise assisted me in the development of an analytic framework (Thorne et., 1997, p.175) and a deeper understanding of the women's mental health experiences.

At the final stage of analysis, I developed a concept map that describes and illustrates the relationships between codes and categories to supplement the understanding of the research outcome (Thorne, 2008). Concept maps provide a visual representation of the findings of interpretive description in a logical and systematic fashion (Hunt, 2009).

Elo and Kyngäs (2008) suggest elements of trustworthiness and validity should be recognized while reporting the process of analysis. I maintained reflective journals for the purpose of consciously acknowledging personal values by documenting my beliefs, assumptions, and objectives in order to create transparency in the research process (Ortlipp, 2008). Further, memos were also maintained throughout the research process. Memos are reflective notes about the concepts or categories and especially relationships between categories that are identified during data analysis (Birks, Chapman, & Francis, 2008). Maintaining these records throughout the research process, with special attention to the analysis of documents and other collateral data sources, demonstrates how these data sources further informed the study findings. Further, the evidence from document data sources were compared with the interview transcripts by asking broad analytical questions (Hunt, 2009), such as "How do the documentary data sources reflect the women's experiences of mental well-being with participation in micro-finance?," and "What are the similarities and differences in the evidence gathered from two data sources?" Analyzing data through broad questions encouraged me to further verify and challenge my analysis of the phenomenon (Hunt, 2009). Throughout the analysis process I sought guidance from my supervisory committee, discussing identified themes and patterns. Thorne and colleagues (2004a) recognized that novice researchers need considerable facilitation and guidance in the interpretive process to work through their early assumptions and to make sense of the emerging concepts and themes.

Throughout the study an audit trail was maintained, to record sampling, data management, and methodological decisions, such as modifications of the interview guide,

coding system, and analytic process. An audit trail is considered a principal technique for establishing confirmability and enhancing research creditability especially with respect to the analysis (Cutcliffe & McKenna, 2002). Further, verbatim transcription augmented by researcher determined notation of nonverbal behaviour, has been cited as critical to the reliability, and the validity and trustworthiness of qualitative research (MacLean et al., 2004). Deliberate illustration of a detailed transcription is essential to allow exploration of non-verbal or emotional cues for analysis.

Methodological Rigour in Qualitative Research

While there are a range of criteria by which the trustworthiness and rigour of qualitative research can be evaluated, Caelli, Ray, and Mill (2003) stress the importance of researchers selecting "an approach that is philosophically and methodologically congruent with their inquiry" and the selected design (p. 5). Lincoln and Guba (1985) set out four criteria to measure trustworthiness in qualitative inquiry: credibility, dependability, conformability, and transferability. Sandelowski (1986) and Creswell (2007) refer to the believability and coherence of data. Table 2 details the summary of principles and strategies employed to promote study rigour.

Table 2: Summary of Principles and Strategies Employed to Promote Study Rigour

Criterion	Principles	Strategies employed
Credibility Authentic representation of participants' experiences	Transparencies in research process & analysis Presence of researcher in the research process Maximum variation in sample Data analysis in source language	Authentic research method Interpretive description Purposeful sampling Triangulation of data sources Field notes and Reflection Paraphrase interpretation of participants' experiences during and after interview (for member checking) Analysis include complete representation of whole data (typical and atypical) Sought consistence guidance from supervisory committee
Transferability Findings have applicability in other contexts outside the study situation	Thick description of research methods, surrounding and setting, including cultural and social relationship provides a baseline understanding for the readers to judge study transferability in another similar setting, Presentation of study findings and provision of subsequent study implications in nursing practice, education and research ensure application to nursing science.	Detailed description of the research methods provided. Rich description of study setting (e.g., developing country, Karachi geo-political situation) allow finding could be applicable to any other developing country. Nursing implication could be applicable to wider population (developed countries). Semi-structure questionnaire developed from the outcome of previous studies
Dependability Demonstrate consistency in findings overtime and across researchers	Concurrent data collection and analysis or constant comparative analysis increase the dependability. Dependability was achieved by comparing analysis by qualitative research experts.	Similarity in responses by participants for similar questions inquired through multiple ways. Double coding of data by committee member from developed country, not familiar with language and culture. Analysis of a portion of data by a person familiar with language and culture.

		Consistent feedback from supervisory committee members.
Conformability A degree of neutrality-findings are shaped by participants and not influenced by researcher's biases, motivation & interest	Detailed description of analysis provided Data triangulation ensure deeper understanding Qualitative research experts' opinion ensure conformability and coherency in data and analysis. Findings are supported by participants' quotes.	Ensure conformability by sharing analysis with a person expert in qualitative studies, bilingual and familiarity with setting and culture A portion of data translated and double coded. Maintained audit trail for research process related decisions and reflections. Multiple data source, interviews, field notes, documents.

Note: Adapted from Baxter & Eyles, 1997; Creswell (2007); Letts, Wilkins, Law et al., 2007; Lincoln & Guba (1985); Patton (2002)

Consistent with interpretive description, credibility of research should meet the following evaluation criteria: epistemological integrity, representative credibility, analytic logic, interpretive authority, moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth (Thorne, 2008; Thorne et al., 2004a). The following discussion details the application of these credibility criteria in this study.

Epistemological integrity. I sought to meet epistemological integrity through demonstrating a "defensible line of reasoning" (Thorne, 2008, p. 223). For instance, the research question in this study on women's perceptions, interpretations, and experiences of mental health was consistent with an epistemological foundation and disciplinary relevance. Considering that low SES influences mental health and given that women with low SES are vulnerable, the study's participants represent an important target group for health promotion. Further, the knowledge gap in the understanding of mental health in

Pakistan and among women loan recipients of micro-finance programs made the study particularly relevant. Epistemological integrity was strengthened by my knowledge of the social determinants of health and evidenced by my nursing experience with individuals and families of marginal social and economic resources. A developing country like Pakistan, where mental health needs and promotion strategies are at a much lower priority due to prevalent economic situation and unmet physical needs, this study findings will contributed to the advancement of knowledge in the promotion of mental health strategies that can be applied in the practice context. Further, methodological considerations guided design, data sources, interpretative strategies and overall study process decisions.

Representative credibility. The second criterion for qualitative research credibility was achieved by demonstrating consistency of the knowledge claims I made with the way I studied the phenomenon. For instance, I focused on understanding mental health experiences among women loan recipients and how this knowledge might best be applied in general and in nursing practice in particular. Further, I selected participants from two diverse micro-finance institutions and with varied years of involvement in micro-finance programs to pursue many angles of vision and adequate variation. Representative credibility was also ensured by in-depth interviews with loan recipients and micro-finance personnel, which served as the primary data source, and assessment of institutions' documents. This provided data triangulation to examine the phenomenon under study and contributed to the trustworthiness of the findings. Prolonged immersion in data, underlining commonalities and variations within findings, and seeking qualitative

experts' (my supervisory committee) opinions throughout the research process represents credibility in particular.

Analytic rigour. I attempted to meet the criterion of analytic rigour by deeply involving myself in the overall study process through recruitment to data collection, transcription, reading and re-reading transcripts, and generating a summary of the overall picture of the phenomenon under study. Furthermore, as an investigator, I made my reasoning transparent from theoretical scaffolding (drawn from the existing literature) to interpretations and knowledge claims (what this study adds). Constant comparison, iterative processes, the pursuit of content inductive analysis steps, and generating an audit trail endorsed analytic rigour.

Interpretive authority. This credibility criterion refers to the trustworthiness of the interpretation of the subjective construction of knowledge, through transparent presentation of a research report and acknowledging power relations and the researcher's position in the study. Though the researcher-as-interpreter may influence the credibility of the study (Thorne, 2008; Thorne et al., 2004a), I endeavored to attain truth by providing participants' narratives in the form of direct quotations for the categories and themes identified for description of mental health experiences. During this process I assured that data was not incongruously or force-fitted into my conceptualization but illuminated participants' realities of their mental health experiences (Janesick, 1994, as cited in Thorne, 2008). I sought consistent guidance and shared the data analysis findings with my supervisory committee members, who concurrence gave me confidence that I remained true to participants' views. Following ethical standards throughout the study process (e.g.,

voluntary participation in the study, allowing participants to choose the date and time for being interviewed) suggest a balance of power relations in the study.

In this study, field notes were documented immediately following each interview to record the context of the data-gathering episodes. Self-reflective and analytical memoing were maintained to enrich my personal reflexivity, explicit thoughts, and speculation about the data and emerging theory (Creswell, 2007; Thorne et al., 1997; Thorne, 2008). Further, decisions and thought processes were documented through an audit trail, to record the steps and rationale taken in the research process. A form designed to assist in summarizing the reviewed documents increased transparency and credibility as well).

Moral defensibility. Thorne (2008) defines moral defensibility as one of the vital credibility criteria that requires researchers to justify the need for the study, the selection of specific participants, and the need to protect them from harm. In this study the criterion of moral defensibility was achieved by providing the study purpose, a sound rational for why the knowledge generated was necessary, and possible risks and benefit to study participants. In addition, I framed my interpretations and recommendations of how knowledge development about mental health perceptions and experiences among Pakistani women is relevant and can be used by health care practitioners, and professional organizations that train health professionals and institutions, such as micro-finance programs, whose purpose may not be consistent with “humanitarian health care agendas” (Thorne, 2008, p. 227).

Disciplinary relevance. Disciplinary relevance is based on the notion that the aim of research and the knowledge generated should assist in "the development of the disciplinary science" (Thorne, 2008, p. 227). The discipline of nursing is committed to enhancing the overall health of individuals, populations, and society by formulating and implementing health, social, economic, and education policy (International Council of Nurses [ICN], 2012). This study will make contributions in nursing science by creating an understanding of mental health predicated on a positive connotation, rather than on a negative connotation, or specifically on the absence of disease. Promotion of positive mental health and primary prevention of mental disorder should be considered as useful first steps in mental health-care delivery. Considering the prevalent economic situation, where unmet physical needs dominate reality, relevant and culturally appropriate interventions are required to bridge mental health needs with revision in public health priorities. Thus, findings revealed from this study will advance nursing knowledge about the common understanding of mental health amongst women in a Pakistani context and to recognize socio-economic variables as an essential determinant to the achievement of overall health. This then will assist health care professionals to assess women's mental health needs and to provide and promote care accordingly.

Pragmatic obligation. Another essential credibility criterion asserted by interpretive description researchers is the recognition of the usability and application of knowledge generated from the research in practice (Thorne, 2008; Thorne et al., 2004a). The knowledge generated in this study is applicable to health care practitioners who are required to provide holistic care by promoting mental health as part of the overall health

of their patients. Consistent with interpretive description, pragmatic obligation demands the attention and relevance of research findings for those whose lives will be impacted by the phenomenon under investigation (Angen, 2000; Emden & Sandelowski, 1999). In this study, women who are micro-finance loan recipients should benefit as policy makers and micro-finance institutions ensure and implement recommendations with the dissemination of research findings. Likewise, other disciplines, such as sociology and economics, that are responsible for promoting the socio-economic health of populations, will also acknowledge and implement interventions to promote the mental health needs of their clients.

Contextual awareness. The domain of contextual awareness is based on the epistemological claim that knowledge created in a specific social, cultural and historical location is relevant to the society that constructed it. In this study, the new knowledge generated was related to the mental health perceptions and experiences among women who were micro-finance loan recipients. Consistent with contextual awareness, this knowledge may be similar for woman in a comparable similar socio-economic group of Pakistani women. However, the constructed truth regarding the same phenomenon may vary if the context is changed. Since the notion of mental health is socially constructed and culture and language play a significant role in its understanding (as discussed in Chapter Two), female micro-finance loan recipients from other parts of the world may differ in their perceptions. The findings of this study are directly relevant to the context of micro-finance in Pakistan; however, findings can inform our understanding of other

Pakistani women who are not involved in micro-finance programs as well as women from other parts of the world.

Probable truth. As a novice researcher, I understand that no evaluation standards can possibly measure and fully verify that my findings are completely valid and have representativeness within the real world (Thorne, 2008). Consistent with interpretive description, this study constructed a "probable truth" to develop a deeper understanding of a phenomenon rather than to find an absolute truth and generalization of the findings. To remain conscious to of the criterion of probable truth, I valued honesty and prudence, as erroneous findings may have serious consequences (Thorne et al., 2004a). Probable truth was also achieved by what Thorne and colleagues (2004a) refer to as avoiding common pitfalls in qualitative data analysis and "over determination of pattern" and overreliance on *"in vivo"* statements (p.16).

Ethical Consideration

This study followed the HIREB procedures of McMaster University. Study proposal was submitted and approval was sought from the HIREB (Appendix 14). In addition, approval was sought from both participating institutions, FMFB and KF. A letter of information and informed consent clearly describes the purpose of the study; potential risks and benefits to participants, the profession and society; incentives; confidentiality; withdrawal; and contact details of the investigator. A copy of this letter of information and informed consent were translated into Urdu (national language of Pakistan) and were provided to participants. Informed oral and/or written consent was obtained from each study participant based on their choice. Participants were given the

opportunity to review the consent and ask questions prior to signing the consent form. Participants were assured that their decision whether or not to be part of the study would not affect their continuing access to micro-finance services or their credibility with their micro-finance institutions.

Possible risks were minimal; nevertheless, initially some participants were apprehensive about sharing their experiences because of lack of trust and confidence in the researcher. Further, a few participants became uncomfortable by being asked questions about themselves, family relations, mental health, and their involvement with micro-finance. The sensitive nature of the questions pertaining to involvement with micro-finance and questions related to its policy issues reported in the interviews demanded constant reinforcement with the participants. Participants were consistently assured about confidentiality and almost all the interviews were conducted in a separate, private room. In one situation, when four participants travelled together to reach the interview location, each was interviewed individually while the other three group members waited in the same room. However, I made sure to keep our voices and tone low enough to prevent the other women from overhearing the interview. Since the interviews were conducted in micro-finance offices, there were incidences when micro-personnel intruded into the room to get files or archives, and interviews were stopped during these interruptions.

Participation in this study was voluntary and did not affect the women's loan status. Participants had the right to refuse to answer any specific questions, and to withdraw from the study at any point in time without penalty. Further, all the interviews

were kept anonymous, and women's responses confidential. This was assured by using codes and pseudonyms during interview and transcription.

There were three case of reporting of family violence and a case of mental distress. Participants were given information on abuse and safety measures and a list of available and affordable local mental health services to seek help. One participant sought assistance for her son for rehabilitation from alcoholism. Relevant details and available resources were shared. As data was audiotaped, tapes were erased once accurate transcription had been verified. Transcripts with codes and pseudonyms were stored in locked cabinets and electronic data was secured in a password-protected computer. As per the HIREB policy, annual study progress reports were submitted. At the completion of the study and after the thesis defense, participants and micro-finance head offices will be informed of the findings and recommendations from the study as suggested in the consent. To date, no study participants have requested to be withdrawn from the study or reported experiencing significant distress following the interview. Only two participants requested to see the study results when available.

Chapter Summary

In this chapter, I described the interpretive description approach to inquiry within the scientific inquiry of qualitative research methods. I detailed the methodological underpinning upon which the study was designed, the rationale for choosing this approach, and its applicability to the domain of my inquiry. In this chapter, I described methodological considerations, the process of analysis, and the relevant criteria to judge credibility. It is hoped that the study outcomes will foster an understanding of mental

health from the perspective of Pakistani women in general and in the context of micro-finance in particular. Thus the knowledge developed from this study will form the bases for assessment, planning, and interventional strategies (Thorne et al., 2004a) by health care practitioners towards the promotion of mental health of Pakistani women.

Chapter Four: Results

In this chapter, I present the findings of the data analysis based on this study of 32 loan recipients of micro-finance programs. I begin with a description of the participants' demographic information followed by a presentation of findings of four overarching research questions focussing on women's: (a) perceptions of mental health, (b) experiences of mental health, (c) responses to promote mental health, and (d) recommendations for change. Data from interviews with administrative personnel of micro-finance programs will be incorporated into the analysis. The text also includes participants' quotations to illustrate concepts described in the findings. A framework identifying the key concepts that emerged from this study and the linkages between different concepts are presented. This chapter concludes with a summary of powerful themes identified in this study and women's suggestions to micro-finance programs for promotion of their mental health.

Demographic Characteristics of Study Participants

A purposeful sample of forty women who were loan recipients from two micro-finance institutions located within the city of Karachi were eligible for this study. These women were invited to participate in the study, with 36 consenting to be interviewed, and 32 completing an interview. Women who first consented but later declined to participate cited lack of time, concern about travelling safely to the interview site, and personal reasons as reasons for nonparticipation. The demographic characteristics of the 32 women loan recipients who participated in this study are summarized in three tables. Table 3 presents the key demographics of participants and their families, whereas Table 4

summarizes the information regarding loans from micro-finance programs and includes the number of loans received and returned, who uses the loan money and how it is used. Table 5, details the income-generation activities that were carried out with the loans. I assigned codes to each participant to represent her respective micro-finance institution. Pseudonyms were also assigned to protect the confidentiality and anonymity of the participants. Assigning pseudonyms to participants, especially to identify their quotations, gives a sense of reality and closeness which may be lost with assigned codes. Pseudonyms were assigned by a name beginning with the last letter of the participant's actual name, for instance, Chanda might be replaced with Aliya. Participants with English/Christian or Urdu/Muslim names were assigned pseudonyms from the similar category.

In this study, micro-finance administrative personnel were also recruited to provide insight regarding the opportunities and challenges women loan recipients may experience during the period of time in which they hold a loan and regarding the impact of these activities on their mental health. Relevant characteristics of the six selected micro-finance administrative personnel who were interviewed are summarized in Table 6.

Women loan recipients in year one to five of the loan period from two selected micro-finance programs comprised a purposive sample for this study. Of the 32 women in the sample, age ranged between 20 and 57 years, and the mean age was 38 years. Over half of the sample (56%, n=18) were between 20 and 39 years of age, while 44% (n=14) were 40 and older. Among this population, 63% (n=20) had some form of formal schooling, where participants had attended some form of secular education institution.

More than a quarter of participants (31%, n=10) completed primary schooling, whereas 9% (n=3) reached secondary schooling (i.e., had attended formal schooling until grade 10). Two participants completed high school, one of which had a university degree. Sixty percent of participants (n=19) had some kind of informal education. This was predominantly through religious education 84% (n=16) either through studying at home or attending relevant schools, whereas 10% (n=2) were enrolled in an adult literacy centre and 5% (n=1) received some form of secular education at home. The primary language among the majority of the participants 50% (n=16) was Panjabi, 31% (n=10) spoke Sindhi and only 16% (n=5) spoke Urdu, which is the National language of the country. All women did speak Urdu but it was not their first language, they were able to converse well. One participant reported being raised speaking both Gujrati and Kachi and considered both of these languages her primary tongue. As reported in Chapter One, Panjabi and Sindhi are provincial languages and are primarily spoken in the provinces of Panjab and Sindh, along with Urdu. About 70% of the people of Pakistan speak Panjabi as either their first or second language (The Languages of Pakistan, 2012). Kachi is another language commonly spoken in the province of Sindh. Although women were not specifically asked to declare their religion on the demographic form, discussions and disclosures of their religious practices and backgrounds were shared during their anecdotal reports of their mental health experiences. Among this group of loan recipients, more than half of the participants were Muslim (n=19, 59%) and 41% (n=13) were Christian.

Among this purposive sample, 88% (n=28) of women were married, 6% (n=2) were single and a similar number of women were widowed. The mean number of children among the married and widowed women was four, and ranged between zero and eight. The average family size (defined as those who lived in the same household and cooked their meals together under the same roof), was six and ranged from three to ten people. Participants were asked who they considered the head of their household to be. Ten (31%) participants considered themselves head of the family, whereas half (50%, n=16) acknowledged their husbands and 19% (n=6) viewed some other person, such as a father-in-law, mother-in-law, brother-in-law, or elder son as the head of the family. In response to a question related to activities carried out by study participants for their livelihood, six percent more women from FMFB (n=8, 36%) than KF (n=3, 30%) indicated that they were employed in addition to the loan investment. In the context of women's dual responsibility to generate funds to improve family income, a question related to their husband's employment was included based on the pilot results of the study questionnaire. Among husbands of study participants, 75% (n=24) were presently working, either as employees or owners of a small business, whereas 6% (n=2) were not working. Participants whose life partner was deceased were almost 13% (n=4), and 6% (n=2) of participants were single.

Table 3: Demographic Characteristics of Study Participants Who are Loan Recipients

Participants' Attributes	**FMFB n**	**KF n**	**Total n(%)**
Participants from Micro-finance Branches	Garden 5 Karimabad 7 Mehmood Abad 10	Liaquatabad 10	32
Mean Age in Years (ranges)	38.2 (20-57)	34 (27-48)	38 (20-57)
Formal Schooling			
Yes	12	8	20 (63%)
No	10	2	12 (37%)
Years of Schooling			
Grade 1-5	5	2	7 (22%)
Grade 6-10	6	5	11 (35%)
Grade 11-12	1	0	1 (3%)
Grade >12	0	1	1 (3%)
Informal Schooling			
Yes	13	6	19(59%)
No	9	4	13(41%)
Mother Tongue			
Sindhi	10	0	10(31%)
Panjabi	7	9	16(50%)
Urdu	4	1	5(16%)
Gujarati & Kachi	1	0	1 (3%)
Marital Status			
Married	18	10	28(88%)
Single	2	0	2(6%)
Widow	2	0	2(6%)
Mean Number of Children (ranges)	3.7 (0-8)	3.8 (0-8)	4 (0-8)
Mean Family Size	6.4 (3-10)	6.4 (4-10)	6 (3-10)
Head of the Family			
Self	9	1	10(31%)
Husband	7	9	16(50%)
Others	6	0	6(19%)
Women working in Addition to Loan Investment			
Yes	8	3	11(35%)
No	14	7	21(65%)
Husband's Work Status			
Employment	7	6	13(41%)
Self-Employed	7	4	11(35%)
Not working	2	0	2(6%)
Deceased	4	0	4(12%)
Women not married/Single	2	0	2(6%)

Loan Characteristics of Study Participants

The number of loans received varied amongst study participants (Table 4). These data were gathered from the participants and were not verified by micro-finance offices or administrative personnel due to confidentiality and anonymity. Furthermore, participants' view were considered final as they had the experience of being loan recipients and marginal variation in numbers of loans or years due to recall may not have a significant impact on the study outcome. Among the participants, 9% (n=3) received their first loan from a micro-finance program and were in the process of repayment via monthly instalments. Half of the study participants (n=16) had received two loans. These women had made full payments with interest on their first loan in instalments over 12 months and were in the process of repaying their second loan at the time of the study. Similarly, almost 16% (n=5) of women were in the third year of their loan, 6% (n=2) were in their fourth year, and 19% (n=6) in their fifth year. Each of these women had repaid their loans each year before receiving the next loan. More than two thirds of study participants 78% (n=25) belonged to the traditional group-lending model of loans, whereby a group of three to five women had joint liability for loan return. About 22% (n=7) were able to provide sufficient evidence to micro-finance institutions for independent collateralization and were therefore solely responsible for loan attainment and recovery. Almost all the study participants (94%, n=30) used their loan for income-generating activities, apart from two participants (6%) who utilized these funds exclusively for household expenses such as rent, utility bills, and groceries.

Among women who sought loans for income generation and business purposes, the majority (44%, n=14) spent these funds independently. A little over 28% (n=9) of women shared a portion of their loan with their husbands towards the activities they were carrying out to improve SES. Nine percent (9%, n=3) shared their loans with their sons and 3% (n=1) with her mother. Approximately 6% (n=2) of participants' loans were used exclusively by their husbands in their businesses. In addition to funds spent to improve the socio-economic activities of the families, a quarter of participants (25%, n=8) also utilized these loan funds to meet the expenses related to their own or family medical issues. Only 13% (n=4) employed these funds for home renovation and 6% (n=2) towards their children's marriage expenses in addition to their income-generating ventures. Participants were also asked if any of their family members, besides themselves, received loans currently or in the past from any micro-finance institutions. While 22% (n=7) reported either their husband, father-in-law, mother-in-law, or mother had been loan recipients of micro-finance programs in the past, none of the participants reported having relatives who were current loan recipients.

Participants were asked about their current involvement as a borrower from any other micro-finance program apart from the two required to be eligible for the study. Participants were specifically asked about their involvement and the number of years or loans received in the past or currently from any micro-finance program. I consider this information to be vital to understand participants' exposure to micro-finance program and how their experiences have changed over time and influenced the phenomenon of inquiry. Nearly 28% (n=9) of participants reported having received loans in the past. Six percent

(n=2) of KF participants reported being associated with and continued to receive loans from other micro-finance institutions or banks at the time of their interview. No FMFB participants were currently receiving loan from other sources.

Introducing financial literacy, or educating micro-finance clients about the basics of borrowing, debt management, saving, and principles of financial management, is a key activity of micro-finance programs. As financial education training is a core component of the KF program to build borrowers' basic financial knowledge and skills, all the participants of KF in this study received this training. In contrast, none of the FMFB participants participated in any formal training. A few women reported that FMFB staff occasionally encouraged them to prepare a budget for their household expenses and to keep a balance of their spending and saving.

The last row of Table 4 shows how study participants came to know about the micro-finance program they received loans from, and their activities. Although one of the major roles of micro-finance personnel and staff is to mobilize and create awareness about micro-finance programs among low income communities, only four women (13%) reported being informed by micro-finance personnel about their loan initiative. More than half (56%, n=18) learnt about their micro-finance program through their neighbours and 31% (n=10) from friends and relatives.

Table 4: Loan Description of Study Participants Who are Loan Recipients

Participants' Loan Attributes	**FMFB n**	**KF n**	**Total n(%)**
Total Participants	22	10	32
Numbers of Loans Received			
1	3	0	3(9%)
2	11	5	16(50%)
3	3	2	5(16%)
4	1	1	2(6%)
5	4	2	6(19%)
Category of the Loan			
Individual	0	7	7(22%)
Group	22	3	25(78%)
Who Uses the Loan			
Self	12	2	14(44%)
Self and husband	5	4	9(28%)
Self and son	2	1	3(9%)
Self and mother	1	0	1(3%)
Husband	1	1	2(6%)
Son	1	0	1(3%)
Family	0	2	2(6%)
Basic Purpose of the Loan			
Initiate or continue economic generation	22	8	30(94%)
Household expenses	0	2	2(6%)
Loans Used for Other Activities Besides Economic Purposes			
Medical	7	1	8(25%)
Home renovation	2	2	4(12%)
Marriage	1	1	2(6%)
Household expenses	2	0	2(6%)
Loan from Other *MF Programs/Number of Years			
Past	8/1-4years	1/2 years	9(28%)
Present	0	2/5-6 year	2(6%)
Family Members Who Received a *MF Loan			
Past	5	2	7(22%)
Present	0	0	0(78%)
Basic Financial Training Received from MF program			
Yes	0	10	10(31%)
No	22	0	22(69%)
How Did You Know about *MF Program?			
Neighbours	15	3	18(56%)
Relatives/friends	5	5	10(31%)
MF mobilization team	2	2	4(13%)

*MF: Micro-finance

Participants were asked to share details of their income-generating activities resulting from the loan they received (Table 5). Most participants were involved in one occupation; however, a few participants were engaged in more than one form of income-generation activities. More than half (53%, n=17) were involved in garment tailoring and stitching. These women bought sewing and stitching machines, materials, and other related supplies from the loan funds and often worked from home. Nearly 12% (n=4) were in the readymade and unstitched garment buying and selling business, whereas 6% (n=2) were running a beauty salon at home, preparing comforters and bed spreads, or engaged in garment embroidery.

Among participants who shared loan funds with their husbands or sons, a little over 31% (n=4) reported that they were involved in the transportation business. For instance, they usually owned a rickshaw (a common vehicle of private transportation) or provided bus services on contract as a mean of income generation. Plumbing, owning a small grocery shop, or becoming a street vendor in a shopping market were common businesses for which male family members used the loan funds. As mentioned previously, two participants from KF did not initiate any labour from the funds received from micro-finance institutions but rather utilized the money for household expenditures. Table 5 details the type of income generation activities carried out with micro-finance loan funds.

Table 5: Type of Income-Generation Activities Carried Out with Micro-Finance Loans

Income Generation Activities	FMFB n=22	KF n=10	Total n=32(%)
Tutoring Small Children	1	0	1(3%)
Garment Tailoring/Stitching	14	3	17(53%)
Embroidery	2	0	2(6%)
Stitching Comforters & Bed Spreads	2	0	2(6%)
Beauty Salon	2	0	2(6%)
Buying and Selling	2	2	4(12%)
Transportation-Rickshaw & Bus	2	2	4(12%)
Plumbing	2	1	3(9%)
Cooking	1	1	2(6%)
Interior Designer	0	1	1(3%)
Own Small Shop/Street Vendor	1	2	3(9%)
Home Expenses	0	2	2(6%)

Note: Some participants provided more than one response, therefore the total is greater than the number of participants, 32.

Consistent with interpretive description and to gain credibility and trustworthiness in qualitative research, the use of multiple data sources was adopted to achieve adequate variety and reliability in the data collected (Morrow, 2005; Throne, 2008). As women loan recipients were in frequent contact with micro-finance administrative personnel at their respective branches during their loan period, these administrative personnel were also interviewed to gain insight regarding women's mental health experience.

A total of six micro-finance administrative personnel were recruited who represented selected branches of FMFB and KF for this study. These micro-finance personnel included male and female branch managers, business development officer, (BDO), or Gender Empowerment and Social Advocacy (GESA) officers with three to six years of experiences working in micro-finance.

The recruited microfinance personnel were responsible for multiple tasks from mobilization and creating awareness about the program to screening potential loan

recipients, investigating eligibility, documenting and allotting loans, and receiving loan instalments. The GESA representative was primarily responsible for the provision of training such as Basic Financial Training (BFL), Advanced Systemized Financial Education (SFE) and Business Management Training. The basic characteristics of the six selected micro-finance administrative personnel who were interviewed are summarized in Table 6.

Table 6: Characteristics of Micro-finance Administrative Personnel

Micro-Finance Institutions	Branches	Participants	Gender	Years of Experience	Current Role
FMFB	Garden Karimabad Mehmood Abad	1 1 1	3 Female	3-6	1. Team leader & Relationship officer 2. Pool In-charge/Leader 3. Relationship officer
KF	Liaquatabad	3	1 Female 2 Male	3-5	1. Branch Manager 2. BDO 3. GESA representative

Having illustrated the demographic characteristics of the study participants, the following section presents the categories and themes identified in response to the research questions. The interpreted themes were informed by the women loan recipients' and micro-finance administrative personnel's interviews, as well as field notes and micro-finance reports studied to gain insight into the phenomenon of mental health. The study was guided by four research questions: (a) how do urban-dwelling women in Karachi, Pakistan who are recipients of a micro-finance loan define mental health?; (b) what are

the perceived impacts of micro-finance loans for urban-dwelling women in Karachi, Pakistan on mental health?; (c) how do these women promote overall mental health?; and (d) what do recommendations do these women make for micro-finance organizations to enhance women's mental health? To answer these research questions, an interview guide consisting of nine guiding questions was used during each interview (see Appendix F for the Semi-Structured Interview Guide).

A matrix method (Averill, 2002; Patton, 2002) was followed to identify, organize, and present the categories and themes based on the research questions presented in Table 7. The themes identified are illustrated with direct quotations of participants' experiences of mental health, which is considered essential to gain an accurate and precise understanding of their experiences with micro-finance (Sandelowski, 1994). Morrow (2005) affirmed that participants' quotes in qualitative research "persuade the reader that the interpretations of the researcher are in fact grounded in the lived experiences of the participants" (p. 256).

Mental Health through Women's Eyes

The first overarching objective of this study was to explore women's understanding of mental health and mental well-being. From this sample of Pakistani women who were loan recipients of micro-finance programs, a rich, nuanced definition of how mental health is perceived within this context emerged. Within this section, I will first describe how women define mental health and identify the essential components of "good" mental health; this will then be followed by a more detailed explanation of how the absence of these components may then ultimately affect their mental health. The data

that informed women's descriptions of what mental health means to them revealed two major themes from the analysis: (a) mental health is a function of the brain or "mind," and (b) mental health is a combination of the presence of peace and the absence of tension. These themes are discussed in detailed in the following section. Selected verbatim quotations are included to illustrate aspects of the analysis.

Table 7: Matrix of Themes and Categories

Study Focus	**Mental Health Through Women's Eyes**	**Experiences of Mental Health and Seeking Loan**	**From Stress to Strength**	**A Way forward**
Theme Categories	Mental Health is a function of the brain or "mind" -positive mental health -poor mental health	I have peace and I have mental health -in state of mental health -progressing towards positive mental health	Having a livelihood brings peace and respect -engage self in work -get peace by securing respect	More than a loan -strategies to improve employment opportunities -access to education -access to health
Theme Categories	Mental health is a combination of the presence of peace and the absence of tension -predictors of positive mental health -outcomes of positive mental health -predictor of poor mental health	I cannot resolve my tension and my mental health is poor -poverty is responsible for my poor mental health -fate is responsible for my poor mental health	God is helping me -practice of faith is a part of my routine -faith & trust in God	A flexibility in policy -acknowledgement & incentives -measures for loan safety
Theme Categories		My mental health is conditional but I have hope -factors responsible for positive mental health -factors responsible for poor mental health	My resilience is my coping -attributes to move forward -changing women's role	Women should get-up, stand-up -get involve -educate next generation
Themes Categories			I sustain myself with the support of my family -family dynamic -positive thinking & attitude	

Mental health is a function of the brain or "mind." Within the context of identifying the meaning of mental health, participants confirmed that mental health has a clear association with the function of the physical brain or metaphysical "mind." The study participants articulated mental health in the context of both its presence and its absence. The majority of participants viewed mental health in its presence, with one participant defining it as the "ability of the brain to function" (Kiran, KFW5). A common understanding of the presence of mental health was in relation to individuals' abilities to utilize their brain in different life events, make rational decisions, or justify their opinion. Participants also articulated that the presence of mental health as "good" and "positive." One participant stated that individuals with positive mental health are considered "being wise" (Bushra, KFW3) or are "able to utilize brain" (Kausar, FMFBW22) and that they are mentally healthy. One typical example provided as proof of knowing that one has good mental health was shared by Sumaira, when she said, "I am able to respond to your questions, and I know what is going on around me" (KFW7). In contrast, a small number of participants described mental health in the context of its absence rather than presence. Women recognized poor mental health as related to "poor brain functioning of brain" (Rosy, FMFBW 15). Participants were explicit that individuals who either "do not use their brain" or who have a "weak" (Misba, FMFBW23) brain are considered to have an absence of mental health or poor mental health. As a result it was perceived that these individuals may lack the ability to think rationally. Women also believed that individuals with absent or poor brain functioning are not usually deemed acceptable by society. During the discussion and exploration, women shared examples of their understanding of

the absence of mental health in the context of what they see around them. For instance, women referred to individuals who wander on the streets and are considered insane and to have poor brain functioning. Furthermore, during the data collection process, there were many incidences of bombings, kidnappings, rapes, and the murder of young girls in Karachi. Women articulated these examples and made the association between poor mental health and being a perpetrator of such violence, and defined such perpetrators as "insane," (Shireen, FMFBW8) or as someone who does not use their brain. These women believed that hurting people or doing immoral things such as "play with lives of children and innocent people" (Fiza, FMFBW21) are not acceptable and could only be done by those who do not have rational thoughts. It is interesting to note that two women suggested that perpetrators of horrific incidents do not even fear God and allow themselves to be involved in such activities. Though women believed that one should live an ethical life, it was not explicitly reported that absent or poor mental health leads to a lack of fear of God or vice versa.

Among these women, very few were able to share their understanding of the differences between mental health and mental well-being. Analysis of the interview transcripts revealed that for some participants, mental health is a state and well-being is a process where "one continue to be mentally healthy" (Hamida, FMFBW2). It requires engagement in a range of different activities to achieve overall well-being. Furthermore, the presence of good mental health was described as a precursor for being able to establish overall mental well-being. Since the Urdu translation of the term well-being is nashhonoma, which connotes nurturing and is often used in the context of children's

growth and development, participants viewed mental well-being as the "growth of mental health" (Afsha, KFW9). One participant explicitly referenced her discussion of mental well-being by comparing it to child care and development: "how children grow every time with food and love, that's how mental well-being is, as we continue to care for our mental health, we will have mental well-being" (Rabiya, FMFBW11). Women were able to articulate that overall well-being is a construct for both physical and mental health. The emphasis is on keeping the self physically healthy through proper nutrition and adequate sleep, which allows the brain to flourish and promotes mental health. A participant noted that "if we eat good food, our mental health will be good too . . . brain will be able to function" (Fauziya, FMFBW19). Two women referenced the presence of physical health issues such as increase blood pressure, high sugar levels, headache, and lack of sleep as factors that also influence brain functioning and that may lead to poor mental health and well-being. This particular concern was raised by Bushra, who was diabetic and hypertensive; she explained that "when your pressure [blood pressure] is high . . . your brain will not work" (KFW3).

Although varied responses appeared under this theme from participants, for many, defining mental health was a challenge. For many participants, mental well-being was similar to mental health. It is also important to consider that women related their limited understanding of the term with their illiteracy and lack of exposure: "These are difficult things, people who are literate must be knowing this, I never went to school and I do not know" said Zarina (FMFBW12). Although a few of the women had heard the term before, they were not sure about the meaning. I felt that in the beginning, participants

were reluctant to share any views out of a fear of being incorrect. I repeated my question in many different ways, frequently using examples and I encouraged women to share whatever they thought of the term "mental health." I assured them that there are no right or wrong answers, and that rather I was interested in their understanding of the term.

Mental health is a combination of the presence of peace and the absence of tension. Consistent among participants was the acknowledgement that good mental health is defined as both the presence of "peace" and the absence of "tensions or worries." It is noteworthy that although the participants in this study were interviewed in Urdu, this concept was referenced frequently using the English word "tension," and the Urdu word *sukoon,* or peace, was also applied in 27 interviews. The unique meaning of peace among these women reflected a cluster of activities which improved their standard of living and gave a sense of satisfaction and happiness in their lives. Among these activities, the primary source of happiness was the availability of basic resources in their day-to-day living such as food, shelter, and employment. Most of the participants also valued accessing opportunities for education necessary in their lives. These participants described how they desire their children to seek education and make a living. It is important to note that literacy was appreciated by both those who had the opportunity to complete their early years of schooling and by those who could not attain any schooling. Many women of this study sample believed that education brings better employment opportunities and is a source of hope for a better future.

Another aspect of peace recognized by these women was related to positive thinking and maintaining positive relationships with others, especially family members, in

order to improve their home environment. Larger family sizes are the norm in Pakistani society, where extended family members often live together in one unit, and where women move to a husband's house after marriage and try to seek support from family members. One participant reflected that mental health "is when one has mental peace and we have everything of need at home . . . when there is no fight at home and everyone is happy" (Misba, FMFBW23). Considering the cultural restrictions and geopolitical situation of the country, it is also interesting to note that a limited number of women referenced peace in the context of freedom and independence. Women viewed their limited mobility and conservatism as hindrances to the achievement of their individual potential, they saw a potential source of happiness and peace. Sumaira, who represented participants from the Liaqatabad branch of the Women Entrepreneurs Council (WEC), said, "mental health is when we are independent, have freedom to move [about the city] without being worried" (KFW7).

As identified above, good mental health included the absence of tensions or worries. The women outlined specific details of the factors or conditions in their lives that creates worry or tensions, thereby reducing overall mental health. The majority of these factors are related to the well-being of their children and family or to the financial stability of the family. Given the unstable political and social environments in where these women live and work, it is interesting to note that 23 women identified geopolitical instability as a factor contributing to stress and tensions. When women did mention the broader issues of terrorism and sectarian killing, they specifically expressed how these

conditions influenced their or other family members' ability to earn a living or to move about the city.

Many women also expressed that excessive self-indulgent thinking and getting lost in their troubles make them feel under pressure or burdened. It was a common belief among these participants that their worries are all interconnected and they feel helpless to find solutions for their tensions. Due to the nature of factors that create tensions and poor mental health among these participants, they feel that there is no end to their miseries. A very strong statement by Sana, who was my very first interviewee, reflects the extent of distress and tension on human lives: "human beings have more than hundred thoughts to worry about, there are hundredth tension in a moment." She then metaphorically said, "human does not earn that much, neither eat that much, as much as he [human] has tension" (FMFBW1).

Women identified that a significant contributing factor impacting their mental health was the presence of stress related to their impoverished status. Women associated their understanding of mental health with the lack of availability of basic resources in their day-to-day living. Fazilat stated that "poverty was considered the biggest reason for tension," and all participants reported that poverty contributes to poor mental health (FMFBW5). The women specifically indicated that, for instance, increases in food and commodities prices, expenses attached to children's education, and healthcare costs were some of the obstacles that influence their mental health. The uncertainty of accessing meals was an extreme example of how poverty affects mental health. Kiran, for example, expressed concern regarding inflation and her ability to make ends meet: "now a days

things are so expensive that if one has eaten one meal, he is not sure about his second meal for the day" (KFW5).

Several participants emphasized the concern of not being able to send their children to school. The complexity of accessing even the primary education system in the country and the cost of tuition, school uniforms, and the course materials for many participants was a source of stress. Participants in this study represent varied years of schooling; however, the majority either had not completed primary schooling or did not receive any formal education. Although education was considered important, for many, finding the resources necessary to continue sending their children to school was burdensome. One participant described how much she wanted her children to be in school so that they would not be "wandering on the streets like cats and dogs" (Nasima, FMFBW17).

One major reason for participants not being able to send their children to school is due to their lack of a consistent source of income. Several participants indicated that they were helpless and powerlessness in this regard. Considering that male family members are expected to contribute a major portion toward family income in Pakistani culture, lack of employment opportunities for these male members is a source of tension for many participants. The women stated that in the absence of permanent employment for their spouses, their family is often deprived of basic needs, which eventually becomes a source of mental stress for them.

The majority of the sample participated in this study represented country's working class, which limited their and their husbands' exposure to basic schooling. This

population of the country commonly makes a living through the establishment of a small business or learning certain vocational skills. Since a large section of the Pakistani population lives below the poverty line and is not literate, finding skills-based employment is often considered difficult for these people. Although many participants viewed the absence of adequate qualification and skills as a barrier to finding decent employment, they also noted that certain types of skills are not well respected. One participant shared her frustration when her spouse had to leave the country to seek employment elsewhere. Sumaira believed that "people who work honestly in this country are not been valued." As she shared her despair and hopelessness for her country, her tone became cynical and she added, "this country will never get improved" (KFW7).

Along with a lack of opportunities for permanent employment, participants also described how Pakistan's poor geopolitical situation affected the provision of employment. The lack of safety and security around the city was consistently and extensively discussed by participants of this study in regards to mental health. They interpreted the geopolitical situation of the country as a cause of recurrent city unrest and disruption of their daily income, which they indicated caused a state of mental distress. Considering the SES of the participants who belong to low SES status, consistent employment is necessary to meet their physical needs. One participant explained that "the frequent city crisis and road blocks paralyze" (Kausar, FMFBW22) their lives. The women felt fearful that their spouses would lose employment opportunities due to systemic issues over which they have no control. Five women specifically shared their experiences of their family members losing employment due to crisis in the city. These

participants reported telling themselves, in reflecting on these issues, that the problems the city and country were facing seemed beyond their control or influence. One participant, Asma claimed that her spouse had a good job, "but was fired" (KFW6) when he was not able to reach work due to repeated crises in the city. During the interviews, it was also revealed that repeated city crises demand that families save some funds to feed their children and to get necessary items when their spouses or other family members could not get to work. It is important to note here that although these participants live hand-to-mouth, many women were still willing to share resources with neighbours and relatives during times of need: "When you can't go to work and earn . . . people go to neighbours and relatives to ask for help . . . if I have money I give them away to help" (Shireen, FMFBW8).

The women in this study also reported feeling stress in situations that hinder the continuity of their own employment. A large number of participants worked from home and were in the tailoring and stitching business, which is considered a "money making business if electrical power does not breakdown very often" (Sabra, FMFBW9). Despite having the skills and expertise necessary for the work, the lack of continuous power supply forced women to seek additional employment and many women "start[ed]working in people's houses" as house maids to make their living (Fazilat, FMFBW5). Women expressed frustration when they could not use their skills for income generation and were required to pay "high electricity bills," when "most of the time" they were "without power" (Kiran, KFW5).

Many participants talked about the broader issue of city safety in terms of frequent bomb blasts and sectarian killings. This made women fear the unpredictable state of the city and they were concerned about their family members' safe return home. The women questioned the state of their mental health, knowing that when there is chaos in the city, they could not always contact or connect with their loved ones. As the data collection processes of this study continued in Karachi, there were repeated incidences of bomb blasts reported in Karachi and other cities of the country. One participant reported a recent episode of a blast on the morning of her interview with me. Though worried and concerned for her relatives who lived near the incident site, she reported for the interview with her young child and shared her story. Similarly, there was a major incident of sectarian killing at a Peshawar church; the killing of more than 100 people and the wounding of 200 more made it the deadliest attack on the Christian community in Pakistan. This incident was reported by three participants and they described how their family had to leave Karachi in panic and haste to find the whereabouts of their relatives in Peshawar. As women shared many stories of the lack of safety in the city, their frustration and helplessness speaks to a need for improved security measures from the law enforcing personnel of the country. A young participant of this study who lost her husband in one of the Karachi's frequent blasts said, "when there is a blast in the city and you get to know from someone, turn on TV [television], you see blood . . . people's body parts . . . you worried about your family until they reach home safely" (Sanober, KFW8).

Along with Pakistan's geopolitical unrest and frequent terrorist acts, the cultural norms of Pakistan's strong patriarchal system further restricts women's ability to move

freely around the city. Women fear sending their young children and especially their daughters out in the city for any activity, including schooling. Many participants also believed that the environment outside their homes is evil, and worried that their younger daughters would be influenced by this environment, and one participant who exclusively used the micro-finance loan for her household expenses pulled her daughters from school due to this fear only. Married women are usually permitted to travel in groups with other women of their age; however, many are expected to move about with a male family member only or, more commonly, a spouse. While as many as four women reported finding this restriction stressful, three also appreciated the company of their male family members in the context of the lack of safety and security. One married participant who is permitted to travel alone described how fear restricted her mobility at certain times of day: "one can travel alone only in day and only if city is peaceful, you cannot even think of leaving your house in the night" (Shabana, FMFBW14).

As this sample purposely included women engaged in a micro-finance program, this also created an opportunity to identify and discuss the worries and tensions that arises related to their involvement in the program. Though women stated that loans were vital to access the resources necessary to meet basic needs through a consistent source of employment, the timely return of monthly instalments was a source of stress and influenced their mental health. Despite the high interest rate associated with micro-finance loans, none of the women expressed this as contributing to their tension. It is important to note that 11 women viewed the either timely return of loan instalments or not seeking any further loans as significant contributing factors to their positive mental

health. Among this group, if someone came to their door steps for loan recovery, many avoided answering and felt afraid. Many participants described these attempts at loan recovery as disrespectful and a cause of additional tension. For instance, a participant reported "mental health is when we stop taking loan from anyone, no need to take loans and no one come to our door to ask for loan payment" (Aysha, FMFBW16). It was also learned that since a loan is disbursed in recipients' names and they are held responsible for its recovery, women make a conscious effort for its timely submission. A female micro-finance employee who was interviewed during this study concurred: "Female clients have more tension to return loans than to receive loan, from the time they [women] get loan, they start mentally preparing themselves about how will they return the loan" (Ambreen, KFMFP2).

In this section women described their understanding of the term mental health and well-being by expressing different messages in a unique way through their stories. Women did not use the word mental health as often as the word "peace" or the phrase "absence of tension," and for many the interview was the first time they had encountered the term, but they were empowered to articulate the situations that could cause tensions and disrupt peace. The demand of everyday living with limited resources, lack of employment opportunities, and the unpredictable security situation were causes of mental stress. Women also indicated the role of brain functioning and the association of poor physical health with poor mental health.

Women's Experiences of Mental Health Related to Seeking a Loan

Women in this study were invited to share their experiences of mental health and how seeking loans from micro-finance programs has influenced their mental health and well-being. Although the broad question focused on the women's perceptions of their state of mental health and well-being, their interviews revealed stories specific to their day-to-day living and events around them at the time of interview, emphasizing the uniqueness of each participant's experiences. In this section, participant experiences were divided into three distinct categories. Each category represents women's descriptions of the state of their mental health and the unique features that they believe influence their mental health experiences. These three categories are: (a) I have peace and I have mental health, (b) I cannot resolve my tension and my mental health is poor, and (c) my mental health is conditional but I have hope. I will first describe the insights the women shared about their experiences of mental health and how they relate their state of mental health with their involvement in micro-finance programs. This will be followed with a review of the women's explicit discussion of the opportunities and challenges of seeking and returning loans and how these impacted their mental health.

I have peace and I have mental health. This category reflects women's positive states of mental health. In this study, the majority of women (n=22) described themselves in a state of mental peace and positive mental health. Since access to basic resources was identified as a key component of mental health, women shared stories that reflected issues related to being poor and indicated that the ability to meet their day-to-day essential needs reduced their tension. Many women also valued their personal traits and their exposure to

education as contributors to the achievement of a better state of mental health and as that which gave them a sense of peace in their lives. Supportive and encouraging family members were also viewed as important to overcoming day-to-day challenges.

Since peace and happiness were considered opposites of tension, women listed activities that made them feel happy and kept them away from tension and worries as contributors to their positive mental health and overall well-being. Typical examples of these activities shared by many participants who viewed themselves in a positive state of mental health included a consistent source of income, employment, and the well-being of their children. Women articulated the connection between their positive state of mental health and their children's access to hard work at school. Shabana described her state of mental health in the following way: "my husband has work, he makes money, I also work from home . . . and my children are in school, I am happy, I do not have any tension" [FMFBW14]. Women were explicit in seeing a promising future for their children as a major component of flourishing mental health. Women also acknowledged that besides being happy, being contented is also crucial for their positive mental health. A sense of satisfaction that women referred to is reflected when a participant named Parveen said "I am happy . . . I earn less, eat less and try to stay in peace at my home . . ." [FMFBW3].

A few women view their mental health experiences as a process rather than as a static stage. One participant, Nisa, described that her mental health experience as a process when she said, "I am gradually moving toward the track of good mental health" [FMFBW4]. The women that did not view their mental health as static explained that although they believe they have control over many things that are important for survival

and the fulfillment of their needs, they are working to reach a more stable state of mental health. It is also interesting to note that women viewed a consistent pattern of improvement in their lives, and believe their future will be better than their present and past.

In defining their subjective experiences of mental health, the women believed that life teaches them many lessons, but that their personal attributes play a significant role in how they learn and react. For instance, motivation, courage, and self-confidence were considered necessary elements and were thought to influence their positive mental health. Examples of these attributes were extensively shared by participants in stories of how they tried to achieve what they had intended to achieve in their lives. One participant explained that her "eagerness increases" [Sumaira, KFW7] when her hard work helps her children to do well in their lives. Since the women were perceived as playing a passive role in the family's financial support, prior to receiving a loan, one woman remembered her role change and how her courage and self-confidence assisted her to fight back against adversity. Hamida said, "when my husband passed away, my kids were young, it was difficult but I learnt to stand up on my feet and made my living" [FMFBW2]. Women also believed that their courage and confidence strengthen when they are valued and recognized by others, which eventually helps them towards a state of positive mental health.

The women also expressed that having some level of literacy and especially exposure to schooling were also considered vital in how one views oneself and how one is viewed by others. Many women explicitly associated education with their positive

mental health. One participant articulated that her high school diploma had given her the "confidence and ability to lead a positive life" as she finds herself contented to achieve a certain level of education (Afsha, KFW9). The women also discussed feeling privileged when others seek their opinion and respect them due to their education. Participants expressed that it was positive for their mental health when they are respected by neighbours and when they are treated like a leader and "push you forward where there is a need to understand things and make decisions" (Sanober, KFW8]. On the contrary, having a university degree and working at a low-salary teaching job was a source of tension for one participant who had a Master's in Education. This woman expressed that though education is important in how we view the world, it results in higher expectations from society, as well as greater responsibilities. Considering her level of education, "initiating a small business at the Flea market was a source of tension;" however, "maintaining dignity through a consistent and good source of income was necessary, when I do not need to ask for extra fund from neighbours and relatives" (Beth, KFW2).

Several participants were explicit in their responses about the supportive roles of their family members towards their mental health and well-being. The women valued collaborative approaches, especially with spouses and other significant family members, to handle their day to day issues. Though the women acknowledged the culturally based asymmetrical power between males and females, they emphasized the importance of both partners being in the workforce to meet the high demands of inflation. The women identified circumstances when they are dependent on their male partners and were

challenged by safety issues. One participant described valuable support provided by her spouse when she initiated a new business funded by the micro-finance loan:

> my husband is my support, he came with me to micro-finance office to apply for a loan, he even took two months off from his work to help me to establish my business, he went with me everywhere, to buy . . . to do things that needed to be done for my work.
>
> (Kiran, KFW5).

It was also important for participants that they were praised and recognized for their effort by their families and neighbours towards the improvement of their family's SES. Women were very thoughtful in their description of how they can achieve more with a little support and encouragement from their spouse. A participant recalled her experiences and said "as my work started making profit, I received encouraging comments from my spouse . . . which increased my confidence" (Sabra, FMFBW9). Micro-finance administrative personnel also recognized many examples of strong family dynamics that encouraged the overall well-being of families.

The women in this study also emphasized ways that engaging in a micro-finance program benefited them. Women who recognized that their mental health was flourishing also recognized that participation in a micro-finance program was a major inspiration for them to attain their positive mental health. The program gave them an avenue to utilize their skills, gain confidence, and be a productive member of their family and society. Participants extensively expressed their regard for micro-finance efforts to initiate "giving loans to female, because whatever was done in past was always done for males" (Nargis,

KFW10). All participants showed high regard and admiration for their respective micro-finance programs. A common response echoed was “micro-finance have done enough for poor people” (Raziya, FMFBW18). Though many women were not very elaborate in their praise of micro-finance institutions, their selection of words and the glimmer in their eyes reflected their satisfaction. One participant said, “They [micro-finance program] have not done less, but have done too much for poor people” (Najma, FMFBW7).

The women shared many stories about their varied years of experience in micro-finance. Several women in the early years of a loan, described loans as beneficial due to the access they provided to a suitable source of income as well as the major relief of tension the loan brought them. Though many women shared their fear of this new experience, their gradual success had overcome their distress. Zohra, who initiated her third loan at the time of interview, said,

> now I am mentally set, in the earlier days when I did not have a sufficient source of income, I kept getting worried that I have spent a big amount of loan in my business . . . but as my work started expanding, God willed it . . . I am happy, I have work, there is no mental worries (FMFBW6).

For those who sought a loan for four to five years and reported being successful, they described their initial years of loan disbursement as challenging, followed by more successful years. Among these participants, there was a gradual consensus that an increase in a loan assisted them to improve their economic activity and improve their overall mental well-being. Only a very few were concerned about the increase in the amount of the loan demanded by the increased interest rate, which may influence poor

mental health especially if they were not able to do well in their businesses. Among this group of women with positive mental health, only one participant who was in her fifth year of a loan shared her opinion of obtaining a future loan. As she reflected on her past, she questioned the possibility of seeking a loan in the future and said,

> I am happy after seeking a loan from micro-finance . . . earlier days were difficult because it took some time for my business to make profit, slowly and gradually my work started progressing . . . even now if I decided to stop taking loan in a few years, I will be fine…I have a good source of income and my mental health is good (Beth, KFW2).

The impact of a loan on women's economic empowerment was also reported by the majority of participants. Though the women did not explicitly mention how the loans influenced their status in their homes, ten women identified themselves as a head of their household. It is important to note that despite the cultural norm where males are deemed considered the head of the family due to his financial responsibilities, a little less than half of the participants viewed themselves in this role. Among this group, two women were widows and two spouses were not employed, therefore these women's role may be related to these circumstances. A shared belief among the others was that changed resulting from the loan allowed them to make decisions related to family income and the loan. Seeking a loan from micro-finance also created a positive impact on three IPV survivors of this study. Though with many difficulties, these women now considered themselves independent and economically empowered.

A few women (n=4) reflected their experiences of seeking loans from other sources before they sought loans from micro-finance programs. Among the money-lenders these women sought out, Pathan Loan is well-known in Pakistan's urban slums due to their exorbitant interest rate. Pathan advances loans to borrowers with a high monthly interest of 10% of the principle. Along with the monthly interest of 10%, the total principle amount has to be returned all at once regardless of the number of monthly interest payments by the borrowers. As a loan sought from Pathan was considered stressful as it may never be paid in full by these women. In contrast participants expressed their excitement that their micro-finance loan "will be finished in 12 months" (Asma, FMEBW19). Participants were happy that, in the presence of micro-finance,

> they do not need to take loan from Pathan anymore . . . they took me away from Pathan loan, if I continued taking loan from Pathan I was never be able to come out and probably die due to the loan pressure. It is their [micro-finance] kindness that they have started this [loan] facility for poor people like us (Fazilat, FMFBW5).

As Table 3 indicates, many women in this study had additional employment apart from their loan. Women expressed the dire need to improve their SES and the pride they felt when their economic contribution towards their family income helped them meet basic needs. While the additional workload has caused some stress for many of the women, it also facilitated access to resources and has brought some peace to their lives. There were women in this study, who had not been able to work in the past due to their responsibility for young children. They detailed their past experiences of how "limited

funds with one person's salary" was never sufficient and how their participation in workforce helped them to move to a better state of mental health [Kiran, KFW5]. Participants valued their supplemented income and anticipated a promising future for their children. One participant's beautiful statement expressed her optimism and hope for the future when she said, "we have spent our lives in whatever ways, but now if our children make the best in their lives, I think, I will be satisfied" (Naila, FMFBW20).

In this discussion of how women shared their experiences of positive mental health, it is important to note that the women often referenced the blessing of divine power in their success. Fazilat, for example, stated that "God has listened to me so well that I do not have tension now" (FMFBW5). The women appreciated and extensively counted their blessings for their positive mental health. It is also noteworthy that in addition to keeping a high regard for micro-finance programs, the participants supplemented their honours with prayer. Regardless of the number of years of the loan or which household member utilized it, the women in this study sought courage from God for the micro-finance institutions and their personnel because it was their belief that ". . . its micro-finance after God" who could support them (Shakila, FMFBW10).

Views from micro-finance personnel were also considered in response to two specific questions that were asked during the interviews. Micro-finance personnel were invited to share their experiences of the role micro-finance played beyond poverty alleviation in women's mental health as well as the opportunities and challenges faced by female borrowers in seeking and returning loans. A consistent view shared by all six personnel participants was that micro-finance played an important role's in respect to

female empowerment. These micro-finance personnel shared their experiences with typical examples of how women are becoming economically independent by investing the small loan they seek from their programs. Economic independence was extensively discussed as a key factor towards positive change in women's roles at home in particular and in society in general. A male personnel participant with more than five years of experiences stated that simply having "a say in family matters" encourages them and "must make them feel proud of themselves," (Adnan, KFMFP1). Apart from the role of micro-finance in changing women's lives, many micro-finance staff believe that "it's not the loan from micro-finance that helps women, it's their skills, hard work and motivation which they put in to improve their lives" (KFMFP3). Staff thought that although most women borrowers are not literate, that they are very bright and have a lot of strength and eagerness to move forward.

I cannot resolve my tension and my mental health is poor. The group of participants who fall under this theme self-reported as having poor or an absence of mental health. A few women explicitly stated that "my brain is not functioning," "I have many tensions," and that they were experiencing poor mental health. Every woman had diverse experiences to share, which were either associated with issues related to consistent employment, their children's well-being, issues related to fate, seeking health care, and lack of positive family dynamics. In contrast to participants who reported being in positive mental health, a common phenomenon that connects these women was a history of living in an impoverished situation. In a few cases, women also referenced fate as being responsible for their disadvantage and poor mental health. Women also shared

their experiences with their involvement in micro-finance programs and its influence on their mental health. It is noteworthy that when women talked about their poor state of mental health, their tensions and worries were clearly visible on their faces. I observed many women tried to avoid responding to my question, looked down, avoided eye contact, and cried in silence.

Participants discussed the complexity of issues related to their low SES. These women recognized lack of funds, due to an insufficient source of income was a key contributing factor towards their poor mental health. The women articulated how their impoverished status connects them to a limited ability to meet basic needs, their children's well-being, and adequate health care services. During the interview process, seven women in particular reported unreliable employment as a source of their poor mental health. Among this group of seven women, there were three who were in their initial years of a loan and were challenged because their income-generation activity had not been successful. These women reported being stressed and worried, and reflected on how they would manage to return their loans. A typical issue was identified by two women who lost their livelihoods and funds related to the city crisis. Women complained that lack of safety affected their employment and their lives. "How do you survive when so much is going on…how do you get mental health," asked one participant whose family lost a large fortune invested with loan funds (Raziya, FMFBW18).

Jamila explained:

> You know how things are in Karachi, when the city shuts down, no one can go out to make money . . . female clients get stressed out when they were not able to do well in their work and they have to return loan (FMFBMFP3).

Participants questioned the role of law enforcement in the country and shared their despondency about the city and for the country.

Among this sample of participants who believe their low SES is responsible for their poor mental health, there were two women who were utilizing their loans exclusively for purposes other than income generating. Since their households had insufficient sources of income from employment, these families decided to take loans to make ends meet. The major portion of these loans goes towards groceries and utility bills. Though these women articulate their lack of skills to initiate an income-generation activity, they also acknowledge lack of courage and confidence in themselves. Having sought a loan and used it for other purposes, these women were struggling to return their loan instalments. The women then collected additional funds with high interest rates to pay back their loans to the micro-finance program. This vicious cycle of fund movement with additional interest is a major source of tension and lack of peace in their lives. It is also important to note that this issue is also shared by those have sought an income-generation activity through their loan. "Women go through hard time when the loan is not been utilized, it is meant for . . . It is very important that micro-finance give correct loan to women," a female staff member from FMFB suggested in reference to evaluating women's ability and skills to utilize funds they seek from the micro-finance program (Asiya, FMFBMFP1).

Poor physical health, especially if an earning member of a family is involved, may also influence income and create an additional demand in the form of increased health care costs. Two participants identified this as a factor for their poor mental health. In the absence of consistent and sufficient sources of income, these women reported struggling to make ends meet and to bear health care expenses. Though the women have high regard for their micro-finance program, seeking health insurance was a challenge for many participants. They believed that the health insurance policy changes frequently and is not really working for them. One participant revealed that,

> they [micro-finance] used to have health insurance but now they do not give any more…, they said asthma will not be covered, only accidents . . . now should we come across an accident to get the health coverage . . . I may lose him (spouse) completely" (Fiza, FMFBW21).

The role of fate in women's poor mental health was also recognized by three women. A general belief among this group was that fate is a constant notion and is related to their negative life events only. Women articulated that poverty brings lots of adversity in life, and they feel powerless to reverse their fate and thus have learned to live with it. "I worked hard throughout my life, but poverty never left me," Zarina said (FMFBW12). It is also interesting to note that women also felt that unfortunate fate runs in families. Women reported a life history of misery and suffering beginning from their mothers to themselves and how it will be passed onto to their daughters. They reported telling themselves in reflecting on their fate that "you get what is in your fate" (Nisa, FMFBW4). I remembered one participant, who looked undernourished very clearly. She answered her

own question when she said “will my fate change, it will never change regardless of how much I grumble or how hard I work” (Amaly, KFW4). Furthermore, these women also had mixed feelings about education. They indicated that their lack of education may have limited their exposure to the world and it may have helped them to change their fortune. Since educating girls is not usually considered important due to the passive role women play in Pakistani society, one woman regretted marrying her daughters at a young age and without giving them the sufficient weapon of education. She shared her powerlessness to see her daughters’ miserable lives and said, “I was eaten by the pain and suffering of my children” (Zarina, FMFBW12)

In a similar context, women who struggled with their poor mental health also recognized issues related to their children as a basis of their worries. As mentioned earlier, though women wished to educate their children to seek a positive future, there are many who either could not afford to send their children to school or their children were reluctant to do so. Since even attendance in primary school demands a certain level of funds, women in this group anticipated improving their source of income to bear the cost of schooling. However, women also questioned the atmosphere of educational institutions. Women were explicit in their discussion of how a bad environment influenced bad company and questioned if seeking education through questionable educational institutions is of any worth. Similarly, two participants were concerned about having their children involved in bad habits such as alcohol and drugs. Though both women reported their spouses were addicted, it is noteworthy that the women claimed that their neighbourhood was responsible for their children’s addiction. Though these

women feared the influence of the environment on their children, they felt helpless due to their poor SES the limits this placed on where they could afford to live. One participant said,

> my children never went to school, I tried they could study but they never did . . . our neighbourhood is really bad, there are lot of addicts…I have my house there, how can I leave this place and go, this is the only shelter I have got (Amaly, KFW4).

Having an anguished family relationship with others is also considered a source of tension. Women shared many stories of troubling relationships with spouses and in-laws and how this impacts their mental health. A thread among these stories is about seeking the cooperation of in-laws, especially when the women live in an extended family. This explanation of how women behave and what is expected of them when they are married revealed stories of sacrifices where they hide their talent, skills, and even their wishes to please others. On the contrary, the women experienced a lot of tension when they failed to gain family confidence or to create a positive atmosphere. One woman emphasized her unhappy and hopeless relationship with her in-laws: "have in-laws be ever good to you? Have in-laws be ever good to you? You think about it?" She then responded to her own question "in-laws are never be good to anyone, nobody is any body's . . . " (Asma, KFW6). Women valued positive thinking for others and a positive home environment crucial for seeking out peace, and they indicated that they struggle to achieve this. A micro-finance administrative personnel member concurred with the value of strong family

relationships and advised that "family should be more considerate towards her [women's] needs, she can achieve so much with love" (Ambreen, KFMFP2).

My mental health is conditional but I have hope. This theme represents women who expressed that certain variations in their day-to-day living have challenged the state of their mental health. Participants in this category discussed the complexity of their existing issues and how it relates to their alteration in mental health. These participants agreed that if a situation goes in their favour, they would feel happy and peaceful. Participants acknowledged that "suffering and pleasure are the part of life" (Fauziya, FMFBW19) and five women associated changes that occurred over the last few months and days before they were interviewed as influencing their mental health. For instance, some of the conditions that hampered women's positive mental health and overall well-being were living as a single parent, alteration in the health status of a family member, and a lack of a spouse's contribution to family income.

As discussed earlier, Pakistan's geopolitical situation influences women's mental health and overall well-being. One participant associated her poor mental health with the fact that she is forced to live without a companion in a country where safety is a pressing issue. Sumaira reflected that her mental health was good until her spouse had to leave the country to seek employment elsewhere. She identified many issues that have affected her overall well-being, most frightening of which was the safety and security of her family. For her, "travelling alone in the city" [KFW7], especially when she had to leave her daughters behind at home, was her biggest concern. As she continued sharing her concerns she displayed her despair and hopelessness for her country. It was important to

Sumaira that a strong family dynamic is maintained by being together, but she feels powerless when the work of her spouse is not being valued in her country and he has to leave his family behind to make a living. Though improvement in SES status through a consistent source of income was extensively considered a significant aspect for positive mental health, Sumaira argued that it is not when it comes at the cost of being away from her loved ones.

Among this group, women also shared how changes in the health status of their loved ones influenced their mental health. With the illness of the bread-earner of the family, and the absence of a consistent source of income this means, there are more basic questions of meeting basic needs. Participants were explicit about the importance of improving their SES to get a better control over their situation. A participant described, "if you have money, a lot of your work can be done" (Naila, FMFBW20). Though some women feel powerless over their circumstances when there is a crisis in the family, they foresaw hope in the future. Some of the situations these women shared in the interview process, may question one's optimistic attitude towards life and resilience during adversity. A participant expressed how she has adapted herself to the situation, when she said "I tried to stay happy whatever is the circumstances…things will change one day, it has to change" (Asma, KFW6).

Similarly, Nasima's story revealed many examples of suffering, as her young child was mis-diagnosed with a life threatening condition, her husband lost his job, and she had to leave her work due to her high-risk pregnancy. Although Nasima went through a difficult time in order to return her very first loan which she sought from FMFB, she

was hopeful that her second loan would result in more positive outcomes for her and her family. Nasima reflected how a little change in her life events influenced her mental health and how her faith helped her see a positive future, when she said,

> My mental health was good, when my children used to go to school, I used to go to work, my husband had a good job . . . with God's permission when I will receive a loan my economic situation will be better again, and I will be able to send my children to school again (FMFBW17).

It is important to note that although the women saw that loans from micro-finance may bring changes in their lives, they believed that what change is good for them is very much dependent on what God decides for them. Participants explicitly shared their views about their faith regardless of their religion.

Seeking a loan from micro-finance has created a positive impact on the majority of the participants, especially when they are able to repay it in a timely fashion, and when others view them with respect and confidence. A multitalented participant who was involved in multiple income-generating activities had mixed feelings about her state of her mental health. Though she feels powerful and happy because she has gained the trust of people in her neighbourhood through her work and words, she feels worthless when she fails to receive support from her spouse. This IPV survivor reflected that although her economic empowerment has helped her to respond to abuse confidently, repaying her loan was a burden, especially when there was limited contribution from her spouse. Rabiya emphasized the need to do the best possible within her situational limitation; however, she recognised how her challenges could be overcome:

> Through my work and loan I was able to feed my children and other needs . . . paying off is hard . . . but it has to be returned, I feel pressure and tension . . . things will improve if I get some of his [spouse] support (FMFBW11).

In this section, participants expressed in multiple ways their experiences of mental health. For many, being able to afford basic needs, including those that support their children's well-being, through a steady source of income brought a ray of light and peace to their lives. The women described mental health as a state, but also as a process whereby they move forward to attain a stronger sense of positive mental health and overall well-being. During this discussion, the women spoke about circumstances in which they decided to seek loans and looked forward to challenging their courage and motivation once they received them. Not being able to meet day-to-day challenges was a cause of distress for many participants, causing them to feel powerless and unfortunate. The several moments when these women where silent and crying possibly revealed their limitations to verbally express the pain and suffering during the interview process. Women in this study shared stories of their struggle and how they longed for a better life for themselves, their children, their families, and for their country as well.

The Promotion of Women's Mental Health: From Stress to Strength

The urban dwelling women who were loan recipients of micro-finance program shared many thoughts about promoting their mental health and well-being. Analysis of data revealed many expressive themes that reflected simple and modest measures that women sought to assist them to pursue peace in their lives. This section, will begin with a discussion of a theme that reflected a key approach to promoting mental health. Women

viewed improving their SES by staying engaged in their employment activities as a significant way to cope with their day to day tensions. A discussion of this theme will be followed by a discussion of other measures women sought, such as seeking help from a higher power through the practice of faith and the importance of the women's personal traits and attitudes to fight adversity. This section includes the significance of family support and positive relationships necessary to move from stress to strength. Four distinct categories provides us with an understanding of how women seek to promote their mental health: (a) having a livelihood brings peace and respect, (b) God is helping me, (c) my resilience is my coping, and (d) I sustain myself with the support of my family.

Having a livelihood brings peace and respect. During the interview process, women consistently shared their experiences of seeking loans from micro-finance institutions and extensively addressed the program positive impact on their mental health. It was fascinating to learn that women related their improvement in socio-economic condition as necessary to enhance their mental health and overall well-being. Participants strongly asserted that pursuing a loan was an act of opportunity rather than a challenge. They identified the importance of the loan, which was associated with income generation, to meet their needs, by paying off school tuition for children, meeting health expenses, and simply using funds for day-to-day household expenses.

Although participants shared several experiences of opportunities of their involvement in the micro-finance programs, the women valued involvement and commitment in their employment as a strategy to divert their tension. Since consistent employment was considered a key indicator to sustain good mental health, the women

occupied themselves in their work to fulfill the demands of their basic needs. One participant related how a set routine kept her healthy and away from unnecessary tensions and worries:

> I keep myself busy with my work, I have taken a loan, this work keeps me busy in my stitching, my home chores and my children responsibility . . . this is my coping…I am busy with my work so my brain does not go here and there and other thinking (Misba, FMFBW23).

This opportunity to keep busy also encourages them to "avoid gossiping with others and to stay away from depression" (Bushra, KFW3) Participants made the best of their time and concentrate on ways to increase their business. It was also noteworthy that women expressed that in the absence of sufficient resources, they did not have many choices in entertainment to reduce their stresses. Since the women did not have many opportunities to relax or reduce their stress, they were reluctant to respond to the question of how they cope with stress. A participant expressed that poverty restrains her from many luxuries when she said,

> We are poor people, what big things we will do to bring peace in our lives, our peace is in our home and children . . . when we have resources, work . . . children study, this is our peace and this is we do…what else do you want me to say? (Shireen, FMFBW8).

Along with engaging in work, the women consistently reported that maintaining self-respect and the respect of their family was also a key element for the promotion of their mental health. Participants strongly believed that in the absence of a verifiable credit

history, small loans from micro-finance programs assisted them to employ income generation activities, and their respect and honor were also maintained. They valued the micro-finance initiative for the support the program provided, and raised questions about the uncertainty of getting support from anywhere else. A participant expressed, "who will give you loan in this difficult day and time? No one . . . only micro-finance is helping us" (Shakila, FMFBW10). In the absence of a lack of support from elsewhere, women worked hard to keep up their record with the micro-finance program by following its policies. They also considered this important because they feared losing respect among their neighbours and relatives. Although women spoke about the smooth recovery of a loan by micro-finance staff members, they feared micro-finance staff might come to their door for loan recovery. Participants viewed this approach as a sign of disrespect to them and this negatively influenced their mental health. One participant related her experiences when she managed to secure respect for her family and considered this as indispensable for her mental health and well-being. A message that she tried to convey in the interview is the following:

> I try to return any kind of loan . . . even with smallest amount . . . Poor people do not have much, but we do have our respect, like rich people, we manage to secure it at any cost…everything may go away but one should not let go is, respect . . . if it is gone, there is nothing for us (Sumaira, KFW7).

It is important to report here how women felt privileged when they were honoured for their timely submission of the loan repayment and expansion of their business. Three participants shared the positive influence on their mental health when they received prizes

from their respective micro-finance programs. One participant was recently honored in a grand prize ceremony organized by the KF in Islamabad. Beth reported in her interview, "I was honoured for my work and received a cash prize of PKR . . . I felt good about myself, I got respect . . . this is one way when women feel good about themselves and their mental health gets better" (Beth, KFW2).

Micro-finance administrative personnel in their interviews also concurred the importance of maintaining respect and its relevance to mental health. They reported that poverty in itself puts borrowers at risk of disgrace and shame and that when borrowers seek a loan they make sure to follow a smooth loan recovery process to maintain their honour. Administrative staff valued women's effort to improve the economic status of their family by working hard. A female staff of KF revealed that "women try to keep them busy with their work . . . they fear if they get late in returning their loan, it is a matter of their prestige" (Bano, FMFBMFP2). A common message by participants was to employ themselves in meaningful work. Keeping their respect and dignity intact with the timely return of their loan is a source of mental health promotion.

"God is helping me." Throughout the interview process, I found consistent reference to God by numerous participants who sought a loan from micro-finance programs. Irrespective of religion, participants called on "Allah", "Kuda" (God in Urdu), or looked to the ceiling to acknowledge a "Divine Force," during their discussions. Performing religious rituals or simply following their faith and keeping a trust in God were widely acknowledged by both Muslim and Christian participants. Women directed themselves towards their faith multiple times throughout the interview. This was either in

reference to accessing day-to-day resources, appreciating micro-finance program roles, or while sharing their methods of coping.

In response to my question about strategies to promote mental health, the practice of faith was one common answer which women provided without second thought. Participants viewed that the regular practice of faith and keeping trust in God assisted them in coping with their daily challenges and this kept them calm and peaceful. A participant expressed, "my faith is my Rosary . . . I do not get peace with anything else" (Kausar, FMFBW22). Participants acknowledged the power of the "Divine" was their first and ultimate resource to access assistance, peace and strength to cope with their daily hardships. They also recognized how their faith helped them to face adversity and provided feelings of relief and comfort. One woman underlined the benefit of seeking help from her faith when she said, "I pray to my God, ask for help, with prayers I feel that I have given away my burden to my God, and He has taken care of my burden" (Fiza, FMFBW21). Women noted that prayers are pivotal and essential. They also prayed more often and for longer hours than usual during periods of hardship. Women recognized their trust in God and indicated that when they "cry in front of Him, pray to Him and He then takes care of" them (Sabra, FMFBW9). Reciting and listening to verses from the Quran were explicitly reported by Muslim women, while offering prayers and visiting church to seek help from God were common approaches identified by Christian participants.

One woman reflected on the religious teaching she received from her religious leaders and emphasized the importance of seeking help and blessing from the one who has created the earth. She emphasized the importance of asymmetrical power between the

"Supreme Being" and a human when she stressed that one should seek help from God and not from humans. Her sincere advice revealed her faith:

> I ask God because He has solutions, if we ask humans . . . they make us realize that, they have done things for us . . . God gives us so much and then, He forgets what He has given us . . . He does not pour things from sky but He creates resources for us ([Fazilat, FMFBW5).

One participant was explicit about her coping and acknowledged that "without prayers we are nothing, I feel very powerful with prayers . . . this is all what I do . . . I have come out from lot of tension" (Nargis, KFW10).

In this discussion of seeking help through faith to promote their mental health and overall well-being, two women reported the importance of keeping faith in God as well as fearing God. Women described this fear of God as helping humans refrain from bad deeds, which sometimes cause tensions and additional problems in their lives. A participant reported two incidences where she was deceived by a group member whom she trusted and it cost her money and influenced her mental peace. As she expressed her concern she said, "People do not fear God, if they do, this world will improve . . . God will teach them lesson" (Shabana, FMFBW14). It was her belief that people who fear God lead an ethically driven life and are able to receive His blessings and peace. One participant noted her method of coping and advised others when she aid, "I fear God and ask for forgiveness, you find peace . . . one should keep faith in Him and He finds ways for you" (Aysha, FMFBW16).

My resilience is my coping. Along with seeking support and strength from prayers and trust in God, there were many stories shared that recognized women's capabilities to adapt and to overcome risk in the advent of adversity. Although women in this study were dependent on the loans to mitigate poverty, they demonstrated resilience to attain economic empowerment, lessen gender inequality, care for their children and homes, meet basic needs, and to aspire to a positive future. Participants identified situations where their courage and resilience had helped the family to overcome adversity and suffering. These situations included the death of a spouse who was an earning member of a family, losing a business or employment related to the city crisis, and survival of IPV. Finding ways to seek relief from mental tensions by avoiding holding onto it and positively working forward echoed in the women's narration. A participant who lost her husband and raised her three children shared her experiences of resilience and coping:

> I do not want people or I myself to feel pity about me . . . I decided not to extend my hand for alms but to challenge myself and stand on my feet . . . when you have confidence, you have peace that you will be able face any challenge (Nisa, FMFBW4).

Several women demonstrated an eagerness, confidence, and courage in their attempts to improve their future. Zohra noted her enthusiasm to work hard increased when she "sees her children doing well in" their studies (FMFBW6).

When the women decided to take a loan and utilize their skills, taking care of their children and finding a source of income were their utmost responsibilities. In this

discussion of coping through resilience, one participant shared many incidences of her hardship and misfortune. Although she viewed her courage and confidence as helping her to face adversity, she also believed that fatalism has a major role to play in human suffering. She explained, "people work hard . . . but they get what is in their fate . . . how much provision we will get, it is in our fate" (Nisa, FMFBW4). This woman's thoughts reflected desire for some rays of hope in the future for her courage. Though fate was considered important in helping them to thrive, participants also considered that their patience and hard work is being valued by society and the God. One survivor of IPV reflected on her experiences and said, "God has rewarded me for my tolerance . . . my son does not allow his father to speak even" (Fazilat, FMFBW5).

In reference to their ability to face life challenges, many of the women described issues such as the lack of exposure to education for girl children, the position of women in Pakistani society, and restricted cultural norms. They regretted that their limited years of schooling placed them in a disadvantage position and felt that better education opportunities would have helped them do much better. These women advocated for measures that could improve women's literacy and their status in the society. A participant advised that "girls should be allowed to seek education as much as they want and as long as they want, there is no age limit to education" (Sanober, KFW8).

Experiences shared by both the KF and FMFB micro-finance personnel confirmed that women were at the forefront to improve their homes and the lives of their children. In reference to women's struggles and facing challenges from society, micro-finance personnel advocated that there is need to change the mindset of society and accept role

change for women. One female staff member reflected on her experiences of working with women and acknowledged the courage and motivation they possess: “I have seen, there are women, if they want to be something, want to be productive in their live, they make goals and try to reach them.” She then referenced God and said “God has given woman enough strength, that she can face the difficult situation and solve the difficulties come in her way” (Ambreen, KFMFP2).

I sustain myself with the support of my family. In this study women were specifically asked about the role of their family members in the promotion of their mental health. Although there were stories of anguish in family relationships, many women acknowledged the provision of support from their spouses and children. Women described scenarios where they were regularly relieved from their stresses by their families. Participants recognized the level of support they received from their spouse and were comforted for their mental tensions. A woman who had shared partial funds with her husband for his plumbing work said, “my husband work very hard, he puts in overtime, he take care of me and takes tension and does not give me tension” (Zohra, FMFBW6). In this discussion of identifying coping strategies to promote mental health, women reflected on activities that they described as part of their daily routine.

A typical intervention suggested by several participants to find some relief from tension was talking about stresses or venting with someone trustworthy. Four women explicitly reported that they shared their day-to-day issues with their families, especially with spouses and sons. One participant recalled her experiences of venting with her spouse and how she valued this practice for her mental health. Sumaira’s spouse left the

country for work, which she considered a loss: “my husband is my biggest support, we used to talk to each other and share every little detail, we find solutions . . . and I get relief talking to him . . . he is not around me . . . and I feel that emptiness” (KFW7).

One woman considered that “husband and wife are the two wheels of the car of life” and that they needed each other’s support to move along happily (Asma, KFW6). This sort of contented relationship was also considered valuable for the well-being of children to keep a positive home environment. Participants described the ways they tried to keep a healthy atmosphere in their homes, where family lives with love and respect. This effort is considered a source of happiness and influenced women’s positive mental health. One woman shared the details of her home situation and what in particular keeps her peaceful is “when my boys return home from work, they come sit by me . . . my younger son put this head on my lap and tell me that I should stay happy . . . my sons do not want to see my sad face” (Fauziya, FMFBW19). A limited number of women (n=6) shared their negative experiences in family relationships. Three were specifically about the lack of support from a spouse, whereas four were about in-laws.

Many women stressed the importance of adopting a positive attitude towards life by maintaining positive thinking and relationships with others. One participant reported telling herself when reflecting on family dynamics, “I don’t say bad things to others to make them feel bad…one should not try to make others worry . . . just stay in peace . . . keep things in heart” (Sana, FMFBW1).

Interviewees also discussed how women should present themselves and what is expected of them in Pakistani society for maintaining family dynamics. Women noted

that girls are raised in a very strict environment and keeping family harmony is taught to them from the very beginning of their lives. Under this teaching, women believed that they make effective contributions towards good family dynamics and try to gain support from their spouse, which is considered important for their overall well-being. A micro-finance administrative personnel member concurred that "I have seen many spouses assist as well as support Baji [female clients] in their work and there are few . . . just not bothered." He indicated the differences in the nature of male partners and said metaphorically that "five fingers are not equal" (Adnan, KFMFP1). Thus, having and maintaining positive relationships was considered necessary to achieve mental health.

Within this theme of stress to strength, women in this study identified several conditions and strategies that facilitate their ability to cope, and that, by extension, promote their overall mental health and well-being. The most prominent theme was related to participants making their living with micro-finance loans and the over whelming positive influence that this additional income had on multiple facets of their well-being. Women felt blessed to have a consistent source of income, which kept them occupied in their work as well as maintaining their respect and dignity. Finding peace by seeking assistance from God and performing religious rituals was extensively reported among both Muslim and Christian participants. Being resilient helped many women survive; however, their strong belief in fatalism has its part to play in the outcome of their endeavours as well. Participants also valued the importance of educating girls and believed that changing the mindset of society would assist women to face life challenges with more confidence. Women also identified simple approaches that momentarily

transcended their tension and worry, including venting with friends, neighbours, and often with spouses. Though women talked about many incidences that either reflected measures of their coping or a sense of struggle to keep positive relationships, spousal support was considered vital in a journey to positive mental health.

Recommendations for Micro-finance Programs: A Way Forward

The fourth research question asked women for recommendations for changes to micro-finance programs to promote women's mental health. The women were specifically asked to list things which they believe might benefit them in achieving their mental peace. It was interesting to note that women commended micro-finance institutions for their efforts to assist them in initiating employment opportunities through loans and many women were reluctant to make any recommendations. A consistent reaction was that as the institutions had already supported them by providing loans, making any further recommendations would not be justified. Further, this question was surprising to 14 of the participants and they struggled to respond, even when an explanation was made. A few women shared that as micro-finance programs are a part of a huge organization and must be following certain policies, any suggestions might not be appreciated. Participants were also concerned whether their suggestions would be of any importance since they were loan recipients. Women were encouraged to make suggestions they would like to see and which might improve their mental health and overall health. Three major themes emerged from the analysis of data for this research question, summarized in the following recommendations: (a) more than a loan, (b) a flexibility in policy, and (c) women should get-up, stand-up.

More than a loan. Participants mentioned a repertoire of activities that may help many women and their families. Although the suggested interventions were geared towards meeting basic needs and resources, they were considered vital to influence women's mental health outcomes. Firstly, a common thought shared by many women was the need to initiate a mechanism whereby women and young girls learn and flourish. Participants indicated a need to establish institutions whereby women are taught certain vocational skills which would help them to find a source of income. Women recognized that there were many vocational training institutions around the city; however, in the presence of geopolitical unrest, women emphasized the need for such institutions in their neighbourhoods. They feared for the safety of their young girls if they needed to travel to these institutions for training. Women believed that micro-finance programs should initiate vocational training institutions due to the trust they have built with their programs over time. A participant was explicit about the unprotected environment of vocational training institutions elsewhere and noted, "it is like a factory environment in other institutions and of course safety would be a concern, if micro-finance open an institution, its environment will be friendly and like home environment" (Shabana, FMFBW14). One participant shared the demand for various skills and her limitations in accessing training when she said,

> everybody wants their daughters to learn new skills and get expertise in stitching and embroidery, learn beauty parlour course, hena application . . . there are institutions but they are far . . . if micro-finance introduce any institution in our

> neighbourhood, I will send my daughter, I will drop her there (Shireen, FMFBW8).

A concern related to safety in the city and environment was repeatedly reported by participants in almost every discussion they shared.

There were other approaches with regards to vocational training also suggested. For instance, women thought that micro-finance programs could assist in connecting women with existing training institutions. The notion of *women-to-women* training and support was also stressed, whereby women who are loan recipients can learn from other loan recipients who have the knowledge and skills. Women found this strategy helpful to both the learner and the trainer "as it will be an additional source of income through teaching skills" (Raziya, FMFBW18). A participant who had multiple skills, valued training other women and shared her dreams: "if micro-finance initiate a training school . . . I would like to teach young girls. . . this is my thinking and this is I am going to try in few years" (Rabiya, FMFBW11).

It is interesting to note that three participants in this study explicitly talked about the importance of vocational skills training for women who received a loan but spent the funds elsewhere and not for income generation activities. Participants reported that many women lack skills or lack the ability to utilize their existing skills and therefore misuse their loans. The only participant in the study who had a university degree spoke about lack of awareness regarding the importance of utilizing loans for economic activities. It was also discussed that incorrect utilization of a loan places these women in a difficult situation and challenges their mental health. Beth questioned the micro-finance programs'

vision when she said "microfinance give money to us so we can improve our lives by finding a correct source of income…but if women do not have the ability or skills to utilize it, what advantage would that be for them?" She also considered that women end up "working as house-maids in the absence of skills" [KFW2]. The need to create awareness and provide opportunities for vocational training for these women was therefore emphasized.

Like the loanees, some micro-finance administrative personnel shared their opinion about introducing interventions beyond provision of funds. Exposure to vocational skills training was one common thought shared by them. They proposed that accessing skills training would reduce the chances of misusing loans and increase the possibilities of more women utilizing their own loan rather than sharing or redirecting it with their male family members. It was suggested that micro-finance programs introduce vocational skills training prior to or during the first cycle of loan disbursement, so that "clients can initiate their work and able to improve their business at least by third cycle of loan" (Jamila, FMFBMFP3). One male staff member also shared the challenges of poverty and noticed that "we work with poor people, who may lose funds very easily because of their periodic adversity . . . finding a method through which borrowers immediately start employment would be more beneficial than instead of giving away funds in hands" (Adnan, KFMFP1).

Apart from vocational skills training, there are basic numeracy and business establishment skills which KF claims that the institution provides to its loan recipients. As mentioned in Chapter Two, the mandate of KF goes beyond micro-credit and therefore

the institution offers training which includes BFL, Advanced SFE, and Business Incubation Labs (BIL). The ten participants who were recruited from KF for this study, seldom talked about these trainings. During the interview process, participants were specifically asked about the purposes and outcomes of this training, and the majority recalled that they were exposed to BFL before receiving the first loan. However, I found women were not very eager to talk about their experiences of participation in training sessions and provided little information about them. Further, their passive responses indicated that such training may not have had any significant impact in their employment. For instance, a participant in her second year of her loan was exposed to BFL and said, "we were taught how to keep record of our expenses . . . they told us to write down everything . . . my calculation is all done in my brain . . . the training was just fine" (Shakila, FMFBW10). Considering the limited educational background of the loan recipient women, one participant questioned the applicability of such training and she noted her experiences and observed,

> I am educated and I keep record of everything, for me it's not hard, but you see women here had hardly gone to school . . . some of them are not able to read or write . . . I am not sure how do they keep record of their expenses . . . I do not know if they learn anything from such trainings (Beth, KFW2).

The KF micro-finance personnel member responsible for conducting training sessions revealed the details and operationalization of training sessions in his interview. With regard to the understanding and applicability of training by women borrowers, this staff member claimed that the training modules were developed in such a way that they should

be of benefit to a woman who is "illiterate to a person with Masters" degree. He also stated that though the majority of women are unlikely to apply basic numeracy training in their work, if implemented even by a limited number of borrowers it was still considered an achievement for KF [Adil, KFMFP3]. The FMFB does not provide vocational or business development skills trainings to its borrowers; however, such training was considered essential for business promotion.

The second recommendation indicated by loan recipients was to initiate a basic literacy program for women who lacked primary education as well as for those who find it difficult to attain basic schooling for their children. Five women also showed their interest in pursuing education along with their employment to improve their "understanding of the world" (Nargis, KFW10). The women emphasized the need to establish schools in their neighbourhoods and keeping tuition fees affordable for their children to access education. A participant who had little basic schooling, believed that she had time which she would like to use in educating herself. Amaly said, "it will be good if micro-finance do something especially for people who sought loan from them . . . teach us how to read and write and do something for our children, so they can study as well" (KFW4).

Besides vocational skills training and measures to access education, a few participants who were loan recipients of FMFB wanted the institution to restart a health insurance program which had been offered before. In the discussion, it was learned that initially, the health insurance policy was mandatory and demanded additional payment which was marginal considering health costs. However, many loan recipients who did not

utilize their health benefits wanted micro-finance to return their health insurance payment at the end of the year. Due to this issue, the institution decided to make health insurance optional. An FMFB staff member shared her observations and experiences of working with loan recipients:

> People [micro-finance loanees] do not have awareness, we explain in detail to clients the advantages of health insurance and we have kept good hospitals in our panel . . . many clients do not opt for getting health insurance with this attitude that we (micro-finance) charge extra amount from them (Bano, FMFBMFP2).

Along with the above mentioned recommendations, participants from both the KF and the FMFB micro-finance program found marketing their products as one of the biggest challenges to expand their work and encouraged the micro-finance institutions to intervene to assist in this. Considering women's limited exposure and mobility in the city, participants emphasized the need for sessions or training where they get connected with marketing experts. Three women particularly identified the importance of networking where women from similar businesses get together to share and learn from each other. Beth suggest another purpose of getting together that relates to women's mental health when she said,

> regular meetings will give an opportunity for sharing and learning . . . this is the time when women are out of their homes, will get a break from home tension and worries . . . women will talk to each other and will feel better about themselves (Beth, KFW2).

Finally, seven women requested assistance in finding employment opportunities for male members of their family. The challenge posed by the geopolitical situation of the city and self-employment, even with a loan, made it difficult for families to have a decent income. Out of 16 of the women who shared or redirected their loan with their spouse or other family member for income-generation activities, four women believed that loan investment does not give them a sufficient source of income. For instance, a participant said, "you put your loan for your work but sometime it does not go the way you have thought . . . we then worry how to pay back the loan…need to find a permanent job for my husband" (Zohra, FMFBW6).

Although women were surprised about the invitation and opportunity to make recommendations to micro-finance programs, participants emphasized that micro-finance programs could take measures to help them improve their lives, but were uncertain about what to suggest. They gave an impression that any activity for the betterment of people like them is appreciated. Women considered micro-finance a powerful institution that has taken care of their needs, especially in circumstances when they were certain that they could not access any assistance from government agencies. The high regard participants have for micro-finance was supplemented by prayers for the institutions and the staff members. One participant praised micro-finance and her beautiful concluding remarks reflected this as she said,

> I pray that God give them (micro-finance) strength to do things they can do that help poor people like us . . . we can improve our lives . . . it will bring happiness

among women, happiness in their homes and happiness in the country (Aysha, FMFBW16).

Flexibility in policy. With regard to existing micro-finance policy, women reported their concern related to accommodating borrowers' requests in terms of loan recovery. There were two specific considerations suggested by participants in this study. Firstly, women who were in the early years of their loan and were group leaders, suggested that group leaders receive some additional benefits for their efforts in coordinating with group members. In the absence of collateral, micro-finance programs do loan recovery in groups and the group leader is responsible for the timely submission of loan instalments.

Two participants claimed that being a group leader "required extra effort and responsibility" (Misba, FMFBW23) and they felt pressure when they were unable to make timely loan returns due to delayed payments from other group members. Sana shared her frustration of her leadership role and recommended that the micro-finance institution recognize her effort by "increasing loan amount or reducing instalments" or possibly by decreasing the interest rate. She also emphasized appreciating leaders' hard work by distributing prizes to make them feel encouraged. Furthermore, the importance of periodic debriefing should be encouraged whereby "group leaders can vent their concerns and issues with micro-finance staff" (FMFBW1).

Another concern for group leaders was related to the safety of funds. Three group leaders expressed fear of losing loan funds collected from the group members through theft or misuse before they were paid to the micro-finance institution. A common concern

shared by these women was about safe-guarding the funds in a situation where "poverty bring adversity and money is needed every day for something or other" (Rosy, FMFBW15). It was also a cause of tension for these women when a cumulative fund had to be submitted to a micro-finance office every month. Considering the frequent episodes of mugging in the city, these women fear travelling with funds which may put their lives at risk. These leaders requested that "micro-finance should accept loan recovery funds as it is being collected rather than all at once" (Naila, FMFBW20). If this method was approved for the loan payments, participants wanted to assure micro-finance institutions that they would still take full accountability for their group members. One leader noted that "if any member do not make their payment I will make sure they do it" (Fiza, FMFBW21).

Women should get-up, stand-up. It was interesting to learn that many participants identified the need to create awareness among women to initiate a source of income, learn skills, and be empowered. Several participants felt that micro-finance programs play a significant role in creating awareness, and six women also spoke exclusively about sending out a message to women in general. In response to my question regarding recommendations to micro-finance programs, one participant's immediate reaction was directing micro-finance to guide women to improve their lives. This participant, who is only in her second year of her loan, very confidently said, "I want to tell micro-finance to tell women who just sit at home and complaint that they do not have anything to do" (Rabiya, FMFBW18). Participants stressed that women should find employment and this will bring happiness and peace through extra resources. A common

thought was shared that women have the ability and courage to move beyond their expected roles. One participant questioned society about women's abilities and responded to her question when she said "men and women's brain are same, women can do anything . . . they can fly an airplane as well, so taking loan and working is a very small thing that women can do" (Naila, FMFBW20).

Two women shared their observations and experiences about families that lack resources and claimed that poverty is the root cause of all the issues. One participant very confidently said that "when women do not work then they ask [for money] from their husbands and when they do not have money to share, then fights start" (Sabra, FMFBW9). One participant shared the transitional phases of women in Pakistani society and how women should learn to bring a role change. Almas, noted that poor and uneducated Pakistani women struggle for their basic rights and respect from the day they were born. Almas explained,

> when woman was at her parents' house, parents consider her a burden and they send her away by getting her marry, when she goes to her husband's house, she was again considered a burden by her husband, but if woman decided to stand and make money she is not a burden for anyone, woman struggle more in her life than what a man does (FMFBW13).

It was also noteworthy that the women emphasized the importance of education for their children in general and education for girls in particular. The women saw education as improving thinking processes and allowing people to "see one thing from all different directions" (Beth, KF2). These women reflected on their own experiences when

they were not allowed to seek education and realized how much they had lost. Interviewees also stressed learning vocational skills as well as improving those skills to enhance their source of income. A female staff member with more than six years of experience shared her observation that now more women are using loans themselves, as compared to in the past when they used to give away the loan to their spouses. Jamila, stressed women's role change and its influence on women's mental health when she revealed that "I think now 50% of women have this concept that they want to do something . . . , which I believe tell us that they have a positive mental health which made her think to do something" (FMFBMFP3).

It was interesting to hear a loan recipient from KF who shared her reservations about women's involvement in certain income-generating activities and making a living. Afsha has a high school education and held loans from micro-finance institutions for the last five years. These loans were being used by her spouse in his work. Afsha questioned women's ability to make a sufficient source of income with a stitching and tailoring business to repay their loans. For her, this employment demands longer working hours and a consistent electric power supply, which she considered difficult to access in the city. Furthermore, she explained that "longer working hours may cause women to ignore their home and child care responsibilities and may worse their home environment as well" (KFW9). Therefore, Afsha believed that males are able to make the best use of a loan because they go out of the home and have a better understanding of how to utilize these loans. In contrast, female have enough responsibilities with a home and children. She also believed that women are more likely to misuse loans as "they get fascinated with

new stuff, like clothes and jewelry." In response to a question about why micro-finance is giving loans to women, Afsha believed that loan recovery is much easier from a female than from a "male because they are very tough and get into quarrel very easily. . . micro-finance staff may scared of them." Afsha's perspective in perfect contrast to a statement made by another participant who said "women are considered more responsible and make the best out of it as compared to men" (Aysha, FMFBW16).

With regard to a way forward, women expressed different messages in unique ways through their stories. Women described significant contributions of micro-finance programs in the promotion of their day-to-day living, which ultimately influenced their mental health. Though astonished about the proposal to offer suggestions to micro-finance, women identified strategies that could help them overcome mental tensions. A need to create opportunities to learn vocational skills along with funds was echoed in women's messages. Micro-finance women loan recipients, as well as administrative personnel, both felt that vocational skills training would have an added advantage to help women with their economic activities and would prevent misuse of funds. Some recommendations for micro-finance existing policies were also identified as a way to relieve tensions and bring motivation to the team leaders for group lending. Finally, women were empowered to articulate interventions that they felt ordinary Pakistani women should be following, as they believed that they have the strength and courage to bring peace in their lives.

The Components and Relationships of Mental Health and Well-Being

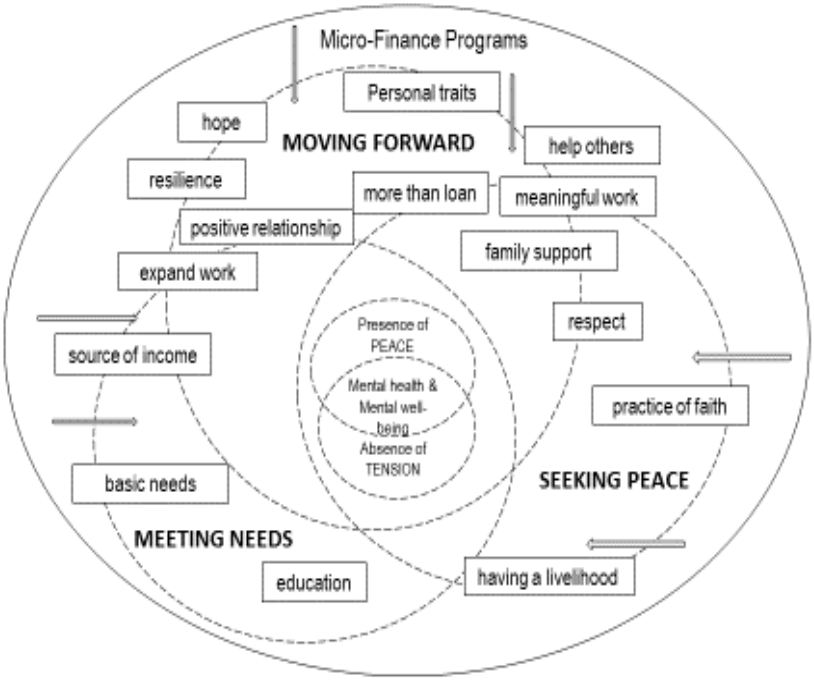
Consistent with interpretive description, which is the foundation of my research methodology, I followed three key methodological elements suggested by Thorne (2008): the purpose, the mechanism, and the product. The overarching objective of this study was to understand the conceptions and experiences of mental health and well-being among urban-dwelling women who are micro-finance loan recipients. This objective was achieved through the mechanism of informed questioning during interviews, reflective exploration, and in-depth analysis of the data. The findings of this study have been organized in a conceptual sequence to recognise the product, upon which new insights for the "application of evidence to practice" could be generated (Hunt, 2009; Thorne, 2008, p. 35). Figure 3 illustrates the relationships between the components of mental health and well-being in the context of micro-finance. In Chapter Five I will build these components and relationship in a form of concept map with application of evidence to guide the practice.

The understanding of the concept of mental health and well-being for the women of this study was unclear to diverse. Despite their differing and multiple perspectives, participants' description of mental health were surprisingly congruent on one fundamental notion. Participants consistently and clearly explained in their own words that mental health is about a presence of peace through an absence of tension. Contained within this central thematic statement are two core concepts, presence of peace and absence of tension, and one desired outcome, overall mental health and well-being. In this section I will first describe the meaning of these two core concepts of presence of peace and

absence of tension and how they are connected to the phenomenon of inquiry. Next, I will discuss the three interconnected processes: meeting needs, seeking peace, and moving forward on which the two core processes rely and contribute to the realization of mental health and well-being.

Figure 3 presents circles in which the core concepts and processes are enclosed. The circle used in this diagram represents the notion of wholeness which welcomes diversity and challenge uniformity in the absence of any linear or directional representation. The overlapping of the circles depicts mutual understanding and the relationships between the core concepts, between the core concepts and the processes, and among processes of the phenomenon of inquiry. The broken or perforated circles indicates the association and influence of the concepts and processes of the phenomenon of inquiry with the external environment. The outer complete circle shows the study context, which was micro-finance programs in Karachi, Pakistan.

Figure 3: Components and Relationships of Mental Health and Well-Being



Presence of peace and absence of tension. Despite the terms mental health and well-being being nebulous for the women in this study, what was echoed in their mixed responses was the presence of peace and absence of tension. Women talked about a broad understanding of mental health, which they viewed as the presence of something positive and simultaneously the absence of something which they considered negative or undesirable. Women articulated peace as synonymous with happiness and pleasure, which were considered precursors to mental health. Happiness was also referenced in the context of satisfaction in life. Similarly, an absence of tension was viewed as the absence of worries. Though women predominantly referenced tension in its absence, as "being fresh," its presence was also recognized by many, as a source of distress and uncontrolled

thoughts. Women believed that life brings them both peace and tension, and mental health is accessing peace or happiness by overcoming tension and worries. It is interesting that mental health is also defined as when a brain or mind is functioning well. Although, both terms, brain and mind, were used interchangeably in relation to its physical location and functioning, being conscious and aware of one's action was considered important. Analysis of participants' accounts indicated that individuals who have proper brain functioning make rational decisions that are acceptable to society. On the contrary, poor or the absence of sound brain functioning results in the lack of rational decision making and thus creates disturbances and causes a lack of peace for the individual and society.

The core concepts of the presence of peace and the absence of tension are influenced by three processes: meeting needs, seeking peace, and moving forward. In the discussion of the presence of peace and absence of tension, participants explicitly referenced what brings peace and keeps them away from tension.

Meeting needs. Meeting needs is considered foundational and indicates meeting a range of tangible, essential, and physiological needs on which life is based. Women recognized their mental health needs are connected with their physical needs. Women were loud and clear in describing how consistent employment, access to basic education, access to health care, and a safe environment were their highest priority needs. Women reflected how an inability to meet needs creates tension and influences poor mental health, while access to resources brings happiness and peace to their lives. In this discussion of accessing resources, participants valued the role of micro-finance in order to establish an economic activity and utilize their skills through a consistent loan. Many of

the women displayed a very high regard for the efforts of micro-finance programs in their poverty alleviation. This support was particularly valued by the women in relation to the poor geopolitical situation of the country and the belief that they would not get any support from government agencies. The women also valued that although micro-finance demands high interest rates with monthly instalments of loan recovery, their loan concludes in a year time. This is considered a major relief and a source of peace as well. Economic independence was viewed as a significant and the most important outcome of women's involvement in micro-finance program. Women reported being relieved when they were able to make a consistent source of income through a loan and were then able to make ends meet. Meeting fundamental needs was the primary indicator and process towards the core concepts of presence of peace and absence of tension in the promotion of mental health.

Seeking peace. This process recognized ways in which peace was sought. Among these measures, turning self to the Almighty or Divine power of God was the most essential and frequently recognized by women. Regardless of participants' religious background, practice of faith was considered an everyday ritual to seek blessings and peace in their lives. For many women additional prayers were also necessary at the time of difficulty to seek strength and to cope with adversity. The unique nature of the peace that women reported through their trust and faith in God, is considered indispensable and incomparable with anything else. Another significant approach that participants valued after their practice of faith, was their involvement in the micro-finance program. It is important to remember that to seek a loan was indispensable for women and they would

not depend on anyone else but the micro-finance programs. Women were explicit in their responses that a loan from micro-finance meant that they would not have to take loans from other, less reputable, loan sources and this eased their worries. Women also pursued peace, when through their employment and loan, they were able to maintain a respectable reputation for themselves and their families. Another view of peace these women sought was about keeping positive thinking and relationships with others and especially with loved ones. Many women stressed how they were able to pursue peace and mental health with the support of their spouses and children. Since poverty brings a lot of adversity and challenged human relationships, women repeatedly talked about the importance of maintaining a peaceful home environment and supportive relationships. Hence peace was sought through multiple ways, which assisted women in attaining mental health and overall well-being.

Moving forward. Continuing to move forward in their lives was considered important for the mental health of these women. Each of these women voiced their struggles and changes they wanted to bring in their lives. For all women, ending the vicious cycle of poverty was the key objective of their lives, which would allow them to see an encouraging future for their children. Analysis of participants' accounts also showed how the women emphasised the notion of "Who Am I" which connected to their personal traits of courage and confidence to move forward. They valued the importance of education and their motivation to bring change would eventually move them close to the peace they sought. It was also noteworthy that when women shared their personal stories of struggling and thriving, they provided advised for other women to find ways to

improve their lives. The emphasis was on creating awareness that women can achieve a lot even with limited or no exposure to education. Working hard, finding opportunities to learn and utilizing skills to initiate a source of income through loan investments and educating children were echoed as their major recommendations. Women stressed the need for change in women's roles and how girls are raised and viewed in a Pakistani society. Participants valued women for having the ability, strength and courage to be economically independent and not to be a burden or to feel helpless. Thus, women pursued peace and happiness and overcame tension and worries by moving forward with confidence and courage.

Chapter Summary

Study findings related to the research questions focussing on describing and interpreting the perceptions and experiences of mental health and well-being among urban-dwelling, Pakistani women participating in micro-finance programs were presented in this chapter. A description of participants' basic demographics as well as the description of the context of their participation in micro-finance programs introduced the chapter. It is interesting to learn that 46% of women spent loan funds independently for income generation and business purposes, but only 10% considered themselves as a head of the family. This section was followed by a descriptive and interpretive analysis of women's subjective conceptions of their mental health in general and as an outcome of their participation in micro-finance program in particular. Women consistently and clearly explained that mental health is related to the "presence of peace," where meeting fundamental needs such as physiological, safety, and family support were considered a

precursor to positive mental health. Findings were then presented, beginning with women's experiences of their mental health outcome with their participation in micro-finance programs. Women described varied experiences of their mental health. The most common descriptions involved women moving towards positive mental health, whereas few considered themselves in poor mental health. A few women believed that their mental health depends on quality of life and that certain positive life changes will influence their mental health. Micro-finance program roles were recognized as crucial along with the practice of faith in the promotion of women's mental health and overall well-being. Analysis of the research findings then proceed to the recommendations for micro-finance programs, whereby importance of vocational skills training was strongly emphasized for appropriate utilization of a loan and finding a consistent source of employment. A framework generated based on study findings representing women's descriptions of the core concepts and three interconnected processes through which women find their ways to improve their mental health concluded this chapter.

Chapter Five: Discussion

The perception of mental health, positive mental health, or subjective well-being is a relatively understudied area (Dow & Woolley, 2011) among adult populations and especially among women. Further, the subjective understanding of mental health among women from developing countries is a much needed area of research, especially when the prevalence rates of mental health issues are higher among women compared to men (WHO, 2010b; WHO, 2013).

Given the evidence that an improved economy and access to employment are two crucial social factors that influence well-being (Dooley, 2003), quality of life, and mental health (Evans & Repper, 2000) and given the growing popularity of micro-finance programs in low-income countries and their apparent success in increasing access to resources, improving nutrition (Kabeer & Mahmud, 2004; Snow & Buss, 2001), enhancing immunization coverage and reduced fertility (Schuler et al., 1997), improving women's empowerment (Holvoet, 2005; Aruna & Jyothirmayi, 2011), and reducing IPV (Jan et al., 2011; Schuler et al., 1996), it is pragmatic to study the mental health experiences of this population. This qualitative interpretive description of urban-dwelling Pakistani women explored and documented in women's own voices, their perceptions of mental health and how their participation in micro-finance programs influenced their mental health. Four major findings emerged. First, mental health is a presence of peace and an absence of tension made possible through access to resources to meet essential and functional needs. Second, women's participation in micro-finance reduces poverty through consistent employment and improves mental health outcomes. Next, the regular practice of faith and

religious rituals were effective and indispensable approaches to reduce mental stress and increase mental health. Finally, access to vocational training would enable women to use their loans in a productive way and would reduce the chances of loan redirection.

The discussion of findings presented in Chapter Four relates to the research questions posed in this study and the themes that emerged from the analysis of the data. This chapter begins with concept mapping of the interpretive findings with their significance to work in the field by way of the WHO's (2005a) and Corey Keyes' (2002) multidimensional model of mental health and well-being. The discussion of the findings will also integrate relevant scholarly work with a broader literature focusing on mental health. Interpretive findings will be compared and contrasted with studies focussing on women's participation in micro-finance programs and their mental health outcomes. In this chapter I present a concept map with the implications for nursing practice, research, and education for mental health promotion and specific recommendations to micro-finance programs. The chapter concludes with details of the study's strengths and limitations and a description of the plan for dissemination of study findings.

Concept Mapping Based on WHO and Corey Keyes' Mental Health Components

After the preliminary findings were reviewed, emerging pattern and themes were studied and matched with the WHO (2005a) definitions of mental health and the Keyes (2002) model of mental health and well-being. The purpose of this step was to understand the conceptualization of Pakistani women's perspective of their mental health with respect to the core definitions of the WHO and Keyes. This step provided an opportunity to uncover meaningful information related to Pakistani women's perspectives of mental

health with respect to their cultural manifestation and relevance. Concept comparison also assisted in identifying the differences in Western and Eastern understandings of the phenomena of mental health and well-being. My intention was to describe, from women's perspectives, their understanding of mental health and how their participation with micro-finance influenced their mental health and overall well-being, not to create a new definition of mental health and well-being for this population. Table 8 provides a visual representation of matched components of mental health. This section begins with highlights of the core components of Keyes' (2002) model of mental health and well-being and the WHO's (2005a) definition of mental health. It will then detail the similarities and differences in concepts with specific examples from the women's transcripts.

As discussed in Chapter Two, Keyes' (2002) multidimensional model of mental health is a combination of three components: emotional, psychological, and social well-being. Emotional well-being refers to subjective happiness and positive affect, whereas psychological and social well-being represent optimum human growth and functioning, whereby individuals thrive in their personal lives as well as in their social lives. The combination of all three components of mental health were referenced as Hedonic and Eudaimonic well-being by clinical and social psychologists (Deci & Ryan, 2008; Diener & Lucas, 1999). Similarly, the WHO's (2005a) definition of mental health is a combination of four essential components that include the realization of one's own abilities, coping with normal stresses, working productively, and contributing to the community.

Table 8 lists the key concepts as they were matched to the components of the WHO definitions of mental health (2005a) and Keyes' (2002) model of mental health and well-being. The participants' perceptions of their mental health are also included in this table. Findings indicate that the female participants identified many concepts of mental health and well-being that are interlinked with the WHO definition and the Keyes model of mental health. However, the findings of this study reflect additional components beyond these two models.

Subjective well-being.

Emotional well-being. With regard to individuals' realizations of their own abilities (WHO, 2005a) and emotional well-being (Keyes, 2002) as the primary domain for positive mental health, the Pakistani women who were loan recipients referenced many similar concepts. Women recognized happiness and their personal traits of confidence, motivation, and courage as the major concepts of positive mental health. Many valued being educated and having some level of schooling as an added advantage, which allowed them to realize their potential. Although women did not explicitly talk about self-determination and self-acceptance in their conceptualization of mental health, these components were recognized when they shared their personal experiences of mental health. Women viewed being content as important for their mental health, as it reduced their mental tension. Keyes considered this concept of being satisfied as also having a positive affect in the domain of emotional well-being.

Participants described a mentally healthy person as someone who has peace, a sense of financial security to meet the demands of basic physiological needs, effective

brain functioning and physical health. Financial security can be viewed in terms of functional well-being when an individual has resources and therefore has psychological and social well-being, as suggested by Keyes (2002). An additional component women referenced for positive mental health is related to the individuals' physical health, including effective functioning of the brain. Women considered that individuals with positive mental health should be physically healthy and they should be able to make logical and rational decisions. These components are explicitly included in the WHO definition and the Keyes model of mental health.

Functional well-being. Functional well-being is the second component of Keyes' multidimensional model of mental health, which includes psychological and social well-being. It recognized the individual's ability to function productively and to cope with the normal stresses of life.

Psychological well-being. The most prominent concept of psychological well-being that urban dwelling Pakistani women referenced in their discussions related to having meaningful work that generates a source of income and provides a sense of financial security. Having meaningful work was considered vital for personal growth as the women were able to utilize their potential and engage in self-development. Participants considered having the ability to adapt to situations in order to meet every day demands, to be hopeful about the future, and to have a purpose in life as vital for their mental health. Keyes (2002) refers to the capacity of an individual to manage the complex environment as environmental mastery.

Environmental mastery may also be linked with the unstable geo-political situation of the country, which women extensively discussed and within which they exhibit their capability to achieve their needs. Many women identified that their gender and cultural restrictions influence their functional well-being, while others found their gender provided an opportunity to seek a loan and therefore have meaningful work. Even women who redirect their loans to their husbands also felt productive and constructive for their indirect contribution towards the family income. One of the concepts suggested by Keyes (2002) in the domain of functional well-being is the individual's self-acceptance of positive mental health. Although participants did not explicitly share this concept, it could be argued that if women accept their limitations based on cultural restrictions, would this not be considered positive mental health? In contrast, how would this compare to those who were eager to respond to their limitations with resilience and courage and modify their environment? Could both groups of women be demonstrating environmental mastery?

Keyes' (2002) conceptualization of psychological well-being also highlights the importance of an individual's positive relationships, personal growth, and purpose in life as vital elements. The WHO (2005a) consistently emphasizes that a mentally healthy person should lead an effective and productive life. Women shared many examples of the importance of positive thinking and keeping positive relationships as necessary for positive mental health. They also recognized self-determination, resilience, and hope as vital to leading a productive life. Since women participants were loan recipients of micro-finance programs, they viewed micro-finance as a social support that provided them hope

about the future through meaningful work. Although not many women explicitly talked about an effective way of coping as a vital component of mental health, they indicated that not indulging in excessive thinking and worries promotes positive mental health. Further, the women shared extensively how their trust in God or the practice of religion gives them strength and was considered an effective coping method for many of the women in this study.

Social well-being. Consistent with psychological well-being, social well-being was also acknowledged by the women participants. The women shared very limited views about social well-being in their perceptions of mental health and well-being; however, some relevant concepts were generated from their discussion about their personal experiences of mental health. For instance, Keyes (2002) highlighted social coherence as one of the components of social well-being. The women were explicit in their discussions of the country's social and political unrest and how this environment influenced their mental health. The women made specific reference to the issues and scenarios they had observed in their day-to-day living and question the state of their mental health. Women were enabled to make conclusions about what was happening in their surrounding and its influence on their mental health and overall well-being.

Social contribution is another component of social well-being that is explicitly detailed in the Keyes (2002) model as well as the WHO (2005a) definition of mental health. Participants who shared their positive state of mental health acknowledged their contributions towards their family income as a positive change in their family dynamic. When the women shared their hopes and purposes in life, they related to the well-being of

their family and children. Several women took this to the next level and indicated how a small contribution towards the family also helps society and the community to flourish. Although women foresaw a positive and improved community, they criticised and shared their despondency about their country. Women valued their social participation as an indicator of their positive mental health when they have the opportunity to meet other women and share and learn. The following section details women's perceptions of mental health in the light of existing literature related to mental health and well-being.

Table 8: Concept Matching of Key Components of Mental Health and Well-Being

WHO Definition of Mental Health	**Realizes His/Her Own Abilities**	**Cope with Normal Stresses of Life**	**Can Work Productively and Fruitfully**	**Able to Make a Contribution to Community**	**Additional Components**
Corey Keyes Mental Health Model	**Subjective Well-Being**	**Functional Well-Being**			
	<u>Emotional wellbeing</u> Life Satisfaction Positive affect	<u>Psychological well-being</u> Self-acceptance Environmental mastery Purpose in life Personal growth Autonomy Positive relationship with others		<u>Social well-being</u> Social contribution Social integration Social actualization Social acceptance Social coherence	
Pakistani Loan Recipient Women's Perceptions of Mental Health	Happiness Contented Positive thinking Confidence Motivation Courage Education Self-acceptance Self-determination	Adaptability Hope Sense of purpose in life Engaged in meaningful work Gender Culture Relationship Autonomy Resilience Religion and spirituality Family support Social support		-Identify changes in the surrounding environment -Family and social contributions -Belief that family, community and society will flourish -Social participation	Meeting basic physiological & essential needs Peace Being fresh Lack of worries Lack of tension Functioning of brain Being wise Have fear of God Influence of physical health Financial security Environmental safety

Perceptions of Women's Mental Health and Well-being: Comparison with Literature

In defining women's perceptions and conceptualizations of the terms mental health and well-being, the most consistent theme extracted was the presence of peace and an absence of tension. The women's description of peace recognized happiness, satisfaction, and positive thinking, which were consistent with the emotional component of Keyes' multidimensional model (2002) of mental health.

A small proportion of qualitative studies focus on understanding mental health, positive mental health, or over all well-being among women (Mirabzadeh et al., 2014), young children (Armstrong, Hill, & Secker, 2000; Majumder et al., 2015; Rosse & John, 2003; Singletary et al., 2015; Svirydzenka et al., 2014), youth and adolescents (Harms et al., 2009; Johansson, Brunnberg, & Eriksson; 2007; Wells, Varjas, Cadenhead, Morillas, & Morris, 2011), multiple ethnic groups (Vaingankar et al., 2012), immigrants (Dow & Woolley, 2011), and nomads (Choudhry & Bokharey, 2013) corroborates the findings of the existing study. Consistent with other qualitative studies, Pakistani women's explicit understanding of happiness and satisfaction (Mirabzadeh et al., 2014) related to the factors which allow them to have a peaceful and comfortable life. Access to essential needs such as food, employment (Choudhry & Bokharey, 2013; Harm et al., 2009; Mirabzadeh et al., 2014) and the well-being of their children were vital elements of their happiness and satisfaction in life. An inability to meet these needs was a source of tension and worry and was considered a major reason for poor mental health.

Findings documented in another study from Pakistan assessed the perceptions of mental health among Pakistani nomads and revealed that meeting physiological and essential needs are the basic requirements not only for maintenance of physical health but for mental health as well (Choudhry & Bokharey). Both Pakistani women and Pakistani nomads considered that a stable, mentally healthy person is one who is fresh and is able to fulfill his or her basic needs. A lack of basic life necessities was also considered the primary reason for stress and was associated with poor mental health among Ugandan orphan youth (Harm et al., 2009). Consistent with the findings of the current study, Albanian immigrants who migrated to southern California considered financial problems or lack of resources to be a major reason for strain and influenced mental health. These participants indicated that a lack of finances might place them at risk for poor mental health but not mental illness (Dow & Woolley, 2011). In a focus group interview, stress due to insufficient finances to raise a family was identified as the major factor of poor mental health among adults of Scotland as compared to young people of a similar population (Armstrong et al., 2000). In general, good mental health was associated with acquiring essential needs along with access to education (Harm et al., 2009) for children and employment (Armstrong et al., 2000; Mirabzadeh et al., 2014). This alternate view of mental health was also reported in a broader understanding of both physical and mental health as shown by a small number of quantitative (Wang, 2004), qualitative (Ott et al., 2011) studies and a quantitative study with some open responses that examined youth's perceptions of their physical and mental health in an intervention study (Singletary et al., 2015). Hence, it is clear from the above findings that access to resources to meet the basic

and essential needs of life was viewed as a mandatory requirement for mental health among varied population across the globe.

In the current study, the women's descriptions of stress and tension were also related to the geopolitical situation of Pakistan. As discussed in Chapter One, Pakistan has been going through many serious economic, political, social, and religious challenges over last decade that have affected the lives of ordinary citizens and their means for survival. Participants explicitly shared concerns related to the safety of their family members, especially those who leave the house to make their living. The importance of environmental safety has been identified as a relevant feature among mental health studies (Armstrong et al., 2000), as political violence may create a threat to personal safety and fear, which place individuals at risk of poor mental health (Taylor et al., 2013). The Pakistani women's perceptions of mental health that related to meeting their basic needs, both their safety needs and essential needs, validate Maslow's hierarchy of needs where individuals try to acquire lower-level needs before achieving upper-level needs that include self-esteem and self-actualization (Maslow, 1970). For these women, mental health demands mental peace and an absence of tension, which one should be able to achieve by the attainment of the basic needs on which human lives depend.

Not surprisingly, and in keeping with the findings of previous studies (Armstrong et al., 2000; Harm et al., 2009; Singletary et al., 2015; Wells et al., 2011), some women in this study were unfamiliar with the term mental health; however, they expressed ideas about what causes good and poor mental health. Typically, the women who did not have basic schooling or had minimal exposure to secular education had difficulty expressing

their understanding of the term. Armstrong and colleagues (2000) also identified this among Mexican youth from deprived and rural areas who had difficulty in understanding the term as compared to students who were from suburban areas. However, key informants who were mental health providers from Mexico, reported that mental health is a term that is not often used by the general population (Wells et al., 2011). In the current study, a small proportion of women connected the term mental health with the functioning of brain or mind. This was also shown in a qualitative study on the experiences of orphans in Uganda and its impact on their mental health (Harm et al., 2009). However, unlike in the Ugandan study, where there was no word for mental health in the Lugandan language, the Urdu language, in which the current study was conducted, has a concise and clear translation, *health of the mind.* This term is typically understood in terms of brain processing and is not limited to the physical location and functioning of the brain. When women talked about mental health, they referenced the brain in its physical context and their description was related to brain functioning, or processing of the mind. The women considered that a mentally healthy person is one who is "wise" and able to "make rational decisions," while poor brain function is considered poor mental health, where the brain is considered weak. Johansson and colleagues (2007), identified a similar understanding of mental health and its functioning and processing abilities among children aged 13 to 16 years in Sweden. An interpretive phenomenology study was carried out among young pre-teens in the United Kingdom to understand their concepts of mental health in order to provide appropriate mental health services. Focus group interviews revealed that children in this study referenced mental health as "peace of

mind" and it was associated with an individual's emotions, thoughts, and behaviours (Roose & John, 2003, p. 547). In contrast, Indiana adolescents viewed mental health in its negative connotation by defining it in terms of "stress and fatigue" (Ott et al., 2011, p. 398). It is important to understand that women in the current study, whether they were or were not familiar with the term, predominantly expressed mental health in its positive understanding.

In defining mental health, the notion of socially acceptable behaviour was a relevant feature. For instance, confusion, disturbed behaviour, and upset (Armstrong et al., 2000), not behaving according to societal norms or not being able to talk to others (Dow & Wolley, 2011; Harm et al., 2009), and displaying negative behaviours that are socially and culturally not acceptable (Wells et al., 2011) were simply considered typical features of poor mental health. In this discussion of poor mental health, the concepts of madness and insanity were specifically shared with a typical example being an individual who is shabbily dressed, wanders on the streets, and is not aware of his or her surroundings (Choudhry & Bokharey, 2013, Harm et al., 2009; Wells et al., 2011).

Other scenarios of what the women identified as insanity were related to individuals who lack respect for human lives. The specific examples that the women described were of individuals who caused bombings or raped young girls. This was likely a reflection of what the women observed in their surroundings or had been informed of by the media. Bombing and sexual assault were regularly reported in Karachi as well as other provinces of the country during the data collection process of this study. In previous studies documenting the presence of socially unacceptable behaviours among individuals

with mental illness (Ham, Wright, Van, Doan, & Broerse, 2011; Harm et al., 2009), no such examples were highlighted. While specific examples related to bombing may not be evident in previous studies related to the perceptions of mental health, these findings can be found in the extensive literature related to experiences and impact of war on mental health (Murthy & Lakshminarayana, 2006).

The notion of insanity or madness is commonly discussed and presented in lieu of perceptions of mental illness (Ham et al., 2011). Because the women in the present study did not cite any specific mental health disorders, it could not be concluded whether poor mental health is the same as mental illness in their understanding. Another interesting findings related to insanity and madness in the construction of mental health and well-being among Pakistani women was in reference to religion or spirituality. Women viewed individuals with poor mental health, who create havoc in human lives, as "lacking fear of God." It is commonly believed that fearing God encourages individuals to do good in their lives because they fear punishment or expect rewards from God (Norenzayan & Hansen, 2006). This fear of God is also understood in reference to having respect for God and is thought to encourage individuals to act in ways that makes God happy and to refrain from those that are not acceptable (Shariff & Norenzayan, 2007). A common belief is that certain religious practices help save individuals from the evil eye, which is often considered the cause of mental disorder (Choudhry & Bokharey, 2013). Mental illness was understood with respect to "spiritual disease" such as black magic and the power of amulets by Pakistani nomads (Choudhry & Bokharey, 2013, p. 6). Two participants in the current study talked about black magic and amulets. One referenced

them as methods of coping with stress that she had observed people use, but that she herself did not believe in. The second participant believed in both black magic and amulets, but recognized them as causing harm and problems in other people's lives.

Consistent with Keyes' emotional and subjective well-being (2002), the presence of positive personal characteristics was considered important for mental health by women in the current study. It was commonly understood that positive thinking, motivation (Armstrong et al, 2000; Vaingankar et al., 2012), courage, and confidence (Armstrong et al., 2000; Mirabzadeh et al., 2014) were necessary elements for individuals to flourish and seek positive mental health. There is good evidence within the literature that positive thinking has shown to improve adaptive functioning and enhance quality of life in various populations (Majumder et al., 2015; Roose & John, 2003; Singletary et al., 2015; Svirydzenka et al., 2014). The WHO (2005a) definition of mental health notes that mentally healthy individuals should have the ability to appreciate their own abilities and this resonates with the women of the current study who valued having certain positive traits as vital for mental health and overall well-being. Further, the women valued the importance of secular education to help individuals to realize their abilities (Vaingankar et al., 2012; WHO, 2005a).

Consistent with findings of previous studies, the women of the current study stressed having a vision for personal growth (Armstrong et al., 2000), self-determination, autonomy (Vaingankar et al., 2012), having a purpose in life (Dow & Woolley, 2011) and moving forward toward a positive future with hope, as indicators of good mental health. These women demonstrated a vision to lead their lives in positive ways and their most

important purpose was to improve the well-being of their children. These concepts of positive mental health are reflected in the WHO (2005a) definition of mental health and in the functional well-being component of Keyes' model of mental health. Quantitative studies focussing on positive mental health indicators have also indicated that individuals with positive well-being possess more productive attitudes towards life and are less likely to demonstrate indicators of poor mental health (Humphreys, Mankowski, Moos, & Finney, 1999; Seeman, 2000).

Consistent with the psychological literature, women who are micro-finance loan recipients indicated the importance of positive relationships as a necessary element for mental health. They insisted on having supportive and healthy relationships with friends, neighbours, and especially family (Armstrong et al., 2000; Vaingankar et al, 2012). WHO (2005a) and Keyes (2002) associate these concepts as necessary to enhance an individual's functional well-being and to facilitate an individual's capacity to work productively with other members of society, thus contributing to family, community and society in general (Keyes, 2002; WHO, 2005a).

For many women in this study, the terms mental health and mental well-being have a similar meaning. Well-being was understood in its wider context and was considered a process, whereas mental health was acknowledged as a state among the few who were able to differentiate between the terms. The terms mental health, positive mental health, and mental well-being are often used in the literature interchangeability in relation to definitions, concepts, and measures (Hubka & Lakaski, 2013; Keyes, 2002). Well-being is also recognized in its multiple dimensions of mental health, such as

psychological well-being, subjective well-being, emotional well-being, etc., (Keyes, 2002) and it takes us back to the notion of Hedonic and Eudemonic traditions of well-being. The WHO definition of mental health also references "mental health as a state of well-being" (WHO, 2005a, p. 2), and suggests indicators of positive mental health.

The Construction of Mental Health and Well-Being

The conceptualization of mental health and positive mental health and its distinction from mental illness has become a focus of attention in recent years among health practitioners and health policy researchers (Hubka & Lakaski, 2013). Considering the multiple and unavoidable social determinants of mental health (Patel & Kleinman, 2003), the development of mental health as a concept is an indispensable area of study through both theoretical discussion as well as empirical observation among a variety of populations (Hubka & Lakaski, 2013). This facilitates understanding and construction of the dynamics of the phenomenon of mental health considering the context of individual culture, language, beliefs, values, and behavioural norms (Hitchcock et al., 2005; Vaingankar et al, 2012). Thus, distinct, relevant and applicable interventions for the promotion of mental health and the prevention of mental health issues could be established (Magyary, 2002). Hubka and Lakaski (2013) advocate consistency in the definition among communities, researchers, policy makers, program planners, and practitioners for operationalization of relevant interventions necessary for mental health promotion. The current study examined the construct of mental health and well-being of Pakistani urban-dwelling women who were loan recipients from micro-finance programs. Findings from this study provided an in-depth understanding and knowledge of

perceptions of mental health among this population of women within the context of Pakistan.

Women's Experiences of Mental Health and Micro-Finance

With regard to women's experiences of their participation in micro-finance programs, the findings of this qualitative study demonstrated positive mental health outcomes. The majority of participants, regardless of the number of years they held a loan from micro-finance programs, revealed that seeking micro-loans and establishing income-generation activities assisted them to reduce tensions related to meeting their fundamental needs. More than one half of the study participants reported experiencing positive mental health as compared to a quarter who considered themselves in a poor state of mental health. Women experiencing poor mental health acknowledged their tensions and miseries and shared a sense of hopelessness and discouragement related to moving toward a positive state of mental health. In this study a small number of study participants who were not in a state of positive mental health could foresee hope and believed that certain positive developments in their lives could move them towards a better and an improved state of mental health.

The available literature related to the mental health of women who are involved in micro-finance is limited; this literature is predominantly quantitative and shows mixed evidence. Considering the qualitative approach of the present study, it may be a challenge to compare its findings with previous quantitative studies. However, this comparison is a crucial step, primarily because the qualitative approach highlights women's voices in the expression of their experiences of mental health. Bangladesh Rural Advancement

Committee (BRAC) study findings showed a significant improvement in mental health using a 36-item short-form health survey among poor BRAC members compared with poor non-members ($p<0.01$). However, the depression scale was non-significant when controlled for other variables (Ahmed, Rana, Chowdhury, & Bhuiya, 2002). In contrast to this finding, a previous study conducted in South Africa among micro-finance recipients revealed decreased symptoms of depression among men as compared to women. However, there was an increased level of perceived stress among both men and women who received a second chance for a loan to improve their mental health with an increase in SES (Fernald et al., 2008). Stress related to the early period of involvement in micro-finance (Fernald et al, 2008) and the recovery of loans was also consistent among a quarter of women participants in the current study who recalled the experiences of their early years with micro-finance. However, a few found receiving a loan a source of relief because it fulfilled their immediate needs and provided a platform to have meaningful work.

The research findings of this qualitative study point to the key aspect of mental health among Pakistani women. Consistent with previous studies (Fryers, Melzer, & Jenkins, 2003; Patel & Kleinman, 2003), poverty was considered the biggest contributor to poor mental health among the participants across one to five years of a loan period, where meeting fundamental basic needs was a challenge for many participants. However, seeking a loan is only beneficial to their mental health if it is correctly utilized for the purpose it was meant. Initiating an income-generation activity and being able to maintain a consistent source of income were the vital elements in positive mental health. Among

poor Bangladeshi loan recipients, poverty was similarly reported as the most significant reason for emotional stress, as well as among poor women who did not have loans. That is, stress resulted as these women faced extreme difficulty in making financial ends meet. (Ahmed et al., 2001). The impact of micro-finance programs on poverty alleviation has been explored for many decades. Researchers focusing on these studies find it particularly challenging to evaluate micro-finance as a variable using rigorous research design because of the complexity and variation of micro-finance programs across the globe (Rooyen et al., 2012; Stewart et al., 2010; & Stewart et al., 2012).

The mixed findings of a systematic review of 17 robust studies revealed that micro-credit and micro-saving sometimes influenced poor people to engage in economic opportunities and therefore might impact their income. However, loan recovery with high interest also demands borrowers to sell non-financial assets to raise funds for the repayment of loans (Stewart et al., 2012). Two other systematic reviews citing Sub-Saharan African studies (Rooyen et al., 2012; Stewart et al., 2010) showed that involvement in micro-finance can entrench poverty and place individuals in additional debt for repayment. Fernald and colleagues (2008) in their RCT study found that incurring loan debt and coping with an increased financial burden may augment psychological stress, and increase poor mental health for some impoverished South Africans.

These findings were reflected by the Pakistani women who participated in the current study, as loan recovery was considered a tension among the women across one to five years of the loan period. However, this was reported only by those women who did

not have any consistent employment or were challenged with geo-political adversity. Interestingly, very few women were concerned about the high interest associated with their micro-finance loans. These findings were consistent for both women recruited from FMFB as well as from KF. One participant specifically talked about giving away her home ceiling fan to micro-finance staff in place of her last loan instalment. In the absence of any financial support from government, loans received from micro-finance programs, regardless of high interest, were considered an asset among the women. These women appreciated that a micro-finance loan would be returned in one year and they could then seek a future loan. Women valued this method of loan recovery from micro-finance programs because it was a favourable alternative to a loan from Pathan, a moneylender with a very high interest rate. Pathan is the most prevalent moneylender in the country, and their high interest rate (Jan, Munir, Rehman, 2011) means that debt incurred by an individual usually runs for multiple generations within one family.

Loan duration and women's mental health. Researchers focussing on micro-finance studies have also examined the relationship between the length of women's participation in micro-finance programs and their mental health outcomes. For instance, Ahmed and colleagues (2001) did not find any effect on women's emotional stress overall. However, they found a gradual increase in emotional stress with involvement in a micro-finance program from the first year onward, reaching a peak around three years, and then declining.

In contrast to the above findings, the present study indicated a mixed outcome. Women in the second year of a loan represented the majority of the study sample and

most of them recognized themselves as having positive mental health. The women who were in the third to fifth years of loan also reported positive mental health. Interestingly, one woman out of three also reported less tension and worries while she sought her first loan only. It is noteworthy that the women who did not recognize themselves in a state of positive mental health but foresaw hope with positive change in their lives were primarily in their second, third, or fifth year of the loan period. Considering the variations in years and uneven representation of women in each year, it was challenging to make a clear conclusion. However, similar to previous studies it may not be wrong to say that women who stayed longer with micro-finance for two years or more than two years reported less tension. Researchers focussing on examining women's mental health with participation in micro-finance programs should also assess the baseline mental health status of women who seek a loan for the first time. This will enable us to understand what kind of women join micro-finance programs. If women with positive mental health are more successful in receiving loans, are they more likely to stay in a positive state of mental health in the early years of a loan?

That women in the early years of a loan also considered themselves to be in a state of positive mental health may bring new insights. Although this is a promising outcome for micro-finance and women's mental health, it is vital to note that a considerable number of women (34%) held two loans. Further, many women were involved in earning an additional source of income besides the loan investment. Activities such as working as a housemaid or as a cleaning lady at a clinic or a school were commonly reported among these women who were in their early years of micro-finance. Among these women, many

have either shared or redirected their loan to other family members for economic purposes. It could be assumed that sharing loan resources may enable women to seek additional employment. These findings related to women's dual role to improve their SES reflect the additional responsibilities these women hold, along with their home and child care duties. It could be argued that improving SES and women's participation in economic activity results in a "newly adopted non-traditional role" in a patriarchal society (Ahmed et al., 2001, p.1964), such that participants of this study were challenged by their dual responsibilities both in and outside the home. This poses two important questions: (a) will an additional work load place these women at risk for poor mental health outcomes if they consistently engage themselves to improve their SES?; and (b) is promoting women's participation in micro-finance along with an additional source of income an appropriate intervention in terms of their mental health outcomes? Further, women's motivation to seek an extra loan and its impact on their mental health and overall well-being should be another area of discussion for policy makers and program planners of micro-finance institutions.

Redirection of loan and women's mental health. Redirecting loans to a male counterpart or other male family member has been recognized in other studies of micro-finance (Fernandez, 2010; Garikipati, 2008; Goetz & SenGupta, 1996; Singh, 2015). A small group of women in the current study redirected their loan to their male family members; however, a significant number shared their loan with family members, including female members as well. Regardless of to whom the loan was redirected or with whom it was shared, it was predominantly this group of women who reported a sense of

peace as the family had meaningful work, was able to meet their needs, and also could ensure a timely return of the loan. Women valued redirecting loans because in Pakistani culture, males hold the major responsibility to put food on the table. Further, females have limited economic opportunities and since they are mostly house-bound, it can be important for them to have their loan at least shared, if not redirected. A similar finding was shared by Singh (2015) in her qualitative study from southern India that showed that redirecting a loan helped families to improve their standard of living as well as to preserve men in their traditional gender roles.

Many women redirected their loan under the belief that micro-finance institutions give loans to females only. Interestingly, most of the women in this study had received loans from FMFB, which offers loans to both males and females. Micro-finance personnel confirmed this lack of knowledge among female loan recipients. Further, considering the traditional cultural restrictions that create a barrier for women to utilize their loans, redirection is a common option. Some literature that examined issues related to redirection or loan sharing also noted that micro-loans are often taken forcibly by women's spouses for non-productive purposes (Garikipati, 2008; Goetz & SenGupta, 1996). Further, in terms of loan return, Garikipati's (2008) study from India indicated that women relied on their personal labour wage to repay the loan when a loan is redirected or used for purposes other than self-managed enterprises. Contrary to this evidence, none of the current study's participants talked about forced redirection or difficulty in loan recovery. In contrast, according to the women in this study, both those who redirected loans and those who maintained them independently were well supported by their spouses

and sons in the timely return of their loans. Similar to the current study, Fernandez (2010) also identified smooth repayment of loans when loans were redirected.

Non-productive use of loans and women's mental health. Along with studies that documented benefits to women participating in micro-finance programs, studies document negative effects on women's membership in a variety of settings with restrictive gender norms (Garikipati, 2008; Goetz & SenGupta, 1996; Mayoux, 1997, 2001; Rahman, 1999; Singh, 2015). Non-productive use of loans is another area of discussion in the literature (Goetz & SenGupta, 1996; Mayoux, 1997). In this study, the majority (94%) of women reported that the loan sought from the micro-finance program was utilized appropriately for economic opportunity; however, two participants (6%) employed their loans exclusively for household and utility expenses. Both of these women experienced poor mental health. Their loans were only a temporary source of resources and brought additional tension and worries. In the presence of a marginal monthly family income, the consistent increase in loan debt and need to seek additional loans from other sources to cover the previous loans further moved them towards deeper levels of poverty and poor mental health (Arnold & Booker, 2013). WHO (2005c) indicated that people living in poverty generally lack common knowledge about improving their standard of living. This is evident among populations where illiteracy limits one's ability to make effective interventions specific to poverty reduction (Ali & Hatta, 2012).

The issue of unproductive use of loans requires considerable attention by micro-finance program planners and policy makers and should prompt planners and policy

makers to follow a stringent and vigilant screening method for its loan borrowers. In the presence of the cultural restriction on women's mobility and the absence of any vocational training skills, these women were not left with many choices but to use their loans unproductively. This makes one question whether micro-finance programs offer poor women a chance to address their poverty (Newman, Schwarz, & Borgia, 2014), and whether loans or money alone can sufficiently address or alleviate poverty, which is a multidimensional problem (Mahmood, Hussain, & Matlay, 2014). Poverty restricts individual access to essential resources and skills that may provide opportunities to participate in activities to reduce financial hardship (Lund et al., 2011). Therefore, to enable these poor women to use their funds appropriately and be successful in their employment initiatives, exposure to vocational skills training is an essential intervention (Brixiova, 2010; Kennedy, Fonner, O'Reilly, & Sweat, 2014; Madhani, Tompkins, Jack, & Fisher, 2015).

Skills training and women's mental health. As the literature related to what works and what does not work in micro-finance is still evolving, the benefit of capacity-building by introducing some level of training is repeatedly emphasized (Kennedy et al., 2014; Brixiova, 2010; Newman et al., 2014; Shaw, 2004). A modified systematic review of micro-finance in South Asia has stressed the importance of introducing skills training for micro-finance borrowers if, in addition to poverty mitigation, the promotion of mental health outcomes is a part of the vision (Madhani et al., 2015). When women loan recipients in the present study referenced poverty as a major issue and a risk factor for their poor mental health, they suggested initiating vocational skills training for themselves

and their young daughters to break the cycle of poverty. These women, along with micro-finance staff, strongly emphasized that exposure to vocational skills would encourage women to utilize their loan in a productive way, thereby mitigating the chance that the loan would be misused.

Vocational skills were also considered important as, in the absence of sufficient employment skills, women would redirect their loans to their male family members. Learning required skills would give women confidence to initiate their employment activities and the ability to respond to gender inequality with courage (Newman et al., 2014). In addition, this could give women the knowledge to train other women (Mahmood et al., 2014). Thus, this model of women-to-women skill building will help the "working poor or entrepreneur poor" to support the extremely poor by sharing knowledge and skills training (Mahmood et al., 2014, p. 234; Mosley & Rock, 2004).

Women's participation in micro-finance and experiences of IPV. Women's mental health is also related to their experiences of IPV. There is sufficient literature related to effects of IPV on poor metal health outcomes. Studies suggested that women experiencing IPV are more likely to report symptoms of anxiety and depression (Kumar, Jayaseelan, Suresh, & Ahuja, 2005; Mapayi et al., 2013). The findings of the current study revealed some promising outcomes. When women described their mental health outcomes as linked to their involvement in micro-finance programs, three women (9.4%) disclosed current or past exposure to IPV. Although women were not specifically asked about their perceptions and experiences of violence, their description of their experiences indicated that they experienced multiple types of IPV (i.e. verbal, emotional, physical,

and sexual violence in the early years of their marital lives). Although two previous systematic reviews indicated a mixed relationship between women's economic involvement and their experiences of IPV (Madhani et al., 2015; Vyas & Watt, 2009), women from the current study recognized that their micro-loan had been a valuable asset to reduce the recurrence of IPV in their lives. These women pursued moving towards positive mental health and well-being with their participation in income-generation activities and increased control of their resources.

The outcome of systematic reviews also showed that increased duration in micro-finance, training and skill development, and educational interventions collectively improved women's mental health outcomes (Madhani et al., 2015) and equipped them with the necessary skills to resolve conflict and avoid violent situations with more confidence (Ahmed et al., 2001; Mohindra et al., 2008). In the current study, participants who experienced IPV had at least sought two loans, had no or very marginal levels of schooling, and all of them were recruited from FMFB, where women were not exposed to any gender, numeracy, literacy, vocational, or business related training. Literature outside the context of micro-finance provides sufficient evidence of the presence of elements of self-efficacy and the ability to respond to distressful life events such as family violence (Benight, Harding-Taylor, Midboe, & Durham, 2004; May & Limandri, 2004). An exploratory qualitative study conducted on female survivors of IPV and domestic violence identified engagement in employment as a major contributor of increasing their self-esteem, empowerment, and mental relief (Rothman, Hathaway, Stidsen, & De Vries, 2007). These findings are consistent with the current study that shows when women

becoming economically independent through employment activities, they are more likely to demonstrate higher self-confidence or self-efficacy. Further, one participant specifically talked about increased protection offered by her children, especially her sons as they grew older, and indicated that moving into the workforce reduced family violence. In light of the current evidence, it could be assumed that women survivors of IPV in the current study had gained higher self-confidence through employment and protection from their children. This area needs further exploration and discussion in the context of micro-finance.

A South African study suggested a reduction in IPV by almost 50% when micro-finance is combined with gender training (Pronyk et al., 2006). These findings may be corroborated with the present study where none of the participants from KF reported experiences of IPV. As mentioned in Chapter Two, KF provides multiple training programs to its borrowers, including gender equality, and also plans periodic open theaters productions on social issues, including IPV. Though participants recruited from KF represented only one third of the sample, and none claimed to have attended any gender training, it is unknown if these participants and their spouses had any exposure to the social theater productions organized by KF. Exposure may have helped the family to refrain from family violence. During my data collection I also learned from KF staff that the foundation had recently telecast a series of plays depicting issues faced by women in Pakistani society, including domestic violence. It could also be concluded that such plays have created awareness and sensitivity about this issue.

Maintaining family dignity and women's mental health. Women were respected for receiving a loan by other members of the community as the recipients are seen to be reliable and trusted. Therefore, keeping and maintaining self and family dignity and integrity were considered a vital element for mental health. When women sought loans they felt more responsible to return it irrespective of who and how the loan was employed. This sense of responsibility was not only related to staying in the good books of the micro-finance records to receive future loans, but also to the women's belief that poverty is mediated by shame. Therefore, micro-finance loans helped the women maintain their dignity while living in poverty, but they also felt that the loan recovery process challenged that sense of dignity. As women in this study conceptualized mental health as the presence of peace and the absence of tension, protecting their prestige safeguards their mental health. The psychological impact of living in poverty has been the discussion of much literature (Lund et al., 2011), and recent studies recognize issues related to dignity and autonomy among this population (Mahmood et al., 2014). Narayan, Patel, Schafft, Rademacher, and Koch-Schulte (1999) studied the relationship between poverty and humiliation outside the context of micro-finance. Their unique findings pose two important questions: (a) if poverty causes shame and humiliation and influences an individual's mental health, would seeking a loan and being unable to make the timely payments place them under additional mental pressure and lead them to poor mental health?; and (b) what interventions are required by micro-finance institutions to help their loan recipients protect their family dignity?

Women's demographics and their mental health. Interpreting the study outcome in the light of major demographic variables will enhance the understanding of the phenomenon of mental health within a low-income cultural context. The findings illustrate the degree to which socio-demographic variables are associated with women's mental health outcomes. Among the 32 participants, those who reported experiences of poor mental health ranged from 38-57 years of age with a mean age of 40. This finding is consistent with other studies from Bangladesh and India, which indicated that women older than 30 were at risk for emotional stress. (Ahmed et al., 2001; Mohindra et al., 2008). A systematic review of women's mental health experiences and their participation in micro-finance programs, also speculated that older women might be at risk for stress and tension due to difficulty in adjusting to the new role of income generator and learning new skills (Madhani et al., 2015). However, this relationship between age and symptoms of stress and depression were not significant in a South African RCT (Fernald et al., 2008).

Education is one significant variable studied over time in relation to SES and mental health (Patel, Flisher, Hetrick, & McGorry, 2007; WHO, 2001). Results of the present study indicated that 63% of participants were exposed to at least some form of secular schooling, whereas only 50% had completed primary schooling. These women predominantly represented the group of women who either experienced a positive state of mental health or were hopeful for a positive future. Participants who recognized themselves in a poor state of mental health were mostly those who either had no basic schooling or had limited years of secular education. These findings suggest support for

the literature indicating illiteracy as a consistent factor for poor mental health (Patel & Kleinman, 2003). Studies in the context of micro-finance and mental health also indicated that attainment of high school (Mohindra et al., 2008), or having education greater than grade 12 (Fernald et al., 2008) are associated with less emotional stress as well as lower combined depression and stress symptoms respectively. Further, formal schooling of the household head was associated with less emotional stress (Ahmed et al., 2001).

Micro-finance programs generally target women who are marginally educated and for whom socio-cultural issues restrict their mobility (Holvoet, 2005). The demographic data for the participants of this study indicated that the majority of woman meet these criteria; however, one woman had a University degree and one had a high school diploma. This makes one wonder if micro-finance programs also attract women with improved educational backgrounds. Do women with higher education find micro-finance an attractive or easily attainable method to improve their SES by investing micro-finance loans? Mohindra et al. (2008) indicated that most of the women in their study had high school education. Although no possible reason was indicated for this, it was questioned if a high school diploma is a requirement for women to join certain micro-finance programs or whether women lacking a diploma may feel less competent and therefore choose not to join micro-finance memberships (Madhani et al., 2015).

Although the majority of participants in this study had a minimal level of education, the importance of seeking an education was echoed in the women's responses. Consistent with scholars examining the impact of micro-finance activities (Kabeer, 2001), women in the current study were inclined to educate their daughters. It is also noteworthy

that participants who had a marginal level of education but claimed to have a positive mental health indicated that additional years of schooling would have helped them do better in improving their SES, which eventually would improve their mental health as well.

Pakistan has been challenged over many years to improve its literacy rate. With a definition of "literacy" as the ability to both read and write and understand a short simple statement, UNICEF (2014) cites Pakistan's total adult literacy rate as 55%. This makes Pakistan 180th in literacy rate out of 221countries, falling after India, China, and Sri Lanka but above Bangladesh and Afghanistan (UNICEF, 2014). Pakistan had projected that by the year 2015, the adult female literacy rate for women aged 25 and over would be 45%, an increase from 40% in 2010 (UNICEF, 2013; UNICEF, 2014). Women in the current study were more highly educated than the general population as 50% had completed primary education. One possible reason was that the sample represented the urban population where there are more educational institutions as compared to rural part of the country, where almost 65% of the population resides.

The notion of being the head of the family or having a dominant role in decision-making is important and relevant to the socio-cultural context of Pakistan. Due to the male dominance in Pakistani society, males are usually considered the head of the family without much debate. Further, Pakistan is a Muslim country and as Islam places more responsibilities on males, including economic responsibility, males are therefore usually considered the head of the household (Dhami & Sheikh, 2000). An interesting finding of this study showed that 31% of female participants identified themselves as the household

head, either in the presence or absence of their male family member. When women defined themselves as the head of the household they considered their dominant role and contribution in economic improvement, as well as their role in family decision-making. Women who identified themselves this way utilized loans independently, half of them did not have any secular education, and they claimed to be in a state of positive mental health. An opposite outcome was revealed in a study in Bangladesh where the level of emotional stress was reported to be much higher among women micro-finance members who were perceived by their household head to be contributors toward household income as compared to non-contributors among non-members (Ahmed et al., 2001). Considering the scarcity of literature focussing on women's empowerment with their involvement in micro-finance, the notion of women's understanding of being the self-perceived household head is an important area for further discussion.

Studies conducted to examine women's mental health outcomes in the context of micro-finance determined that being divorced, separated or widowed; having more than three living children (Fernald et al., 2008); having family members with poor health status; a low level of schooling of household heads; and family in economic crisis place women at higher risk for poor mental health (Ahmed et al., 2001; Mohindra et al., 2008). These findings corroborate with the current study to an extent, where a larger family size and poor physical health status of a family member makes it difficult for many families to make ends meet. However, widowed women reported positive mental health as they have adapted to a role change over time.

From Stress to Strength

Coping is usually considered an outcome of positive mental health (Vaingankar et al., 2012). Despite multiple adversities, women recipients of micro-finance described many positive coping measures to reduce their tension and to promote mental peace. The practice of faith or religious rituals were the most consistent coping methods shared by the women. There is a growing interest in the field of psychology (Ano & Vasconcelles, 2005; Jones; 2004) and among health practitioners (Baldacchino & Draper, 2001; Ganga & Kutty, 2013; Koslander & Arvidson, 2007) in the influence of religion or spirituality on an individual's health and especially mental health (Borras et al., 2007; Corrigan, McCorkle, Schell, & Kidder, 2003; Ganga & Kutty, 2013). Turning to religion and praying more often during stressful situations has been found to have a strong positive correlation with indicators of mental health (Schuster et al., 2001; Snider & McPhedran, 2014). The findings of this study corroborate these findings as the women participants sought assistance from the divine being or Almighty by regular and additional prayers, reciting verses from the Quran or the Bible, singing religious songs, or visiting church during periods of adversity and mental stress.

It was commonly believed among the women that the practice of faith and keeping a strong trust in God or the Almighty relieved their tensions and helped them cope with the situation. Considering that "religion is based on belief" and there is "no objective proof" (Greenberg, 2013, p. 41), religious practices provide a sense of meaning and purpose during difficult life circumstances (Koenig, 2009). Regular practice of religious rituals and prayers were also considered important by participants to gain

strength and courage, facilitate acceptance of suffering, and provide a sense of indirect control over the situation (Koenig, 2009). When women shared experiences of coping through their religious practices, their sense of hope and courage were evident on their faces. However, some of the women indicated that their religious practices were their only option for coping, considering their limited resources. As Koenig (2009) explains, that religion is the only coping resource that "is available to anyone at any time, regardless of financial social, physical or mental circumstances." (p. 285).

There is consensus among the research focussing on religion and health, that people who belong to a faith community or are more deeply involved in religion have improved mental health as compared to individuals who are less involved in religion (Koenig, King, & Carson, 2012; Krause, 2015). The majority of the women in the current study felt that holding religious or spiritual beliefs positively influenced their mental health. The practice of religious involvement and seeking help from religion for physical recovery and psychological well-being is prevalent in Asian countries (Vaingankar et al., 2012). Pakistani nomads preferred to visit shrines and consult faith healers who are chosen by God for their mental health issues (Choudhry & Bokharey, 2013). Although they discussed the importance of faith, none of the study participants talked about visits to shrines or faith healers for their mental health promotion.

Some women did however raise the notion of fate, which is beyond their control, as a contributing factor for poor mental health. The belief in fatalism is the common understanding that adversity or hardship, and more specifically, "health, illness and even death are predetermined" (Heiniger, Sherman, Shaw, & Costa, 2015, p. 165), and that

individuals lack control over such issues in their lives (Neff & Hoppe, 1993). Although Pakistan scored the highest in the world on a measure of fatalism in an international survey (World Values Survey data, 2005, as cited in Acevedo, 2008), it was interesting to note that fatalism in terms of happiness and positive mental health was rarely shared by women in this study. Fatalism and its impact on health behaviours and health promotion has been studied in numerous studies and it is recognized in the context of cultural values and ethnicity. It is also recognized as a method of coping and of accepting things the way they when an individual's personal effort over the situation is not of much worth (Cheng, Sit, Twinn, Cheng, & Thorne, 2013). It could be said that belief in fate was also considered a measure of coping in addition to a source of tension among the women in the current study.

Some of the most commonly proposed mechanisms that influenced the women's health and well-being included the provision of family support, especially spousal support, and strong family dynamics. The significance of trusting and satisfying relationships have been well documented for subjective well-being (Keyes, 2002; WHO, 2004b) and quality of life (Becker et al., 1998). Women valued the importance of social support and networks, their personal attributes, positive emotions, and hope as indicated in previous studies (Armstrong et al., 2000; Keyes, 2002; Vaingankar et al., 2012). It is also important to note that the women encouraged other women to assume these qualities to achieve positive mental health.

Diener (2003) affirms that "coping is a strength, and good coping represents resilience!" (p. 115). There is considerable literature suggesting that adversities have

negative implications for mental health and overall well-being (Edwards, Holden, Felitti, & Anda, 2003; Lucas, 2007). However, despite this substantial knowledge, it is also believed that adversity promotes and builds resilience, which enables individuals to face future challenges with more courage and confidence (Seery, 2011; Seery, Holmon, & Silver, 2010). The Pakistani women's effective coping through resilience in the face of multiple adversities mirrors these findings. In the absence of consistent employment opportunities, ongoing geo-political conflicts, sectarian crime, and poor health and education institutions in the country, many of the loan recipients found ways to cope with their many life adversities. However, ongoing political and community violence have been found to place families and especially women and mothers at risk of mental health problems and maladjustment in coping strategies (Taylor et al., 2013). These finding resonate with the current study when a similar exposure to ongoing violence placed many women at risk of poor mental health. It could also be speculated that exposure to subsequent forms of major adversity and for a longer duration could cause these women to feel hopeless and a loss of control over their life, which influences poor mental health (Seery et al., 2010).

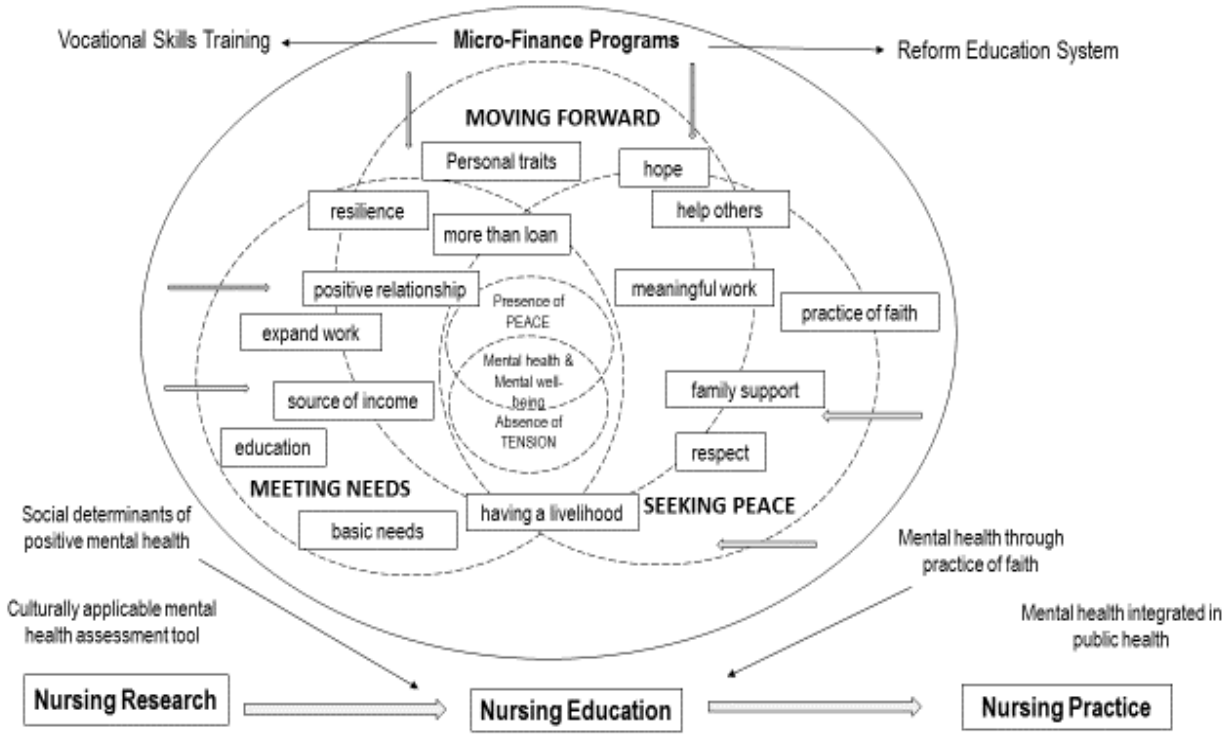
Study Implications

Within the paradigm of interpretive description, combining description and interpretation values both the "careful and systematic analysis of a phenomenon and an equally pressing need for putting that analysis back into the context of the practice field" (Thorne, 2008, p. 50). In the absence of a clear understanding of perceptions of mental health and the lack of clarity in the literature about the impact of micro-finance on

women's mental health, the evidence emerging from this study will inform public health policy and practice. Thus the practice goal of interpretive description to conduct research for solving complex health issues is addressed by this study (Sandelowski, 2000; Thorne, 2008; Viswanathan et al., 2004).

In response to the study findings of how mental health is understood and experienced by the 32 women in this study, it is deemed vital to design interventions that are essential and relevant to the needs of this population. The evidence gathered from this inquiry into the phenomenon of mental health and well-being highlights implications for nursing research, practice, and education. These implications contribute to the concept map (Figure 4), which was developed based on the findings of this study, to guide future nursing practice. The following section details these implications as they are integrated in the concept map in Figure 4.

Figure 4: Concept Map: Components, Relationship and Evidence to Practice for the Promotion of Mental Health and Well-Being



Nursing research.

The current study has resulted in a concept map which recognizes the perceptions, experiences, mental health needs, and coping strategies of a specific group of women who are loan recipients of two micro-finance programs. Although these women represent the average low-income woman in urban Pakistan, the findings from future studies with diverse samples could build on the evidence of the current study. Therefore, future research studies should include women from urban and rural settlements, with various SES and educational backgrounds, to fully understand the varied perspectives and

understandings of mental health among the Pakistani women population. These studies should aim at developing a socio-culturally appropriate mental health framework or assessment tool with indicators of positive mental health relevant for this population. The existing mental health tools are predominantly based on western constructions of mental health and well-being (Keyes, 2002). These models do not recognize the significant demands of meeting essential needs and the political instability that the women in this study face daily. Considering the influence of social determinants of health and especially their impact on mental health, a simple, culturally applicable, and measurable mental health tool must be established for use in nursing practice in Pakistan.

Further, considering the increased mental health burden around the globe and especially in low-income countries (Lund et al., 2011; Patel & Kleinman, 2003), mental health and particularly positive mental health should be examined to identify relevant and effective mechanisms for the promotion of positive mental health and well-being and thus preventing the increased prevalence of mental disorders (Patel, 2008). Studies in the field of mental health are primarily quantitative; future studies should include qualitative or mixed methods approaches for a broader understanding of this challenging yet crucial phenomenon.

In the process of this study, I was exposed to a substantial amount of literature. This experience made me recognize that empirical studies focussing on mental health are predominantly focussed on mental disorders or mental illness rather than mental health, mental well-being, and positive mental health. Among many such studies, study titles referred to “mental health,” but in fact discussed pathology or disorder. This begs a better

and clearer understanding of the concept of mental health distinct from mental illness, and one that considers mental health as a continuum with positive mental health at one end and mental illness or disease at the other (Keyes, 2002).

There is a considerable amount of literature on religion, spirituality and health in general and mental disorders specifically (Borras et al., 2007; Corrigan et al., 2003; Ganga & Kutty, 2013; Snider & McPhedran, 2014). Participants in this study claimed that the regular practice of religion or keeping trust in God gives them courage and strength to face adversity and hardship and reduce their tension. Considering the strong role of religious practices in mental health promotion among Pakistani women, this area needs further exploration from the point of view of this population, to support the development of evidence-based interventions. Keeping in mind that mental health needs in developing and low-income countries are often ignored (Patel & Kleinman, 2003; Patel & Thara, 2001), evidence generated from such studies will provide a promising avenue to include this topic in nursing education and practice in order to reduce future mental health burden in the country. In recognition of the importance of religious practices for mental health promotion and considering that nurses provide holistic care, the importance and applicability of religious or spiritual care in nursing should be examined among nurses as well.

The women participants in this study shared many examples of resilience as an asset for their coping. This notion needs further exploration especially among women from low income countries where they are the most vulnerable and considered at high risk for mental illness (Patel & Kleinman, 2003). Another reason to study this population is

because women have the major responsibility of raising future generations; therefore, it is important that women's overall well-being should be the utmost priority.

Nursing education.

As a discipline of art and science, nursing recognizes the provision of holistic nursing care, where humans are manifested as a unit of mind, body, and spirit (Calloway, 2007). In the existing nursing role in Pakistan, we have witnessed nurses performing remarkable work focussing on the physical health of individuals and communities through health promotion and disease prevention to preserve lives. In regard to mental health, nursing has predominantly been associated with the treatment of mental health disorders. However, the WHO's definition of mental health concentrates on an individual's ability to cope with the normal stresses of life and to lead a productive life by contributing to society and community (WHO, 2005a). The WHO (2002) urges the nursing profession to be the leader in mental health promotion efforts throughout the world.

Nursing education advocates for a transformed health care system, which requires the examination of educational practices and the creation of a new learning paradigm grounded in evidence (Lis, Hanson, Burgermeister, Banfield, 2014). Considering the increased burden of mental, behavioural, and psychological disorders, it is important to learn how mental health is understood in this discipline. The concepts related to mental health taught in the nursing curriculum are predominantly in reference to psychiatric disorders and are presented from a Eurocentric perspective. This results in an understanding of mental health that is limited to the context of illness and disorders with

western treatment modalities. What is missing here is the understanding of mental health in its positive context and culturally appropriate approaches to the promotion of mental health for individuals and communities that may or may not be at a risk to develop mental disorders. Therefore, it is important for nurse educators to revisit the way they understand and teach concepts related to mental health to nursing students, lady health visitors (LHV) and other health care providers. Jacob (2001) emphasised the need to shift and integrate mental health concepts in a broader focus on public health or community health. This will play a key role in incorporating mental health in primary health-care settings to cover a wider population. Further, research informs nursing education and practice, where culturally based understandings of perceptions of mental health are important to integrate into curricula so nurses can provide appropriate care. The provision of culturally competent care is an important, relevant, and effective component of current education practice in the health sciences (Shen, 2015). Hence, the mandate is to improve mental health assessment and strengthen the promotion of overall well-being in addition to disease prevention.

A significant finding of this study indicated that the practice of faith or religious ritual in general is a key method to promote mental health and well-being. Participants recognized the need for religious practice to reduce their mental tension. Nurses work in a profession that demands the provision of holistic care in a multi-faith, multi-cultural, and pluralistic society and so have additional responsibilities placed on them (Wilfred, 2006). This study suggests that the integration of concepts related to religion should not be limited to concepts like “last offices” or palliative care. As the practice of faith was a

significant coping measure for mental health promotion among the women in this study, nursing education should redesign the curriculum and address these necessary concepts in the overall health of patients. The integration of spiritual care in nursing education and practice will improve nurses' knowledge and confidence to meet their patients' needs.

Nursing practice.

Promotion of mental health demands diverse interventions. Firstly, the integration of mental health concepts in community and public health would enable a vital step for a reorientation of mental health education, practice and services by the changing focus from an "illness culture" towards the principles of mental health promotion (Hubka & Lakaski, 2013, p. 661; Jacob, 2001). In the Pakistani context, where LHVs play a significant role in the provision of primary health care in semi-urban and rural settlements (where 65% of the population lives) through home visitations, LHVs would integrate assessment and interventions related to mental health promotion, along with maternal and child health care, vaccination, sanitation, and birth control measures (WHO, 2008b). Women participants in this study shared their thoughts about what mental health means to them. While caring for this population and understanding their perceptions of mental health, it will be easier for nurses to plan culturally competent care for their overall health promotion strategies by including mental health needs as well.

Health is an interconnected state of both physical and mental well-being and because they share many of the same social, economic, and environmental determinants, one cannot be separated from the other (WHO, 2004b). The present study suggests that determinants of positive mental health for the women participants include social support,

resilience, practice of faith, and improvement of SES. Nurses should develop knowledge about and understand these links to support a scientific basis for developing positive mental health interventions (Carr, 2012; Wand, 2011).

Since nurses in Pakistan are now moving beyond the bedside and traditional nursing roles, they should be trained to lessen the "social effects of illness rather than on the illness in itself" (Volland, 1996, p. 313). This is particularly important, as the role of the social worker is absent in the country. Thus, as nurses work in a community health nurse role, besides focusing on the community assessment and health education, they should identify opportunities for educational awareness, specific to capacity building and economic skills building interventions (Hirani et al., 2010). Nurses should help women connecting with the NGOs, with the specific goals of improving the social determinants of health for this population and ultimately for the country. Further, these nurses should address the importance of issues that impact social determinants (such as, social support, unemployment, employment insecurity, safety and security, lack of health care). As well, they should work towards implementing realistic and achievable measures, which are congruent with the needs of this populations. For instance, nurses and LHVs in their home visitation should explore about women's social support, emotions and their responses, as well as their coping measures. These women should also be examined for their resilience and self-efficacy by establishing and implementing a culturally sensitive tools. It is fundamental that these nurses should help women in identifying measures as well as acknowledge their effort for the promotion of their mental health. This would place the focus of health promotion not only on the health outcomes of the social

determinants of health but rather on the actual determinants. Another area where nurses should move beyond their traditional role is being considered for and holding leadership positions in policy decision-making. This will provide the opportunity for a better understanding of and appropriate distribution of resources to address the complex pathways between mental health and social determinants of health (Hubka & Lakaski, 2013).

The findings from the study also suggest that HCPs should appreciate their patients' religious practices which are a resource for their healthy mental and social functioning and recognize those beliefs that are distorted and contribute to pathology (Koenig, 2009). Nurses should learn to address this dimension of holistic care and explore methods that would help meet their patients mental health needs.

Recommendations

The participants in this study had some recommendations for enhancing their mental health and well-being through changes in policy at the micro-finance program level and at the governmental level. The recommendations represented below include their views, as well as my own.

As poor SES and illiteracy limit individuals' efforts to make effective interventions to improve their live (Lund et al., 2011), emergent results stressed the need to create awareness among this population to develop courage and find ways to move forward. Micro-finance programs should play a significant role in creating such awareness. Through its theater and media, KF is creating awareness about many

culturally relevant issues. Other micro-finance programs and NGOs focusing on health and social issues should also move forward and reach out to the women of Pakistan.

The need for and the importance of vocational skills training were echoed by the women. There are many possible ways to meet this need for these and other women. The very basic approach would be for micro-finance programs to initiate affordable and accessible skills training institutions in locations which could serve a larger sector of loan recipient women. Secondly, it is important to note that women participants shared a high regard for and comfort with micro-finance programs and their staff. Therefore, considering that many training institutions already exist in Karachi, micro-finance programs should collaborate with those institutions, where women would be trained for skills that are in demand. Finally, the "women-to-women" approach was recommended. Micro-finance programs should connect with experienced female entrepreneurs who have skills and knowledge and who exhibit a positive attitude towards establishing training opportunities and mentoring other women who are novices in their skills. This attempt will "kill two birds with one stone." It is an effective way to assist entrepreneurs to advance their businesses as trainers and also to prepare novices with the skills and knowledge they require to move into the workforce. This would then improve women's self-efficacy and social support and, eventually, their positive mental health.

Recurrent political instability and sectarian violence has challenged Pakistan and placed the country at the very low end of achieving the MDGs (2015), which focus on eradicating poverty and achieving primary education as a minimum standard. Poverty was identified as the major indicator of poor mental health among participants of this study.

As well, Pakistan's marginal literacy rate, and yet the importance of and wish to access basic education among women demands that many stakeholders put serious thought into these crucial issues. Considering that Pakistan consistently has lacked resources for basic education, KF has established initiatives to reform the education system in the country by improving the capacity building of teachers at some private educational institutions (Kashf Foundation Annual Report, 2012-2013). In the absence of governmental action in this area, multinational companies and other micro-finance institutions could also develop innovative initiatives and implement effective interventions to improve the literacy level of the country.

The findings also suggest that micro-finance institutions consider providing health insurance to reduce the risk of its loan recipients moving into deeper poverty than their existing level in the event of a health crisis. This would reduce tension and worry and hence alleviate mental health issues. Further, micro-finance programs should revise their screening procedures for loan assignment and distribution. Since non-productive use of loans has been identified as a significant contributor to women's deeper entrenchment in poverty and poor mental health, micro-finance staff need to be vigilant in identifying the productive use of loans in their home visitations for loan provision and recovery. This is not to penalize loan recipients for non-productive use of their loans but rather to provide support, counselling, and direction for its effective utilization. The hope is that the productive use of the loans will eventually mitigate poverty and improve positive mental health outcomes.

Women in this study see economic stability, opportunity for education, access to health care and environmental safety as basic priority needs and precursors of mental health. As many of these determinants of mental health lie outside the health sector, addressing mental health promotion strategies requires the understanding, commitment, and collaboration of many stakeholders from many disciplines (Sturgeon, 2006). The WHO (2004b) affirmed that since "the activities of mental health promotion are mainly socio-political, including reducing unemployment, improving schooling and housing, reducing stigma and discrimination . . . , the key agents are politicians, educators, and members of NGOs" (p. 26), who should work as partners. It is therefore of utmost importance that mental health and its promotion be integrated with public policies and public health strategies. Government bodies and NGOs such as micro-finance programs should work collaboratively to identify strategies to address measures such as economic insecurity and poverty alleviation. Furthermore, there needs to be a focus on human rights with access to basic human needs and resources including health care and education for all citizens through the provision of a supportive infrastructure, capacity building, and implementation of required legislation for safety and security.

Strengths and Limitations of the Study

Strengths.

Considering the many hallmark features of interpretive description, such as theoretical scaffolding, purposeful sampling, data triangulation, maximum variations, constant comparative analysis and the application of findings to nursing practice, the selection of this methodology was an appropriate and compatible approach to answer my

research questions and to capture knowledge beyond the research questions (Thorne, 2008). Theoretical scaffolding enabled in identifying the existing knowledge and provided a frame of reference to develop the interview guide. Urban-dwelling women who were loan recipients of the micro-finance programs and micro-finance administrative personnel responsible for managing the programs, provided a purposeful sampling strategy. The diversity and heterogeneity of women's perceptions and experiences of their mental health was sought by employing multiple data types, obtaining data from two different micro-finance programs, which includes four different sites (i.e., one branch of KF and three branches of FMFB), and through varied years of participants' experiences in micro-finance programs (Thorne, 2008). The multiple data types allowed me to obtain an in-depth understanding of women's perceptions of mental health and well-being and experiences with their participation in a micro-finance program. I interviewed women who received loans from micro-finance and micro-finance personnel who were responsible for the screening and distribution and recovery of the loans. This study includes participants who were Muslim and Christian, which represent the predominant population of Pakistan, allowing for a broader understanding of the phenomenon of mental health and well-being within its context.

Observations of participants' non-verbal clues, gestures, and silences further brought insight in understanding their experiences of the phenomenon. A review of documents gave a comprehensive understanding of the micro-finance programs' missions and visions and the influence on participants' mental health and overall well-being. Field notes and reflective journals were maintained during data collection processes and an

audit trail was maintained throughout the study to clearly document the information gathered and modifications made during the study process. The constant comparative method and inductive analysis enhanced study rigour and generated new insights. Member checking was achieved by paraphrasing participants' statements or by seeking clarification after the completion of the discussion of each question or during the interview, if required. Every effort was made to achieve trustworthiness and to promote study rigour.

The flexibility in data analysis procedures of the interpretive description approach could be a challenge for a novice researcher; however, it increases the perspectives on qualitative data analysis and provides the researcher the luxury of choice. I sought regular and consistent guidance from the members of my PhD thesis committee, whose qualitative methodological expertise assisted me to ground the study in the voice of participants with full attention to endorsing study rigour. Data analysis in the source language preserved women's voices, avoided data wasting and distortion, and further enhanced the study credibility. Further, a portion of data was translated and double coded by my supervisory committee member and a list of categories in Urdu with an English translation and participants' verbatim expressions was shared with a qualitative expert who was bilingual and familiar with the participants' culture. These measures have strengthened the trustworthiness of the study.

This qualitative study is one of its kind in the context of micro-finance and in examining perceptions and experiences among Pakistani women. The knowledge and experiences shared by the participants have contributed to the existing literature about

definitions and perceptions of the mental health and well-being of Pakistani women. The study could also represent women in other low-income situations and might provide support for future studies in other countries. Previous studies in the field of women's mental health in the context of micro-finance are predominantly quantitative; however, the descriptive nature and qualitative research methodologies of my study means that it does resonate with the research of others. The study's focus on mental health and well-being in the context of micro-finance and the key findings highlighted here are relevant to knowledge in nursing.

Limitations

Along with study strengths, there are several limitations of this study that are important to note.

1. Participants were recruited from two different micro-finance institutions and had varied years of experience in a micro-finance program. However, the majority of the women who participated in the study were from FMFB and in their second year of a loan, and there were only three women who were in the first year of a loan. Further, there were women who had sought a loan previously from other institutions as well. Although, this brings maximum variation in sampling, the unequal representation of women in each year could have also resulted in the incomplete capture of their experiences of mental health in the context of micro-finance.
2. Although I received an encouraging response from KF during the recruitment process, many women were not able to return for interviews due to periodic city

crises and fear of travelling to the micro-finance office. If interviews for these women had taken place at another convenient location, the response rate for women representing KF would have improved.

3. All of the participants shared a positive understanding of mental health and well-being, as well as positive experiences of their mental health with the micro-finance program. They can thus be considered typical cases. Increasing and broadening the sample through recruiting women from other institutions or other branches of the selected micro-finance programs may have led to identifying atypical cases of the phenomenon of inquiry.
4. All of the interviews took place in a location mutually agreed upon by participants and myself, all were conducted in private, and confidentiality was assured; however, these interviews took place in the offices of micro-finance programs. The fear of being overheard, and its influence on any future loans, may have encouraged women to share only a positive view of the micro-finance programs. Perhaps their responses would have been different if they had been interviewed at their homes or at some neutral place.
5. A possible limitation could be that, the women were predominantly very positive about their initial experiences with micro-finance. Since women participants in this study were from varied years of their involvement in the micro-finance program, there may be a chance of recall bias while sharing their initial experiences especially among participants who were in their fourth and fifth year of a loan.

6. Measures were taken to maintain study rigour. However, in the absence of formal member checking and validation of a thoughtful clinician test, study dependability may have been affected to a certain extent.
7. In this study, women shared positive measures to cope with their mental pressure. This could be because of the way the question related to coping measures was asked. This question was asked in two different ways, depending on the discussion that preceded it. For instance, women were asked: "what do you do to reduce your tension or stress, you have just shared?" or "what measures do you take to promote your mental health?" Although many positive probes were suggested to explore additional responses, women shared only their positive coping mechanisms. It was important to note that there were a few women who were in the habit of using betel nut and Gutka (an intense form of tobacco), and reported this habit when inquired. They reported that these items make them peaceful and calm. This makes me wonder if my initial question should have been framed differently to encourage the women to share their habits of using betel nuts and Gutka, and possibly other coping strategies. Probes seeking negative coping measures could have been included to seek these types of coping strategies.

Dissemination of study findings

No study is complete until the findings are shared and relevant measures are introduced. This study demands many stakeholders to play an active role in the mental health promotion of Pakistani women. First of all, the study findings will be shared with the study participants. Only two micro-finance loan recipient women shared their interest

to learn about the findings. These women will be contacted via cell phone for the information to be shared. Secondly, a report of the study findings and recommendations specific to the micro-finance programs will be shared with both the participating microfinance programs: Kashf Foundation and the First Microfinance Bank. Thirdly, to improve the practice in the health care settings in Pakistan, a brief report including study outcomes and pertinent interventions related to the promotion of mental health will be shared with the Ministry of Health of the Government of Pakistan. Further, measures such as transformation of nursing curricula will be recommended to the Pakistan Nursing Council through a report or a presentation. Finally, dissemination of this study findings would also be undertaken with manuscripts published in scholarly and scientific journals.

Conclusion

This interpretive description of Pakistani women's perceptions and experiences of their mental health in relation to their participation in a micro-finance program adds to our evolving knowledge. It provides an understanding of what constitutes perceptions of women's mental health among micro-finance loan holders, many of whom live below the poverty line. The study provides insights into which elements underlie the women's mental health, influence their peace, and assist them to promote their mental health and overall well-being.

These findings are largely congruent with published work reporting perceptions of mental health among varied populations and experiences in the context of micro-finance. Peace was the term used consistently for mental health, and poverty was reported as the most common determinant of poor mental health. The practice of faith, engagement in

meaningful work, social and family support, and positive thinking, courage, hope, and resilience promote effective coping and mental health. Many of the women in the study showed how they have become aware of new opportunities, have become empowered, and are challenging the status quo in terms of gender roles. Through attaining loans, they have become economically independent, they have the respect of their families and neighbours, they have the capacity to support education for their girl children, and they are showing the next generation another role for women within society. Through their resilience and courage, they have not only improved their own mental health, they are reflecting a new Pakistani woman. It is important to recognize that these are the "everyday women" of Pakistan. Their demographics reflect those of the average Pakistani women, but through their own resilience and the support of micro-finance institutions and their families, they can and do thrive.

There is a general consensus in the literature that saving and credit services are succeeding in poverty alleviation among poor women. Along with many other small studies, this study suggests that micro-finance as the sole intervention is not adequate to fight the long-standing issue of poverty. Financial services of micro-loans, along with vocational skills training, would assist women to utilize their loans in profitable income-generation activities to mitigate poverty. This then brings them peace and reduces a major source of mental tension among this population.

This study also contributes to nursing research, practice and knowledge by exploring understandings of mental health and the experiences of women from Pakistan as a low-income country. Detailed knowledge and in-depth understandings of the

phenomenon will create a new learning paradigm and encourage transformation in nursing curricula specific to mental health and well-being from the current curative medical model based in pathology. Development of a culturally based assessment tool with positive indicators, through future research, will provide nurses and lady health visitors the opportunity to follow mental health promotion along with the indicators of primary health care in hospital as well as community settings.

Poverty is described as the greatest cause of suffering on earth by the WHO (1995c). People with low SES are more likely to be exposed to more stressors and have fewer resources to manage them (Patel & Kleinman, 2003; Patel, 2008). Countries with poor resources view mental health needs as the lowest priority as compared to physical needs (Jacob, 2001). However, when the ability to meet basic physical needs, is compromised, individuals and communities are put at a greater risk of poor mental health. Pakistan, being a poor, developing country with a limited budget for basic health and the added challenges of political unrest, has a long way to go to achieve many of the MDGs in years to come. The country will celebrate 70 years of independence in 2017. This is the time for thoughtful planning, intensive interventions and the provision of appropriate resources for poverty reduction and health, under a candid leadership for a promising future for the country and its people.

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Appendix 1: Characteristics of Corey Keyes Multidimensional Model of Mental Health and Well-Being

Hedonic Well-Being	**Eudaemonic Well-Being**	
Subjective well-being	Functional well-being	
Emotional wellbeing	**Psychological well-being**	**Social well-being**
Positive Affect feels happy, cheerful, in good spirits, calm & enthusiasm	Self-Acceptance holds positive attitude toward self and past life; and accepts varied aspects of self	Social Contribution feels that one's own life is useful to society; one's activities is valued by others
Life Satisfaction experience a sense of satisfaction with life in general or specific areas of one's life	Environmental Mastery exhibits the capability to manage a complex environment; & create environment to one's needs	Social Integration have a sense of belonging to a community; feel supported & drives comfort from the community
	Purpose in Life have goals and beliefs that affirms one's sense of direction in life; & feels that life had a purpose & meaning	Social Actualization believe that people, social groups, & society have potentials; & can evolve or grow positively
	Personal Growth shows insight into one's own potential; have a sense of development; & open to new and challenging experiences	Social Acceptance have a positive attitude towards others while acknowledging & accepting people's differences & their complexity
	Autonomy exhibits a self-determining individual; actions are guided by socially accepted & conventional standards; & evaluate self by personal standards	Social Coherence demonstrates interest in society or social life; feels that society is intelligible, logical, predictable, & meaningful
	Positive Relationship with Others have warm, satisfying, trusting relationship; & being capable of empathy and intimacy	

Note: Adapted from Keyes (2002); Westerhof & Keyes (2010)

Appendix 2: Script at First Contact with Women Participants

Script: Aslalam-O-Alikum
My name is Farhana Madhani, I am a nurse and a faculty member at the Aga Khan University School of Nursing and Midwifery in Karachi, Pakistan. Presently, I am pursuing higher education i.e. PhD in nursing and as an expectation of this degree I am doing a research.

The purpose of this study is to examine the perceptions and experiences of mental health and well-being among urban-dwelling, Pakistani women who are participating in micro-finance programs. This study will also explore how participating in micro-finance program impacts your mental well-being and the strategies women like you use to promote their mental well-being. Ultimately, the overall purpose for conducting this study will be to identify recommendations for changes and enhancements to existing micro-finance programs to improve women's overall mental health and well-being.

I hope that what is learned as a result of this study will help us to better understand how seeking loans from micro-finance influence women in achieving their mental health and well-being. Further, lessons learned from this study will be shared with micro-finance programs in order to initiate modification in program policy to better serve female clients who are their loan recipients. Information shared with micro-finance institutions will be reported in a summarization format and no reference will be made to your ideas or comments.

If you are willing to participate in this study, I will be asking you some basic information about you and your participation in micro-finance program. The information obtained from you will be kept confidential and will assist in determining if you are eligible to participate in the study. Your decision whether or not to be part of the study will not affect your continuing access to micro-finance services. You may opt not to respond to any one or all of the questions. Do you have any questions at this point?

May I ask you few preliminary questions to determine if you are eligible to participate in this study?

If the woman's answer is Yes, I will ask questions from the inclusion screening questionnaire

If woman is eligible, I will read out letter of information and consent to seek her willingness and verbal consent to participate in the study.

If woman respond in No, Thanks for taking out time to talk to me, if you decide to participate in this study, you may contact me on my cell number 0300-707-2980.

Thank you, once again

Appendix 3: Inclusion Screening Questionnaire for Women Participants

This form will be completed for women loan recipients of micro-finance (MF) to identify their eligibility as a study participant and who are willing to participate in the study.

Script: Aslalam-O-Alikum
I will be asking you some basic information about you and your participation in micro-finance program. The information obtained from you will be kept confidential and will assess if you are eligible to participate in the study. Your participation is completely voluntarily and you may opt not to respond to any one or all of the questions.

Participant's name: _____

Name/s of MF organization currently involved in:_____

Years of experiences with micro-finance: _____

Numbers of loan received to date: _____

Exposure to any training from MF or elsewhere: Yes/No_____

If yes, names, year, duration and relevant details of training:_____

_____

Able to speak Urdu: Yes/No _____

Contact details: (more than one):_____

Interviewer Notes:

Participant eligible: 1~ Yes 2~No

If eligible why?: _____

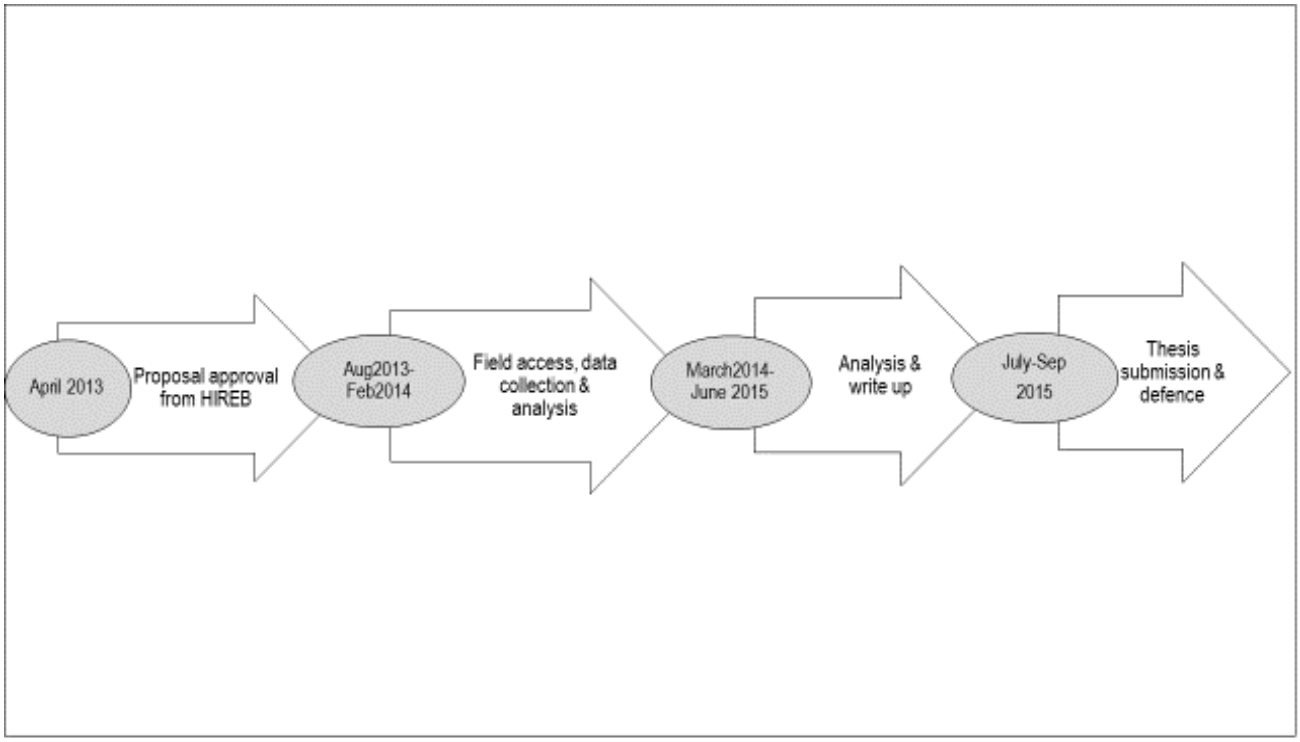
If not eligible why?:_____

If eligible pseudonym/study ID? _____

Appendix 4: Contact Sheet and Interview Schedule

Name	Interview date/time	Location	Cell #	Alternate #

Appendix 5: Project Timeline



Appendix 6: Semi-Structured Interview Guide for Women Participants

Script: Aslalam-O-Alikum

My name is Farhana Madhani, I am a nurse and a faculty member at the Aga Khan University School of Nursing and Midwifery in Karachi, Pakistan.

Thank you for taking the time to talk to me today. The purpose of this study is to examine the perceptions and experiences of mental health and well-being among urban-dwelling, Pakistani women who are participating in micro-finance programs. This study will also explore how participating in micro-finance program impacts your mental health/well-being and the strategies women like you use to promote their mental health/well-being. Ultimately, the overall purpose for conducting this study will be to identify recommendations for changes and enhancements to existing micro-finance programs to improve women's overall mental health and well-being. I will be seeking some information from you about your perception of mental health/well-being and experiences with your micro-finance program overtime. The information obtained from you will be kept confidential, your participation is completely voluntarily and you may opt not to respond to any one or all of the questions.

Study ID	
Interview Date	
Length of Interview	
Need for additional interview	
Any comments	

1. **Background information:** As you have mentioned earlier, you are a loan recipient of FMFB/Kashf (name of a micro-finance program, participant is a member) for the last few years (number of years, participant is a member). Can you share your experience of how you or your family came to know about FMFB/Kashf (name of relevant micro-finance program) and you initially got involved.
2. **Perceptions and experiences of mental health/well-being:** There are many different ways to describe mental health/well-being; I would like to ask you a few questions related to your perception of mental health/well-being.

2.1 What is your understanding of the term mental health/well-being?/ What comes in your mind when you hear the term "mental well-being"?

2.2 What does mental health/well-being mean to you personally?/How do you describe your own mental well-being?

3. **Mental health/well-being and micro-finance:** Having been involved in micro-finance programming for a while now (personalized from demographic data), I would like to ask a few questions related to the impact of micro-finance on your mental well-being.

   3.1 In your opinion, in what ways and how has being a micro-finance loan recipient impacted your mental health/well-being over a period of time?/ How does this additional responsibility of participating in micro-finance program for economic purposes influence your mental health/well-being?

   3.2 In your opinion, what has been the most significant role that micro-finance program has played to enhance or challenge your mental health/well-being? (Probes: How? In what ways? What made you say this?)

   3.3 As a result of your participation in the micro-finance programs, have there been any negative impacts of this experience on your mental health/well-being? (Probes: How? In what ways? What made you say this?)

4. **Promotion of mental health/ well-being:** There are many different ways to promote mental well-being, now I would like to ask you:

   4.1 In your opinion what promotes your mental health/well-being?/ What strategies help you to promote your mental well-being?

   4.2 Please describe what roles your spouse and family members have played/playing towards your mental health/well-being in general and in the context of micro-finance in particular? (avoid "spouse" if women is single, divorce or widow).

   4.3 Based on your response to previous questions, what recommendations would you suggest to micro-finance programs to enhance your experience as a loanee and encourage your ongoing participation?

5. Is there anything else you would like to share with me about your mental health/well-being or your experience with micro-finance?

Appendix 7: Demographic Questionnaire and Semi-Structured Interview Guide for Micro-Finance Personnel

Script: Aslalam-O-Alikum.

My name is Farhana Madhani, I am a nurse and a faculty member at the Aga Khan University School of Nursing and Midwifery in Karachi, Pakistan.

Thank you for taking the time to talk to me today. The purpose of this study is to examine the perceptions and experiences of mental health and well-being among urban-dwelling, Pakistani women who are participating in micro-finance programs. This study will also explore how participating in micro-finance program impacts their mental health/well-being and the strategies they use to promote their mental health/well-being. Ultimately, the overall purpose for conducting this study will be to identify recommendations for changes and enhancements to existing micro-finance programs to improve women's overall mental health and well-being. Since you are one of the key informants of distributing and receiving these loans at MF I will be seeking some information from you about your experiences.

Study ID	
Interview date	
MF programs and Years of Experience	
Current role, responsibility, years in current role	

1. **Roles of MF:** Although we understand that MF plays a significant role in poverty alleviation, I would like to ask you to elaborate on how you think your MF program (state name of the respective MF institution) is helping its female clients apart from poverty alleviation?
2. **Opportunities and Challenges:** Since you have had the experience of working with female clients who are loan recipient of MF, please share your views in terms of opportunities and challenges these female clients are or may be facing in receiving and returning loans?
3. **Recommendations:** Based on some of the challenges you have mentioned, please discuss what recommendations you may suggest to 1) these female clients and/or 2) organizational policymaker for future practices that may improve female participation in MF and enhance their mental well-being?
4. Do you want to share any other information specific to the topic we talked about?

Appendix 8: Letter of Information/Consent for Women Participants

Study Title: Participation in Micro-Finance programs and women's mental health and well-being in Karachi, Pakistan: An Interpretive Descriptive study

Investigators:

Principal Investigator:
Dr. Catherine Tompkins
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Student Investigator:
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Purpose of the Study:

I am doing this study as a part of my PhD thesis requirement. The purpose of this study is to understand the views and experiences of mental health and well-being among urban-dwelling Pakistani women who are the loan recipients of a micro-finance program for a period of 1 to 5 years. This study will also explore the coping responses these women use to maintain and promote their mental health/well-being.

As you are one of micro-finance loan recipients, you are invited to take part in this study. I hope that what is learned as a result of this study will help us to better understand how seeking loans from micro-finance influence women in achieving their mental health and well-being. Further, to initiate modification in micro-finance program policy to better serve female clients who are their loan recipients.

Procedures involved in the Research:

If you are willing to participate in this study, you will be interviewed by me. I will ask you for information such as your age, education, employment history and number of loans received from micro-finance institutions. I will also be asking your understanding and experiences of mental health and well-being and how participation in micro-finance has influenced your mental health and well-being. The duration of the interview may vary between an hour and a half to two hours and will be carried out at a place and time convenient to both of us. During the interview I will take notes and will audio-tape the interview with your permission. You can refuse audio taping of the interview if you prefer. The information provided by you during the interview will be kept confidential and will only be used for this study. You may decide not to respond to any one or all of the questions.

Potential Harms, Risks or Discomforts:

You should be aware that there are no risks involved when you take part in this study.

However, you may feel uncomfortable or uneasy or may worry or find stressful to respond to some of the questions. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable, and you can withdraw or stop taking part at any time.

Potential Benefits:
By participating in this study you could help us to inform and suggest micro-finance programs some actions or measures that may promote mental health and well-being of Pakistani women like you. You should be benefit in future with modification in micro-finance program policy to better serve female clients who are their loan recipients.

Payment or Reimbursement:
There is no financial compensation to participate in this study. However, a small token in a form of either a calculator, a saving box or account monitoring book will be offered to you. In addition, transport fare will be reimbursed if the interview is taken place away from home.

Confidentiality:
Your participation in this study will be confidential. No one but me will know whether you participated, I will not use your name or any information that would allow you to be identified. I will make every effort to protect (guarantee) your confidentiality and privacy. Study findings in a form of a summary report will be shared with micro-finance institutions, however your identity (name) will not be disclosed, and I will use fake names if your quotes and story are shared. The information you provide will be kept in a locked cabinet where only I will have access to it. Information kept on a computer will be protected by a password. Once the study has been completed, the data will be destroyed.

Participation and Withdrawal:
Your participation in this study is voluntary. Your decision whether or not to be part of the study will not affect your continuing access to micro-finance services. It is your choice to be part of the study or not. If you decide to be part of the study, you can withdraw from the interview for whatever reason, at any time, even after signing the consent form. If you decide to withdraw, there will be no consequences/penalty to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results:
I expect to have this study completed by approximately June, 2014. If you would like a brief summary of the results, please let me know how you would like to be informed.

Questions about the Study
If you have questions or need more information about the study itself, please contact me at:

Farhanairfan24@gmail.com, 0300-7072980.

This study has been reviewed by Hamilton Integrated Research Ethics Board and the Aga Khan University and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

Office of the Chair of the Integrated Research Ethics Board
Telephone: (905) 521-2100 ext. 42013
c/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by
  Farhana Madhani (PhD student) and her supervisor Dr. Catherine Tompkins of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____

Name of Participant (Printed) _____

1. I agree that the interview can be audio recorded.
… Yes.
… No.

2. …Yes, I would like to receive a summary of the study's results.
Please inform me in person _____
Or by contacting this phone # _____
Or send them to this email address _____
Or to this mailing address: _____

… No, I do not want to receive a summary of the study's results.

3. I agree to be contacted for a follow-up interview, and understand that I can always refuse the request.
... Yes. Please contact me at: _____
... No.

Appendix 9: Letter of Information/Consent for Micro-Finance Personnel

Study Title: Participation in Micro-Finance programs and women's mental health and well-being in Karachi, Pakistan: An Interpretive Descriptive study

Investigators:

Principal Investigator:
Dr. Catherine Tompkins
Associate Dean Health Science
Director, School of Nursing
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 22400
E-mail: (tompkins@mcmaster.ca)

Student Investigator:
Name: Farhana Madhani
Department of Health Sciences
School of Nursing
McMaster University
Hamilton, Ontario, Canada
(289)788-2294
E-mail: (madhanfi@mcmaster.ca)
(farhanairfan24@gmail.com)

Background and Purpose of the Study:

It is know that Micro-Finance is considered a tool in the developing world to reduce poverty. Women in particular, spend more of their income than men on their household and improving family welfare. Much is known about women's roles in poverty alleviation through micro-finance activities, however little is known about its association with women's mental health and well-being in general and Pakistan in particular. Therefore, the purposes of this study are three fold. Firstly, to describe and interpret the perceptions and experiences of mental health/well-being among urban-dwelling, Pakistani women participating in micro-finance programs. Secondly, to explore the strategies these women use to promote their mental health/well-being and finally, to identify recommendations for changes and enhancements to existing micro-finance programs to improve women's overall mental health and well-being.

I am doing this study as a part of my PhD thesis requirement. I hope that what is learned as a result of this study will help us to better understand how seeking loans from micro-finance influence women in achieving their mental health and well-being. Further, lesson learned from this study will be shared with micro-finance programs in a summary report in order to initiate modification in program policy to better serve female clients who are their loan recipients.

You are invited to take part in this study as a key informant who has the experience of working at _____ (name of micro-finance institution) for more than three years. If you are willing to participate in this study, you will be interviewed by me. I will ask you for information the program, context and the services your micro-finance institution provides. You will also be asked to share your experiences and observations in terms of opportunities and challenges women loan recipients' experience, and the support provided to these women by your micro-finance institution.

Consent

1. I have read the information presented in the information letter about a study being conducted by
   Farhana Madhani (PhD student) and her supervisor Dr. Catherine Tompkins of McMaster University.
2. I understand that my participation in this interview is voluntary and there are no monetary benefits to participate in this study.
3. I understand that if I agree to participate in this study, I may withdraw from the study at any time.
4. I understand that I will be interviewed and ask questions about the program and services _____(name of the micro-finance institution) provides and my experiences of working with women who are its loan recipients.
5. I understand that the duration of the interview may vary between 45 minutes to an hour.
6. I have the right to not answer any question I don't like or to stop the interview and withdraw my answers, at any stage of the interview, without having to explain why.
7. I understand that what I say will be kept confidential by the researchers and will only be used for this research purposes. My name will not be used in any research reports and nothing will be published that might identify me.
8. I agree to some of my comments or statements being quoted in the report, provided that I cannot be identified. YES / NO
9. I agree to the interview being audio recorded. YES / NO
10. I agree that interviewer will take notes during the interview. YES/NO
11. I expect to have this study completed by approximately June, 2014. I would like to be informed about the key finding through a presentation or a report. YES / NO
12. I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
13. I understand that if I have any further questions I can contact one of the researchers listed on the information sheet
14. I have been given a copy of this form.
15. I agree to be contacted about a follow-up interview, and understand that I can always decline the request YES/NO. Please contact me
    _____

Signature: _____

Name of Participant (Printed) _____

Questions about the Study

If you have questions or need more information about the study itself, please contact me at:
Farhanairfan24@gmail.com, 0300-7072980.

This study has been reviewed by Hamilton Integrated Research Ethics Board and the Aga

Khan University and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

Office of the Chair of the Integrated Research Ethics Board
Telephone: (905) 521-2100 ext. 42013
c/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

Appendix 10: Demographic Questionnaire for Women Participants

This form will be completed for all the eligible participants identified through screening questionnaire and who are willing to participate in the study.

Study Purpose:

Script: Aslalam-O-Alikum
I will be asking you some basic demographic information about you and your family. The information obtained from you will be kept confidential, your participation is completely voluntarily and you may opt not to respond to any one or all of the questions.

Study ID:_____

1. How old are you? |____|____| years
2. Have you ever had formal schooling? 1. Yes 2. No (skip to 3)

2a. How many years of formal schooling |____|____| years

3. Have you had any type of informal education? 1. Yes 2. No – (skip to 4)

3a. What type (mark all that apply)

1. Madrassa 2. Adult Literacy 3. Home schooling 4. Self learnt (reading)

5. Self learnt (reading & writing) 6. Learnt quran

7. Other (specify)_____

4. What is your mother tongue (Choose one)

1. Sindhi 2. Urdu 3. Punjabi 4. Marwari 5. Saraiki 6. Pushto

7. Balochi 8. Other (specify):_____

1. What is your marital status: 1. Single 2. Married 3. Divorced

   4. Widow 5. Others_____
2. Total number of children:_____

   6a. Number of girls_____ 6b. Number of boys_____
3. How many people live in your household: |____|____|
4. Who is the head of the family(relationship with participant):_____
5. What is your status in the family(in terms of relationship among other family members who live in the same house-hold): (mark all that apply)

1. Wife 2. Mother 3. Daughter in-law 4. Mother in-law 5. Sister

6. Sister 7. Others_____

6. How many years have you been a recipient of a micro-finance loan: |____|____|
7. What kind of loan scheme are you involved in:
   1. Individual 2. Group 3. Others_____
8. How many loans have you received from MF:_____
9. How many repayments have you made:_____
10. When you receive the loan, who uses the money:
    1. Self 2. Husband 3. Other family member/s (relationship)_____
11. Please describe how the loan money is being used: _____
    _____
12. Please describe the work you do for economic generation: _____
    _____
    _____
13. Have you ever received loan/s from MF for some other purpose (other than economic purpose):
    1. Yes 2. No – (skip to 16)
    If yes, please describe the reason:_____
    _____

24. Are there any other family member/s living in the same household who are the recipients

of MF loans besides you: If yes,

what is your relationship with the person:_____

Question added after pilot:

1. Have you taken loan from other institutions in past or presenting taking: If yes:

Please tell me since how long and if you are still taking loan?

Appendix 11: Summary Sheet for Field Notes

Date and day of field visit:_____

Starting and ending time:_____

Placement: _____

Activities	People involved	Actions/behaviors	Purposes	Outcomes	Other observations

The following questions assisted in making observations and taking field notes:
What activity is going on?
Who are the people involved in?
What are their actions and why?
What are their behaviors?
What is the purpose?
What is the outcome?
What emotion felt and expressed?
What does the surrounding look like?
What is the sequence of activity that takes place overtime?
What are the other observations?

Appendix 12: Summary Sheet for Reflection

Interview digital code	Positive Indicators	Areas of Improvement	Comments

Questions or areas to follow while listening to recording:

1. How was the introduction?
2. What was asked?
3. Framing of the question?
4. Any Red flags?? Signs or Non-verbal cues?
5. What were the interruptions?
6. What actions were carried out?
7. How was participant's reaction?
8. Lead and Follow up questions?
9. Summarization and paraphrasing?
10. Closing Remarks?

Appendix 13: Summary Sheet for Documents

Document name &Year of Publication	Purpose	Relevance with mental health	Comments

The following questions assisted in review of micro-finance reports, booklets and summaries:

1. What is the purpose of the document?
2. How is it related to study-phenomenon-mental health and well-being?
3. What are the similarities with participants' (women and MF personnel) description and documents?
4. What are the differences with participants' descriptions and documents?
5. What are the additional points, did not discuss by women participants or MF personnel?
6. Usefulness of document to the study (yes, no)?

Appendix 14: Letter of Approval from Hamilton Integrated Research Ethics Board

Hamilton Health Sciences

McMaster University
Inspiring Innovation and Discovery

St. Joseph's Healthcare Hamilton

Hamilton Integrated Research Ethics Board (HIREB)
293 Wellington St. N., Suite 102, Hamilton, ON L8L 8E7
Telephone: 905-521-2100, Ext. 42013
Fax: 905-577-8378

April 15, 2013

PROJECT NUMBER:	**13-195**
PROJECT TITLE:	Participation in Micro-Finance Programs and Women's Mental Health and Well-Being in Karachi, Pakistan: An Interpretive Description
PRINCIPAL INVESTIGATOR:	**Farhana Madhani**
LOCAL PI:	**Dr. Catherine Tompkins**

This will acknowledge receipt of your letter dated April 8, 2013 which enclosed revised copies of the Information/Consent Forms along with response to the additional queries of the Board for the above-named study. These issues were raised by the Hamilton Integrated Research Ethics Board at their meeting held on March 19, 2013. Based on this additional information, we wish to advise your study has been given ***final*** approval from the full HIREB.

The following documents have been approved on both ethical and scientific grounds:

- The submission,
- Study Protocol version dated April 8, 2013
- Information/Consent Form for Women Participants version 2 dated April 1, 2013
- Information/Consent Form for Micro-Finance Personnel version 2 dated April 1, 2013
- Contact Sheet
- Telephone Script/Script at First Contact with Women Participants
- Inclusion Screening Questionnaire for Women Participants
- Semi-Structured Interview Guide for Women Participants
- Demographic Questionnaire for Women Participant
- Demographic Data Questionnaire and Semi-Structured Interview Guide for Micro-Finance Personnel
- Summary Sheet for Field Notes
- Summary Sheet for Documents
- Time Line and Activity Chart

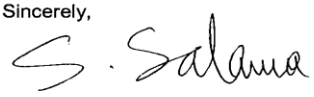
Please note attached you will find the Information/Consent Forms with the HIREB approval affixed; all consent forms used in this study must be copies of the attached materials.

The Hamilton Integrated Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; for studies conducted at St. Joseph's Hospital, HIREB complies with the health ethics guide of the Catholic Alliance of Canada

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HIREB meeting on March 19, 2013. Continuation beyond that date will require further review and renewal of HIREB approval. Any changes or revisions to the original submission must be submitted on an HIREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

PLEASE QUOTE THE ABOVE-REFERENCE PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,



Suzette Salama PhD.,
Chair, Hamilton Integrated Research Ethics Board

HIREB #: 13-195