

Original Article

Perception of Depression and Anxiety among Women in Santhia, Pabna

Md. Al-Amin¹, Subarna Parvin²

Abstract

Background: Depression and anxiety are common mental health problems that affect women's emotional well-being, daily functioning, and quality of life. In rural communities, limited awareness, poor mental health literacy, and lack of access to services may influence women's perception of these conditions.

Objective(s): To assess the perception of depression and anxiety among women in Santhia, Pabna.

Materials and methods: This descriptive cross-sectional study was conducted among 280 women in Santhia, Pabna. Data were collected using a pretested semi-structured questionnaire through face-to-face interviews. The questionnaire included items on sociodemographic characteristics, awareness, knowledge, perceived impact, perceived causes, beliefs about treatment, and awareness of mental health services. Data were analyzed using descriptive statistics and inferential tests to determine associations between selected sociodemographic variables and perception-related scores.

Results: Among the respondents, 80.0% were aware of depression and 75.0% were aware of anxiety. Most participants (40.0%) were somewhat knowledgeable, while 30.0% had little knowledge and 20.0% had no knowledge regarding depression and anxiety. A large majority (90.0%) agreed that depression and anxiety affect daily life, and 80.0% perceived these conditions as somewhat or very common among women. Sixty percent believed that depression and anxiety can be treated with professional help, yet only 40.0% were aware of mental health services. Education showed a significant association with willingness to seek professional help ($p=0.019$), and marital status was significantly associated with perception of depression's impact on daily life ($p=0.041$).

Conclusion: Women in Santhia had moderate awareness but limited in-depth knowledge regarding depression and anxiety. The study highlights the need for community-based mental health education and improved awareness of available mental health services among rural women.

KYANCJ 2026; 07 (01): 23-31

Key words: Depression, Anxiety, Perception, Women, Mental health services

DOI: <https://doi.org/10.3329/kyancj.v7i1.94204>

Introduction

Depression and anxiety are among the most common mental health disorders worldwide and constitute a major public health concern due to their high prevalence, chronicity, and impact on quality of life. According to the World Health Organization, depression affects more than 280 million people globally, while anxiety disorders affect a substantial proportion of the population, often coexisting with depression and contributing to significant disability and economic

burden.¹ These conditions are particularly important in low- and middle-income countries, where mental health services are limited and social stigma remains a major barrier to care.

Women are disproportionately affected by depression and anxiety due to a combination of biological, psychological, and socio-cultural factors. Hormonal changes, gender-based violence, socioeconomic dependency, and caregiving responsibilities

1. Senior Staff Nurse, Mental Hospital, Pabna, Bangladesh.

2. Nursing Instructor, Khwaja Yunus Ali Nursing College, Enayetpur, Sirajganj, Bangladesh.

Correspondence: Md. Al-Amin, Senior Staff Nurse, Mental Hospital, Pabna, Bangladesh.
Cell Phone: +880 1773218893, E-mail: alamin1993@gmail.com

increase women's vulnerability to mental health disorders.²

In many traditional societies, including Bangladesh, women often face restricted autonomy, early marriage, and limited access to education and employment opportunities, which further exacerbate psychological distress.³

In Bangladesh, mental health has historically been a neglected component of the healthcare system. Community-based studies indicate a considerable burden of depression and anxiety among women, particularly in rural areas.⁴ Social determinants such as poverty, marital discord, domestic violence, and lack of social support have been identified as significant contributors to poor mental health outcomes among Bangladeshi women.⁵ Moreover, misconceptions and negative perceptions about mental illness often lead to underreporting and delayed treatment-seeking behavior.⁶

Perception of mental health disorders plays a crucial role in shaping health-seeking behavior and adherence to treatment. In rural communities like Santhia upazila of Pabna district, cultural beliefs, stigma, and lack of awareness may influence how women interpret symptoms of depression and anxiety and whether they seek professional help or rely on informal support systems.⁷ Understanding these perceptions is essential for designing culturally appropriate interventions and improving access to mental health services.

Therefore, this study aims to explore the perception of depression and anxiety among women in Santhia, Pabna, with a focus on identifying knowledge gaps, prevailing beliefs, and barriers to care in a rural Bangladeshi context.

Materials and methods

This descriptive cross-sectional study was conducted over a period of one year, from January 2024 to December 2024, under the Institute of Biological Sciences, University of Rajshahi, Bangladesh, in collaboration with women residing in rural areas of Santhia. The study aimed to assess the perception and awareness of depression and anxiety among rural women aged 18 years and above. Purposive sampling technique was applied to select participants from different villages, and although efforts were made to recruit as many eligible respondents as possible, a total of 280 participants were finally included. Inclusion criteria comprised permanent female residents of the study area who were willing to participate, able to provide informed consent, and capable of understanding and responding to the study instruments, whereas temporary residents, those unwilling to consent, and women with severe physical or mental impairments preventing participation were excluded. Data were

collected using a pretested semi-structured questionnaire that included sections on socio-demographic characteristics, awareness of depression and anxiety (symptoms, causes, and treatment), perceptions and attitudes (including stigma and beliefs regarding severity), and sources of mental health information. Prior to data collection, ethical approval was obtained from the concerned institutional review authority, and field data collectors were adequately trained regarding study objectives, interviewing techniques, and ethical considerations, particularly for handling sensitive mental health topics. Data were analyzed using statistical software SPSS. Informed written consent was obtained from all participants after explaining the purpose, procedures, risks, and benefits of the study in the local language, ensuring voluntary participation, anonymity, and confidentiality throughout.

Results

Table I presents the sociodemographic profile of the respondents included in the study on the perception of depression and anxiety among women in Santhia. A total of 280 respondents were analyzed.

Regarding age distribution, the majority of participants were within the 25-34 years age group (30.0%), followed by those aged 35-44 years (26.8%). Equal proportions of respondents were found in the 18-24 years and 45-54 years groups (20.0% each), while only a small fraction (3.2%) belonged to the 55 years and above category. This indicates that most respondents were in their young to middle adulthood period.

In terms of marital status, a significant majority of the respondents were married (70.0%), whereas 56 (20.0%) were single. Widowed and divorced women each constituted 5.0% of the study population, reflecting a predominantly married sample.

Educational status revealed that most respondents had at least primary or secondary level education, with 84 (30.0%) each in primary and secondary categories. A smaller proportion had no formal education (15.0%) or higher secondary education (15.0%), while only 28 (10.0%) had attained a bachelor's degree or higher. This suggests a moderate level of educational attainment among the participants.

With regard to occupation, half of the respondents [140 (50.0%)] were homemakers, indicating the dominant role of household responsibilities among rural women. Employed women accounted for 20.0%, while self-employed, students, and unemployed respondents each represented 10.0% of the sample.

Overall, the table demonstrates that the study population primarily consisted of married, moderately

Table I: Sociodemographic characteristics of the respondents (n=280)

Variable	Frequency	Percent
Age		
18-24	56	20.0
25-34	84	30.0
35-44	75	26.8
45-54	56	20.0
55+	9	3.2
Mean: 35.46, SD: ± 10.47		
Marital status		
Single	56	20.0
Married	196	70.0
Widowed	14	5.0
Divorced	14	5.0
Education		
No formal education	42	15.0
Primary	84	30.0
Secondary	84	30.0
Higher Secondary	42	15.0
Bachelor's Degree or higher	28	10.0
Occupation		
Homemaker	140	50.0
Employed	56	20.0
Self-employed	28	10.0
Student	28	10.0
Unemployed	28	10.0

educated women in their reproductive and economically active age groups, with a large proportion engaged in homemaking activities. These characteristics are important for understanding their perceptions and awareness of mental health issues such as depression and anxiety.

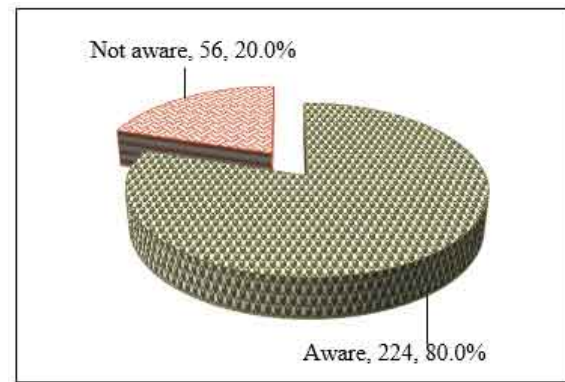
**Figure 1:** Distribution of Participants about Awareness of Depression (n=280)

Figure 1 illustrates the distribution of respondents according to their awareness of depression among women in Santhia (n=280). The majority of participants, 224 (80.0%), reported that they were aware of depression, while 56 (20.0%) respondents indicated that they were not aware of the condition.

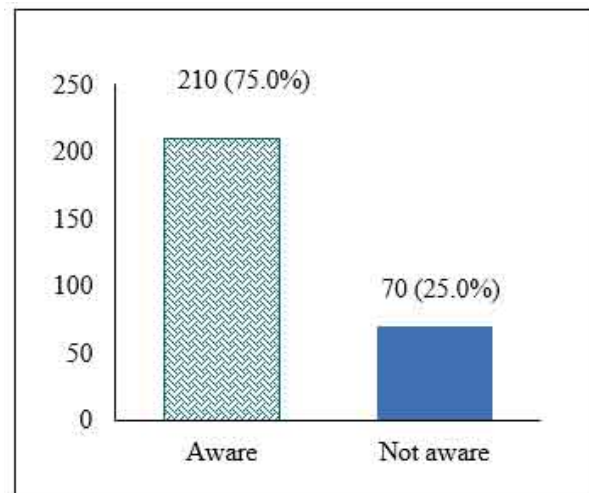
**Figure 2:** Distribution of Participants about Awareness of Anxiety (n=280)

Figure 2 shows the distribution of respondents according to their awareness of anxiety among women in Santhia (n=280). Out of the total participants, 210 (75.0%) reported that they were aware of anxiety, whereas 70 (25.0%) indicated that they were not aware of it.

This indicates that although a majority of the respondents had awareness about anxiety, the level of awareness was slightly lower compared to depression. The presence of a considerable proportion of women lacking awareness highlights the need for targeted mental health education and community-based awareness programs to improve understanding of anxiety disorders in rural settings.

Table II: Participants' Knowledge Level about Depression and Anxiety (n=280)

Knowledge Level About Depression & Anxiety	Frequency	Percent
Very knowledgeable	28	10.0
Somewhat knowledgeable	112	40.0
Little knowledge	84	30.0
No knowledge at all	56	20.0
Total	280	100.0

Table II presents the distribution of respondents according to their level of knowledge regarding depression and anxiety among women in Santhia (n=280). The findings reveal that the largest proportion of participants, 112 (40.0%), were somewhat knowledgeable about depression and anxiety. A considerable number of respondents, 84 (30.0%), had little knowledge, while 56 (20.0%) reported having no knowledge at all. Only a small proportion, 28 (10.0%), were found to be very knowledgeable.

Overall, the results indicate that although a majority of participants possessed at least some level of awareness, in-depth knowledge about depression and anxiety was limited. The substantial proportion of women with little or no knowledge highlights a significant gap in mental health literacy in the rural community, emphasizing the need for effective awareness and educational interventions.

Table III: Participants' Opinions on Whether Depression and Anxiety Can Affect Daily Life

Depression and Anxiety Affect Daily Life	Frequency	Percent
Strongly agree	140	50.0
Agree	112	40.0
Disagree	14	5.0
Strongly disagree	14	5.0
Total	280	100.0

Table III illustrates the opinions of respondents regarding the impact of depression and anxiety on daily life among women in Santhia (n=280). The findings show that half of the participants, 140 (50.0%), strongly agreed that depression and anxiety affect daily life, while a substantial proportion, 112 (40.0%), agreed with this statement. In contrast, only a small number of respondents disagreed (14; 5.0%) or strongly disagreed (14; 5.0%).

Overall, the results indicate that an overwhelming majority (90.0%) of the participants acknowledged that depression and anxiety have a significant impact on daily functioning. This reflects a high level of recognition among the respondents regarding the seriousness and real-life consequences of mental health conditions, although a small minority still underestimate their effects.

Table IV: Participants' Opinions on Commonality of Depression and Anxiety among Women

Commonality of Depression & Anxiety	Frequency	Percent
Very common	84	30.0
Somewhat common	140	50.0
Rare	42	15.0
Not at all common	14	5.0
Total	280	100.0

Table IV presents the participants' opinions regarding the commonality of depression and anxiety among women. The findings indicate that half of the respondents [140 (50.0%)] perceived depression and anxiety as somewhat common. Additionally, 84 (30.0%) of the participants considered these conditions to be very common, reflecting a substantial level of awareness about their prevalence among women. On the other hand, 42 (15.0%) of the respondents reported that depression and anxiety are rare, while a small proportion 14 (5.0%) believed they are not at all common.

Table V: Participants' Belief on Treatability of Depression and Anxiety (n=280)

Belief on Treatability of Depression & Anxiety	Frequency	Percent
Yes, with professional help	168	60.0
Yes, without professional help	56	20.0
No	56	20.0
Total	280	100.0

Table V shows the participants' beliefs regarding the treatability of depression and anxiety. The majority of respondents [168 (60.0%)] believed that depression and anxiety can be treated with professional help, indicating a favorable perception toward seeking medical

or psychological care. However, 56 (20.0%) participants expressed that these conditions can be managed without professional help, which may reflect reliance on self-care, family support, or traditional practices. Another 56 (20.0%) respondents believed that depression and anxiety are not treatable, highlighting the presence of misconceptions or lack of awareness about mental health treatment options.

Table VI: Participants' Opinions on Causes of Depression and Anxiety (n=280)

Main Causes of Depression & Anxiety	Frequency	Percent
Family or relationship problems	168	60.0
Financial difficulties	140	50.0
Health issues	112	40.0
Genetics or family history	84	30.0
Social stigma or isolation	70	25.0
Lack of education or awareness	70	25.0

Table VI illustrates the participants' opinions regarding the causes of depression and anxiety (n = 280). The findings reveal that family or relationship problems were the most commonly identified cause, reported by 168 (60.0%) participants. Half of the respondents [140 (50.0%)] considered financial difficulties as a major contributing factor. Additionally, 112 (40.0%) participants identified health issues as a cause of depression and anxiety. A notable proportion of respondents also attributed these conditions to genetics or family history [84 (30.0%)]. Furthermore, social stigma or isolation and lack of education or awareness were each reported by 70 (25.0%) participants as contributing factors.

Table VII presents the participants' beliefs about stressful life events as causes of depression and anxiety (n = 280). The majority of respondents expressed agreement with this statement, with 140 (50.0%) agreeing and 112 (40.0%) strongly agreeing. In contrast, only a small proportion of participants disagreed, with 14 (5.0%) disagreeing and another 14 (5.0%) strongly disagreeing.

Table VII: Participants' Beliefs about Stressful Life Events as Causes of Depression and Anxiety

Stressful Life Events Cause Depression	Frequency	Percent
Strongly agree	112	40.0
Agree	140	50.0
Disagree	14	5.0
Strongly disagree	14	5.0
Total	280	100.0

Table VIII: Participants' Opinions on Women's Proneness to Depression and Anxiety (n=280)

Women Are More Prone to Depression/Anxiety	Frequency	Percent
Strongly agree	84	30.0
Agree	140	50.0
Disagree	42	15.0
Strongly disagree	14	5.0
Total	280	100.0

Table VIII presents the participants' opinions regarding women's proneness to depression and anxiety. The majority of respondents [140 (50.0%)] expressed agreement with this statement, with 140 (50.0%) agreeing and 84 (30.0%) strongly agreeing. On the other hand, 42 (15.0%) participants disagreed, while a smaller proportion, 14 (5.0%), strongly disagreed.

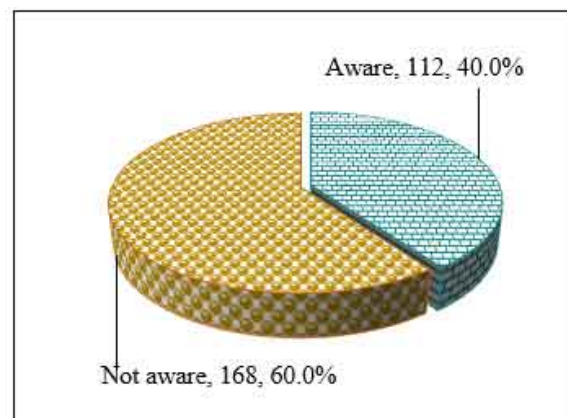


Figure 3: Distribution of Participants' Awareness of Mental Health Services (n=280)

Figure 3 presents the distribution of participants' awareness of mental health services. The findings indicate that 112 (40.0%) participants were aware of available mental health services. In contrast, a larger proportion, 168 (60.0%), reported that they were not aware of such services.

Table IX: Education Levels and Willingness to Seek Professional Help (n=280)

Education Level	Willingness Score		p-value
	Mean	SD	
No formal education (n= 42)	2.1	0.9	0.019
Primary (n= 84)	3.0	0.8	
Secondary (n= 84)	3.3	0.7	
Higher Secondary (n= 42)	3.6	0.6	
Bachelor's Degree or higher (n= 28)	4.1	0.5	

Table X: Marital Status and Perception of Depression's Impact on Daily Life (n = 280)

Marital Status	Perception Score		p-value
	Mean	SD	
Single (n= 56)	3.8	0.9	0.041
Married (n= 196)	4.4	0.7	
Widowed (n= 14)	3.6	1.1	
Divorced (n= 14)	3.7	1.0	

Table XI: Occupation and Awareness of Mental Health Services (n=280)

Occupation	Awareness Score		p-value
	Mean	SD	
Homemaker (n=140)	3.8	0.9	0.052
Employed (n=56)	4.2	0.7	
Self-employed (n=28)	3.9	0.8	
Student (n=28)	4.0	0.7	
Unemployed (n=28)	3.7	1.0	

Table IX presents the relationship between participants' education levels and their willingness to seek professional help for depression or anxiety (n = 280). The results indicate a statistically significant association between education level and willingness (p = 0.019). Participants with a Bachelor's degree or higher demonstrated the highest mean willingness

score (4.1 ± 0.5), followed by those with Higher Secondary education (3.6 ± 0.6) and Secondary education (3.3 ± 0.7). Participants with Primary education had a mean score of 3.0 ± 0.8 , while those with no formal education had the lowest mean willingness score (2.1 ± 0.9).

Overall, the findings suggest that higher educational attainment is associated with greater willingness to seek professional help, emphasizing the role of education in promoting positive mental health behaviors.

Table X presents the relationship between participants' marital status and their perception of depression's impact on daily life (n = 280). The results show a statistically significant association (p = 0.041) between marital status and perception scores. Participants who were married reported the highest mean perception score (4.4 ± 0.7), indicating a stronger recognition of how depression affects daily life. Single participants had a mean score of 3.8 ± 0.9 , while widowed (3.6 ± 1.1) and divorced participants (3.7 ± 1.0) showed comparatively lower perception scores.

Overall, the findings suggest that marital status may influence how individuals perceive the daily-life impact of depression, with married participants showing greater awareness of its effects.

Table XI demonstrates the relationship between occupation and awareness of mental health services among the respondents. Among the different occupational groups, employed women had the highest mean awareness score (4.2 ± 0.7), followed by students (4.0 ± 0.7), self-employed women (3.9 ± 0.8),

and homemakers (3.8 ± 0.9). The lowest mean awareness score was observed among unemployed women (3.7 ± 1.0). However, the difference in awareness scores across occupational categories was not statistically significant (p = 0.052). This finding suggests that occupation was not significantly associated with awareness of mental health services among the study participants.

Discussion

This study explored the perception of depression and anxiety among women in Santhia, Pabna, and revealed several important findings related to awareness, knowledge, perceived causes, treatment beliefs, and factors associated with help-seeking and service awareness. The respondents were predominantly married women in the young to middle adult age group, with most having primary or secondary education and half being homemakers. This sociodemographic pattern reflects the typical profile of rural women in South Asian communities, where marital roles, household responsibilities, and moderate educational attainment strongly shape health perception and care-seeking behavior. Similar community-based work among women has shown that social position, education, and family responsibilities influence mental health literacy and help-seeking practices.^{8,9}

A large majority of respondents reported being aware of depression (80.0%) and anxiety (75.0%). This suggests that the terms themselves were familiar to many women in the study area. However, awareness did not necessarily translate into deeper understanding, because only 10.0% of respondents were very knowledgeable, while 50.0% had little or no knowledge. This finding is consistent with previous evidence showing that recognition of mental health problems may be relatively common, but accurate understanding of symptoms, causes, and treatment options remains limited, especially in rural and resource-constrained settings.^{10,11} In rural Bangladesh, poor mental health literacy has been identified as an important barrier to timely recognition and support-seeking.¹⁰

The present study also found that 90.0% of respondents agreed or strongly agreed that depression and anxiety affect daily life. This is an encouraging finding, as it indicates that most participants recognized the functional consequences of common mental disorders. The finding is in line with global evidence showing that depression can affect work, family life, and social functioning, and that anxiety disorders similarly impair daily activities and quality of life.^{12,13} At the same time, the small proportion of respondents who disagreed may indicate the continuing presence of misconceptions, normalization of distress, or stigma toward mental illness in the community. Such attitudes have also been described in previous studies on women's mental healthcare-seeking behavior in Bangladesh.¹⁴

Regarding perceived frequency, 80.0% of respondents considered depression and anxiety somewhat or very common among women. This perception appears realistic, as women are known to bear a higher burden of depressive disorders than men globally.^{12,15} Biological

vulnerability, gender-based roles, economic dependency, caregiving burden, and exposure to social adversity have all been proposed as contributing factors.^{12,15} The respondents' belief that women are more prone to depression and anxiety is therefore broadly supported by the literature. In this study, 80.0% either agreed or strongly agreed with this statement, suggesting a relatively strong perception of women's vulnerability to mental health problems.

In relation to treatment beliefs, 60.0% of participants believed that depression and anxiety can be treated with professional help, which reflects a favorable perception toward formal care. However, 20.0% believed these conditions could be managed without professional help, and another 20.0% believed that they were not treatable. This mixed pattern suggests that although positive attitudes toward treatment exist, misconceptions remain substantial. Similar findings have been reported in other settings, where cultural beliefs, stigma, low trust in services, and poor understanding of treatment effectiveness reduce the likelihood of seeking professional care.^{14,16} Evidence from intervention reviews suggests that improving awareness alone is not enough; education must also address beliefs about treatability, professional support, and available pathways to care.¹⁶

The respondents in this study most commonly identified family or relationship problems, financial difficulties, and health issues as causes of depression and anxiety. Stressful life events were also strongly recognized, with 90.0% agreeing or strongly agreeing that such events can lead to these conditions. These findings are consistent with established evidence indicating that psychosocial stressors, economic hardship, social isolation, and chronic illness are major contributors to common mental disorders.^{13,17} The prominence of family and relationship problems in the present study is especially relevant in the context of rural women, whose emotional well-being is often closely tied to family structure, marital dynamics, and domestic responsibilities. Studies among rural women in South Asia have similarly documented the role of interpersonal stress, social disadvantage, and limited autonomy in shaping mental distress.^{9,17}

One of the most important findings of the present study is that only 40.0% of respondents were aware of mental health services, while 60.0% were not aware of such services. This indicates a major gap between awareness of mental health conditions and awareness of where or how to obtain care. The result is highly consistent with previous reports from Bangladesh and other low- and middle-income countries, where service availability is limited, mental health systems remain under-resourced, and community members often do not know where to seek support.^{14,18,19} WHO has also emphasized

that many mental health conditions can be treated effectively at relatively low cost, but access remains poor and treatment gaps are wide, especially in low-resource settings.^{13,19}

The association analyses provide further insight into factors influencing perception and help-seeking. Education showed a statistically significant relationship with willingness to seek professional help ($p=0.019$), with willingness scores increasing as educational attainment increased. This finding strongly suggests that education plays a key role in promoting mental health literacy, reducing misconceptions, and improving openness toward professional services. Similar patterns have been reported in studies showing that better-informed and more educated individuals are more likely to recognize symptoms, understand treatment benefits, and seek formal care.^{10,16} This has important practical implications, as women with low or no formal education may require specially designed, culturally appropriate mental health education strategies.

Marital status was also significantly associated with perception of depression's impact on daily life ($p=0.041$), with married women showing the highest perception score. This may be because married women carry broader household, caregiving, and relational responsibilities and are therefore more likely to observe the disruptive effects of depression on daily functioning. Although direct comparisons are limited, this interpretation is supported by research showing that women's mental health perceptions are often shaped by their family roles, caregiving burdens, and lived social experiences.^{8,17} Widowed and divorced women had lower perception scores, which may reflect reduced social support, different life experiences, or smaller subgroup sizes in the present study.

Occupation, on the other hand, did not show a statistically significant association with awareness of mental health services ($p=0.052$), although employed women had the highest mean score. Even though this result narrowly missed conventional statistical significance, the trend suggests that women with greater social exposure, mobility, or institutional contact may be more likely to know about available services than homemakers or unemployed women. Comparable studies have noted that exposure to information networks, workplaces, educational institutions, and media can enhance mental health awareness and help-seeking.^{8,16} Thus, while occupation was not a significant predictor in this sample, it may still have practical relevance in larger studies.

Overall, the findings of this study indicate that women in Santhia possess a fair level of general awareness about depression and anxiety and generally recognize their seriousness, commonness, and effects on daily life. However, detailed knowledge remains limited, misconceptions about treatability persist, and awareness

of mental health services is poor. These findings point to an urgent need for community-based mental health education, especially for less educated and socially less connected women. Interventions involving primary healthcare workers, community outreach, locally adapted awareness campaigns, and WHO-recommended community-based mental health approaches may be helpful in improving mental health literacy and service utilization in rural Bangladesh.^{8,18,20}

Conclusion

The present study concludes that women in Santhia, Pabna had a moderate level of awareness regarding depression and anxiety, and most respondents recognized that these conditions affect daily life and are relatively common among women. However, detailed knowledge about depression and anxiety was limited, and a considerable proportion of participants were not aware of available mental health services. Misconceptions regarding the treatability of these conditions were also observed among some respondents. Education was significantly associated with willingness to seek professional help, while marital status influenced perception of depression's impact on daily life. Although occupation showed some variation in awareness of mental health services, the association was not statistically significant. Overall, the findings highlight the need for community-based mental health education, improved awareness of available services, and targeted interventions to promote positive attitudes toward professional help-seeking among rural women.

References

1. World Health Organization. Depression and other common mental disorders: global health estimates. Geneva: WHO; 2017.
2. Albert PR. Why is depression more prevalent in women? *J Psychiatry Neurosci*. 2015;40(4):219-221.
3. Niaz U, Hassan S. Culture and mental health of women in South-East Asia. *World Psychiatry*. 2006;5(2):118-120
4. Hossain MD, Ahmed HU, Chowdhury WA, Niessen LW, Alam DS. Mental disorders in Bangladesh: a systematic review. *BMC Psychiatry*. 2014;14:216.
5. Islam A, Biswas T. Mental health and the health system in Bangladesh: situation analysis. *WHO South-East Asia J Public Health*. 2015;4(2):156-163.
6. Mullick MSI, Goodman R. The prevalence of psychiatric disorders among 5-10 year olds in rural, urban and slum areas in Bangladesh: an exploratory study. *Soc Psychiatry Psychiatr Epidemiol*. 2005;40(8):663-671.

7. Giasuddin NA, Chowdhury NF, Hashimoto N, Fujisawa D, Waheed S. Pathways to psychiatric care in Bangladesh. *Soc Psychiatry Psychiatr Epidemiol*. 2012;47(1):129-136.
8. Afreen R, Kumar R, Das S, et al. Enhancing mental health literacy and care through community-based participatory research among women. *Front Public Health*. 2024. Available from: PMC11669598.
9. Iyer K, Bang A, Bang R. Mental health resources, barriers, and intervention needs among women living in rural Maharashtra, India. *Int J Environ Res Public Health*. 2023. Available from: PMC10765017.
10. Uddin MN, Bhar S, Islam FMA. An assessment of awareness of mental health conditions and its association with socio-demographic characteristics: a cross-sectional study in a rural district in Bangladesh. *BMC Health Serv Res*. 2019;19:562. Available from: PMC6692949.
11. Huque R, Hossain S, Rahman M, et al. Mental health care seeking behavior in Bangladesh. *BMC Psychiatry*. 2025. Available from: PMC12335107.
12. World Health Organization. Depression. Geneva: WHO; 2025.
13. World Health Organization. Mental health. Geneva: WHO; 2025.
14. Koly KN, Osman FA, Sultana N, et al. Mental healthcare-seeking behavior of women in Bangladesh: content analysis of social media posts. *BMC Women's Health*. 2022;22:512. Available from: PMC9760542.
15. World Health Organization. Depressive disorder (depression). Geneva: WHO; 2025.
16. van den Broek M, Bosmans J, de Winter L, et al. Interventions to increase help-seeking for mental health care: a systematic review. *Front Psychiatry*. 2023. Available from: PMC10499262.
17. World Health Organization. Mental health in emergencies. Geneva: WHO; 2025.
18. World Health Organization. From isolation to inclusion: community-based mental health care. Geneva: WHO; 2025.
19. World Health Organization. Over a billion people living with mental health conditions: services require urgent scale-up. Geneva: WHO; 2025.
20. World Health Organization. Mental Health Gap Action Programme (mhGAP). Geneva: WHO.