Health Seeking Behavior of People Who Experience Mental Illness in Nepal

Manju Pandey

Nepal

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A thesis submitted in partial fulfillment of the requirement for the degree of Masters of Public Health/International Course in Health Development

By:
Manju Pandey
Nepal

Declaration:

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Signature: ……..

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Abstract

Background: Nepal formulated a Mental Health policy in 1996. People who suffer from mental illness still lack access to quality mental health care in their own community and are at risk of being stigmatized.

Objective: The aim of this study is to explore factors determining health seeking behavior of people with mental illness and give recommendations to health authorities to develop quality mental health services.

Study Methods: A literature review is carried out from published and unpublished articles. The conceptual framework for the study is adapted from Andersen's Behavioral Model, which looks at various socio-cultural factors related to behavior during illness and the search for appropriate care.

Findings: The determinants for health seeking behavior are interconnected. Different socio-cultural factors, a weak health care system, an unsupportive environment and gender influence people's choices when seeking help. Lack of felt need and lack of access and availability of mental health services are serious barriers for people with mental illness, leading to further deterioration of mental health.

Conclusion: Although a mental health policy is in place for 15 years, the government is unable to provide affordable mental health services of good quality. An optimal mix of mental health services from primary to tertiary level to bridge gaps between need and available services is essential.

Recommendation: Integrating mental health services into Primary Health System, improving skills of health workers to diagnose, treat and refer patients with mental illness will create the much needed mental health services.

Key Words: Health Seeking, Mental Health, Mental Illness, Nepal.

Word Count: 12,191

Glossary

The terms defined below are for the use in the thesis at hand and for the purpose of this different terms will be used. Some of the scientific terms, which are used frequently in relation with the topic, are as follows:-

Community-based Psychiatric Inpatient Unit: Those psychiatric units which provide care and treatment to the admitted patients for mental illness within a community based facility is known as Community–based psychiatric inpatient unit. These units usually provide care to those who are with acute problems of mental illness. The period of stay is usually short. It may vary from weeks to months (WHO 2005).

Health Seeking Behavior: Health seeking behavior is defined as the behavior of a person to seek help, advice and support from health professionals in a health care service centers and/or health care providers (physicians/ psychiatrist/psychologist/nurses) and/or any other non-health professionals (traditional/faith healers/astrologist/religious healers) for the treatment of illness and promotion of mental and physical health (El Kahi et al. 2012).

Mental Health Camp: Mental health camp is a place where certain expertise of mental health is gathered and they provide mental health services to the people attending the camp. Normally, in Nepal people are checked for their mental status that comes for check up. A diagnosis is mostly made and few drugs are also provided. In case of severity in illness they are referred to appropriate mental health service centers for further treatment and care.

Mental Health Day Treatment Facility: It is a kind of treatment facility which provides care to the patients with mental health problems during day time. It is available to groups of patients at same time rather that individuals at a time. It takes care of patients for whole day and provides different kinds of workshops like- employment and rehabilitation workshops (WHO 2005).

Mental Health Outpatient Facility: Those facilities which provide services to the patients with mental illness on an outpatient basis are known as mental health outpatient facility (WHO 2005).

Mental Illness: Mental illness is defined as- "the health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (U.S. Department of Health and Human Services cited in CDC 2013).

Psychiatrist: A psychiatrist is a medical doctor specialized in psychiatry (Mental health and illness) with at least two years of post–graduate training in psychiatry (WHO 2005).

Psychologist: A psychologist is someone who has had formal training in psychology in a university of college and provides counseling to the patients in need (WHO 2005). It is not always necessary psychologist come from a medical background.

Psychotropic Drugs: Those drugs/medications which are used for the treatment of mental illness are known as psychotropic drugs (Mental Health Connection of Tarrant Country n.d.).

List of Abbreviations

AHWs - Auxiliary Health Workers

AIDS - Acquired Immuno-deficiency Syndrome

AIMS - Assessment Instrument for Mental Health Services

CIA - Central Intelligence Agency

CMAs - Community Medicine Auxiliaries

CMC Nepal - Center for Mental Health and Counseling Nepal

CPM - Conspicuous Psychiatric Morbidity

DoHS - Department of Health Services

DFID - Department for International Development

DHS - Demographic and Health Survey

FCHVs - Female Community Health Volunteers

GDP - Gross Domestic Product

GNI - Gross National Income

GP - General Practitioner

GTZ - German Technical Cooperation

HA - Health Assistant

HDI - Human Development Index

HIV - Human Immunodeficiency Virus

HRH - Human Resources for Health

INGO - International Non-governmental Organization

KOICA - Korea International Cooperation Agency

LEADS Nepal - Livelihood Education and Development Society Nepal

MDGs - Millennium Development Goals

MOF - Ministry of Finance

MoHP - Ministry of Health and population

NCD's - Non-communicable Diseases

NGO - Non-governmental Organization

NHSP - Nepal Health Sector Programme

OOP - Out-of-Pocket

PHC - Primary Health Care

PSTD - Post-traumatic Stress Disorder

SHP - Sub-Health Post

TPO - Transcultural Psychosocial Organization

UNDP - United Nations Development Programme

UNICEF - United Nations Children's Fund

WHO - World Health Organization

Introduction

According to World Health Organization (WHO) (2014) - "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community". WHO (2009) estimates total number of people suffering from mental illness around the globe to be more than 450 million. The global burden of disease for mental disorder accounts for about 13% and this figure will rise to nearly 15% by 2030 according the Mathers & Loncar (2006). Among many mental health problems depression alone is likely to be the second highest contributor for the global burden of disease. As well, mental illnesses are the major risk factor among one million suicides that occurs annually (WHO n.d.a).

The South Asian region consists of the largest population in the world (around 23%) with one-fifth of the population suffering from mental illness (Trivedi et al. 2007). Nepal is one of the developing countries in South Asia region where the exact number of people with mental illness is unknown, however the World Bank (2011) estimates that- about 18% of the people are suffering from mental illness out of total burden of Non-communicable diseases (NCD's).

Mental illness and other mental health problems may not be an emergency condition but are conditions which could lead to long lasting disability and increase the economic burden of the country due to loss of work, increased dependency and higher cost for treatment and care (Bloom et al. 2011). Also, different cultural beliefs regarding mental illness, traditions of seeking help from traditional healers and other related factors like - stigma related to mental illness, unavailability and inaccessibility of mental health services especially in rural parts are huge problems leading to deteriorating condition of people who suffer from mental illness.

There is need for a clearer understanding of the factors that might contribute to the availability of and the way in which people access mental health services such as for instance - culture, economy, availability and quality of mental health services and what are the barriers for service utilization that people suffering from mental illness encounter. Also, it is essential to know better how the family of the people with mental illness and their communities respond to people with mental illness. Therefore, in this thesis the factors that determine health seeking behavior in Nepal and, the perceptions of people about mental illness will be assessed and discussed based on supporting literatures. Recommendations will be provided for the

concerning health authorities, mental health service providers with the aim to reduce the treatment and service gap and to enable the provision of quality mental health services in Nepal.

During my nursing studies, I had keen interest in Mental Health Nursing. After my nursing education, I started working as Nursing Instructor. As a Nursing Instructor I have been teaching Mental Health Nursing to my students since 2010. During the instruction various practical sessions were also required in hospitals and community, where people suffering from mental illness had to be cared for. Through this thesis, I am exploring the questions I had in my mind while working with mentally ill people in hospital and community as a student and as an instructor in Nepal. The questions like - What makes people seek health services?, Why do people don't go and seek health services when they have mental illness? made me think always. Further investigation will be undertaken after returning to Nepal.

Organization of the Thesis

Chapter **One** gives a general overview of the country in terms of geography, demographics, culture, gender, economy, politics and the available resources in health and health systems. Chapter **Two** introduces the problem, presents the objectives of the thesis, describes the methodology used for literature review and presents a conceptual framework for health seeking behavior. Chapter **Three** describes the study results and findings regarding mental health and mental illness in Nepal. Chapter **Four** discusses together with study findings and tries to analyse them on the basis of the understanding of study results for health seeking behavior in Nepal. Finally, Chapter **Five** gives the conclusion of the study and gives some recommendations to the concerning health authorities in order to provide quality mental health services to people of Nepal.

CHAPTER I

Background Information of Nepal

1.1 General Overview of the Country

Geographical Aspects

Nepal is a landlocked country surrounded by two countries, China towards North and India towards its East, West and South. It occupies an area of about 147,181 square kilometers with lowest elevations ranging from 90 meters to highest up to 8,848 meters. Nepal is rectangular in shape with 885 kilometers of length from east to west and 193 kilometers width from north to south (MoHP 2012). Topographically it is divided into three ecologically distinct zones; Mountains, Hills and Terai with the areas occupying about 35%, 42% and 23% respectively. The temperatures and climate varies accordingly in different zones with the varying altitude. According to the climate there are five climatic zones which are tropical and subtropical zones, temperate zones, cold zone, subarctic zone and arctic zone. The temperature of hills and mountains remains from 43° Celsius and 29° Celsius in summer and -1° Celsius and far below 0° Celsius in winter respectively. In terai the temperature can rise up to 44° Celsius in summer and fall up to 1° Celsius in winter (MoHP 2012).

For different administrative purposes Nepal is divided in five developmental regions, 14 zones and 75 districts (See annex 1). Districts are further divided into Village Development Committees (VDCs) and municipalities in rural and urban parts of Nepal respectively. There are currently 3,915 VDCs and 58 municipalities in the country. Kathmandu is the capital of the country (MoHP 2012).

Demographic Aspects

According to CBS (2012), the population was about 27 million in 2011 of which 13 million are male and 14 million are female. There is an annual growth rate of 2% in the population (UNICEF 2013). In general about 35% of the population is under the age of 15 years and 10% is above the age of 65 years (MoHP 2011). There are 125 listed diverse ethnic groups in the country with their distinct language and culture however; the principal language used in the country is Nepali (MoHP 2012). The major ethnic groups are Brahmins, Chettri, Newar, Tharu, Tamang and Magar. There are 10 different types of religions. The majority (81%) are Hindu's and rest are

Buddhist (9%), Islam (4.4%), Kirat (3.1%), Christian (1.4%) and others (Prakriti, Bon, Jain, Bahai and Sikh) (CBS 2012).

Socio-Cultural Aspects

Nepal is a country with multiple cultures and multiple ethnic groups (Dahal 2003) where majority (81%) of the population is Hindu's (CBS 2012). There are many different ethnic groups and castes in Nepal and all of them have belief in supernatural powers. Most of the people in Nepal worship gods and spirits and also believe that illness is caused due to supernatural powers (gods, evil spirits, witches and demons) when their demands and desires and not fulfilled during any kind of ceremony or ritual (Subba 2007). There are different beliefs about the health and causes of illness (biomedical, natural or supernatural causes) in Nepal and health seeking behavior varies according to the belief in the causes of illness (Wasti et al. 2011). People visit doctors, priest and other faith/traditional healers to diagnose the illness and adhere to treatment procedures according to their belief in causes (Subedi cited Wasti et al. 2011).

Gender and Family Aspects

Nepal has a patriarchal society from ancient times where men are bread winner and decision maker of the family. People live in large joint families traditionally, where the eldest male (most of the time father) is head of the family controlling all family, household affairs and owes the overall property of the house (Goldstein & Beall 1986). Nowadays, the trend is changing and people have also started living in nuclear family and making decision according to their needs and desire about their marriage and family life, education and carrier development (Ghimere & Axinn 2006). The age of marriage and deciding on family is 18 years for both male and female with parental consent and 20 years without parental consent in Nepal (Maharjan et al. 2012).

Throughout centuries of tradition, women have long faced inequality, violence and discrimination on the fact they are expected to conduct all household chores including taking care of house, families, domestic animals and farming. This can be distressing physically and mentally (Wydra et.al 2010). Recently, the trend is changing in family structure of Nepal, there women's are given priority in decision making which can also be seen by increased female headed housed in the country from nearly 15% in 2001 to around 26% in 2011 (CBS 2012).

Political Aspects

Nepal has multi party democratic system with seven different political parties, where Nepali Congress and Nepal Communist party are the biggest political parties (Wild & Subedi 2010; FES n.d.). The National council and House of Representatives are the legislative bodies and there are 205 elected members in the parliament. The council of ministers has the executive power and is headed by the prime minister (Nepal's Political Structure n.d.). In the last decade there has been political instability in the country due to fighting between different political parties and also within political parties. In 2006, there was mass movement in the country after 10 years of armed conflict, during which the abolition of the King Gyanendra took place, giving rise to new democratic system with the president as the honorable head of the state (Dahal 2008).

Economic Aspects

Nepal is one of the poorest country in the world ranking at 157th position out of 187 countries with the Human Development Index (HDI) of 0.463 in 2012 (UNDP 2013) and Gross domestic product (GDP) of US $607 per capita in 2011 (UN Data 2013). Majority (66%) of Nepal's population are involved in agriculture contributing 39% of countries GDP currently (DOA 2014) as well countries economy is supported by tourism, forestry, industrial labor, formal and informal works and remittances from abroad. Still around a quarter (25%) of population are living below poverty line (World Bank 2010) and estimated 46% are unemployed (CIA 2014). The inflation rate is as high as 10% in 2013 (CIA 2014) increasing the poverty in the country.

General Health Aspects

Mortality, Threats to Mortality and Common Diseases

According to the World Bank (2011), out of total mortality caused by different illness and disability 60% of death occurs due to different non-communicable diseases (NCD's) and 40% due to communicable diseases, maternal and child ill health and other nutritional deficiencies. The major diseases in NCD's are cardiovascular diseases, injuries, mental illnesses, cancer and other. Mental illness accounts for 18% of disease burden in all NCD are which is leading to disability, morbidity and mortality (The World Bank 2011). About 2% of the total population suffers from some kind of disability including mental disability, out of which 6% of them are mentally disabled (CBS 2012).

Overview of Structure of Formal and General Health System

Nepal's National Health policy was adopted in 1991 whose prime motive was to improve the health of the people in Nepal by extending primary health care systems to rural populations (MoHP 2014a). The policy is addressing different issues for preventive, promotive and curative health services with emphasis on basic primary health care services, community participation, human resources for health (HRH) development, resource mobilization and improved drug supply for essential drugs (MoHP 2014a). Since the implementation of this policy there has been commendable improvement in the health status of people in Nepal (Shrestha & Pathak 2012). Recently, the second Nepal Health Sector Programme (NHSP-2) started focusing on meeting the millennium development goals (MDGs). Also, it offers a strong base for developing the essential health care package and some new programmes have been added e.g. mental health, oral health, environmental health, community based newborn care and community based nutrition care and support programme (MoHP 2010).

Table - 1 Health Care Facilities under Department of Health Services, Nepal

Health Facility	Number
Central Hospital	8
Regional Hospital	3
Sub- Regional Hospital	2
Zonal Hospital	10
District Hospital	72
Primary Health Care Centre(PHCC)/Health Centre	207
Health Post(HP)	1689
Sub-Health Post(SHP)	22127

Source: (MoHP 2014b) (DoHS, Annual Report 2012/13)

In 2013/14 the government of Nepal has increased the health budget to 6.5% out of the total government budget (Ghimire & Gautam 2013) and approximately 86% of the health budget is allocated to preventive services. Nearly 14% is allocated for curative services by Ministry of Health and Population (MoHP) (MoHP 2013). The Department of Health Services (DoHS) is responsible to conduct all kinds of preventive, promotive, curative and rehabilitative health services and is regulated under MoHP. Sub-health Post (SHP) is the lowest contact level under the Organogram (See annex 2) where essential health services are provided by the government to all people, free of costs.

CHAPTER II

Problem Statement, Justification, Objectives, Methodology and Limitation

2.1 Statement of the Problem

In Nepal more than 80% of the population lives in rural parts of the country and depends on agriculture and farming for their living (CIA 2014; IFAD n.d.). There is very limited data regarding the prevalence of mental illness in the rural communities of Nepal (Shakya 2010; Khattri et al. 2013). However, it cannot be ignored as it is likely that many people experience mental illness. This affects family, social life and the economy of the family. The burden of mental illness may be higher than the official estimates because most of the time it is unreported in health centers until it becomes severe affecting family and society (Lamichhane et al. 2012; Doyne 2014). One of the researches done in Baglung district showed that the prevalence of mental illness was about 38% in the whole district (Khattri et al. 2013).

There can be many causes for mental illness; however, the perception of people regarding the causation of disease is different in different societies. Some research suggest that family tensions, lack of control over developmental changes, genetic factors, evil spirits, black magic and sins of present and past life leads to mental illnesses (Kermode et al. 2009; Salve et al. 2013). Also, physical and emotional trauma, lack of social support, chronic medical conditions, alcohol and substance abuse are seen as important causes leading to mental illnesses (Das, Adhikari & Sharma 2013). The vulnerability for mental illness might also increase when these are associated with poverty, political violence, gender based violence and discrimination putting the poor, illiterate marginalized groups and women's in higher risk for development of mental illness (LEADS Nepal 2010).

Mostly those people who are suffering from different mental illness are considered to be unproductive, an economic burden and worthless to the family, dangerous and a nuisance to the society (Kumar 2013). In cases where they are not able to care for themselves, they look dirty or become aggressive to people for no reason (Kumar 2013). This can lead to rejection, exclusion and discrimination from the family and colleagues. Many people with mental illness face the risk of being stigmatized by their families or communities (Adhikari, Pradhan & Sharma 2008). The worst case scenario in many countries for people with mental illness is that they are locked in a room or tied up with rope or chained in a pole somewhere in the corner of

the house like an animal, with the risk that they harm themselves by attempting suicide (LEADS Nepal 2010).

Many times people who suffer from mental illness seek help for treatment and care from traditional/faith healers and practitioner of ayurvedic and homeopathic medicine (Patel, Simunyu & Gwanzura 1997). In India seeking help from faith healer and religious people to treat mental illness is very common because of the belief in black magic and supernatural powers (Pradhan et al. 2001; Raghuram et al. 2002; Campion & Bhugra 1997). In many developing countries people living in rural areas have been seeking help from faith healers for their physical and mental illness since centuries and they have developed strong trust and belief in them for treatment and cure of their illnesses (Gater et al. 1991).

There is a lack of research result in the field of Mental Health. However, the few studies available show that a minority of the population, suffering from mental illness seek treatment in formal sector and majority hide their mental illness even though it is causing disturbance in family and social roles (Pradhan et al. 2013). They visit faith healer because they are easily accessible, close and trust worthy for them. They believe that their health condition will not be revealed to the community and they will not be stigmatized (Pradhan et al. 2013), which usually increases the hesitation for seeking professional help (health workers). According to WHO (n.d.b) - 75% of people living in low income countries lack access to treatment to mental illness. In many lower middle income countries the majority of the health services are concentrated in the urban areas and rural population lack a psychological support system, which creates a huge treatment and service gap (85% treatment and service gap regarding the mental health services in rural communities) (CMC-Nepal 2013).

The role of the individual, family and community also plays a vital role in whether a person with mental illness will use health care services. Many times patients and families visit professional and non-professional services according to the recommendation of their friends and relatives (Pradhan et al. 2013). The health seeking behavior is also dependent on the preference and trust for the health care provider by the patient and family (Pradhan et al. 2013).

Thus, health seeking behavior is an important issue which should be studied for providing quality mental health services.

2.2 Justification of the Study

Globally, mental illness is one of the leading cause (7.4%) for disability adjusted life years (DALYs) accounting for 37% of loss of healthy life years due to NCD's (Whiteford et al. 2013; WHO 2011). WHO (2011) estimates that out of all patients using a health service, approximately 25% suffer from at least one mental, neurological or behavioral disorder. Most of these are undiagnosed or untreated. Mental illness is the top driver for output loss (35%) leading to economic burden globally (Bloom et al. 2011). This is due to loss of productivity, loss of work, long lasting disability and regular treatment expenses (Insel 2011). Many researches in different parts of Nepal have analyzed changes in situation of people with mental health in past decades and recent time and have presented the results of significant progress and improvement in mental health situation in Nepal (MoHP 2010). There have also been various researches looking at different issues but, most of them are focused on refugees and few are done with people in post conflict situations (Luitel et al. 2013). However, it is felt that there is lack of researches done in Nepal looking at health seeking behavior of people suffering from mental illness.

There are various factors which determine a person's decision making for the seeking services for treatment and cure. This is very important to know in order to provide a good quality of mental health services. Hence, there is need for further research in this area. This study intends to identify and describe these factors. The services and support system available for people with mental illness will also be analyzed and the gaps in available mental health services will be identified. So that, proper recommendation can be provided to the concerning authority to provide quality mental health services in Nepal creating suitable or favorable health services for mentally ill people.

2.3 Study Objectives

General Objective

To explore the factors determining health seeking behavior of people who experience mental illness in Nepal and give recommendations to provide quality mental health services to the concerning health authorities.

Specific Objectives

1. To identify and describe health seeking behavior of people suffering from mental illness in Nepal.
2. To analyse services and support systems that are available.

3. To identify the gaps in mental health services provided.
4. To give recommendations to the concerning health authorities in order to provide quality mental health services.

2.4 Methodology

Study Search Strategy

This thesis is based on a literature review of grey literatures and both published and unpublished research articles done by different researchers in the field related to mental health, mental illness and their health service seeking behavior during mental illness. The literature search was performed through use of different databases like - Pub Med, Science Direct, Google Scholar, Scopus. In these databases and search engine combination of words like - Mental Health in Nepal, Mental Health Policy, Stigma, Discrimination, Perception, Health seeking Behavior, Consequences of Mental Illness, Knowledge and Attitude towards mental illness were used.

Research articles alone are assumed to be inadequate to find the answer researcher wanted to get, so different grey literatures from MoHP (Nepal), WHO, United Nations Children's Fund (UNICEF) and other local non-governmental organization (NGO)/international non-governmental organization (INGO) reports, local and international website and news articles available in internet are also searched and assessed.

Research articles focusing on mental illness from 1995 until 2014 providing information about mental illness in regard to Nepal and published in English language are included and analyzed for search of information's related to the topic. However, a few articles from 1986 and 1991 are also included exceptionally, to get more information on the findings for the support of this study. The extended search for literature, research articles and other supportive information was necessary because it appeared that it was very difficult to find recent articles related to utilization of mental health services in context of Nepal only. To construct a better contemporary image, research articles from India are also taken for result findings in this study. Articles from other than Nepal and India, those before 1995 and those not related to mental illness are excluded.

Conceptual Framework

To understand the various interrelated factors that determine health seeking behavior during mental illness of the people in Nepal, different conceptual frameworks to analyse data were assessed. Three conceptual frameworks were used as a tool for analysis in this study; the Health Belief Model,

Knippenberg's model and Andersen's Behavioral Model. During analysis it was experienced that the first two models were being unable to answer the entire questions researcher wanted to find.

Andersen's Behavioral Model has been upgraded continuously since it was first developed in 1968 (Andersen 1995). So, the latest updated model named as "An emerging Phase-4 model of Andersen's Behavioral Model" is used in this study. Along with this model another descriptive model known as Andersen's 3 Factor Model of Health Service Use is adapted and used. This is because it helped to explain all population characteristics of emerging phase-4 model individually in a clear way with relation to health seeking behavior during mental illness. Thus, being suitable for the topic and able to explore all associated factors related to health seeking behavior during mental illness and need, these two associated model are used for this study.

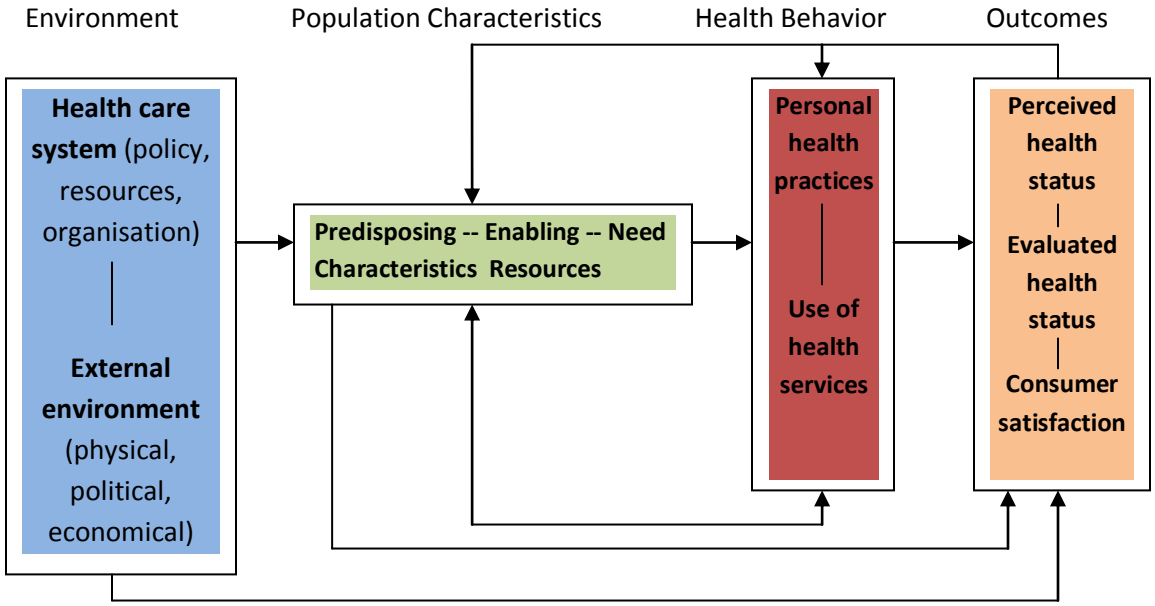
Andersen's Behavioral Model was developed by Ronald M. Andersen in 1968 to understand families' behavior in utilization of health services in need in the USA (Andersen 1995). This model was then revised in several phases and finally, in 1995, an emerging Phase-4 model of Andersen's Behavioral Model was developed (Andersen 1995). The emerging model portrays different factors which influence health service use and health status of the people using health services (Andersen 1995). This model is very useful to understand the health seeking behavior of different individuals as it is flexible to analyze different factors which influence the behavior for seeking help and access to available health services. The model also helps to analyse different environment factors, population characteristics factors, health behavior factors that determine people's health seeking behavior. It also includes variables which help to get feedback about the health services from the outcomes available from perceived need for services as well as health behavior of the patient after use of health services (Andersen 1995).

The second model associated with Andersen's model was developed by Ronald Andersen and John F. Neuman in 1973 and focuses on three main population characteristics (Andersen & Neuman 2005) that influence the individual:

1) Predisposing Factors: This deals with the demographic, social structure and social beliefs of the person which are very important determinants for people's health seeking behavior during illness.
2) Enabling Factors: This deals with the support system related with family and community which a patient needs during the illness and also which influences strongly to the patient to seek health services.
3) Need Factor: This is the most important factor which creates perceived need and utilization and adherence of health services when in need.

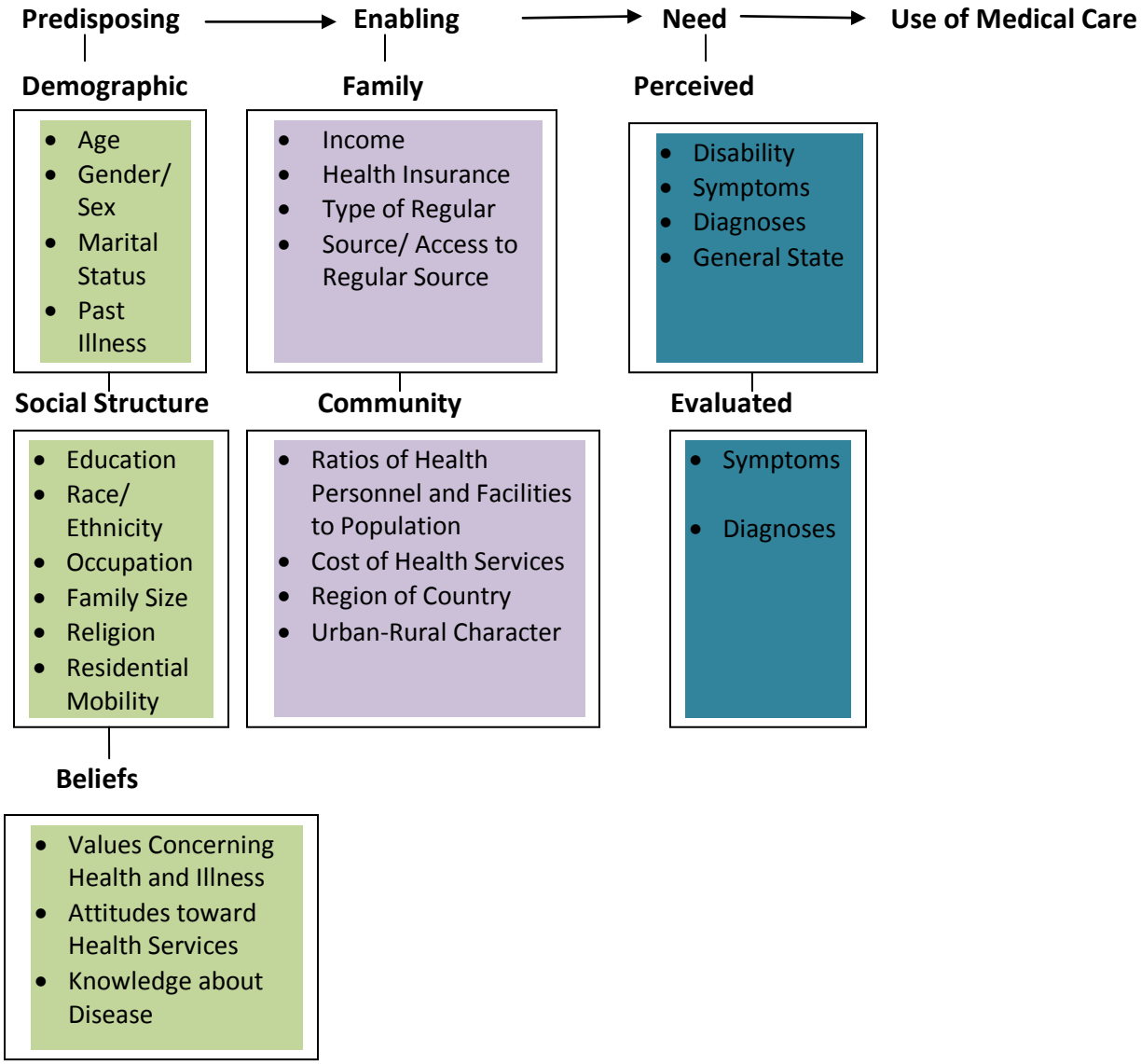
As Andersen's model deals with various factors, from community to family to individual level, this model has been used to determine health seeking behavior of people suffering from mental illness in this study.

An Emerging Model Phase-4 of the Andersen's Behavioral Model



Source: (Andersen 1995)

Andersen's 3 Factor Model of Health Service Use



Source: (Adapted from Andersen & Neuman 2005)

2.5 Limitation of the Study

This paper is the product of review and analysis of different published and unpublished literature. There is lack of recent data available regarding prevalence, causes, consequences and health seeking behavior with mental illness in health system reports. Also, very few studies regarding the Mental Health have been done in Nepal. So, examples from different countries are taken which may not be totally comparable for recent context of Nepal. It was not possible to perform primary data collection as the time was limited. Moreover, the research was limited to English sources only.

CHAPTER III

Health Seeking Behavior, Support System and Services of/for People suffering from Mental Illness and Gaps in Mental Health Services

In this chapter the result findings are presented. The findings are described according to the different factors/variables present in the conceptual framework, and are analyzed according to the objectives set for the study. Firstly, the health behavior is discussed and analyzed, followed by population characteristics, environmental factors. Finally, the outcomes regarding patient's perception regarding their health condition, their satisfaction from available health service and their health condition after the use of health services are analyzed to get feedback about the health services.

3.1 Health Behavior

3.1.1 Personal Health Practices

People suffering from mental illness are in a vulnerable condition in most part of Nepal as they lack access to mental health services. They also hesitate to seek services in the fear of stigma and discrimination from the society knowing they are suffering from mental illness (Pradhan et al. 2013). Some of the experience shared by mentally ill patients also show they are in very pitiful condition.

One of the patients in Mental Hospital of Nepal shared that - She is "no longer interested in maintaining her personal hygiene" and feels her "life is worthless" (Bhattarai 2011).

In the same way another patient also shares her feeling saying - "life is meaningless" and "wants to commit suicide" (Bhattarai 2011).

One of the consultant psychiatrists from the same report shared - "most patients visit hospital when the condition is severe and difficult to manage after suffering from long time with mental illness" (Bhattarai 2011).

"Families also ignore the responsibilities towards the patient deteriorating the condition of the patient" says another employee during the interview (Bhattarai 2011).

Various patients visit traditional healers and faith healers, thinking mental illness is caused by supernatural power and they can solve their problem, meanwhile keeping silent about their health condition (Pradhan et al. 2013).

3.1.2 Use of Health Services

Use of mental health services by people with mental illness has been a major challenge in Nepal because of lack of availability and accessibility of mental health services all over the country (WHO-AIMS Report 2006; Das, Adhikari & Sharma 2013). A few studies done in Nepal and India shows that nowadays mentally ill patients prefer to seek the help of psychiatrist or use mental health services. According to the study done by Pradhan et al. (2013) out of all respondents in the study around 65% visited a psychiatrist directly. Similarly, psychiatrists were also the preferred choice as the first contact (almost 25% at outpatient service and 20.5% psychiatrist outside) in another study (Mishra et al. 2011).

In the same way, another study also showed that the majority (57.7%) of the patients preferred to choose psychiatrist as the first choice (Chadda et al. 2001). Mostly, those with mental illness prefer to seek help from psychiatrist in a private psychiatric clinic as far as they can afford (Jha 2007). Most of the patients preferred to choose mental health services because they believed that a specialist should be consulted for best treatment. Whereas, few thought services were cheaper and some of them were unsatisfied with other treatment modalities for their ill condition (Mishra et al. 2011; Chadda et al. 2001). The reasons for seeking help in a mental hospital varied, as well the time interval that varied from 22 days to 20 years (Chadda et al. 2001). Although these days the number of patients seeking health services are increasing, still those suffering from severe mental illness remain reluctant to seek appropriate care (LEADS Nepal 2010).

3.2 Population Characteristics

3.2.1 Predisposing Factors

Demographic Factors

Age

Studies done in different district of Nepal shows that the majority of people suffering from mental illness are found in the age between 20-40 years. A study done in Kusmi Village in the Baglung District showed that mental illness was found mainly among adults older than 30 years (Khattri et al.

2013). A similar study done in the Dang district showed that people of age 16-45 years suffered most (around 78%) from mental illness (Das, Adhikari & Sharma 2013). Khan and Belbase (2013) in their study in a mental health camp in the Kanchanpur district showed that the majority (36%) of patients attending the camp were between the age of 21-30 years followed by age group 11-20 years (19%) and 31-40 years (16%).

Gender/Sex

Studies also show that there is some relation between mental illness and gender/sex of the person. With regard to relation with gender and mental illness a survey done in Nepal presented that females suffered more compared to males with a sex ratio of 2.8:1 in the health post and 1.1:1 in the district hospital (Wright cited in Trivedi, Sareen & Dhyani 2008). Similar, results were also reported in the study done in the western region of Nepal, where nearly 52% females suffered by mental illness compared to 48% males (Lamichhane et al. 2012). Kohrt & Worthman (2009) also found in their study that females are two times more likely to suffer from severe anxiety (a form of mental illness) compared to males. These findings illustrate women's are at higher risk for suffering mental illnesses.

Marital Status

Some studies have presented results where marital status of patients was also one of the socio-demographic factors for illness. The study conducted in Lagankhel Mental Hospital presented that - out of all patients (852) admitted in the hospital the majority (60.3%) were married, followed by 37% of unmarried and 3% of them were separated (Shrestha et al. 2011). Similar results were also found in the in the survey done in Kathmandu, where out of 50 patients involved in the study 34 (68%) of them were married and rest were single (Hashimoto et al. 2010). These findings show that being married can also be one of the important determinant for having mental illness and also it can be assumed that those who are married seek help for treatment faster compared to singles and divorced in need.

Past Illness

Different physical illness and bodily conditions could also be one of the stressors leading to mental illness. Long term chronic illness like - diabetes, cancer and other diseases such as - HIV/AIDS can put the patient on higher risk for mental illness. One of the cross-sectional studies done in a clinical setting for type-2 diabetes mellitus, showed that 40.3% respondent developed depression (type of mental illness) after being a long term sufferer (Niraula et al. 2013). Similar results of depression were also found

in patients diagnosed with HIV in Kathmandu valley. Nearly 26% of patients involved in the study presented symptoms of depression and 14 % reported to have suicidal ideation 2 weeks prior to the study period. Out of them 17% of the patients actually attempted suicide after being diagnosed of HIV (Amiya et al. 2014)

Social Structure

Education

Studies that look at the relationship between the level of education and mental illness, shows contradicting results. Some studies show that those who are enrolled in studies suffer more of mental illness whereas some show illiterate suffer more because they get fewer opportunities for development in life (e.g. economic, career etc.). A study conducted in the Dang district presented that maximum (almost 43%) that passed tenth grade suffered from mental illness followed by 33% who studied intermediate and above level (Das, Adhikari & Sharma 2013). Whereas, another study by Luitel et al. (2013) showed that those who are illiterate suffer most from mental illness as they have less economic opportunities compared to literate people.

Race/Ethnicity

In Nepal there are no racial differences as all of the people living in Nepal are of same race. However, there is diversity in caste and ethnic groups. Therefore, it is difficult to draw conclusions which ethnic group or caste suffers most from mental illness. Some studies shows that the distribution of mental illness was highest in Tharu's (51.5%) followed by Brahmin's (25%) (Khan & Belbase 2013). Another study done in the Dang district shows that the respondents showing mental illness was higher in Brahmin/Chhetri (43.2%) followed by Janajati (38.6%) and Dalit (18.2%) (Das, Adhikari & Sharma 2013). Similar results were also seen in the study done by Luitel et al. (2013) where Brahmin/Chhetri had the highest (40.8%) prevalence of mental illness followed by Janajati (32.1%) and Tharu (15.3%). Whereas in a study for political violence in Nepal, dalit's were the people who suffered most with poor mental health compared to other ethnic group (Kohrt et.al 2012). These findings show that the prevalence of mental illness among same ethnic groups in different studies and districts of Nepal are different.

Occupation

Occupation also plays important role with increasing or decreasing the mental stress and coping ability with different situations. Studies show that unemployed and people earning less are more prone to mental illness. Khan

& Belbase (2013) in their study for mental illness in the Kanchanpur district found that the majority (42.2%) of the patients attending the mental health camp were unemployed followed by 21.1% students and 16.4% of farmers. Another recent study conducted in Chitwan shows that farmers were the ones who visited (about 55%) for professional help most frequently out of all patients visiting psychiatric department (Sedain 2014).

Family Size

There are no result findings available which show the relationship between family size and mental illness. The trend for size of the family is changing and researches need to be done which can also look the effect of family size on mental illness.

Religion

In Nepal majority (81%) of population are Hindu's (CBS 2012). This makes it difficult to look at the relationship between religion and mental illness. One of the studies done among foreign job holders showed that out of all patients with mental illness in the study, the majority (90%) were Hindu and only 10% of them were Islam/Muslim (Shyangwa et al. 2009).

Residential Mobility

Residential mobility has a strong relationship with mental illness as shown by the researches. In Nepal, there has been continuous internal migration and external migration for more than a decade. The cause of internal and external migration was mainly - poverty, inequitable distribution of income, unemployment, difficult livelihood and food insecurity (Bhattarai 2005; KC 2012). As well, years of armed conflict played a vital role in internal and external displacement creating an insecure environment for employment and threat to life and property (Bhattarai 2006). Those who had limited opportunities within the country started to migrate to different countries in search of employment which can also be one of the causes to increase stress in their life. In the study for foreign job holders, Nepalese people working in gulf countries (Saudi Arabia, Dubai, Kuwait and Qatar) suffered most (60%) from mental illness followed by migrants to Malaysia (20%) (Shyangwa et al. 2009). Another study by Thapa & Hauff (2005) showed that those people who were displaced during armed conflict in Nepal facing destruction of property and shelter and reaching new places suffered from anxiety and depression.

Belief

Values Concerning Health and Illness

Being a multi ethnic and multi cultural country, Nepalese hold different beliefs for causes of good health and illness. Health and illness are viewed from natural, biomedical and supernatural perspectives in the Nepalese society. It is believed by most of the people that illness is caused by supernatural powers, demons, witches and deities (Beine cited in Wasti et al. 2011). Many times patients having mental illness believe their mental condition is due to black magic and not because of other causes in the body and brain. This brings them to seek help from traditional healers for treatment and cure of mental ill conditions (Pradhan et al. 2013). In a study done by Kohrt & Hruschka (2010) most of the respondents believed that psychological trauma was due to past life sins and bad fortune. They also believed that sufferings are caused due to supernatural powers and eating food and water which are cursed by witches and black magic (Kohrt & Hruschka 2010).

Attitude towards Health Services

There is a variation in attitude of the people regarding health services when it comes to health seeking for mental illness. This is because; being a patient of mental illness is a matter for stigma and discrimination in the society. Although, few studies show that psychiatrist is the preferred choice for treatment of mental illness these days (Chadda et al. 2001; Jha 2007; Mishra et al. 2011). But, the social obstacles for treatment from health professionals cannot be ignored. The trust in traditional healers for being highly confidential about the patient's mental illness and assurance of facing no stigma from the society, people prefer traditional healers over psychiatrist even in urban areas along with rural areas (Pradhan et al. 2013). Another study in Dang district showed that patients lack to seek treatment due to fear of discrimination and stigma (31.8%) which was followed by patients mentioning lack of access to appropriate treatment (28.4%) and improper behavior and negligence by health workers (10.2%) for treatment and cure (Das, Adhikari & Sharma 2013).

Knowledge about diseases

A study done in the Jhapa district showed that people living in urban community had higher knowledge about mental health and mental illness compared to rural community (Singh, Singh & Singh 2013). Similarly, another study in the Dang district showed that most of the respondents had knowledge about causes of disease like – Recent experience of physical and

emotional trauma (25%), alcohol and substance abuse (20.5%), Chronic Medical conditions (19.3%) whereas, 30.7% had mixed response of all the causes and only 4.5% of respondents had no knowledge on mental illness (Das, Adhiakari & Sharma 2013).

A study done by LEADS Nepal (2010) showed that people in Myagdi and Baglung district do not consider mental illness as illness but they believe that it is kind of moral weakness caused by supernatural power, sins of past life or any kind of celibacy. Another study done in nursing staffs by Shyangwa, Singh & Khandelwal (2003) showed that majority of the nursing staff knew that it was caused by biochemical disturbances (90%). Some of them also believed that financial constraint (68.2%) and genetic heritability (65.4%) were also the cause for mental sufferings and illness.

3.2.2 Enabling Factors

Family

Income

The economic status of the family is also an important factor which determines people's decision to seek health care services during illness. The study done in five districts of Nepal in Kushbadiya community showed that being poor and having low socio-economic status in the community people hesitate to seek help in government health facility (Budhathoki 2012). Mostly, people seek traditional healer assuming they are cheap and cost-effective (Pradhan et al. 2013). The majority of the patients (84.2%) were spending more (more than $20) for visit to traditional healers compared to spending for psychiatric consultation in health centers (Pradhan et al. 2013). Some studies show poverty and low income is both the cause and barrier for mental illness because lack of income increases the stress in family life and inability to afford the services aggravates the condition of mental illness (Knapp et al. 2006; Rijal 2011).

Health Insurance

Nepal lacks a health insurance system (Dixon et al. 2006). The government has formulated a National Health Insurance Policy 2013, (Nepal – Health Insurance Policy 2013) which is yet to be implemented. However, the government has planned to pilot this national health insurance scheme in 5 districts of Nepal with the technical support of Korea International Cooperation Agency (KOICA) (Press release Ministry of Finance 2014). There are currently 17 private health insurance companies in Nepal who provides health care benefits but they are limited to hospital charges, charge of

operation and doctor fees which are seen as direct payment, indirect payment spent during the treatment are not covered by these insurance companies (GTZ & MoHP n.d.).

In Nepal out-of-pocket (OOP) payment is the main source of payment for mental health services which limits the heath seeking behavior and access of mental health services (Dixon et al. 2006). In addition, private health insurance companies exclude service users from mental health benefits and refuse to take responsibility of pre-existing mental ill conditions. As well, in most of the cases they limit people from insurance scheme when they are unemployed (Dixon et al. 2006). These conditions limit people to access mental health services in need because they have to pay all services used through OOP payment.

Type of Regular Source/Access to regular source

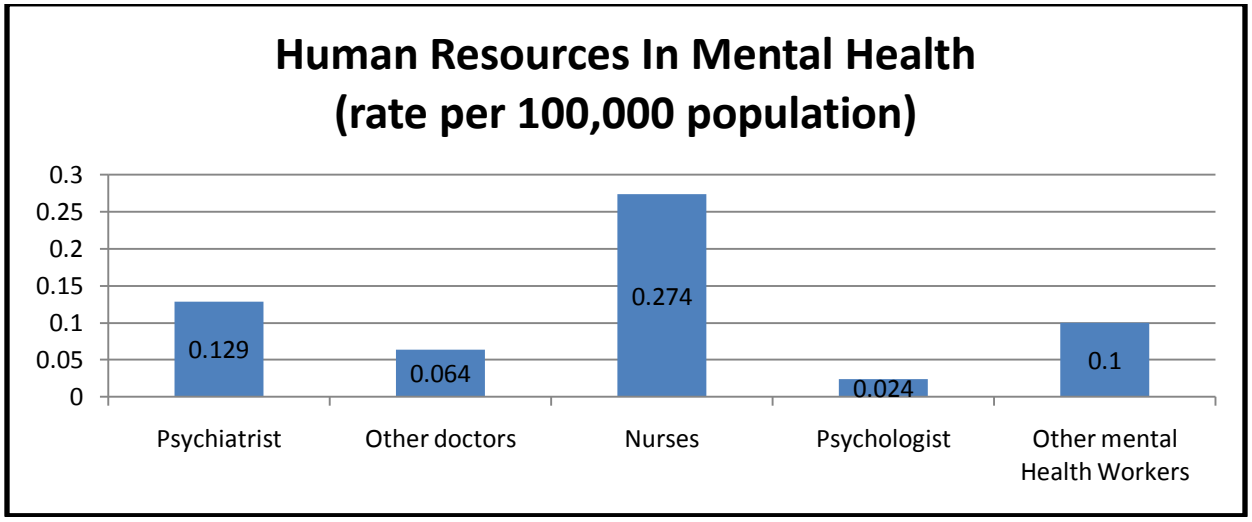
Studies show that the type and access to regular source of income is one of the causes for mental illness, as well it affects health seeking behavior for mental health services. Those who have domestic violence from their partner, alcoholic spouse, poor working and financial condition and those whose spouses are domestic workers, drivers, painter, and security guard with irregular income status are sufferer of mental illness (Travasso, Rajaraman & Heymann 2014).

Community

Ratios of Health Personal and Facilities to population

The condition of mental health system in Nepal is very poor. From the data available from WHO-AIMS Report (2006), there are only 18 outpatient mental health facilities available in the country which treats about 298 users per 100,000 general populations. There are 3 day treatment facilities which treat 0.766 users per 100,000 and 17 community based-psychiatric inpatient units for a total of 1 bed per 100,000 populations available in the country (WHO-AIMS Report 2006). There is only one government mental hospital in the country which treats 3.43 users with the availability of 0.20 beds for 100,000 populations. The same report shows that the total number of health personal working in mental health facilities including private sector is 0.59 per 100,000 populations. Looking more closely at these figures in the graph below, there is only a small number of staff in mental health services in Nepal (WHO-AIMS Report 2006; LEADS Nepal 2010).

Graph 1: Human Resources in Mental Health in Nepal



Source: (WHO-AIMS Report 2006)

Cost of Health Service

The MoHP has no clear allocation of budget towards mental health services and a negligible proportion of population has free access to essential psychotropic medicines (WHO-AIMS Report 2006). Patients suffering from mental illness have to pay OOP for health services and drugs (Dixon et al. 2006). Those who have to pay on their own spend around 9 Nepalese Rupees (NRs) (around $0.10) per day per each antipsychotic or antidepressant drugs, which comes to be around 8% of the daily wage of a day laborer in the country (WHO-AIMS Report 2006).

According to IRIN News (2010) the cost of medications is expensive and unaffordable for most of the affected families in the country. The same news reported the case of a patient from Nepalgunj (mid-west, Nepal) who had to sell her livestock and land for the payment of mental health services. Another study shows that the spending by a family is around 25,000 NRs (around £200) a year, when a family member becomes mentally ill which is very expensive for the poor families in Nepal (Jha 2007).

Region of Country

Mental illness is one of the common problems all over the country. No region of the country is left untouched with this problem. According to Shrestha et al. (2011) the distribution pattern according to eastern, central, western, mid-western and far-western region of mentally ill patients admitted in central mental hospital is 17.4%, 63.8%, 11%, 6.5% and 13% respectively.

Similarly, another study done in private psychiatric tertiary hospital showed that the morbidity pattern according to the region was 5.6%, 77.8%, 12.7%, 2.7% and 1.2% at eastern, central, western, mid-western and far-western region respectively (Shrestha, Pradhan & Sharma 2011). In both above studies the number of patients is seen high in central region which may be due to the fact that both hospitals are tertiary care level hospitals located in central region of Nepal. There are other surveys that have been done in different regions of Nepal. For instance, in the Parbat district and the Syangja district of the western region about 35.4% of patients presented for conspicuous psychiatric morbidity (CPM) (Upadhaya & Pol 2003).

Urban- Rural Character

Nepal is a country where most of the population lives in rural areas. Only 16% of the total population lives in urban areas (WHO n.d.c). Mental illness in Nepal is prevalent all over the country but the studies show that the majority of people suffering from mental illness come from rural Nepal. A study done in three districts (Dang, Tanahun and Chitwan) by Luitel et al. (2013) showed that the prevalence was higher in the Dang and Chitwan districts compared to the Tanahun district. This may be because both the Dang and Chitwan districts were affected more by conflict during the Maoist insurgency in Nepal (Luitel et al. 2013).

In the same way another study done in the Baglung district which is a rural area showed the overall prevalence of mental illness to be 37.5% (Khattri et al. 2013). Looking at the availability of human resources, there is a huge difference between urban and rural areas. The number of psychiatrist and nurses is 8.52 and 6.56 times higher in urban compared to the density of psychiatrist and nurses in the entire country (WHO-AIMS Report 2006). In the same way there is also disparity among the availability of the services in the country. The majority of the mental health services are concentrated in capital city (Kathmandu) and some other major cities of the country withholding back the rural population from psychosocial support mechanism and essential mental health services (CMC 2013).

3.2.3 Need

Perceived Need (Disability, Symptoms, Diagnosis and General State)

In Nepalese society a mentally ill person often faces discrimination and stigma pushing them to hide their problem and avoid appropriate and necessary treatment (Pradhan et al. 2013). Because of the stigmas, only that whose condition is severe comes to seek services. Those people who reported they had very bad, bad and moderate heath condition (Self

reported health) experienced similar level of mental and physical disability (mean score- 82.4, 55.2 and 39.7) respectively (Thapa & Hauff 2012). They showed symptoms of higher level of anxiety, depression and post-traumatic stress disorder (PTSD) which had high significance in how they experienced their own health (Thapa & Hauff 2012). Most respondents in the study suffered from various mental illnesses but only 29.7% of them took medical help and few (15.2%) went to alternative healer for treatment (Thapa & Hauff 2012). Most of the study participants only sought medical help and bought medicines when they developed higher disability related to the illness. Otherwise, they did not realize they had deterioration in the mental state which was not normal and required medical help (Thapa & Hauff 2012).

Evaluated Need (Symptoms and Diagnosis)

In Nepal people with mental illness are discriminated and stigmatized. So often, the professionals (physicians/doctors) hesitate to tell patients about their mental illness and provide them treatment according to their signs and symptoms without telling them their diagnosis (Kohrt & Harper 2008).

> *One of the physicians shared that patients "see it as the end of the world", "husbands feel like abandoning their spouse" and families "think the worse" when they come to know their diagnosis is mental illness (Kohrt & Harper 2008).*

Similarly, the respondents in the study said that people with mental illness were violent and dangerous (30%) and 37% of them symbolized them as "insane" people, who could show different physical symptoms when suffering from mental illness (93.6%) (Shyangwa, Singh & Khandelwal 2003). In the same study the majority (93.5%) of participants also responded that those mentally ill patients should seek proper treatment from psychiatrist as they cannot care for themselves (43%) and their families (67%) (Shyangwa, Singh & Khandelwal 2003).

3.3 Environment

3.3.1 Health Care System

Policy

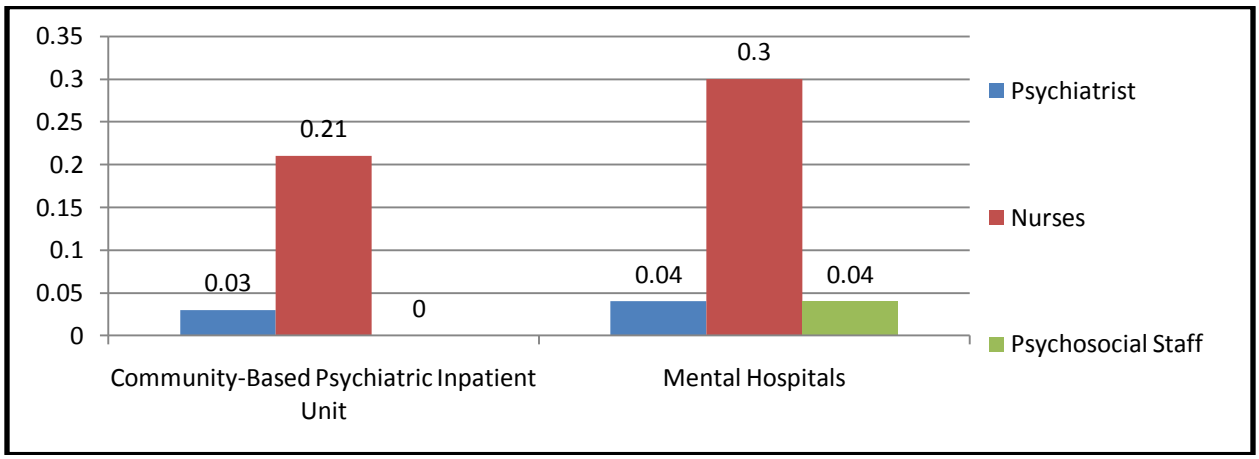
The National Mental Health Policy 1996 was formulated in Nepal in the year 1995 with the joint meeting of Psychiatrist, Psychologist, Representatives of National Planning Commission and Ministry of Health. The 1996 National Mental Health Policy planned to ensure accessibility and availability of

minimum mental health services to the general population by year 2000. As well, it also had planned to integrate mental health service in the general health service system of the country. The policy also mentioned to prepare human resources in mental health, protect fundamental rights of the mentally ill, and improve awareness on mental health in the country (National Mental Health Policy 1996). Hitherto this policy is the only legal document in Nepal which deals completely with mental health (Mental Health Worldwide 2013). It has been more than 15 years since the mental health policy was formulated in Nepal. However, it has still not been implemented and mental health services are not integrated in general health service system as mentioned in the policy 1996. Likewise, there is no separate mental health legislation present which protects people with mental illness in the country (WHO-AIMS Report 2006).

Resources

Mental Health is one of the neglected health issues in Nepal. According to Leads Nepal (2010) less than 1% of health expenditure is allocated for mental health (0.14%) out of total health expenditure in Nepal. Regarding human resources there is a minimal number of manpower working in mental health: 32 Psychiatrist, 16 other medical doctors (not specialized in psychiatry), 68 nurses, 6 Psychologist and 25 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants (HA), medical assistants, professional and paraprofessional psychosocial counselors) in total in whole country (WHO-AIMS Report 2006). There is disparity in staffing in community based psychiatric inpatient unit and mental hospitals (WHO-AIMS Report 2006) as shown in the graph below.

Graph 2: Average Number of Staffs per Bed



Source: (WHO-AIMS Report 2006)

As well as, along with number of human resources, qualified health staffs for delivering good mental health services is also essential. However, in Nepal only 2% of training of medical doctors and nurses is allocated for mental health and in most of the cases there are hardly any refresher trainings for the existing staffs. Meanwhile, the personnel that are qualified to provide mental health services are scarce (WHO- AIMS Report 2006).

Organization

The organization of mental health in Nepal is in a pitiful situation. According to the Organogram (See annex 2) of the country, there are different divisions under the Ministry of Health and Population (Department of Health Services). There are different sectors of health but still there is no separate division for mental health in Nepal (WHO-AIMS Report 2006). The facilities for mental health services are scarce compared to the extreme need for inpatient care (WHO-AIMS Report 2006). There is 1 NGO which is running community mental health service (in only 7 districts) and some private medical colleges and NGO's based in Nepal which provide different promotive, preventive and curative services to patients with mental illness like - Dhulikhel Hospital, Patan Hospital, Universal College of Medical Sciences, Teaching Hospital, Transcultural Psychosocial Organization (TPO) Nepal, Center for Mental Health Counseling Nepal (CMC-Nepal), Koshish Nepal and others respectively (Man 2012).

There are both physician based primary health care (PHC) and non physician based PHC clinics, which provide primary health care to the local people but there is negligible mental health services. Only 21-50% of physician based PHC clinics and only (1-20%) few non-physician based PHC clinics has a treatment protocol for key mental health conditions (WHO-AIMS Report 2006). This lack of quality services is one of the key factors for misdiagnosis and under treatment of patients with mental illness at the peripheral level.

3.3.2 External Environment

Physical

The external physical environment is a very important factor for proper delivery of the health services. The infrastructure for mental health services is poor and the majorities (80%) of the inpatient unit where patient can be attended and given curative services are located in or near the big cities (WHO-AIMS Report 2006; CMC-Nepal 2013). This creates inequity and become a barrier for the access of services for rural population (WHO-AIMS Report 2006). When we look at the availability of the psychotropic drugs for patients with mental illness there is inclusion of psychotropic drugs in the

essential drug list up to the PHC level. However, it is not always available for the patients and they need to buy medicines in the clinics near the facilities, which becomes expensive for them to buy (WHO-AIMS Report 2006; Leads Nepal 2010). On the other hand there is "no consumer association existing in the country which can focus on mental health service" (WHO- AIMS Report 2006).

Political

Nepal is a country which is coming out of 10 long years of internal conflict and war and is in the post conflict situation (Luitel et al. 2013). During this period there were serious human rights violations, people were tortured and many people lived under fear of war and safety (Luitel et al. 2013). Due to conflict and political unrest in the country mental health services which were about to begin and were in an initial state got further fragmented (Shrestha cited in Singh, Dahal & Mills 2005). This political unrest and conflict has also resulted in destruction of more than 1000 health post in rural areas and harassment, kidnapping, threatening of many health worker along with dozens of them being killed (Collins 2006; Maskey cited in Devkota & Teijlingen 2010). The delay in integration of mental health services in the general health services also indicates that there is lack of political will towards the policy along with political instability (IRIN 2013).

Economical

There is a strong relationship between mental illness and economy as presented from various researches in the country (LEADS Nepal 2010; Regmi et al. 2004; Das, Adhikari & Sharma 2013). Poor economy of the family, lack of opportunities for earning and poverty leads to mental disturbances increasing the financial burden in the family if mental disturbances turns to mental illness (Regmi et al. 2004; Jha 2007). Moreover, the country's economic condition and lack of budget allocation for mental health services affects the distribution of quality mental health services in the country (WHO- AIMS Report 2006; LEADS Nepal 2010).

3.4 Outcome

3.4.1 Perceived Health Status

Patients with mental illness also reported the improvement or change in their mental status after taking medication and getting treatment from mental health services which shows mental health services if available are very effective to change the life of the patients.

A patient shared - "she visits mental health center regularly for counseling and supply of medications" as "if she misses her medication for a single day she feels like she is transported back to her past and hears sounds of bomb and feels her husband will be taken when someone comes to her house" (Bhattarai 2011).

Similar story was also shared by another patient where she wanted treatment as her mental status was not good and "she was seeing people as demons". She doesn't want to be "ill-treated and beaten up by the people again as in the past" because of her behavior so she was seeking medications as it helped her a lot by improving her mental condition (Rajbhandry 2011).

This story shows that mentally ill patients have experienced change in their mental health after treatment and care and want mental health services to be available and accessible in the community for better treatment and the improvement of life.

3.4.2 Evaluated Health Status

Mental illness can be cured if appropriate treatment is provided. There are many examples from the country of successful improvement of health status after the treatment of mentally ill people.

An auxiliary health nurse from Chitwan, Nepal said - that "patients with depression recovered after taking medications for 4-6 months and have recovered and not returned back to the health post after treatment" (Luitel, Pokhrel & Makan 2014).

He also shared experience of other psychosis patient who "showed great improvement in his mental status after taking medication and is now able to help family by doing household works and participates in social programs" (Luitel, Pokhrel & Makan 2014).

There are also various examples of patients shared by an NGO called "KOSHISH" who were in a critical condition due to mental illness when rescued by KOSHISH. Later, after the treatment and rehabilitation of these patients, their mental status improved to a great extent and is now re-integrated in their family and is living a normal life (Devkota 2011). This examples show mental health services is essential for the improvement of

mental status of patients with mental illness so that they can get insight into their life and reintegrate in their family and community and live a normal happy life again.

3.4.3 Consumer Satisfaction

Studies on health seeking behavior of patient with mental illness are rare in Nepal. Moreover, none of the studies were executed on consumer satisfaction on mental health services. India, neighboring country of Nepal, has a few studies regarding the consumer satisfaction. One of the studies done by HoliKatti et al. (2012) suggests that the satisfaction level was dependent on the type of mental illness the individual was suffering from. Most of the patients in their study who had schizophrenia had more satisfaction with inpatient and day treatment compared to outpatient treatment whereas; other patient's with other diagnosis were less satisfied with the day treatment. In Nepal only 15% of patients with mental illness have availability of mental health services and 85% of populations lack the services because most of the services are concentrated in big cities and also mental health services are not integrated in the general health care services (WHO-AIMS Report 2006; CMC-Nepal 2013). A study done in the Dang district showed that 28.4% had no access to appropriate treatment for mental illness, likewise 13.6% of respondent also said there was negligence of health workers and had improper behavior towards the patients (Das, Adhikari and Sharma 2013). In the same study around 41% of participants said there was unavailability of mental health services in the district and around 40% said they had financial problems to seek mental health services (Das, Adhikari and Sharma 2013).

CHAPTER IV

Discussion

4.1 Discussion

This chapter is focused on trends found in the literature about mental illness and people's health seeking behavior for mental health services in particular with the country, Nepal prospective and other similar context. Constrain and enabling factors in seeking mental health services are identified and discussed hereunder.

This study was done with the objectives: to identify and describe health seeking behavior; analyse services and support systems available; and identify the gaps in mental health services provided in Nepal. The main determinants of health seeking behavior are health behavior during illness, the characteristics of the population, the environment and others are intertwined with each other. It also seems that there are multiple socio-cultural determinants which affect individually and collectively in health seeking behavior of a person suffering from mental illness.

Health Behavior

Nepalese community has a strong belief in socio-cultural values, custom and traditions, and to challenge these beliefs might result in social isolation, stigma and discrimination. Having mental illness a very sensitive issue, people fear to self-determine as a person with mental illness, because of fear to social discrimination and being stigmatized. This fear of discrimination and being stigmatized aggravate to another fear to take independent initiative and seek treatment in limited available mental health services. On the other hand people prefer to consult straight to psychiatrist doctor as far as possible. However, despite their preference to seek help from mental health professionals, they also face numerous challenges: the poor accessibility and lack of availability of mental health services in particular to rural areas, the services offered are often expensive and health staff lack sufficient skills (communication with patients, diagnosis and treatment for mental illness) which creates barrier for seeking mental health services. In most of the cases people seek mental health services when their mental health condition is deteriorating and/or any physical illness developed as a consequence of mental illness. Meanwhile, in some of the cases people even try to attempt suicide as a consequence of mental illness,

and that is the time when people feel they need immediate help from the experts, otherwise they keep on ignoring their mental illness.

There is variation in results showing that they prefer using mental health services. However, some findings contradict this result showing that they only use services when their health situation is at critical condition. This is because people yet have some beliefs in supernatural powers affecting the health especially, when it is related with mental health. In Nepal, people with mental illness also fears rejection from the family members, being stigmatized and discriminated from their relatives and community. Some people also fear to seek help for health services as they feel stigmatized from the health workers as a patient with mental illness.

Similarly, other reasons for delaying the early help and consultation may also be that they are unaware about the causes, consequences and treatment of mental illness. Sometimes, they may also not know where to go and whom to consult when they suffer from mental illness. So, as a result traditional and religious healers are the choice, whom they trust and continue to seek help, expecting their mental illness will improve. This is why the mental condition of the people with mental illness deteriorates day by day bringing them in a state where they cannot take care of themselves and feel like ending their lives.

Population Characteristics

The findings produce interesting result, that to make a decision for seeking mental health services in Nepal, are influenced by many factors, which are interrelated and interact. The individual characteristics also determine to a large extent for the suffering of a person with mental illness. Findings suggested that the prevalence of mental illness is more (nearly double) in females in general population compared to male in Nepal (Wright cited in Trivedi, Sareen & Dhyani 2008; Kohrt & Worthman 2009). This indicates somehow being female and gender role in societal culture of patriarchy is the greatest problems that impact mental state. From the personal experience and the observations from the researchers in Nepal it is known that Nepal has a male dominant society where the position of the women is still marginalized compared to males. The female has to leave her home and hometown after marriage to stay at her husband's place, where they are expected to do all the household and social activities.

In most of the cases the decision making power of women is very limited and many women experience domestic violence and discrimination from the family. It is also evident from the finding that most of the mentally ill patients are above 20 years of age and are married. Being married in early

age and completing all family responsibilities in young age with extra familial burden and other social works together is difficult for young females increasing the mental pressure above their coping capacity. Also, because they are married in early age they get less opportunity to complete their education, employment and become independent. Consequently, generating inferiority for themselves in the family and affecting the mental state.

Similarly, the level of education, employment, income level affects and plays a vital role in alleviating and aggravating the situation related to mental illness. This is because; low educational level reduces the chances for getting better income and employment opportunities. Therefore, these conditions also probe individuals to struggle more to get what they want in life. The issue of "have" and "have not" for basic need, modern facilities and a sense of responsibility to fulfill demands of everyone increases frustration. As a result, searching for better opportunities for employment people start to migrate inside and outside the country that disintegrate the family in pieces which increases further mental stress of separation.

Environment

Nepal is one of the countries in the world having mental health policy in place. However, having Mental Health Policy in place for more than 15 years, mental health is not part of integrated health into the primary health care. Also, the available health personal are poorly equipped with capacity, medicine and supplies. The government has included psychotropic drugs in essential drug list up to the Primary Health Care level but the availability of drugs year around and frequent stock outs pose problem to people in utilization. Despite of impressive plans from the government, it is seen that there is an issue of equity coupled with availability and accessibility of available mental health services. This assumption is government does not prioritize mental illness as one of the condition where immediate actions should be taken. The low allocation of budget for mental health services also gives the impression that mental health services are quite ignored and least prioritized by the government.

The reasons behind this condition may be that Nepal has continuous political instability since more than a decade and government has been failing to make strong decisions for this public health concern. These decisions by the government can also be highly influenced by the targets set by the international bodies to meet developmental goals (MDGs) where mental health is not even mentioned as a developmental target. Nepal is dependent on donor funds (33.8%) for most of the developmental activities (MoHP 2013) and maybe there is no fund available from any of the donor agencies who are willing to support area of mental health in Nepal. Likewise, people

also cannot utilize the mental health services because they do not get empathetic response from the health staffs which make them, feel stigmatized and discriminated by the health workers. This attitude of the staffs is also highly dependent on the level of knowledge which they have about mental illness.

It is also evident from the findings that health workers lack training in field of mental health, directly affecting the patient's condition. They are unable to diagnose the illness appropriately and also judge the severity of mental illness. In addition, all the health workers also come from the same cultural background and thoughts, which makes them difficult to change the social behavior over people suffering from mental illness. It is evident from the literatures that there is scarce of all the resources like - money, human resources and lack of facilities to get appropriate services when in need. Moreover, availability of mental health services mostly concentrated in urban cities compared to rural areas making rural people unable to access when they are in need. Also, the cost of mental health services becomes very expensive to those people of rural areas as they have to pay for the services with direct and indirect cost like - user fees for the services, payment for expensive medicines, cost for transportation, loss of work and business. That is why, it is essential to look at the best practices which other developing countries are doing for improving the mental health and tackling mental illness (See annex 3).

Communication is the key factor which health professionals should be aware of, while taking care of mentally ill person. A good communication between patient and health care workers (Psychiatrist/nurse and others) is essential for successful treatment. In particular, it creates a trustworthy relationship between patient and provider to continue the treatment and have faith in procedure to attain good result. It has also been clear from the findings that Nepal lacks trained human resources and facilities for mental health in the country. Moreover, those who are working in different health care level lack skills and training to diagnose and treat mental illness which becomes barrier between patient and provider for building trust on treatment and care. There has also been a challenge in Nepal for referral between rural community based health services to higher level mental health service centers (which are mostly present in big cities), which may be because health workers lack skills to make appropriate diagnosis of mental illness.

The examples from few countries in the world (India, Iran, Saudi Arabia and Sri Lanka) shows that integration of mental health services in PHC level can be very effective to reach the people and convince them to utilize the available services. As well, people can get needed services in affordable prices in their own community and the presence of services will constantly

help to make them aware of causes and treatment of mental illness (See annex 3). Also, training the lower level existing health workers gives them opportunity to improve their knowledge and diagnose mental illness as soon as possible and refer them to appropriate higher level mental health service centers (See annex 3).

Outcome

Literature review also suggest that those who are able to access mental health services and get appropriate treatment had a result that they have improved mental health status. As well as, health workers also feel that their attempt has helped to improve the patient's condition. This result conveys that there is immediate need to take steps to improve the skills of health workers to deal with patient's condition and equip the facilities with all the drugs and supplies for successful treatment of patients. If there will be availability of mental health services nearby in local community and if individual and community are aware of mental health and illness people will utilize the services timely preventing further deterioration in mental and physical health.

CHAPTER V

Conclusion and Recommendations

5.1 Conclusion

Health seeking from appropriate health services for the people with mental illness is very complex. The findings show that the factors that determine health seeking behavior are closely interlinked. The socio-cultural belief of people leads to a delay in health seeking behaviour, and hence leading to deteriorating mental health condition. It is very likely that socio-cultural beliefs lead to a fear of being discriminated and stigmatized by the families and communities. Such believes are difficult to challenge and to change.

Also, the quality and availability of the health services are serious barriers for people to seek appropriate health care. Despite the government policies being in place for more than 15 years, not sufficient resources both in manpower and finances are allocated to have mental health services available on all levels from community based services to more specialized services. But, it is now necessary to take right approach where quality of the services can be improved and made available up to the lower level of the community where people can accept and access mental health services easily. However, the steps taken by different countries also indicates that an effective approach for improving accessibility, availability and acceptability to mental health service is not available but a step wise approach with wise local application are required (See annex 3 and annex 4).

Therefore, Nepal should take a step forward with an optimal mix of services for mental health (See annex 4) to improve the quality of mental health services in Nepal and bridge the gaps where it is lacking to provide effective services. Some serious interventions to improve the mental health of people are required in Nepal. Also, it is required to ensure the availability of equitable mental health services at affordable price at the lowest level of health service delivery which is acceptable by the local community.

5.2 Recommendations

For Policy Makers and Ministry of Health and Population

Government should play a vital role and take steps forward to improve mental health status of the people. So, following concerns are recommended:

- Strengthen the available mental health services in secondary and tertiary level health services and integrate mental health services in into the primary care to ensure equity, equality, availability, accessibility and affordability of the health services. As well, enact mental health legislation in the country in order to protect the right of patients with mental illness.
- Collect the data's regarding the prevalence, type of mental illness and conduct survey for accessibility of mental health services in the different regions of the country, so that accurate services can be developed.
- Ensure adequate allocation of financing for the support of mental health services in the country. As well, increase and equip human resources for providing mental health services in different levels of health service centers, in particular on a community level to ensure that people can find support at the early stage of illness and early interventions are possible.
- Ensure continuous and adequate supply of essential psychotropic drugs at all health care facilities up to Health Post level. So that, patient's may not be deprived of required drugs.
- Develop and revise the curriculum and training manual of all health workers including paramedic's like- Health Assistants (HA), Auxiliary Health Workers (AHWs) and Community Medicine Auxiliaries (CMAs). And, provide basic training to community health workers and Female Community Health Volunteers (FCHVs) in order to help them identify cases of mental illness and refer them to appropriate mental health services on time.
- Organize awareness raising activities in mental illness all over the country, for general people and also for faith healers. So that, they become better able to recognize the severity of mental illness and refer people with mental illness to appropriate health center for further treatment in time. Also, encourage traditional healers and the formal health services at the community level to link, to ensure referral of patients with mental illness on time.

For Health Care Service providers

- Provide training to new health workers including paramedic's and refresher trainings to existing old health workers. So that, each health worker at the periphery level becomes able to recognize the severity of mental illness and refer them to appropriate health service centers.
- Ensure the respect for the patient with mental illness and treat them with dignity and respect as other patients with different physical illness. As well, establish trust worthy relationships with the patients and their family members by giving them appropriate and true

information about the patient. So that, they believe in the treatment and other care modalities they are getting and continue the care.

For Family and Community

- Strengthening the support structure for the patient by involving the family and community during the treatment and care. As well, Support people with mental illness without stigmatization and discrimination in the society. So that, patients can freely come to mental health services to take counseling and treatment for their illness in need.
- Families and community be aware of causes and treatment of mental illness and increase awareness among others (those who are unaware) by providing information on mental illness and mental health services.

For Further Research and Intervention

- Researches using the primary data collection in the Nepalese community, where health seeing behavior of mentally ill patients and factors associated with mental illness can be assessed is essential to be done.
- Further research should be conducted to determine changing perception of people towards mental illness and recognize the acceptability of mental health services in the country by the community people. As well, the effect of socio-cultural beliefs on stigma and health seeking behavior of mentally ill people should be analyzed.

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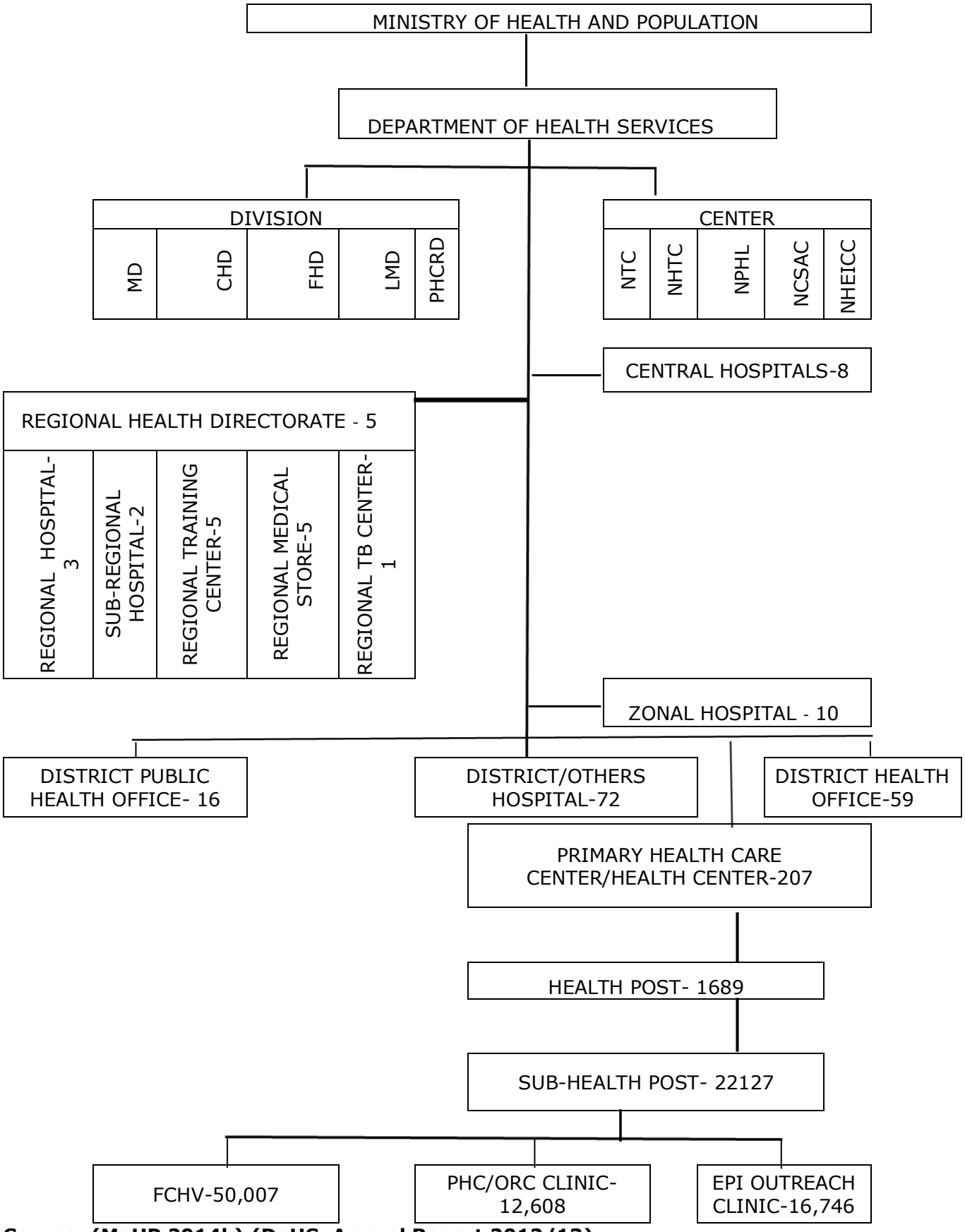
Annexes

Annex 1: Map of Nepal

Source: (http://www.nepalmotorbike.com/image/nepal-map.gif)

Annex 2: Organogram of Department of Health Services



Source: (MoHP 2014b) (DoHS, Annual Report 2012/13)

Annex 3: Best Practices and Case Summaries of Countries on Mental Health Services

There are some examples from four other countries with some similarities like Nepal in Asia who has stood out in the world among all the countries for reducing the treatment gap for mental health services and promote mental health of the general people. The examples from few countries are as follows:-

1. India

India is one of the neighboring countries of Nepal who integrated mental health in general health services in 2002. The government of India had launched the district mental health programme in 1995 which has been extended to all districts in India through 2007-2012 National Mental Health Plan. Out of all the districts in India, the Thiruvananthapuram District from Kerela State has displayed the best results from the integration of mental health in primary care since 1999 (WHO 2008). In this district the lowest level health workers and other community people (Community workers and volunteers, junior public health nurses and accredited social health workers, school teachers, panchayat member and the district mental health programme team members) identify the people with mental illness and guide them to facilities of general primary care (PHC, Community Health Centers and Taluk hospitals) which provide out-patient facilities to the patients (WHO 2008).

In addition, the outreach mental health clinic services are also organized. Here, specialist district mental health team provides services to all the patients visiting the clinics, including the patients referred from regular Primary and Community health centers. A trained medical officer from the district mental health programme makes the diagnosis and prescribes medication to the patients. S/he also, provides active follow ups to the patients between mental health clinics. As well, all new patients receives an health education on their first visit including information about their mental illness, its causes, prevention, treatment, monitoring and management with a care giver/family member which motivates the patients to continue the treatment (WHO 2008).

Additionally, different level of health and social workers are provided training to identify mental illness and provide counseling and follow ups. The social worker organizes a meeting with those who are in need and provide counseling and follow-ups to the patients on regular basis. If needed social workers also conduct periodic group therapies and make home visits to

assess the condition of the family to ensure continuous treatment for the patient (WHO 2008).
The district has also made free and continuous availability of psychotropic medications in all general primary care and mental health clinics. These initiations have made availability of the drugs easy to all the patients, with reduced cost and time for treatment. In current situation, mental health clinics has been operating in 22 different locations throughout the Thiruvananthapuram District, where a monthly visit is made by district mental health team in all the clinics to provide best services for the patients in need (WHO 2008). Thus, this intervention for mental health in the Thiruvananthapuram district of India, have been successful to provide equitable mental health services which are easily accessible, available and affordable to all general populations of the following district.

2. Iran

The Islamic Republic of Iran is another country in Asia who has fully integrated mental health into primary care since 1980's (WHO 2008). At the lowest level, the community health workers and Behvarzes (a local person from the same village) identify the cases of mental illness in a community. They then refer those identified cases to General Practitioner (GP) of respective health centers in rural and urban province of Iran. The Behvarzes also have a clearly defined mental health responsibility where they are expected to provide community education, active case finding, referral, follow-up and maintenance of patient registers. Both the community health workers and Behvarzes are formally trained and have played a vital role for active case finding and providing support, care and treatment of the people with mental illness (WHO 2008).

The GP in both urban and rural health centers provides diagnosis and needed treatment to both local and referred patients as a part of the general health responsibilities providing them integrated and holistic services. In cases where, the GP is not able to manage being the condition of the patient complex, s/he is referred to provincial health centers for further treatment and management (WHO 2008). The Ministry of Health and Ministry of Education of Iran came together to support the mental health workers to provide a strong support and train health workers to enhance the quality of health services at all level of health care. Every 2-3 years all GP's of rural and urban health centers receive required training and refresher training by provincial level psychiatrist to update their knowledge and also retrain lower level disease control technicians in their catchment area (WHO 2008).

Thus, the integration of mental health in primary care level and integrated management of physical and mental health illness has helped to reduce the

stigma in the community for people with mental illness providing large proportion of population with accessible, affordable and acceptable mental health care for all population.

3. Saudi Arabia

Saudi Arabia is another country in Asia who gives best example for the result of integration of mental health services into primary care. Ash-Sharquiyah is the largest province lying in eastern part of Saudi Arabia with 112 Primary Care Centers and 2 Community Mental Health Centers in whole province. The Ministry of Health of Saudi Arabia established a National mental Health committee in 1990 with a motive to take initial steps for development of mental health in primary care. With the establishment of mental health committee training was provided to primary care physicians for the improvement of knowledge to identify the cases and to provide diagnosis and treatment to the people with mental illness (WHO 2008).

The primary care physicians are the ones who provide basic mental services to the people with mental illness through primary care. In the conditions where the primary care physicians lack the competency to diagnose and treat the patients they are referred to Community Mental Health Centers in the province for further treatment and management. During the process of management of the mentally ill patients the families of the patient are also involved during the consultation and needed information are delivered to help so that they can provide effective support to the patient (WHO 2008).

The government has also ensured to provide needed training and ongoing support to mental health specialist who provides mental health services to the people with mental illness (WHO 2008). This intervention has been able to provide mental health services to all the people of eastern province in their own community with reduced stigma and discrimination for mental illness.

4. Sri Lanka

Sri Lanka is one of the countries who have some similarities with Nepal on issues regarding mental health. Sri Lanka came to an end of 25 years of civil war in 2009 and has one of the world's highest suicide rates with an average of 6000 deaths in a year (Siva 2010). Therefore, Ministry of health of Sri Lanka has Mental Health Policy (2005-2015) which focuses on: recruitment of psychosocial trainer and community mental health education officers at community resource centers to provide primary care mental health services (Samarasekare, Davies & Siribaddana 2012).

As per WHO, top 10 recommendations; training of health workers from primary level to tertiary level is very essential in order to provide quality services by integration of mental health in primary care (Budosan 2011; Jenkins et al. 2012). Likewise other countries in the world, Sri Lanka is also suffering from scarce of human resources working for mental health so, Ministry of health of Sri Lanka in collaboration with National Institute of Mental health conducted mental health care training of primary health care workers in 2004 in two administrative districts. Also in 2009, another mental health care training was provided to 45 psychiatrist, 110 medical officers and 95 registered medical practioners, so as to improve mental health services and integrate mental health in primary care (Budosan 2011; Jenkins et al. 2012).

In the same way, Sri Lanka has been delivering a community services run by a community volunteers under a mechanism called 'Mental Health Care through Community Partnership' since 2003 at the Southern Province (WHO 2010). The community volunteers run a monthly mental health camp in collaboration with specialist mental health hospital, outreach clinics and outpatient clinics for drug administration in collaboration with general and primary hospitals (WHO 2010). This initiative of community services has increased the self-esteem of mentally ill patients as they are also involved as a committee member of the community volunteers. This initiative have been able to deliver acceptable, available, accessible and affordable mental health services as the community level decreasing the gap of mental health care services in the country (WHO 2010).

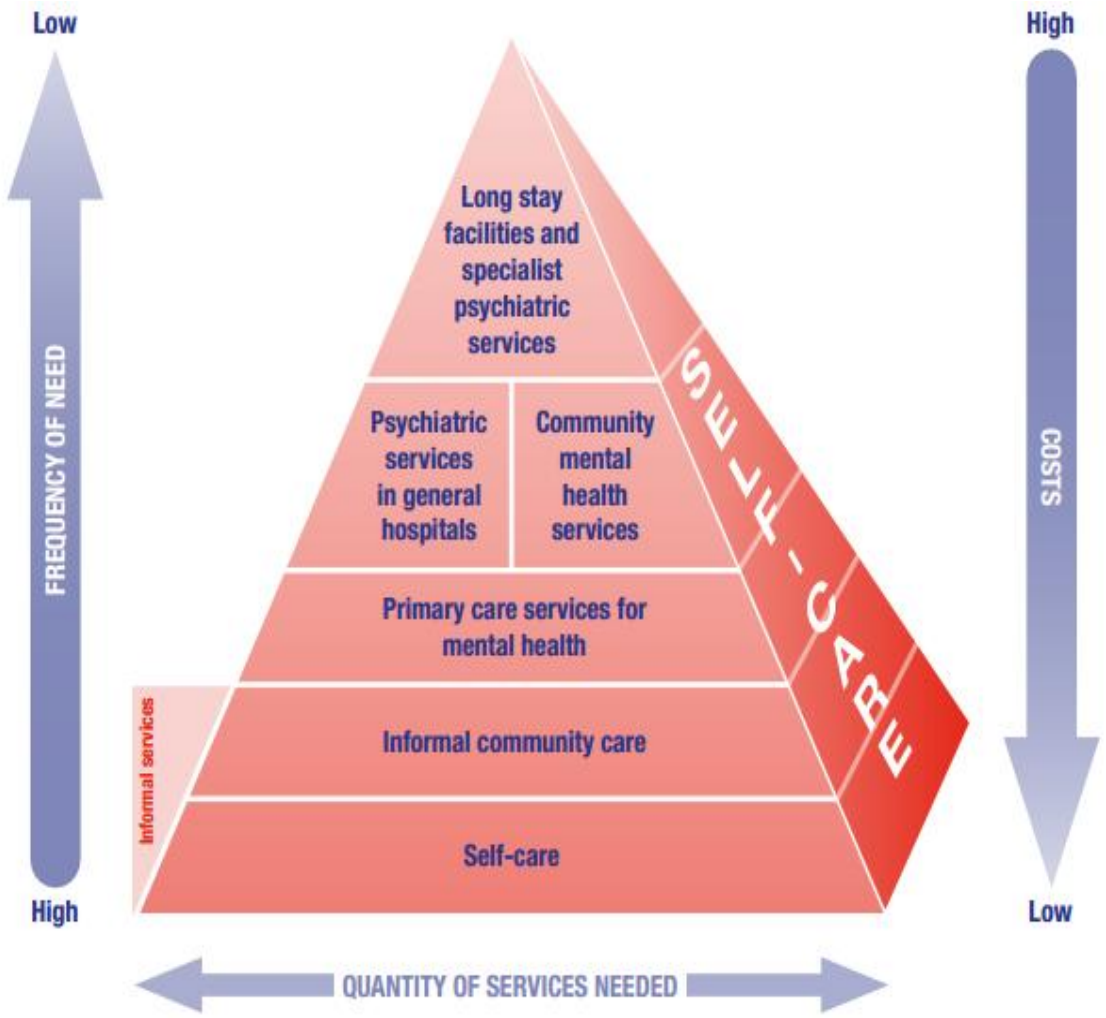
Thus, it is very effective intervention for a government to integrate mental health services in primary care from above examples of the 4 countries. The reasons for integration mental health in primary care is illustrated as follows-

Seven Good Reasons for Integrating Mental Health in Primary care

- The burden of mental illness is huge.
- Mental and physical illnesses are interwoven with each other.
- The treatment gap for mental illness is huge.
- Primary care for mental health enhances access.
- Primary care for mental health promotes respect of human rights.
- Primary care for mental health is affordable and cost effective.
- Primary care for mental health generates good health outcomes.

Source: (WHO 2008)

Annex 4: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health



Source: (WHO 2008)