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From Stigma to Support: Mental Health and Community Engagement in Pakistan

Khadija Tariq Khan [1] Muhammad Jazib Niaz [2]

[1] Visiting Lecturer, Department of Social Work, University of the Punjab, Lahore, Punjab, Pakistan.
Email: Khadija.dsw@pu.edu.pk

[2] M.Phil. Scholar, Department of Social Work, University of the Punjab, Lahore, Punjab, Pakistan.
Email: mjazibniaz@gmail.com

Corresponding Author: Khadija Tariq Khan
✉ Khadija.dsw@pu.edu.pk

ABSTRACT: Mental health conditions are one of the greatest and increasing national health problems in Pakistan, and access to proper services is also critically low. This review synthesis summarizes the available evidence on psychiatric disorders prevalence, barriers to care in the form of structure and cultural factors, and how community-based interventions can help to close these gaps. The systematic search report was conducted in PubMed, Web of Science, Scopus, medRxiv, and institutional resources, including WHO and national reports, which were published between 2015 and 2025. The results have shown that approximately one-third of adults in Pakistan have a common mental disorder, with women and adolescents being their disproportionate victims. The lack of mental health professionals, low budgetary allocation and fragmented provincial governance are some of the limitations on the delivery of services. The stigma, supernatural explanatory beliefs and gender restrictive norms among the cultural barriers contribute more to discouragement of help seeking. With these obstacles, community-based interventions such as task-shifting to Lady Health Workers, digital mental health, school-based, and interaction with faith leaders show potential results. There is, however, limited evidence on sustainability, scalability, equity and cost-effectiveness. Developing community-based and culturally-sensitive mental health is the first step towards the provision of equitable and sustainable care in Pakistan.

KEYWORDS: Digital Mental Health, Stigma, Community Participation, Healthcare Integration, Mental Health Policy

Introduction

Mental health is a central component of the population health and affects personal well-being, social performance, and economic capacity as well as provide resilience to environmental disturbances like natural disasters and pandemics. Common mental disorders, including depression, anxiety, and substance use disorders, are widespread in low- and middle-income countries (LMICs), like Pakistan, and there are scarce resources and conflicting health needs (Irfan, 2021). More than 240 million population of Pakistan is vulnerable to complicated integration of risk factors that may result in poor mental health, like persistent poverty, food insufficiency, recurring natural calamities, forced internal migration, conflict-stricken communities, gender disparities and limited awareness of mental health (Ali, 2025; Dayani et al., 2024).

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Existing national and regional publications, evaluation reports, and evidence-based research indicates the immense unmet need, prolonged lifespan, and point prevalence of psychiatric conditions are reported by morbidity indicators, and manpower and financial indicators reveal acute shortfalls (Rahman et al., 2024; World Health Organization, 2021). Despite these systemic shortcomings, there has been a robust growth of community-based strategies of mental-health in Pakistan.

Governmental and non-governmental efforts have attempted to decentralise mental-health services by integrating these services with primary-care and community-health-worker programmes, introducing telephone helplines, and the pilot introduction of digital counselling platforms. At the same time, civilisation-society and faith-based organisations are mobilised both on raising awareness and psychosocial support, especially when it comes to climate-related disaster and the COVID-19 pandemic (Akhtar et al., 2025; Knowledge Action Portal, 2021).

However, the social fabric with stigma, family decision making and explanatory models which, in many cases, attribute suffering to the supernatural is an influential factor in help seeking behaviour and continuity in treatment (Khan & Irfan, 2023; Daraz et al., 2025). The questions that policy-makers and implementers have to answer are: Which community-engagement strategies prove to be better in accessing and achieving better results? What are some ways of culturally modifying interventions to reduce stigma without disconnecting communities? And what is the best way to use finite resources of specialists with the help of task-sharing and online means?

Aim and Objectives

The purpose of this review is to compile the current evidence (2015-2025, and primarily the most recent national and programmatic data) regarding the prevalence and accessibility of mental health, as well as the stigma and supportive support systems provided by the community in Pakistan. The specific objectives of this study are:

1. Estimates of the burden of mental disorders at the population level: Summarize and describe health-system capacity and financing of mental health.
2. Examine cultural and social factors of stigma and help-seeking among Pakistani communities.
3. Identify and evaluate community engagement strategies (task-shifting, helplines, school and faith-based programs, digital interventions) and how they have been shown to be effective, equitable and scalable.
4. Determine methodological gaps and suggest research and policy priorities to enhance available, culturally congruent mental health services that are community-based.

Methodology

Design and reporting

The systematic review follows the best-practice guidelines of narrative and systematic syntheses, wherein transparent search and selection guidelines, dual screening when possible, and a rather well-structured summary of quantitative and qualitative data are explicitly used. It focused on the evidence based on nationally representative surveys, rigorously peer-reviewed intervention trials, implementation-evaluation studies, official policy documents, and methodologically sound grey literature sources, including WHO country-specific publications and national governmental action plans, where available. The review

methodology is reported as per PRISMA-style requirements of search and selection because the evidence base is diverse and the number of sources is too many, the synthesis is interpretive and thematic instead of quantitative meta-analysis.

Eligibility Criteria

Category	Inclusion Criteria	Exclusion Criteria
Resource types	- Empirical studies involving quantitative, qualitative and mixed-methods studies. - Implementation reports - National surveys - Policy documents - Program evaluations	- Opinion articles or commentaries which have no primary data or program reviews (except when they have unique policy descriptions and there is no other source of such description).
Core domains	- Mental health prevalence - Service availability - Stigma - Help-seeking -Interventions at the community level	-The studies will be considered only when they concentrate only on clinical subpopulation in the high-income nations, unless they include the Pakistani diaspora and are explicitly presented with transferability.
Duration	-Publications, reports or data sets published between 2015 and September 2025.	-Sources beyond this time period.
Regional coverage	-Pakistan (national or community-level target)	-Articles not related to Pakistan.
Reference hierarchy	- Peer-reviewed articles and sources at the national level	- Non-peer-reviewed or locally limited reports are not included unless they include such special data that cannot be found elsewhere.
Language	-Documents in English language and that are translated to English.	- Non-English sources not translated.

Information Sources and Search Strategy

A systematic literature review was conducted in a collection of bibliographic databases, including PubMed/PMC, Web of Science and Scopus, preprint archives, including: medRxiv, key academic publishers, including Springer and Elsevier, and grey-literature sources, including WHO Mental Health Atlas, national health ministry web portals, NGO publications and Knowledge Action Portal. The search strategy was a combination of concepts that were relevant to Pakistan and mental health, stigma, community engagement, accessibility, and names of particular interventions, such as task shifting, lady health workers, helpline, digital counselling, and community-based psychosocial support. The form of example search strings was based on (Pakistan) and (mental health) and (stigma or help seeking or accessibility or community engagement or task shifting or helpline or digital intervention or community engagement). The database searches were supplemented by citation-tracking and systematic reference-list reviews of important reports, such as the WHO Atlas and provincial mental health acts. Searches were conducted till July 2025.

Selection Process

The search results were summarised in reference-management software and then de-duplicated. When it comes to peer-reviewed literature the screening of the titles and abstracts was done to filter out irrelevant records, the full text was accessed when it utilised inclusion criteria or when the relevance was unclear. The policy documents and grey literature were evaluated using the same eligibility framework. Whenever possible, data were screened and extracted by two reviewers who then discussed and agreed on areas of discrepancy; a third reviewer adjudicated where necessary. A single-reviewer screening strategy was used on some large-scale or time-constrained grey documents (such as national action frameworks or preprints among others), with the limitations clearly documented.

Data Extraction

The standardized extraction template contained the following items, bibliographic information, study design, population and setting, what was measured, including prevalence, service utilisation, and evidence of stigma (e.g. reported discriminatory attitudes or self-stigma scales), what was delivered, including the components of interventions and agents of delivery, e.g., lady health workers, teachers, and faith leaders, the context of implementation, what was reported to have worked, equity-related findings (e.g. by gender, rural/urban, socio-economic strata), and methodological shortcomings In case of policy and programme documents, the extraction was devoted to the legal status, funding obligations, the number of the workforce, and mentioned integration strategies, e.g., inclusion in primary healthcare benefit packages.

Synthesis Approach

The heterogeneity of the included studies made it impossible to perform a formal meta-analysis and, therefore, a narrative thematic synthesis was performed. Some of the major themes were found to include: (1) epidemiology and system capacity; (2) cultural determinants of stigma and help-seeking; (3) models of community engagement and evidence of impact; and (4) policy, financing and scalability issues. We provide a synthesis of quantitative indicators where available (i.e., point prevalence estimates and number of psychiatrists per 100,000 inhabitants), qualitative understanding of stigma in the community through studies of communities, and explanatory models and intervention evidence, of the relevant theme. Interventions are designed by medium of delivery (lady health workers, schools, faith-based settings, helplines, digital tools) and implementation insights (training, supervision, referral pathways, acceptability) are summarized. Evidence is mapped, where possible, to equity dimensions, such as gender, rural versus urban residence and socioeconomic status.

Key Sources and Justification (Load-bearing Evidence)

The review is based on a number of high-impact/recent sources to make core assertions, the National Psychiatric Morbidity Survey (Rahman et al., 2024) and similar prevalence reports can give up-to-date estimates of the burden on the population; WHO data and the Mental Health Atlas offer authoritative workforce and financing indicators (WHO, 2021); several desk-analyses of the mental health system in Pakistan can summarize structural and policy gaps (Dayani et al., 2024); implementation research recent

These materials were given priority based on the national relevance, the date and the methodological rigor and are alluded to all over the synthesis to derive conclusions.

Limitations of the Review

The major limitations include the heterogeneity of study methods, the use of grey literature to describe some characterizations of national policies, the relative recency and preprint of some national prevalence estimates, which require cautious interpretation and the unreported long-term outcomes and cost-effectiveness of some promising community interventions. In the areas where evidence is still limited or in its infancy, the review points to areas of uncertainty and the need to have well-conducted implementation trials and representative levels of surveillance.

Findings

Epidemiology of Mental Health Disorders in Pakistan

Burden and Prevalence: Mental illnesses are an important but insufficiently addressed population health issue in Pakistan. In 2024, the National Psychiatric Morbidity Survey (NPMS), which is available in preprint, estimated over one-third of adults in the country met diagnostic criteria of at least one common mental disorder (CMD), such as depression, generalized anxiety disorder, and somatic symptom disorders (Rahman et al., 2024). Such an estimate underscores the high scale of psychiatric morbidity especially considering that the population of Pakistan is more than 240 million. The number aligns with previous studies conducted in the region that have documented high levels of CMD, which suggests the maintenance and the possible worsening of mental health requirements (mahesar et al., 2024). There are gendered patterns of prevalence data. It is a well-known fact that women in comparison with men have higher rates of depressive and anxiety symptoms that are usually explained by structural inequalities, gender-based violence, social isolation, and reproductive health burdens (Khan & Irfan, 2023). These findings are consistent with the literature available internationally that records the high susceptibility of women to CMDs in patriarchal communities (WHO, 2021). Adolescents and young adults represent another group that is becoming more vulnerable; a 2022 nationwide survey of schools showed that adolescents experienced persistent sadness, hopelessness, or lack of interest in day-to-day activities, girls being the most disproportionately affected (Ibbad et al., 2022). Severe mental illnesses (SMIs) including schizophrenia, bipolar and psychotic spectrum disorders are less prevalent than CMDs but produce disproportional disability. The stigma linked to SMIs is often noted by families taking care of their patients who experience severe financial hardship, social segregation, and reduced chances of marriage (Siddiqui et al., 2022).

Comorbidities and Vulnerabilities: Psychiatric disorders in Pakistan are rarely present on their own, but they often co-occur with the somatic conditions such as cardiovascular disease, diabetes mellitus, and pregnancy-related issues (Dayani et al., 2024). It has empirically been shown that patients with depressive disorders that are not treated have lower compliance with pharmacotherapy of chronic diseases, which Increases the morbidity and mortality rates (Thompson & Saleem, 2025). Psychological distress is further enhanced by the environmental vulnerability. Pakistan is one of the countries with the highest vulnerability to climate in the world, and it suffers frequent floods, droughts, heat waves. Some research carried out after the devastating floods of 2010 discovered post-traumatic stress disorder (PTSD) to be common between displaced

populations with the prevalence between 15- 30% (Ali, 2025). The longitudinal assessments indicate that trauma symptoms can last several years after such incidents which shows the inadequacy of the post-disaster psychosocial support services. Similarly, the mental-health pressure increased significantly during the COVID-19 pandemic; the research has reported a higher number of anxiety, depression, and suicidality cases during lockdowns, especially among young people and households with low incomes (Baloch et al., 2021).

Health System Capacity and Accessibility

Mental health Workforce: A severe shortage of mental health providers is being witnessed in Pakistan. The number of psychiatrists is less than 500 to treat a population of over 240 million, and this amounts to about 0.19 psychiatrists per 100, 000 people (WHO, 2021). Psychologists, psychiatric nurses and social workers are also underrepresented, with most of these cadres being found in large urban areas like Karachi, Lahore and Islamabad (Dayani et al., 2024). Thus, the rural and remote populations have not been addressed significantly.

Financing and Infrastructure: Mental health is a marginal aspect of the national health budget and spends less than 1 % of the total national health expenditure in terms of financing and infrastructure (WHO, 2021). The few resources which are allocated are skewed to tertiary psychiatric hospitals, with little at community level. This institutional-focused orientation is a way of perpetrating stigma by conflating psychiatric disease with institutionalisation, and also creates geographic and socioeconomic access disparities (Rahman et al., 2024).

Policy Frameworks and Integration: The policy frameworks and integration activities have also been below the expectation. New laws, including the Sindh Mental Health Act (2013) and Punjab Mental Health Act (2014), were aimed at modernising mental health and integrating the protection of the rights of patients (Ajmal et al., 2024). However, there has been a patchy implementation, which was defined by a lack of proper monitoring, the lack of financing systems, and poor coordination among provinces (Dayani et al., 2024). The efforts to introduce mental health into primary healthcare has been patchy, pilot programmes introducing mental-health screening into family-physician practices, as well as basic health units prove to be effective, especially when Lady Health Workers (LHWs) can be trained (Rabbani et al., 2025). However, the barriers to the sustainability and scalability of such initiatives are systemic such as a lack of supervision, referral pathways, and financial incentives.

Barriers to Accessibility: Structural, socioeconomic and cultural barriers define accessibility to mental healthcare. Geographic maldistribution leads to the situation when many rural districts do not have psychiatrists or psychologists. The excessive out-of-pocket spending on consultations and psychotropic drugs discourages care seeking particularly in the low-income households (Thompson & Saleem, 2025). There are also gender mobility restrictions that block women access to services since most of them need male companions to be with them (Khan & Irfan, 2023). Language and literacy barrier undermine the program of public awareness and limit the understanding of the written educational content, so they require oral and audiovisual formats that would be culturally sensitive.

Stigma and Cultural Determinants

Public Stigma and Supernatural Beliefs: In Pakistan, one of the major discouraging factors to using mental health is the public stigma. The root cause of this stigma is misconceptions of mental illness as a supernatural

event, i.e. black magic, possession of spirits, or divine retribution (Daraz et al., 2025). As a result, most families will first turn to faith healers instead of mental-health practitioners. Although some faith healers might offer psychosocial help, they use spiritual healing as an alternative to biomedical treatment and this may worsen the situation.

Self-stigma and Family Dynamics: Self-stigma, which implies the assimilation of the negative beliefs of society, promotes concealing the symptoms or stopping treatment at an early stage (Choudhry et al., 2021; Khan & Irfan, 2023). The power of family stigma is significant because members of the family usually are afraid of social disgrace and can hide a mental illness of a family member to protect the statuses, opportunities to get married, or jobs (Siddiqui et al., 2022).

Structural Stigma: The structural stigma causes the lack of funds, the lack of insurance, the discriminatory policies in the workplace, and the lack of legal provisions regarding psychiatric disabilities (Dayani et al., 2024). Mental illness is not often included in disability laws and such individuals have no accommodations or benefits.

Gender and Age Intersections: Women are disproportionate sufferers of stigma, which is exacerbated by the lack of autonomy and being affected by domestic violence. Mental women are often considered inappropriate to marry or have a family, which further aggravates isolation (Sahai-Siddiqui, 2025). Young people, on the other hand, are usually disregarded by adults who blame their psychological issues on their immaturity or weaknesses, which leads to their late identification and treatment (Akhtar et al., 2025).

Community Engagement Models

Task-shifting Through Lady Health Workers: Task-shifting via Lady Health Workers (LHWs) is one of the most effective mental health service delivery innovations in Pakistan. LHWs were initially trained to deliver maternal and child health services but since then they have been re-trained to offer low-intensity cognitive behavioural therapy (CBT) interventions in addressing perinatal depression. In early 2000s The Thinking Healthy Programme, which was piloted and later implemented in select districts, showed substantial differences in depressive symptoms in mothers and accompanied with subsequent changes in child health results (Rahman et al., 2008; Rahman et al., 2008).

Scaling is a daunting problem, although there is strong evidence of efficacy. LHWs are often faced with excessive workloads, low wages and lack of supervision. Unless they are supported by the powerful institutional support and incorporated into the main health services, these programmes become unsustainable (Rabbani et al., 2025).

Helplines and Digital Platforms: Helplines and online platforms have grown in an alarming rate, especially during the post-COVID-19 period. Umang Pakistan helpline provides referrals, confidential counselling and information, and it targets youth and women (Knowledge Action Portal, 2021). Digital CBT, psychoeducation and self-help video interventions have been piloted and shown to be highly feasible and acceptable through mobile health applications specifically mPareshan (Akhtar et al., 2025; Rabbani et al., 2025). Digital platforms also reduce the obstacles of stigma and mobility as it provides access to anonymous information. However, digital disparities, particularly gender-based differences in mobile phone access and internet access, interfere with equal access. Issues of privacy, confidentiality, and regulatory control are also another source of concern, which makes large-scale adoption even more complex.

School-based Interventions: Schools can be used as a venue to raise awareness, reduce stigma and detect mental distress early. Pilot programmes prepared teachers by providing them with the training needed to recognize at-risk students and to incorporate the use of psychosocial support as a part of curricula. Results showed the enhancement of knowledge and decreased stigma in adolescents, but teachers claimed that they did not find it easy to balance their academic and psychosocial support roles. Mental health curricula have been institutionalised, but they are still meager, and require greater government and administrative support (Imran et al., 2018; Imran et al., 2018).

Faith-based and Community Leadership Approaches: Involvement of religious and community leaders is a two-sided approach. Training of imams and community elders on how to identify distress and access the services of professional care has increased the acceptability and utilisation of the services in conservative communities, on the one hand (Daraz et al., 2025). On the other hand, there are leaders who continue with supernatural explanations without their intent to promote stigma and postpone formal treatment. The sustainable models involve considerate relationships between religious systems and biomedical services.

Psychosocial Support During Crises: Ad hoc psychosocial support programmes have been triggered by natural disasters and humanitarian emergencies. After the floods in 2010 and 2022, NGOs came to the community with their mobile teams, assisting people with group counselling, trauma-focused therapy, and resilience trainings (Ali, 2025). These interventions were temporary and were not integrated into long-term systems despite the high level of demand. Post-disaster programmes are not proactive but reactive and are not owned much by the government.

Effectiveness of Community Interventions

There is an overall indication of evidence across the types of interventions that community-based approaches have a high potential. There was also task-shifting programme like clinically significant changes in perinatal depression (Rahman et al., 2024). In pilot studies, digital counselling interventions such as mPareshan reduced depressive symptoms and enhanced the adherence to treatment (Rabbani et al., 2025). Interventions in schools were more beneficial to raise awareness and decrease stigma, especially when aimed at students and teachers (Imran et al., 2022). The process of stigma reduction with religious leaders showed a relative increase in attitude with inconsistent sustainability (Daraz et al., 2025). Psychosocial programmes on disasters were well taken but had poor continuity and scalability.

Gaps and Challenges

Despite the recognition of the importance of mental health that has grown in Pakistan, there are a number of gaps and barriers that hinder progress. One gap that stands out is the lack of reliable epidemiological information, particularly in children, adolescents, and rural groups, which limits evidence-based planning and allocation of resources (Rahman et al., 2024). The shortage of skilled professionals including psychiatrists, psychologists, and psychiatric nurses is still acute since it has not been topped by the provision of services in rural areas, thus leaving the rural population under-serviced (WHO, 2022). On the systemic level, mental health faces the constant underfunding, fragmented governance between the federal and provincial governments, and lack of integration into primary healthcare. These challenges are made even more

challenging by stigmatization because current cultural misconceptions and social stigma discourage individuals and families to seek help and maintain treatment gaps and social isolation (Akhtar et al., 2025).

Despite the effectiveness of the new interventions, such as digital platforms and community health worker programmes, their potential in scale is limited due to the lack of infrastructure, digital disparities, and the lack of appropriate supervisory machinery. Moreover, the absence of widespread monitoring, appraisal, and long-term sustainability processes lead to the high level of successful pilot projects not being integrated into national policy or practice. Together, those inequalities highlight the urgency of the need to reform the system, provide equal funding, and approaches that are culturally sensitive to reduce the growing burden of untreated mental disorders in Pakistan.

Discussion

Overview of Key Findings

The present review describes a paradoxical situation in the context of Pakistan mental health, a surging prevalence of psychiatric morbidity compared to significantly underdeveloped systems of health, deep-rooted stigma, and incoherent community-based innovations. Currently, the strongest body of evidence availed by a study in this area is probably the National Psychiatric Morbidity Survey (NPMS) states that close to a third of Pakistani adults are vulnerable to common mental diseases (Rahman et al., 2024). The same tendency in prevalence has been reported in most other South Asian countries, but the service shortages in Pakistan are especially severe (Dayani et al., 2024). Parallel to that, Pakistan has already tried various novel models of community-engagement, such as the Thinking Healthy Programme, mobile health interventions like mPareshan, the use of school-based stigma-reduction activities, and the integration of faith leaders into referral channels (Rabbani et al., 2025; Daraz et al., 2025). These programs depict context-bound avenues towards the improvement of access even within a limited system. However, sustainability, integration and equity are issues that have not been addressed. Here, the above findings are construed in a bigger context that encompasses regional comparisons, cultural influences, systemic impediments and global paradigms of mental health. It then discusses the policy formulation implications, clinical practice implications, and future research directions.

Comparative Perspective: South Asia and Beyond

Shared Regional Challenges: The situation in mental health in Pakistan can be enumerated as witnessed in the neighboring South Asian countries of India, Bangladesh, and Nepal, where structural barriers, social stigma, and lack of sufficient resources have a significant role in the provision of services. As an example, India has less than one psychiatrist per 100,000 inhabitants, and there are strong urban-rural inequalities (Patel et al., 2022). Bangladesh, despite its resource investments in the disaster-related psychosocial programmes, faces numerous challenges in realizing these initiatives as part of a long-lasting care provision (Hasan et al, 2022). Although Nepal has diversified the use of community-based psychosocial worker networks in the wake of the 2015 earthquake, their sustainability is greatly dependent on the external donor aid (Kane et al., 2017; Kc et al., 2019).

The salient fact about Pakistan is not the scale of psychiatric morbidity, shown through the National Psychiatric Morbidity Survey 2024 but the haphazardness of the mental health law. Provincial laws are not

always enforced and do not succeed in harmonising the jurisdictions (Dayani et al., 2024). Pakistan does not have a consistent federal policy that would coordinate provincial goals with national priorities, unlike India that has established a national mental health policy in 2014 and implemented it to some extent in the insurance plans.

Global Lessons: One of the most commonly recognised solutions to closing the treatment gap in low and middle-income countries (LMICs) is task-shifting and digital innovations (WHO, 2022). The Lady Health Worker-led Thinking Healthy Programme in Pakistan is often mentioned as one of the examples of the culturally competent, scalable perinatal mental-health initiatives (Rahman et al., 2008; Rahman et al., 2024). However, efforts to replicate have faced massive bottlenecks especially on the supervisory structures and the funding of health-systems. Pakistani digital mental-health projects are similar to other comparable programmes in Kenya, Nigeria, and Indonesia where mobile counselling platforms have been found to be particularly useful in increasing accessibility but are limited by inequities in connectivity (Naslund & Deng, 2022). The resultant digital gender gap is particularly intense in Pakistan, a minority of less than 50-percent of women possess smartphones as opposed to a majority of over 75-percent of men (GSMA, 2023). To this end, evidence based on global experience of digital-health interventions states that the expansion of these interventions has to be supported by matching investments in digital literacy as well as equitable access.

Stigma: Cultural Embeddedness and Transformation

Deep-rooted Stigma: The deep-rooted nature of stigma in Pakistan despite its awareness campaigns implies that such stigma is embedded in the culture. Supernatural beliefs that blame mental sickness on witchcraft or supernatural punishment are still common and by doing so families now choose faith healers instead of psychiatrists (Daraz et al., 2025). Such perceptions are similar to the experiences of sub-Saharan Africa, where the first point of contact of a large number of patients remains spiritual and traditional healers (Mutale et al., 2020).

In contrast to certain western settings, where treatment-seeking has been slowly enhanced by stigma-reduction campaigns, family honor, and social reputation are other stigmatization-related deterrents in Pakistan (Siddiqui et al., 2022). The likelihood of marriage is usually threatened in situations where the family member has a known case of a mental illness, which promotes secrecy over openness (Khan & Irfan, 2023).

Opportunities for Culturally Adapted Approaches: However, cultural determinants are also useful, which can be exploited as facilitators. The facts show that educating religious leaders to identify the symptoms and promote biomedical care increase the level of trust within the community (Daraz et al., 2025). Religionally-driven integration has been effective, where mosque-based interventions enhanced levels of stigma and referral routes (Elfattah, 2025; Ibrahim & Whitley, 2020). Therefore, stigma is a significant obstacle, but culturally consistent interventions to bring religious concepts and mental health promotion into accordance can help to promote lasting change.

Accessibility and Systemic Gaps

Workforce Crisis: The most important bottleneck is the extreme shortage of psychiatrists that is about 0.19 per 100000 population in Pakistan (WHO, 2020). Conversely, other low- and middle-income nations with comparable levels of development (such as Sri Lanka) have made greater investments in psychiatric education

and are now at 0.5 providers per 100,000 (Patel et al., 2022). The fact that Pakistan is heavily dependent on tertiary psychiatric hospitals leads to the concentration of care in urban centers thus solidifying rural inequalities.

Task-shifting suggests that this can provide a possible solution, but the effectiveness depends on the good supervisory systems. The empirical evidence shows that only in case the fidelity is monitored by the supervisors, and technical assistance is given, the therapy provided by lady health workers will yield satisfactory results (Rahman et al., 2024). Without such control, the quality of care improves, and the dropout rates increase.

Financing and Policy Inertia: The spending in mental-health takes less than 1 % of the total health budget and it represents a systemic neglect (Dayani et al., 2024). The decentralization of health to provincial governments is constitutional, but the absence of a powerful federal coordinating body prevents policy consistency. This is very different to Nepal where decentralisation is accompanied by clear national guidelines that incorporate mental health into primary care (Kane et al., 2017; Kc et al., 2019).

Barriers for Vulnerable Groups: The most challenging barriers to care are faced by women, adolescents, and by rural poor communities. Women often need the presence of men to be able to visit clinics, and rural families have to cover a long distance before they reach the tertiary centers (Khan & Irfan, 2023). Though the treatment of adolescents is significantly less prevalent, this group of people remains mostly out of scope of services targeted at either maternal or adult population (Siddiqui et al., 2022). Such inequalities indicate the need to have differentiated service models taking into consideration gender, age and geographic differences.

Community Engagement: Strengths and Limitations

Task-shifting as a Flagship Model: The Thinking Healthy Programme remains the most highly-assessed mental-health intervention in Pakistan, with its clinical-effectiveness in the prevention of perinatal depression being established by randomized controlled trials (Rahman et al., 2008; Rahman et al., 2024). However, national scale-up initiatives have faced challenges that can be explained by lack of funding, high workloads among Lady Health Workers (LHWs), and the lack of institutional ownership (Rabbani et al., 2025).

The greater implication is that pilot success would not necessarily mean scalability unless these programmes are instituted in national financing processes and coordination with normal primary-care delivery; otherwise, such programmes would become solitary islands of excellence.

Digital Innovations: Developed digital technologies, as was the case with mPareshan have potential to reduce stigma and geographical obstacles (Akhtar et al., 2025). Nevertheless, they also reveal the merits of digital inequities for women, rural families, and low-income groups are excluded since they have no access to devices. The given phenomenon is an example of a greater criticism that, unless made explicitly inclusivity-focused, digital health initiatives may contribute to the existing disparities (Naslund & Deng, 2022).

Schools and Youth Engagement: The evidence of school-based programmes indicates the possibility to lower the stigma and encourage early-stage detection among the adolescents (Imran et al., 2022). However, the dual role of teachers creates issues as to what is realistic without systemic integration of the curriculum. India has also shown that the integration of psychosocial skills as part of the formal curriculum is more sustainable than teacher-based extra-curricular activities (Patel et al., 2022).

Faith-based Engagement: Religious involvement has its opportunities and threats. It can be more legitimate through collaborations with imams and community elders but must be carefully framed or such collaborations may unwittingly support supernatural explanations (Daraz et al., 2025). According to the studies, it is possible to reduce this risk with the help of organized training and monitoring (Elfattah, 2025; Ibrahim & Whitley, 2020).

Conclusion

The review shows that Pakistan is at the cross-roads of its mental health strategy. The results show a grim picture, even though there is a compelling and growing volume of psychiatric morbidity, with approximately one-third of the adults affected (Rahman et al., 2024), the area of mental health is among the least addressed branches of the healthcare system. Lack of workforce, chronic under-investment, incoherent provincial laws and deeply-rooted stigma still limits access to effective care. The reasons are not new to Pakistan, but these issues represent systemic gaps in low-and-middle-income countries (LMICs). However, the mixture of a large disease burden, urbanization rate, displacement due to climate change, and a young demographic bulge makes the situation in Pakistan especially emergent and complicated (Dayani et al., 2024; Thompson & Saleem, 2025).

These overwhelming odds notwithstanding, Pakistan has been a pioneer in community engagement models that both give hope and lessons to the world. Clinically effective in lowering perinatal depression, the Thinking Healthy Programme has been implemented through Lady Health Workers (LHWs), and has been used in a number of other LMICs (Rahman et al., 2008; Rahman et al., 2024). Digital interventions like mPareshan are new ways of responding to stigma and geographic disparities, and school-based and religious leader collaborations demonstrate culturally-based approaches to stigma reduction and resource mobilisation (Akhtar et al., 2025; Daraz et al., 2025; Imran et al., 2022). Together, these efforts are evidence that solutions are feasible and can be cost-effective, scalable, and community-based, should they be systemically invested in and integrated.

One of the issues that come out strongly in this review is the paradox of potential as opposed to reality. The effectiveness of pilot programmes is strong, but they have not been translated into national policy sustainability. This is indicative of governance weaknesses, failure to invest in the sector as well as intersectoral cooperation. As an illustration, too many workloads and insufficient supervision sabotage success of LHW interventions whereas digital innovations are not accessible to much of rural and female populations because of the digital divide (GSMA, 2023). Similarly, the stigma-reduction programs have short-term benefits but no long-term systems to support changes in culture.

The experience of Pakistan, in the context of a global health approach, is representative of the challenges and opportunities that LMIC mental health systems represent. It shows how community health workers and digital health can be put into good use but also points to the risks of overlooking systemic enablers like financing, equity, and governance. The success or failure of Pakistan to institutionalize these lessons may be used as an example by other LMICs struggling to cope with similar problems. All in all, the response to the mental health crisis in Pakistan needs to be multi-faceted like increasing workforce, making mental health financing equitable, incorporating mental health into primary care, mobilizing the community resources, and managing stigma systematically. Without these reforms, mental illness will still continue imposing not only on

personal suffering but also on social and economic levels, which is to the detriment of productivity, education and social integration. On the contrary, focusing on mental health will provide a channel to enhance the well-being of the population, community resilience and sustainable development.

Recommendations

Based on the evidence synthesized in this review, the following recommendations are proposed for policymakers, practitioners, and researchers:

Policy level

- Develop a federal system to coordinate provincial mental health laws, create national standards, and to allocate specific resources.
- Please make sure that you are involved in accordance with the recommendations of the World Health Organization World Mental Health Report (WHO, 2022).
- Spend no less than 5 % of the total health budget on mental health, thus in accordance with international guidelines.
- Invest in building community-based services rather than focusing resources on psychiatric hospitals.
- Intensify Training in psychiatry psychiatric residency programmes, psychology training, and psychiatric nursing training.
- encourage the rural deployment through incentives in form of salary bonuses, housing allowances, and career progression opportunities.
- Formalise alliances between the Ministries of Health, Education, Social Welfare, and Information in order to mainstream mental health in schools, at workplaces, and in media campaigns.

Practice level

- Institutionalise an extensive mental health training of Lady Health Workers (LHWs) and ensure an organised supervision systems to maintain quality.
- Provide monetary rewards and institutional systems of recognition to curb staff turnover. o Invest in rural Internet access and subsidised smartphone access among women.
- Design has culturally adapted mobile applications using native languages, with strong privacy and confidentiality protection.
- Incorporate psychosocial education in national curricula with a focus on teaching resilience, coping and reducing stigma.
- introduce regular teacher and school counsellor training courses, avoiding one-off training. o Implement systematic training to imams and community elders, on mental health literacy and use of referral systems.
- Oversee implementation procedures and make sure that biomedical and psychosocial treatment is not undermined by supernatural explanatory models.
- Institutionalise the support of mental health in the disaster risk reduction strategies in Pakistan.
- Train rapid response teams on population-specific (floods and earthquakes) psychosocial care that is trauma-informed.

Research

- Develop benchmark datasets to direct interventions on the youth populations.
- Shift to measures of impact in years, as opposed to months, of short-term pilot outcome measures.
- Produce economic data to justify the decisions and priorities of policymakers in their funding. o Examine interaction and interplay between gender, class, rurality, and status of disability to determine access and outcomes.
- Research on privacy, confidentiality, and data control in online counseling interventions to make them trusted and adopted.

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