

MENTAL HEALTH IN NEPAL:

**A COMMUNITY SURVEY OF
ANANDABAN VILLAGE IN
WESTERN REGION OF NEPAL**

ADHIKARI, K.P., HUTTUNEN, J.

&

KILJUNEN, R.

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FOREWORD

United Mission to Nepal has started its Mental Health Program 1984. Since the very beginning one of the main focus areas has been building up and developing community mental health program. During the recent years experiences have accumulates and there has been several surveys to collect data for epidemiological purposes as well to plan the work ahead. This study is counting the work which Adhikari, K. & Dennison, B. (1999) did in Gotikhel, South Lalitpur and is done in Anandaban, Western Region. Their mental health awareness raising activities or mental health service are not yet provided

This study would have not been done without the help of various people. The authors would like to thank warmly Dr. Sarah Acland, Dr. Joe LeMaster, Ms Regina Hess, Mr. Pashupati Mahat and Mr. Klaas-Jan Pol and our office staff who gave their time and valuable suggestions as well support and practical help during this project. Without our eager and dedicated research assistants, who tolerated all the troubles of rainy season, as well without the co-operation of local people at the village in Anandaban we would not been able to conduct this study.

Mr. Krishna P. Adhikari

Ms. Johanna Huttunen

Ms. Raija Kiljunen

Mental Health Program

United Mission to Nepal

P.O. Box 126

Kathmandu, Nepal

ABSTRACT

Anandaban in Rupandehi was selected as the study area because of exploring the possibilities to start mental health work there as a part of Western Region Community Mental Health Program. The prevalence of mental distress was assessed by Self-Reporting Questionnaire (SRQ) and interviews were conducted to assess health service needs and the level of mental health awareness in community. Also group discussions (53 participants in 4 groups) were used in order to find out mental health awareness separately from study population (414 people).

Mental distress measured by SRQ was observed in 13.1% of the population, women's rates were higher (17.6%) and they were three times more vulnerable to mental distress than men (8.5%). The women, who expressed higher scores in SRQ were older, married, illiterate, or more children or more people living in their house. Men who were illiterate, older or having more children scored also higher than other men.

Awareness and knowledge of mental health in community is on surprising high level even specific awareness raising programs have not been conducted there. Better socio-economic situation and educational status of the people might possibly explain the result. Already existing mental health awareness in community may give possibilities to psychosocial interventions, which could address the need of the mentally distressed people. When health service needs were inquired it was found that there was need for better availability and quality of the services. Some of the participants of this study expressed having long term suffering from various mental distresses; even they had visited already different health services.

1. Introduction

1.0 Mental Health in the developing world

Mental disorders, severe and less severe, are to be found around the world. In the developing world most of the suffering people are first treated by traditional healing systems, or primary health care services. The 1993 World Development Report estimated that mental health problems the world over produce 8.1 % of Global Burden of Disease (GBD) measured in Disability-Adjusted life years (DALY's), a toll greater than that exacted by tuberculosis, cancer or heart disease. Schizophrenia is a low-prevalence, but high severity disorder, depression is a high prevalence and moderate to high severity disorder. Surveys of patients attending primary health care clinics in Africa and in Latin-America indicate that for as many as 1/5 to 1/3 of the cases depression is the principal or secondary reason for seeking care. The World Bank Report estimated that depression ranks fifth in illness burden among men, and seventh in developing countries surveyed (Desjarlais, 1995).

Cross-cultural epidemiological studies suggest that somatization of depression is a common phenomenon in non-Western societies (Jablensky et al., 1981) People experience depression as a disabling set of physical symptoms including chronic pain, fatigue, and different aches of body parts. The influence of local medical knowledge on the experience and expression of mental illness is recursive. How illness is understood and responded to actually shapes the illness itself, organizing symptoms, interpretations and care-seeking activities in behavioral pathways that differ across societies and ethnic groups (Desjarlais, 1995)

Medical patients with psychiatric diagnoses tend to use two to four times as much non-psychiatric medical care as other patients. Al-Subaie et al. (1998) found this to be the case with depression and people given a somatoform-disorder diagnosis in Saudi Arabia. The World Health Organization (WHO) has designed a psychiatric case-finding instrument for the detection of psychiatric patients among visitors of health-care facilities, especially for use in developing countries. Based on the need to screen possible psychiatric cases the instrument of WHO has widely used in different studies during recent years around the world (Kortmann, 1990).

1.1 Nepal and Mental Health

Nepal is a small, mountainous country between India and China. Both natural and cultural diversity shapes the living conditions and life styles among the population. The Himalayas stretch all across the northern border of Nepal. At altitudes of over 3000 m, the Himalayan zone makes up over 25% of Nepal's land area. About 10 % of the population live in this high area. The Middle Hills are Nepal's heartland, which no longer hold the majority of the population. The Terai is the north limit of the enormous flood plain of the Ganges River. The proportion of population living in the Terai has been growing (Burbank, 1992).

There are many ethnic, religious and culturally different groups. The population is estimated to be 23, 4 million in 2001, 40 % of whom are under 15 years of age (Statistical year book of Nepal, 1999). Kathmandu Valley and Southern cities in Terai are growing fast, people from hilly areas are moving to seek work and better living opportunities inside the country as well in India. It is difficult to live in remote areas without access to transportation, education, and work and appropriate health service.

Average adult literacy rate for the whole country is 39.6%, female literacy rate is 25.1% and male literacy rate 54.9%. Across the country the figures are very different, being high in men (58.5%) in the Western Region and low in women (14.9%) in the Far Western region. Life expectancy at birth is 58.25 years (Nepal in figures, 1999). Child mortality is 128/1000 (UNICEF, 1994), maternal mortality is 1500/ 100 000 (State of the rights, 1998) Health service is concentrated in places where there are roads and cities. In Nepal there are 5 doctors and 5 nurses to every 100 000 people (UNDP, 1999).

Mental health services are even less available, being nowadays only in four regions. Concepts of mental health and illness have, among the general population, been based largely on traditional and religious attitudes and beliefs. This has meant that most of the people have been and still today are dependent on the traditional ways of understanding and treating mental illness, when it hits themselves or their family members. Access to mental health

services is still not easy, even though it has improved in the certain areas where specific efforts for service-building have been done.

The modern mental health system in Nepal has been developing since the 1960's. In 1980 the WHO started to provide funds for mental health work. Mental Hospital (1983) has been providing 42 beds. United Mission to Nepal (UMN) started a mental health program in 1984. Tribhuvan University Teaching Hospital (TUTH) of the Institute of Medicine (IOM) opened its psychiatry department with a 12-bedded ward and out patient department in 1986. The next step was the expansion of community mental health programs; in 1989 a Community Mental Health Project started in Morang District, and the Western Region Community Mental Health Program started in 1992. Four districts, Morang, Banke, Kaski and Syanja, came to be covered by community mental health programs (Tausig & Subedi, 1997, Adhikari & Denison, 1999).

1.2 Western Region Community Mental Health Program

UMN Mental Health Program and IOM Mental Health Project started the Western Region Community Mental Health Program (WRCMHP). The first phase was called District Community Mental Health Program Kaski (1992 – 1993) and it carried out the following activities: training of health workers, provision of patient record cards, follow-up sheets, and different educational material and essential medicines to the health posts as well supervision and referral service. During the second phase (1992 – 1995) mental health service was extended to Syanja District and the training base was established in Pokhara for continuing training of primary health care workers and organizing refresher training as well training to traditional healers, school teachers and police. (Upadhyaya, 1999)

Third phase (1997 – 2000) continued earlier activities modified according to need and feasibility study was done in Baglung and Tanahun districts for possible extension of program and later the activities were started on those areas. WRCMPH is meant to serve as a working

example of implementing community mental health program for the government The future plan is to introduce the WRCMHP in the Rupandehi, Kapilbastu and Nawalparasi districts.

1.3 Anandaban

In the present study, Anandaban VDC of the Rupandehi-district was selected to evaluate the possibilities of a program expansion. The survey's field phase was done in August 1999. Anandaban is situated in the South of Rupandehi district (approximately 300 km from Kathmandu). Its headquarters is Bhairahawa. Anandaban VDC is divided into nine wards. It has a population of 18,074 (Census of Western directory region source, 2055). The main communities are Brahmins, Magar and Tharu. Most of the population (68.2%) is dependent on agriculture; business (13.3%) is the next biggest occupational group. Other occupational groups are: service 5.6%, industries 2.6%, bus business 2.6% and others 7.8% In Western Region literacy rate is 58.5% for men and 28.9% for women. (Anandaban VDC Report, 1998). In Rupandehi district as a whole, there is a total of 86,650 households; average household size is 6.0; and literacy rate of 6 years and above is 40.2% (Sharma & Gautam, 1999).

For the concerns of education there are one primary, one middle and one high school based in Anandaban. Other facilities like Post Office, Bank, Health Post, VDC office are also settled there. Drinking water is available throughout the year. Telephone lines are widely distributed. Electricity is provided in every ward, but proper electric lines are needed. The drainage systems are not well organized. A police station is near by and the nearest Hospital is the Butwal Zonal Hospital.

1.4 Objectives

The perception that mental disorders are rare among people living in remote parts of countries of the South is unjustified (Mumford, 1996). The causative factors may differ from factors found in the West. There is a need for empirical data and analysis of the problems. This survey aims to understand the mental distress, health practice, service expectations and

the level of awareness of mental health issues in the Terai area in Nepal. The aim is also to compare part of the results with the earlier study, Adhikari & Dennison (1999), that was done in the hilly area of South Lalitpur.

Specific Objectives

1. To estimate the prevalence of non-psychotic mental distress in Anandaban VDC, which is part of Rupandehi District.
2. To identify socio-demographic factors which are related to the prevalence of mental disorders.
3. To ascertain the level of awareness of the community to mental health.
4. To assess quantity and quality of the current health services which are available to the community.

2. Literature review

2.1 Studies Using Self-Reporting Questionnaire

The Self-reporting Questionnaire (SRQ) was designed to screen for mental illness; the tool may help the health worker to identify mental illness among various people, especially those with many physical complaints, to prevent expensive somatic investigations. WHO has designed the SRQ especially for developing countries in 1984. The SRQ requires only a simple yes or no answer of each of its 24 short questions. The respondent is considered to be a potential psychiatric case, if the number of "yes" answers on the first twenty questions (so called non-psychotic items) reaches or surpasses a fixed value, the cut-off point value, if at least one yes answer is given for the last four questions, or if both criteria are met. A wide variety of cut-off point values have been used in different research settings, varying between 3/4 in Sudan and 10/11 in Columbia (Kortmann, 1990).

Harding et al. (1980) studied the prevalence of mental disorder in primary health care in four developing countries: Columbia, India, Sudan and the Philippines. A Self-Reporting Questionnaire (SRQ) was designed for this study. Health care attendees over 16 years old

were screened. A cut off score for non-psychotic questions was selected for each study area, the cut off scores for the four areas were 10/11, 5/6,3/4,6/7. Those who scored above the cut-off scores, or those scoring at least one positive item on the psychotic questions, were regarded as potential cases and were followed up, as well as a sample of those who scored less than the cut -off score and did not have any answers on psychotic items. The follow up was done in the form of a psychiatric interview, a diagnostic assessment and formulation, and a case register. All together 1624 persons were screened, and the prevalence of mental disorder in four areas was 10.8%, 17.7%, 10.6% and 16.3%, overall prevalence being 13.9%.

Mari and Williams (1986) conducted a study with the first 20 questions of the SRQ (for non-psychotic disorder, SRQ-20) in primary care settings in Brazil. The purpose was to assess the feasibility and validity of the SRQ. A time-sample of attendees aged 16 or more was selected (875), after which psychiatric interviews with 260 people were conducted blind, without knowing the SRQ results. The result showed the SRQ-20 to be a feasible screening instrument for non-psychotic disorders. When a cut-off point of 7/8 was used, sensitivity was 83% and specificity 80%, and the SRQ was found to be acceptable as an indicator of morbidity at a population level.

Mumford et al. (1997) did carry out a community survey of stress and psychiatric disorders in rural Punjab, Pakistan. A two- stage research setting was used. At the first stage, the screening instruments were SRQ-20 and Bradford Somatic Inventory (BSI, Mumford et al. 1991). SRQ and BSI were administered orally to the villagers (644) who were 18 years and older. About the quarter of the men were living away from the village at the time of the survey. Two cut-off points of SRQ, 5/6 and 9/10, were used. Psychiatric assessment (second stage) was done for all the people who scored above cut-off points in screening tools. There were the higher and lower thresholds results reported as follows: prevalence of 66% for women and of 25% of for men; prevalence of 72% for women and of 44% for men. Using lower threshold the sensitivity of the SRQ was 85% and specificity was 70%.

Al-Subaie (1998) conducted study using SRQ and psychiatric interview in a hospital setting where people, who were referred to endoscopy, formed the research group (166 males,

126 females, mean age 35 years). The purpose of the research was to assess the validity of the Arabic Self-Reporting Questionnaire (SRQ). Using a cut-off point of 6 there were 176 (60.3%) psychiatric cases identified by SRQ compared to 142 (48.6%) who were identified by independent psychiatric interview.

The cut-off point between six and seven was found to yield a sensitivity of 93%, a specificity of 70% and misclassification rate of 19%. The tendency of SRQ to err in yielding more false positive than false negative cases was seen as very important, since false-positives will be identified in the subsequent second stages of research, while excluded positives will be lost. The conclusion of this research was that it supports the usefulness of the SRQ as a cost-effective screening instrument for psychiatric morbidity in two-stage large population research.

Creed (1999) studied people from the Indian subcontinent living in the UK and India to assess the prevalence of non-psychotic disorders, to compare different religious groups, and to compare the prevalence with that in a sibling population in India. After random sampling, 376 participants, of whom 57 gave information of their family in India, were screened by SRQ for non-psychotic disorders and for life events using the brief list of threatening life events. Similar measures were administered to siblings in India. A cut-off score of 8 or more was used to assess prevalence of probable psychiatric disorder.

The results showed that 5% of men and 16% of women among Sikhs (223), 13% of men and 27% of women among Hindus (100), and 23% of men and 57% of women among Muslims (49), had elevated SRQ scores. A total of 117 siblings in India reported similar scores. There was difference in expression of threatening live events; they were expressed more in India than in UK. The study result indicates that psychiatric disorder in ethnic groups varies across religious groups, which can be associated with social difficulties in these groups.

2.2 Studies in Nepal

Studies on mental health in Nepal were started by Shrestha et al. (1983), studying the prevalence and distribution of mental illness in a semi-rural community. The study areas, which are relevant to this study, are as follows: number of patients in primary health care facilities with psychiatric morbidity (Wright et al., 1990), the evaluation of the first five years of the pilot community mental health program (Wright, 1991), the estimation of the prevalence of psychiatric illness in Yala urban area (Pol et al., 1998), and the estimation of non-psychotic mental disorders in a rural community (Adhikari & Denison, 1999).

Shrestha et al. (1983) conducted his study with 202 households in a community of 1202 people in the Kathmandu Valley. Preliminary psychiatric interview of all residents over 9 years and screening was done using the Indian Psychiatric Survey Schedule. The possible cases were examined in-depth by psychiatric examination using DSM III criteria. Out of the 803 people interviewed, 113 were identified as psychiatric cases, which gave a prevalence of 13.6% in this population.

Analyses were carried out to see whether age, sex, marital status, income, education or family type was related to the presence of psychiatric disorders. Those who aged 21 – 30 had a higher rate of prevalence than other age groups. Rates of psychiatric cases were not statistically different among men and women, even though women tended to have higher scores. Marital status was significantly related to mental disorders, those who were widowed or separated (18%) having higher rates of mental disorder compared to those who were married (15%); the unmarried had the lowest rates (7.8%). While people were divided into under and over 30 years of age regarding their education, no significant relation to mental disorder was found. That was also the case when comparing the family types.

The purpose of Wright et al.'s (1990) study was to screen psychiatric morbidity. The Self-Reporting Questionnaire (SRQ) was translated into Nepali and modified for local use. 146 patients over 16 were screened at Chapagaon health post, and 150 patients were interviewed at the out patient department in Patan Hospital, using the SRQ. A cut-off score

was selected to be 11 in questions (1 - 20) and one or more in questions 21 - 25. The prevalence for psychiatric "caseness" was from 23% to 28%. It was found that the somatic symptoms of psychiatric distress were prevalent.

The Community Mental Health Programme of Lalitpur district was evaluated after five years of functioning (Wright, 1991). The evaluation considered the following: utilization of services; knowledge, attitudes and practices of community members and Community Health Workers, costs of program, and usage of the program as a teaching and demonstration base. The community interviews (VHW, TBA, and TH) were held in different health posts (7). It was found that awareness of mental health problems ranged from Traditional Healers' 14% regarding depression and psychosis to Village Health Committee members' 75% regarding epilepsy and mental retardation. Different health workers had a high level of awareness (75 %) that treatment was available at the health post.

Pol et al. (1998) carried out a study in the Yala Urban Health Project (YHUP) in Patan, to estimate the prevalence of psychiatric illness in the area and to assess the community response to the illness. During the first stage, the screening instrument was the Nepali version of SRQ, which was translated into the Newari language. During the second phase an instrument was used, which was based on a flow-chart and diagnostic decision tree. The questions of the SRQ were classified, and it was found that 12 related to psychological and 8 to physical problems. Cut-off point for SRQ was 10/11 on the non-psychotic questions or 6/7 on those non-psychotic questions that are psychologically related. The results showed that around 11% of the population (252) of the study area had mental health problems.

Adhikari & Denison's (1999) study was done in Gotikhel, a village in South Lalitpur. The aim was to estimate the prevalence of non-psychotic mental disorders and to identify socio-demographic factors related to that prevalence, and to ascertain the level of awareness of the community to mental health. The tools they used were in the first phase the Self-Reporting Questionnaire (SRQ-20) for screening, and the flow-chart and diagnostic decision tree for diagnosis of mental disorders in the selected group in the second phase. A high cut-off point 10/11 was selected for the SRQ in order to increase the specificity of the questionnaire.

The results showed 10.2% prevalence in the study population, 11.8% in women and 8.5% in men. The result was comparable to earlier studies in Nepal. Due to the small number of participants for the second stage the material was not used for further analysis, and prevalence is based on the first stage results.

3. Methodology

3.1 Sample population

Anandaban VDC (Village District Committee) was chosen because of future plans to expand the program towards the Terai and to explore the feasibility of that. Anandaban lies between Bhairahawa and Butwal municipality. In this area people can later be referred both to hospital and health posts for mental health service. The study area is easily accessible by road, and it was possible to run the data collection during the rainy season. A preliminary visit (12.8. – 15.8.1999) to the area revealed interest and willingness to co-operate in the District Health Office and in Anandaban VDC; which was chosen as suitable after visiting three VDC's in the area.

This is a community survey of the prevalence of non-psychotic mental distress using the SRQ, carried out in Anandaban VDC of Rupandehi district. The study did not use a strict randomization of the study population, but information from population census was used while choosing the location of study in the VDC. From the report of the chairman and representatives of VDC and Wards, three central wards had been found, consisting of a more homogenous population with adequate density than other wards of the VDC. The lack of time, and the rainy season, were also factors considered while selecting the place of the study. As visiting all the houses is impossible so, in order to cover a wide range of population in a short time, from different ethnic groups. These three wards were considered as a study site.

A total population of 414 from these three wards was included in the present study. They were picked more on a purposive basis rather than randomly. The study population was defined as adults, aged 16 and above, living in these wards.

3.2 Screening instrument

The Self-Reporting Questionnaire (SRQ, Harding et. al., 1980) was used as a screening instrument in this small-scale survey. It has been already used in previous research in Nepal. The main interest is to find out the level of non-psychotic distress among the target population. The first 20 questions are designed to detect non-psychotic disorders and were selected initially from items in four different instruments (PASSR, PGI Health Questionnaire, GHO and the shortened version of PSE) from which the SRQ was constructed. Psychosis items (4) were based on items in Foulds' Symptom Inventory. Wright et al. (1990) designed one question for epilepsy (Adhikari & Dennison, 1999).

The Nepali version of the SRQ used by Wright et al. (1990), Pol et al. (1998) and Adhikari & Denison (1999), was taken for screening purposes in this survey. The SRQ cut-off point was selected according to earlier studies to be 11 or above on the non-psychotic questions of SRQ (SRQ- 20); seven or more on the psychological questions in SRQ was regarded as evidence of possible mental distress.

The questionnaire (Appendix II) was prepared for the data collection, which included questions relating to socio-demographic information, health service needs and SRQ. Socio-demographic questions included household type, number of people living in the household, number of rooms in the household, marital and educational status, age at marriage and years married, number of children, occupation, income levels, food supply, and substance use. Health service needs questions included: where people go for service, can they use the service, whether they are referred, what they think about the quantity and quality of the service and what kind of health service they would like to have in future. After SRQ questions were presented the people were asked, how long had they had the complaints mentioned, what they think of the reasons for their problems and had they asked help for them, as well as how helpful they found the treatment.

3.3 Training

Two male and two female research assistants were chosen from MA Psychology or Social Science graduates of Tribhuvan University, Kathmandu. They were trained in the administration of the SRQ in one day's training, during which they practiced interviews observed by the authors. During the one-day training research assistants were taught about general principles of giving interviews and what sorts of precautions the questioner should take. Before taking interviews all research assistants were given a brief explanation, and their consent was obtained

3.4 Study Procedure

During the interviews female research assistant interviewed the female participants and male research assistants interviewed the male participants. The procedure of the interviews was as follows: First a list was written of all the adults and children living in the house, those family members who were absent, and the reason for their absence. A separate identity number was given to each house. As some of the participants were illiterate, the SRQ was administered orally in the Nepali language to every member of the household aged 16 years or more. Privacy was maintained as much as possible during the interview. Research assistants often had to go several times to the same house in order to obtain data for all adults in the study sample and thus try to reduce the possible selection bias.

3.5 Data Analysis

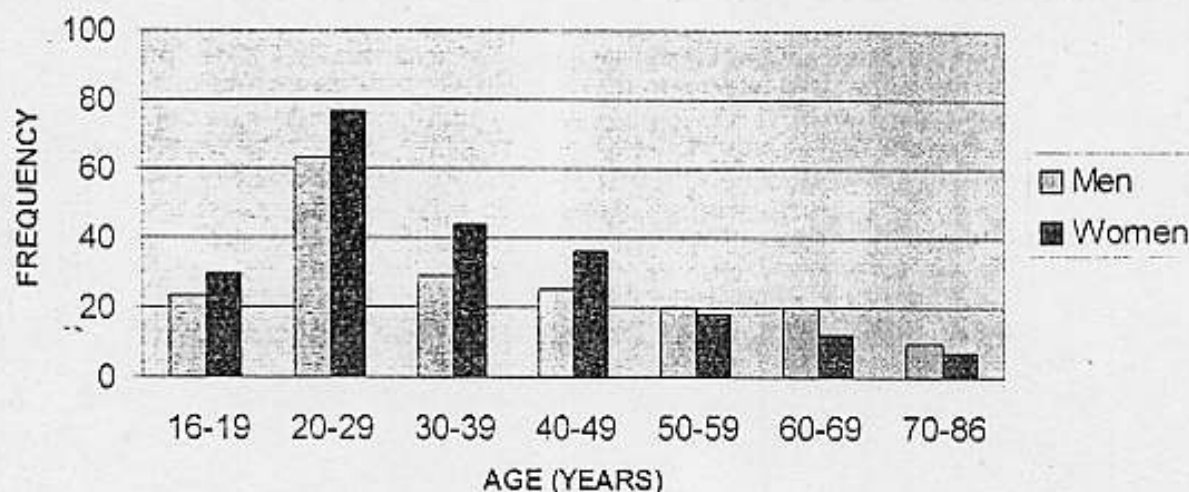
All the data was entered in the computer software and subsequently analyzed by the use of EPI-6-Info version. Obtained results are discussed in the appropriate headings below.

4. Results

4.1 Demography

There were 414 adults (190 men and 224 women) with an average age of 31.8 years, SD 16.5 (Figure 1), 288 children younger than 16 years were living in households during the survey. There were 104 persons who were staying away from home at that time. They were mostly sons (60) who had gone for work or study. 13 daughters-in-law were visiting their natal home (*maiti*) or studying. These people represented 70.2% of those who were away. 13.5% of the household heads were working elsewhere, only a few of them were temporarily away. The remainders of the people, who were not present, were different family members for various reasons. The length of staying away was usually around four years, variation of the time period being very wide.

Figure 1. The population of Anandaban by age and gender



Majority of the people were Brahmins (65.7%), the other ethnic groups were significantly smaller. There were Tharus, Chhetris and Magars (up to 83.6%) and some Newars, Damais, Sarkis, Rais and Kamis (9.9%). The population was nearly all Hindu (94.2%) by religion. The other significant groups were Muslims (3.6%) and Buddhist (1.2%).

The majority of the population was speaking Nepali language (86%) as their mother tongue. Some of them had Tharu (7%) or Urdu (2.4%) as their first language. There were 39 persons who could speak also three or more languages other than their mother tongue.

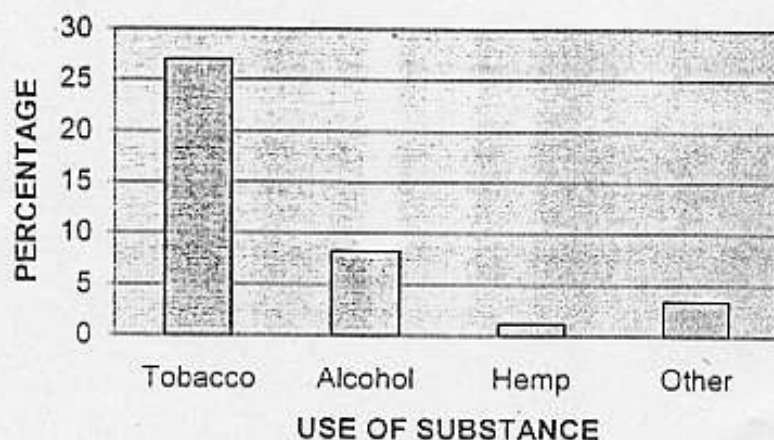
60.3 % of the adults were married, some of the married women (7.1%) lived in the situations where the husband had another wife(s). 23.5% of the adults were single, and 5.8% were widowed. Women's mean age of marriage was 15 years, mean age of marriage for men was 20 years. Literacy rate was 74.8%, for men 86% and for women 65%. In Western Region generally the literacy rate is 58.5% for men and 28.9% for women. This shows that in Anandaban men were highly educated and the picture is even clearer with women, they are more than twice as literate as women generally in Western Region.

55.7% of the population was involved with agriculture, 16% of the inhabitants were students. 7.1% were working in business, or were housewives (4.4%). Only a few people had jobs such as teaching, government service, industry and transportation (6.4%). Other nonspecific occupations were reported to be 10.3%.

Families were either joint (58.3%) or nuclear families (41.7%) and they had on average three children. 53 % of the people earned up to 3000 Rupees per month, 35.6% earned up to 6000 Rupees per month. People were relatively wealthy, only 9.2% earned less than 1000 Rupees, but 10.7% earned more than 6000 Rupees monthly. Mean household size was seven people and there were on average five rooms for them. Most of the houses had concrete roofs (82.9%). Most of the households (87.2%) said they had enough food for the whole year. Reasons for not having enough food were having loans, or tenant farming. 87% of the people owned land and 85.5% had their own houses, while 11% lived in rented houses.

When study population was asked about their smoking and drinking habits, people reported mostly using tobacco either in the form of cigarettes or chewing tobacco (Figure 2). Those who mentioned using tobacco, used it on average six times a day, those who reported using alcohol took one glass or bottle once a week, those who used *hemp* used it four times a day on average.

Figure 2 Expressed use of tobacco, alcohol and other drugs



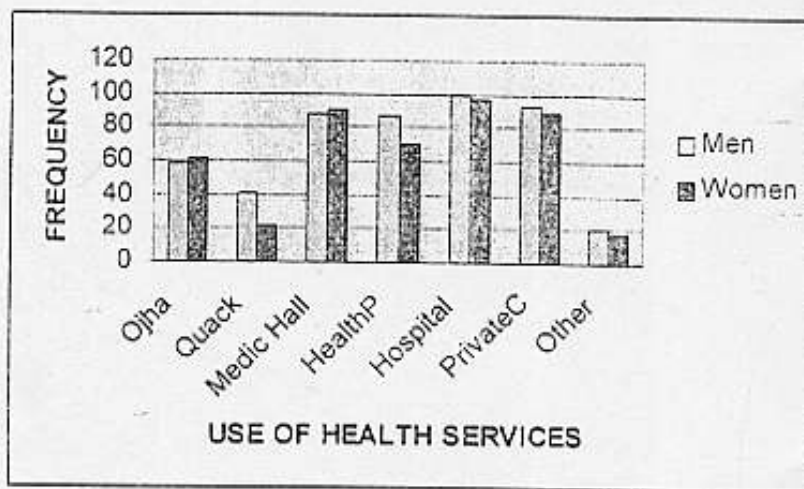
People who were socially active belonged mostly to farmers clubs (26%) or mothers groups (24.7%). Social clubs also interested some people (15%). There were many different social groups (17), so there was a lot to choose if there was interest in this kind of activities. Four of the people were part of the VDC's administration. When people were asked about their friendships 77.7% of them said that they had intimate friends to whom they could tell secrets and such persons were either spouse or another family member.

There were three questions regarding problems in family. 9.9% of the people said that someone in their family used so much alcohol that it caused constant problems in family life (41 persons, 23 women, 18 men). In 3.1% of the families someone had committed suicide (13 persons, 7 women, 6 men). When asked whether there was someone in the family who had mental illness (15.7%), out of the identified people (65) there were 32 women and 33 men.

4.2 Health Service Needs

Seven questions were included in the questionnaire to ask about Health Service Needs. The Health Post was roughly at the same distance from all the interviewed population. First it was asked to which health services the people go when they have problems. Both men and women would go most frequently to the Hospital (Table 3). Seeking help from a Medical Hall, in women, and consulting the Private Clinic, in men, is next most frequent. Third choice for women was Private Clinic and for men it was Medical Hall. The next choice for women and men was the Health Post. The last option for both women and men was to visit Ojha. While comparing the results between men and women, there were not found any statistically significant differences among them regarding using different health services.

Figure 3. Use of different health services



When asked which health service people chose first the answers did not differ much from those which they gave for general question which health service they select. Both men and women visited first Hospital. This is followed going to Private Clinic by men (20.1%) and to Ojha by women (16.1%). Third choice for women was Private Clinic (15.2%) and for men it was Health Post (14.8%) and Medical Hall (14.8%) Fourthly women visited medical hall (14.8%) Last choice for women to go first was Health Post (12.1%) and for men to visit

Ojha (7.9%). There was not statistical difference between men and women while selecting the place to seek first help to themselves.

People were asked if there are enough Health Service available. 54.7% of the women answered "yes", and 56.8% of the men (no significant statistical difference between men and women). Those who expressed that there is not enough service (46.5% women, 43.2% men) were asked then, what was the problem. The main problems, which were mentioned, were lack of medicine and lack of staff. Men emphasized the ignorance of staff as well as other problems. Men expressed more problems than women did (1.0 vs. 2.0, K-W $h=7.56$, $P=01$).

The next question tried to find out people's opinions about the quality of health service, how people felt they are treated. 58.9 % of the men and 61.1% of the women were satisfied. Those who were not satisfied were 41.1% of men and 38.9% of women (no significant statistical difference between men and women, (Table 1). Those who expressed the source of their dissatisfaction mentioned staff attitude and behavior (men 45.5%, women 64.6%) or their technical knowledge (men 40.3%, women 22.0%) The expressed dissatisfaction differed among men and women statistically ($X^2=6.98$, $df=2$, $P=.05$)

Table 1. Satisfaction with the available health service

Group	Female	Frequency	%	Male	Frequency	%
1. Behav	82	53	64.6	77	35	45.5
2. Attitu.	82	18	22.0	77	31	40.3
3. Other	82	11	13.4	77	11	14.3

Then it was asked if it is possible for the people to go to hospital, if they were referred there. 79.2% of women and 97.3% of the men felt they would be able to go. The difference between men and women as to possibility of using hospital service differs significantly. So, women expressed less possibility to use the hospital than men did ($RR = 0.10$, $P= .05$). Those who were not able to go mentioned lack of money as the main reason for not being able to go if they were referred.

The last question that was asked was what kind of health services people would like to have in the future. This was designed as an open question, not all the people did give their opinion

(N= 205). Multiple answers were possible and three main categories were found as shown in the following table 2.

Table 2. Type of health services desired

Type of health services	N	Freq.	%	N	Freq.	%
Hospital, with free Medicine and close by	205	87	42.4	185	51	27.5
Better Health Post, With free medicine and close by	205	84	40.9	185	32	17.2
Doctors, including specialists	205	13	6.3	185	28	15.1

Both men and women gave very similar answers. The first priority was a hospital; the second priority was better health posts. These were combined with the demand for free medicine, and being near at hand. The third category was the demand for doctors, including also specialists.

4.3 Prevalence with SRQ

In this survey it was decided that the SRQ cut-off point would be 11 or above on the non-psychotic questions and regardless of the total score it was selected a score of 7 or more on the psychological questions to give possible evidence of mental distress in SRQ. The higher threshold allowed for greater specificity, and a consistency with the choice of cut-off point used by Pol et al. (1998) and Adhikari and Denison (1999). While using this criteria a point prevalence of 13.1%, in women 17.6% and in men 8.5%, was found in this study.

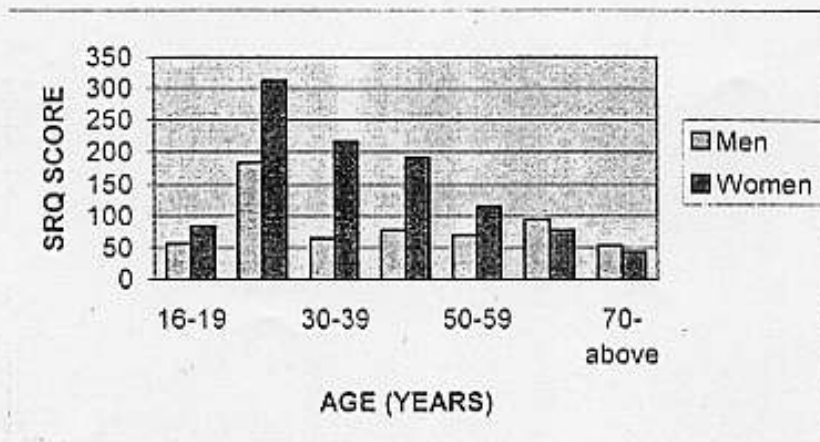
4.4 SRQ and socio-demographic factors

Age

There is steep rise in SRQ scores in the age range of 20-29 years (Figure 4). A lot of distress symptoms were reported in the SRQ by this age group, but also the number of people is largest in this age group. SRQ scores of women start declining from age group 30-39 years. It shows declining patterning of the SRQ scores as age increases, but there is not evidence that they have less distress, this can be verified only after the statistical analysis between age groups is done. There is a similar pattern of distress symptoms experienced by the age of 16-29 years olds and 70 years olds and above people. Women of ages ranging from 20-59 were seen to experience more symptoms, as they scored higher in the SRQ than other age groups.

There is a similar pattern in men as well; more men of age group 20-29 scoring higher than other age groups on the SRQ, although they were experiencing less amount symptoms than women of similar age. Otherwise SRQ scores of men age ranging from 16-59 did not differ very much. There is only the second slight raise in SRQ scores in the age range of 60-69 years in men.

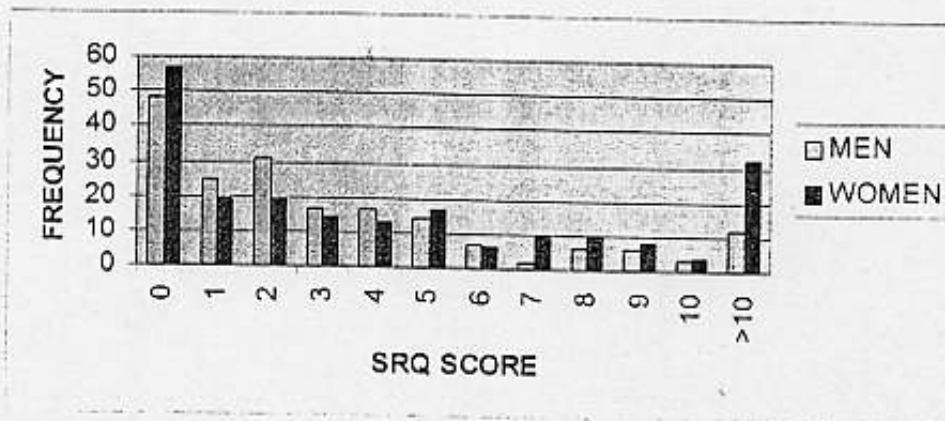
Figure 4. Mean SRQ scores by Age and Gender



Gender

While looking at SRQ scores according to gender it was found that women and men differed in their scores (Figure 5). Women expressed more symptoms (women 15.6%, vs. men 5.3%) and they had nearly three times more risk relative to men for higher SRQ scores (RR =2.97, p=.001). People between ages 16 – 29 (6.7%) had relatively lower risk (25%) to have higher SRQ scores than those who were over 30 years (14.5% and P = .05). It was found that younger women (9.3%) had 44% more risk in their SRQ scores compared to older women (21.9%) Younger men (16-29) did not differ from older men (>30) in this respect.

Figure 5. SRQ scores gender frequency



Ethnic group

Distribution of the different ethnic groups in the sample has been mentioned already in the demography in result. When the major ethnic group, Brahmins, were compared with other ethnic groups there were no significant differences in SRQ scores in the ethnicity. Brahmin and non-Brahmin did not differ significantly in this regard.

Marital Status

When marital status was the criterion, dividing the population into unmarried and married persons, the effect on median SRQ scores was found in the women's group. Those who were

not married had fewer expressed symptoms than those who were married did (1.0 vs. 5.0, K-W $h=12.111$, $P=.001$). In men, marital status did not bring any difference to their median SRQ scores.

When younger, unmarried women of 16 - 29 years age, were compared to married women of the same age their median SRQ scores did not vary from each other. When a similar comparison was done with younger unmarried and married men (16 - 29 years) there was no significant effect of marital status on median SRQ scores (Table 3). When age at the time of marriage was analyzed, those who were married before the age of 16 and later did not differ significantly in effect to median SRQ scores on either sex.

Table 3. Marital status and SRQ scores

Variable		Median		K- W h	p-value	
Marital Status						
women	16 -29	no married	1	(0 - 13)	3.53	Ns
		married	3.5	(0 - 26)		
men	16 -29	no married	2	(0 - 12)	0.22	Ns
		married	2	(0 - 12)		

* Significant at the level of .05 ** Significant at the level of .01

***Significant at the level of .001

Number of children from marriage

Women who had more children (>4) had more than twice the risk of higher SRQ scores than those women who had less children (≤ 4) (RR=2.24, $p=.04$), but that was not the case with men.

Family type

When people belonged to a joint family they were found to have higher median scores on the SRQ than those who lived in a nuclear family (Table 4). The difference is statically

significant. So, larger family size as in the joint family was not found to be effective in reducing the experience of distress on the SRQ.

Number of people in household

Those people who had more than 7 members living in their house had higher median SRQ scores compared to those who had less than 7 people living in household (Table 4).

Educational status

While analyzing the whole population, it was seen that there was a clear difference between illiterate and literate people, associated with their SRQ scores. Those who were illiterate (21.3%) had a relative risk nearly three times those who were literate (7.2%), of having higher SRQ scores (RR=2.96, P=. 001). The difference between illiterate and literate people was significant both in women's (RR=2.10, P=. 03) and men's (RR=4.02, P=. 05) groups. When women's groups under and above 40 years were compared, the age did not bring significant effect on their median SRQ scores. The same situation was true with under and over 40 years-old men.

Table 4. Family type, number of people of household and education

Variable		Median		K - W h	P-value	
Family type	joint	4	(0 - 29)	8.84	**	
	nuclear	2	(0 - 44)			
Number of the people of household	>7	4	(0 - 23)	4.65	*	
	<=7	2	(0 - 44)			
Education	illiterate	5	(0 - 29)	23.92	***	
	literate	2	(0 - 44)			
men	illiterate	3	(0 - 17)	4.23	*	
	literate	2	(0 - 15)			
women	illiterate	4	(0 - 23)	4.65	*	
	literate	2	(0 - 44)			
men	< 40	illiterate	2	(0 - 9)	0.18	Ns
		literate	2	(0 - 14)		
women	< 40	illiterate	3.5	(0 - 29)	1.38	Ns
		literate	2	(0 - 44)		

* Significant at the level of .05 ** Significant at the level of .01

*** Significant at the level of .001

Occupation

Occupations were divided into students, farmers, business and housewife groups. It was seen that women who were farmers (62.4%), had relatively one and half times more risk than men farmers (37.6%) of having higher SRQ scores (RR=1.41, P=. 001). Within the women's group there was no effect of occupation on SRQ scores, and the situation was the same within the men's group. Students were found to have lower SRQ scores than other occupations such as farmers. Non-students were seen to have 12.6% relative risk. The difference between non-students and students in relative risk is significant (P= .01). When business people were compared with other occupational groups there was not statistical difference in their SRQ scores. When housewives were compared with other occupational groups it was found that they had significantly higher relative risk than others did for high SRQ scores (RR=74%, P=. 001).

Males did not differ occupation-wise. But for females, being a non-student was likely to increase SRQ scores, leading to an increase in relative risk. Female students had 14% relative risk over other women of having higher SRQ scores, but male students did not differ statistically from men with other occupations. When students were compared with those who worked, their median SRQ scores were lower (1.0 vs. 3.0, K-W h=13.380, P=. 001).

Income levels

No statistically significant effect of income level on SRQ scores was found while looking at the whole study population, or men and women in their groups. This finding could perhaps be influenced by the relatively good economic status of the area

Food supply

Because especially very poor people have problems, either of not having land, or not getting enough food for the year, people were asked if they had food enough. There was 33% relative risk with those who did not have enough food (26.4%) over those who had food (8.6%) to have higher SRQ scores ($P = .001$). To be without enough food in women's groups was associated with relatively higher SRQ scores (48.9% vs. 11.6%, RR 14%, $P = .001$). In men's group the same association was not seen.

Substance use

People of the study were categorized according to their use of any substance. There were no indications that substance use had effect on SRQ scores in the whole group. But the difference was significant ($P = .05$) among women. Those, who used any substance (35.3%), had two and half times risk over non-user women (14.0%) of having higher SRQ scores (RR=2.52). The same was not true with men. Women who used alcohol were experiencing significantly high non-psychotic problems than those who did not use alcohol (K-W $\chi^2 = 14.36$, $P = .001$). Both alcohol and smoking in men showed less effect on non-psychotic complaints, as there was no statistically significant difference between these variables.

4.5 Psychological Questions and socio-demographic factors

Age

In the total sample the age group of 16-29 were found to have been less vulnerable in experiencing psychological symptoms (Table 5) than those over 30 years of age. While considering men and women separately, women experienced significantly fewer symptoms in the age range of 16 -29 years than those women over 30 did. Men of both age ranges were not found to experience statistically significant difference in the psychological symptoms in the SRQ.

Table 5. Age and the psychological distress

Variable		Median		K -W h	p-value
Age	16 - 29	1	(0 - 19)	5.31	*
	30 -	2	(0 - 41)		
men	16 - 29	1	(0 - 11)	0.59	Ns
	30 -	1	(0 - 12)		
women	16 - 29	1	(0 - 19)	6.27	**
	30 -	3	(0 - 41)		

*Significant at the level of .05 ** Significant at the level of .01

***Significant at the level of .001

Ethnic group

There were no significant differences in mean SRQ scores between different ethnic groups. When the ethnic group was categorized as Brahmin and non-Brahmin (as the majority of the people of the present study were Brahmin), there was also no statistically significant difference in the mean SRQ scores.

Marital status

Women, who were not married, had less psychological complaints than married ones (Table 6). their median SRQ scores regarding these questions were smaller (1.0 vs., 5.0, K-W h=12.111, P=. 001). The same was not found when compared unmarried and married men. When age of marriage was analyzed, those who married early (<16 years) were not different from those who married later (16 years or above) in their psychological median SRQ scores.

Table 5. Age and the psychological distress

Variable		Median		K -W h	p-value
Age	16 - 29	1	(0 - 19)	5.31	*
	30 -	2	(0 - 41)		
men	16 - 29	1	(0 - 11)	0.59	Ns
	30 -	1	(0 - 12)		
women	16 - 29	1	(0 - 19)	6.27	**
	30 -	3	(0 - 41)		

*Significant at the level of .05 ** Significant at the level of .01

***Significant at the level of .001

Ethnic group

There were no significant differences in mean SRQ scores between different ethnic groups. When the ethnic group was categorized as Brahmin and non-Brahmin (as the majority of the people of the present study were Brahmin), there was also no statistically significant difference in the mean SRQ scores.

Marital status

Women, who were not married, had less psychological complaints than married ones (Table 6), their median SRQ scores regarding these questions were smaller (1.0 vs.. 5.0, K-W $h=12.111$, $P=.001$). The same was not found when compared unmarried and married men. When age of marriage was analyzed, those who married early (<16 years) were not different from those who married later (16 years or above) in their psychological median SRQ scores.

Family type

It is seen in this result that the family type has not affected significantly in any of the studied SRQ variables, and subcategories of variables. It has no significant effect on psychological symptoms.

Number of people in household

Families having higher numbers of people (>7) were significantly different in experiencing psychological symptoms than those having fewer members (Table 6).

Educational status

There is a significant effect of education in experiencing psychological symptoms of the SRQ. Illiterate persons were three times more likely to experience psychological symptoms than the literate members of this population (Table 6) in SRQ. So education can be considered as an important variable affecting psychological well being. It may be because education is considered to increase the coping repertoire.

Occupation

When students were compared with those who worked, their psychological median SRQ scores were lower (Table 6). Farmers had expressed more psychological symptoms than other occupational groups (2.0 vs.1.0.K-W $h=4.37$, $P= .05$). The workers and the farmers experienced significantly higher numbers of psychological symptoms. Business people did not differ from other occupational groups in their psychological complaints on SRQ. Housewives scored significantly higher scores in the psychological symptoms on SRQ than others (K-W $h = 8.65$, $P= .01$).

Income levels

Income has been considered in the study as a variable of family source of income and has been categorized into 1-3 thousands and above. The result showed that family income has no significant effect on psychological variables in SRQ scores.

Food supply

People with inadequate food supply had more risk (median = 2.5) of experiencing psychological symptoms than the people with enough food supply (median =1.5). The difference is significant (K-W $h = 6.55$, $P = .01$). Females not having sufficient food scored significantly higher on the SRQ (7.0 vs. 2.0, K-W $h = 14.23$, $P = .001$) than their male counterparts. The data on food supply were asked directly from participants, as to whether they do have a sufficient amount of food or not.

Substance abuse

Whether or not alcohol was used did have an effect on psychological symptoms in SRQ scores in the total population (K-W $h = 5.13$, $P = .05$). Users of alcohol differed significantly from the alcohol nonusers in experiencing psychological symptoms on SRQ. In men the difference was not found to be significant, but women who used alcohol expressed significantly more psychological complaints (8.0 vs. 2.0, K-W $h = 4.27$, $P = .05$). Women smokers differed significantly in experiencing psychological symptoms in SRQ (K-W $h = 4.28$, $P = .05$) than women non-smokers. Smoking was not found to be significant statistically in men.

4.6 Physical Questions and socio-demographic factors

SRQ questions were also categorized according to physical complaints (e.g. is your digestion poor...). There was no cut-off point used when these answers were analyzed with socio-

demographic variables. Here the results are summarized and presented only if there were statistically significant results.

People over 30 years old had more physical distress than younger ones (Table 7), unmarried women had fewer physical symptoms than married ones (0.0 vs. 1.0, K-W $h=10.39$, $p=.001$). . When men under 50 years, who had more children (>4) were compared with same age group, men with less children expressed significantly more physical complaints (2 vs. 0, K-W $h=4.27$, $p=.05$), women complained of more psychological distress when they had more children. Illiterate people expressed more physical complaints compared to literate ones (2.0 vs. 1.0, K-W $h = 12.71$, $P= .001$). While looking at occupation and physical complaints, it was found that students expressed less than other occupational groups did (0.0 vs. 1.0, K-W $h = 7.016$, $P=.01$) in SRQ.

Table 7. Age and experienced physical distress

Variable		Median		K - W h	p-value
Age	16 - 29	0	(0 - 7)	18.1	***
	30 -	1	(0 - 14)		
men	16 - 29	0	(0 - 5)	5.25	*
	30 -	1	(0 - 5)		
women	16 - 29	0	(0 - 7)	14.23	***
	30 -	2	(0 - 14)		

*Significant at the level of .05 ** Significant at the level of .01

***Significant at the level of .001

The most common place for people to go, while seeking help for their symptoms (expressed in SRQ) was the hospital (56.6%). The next choice was a private clinic (25.5%), or medical hall (17.2%). 73.2% of the people answered the question about what was the causation of their problems. The opinions can be divided into the following groups. 35.4 %, of those who answered, attributed the reasons to be physical ones. 32.9 % attributed psychological causes and 30.8% attributed social causes. Only 1.3 % of the people attributed the cause of the problems to supernatural powers.

When people were asked how long they had complaints (according to SRQ answers) they usually said that the problems had lasted a very long time. Only 6.9% of the people said that they had complaints acutely or recently (up to 6 months) whereas a majority of them reported problems lasting up to two years (30.2%) or lasting up to five years (31.5%). Even longer duration of problems was expressed by 14.4 % of the people with problem duration between 5 to 10 years. Most of the people suffered chronically from the problems, which they identified according to SRQ questionnaire.

4.7 Analysis for Discussion Groups

For the concerns of the qualitative part of the survey, group interviews were designed. Each interview was divided in three parts: Mental Health Awareness, Attitudes towards the health post, and Questions about a story about depression. The following groups were selected (Table 8) and each of them were given the same questions. 1.VDC (Village Development Committee members) 2.Fathers (group from community) 3.Mothers (group from community) 4.FCHV (Female Community Health Worker). Another group of Traditional Healers was selected, they received additional questions according to their healing-knowledge. Finally an interview was held with the psychiatrist of the Rupandehi district. The results of the group discussions are shown in the following tables and described.

Table 8. Participants for Discussion Groups

Participants from different groups	N	Mean Age	Sex
1. VDC	15	41.2 41.0	13 men 2 woman
2. Fathers	10	30.8	Men
3. Mothers	14	38.5	Women
4. FCHV	11	35.7	Women
5. TH	2	48.5	Men
6. Psychiatrist	1		Man

Group Interviews: Mental Health Awareness

The question asked about Mental Health Awareness contains two parts. From the interview, categories were extracted and compared with the other groups. The answers were categorized according to the open questions range and those, which were most common, were chosen for reporting.

Table 9. Knowledge of mental health

Mental health	VDC	Father	Mother	FCHV
1. Free from anxiety	X	X		X
2. Free from tension	X	X		X
3. Free from faculty tension		X		X
4. Discipline	X		X	

When asked what do you know of health, three main categories are found in the four groups. To be free from disease was the most common idea, of how people in all groups described what health is. The next was physical fitness for men and eating nutritious food for women. Men in both groups (VDC and fathers) described mental health (Table 9) as being free from anxiety and tension, as did female community health volunteers (FCHV). Mothers connected mental health with discipline, as did VDC group.

All the groups had some kind of experience of mentally ill people (Table 10. Running on the road (VDS, fathers, mothers) and violent behavior (fathers, mothers, FCHV) was recognized. If the person could not fit to his/her place (VDC, FCHV) or was depressed and sad (VDC, mothers) the person was thought to be mentally ill. When different groups gave their answers to the question who in this VDC was mentally ill, the variation of the cases was so huge (from 8 to 92 cases) to that it cannot be reliable and probably does not reflect the actual situation. The numbers can be obtained also from individual-interviews and this gives

the number of mentally ill as 65, but still this is the more subjective opinion of the interviewees.

Table 10. Types of mental illness experienced by different groups

Types of mental illness	VDC	Father	Mother	FCHV
1. Running on the road	X	X	X	
2. Violent		X	X	X
3. Can't fit in one place	X			X
4. Depressed and sad	X		X	

People in the three groups (VDC, father mother) thought family problems (Table 11) to be causes of mental illness. All the groups recognized alcohol and women thought that (Mother and FCHV) husband's 2nd marriage could be the cause of mental illness. VDC, father and FCHV groups mentioned economic problems. When asked what would be a good response towards mentally ill people, answers scattered a lot. VDC group was thinking it would be hospital and counseling. They also preferred giving love and affection. Mothers agree with giving love and affection and mentioned that females should be treated equally. Fathers thought a good response is to give treatment in time. Female Community Health Volunteers thought economic support should not be given only to men.

Table 11. Causes of mental illness

Causes of mental illness	VDC	Father	Mother	FCHV
1. Family problem	X	X	X	
2. Alcohol	X	X	X	X
3. Husband 2 nd marriage			X	X
4. Economic problem	X	X		X

When asked where treatment is available, all the groups reported it being available in Kathmandu, and they mentioned also Ghorakpur, Ranchi (VDC, Mothers, FCHV) and Vellore (fathers, mothers) in India. When people were asked where they learned things related to mental health they answered, by experience. The second was media, VDC, fathers and FCHV's groups got information through magazines, books, pamphlets and posters. FCHV's also had learned about mental health through their training.

Group Interviews: Attitudes towards the Health Posts

There were questions, which explored people's attitudes toward local health services, and health posts. There were two questions. When it was asked, what should be done to improve the situation, supervision and control of the staff was suggested by three groups (VDC, fathers and mothers), second option was to form health committee (VDC, Mothers). Staff was not seen to take their responsibility and they were evaluated as having no motivation for the work (mothers).

Group Interviews: Questions about a Depression – story

A short imagined story about the 20 years old Pabitra was given (Table 12) including her symptoms of illness and some background information (for complete story see appendix III). When asked what might have caused her symptoms, all the groups thought that it was because Pabitra was pregnant and having mental illness, as well as not being able to go to her *maiti*. Mothers also explained that she had no love, no proper food and had too much work. The reason for her not to tell her problem was seen as her having fear (fathers, mothers, FCHV) and being embarrassed (VDC).

Table 12. The reported causes of Pabitra's symptoms

Reported causes	VDC	Father	Mother	FCHV
1. Mental illness	X	X	X	X
2. Pregnant	X	X	X	X
3. Could not go to her <i>maiti</i>	X	X	X	X
4. No love			X	
5. No proper food			X	
6. Too much work			X	

When asked about the solutions the following answers were given: Mothers suggested giving love and affection, giving nutritious food and sending her to hospital or treatment. Fathers were thinking sending her to *maiti* and giving her love and affection. VDC group was suggesting nutritious food and treatment.

Traditional Healers (TH) Group Interview

Out of 8-9 Traditional Healers only two came to the group interview. The Traditional Healers say that usually the people go to see a doctor. If this brings no improvement, they come to visit the Dhami/Jhakri. The average distance, where the people come from differs from hours to days. The common diseases spread from headache, abdominal pain, shaking hand, fever, and saliva secretion, wandering in the street and sitting alone. The Dhami/Jhakri learned their healing knowledge themselves, and/or from grandfathers. Their ways of treatment are as follows:

- Taking the history
- Finding out the problem
- Counting the rice and see if there's any problem of devil's eye,
Goddesses or witch influence
- Then they blow with ash and give a liquid-mix of ash and water to the patient.

The two healers stated that they didn't know anything about mental health. According to their understanding the illness in general belongs to loss of spirits. They pointed out that they sometimes refer people to hospital, if there's no improvement after their treatment. The two healers would be interested to get mental health training, if it is not too far away from their village.

Interview with the Psychiatrist, Lumbini Zonal Hospital

The psychiatrist has worked for two years as a medical officer in the Lumbini Zonal Hospital. He is also taking care of the mentally ill patients. Daily he sees four to five patients in the medical OPD and again four to five patients in his private clinic. Very common diagnoses are psychosis, neuroses (mostly depression) epilepsy and some cases of attempted suicide. There are also many cases of alcohol and drug abuse.

The treatment of this psychiatrist ranged from medicine to counseling, and psychotherapy. He meets his patients every two to three weeks, then monthly and after that quarterly. These patients came from several places like Chitwan, Baglung, Dang and Palpa. Three other psychiatrists come once a month to run a private clinic in Rupandehi. The psychiatrist mentioned that the networking with other doctors is not very cooperative. It was pointed out that a mental awareness raising program and training to other medical doctors and paramedics will be very helpful to improve the treatment for mental disorders.

5. Discussion

5.1 Summary of results

Socio-demographic description

This survey involved 414 adults with an average age of 31.8 years; 45.9% were men and 54.1% were women. The peak age was between 20 -29 years of age; most of the people were between 16 - 49 years of age. Brahmin was found to be the most common ethnic group (65.7%), nearly all were Hindus (94.2%), and the majority spoke the Nepali language. More than half (60.3%) of the people were married. Literacy rate for men was 86% and for women 65%; in Anandaban men were highly literate and the picture is even clearer with women, who are more than twice as literate as women generally are in Western Region (Anandaban VDC Report, 1998).

More than half of the study population were farmers (55.7%) by occupation, 16% of them were students, 7.1% worked in business and 4.4% of females as housewives. Families were either joint or nuclear (58.3%, 41.7%). Each household had on average seven members and they shared on average five rooms. Most of the households had enough food for the whole year. Less than 10% of the people reported that some family member used alcohol to the extent, which caused constant problems. Suicide was reported to have been committed in 3.1% of the families. Mental illness in the family was identified as 15.7%, a figure, which is greater than other studies done in Nepal (Pol et al., 1998, Adhikari & Denison, 1999). This assessment is based on the subjective observations of family members and should be confirmed with more objective methods, before it could be seen as reliable.

Health Service needs

Mostly the people used hospital; medical hall and private clinic, and they reported usually going first to the hospital. A little over half of the people were satisfied as to the availability and quality of health services. Those who expressed their dissatisfaction mentioned lack of medicine and staff, ignorance of staff (men) and attitude and behavior of staff (women). When the actual possibility of going to hospital was inquired about, women expressed it as being less possible to use hospital services than men did. When asked what type of health services

they will need in future, the population of this study wanted to have access to better health services. Their expectations and hopes seem to be partly unrealistic, like having hospital near by, with free medicine, and well equipped with better staff and services.

Prevalence of mental distress

SRQ has not been seen as an adequate measure of the overall level of burden of mental disorders, that it indicates only the likelihood of mental distress in an individual (Kebede et al., 1999). It has been thought (Alem et al., 1999) that mental distress has a wider coverage, including emotional problems which may not be accommodated in the available clinical descriptions of mental disorders. Here the term mental distress is used instead of mental disorder while reporting SRQ results.

A high cut-off score 10/11 was chosen on the non-psychotic questions of SRQ (SRQ-20) and alternative criteria was chosen to be scoring above 7 on the psychological questions on the SRQ-20 as was done in Adhikari & Dennison (1999) study. A point prevalence of 13.1 % was found 17.6% in women and 8.5% in men. Compared to Gotikhel in Anandaban women expressed more mental distress (17.6% vs. 11.8%), but men expressed similar amount mental distress in both places (8.5%).

In Nepal Pol et al (1998) reported a point prevalence being 11% in Patan, Kathmandu, Wright et al. (1990) reported psychiatric "caseness" in health post and hospital setting being 23 to 28% with SRQ. Shrestha et al. (1983) got prevalence of 13.6% in their study population. While looking prevalence rates of mental distress measured by SRQ, in community studies around the world, they vary a lot, as well the cut-off points, which are used. Large rural and semi-rural community study, using SRQ, was recently done by Alem et al. (1999) in Ethiopia. The study population was 10 468 and prevalence of mental distress was 17% and it was higher than previous community-based studies in Ethiopia.

Because the high number of participants scored positively on psychosis and epilepsy questions, those results were not reported. The questions seemed to represent only certain

mild features of people's problems, or they do not represent people's experience and are thus given more ordinary explanation than that of severe mental disturbance. The thought arises if it is possible to ask directly from the people to recognize their own severe disturbance.

Mental distress and socio-demographic factors

A positive association was found between older age and mental distress, those who are less than 30 years old do not display so much mental distress as over 30 year-olds. This finding is along the lines of other earlier studies (Mumford et al., 1997, Adhikari & Dennison, 1999, Alem et al., 1999, Kebede et al, 1999). The tendency to have more symptoms may be owing to the probable accumulation of stressful life events and biological changes with increasing age. (Alem et al. 1999)

Women had nearly three times more risk relative to men for mental distress. Adhikari & Denison's (1999) finding was on similar lines. Women being vulnerable to mental distress independently of other socio-demographic factors have been reported in Africa. It has been thought, that women's heavier burden of social and household responsibility predisposes them to a higher risk for mental distress (Kebede et al., 1999).

In the Anandaban population marital status in women was associated positively with mental distress, married women expressing more distress than unmarried ones. The single group has been found to suffer from mental distress to a lesser extent than married and other women (Alem et al., 1999). In this study, in the younger age group, 16 - 29 year olds, no difference in distress was found between unmarried and married women. In Gotikhel (Adhikari & Dennison, 1999) the situation was similar, with the exception, that early marriage age (< 16 years) added mental distress; this was not the case in Anandaban. The possible explanation might be that the socio-economic conditions (literacy, space in house, better income) in Terai are better compared to the hilly areas, thus possibly indirectly giving a better start even for younger married women in their life.

There was a significant association between illiteracy and mental distress. Those who were illiterate had a risk nearly three times of those who were literate, for increased mental distress, the result resembling Alem et al.'s (1999) results in Ethiopia. Literacy seems to act as a protective factor for both men and women, reducing vulnerability to mental distress. In Gotikhel (Adhikari & Dennison, 1999) the trend for illiterate people to have higher mental distress could be observed, but it was not statistically significant.

Monthly income was not connected to mental distress in Anandaban, but was in Gothikhel (Adhikari & Dennison, 1999), where men earning less than 3000 rupees evidenced higher levels of distress than those earning more than that. Low income has been strongly associated with mental distress in Africa (Alem et al., 1999). Anandaban is relatively economically wealthier than Gotikhel, and this could possibly explain the result.

Drinking alcohol was associated with higher mental distress in women in Anandaban, and in men in Gotikhel. The connection between problem drinking and mental distress can not be ascertained in a cross-sectional study, and the current difference in results remains unclear. The relation between reported family history of mental illness was not analyzed in this study, but mental distress has been found to be more common among those people who reported mental illness in the family (Alem et al., 1999, Kebede et al., 1999).

When people were asked if they had sought help for the problems which they expressed in the SRQ, more than half of them had used the hospital. They attributed their distress to physical, mental and social causes. Suffering from these distresses had lasted a very long time, in the majority of people from two to five years.

Community awareness of mental health

Discussion groups were formed to ascertain the level of awareness in the community of mental health. Interviews had three parts: questions about mental health awareness; a story about depression; and attitudes towards the health post. Mothers' and fathers' groups were selected from the community; Village Development Committee (VDC) members and Female

Community Health Volunteers (FCHV) were also interviewed. All together 53 people, 49.1% men and 50.9% women, participated in the interviews.

Discussion groups indicated high levels of knowledge about mental health; although no specific awareness programs have focused on this population. Mental health was seen mainly as being without anxiety and tension, and causes were attributed to family problems, alcohol, husband's second marriage (women) and economic problems (men). The recommendations for treatment were using health services and counseling, as well as giving positive emotional support.

The result is along similar lines as in Gotikhel (Adhikari & Dennison, 1999), with the exception that there, students recommended traditional healing as a treatment for mental illness. The results of the discussion groups are interesting, because they indicate that mental health awareness is already at a high level. This might be the result of the good educational level, which provides a better opportunity to know about general health matters: or might result from family and community experiences of mentally disturbed people, knowing about their treatment and thus attributing causes more to psychosocial reasons.

The two traditional healers reported that people usually visit the doctor and then come to consult them if there is no improvement. They also sometimes referred people to hospital, if there was no improvement after their treatment. Knowledge of mental illness was unknown to the traditional healers and they attributed illness to loss of spirits. There seems to be interaction between allopathic medicine and traditional healing methods in Anandaban, most people gave the picture of less use of traditional healers. The traditional healers expressed interest in getting training in mental health. In Gotikhel, the community's perception of causes of mental illness was seen as an indication of confidence in the allopathic health facilities available; here trained traditional healers were sending people to health services (Adhikari & Dennison, 1999).

5.2 Methodological issues

The sample for this survey was selected more on a census basis than by random sampling. This limits the applicability and generalization of results. The sample was from the central wards and had thus better access to village facilities than those living further away. Discussion group results may not represent the whole village. The results can be seen as giving probable trends, but not describing the whole area or district. This survey used the SRQ as a screening tool to obtain prevalence for mental distress, but did not proceed (according to the two-stage model of research) to the second stage, in order to confirm the prevalence of diagnosable psychiatric disorders in the study population. The main reasons were that there were not enough research assistants available who were competent to do psychiatric diagnosis, and the field phase was done during the limited time period when one of the researchers was able to stay in Nepal.

5.3 Implications of the study

The prevalence of 13.1% of mental distress in Andaban study population indicates human suffering, which had to be addressed, and need for help, which have to be organized. This suffering has strong effect on family and working as well on personal life of adult population in the area.

The socio-demographic factors, which were identified, indicate possible psychosocial interventions together with improved health services. Women seem to be clearly vulnerable to many distresses in their life; being married, illiterate, older, and having more children and people living household. These distresses are related to mental distress. Men also have mental distresses, although lesser amount than women. Men, who were illiterate, having more children and more people in household, were at risk of having more mental distress compared to other men. The high level of mental health awareness indicates that perhaps better socio-economic situation, literacy and health knowledge are the contributing factors, even without any mental health awareness programs.

5.4 Conclusions

1. The prevalence of non-psychotic mental distress in the village of Anandaban is 13.1%, in women 17.6% and in men 8.5%. This is nearly same kind of result, which has been found in Nepal and around the world earlier. In both developed and developing countries population is experiencing mental distress, and developing countries are not in any favor in this respect.
2. People expressed that they have suffered from two to five years from the problems, that they reported during the study. This means that health services, usually hospital, was not able to give adequate treatment to these people.
3. There is already high level of mental health awareness in community, even without any specific awareness programs have not taken place. This kind of positive situation might give possibility to plan new kind of interventions for community.
4. Based on this survey the area of Anandaban is suitable for implementation Mental Health services, the planning could be done with local and regional health authorities.

References

- Adhikari, K.P. & Denison B.D.B.** (1999) Mental Health in Nepal: A Community survey of a village in South Laltipur, Central Nepal. United Mission to Nepal, Kathmandu.
- Alem, K., Kebele, D., Woldesemiati, Jacobson, L. Kullgren, G.** (1999) The prevalence and socio-demographic correlates of mental distress in Butajira, Ethiopia. *Acta Psychiatrica Scandavica*, 63,367 - 383.
- Al-Subaie, A., Mohammed, K., Al-Malik, T.** (1998) The Arabic Self-reporting Questionnaire (SRQ) as a psychiatric screening instrument in medical patients. *Ann Saudi Med.*, 18, 308 - 310.
- Anandaban VDC Report** (1998) Western Region Directory. Pokhara
- Burbank, J** (1992) Culture Shock! Nepal. Times Editions. Singapore
- Creed, F., Winterbottom, M., Tomenson, B. et al.** (1999) Preliminary study of non-psychotic disorders in people from the Indian subcontinent living in the UK and India. *Acta Psychiatrica Scandavica*, 63,367 - 383.
- Desjarlis, R. Eisenberg, R. Good, B. & Kleinman, A.** (1995) World Mental Health. problems and priorities in Low-income Countries. New York & Oxford. Oxford University Press.
- Harding, T.W., DeArango, N. V., Balzar, J., et al.** (1980) Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychological medicine*, 10, 231 - 241.
- Jablensky, A., Startoriosis, N., Gulbinat, N., Ernberg, G.** (1981) characteristics of depressive patients contacting psychiatric services in four cultures: a report from WHO Collaborative Study on the Assessment of Depressive Disorders. *Acta Psychiatrica Scandavica*, 63,367 - 383.
- Kebede, D, Alem, A. & Rashid, E.** (1999) The prevalence and socio-demographic correlates of mental distress in Addis Ababa, Ethiopia. *Acta Psychiatrica Scandavica*, 63,367 - 383.
- Kortmann, F.** (1990) Psychiatric case finding in Ethiopia: Shortcomings of the Self-Reporting Questionnaire. *Culture Medicine and Psychiatry*, 14, 381 - 391
- Mumford, D.B., Bavington, T.J., Bhatnagar, K. S. et al.** (1991) The Bradford Somatic Inventory. A multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan subcontinent. *British Journal of Psychiatry*, 158, 379 -386.

Mumford, D.B., Nazir, M. Jilani, F. M. et al (1996) Stress and psychiatric disorder in the Hindu Kush: a community survey of mountain village in Chitral, Pakistan. *British Journal of Psychiatry*, 168, 299 – 307

Mumford, D.B., Saeed, K., Ahmad, I., Latif, S. & Mubbasher M. H. (1997) Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*, 170, 1473 – 476.

Nepal in figures (1999) Central Bureau of Statistics. Kathmandu

Pol K., Nakarmi, B., Thapa B., Acland, S. (1998) Yalla Urban Health Project: A Mental Health Prevalence Study. UMN Kathmandu.

Sharma, H. B., Gautam, R. P. (ed.) (1999) Nepal District profile. National Research Associates. Kathmandu.

Shrestha, M.D., Pach, A., Rimal, P.K. (1983) A Social and Psychiatric study of Mental illness in Nepal. Kathmandu.

State of the rights of the child in Nepal (1998) CWIN. Kathmandu

Statistical yearbook of Nepal (1999) Central Bureau of Statistics. Kathmandu

Tausing, M & Subedi S. (1997) The modern mental health system in Nepal: Organizational persistence in the absence of legitimating myths. *Social Science Medicine*. 3, 441 – 447.

UNICEF (1998) the State of the World's Children. Oxford University Press.

UNDP (1999) Human Development report. New York.

Upadhyaya, K.D. (1999) Western regional community mental health service in Report on Western region community mental health program.. District Officers Co-ordination meeting 2.6.1999. Pokhara.

Wright, C., Nepal, M.K., Bruce-Jones W.D.A. (1990) Mental health patients in primary health care services in Nepal, *J. Inst. Med.* 12, 65 – 74.

Wright, C. (1991) Community Mental Health Services-five years on and what has been learnt? *J. Nep. Med .Assoc.*, 29,122.

APPENDIX I

Abbreviations used in report

BSI	Bradford Somatic Inventory
CPM	Conspicuous Psychiatric Morbidity
DALY	Disability Adjusted Life Years
DSM	Diagnostic and Statistical Manual of Mental Disorder
FCHV	Female Community Health Volunteer
GBD	Global Burden of Disease
IOM	Institute of Medicine
SD	Standard Deviation
SRQ	Self Rating Questionnaire
TBA	Traditional Birth Attendants
TH	Traditional Healers
TUTH	Tribhuvan University Teaching Hospital
UK	United Kingdom
UMN	United Mission to Nepal
UNDP	United Nations Development Program
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organisation
WRCMHP	Western Region Community Mental Health Programme
YUHP	Yala Urban Health Programme

APPENDIX II

QUESTIONNAIRE FOR RESEARCH IN ANANDABAN, WESTERN REGION

IDENTIFYING INFORMATION

1. Date of Interview (day/month/year):
अन्तरवार्ता लिएको तिथि: (तारिखमा)
2. Name: नाम: 3. House No.: घरको नं.....
4. District: जिल्ला: 5. VDC: गा.वि.स. 6. Ward no. वडा नं.....

GENERAL INFORMATION

7. Caste: धरः
 1. Bahun ब्राह्मण
 2. Chhetri क्षेत्री
 3. Tharu थारु
 4. Magar मगर
 5. Kami कामी
 6. Damai दमाई
 7. Sarki सार्की
 8. Gurung गुरुङ
 9. Newar नेवार
 10. Tamang तामाङ
 11. Rai राई
 12. Tibetan तिब्बती
 13. Sherpa शेर्पा
 14. Other अन्य
8. Age: उमेर: 9. Sex: Male स्त्री / Female पुरुष
10. Education: शिक्षा
 1. Illiterate: निरक्षर
 2. Can read and write but didn't go to school:
पढ्न लेख्न सक्ने तर स्कुल नगएको
 3. School till class: पढेको कक्षा:
 4. Passed SLC: एस.एल.सि. पास
 5. Higher education: उच्च शिक्षा हाँसिल.....
11. Religion: धर्म.....
 1. Hindu हिन्दु
 2. Buddhist बौद्ध
 3. Muslim मुसलमान
 4. Christian ईसाई
 5. Other, which अन्य
12. First language: ... मातृभाषा

1. Nepali नेपाली	7. Bhojpuri भोजपुरी
2. Tharu थारु	8. Urdu उर्दु
3. Newari नेवारी	
4. Yadab यादव	Other languages... अरु भाषा
5. Gupta गुप्ता
6. Magar मगर

13. Marital status: वैवाहिक अवस्था:
 1. (M/F) single एकलौ
 2. (M/F) remarried दोस्रो विवाह.
 3. (M/F) married, only one wife
विवाहित, एक मात्र श्रीमती

- विवाहित, पहिलो श्रीमती, लोग्नेको अर्को श्रीमती छ?
5. (M/F) married, (is/has) 2nd wife
विवाहित दोस्रो श्रीमती
6. (M/F) widowed विधवा
7. (M/F) divorced पार पाबुके भएको
8. Other, अन्य

14. Age, when married? विवाह गर्दाको उमेर?

15. Years married? विवाहित उमेर?

16. How many children? कति बटा बच्चाहरु छन्?

1. Sons/ छोरा

2. Daughters/छोरी

17. Occupation: व्यवसाय

Occupational area: व्यावसायिक क्षेत्र

- | | |
|---|-----------------------------------|
| 1. Agriculture कृषि | 6. Transportation यातायात व्यवसाय |
| 2. Own business of business partner आफ्नो व्यवसाय वा साझेदारी | 7. Housewife गृहणी |
| 3. Teaching | 8. Student विद्यार्थी |
| 4. Governmental service सरकारी नोकरी | 9. Other, what अन्य |
| 5. Industry उद्योग | |

18. Roof structure छानाको प्रकार

1. Tin जस्ता 2. Mud माटो 3. Straw खर वा चराल
4. Tile टायल 5. Brick ईट 6. Others अन्य

19. Do you have enough food for the whole year?

के तपाईंको घरमा बर्ष दिन भरीलाई खानपुग्छ?

Yes पुग्छ / No पर्दैन

If no, specify what is done? यदि पुग्दैन भने के गर्नुहुन्छ?

20. What is your family income per month?

तपाईंको परिवारले प्रत्येक महिना कति कमाउनु हुन्छ?

- | | |
|----------------------|---------------------|
| 1. Less than 1000 Rs | रु. १००० भन्दा कम |
| 2. 1000-3000 Rs | रु. १००० देखि ३००० |
| 3. 3000-6000 Rs | रु. ३००० देखि ६००० |
| 4. More than 6000 Rs | रु. ६००० भन्दा नाथि |

21. Does your family own land? के तपाईंको परिवारको आफ्नो जग्गा छ?

Yes छ / No छैन

22. The family lives in: बसाई

1. Ghar (Husbands house) घर
2. Maiti (Wife's parental home) माइति
3. Deraa (Rental room/house) डेरा
4. Other, अन्य

23. Family type: परिवारको प्रकार

1. Joint family संयुक्त परिवार
2. Nuclear family एकलो परिवार
3. Other, अन्य

24. How many people live in the same household? एउटै घर धुतीमा कति जना वस्छन्?

25. How many rooms are there in your house? तपाईंको घरमा कति कोठाहरु छन्?

26. Member of the following committees: तल उल्लेखित कमिटिको सदस्य हुनुहुन्छ?

- 1.(क) गा.वि.स.नगरपालिका/ VDC, municipality
- 2.(ख) आमा समूह/ Mothers group
- 3.(ग) अन्य/Other, what.....

27. How much do you smoke and use alcohol? तपाईंले चुरोट र रक्सी कति धेरै पिउनु हुन्छ ?

1. Alcohol/Beer: Yes / No : Glasses/bottles per week:.....
रक्सी, बियर (छ/ छैन) ग्लास,बोटल, प्रतिहप्ता
2. Cigarettes: Yes / No : How many per day:.....
चुरोट (छ/ छैन) दिनको कति खिल्लो
3. Tobacco: Yes / No : Times per day:.....
तुती (छ/ छैन) कति चोटो (दिनको)
4. Hemp: Yes / No : Times per day:.....
गान्जा (छ/ छैन) कति चोटो
5. Other: Yes / No:
अन्य (छ/ छैन)

28. Do you have intimate friends who you can tell your secrets to?

के तपाईंको निम्नै साथी छ जसलाई आफ्नो गोप्य कुरा भन्नु सक्नु हुन्छ ?

Yes / छ No/ छैन

If yes, who are they? यदि छ भने को ?

- | | | |
|-------------------|------------------|----------------------|
| 1. Father/mother | बुबा/आमा | 4. Friends साथी |
| 2. Husband/wife | श्रीमान्/श्रीमती | 5. Others, who? अन्य |
| 3. Brother/sister | दाज्जु/दिदी | |

QUESTIONS CONCERNING HEALTH SERVICE NEEDS

29. If you or someone in your family has problems or is ill, where do you go to?

यदि तपाईंलाई वा तपाईंको परिवारमा स्वास्थ्य समस्या भयो भने कहाँ जानु हुन्छ ?

1. Ojha/ jhankri/ dharmi/ traditional healer: Yes/ No
भोभा, भाको, धामी
2. Quack (practicing medicine without training): Yes/ No
क्वाक
3. Medical hall: Yes/ No
मेडिकल/ औषधि पसल
4. Health Post / Sub Health Post Yes/ No
स्वास्थ्य चौकी/ उपस्वास्थ्य चौकी
5. Hospital Yes/ No
अस्पताल
6. Private clinic Yes/ No
प्राइवेट क्लिनिक
7. Other, what?..... Yes/ No
अन्य हो/ होइन

30. Which of the places that you mentioned do you visit first? Number:.....

तपाईंले भन्नु भएको मध्ये सबभन्दा पहिला कसकोमा जानु हुन्छ ?

31. What is the distance from your house to the Health Post or Sub Health Post?

तपाइको घरबाट स्वास्थ्य चौकी जान कति समय लाग्छ ?

1. Less than 10 minutes १० मिनेट भन्दा कम
2. 10-30 minutes १० देखि ३० मिनेट
3. More than 30 minutes ३० मिनेट भन्दा बढि

32. Are there enough health services available to you? (Quantity)

के त्वाहा प्रशस्त मात्रामा स्वास्थ्य सेवा उपलब्ध छ ?

Yes / छ No / छैन

If no, what is the problem? छैन भने के समस्या छ

1. Lack of medicine औषधीको कमी
2. Lack of staff कर्मचारीको कमी
3. Other, what अन्य

33. Are you satisfied with the way you are treated? (Quality)

के तपाइले पाएको उपचारमा तपाईं सन्तुष्ट हुनु हुन्छ ?

Yes / छ No / छैन

If no, why not? छैन भने किन

1. Staff's attitude and behaviour कर्मचारीको व्यवहार
2. Technical knowledge प्राविधिक ज्ञानको कमी
3. Other अन्य.....

34. If you are referred to the hospital is it possible for you to go?

यदि तपाइलाई रिफर (जानभनेमा) गरेमा अस्पताल जान सभव छ ?

Yes / छ No / छैन

If no, why not? यदि छैन भने किन :

1. Lack of money पैसाको कमी
2. Lack of guidance अगुवाको कमी
3. Lack of opportunity मौकाको कमी
4. Other, what? अन्य के.....

35. What kind of health services would you like to have in the future?

तपाइले कस्तो खालको स्वास्थ्य सेवा भविष्यमा भएको देख्न चाहनु हुन्छ ?

.....

SELF RATING QUESTIONNAIRE

- | | |
|--|----------|
| 36. Do you often have headache? के तपाईंको अक्सर (बारम्बार) टाउको दुख्छ? | Yes / No |
| 37. Is your appetite poor? के तपाईंलाई भोक लाग्दैन? | Yes / No |
| 38. Do you sleep badly? के तपाईंलाई निद्रा लाग्दैन? | Yes / No |
| 39. Are you easily frightened? के तपाईं सानो कुरामा पनि डराउनु हुन्छ? | Yes / No |
| 40. Do your hands shake? के तपाईंको हात काप्छ? | Yes / No |
| 41. Do you feel nervous, tense or worried?
के तपाईं अघित, बैचैन वा चिन्तित हुनु हुन्छ? | Yes / No |
| 42. Is your digestion poor? के तपाईंलाई खाना राम्ररी पच्दैन? | Yes / No |
| 43. Do you have trouble thinking clearly? के तपाईंलाई राम्ररी सोच्न गाह्रो हुन्छ? | Yes / No |
| 44. Do you feel unhappy? के तपाईंको मन दुःखी छ? | Yes / No |
| 45. Do you cry more than usual? के तपाईं पहिले भन्दा बढी रनु हुन्छ? | Yes / No |
| 46. Do you find it difficult to enjoy your daily activities?
के तपाईंलाई आफ्नो दैनिक काम गर्न गाह्रो लाग्छ? | Yes / No |
| 47. Do you find it difficult to make decisions?
के तपाईंलाई निर्णय लिन कठिन हुन्छ? | Yes / No |
| 48. Is your daily work suffering? के तपाईंको दिन दिनको काम बिग्रीरहेको छ? | Yes / No |
| 49. Are you unable to play a useful part in life? | |

- के तपाईंले आफ्नो जीवनमा राम्रो काम गर्न नसकेको जस्तो लाग्छ? Yes / No
50. Have you lost interest in things?
के तपाईंको कुनै पनि कुरामा रूचि हराएको जस्तो लाग्छ? Yes / No
51. Do you feel that you are a worthless person?
के तपाईंले आफूलाई काम नलाग्ने ठान्नु हुन्छ? Yes / No
52. Has the thought of ending your life been on your mind?
के तपाईंलाई मरौं-मरौं जस्तो लाग्छ? Yes / No
53. Do you feel tired all the time?
के तपाईं जति बेला पनि धाकेको जस्तो अनुभव गर्नु हुन्छ? Yes / No
54. Do you have uncomfortable feelings in your stomach?
के तपाईं पेटमा गडबडी भएको अनुभव गर्नु हुन्छ? Yes / No
55. Are you easily tired? के तपाईंलाई छिट्टै थकाई लाग्छ? Yes / No
56. Do you feel that somebody has been trying to harm you in some way?
के तपाईंलाई कसैले कुनै किसिमको दुख: दिने प्रयास गरे जस्तो लाग्छ? Yes / No
57. Are you a much more important person than most people think?
के तपाईं अरूले ठानेको भन्दा आफूलाई ठूलो ठान्नुहुन्छ? Yes / No
58. Have you noticed any interference or anything else unusual with your thinking?
के तपाईंलाई आफ्नो सोचाईमा कुनै किसिमको बाधा अडचन आए जस्तो लाग्छ? Yes / No
59. When you sit alone do you ever hear voices that you can hear but others can't?
के तपाईं एकलै बसेको बेलामा त्यस्तो आवाज सुन्नु हुन्छ? जुन तपाईंले मात्र सुन्नु हुन्छ तर अरूले सुन्न सक्दैन? Yes / No
60. Do you sometimes suddenly fall down and lose consciousness? Do others say that you shake during that time?
के तपाईं कहिले काही अचानक बेहोस हुनुहुन्छ? के तपाईं बेहोस भएको बेलामा तपाईंको जीउ (शरीर) पनि काँप्छ? Yes / No

ADDITIONAL QUESTIONS

61. How long have you had these complaints? यस्तो समस्या भएको कति भयो ?
1. Less than 1 week एक हप्ता भन्दा कम
2. 1-2 weeks १/२ हप्ता
3. More than 2 weeks २ हप्ता भन्दा बढि
Details: विस्तृत.....
62. What do you think is the reason for your problems?
तपाईंको विचारमा तपाईंको समस्याको कारण के हो जस्तो लाग्छ ?
63. Who taught you this? यो कसले सिकायो ?
1. Father बुबा
2. Mother आमा
3. Friends साथी भाईहरू
4. Teachers शिक्षक
5. Others, who अन्य को
6. Nobody
64. Have you ever asked for help or treatment for one of these problems?
यी समस्या मध्येबाट समाधानलाई कसैलाई भन्नु भयो ?
Yes / छ No / छैन
If yes, where? यदि छ भने कहा ?
1. Ojha/ jhankri/ dharmi/ traditional healer: Yes / No
ओभा, जाकी, धामी
2. Quack (practicing medicine without training): Yes / No
क्वाक
3. Medical hall: Yes / No
मेडिकल हल/ औषधि पसल
4. Health Post / Sub Health Post Yes / No
स्वास्थ्य चौकी

- | | |
|---------------------------------------|----------|
| 5. Hospital
अस्पताल | Yes / No |
| 6. Private clinic
प्राइभेट क्लिनिक | Yes / No |
| 7. Other, what?
अन्य | Yes / No |

65. How helpful did you find this treatment? यो उपचार कतिबेला सहयोगी पाउनु भयो ?

1. Very helpful धेरै सहयोगी
2. Somewhat helpful केही सहयोगी
3. Not helpful सहयोगी

66. Would you return to the same place as before if you experienced the same problem?

यदि यस्तो समस्या फेरी फेरी आयो भने के पहिल्लाको ठाउँमा जानु हुन्छ ?

Yes / छ No / छैन

67. Would you go somewhere else if you experienced these problems again?

उदि यस्तो समस्या भए के अर्को ठाउँमा जानु हुन्छ ?

Yes / छ No / छैन

If yes, where? यदि हो भने ?

- | | |
|---|----------|
| 1. Ojha / jhankri / dhama / traditional healer:
ओझा, धामी, भातकी | Yes / No |
| 2. Quack (practicing medicine without training):
क्वाक | Yes / No |
| 3. Medical hall:
मेडिकल हल/ओपेथि पसल | Yes / No |
| 4. Health Post / Sub Health Post
स्वास्थ्य चौकी | Yes / No |
| 5. Hospital
अस्पताल | Yes / No |
| 6. Private clinic
प्राइभेट | Yes / No |
| 7. Other, what?.....
अन्य | Yes / No |

68. Does someone in your family use too much alcohol so that it causes constant troubles in family life? के तपाईंको परिवारमा कसैले धेरै रक्सी पिउनु हुन्छ र यसले समस्या गरेको छ ?

Yes / छ No / छैन

If yes: यदि छ भने को

Who?: को ?

When and for how long? कहिले र कति भयो ?

69. Has anyone in your family committed suicide?

के तपाईंको परिवारमा कसैले आत्महत्या गरेका छ ?

Yes छ / No छैन

If yes: यदि छ भने

Who?: को ?

When?: कहिले ?

70. Has anyone in your family had mental illness?

के तपाईंको परिवारमा कसैलाई मानसिक रोग छ ?

Yes छ / No छैन

If yes: यदि छ भने

Who? को ?

What kind? कस्तो प्रकारको ?

When? कहिले देखि?

Thank You for taking part in the interview!

अन्तर्वार्तामा भाग लिई दिनु भएकोमा धेरै धेरै धन्यवाद !

APPENDIX III

A summary of the questions asked during the discussion groups.

(i) mental health awareness (for students, mothers, fathers, VDC)

What do you know of health?

What do you know of mental health?

What is your experience of mentally ill people?

What are the causes of mental illness?

What would be a good response towards mentally ill people?

Where is there treatment available?

Where did you learn these things from?

(ii) depression story questions (for mothers, fathers, VDC, traditional healers)

Pabitra is 20 years old. Six months ago she got married, and in the time since she left her maternal home (maiti) she has not returned to visit her family. She is now living with her husband's family who live in a village four hours walk from her maiti. In her new home she lives with her husband, his mother and father, and his younger brother and sister.

In the last month, she has been having headaches, dizzy spells, and has had a poor appetite. She wakes frequently in the night, and during the day her limbs feel heavy and *tires easily*.

She has not spoken about these problems to anyone, although her husband's family has noticed her loss of energy.

What is the cause of these symptoms?

Why does she not tell of her problems?

What should her family do?

(iii) attitudes towards health post (for mothers, fathers, VDC, traditional healers)

What changes have you noticed in the past five years?

What should be done to improve the situation?

(iv) traditional healer information

Type of mental illness experienced?

What are the causes of mental illness?

How do you treat mental illness?

How many traditional healers are there in Gotikhel VDC?