

Demand and access to mental health services: a qualitative formative study in Nepal

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INTRODUCTION

Nepal is experiencing a significant 'treatment gap' in mental health care. People with mental disorders do not always receive appropriate treatment due to a range of structural and individual issues, including stigma and poverty.

The Programme for Improving Mental Health Care (PRIME) has developed a mental health care plan to address this issue in Nepal and four other low and middle income countries.

This study aims to inform the development of PRIME's comprehensive care plan by investigating the perceptions of stakeholders at different levels of the care system in the district of Chitwan in southern Nepal: health professionals, lay workers and community members. This research focuses specifically on issues of demand and access to care.

This study identifies barriers to accessing care in Nepal that reach beyond the health facility and into the social fabric of the community.

PRIME's goals are to:

- (1) Develop evidence on the implementation and scaling-up of mental health treatment in primary & maternal health care, in low resource settings
- (2) Enhance the uptake of its research evidence amongst key policy partners and relevant stakeholders



programme for improving mental health care

Evidence on scaling-up mental health services for development

SETTING

CHITWAN, NEPAL

Data collection took place in Chitwan, a rural district in the southern, central development region of Nepal. Chitwan has slightly better development indicators than other parts of the country and has a higher literacy rate than the national average. Due to migration from all other districts of Nepal, there is a diverse mix of castes and ethnicities in the area, with several different languages spoken. This heterogeneity was one reason the setting was selected for the study. Chitwan was also selected for its emergency referral facilities, and the fact that baseline epidemiological data were available on mental health in the area.



METHODS OF STUDY

Study design

This study consisted of individual in-depth key informant interviews (KII) and focus group discussions (FGD). FGDs were used to identify the perceptions of existing groups of stakeholders (such as female community leaders). Individual interviews were necessary to elicit confidential responses to questions about more sensitive mental health related issues.

Data analysis

The data were analysed using a Framework Analysis method. Key themes (awareness, demand, detection and identification, and access) were identified a priori, to provide a basis for the thematic framework. This was developed throughout the analysis as new themes were identified inductively from the data. The a priori themes were based on the strategy for the care package, which was developed over a series of workshops involving healthcare providers, policy makers, health managers and representatives of mental health care organisations and groups. These strategy development workshops were based on the Theory of Change (ToC) method: an outcomes-based approach for planning and visualising pathways to change. The outcome of these workshops (the final ToC for the care package) was integrated into the final data analysis of this study, so that the findings could be used to fine-tune the package and to inform its implementation. The chart on the opposite page shows the section of the ToC that is relevant to demand and access. It illustrates the basic conceptual framework for the findings: influences on demand and access at community and health facility levels, and strategies to improve demand and access at community and health facility levels.

Sampling procedure

The sample was selected from three categories of stakeholder: those working at the health organisation level, workers at the health facility level and members of the community. A purposive sampling technique, with predefined criteria, was used on all levels and snowball sampling was used at the community level.

RESPONDENT DEMOGRAPHICS

SOCIO-DEMOGRAPHIC CHARACTERISTICS	KIIs	FGDs	TOTAL
SEX			
Male	16	30	46
Female	17	54	71
AGE			
Up to 24	2	1	3
25-59	29	79	108
60+	2	4	6
EDUCATION			
Literate only/informal education	4	9	13
Secondary level	10	39	49
Intermediate	3	23	26
University	16	13	29
RELIGION			
Hindu	28	77	105
Buddhist	4	5	9
Christian	1	2	3
CASTE/ETHNICITY			
Brahmin/chhetri	24	62	86
Janajati	6	12	18
Others	3	10	13
OCCUPATION			
Health workers	14	36	50
Senior govt. officer	3	-	3
Female community health volunteers/mothers groups	3	27	30
NGO staff	3	-	3
Others (teachers, traditional healers, political leaders etc.)	10	21	31
TOTAL	33	84	117

THEORY OF CHANGE MAP AS A FRAMEWORK FOR DATA ANALYSIS



Figure 1 Theory of change map as a framework for data analysis

RESULTS: MAIN THEMES EMERGING FROM DATA

	Factors influencing demand and access	Strategies to improve demand and access
Health facility level	<ul style="list-style-type: none"> Service availability: lack of senior staff and insufficient trained village health workers Mistreatment within health centres 	<ul style="list-style-type: none"> Increasing training and resources Building trust in services Protecting family status with increased confidentiality
Community level	<ul style="list-style-type: none"> Mental health stigma in the wider community Low mental health awareness across castes, negatively affecting detection and identification Lack of information about services Conflicting roles of affected families: expected to support access but are in fact barriers Cultural norms of visiting traditional healers Religious practices (affecting women) 	<ul style="list-style-type: none"> Reducing the mind-body dichotomy in treatment: working with local notions of stigma around medication specifically for the mind Awareness-raising: Public vs. private information channels Awareness-raising: Trusted and respected figures

POLICY RECOMMENDATIONS

This formative research contributes to the development of a mental health care plan in Nepal. It sheds light on key issues regarding mental health awareness, help-seeking and community detection and identification, in a low and middle income country that is currently under-researched. The focus on demand and access highlights the barriers to mental health care that reach beyond the health facility and into the social fabric of the community:

- 1) the lack of trust in services
- 2) low mental health awareness
- 3) high mental health stigma
- 4) low detection and identification within families
- 5) cultural and religious norms

Stigma and discrimination should be tackled using approaches advocated by stakeholders, which involves raising awareness about mental health and services through trusted and respected figures, and providing mass awareness raising, whilst remaining sensitive to the needs of community members for confidentiality and privacy. This includes the needs of the families of service users. This will maximise the acceptability of the package for stakeholders, and broaden the reach of its services, as the care plan is scaled-up throughout Nepal.

REFERENCE

Policy brief based on research by: Natassia F Brenman, Nagendra P Luitel, Sumaya Mall and Mark J D Jordans

Title: Demand and access to mental health services: a qualitative formative study in Nepal

Journal: BMC International Health and Human Rights 2014, 14:22

Available (Open Access): <http://www.biomedcentral.com/1472-698X/14/22>



PRIME is a Research Programme Consortium (RPC) led by the Centre for Public Mental Health at the University of Cape Town (South Africa), and funded by the UK government's Department for International Development (UKAID). The programme aims to develop world-class research evidence on the implementation, and scaling-up of treatment programmes for priority mental disorders in primary and maternal health care contexts, in low resource settings.

Partners and collaborators include the World Health Organization (WHO), the Centre for Global Mental Health (incorporating London School of Hygiene & Tropical Medicine and King's Health Partners, UK), Ministries of Health and research institutions in Ethiopia (Addis Ababa University), India (Public Health Foundation of India), Nepal (TPO Nepal), South Africa (University of Kwazulu-Natal & Human Sciences Research Council) and Uganda (Makerere University & Butabika Hospital); and international NGOs such as BasicNeeds, Healthnet TPO and Sangath.

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Policy brief design and layout: Charl Linde

This document is an output from a project funded by UK Aid from the Department for International Development (DFID) for the benefit of developing countries. However, the views expressed and information contained in it are not necessarily those of or endorsed by DFID, which can accept no responsibility for such views or information or for any reliance placed on them.

