CHAPTER 1
INTRODUCTION

Many scholars have attempted to explain the link between poverty and mental health. Poverty itself can be looked at from different perspectives with varying definitions and determinants. Research has identified social structure and culture as important indicators of a nation's wealth. Economic, psychological and sociologic approaches have been used to illustrate the relationship between poverty and mental health. It has been highlighted that the poor are at a higher risk of mental illness because there is an inverse correlation between the wealth of a society and the prevalence of mental disorders (Patel, 2001).

The public health significance of poverty and its influence on mental health, particularly in women, is not fully understood. This is a mixed methods study based on the hypothesis that women in Nepal in Hagam Village Development Committee (VDC) of Sindhuphalchowk district are at risk of development of mental illness. Therefore, semi-structured interviews were carried out amongst women and a Self Rating Questionnaire (SRQ), which was prepared specifically for Nepal, was administered to identify the presence of mental illness. Findings were explored and women's coping mechanisms identified in both villages, Yanglakot and Bisinghar. This study was created in collaboration with PHASE Nepal, a non-governmental organization (NGO) that has an outreach center (ORC) in Yanglakot and also participates at the sub-health post (SHP) in Bisinghar. There was the need for information on women's mental health in the area, associated social stigma and coping mechanisms against developing mental illness.

This write-up is organized into six chapters. In the first, the background and study setting as well as prospective aims are presented. This is followed by a literature review on the complex identification of poverty and mental health. Subsequently, the methods implemented in carrying out this study and the resultant findings were highlighted. Finally, outcomes, challenges and linkages were discussed and recommendations made.

1.1 Background

1.1.1 Socio-economic conditions in Nepal

The Federal Republic of Nepal is a landlocked sovereign state situated in southern Asia, bordering India to the south, east and west, as well as sharing the northern border with China. Nepal is classified into three terrains; the Terai region (flat river plain) in the south, the hill region in the middle and the Himalayas region in the north (CIA, 2011). It has five major regions; Eastern, Central, Western, Mid-Western, and Far-Western Region, and 75 districts (Watkinson-Powell and Lee, 2011). According to the World Bank (2011b) and Central Intelligence Agency (CIA) (2011), Nepal has an estimated population of 29.3 million, placing it 41st amongst global nations. In 2009, the literacy rate above the age of 15 was estimated to be 59%, an improvement from 21% in 1981 (CIA, 2011). The Gross domestic product in 2009 was 12.5 billion USD and the total population's life expectancy at birth was predicted to be 66.16 years (WB, 2011b).

According to United Nations Development Program (UNDP), Nepal is one of the poorest countries in the world. In 2004, the headcount ratio at national poverty line was 30.9%, showing an approximate 11% decrease since 1996 (WB, 2011b). As stated by the World Bank (2011a), 70% of world's poor depend on agriculture as their main source of employment and income. Consequently, in case of Nepal, majority of the population lives in rural areas. It is estimated that by 2010, 81% of the Nepalese population lived in rural areas (CIA, 2011); leading to deforestation, environmental degradation, and increasing demand of water and agriculture, which further perpetuate poverty. Nonetheless, it is important to note that despite the general increase in population by 1.596% in 2011, the rural population of Nepal has declined since 1960, which was 96.5, to 82.3 in 2009 (WB, 2011c).

According to the 2010 progress report on Nepal's Millennium Development Goals (MDGs), Nepal has made progress towards MDG 1, eradicating extreme poverty and hunger; nonetheless, social and economic disparity between urban and rural persists to be problem. As of 2004, urban poverty was estimated to be 10%, while rural poverty was 35%. It was found that the mid-western development region is the poorest; in 2004 poverty in the mid-western development region was estimated to be 44.8% while it was 27.1% in the central development region. As of 2009, the numbers for both regions was found to have improved immensely, 34% to 22.5%. In terms of halving the proportion of people whose income is less than one dollar a day, Nepal is likely to achieve the target by 2015, while the second target, which is halving the proportion of people who

suffer from hunger, is reported to be potentially likely. The third target, which is to provide full and productive employment and decent work for all is reported to be unlikely.

1.1.2 Burden of Mental Illness

Mental health is an unrecognized area of public health in most developing countries and is a general term referring to behaviors related to mental well-being. Mental illness is considered a taboo in most developing countries because of the associated stigma. Miranda and Patel (2005) argue that mental disorders are the most important causes of sickness and disability (including premature mortality in certain age groups) in developing countries. According to Desai and Isaac (2001) "mental health can be characterized by psychological and behavioral symptoms, resulting from changes in one's thinking, attention, concentration, memory and judgment." If one experiences these symptoms for a prolonged period of time, impairment in personal, social and occupational functioning will become apparent (Desai and Isaac, 2001). There are different types of mental health disorders: psychosocial, neurological, mood, neurotic, stress-related and substance abuse (WHO, 2001 and 2003). This study however, only focuses on identifying neurotic, psychotic and epilepsy disorders in women residing in Hagam. It will also draw on the general aspects of mental health in context to the World Health Organization health definition.

Neurotic disorder is a disorder characterized by anxiety and distress over circumstance (MDGuidelines, 2010b). The term neurotic disorder is no longer in use in psychiatric diagnosis, as the characteristics identifying neurosis itself have been identified as specific diagnostic groups (MDGuidelines, 2010b). In psychoses/psychotic disorder, however, there is a sever impairment of perception and understanding of reality (MDGuidelines, 2010c). During this case, individuals usually have little awareness of their illness. General symptoms experienced include delusions, hallucination, confusion, disorganized speech, exaggerated emotions and bizarre behavior (MDGuidelines, 2010c). On the other hand, epilepsy is a type of mental disorder where individuals experience repeated episodes of seizure (seizure of any type) with an unknown cause (MDGuidelines, 2010a).

According to the World Health Report (WHO, 2001), an estimated 450 million people suffer from a mental or behavioral disorder. It is estimated that these disorders account for 12% of the global burden of disease; on the contrary, the budgets for mental health in most countries, constitute less than 1% of their total health expenditure (WHO, 2001, pp.3). 10%–30% of mothers in developing countries are estimated to suffer from depression (Miranda and Patel, 2005). In 1990, depression

was the fourth highest global cause of morbidity and mortality; however, this is projected to rise by 2020 (Mollica *et al.*, 2004). The World Health Organization (2003) estimated that yearly, about 1 million people commit suicide and neuropsychiatric disorders such as depression and anxiety account for 33% of the years lived with disability (YLD) worldwide. In Nepal, majority of suicide cases are related to depressive and post-traumatic stress (PTSD) disorders. Suicide accounts for 16% of death for women of reproductive age (DoHS, 2008/9).

1.1.3 Organizational Setup of PHASE Nepal

Established in 2006, PHASE Nepal is an NGO registered under the Social Development Act 2034 at the Kathmandu office and has an affiliation with Social Welfare Council of Nepal (PHASE Nepal, 2011e). The organization is centered on primary health care clinics providing "support to government system through supervision, staff training and material resources" (PHASE Nepal, 2011d and Watkinson-Powell and Lee, 2011, p. 5). PHASE Nepal's vision is to create a sustainable society by empowering people and eliminating all forms of discrimination thereby improving livelihoods, educational status, health services, food security and sensitizing people to claim their rights to access and control (PHASE Nepal, 2011a and 2011c). Along with many program components to achieve their objectives, PHASE Nepal operates in Humla, Gorkha, and Sindhupalchowk districts, which are remote areas with restricted access to primary healthcare (PHASE Nepal, 2011b and Watkinson-Powell and Lee, 2011).

1.2 Justification of Study

This research is noteworthy, as it provides understanding of mental health at the level of the grassroots and it incorporates the influence of socio-economic determinants. As demonstrated by Bhatta and Sharma (2006), more research is required to understand the dynamics of poverty in Nepal beyond economic indicators. Most importantly, it tries to argue on the social construction of gender where women are seen as invisible part of the society. While it is valuable to understand and examine mental health in the whole population, it is vital to focus on women as they are seen as the core of development in this new era. Hence, this research attempts to provide insight on whether poverty can precipitate mental health disorders among women in Hagam VDC. There is minimal knowledge on how socio-economic factors affect an individual's mental health specifically. This study aims to provide new perspective on mental health disorders in relation to poverty in Hagam. Due to the dearth and lack of data on mental health in the area, this research will

add evidence to the limited information available in the area. The findings will be utilized by PHASE Nepal for future planning and preventive strategy implementations.

1.3 Aims and Objectives

This study will investigate the interaction of poverty and mental illness in women in Hagam VDC.

The specific objectives are to:

I. Understand rural women's perception of poverty and insecurity and its effect on mental health in Hagam;
II. Identify existing mental illnesses in the community of Hagam;
III. Ascertain the relationship between poverty and mental illness;
IV. Explore women's coping mechanisms against development of mental illness.

1.4 Research Question

I. How do women in Hagam view poverty and what is its effect on their mental health? What does poverty mean to women in Hagam?
II. What are the common mental illnesses in women in Hagam?
III. What is the perception of health workers on mental health and how does this affect information flow in the community?

CHAPTER 2
LITERATURE REVIEW

Bhatta and Sharma (2006) have stated that the important indicators of poverty in Nepal are food insecurity, malnutrition, illiteracy and social exclusion with agriculture the major driver of the economy. Its high dependence on agriculture, small landholdings, low productivity in agriculture and non-agricultural income, has lead to major food insecurity and an escalation of ethnical conflicts (Bhatta and Sharma, 2006). They concluded their study by stating the need for more rigorous study on poverty dynamics in Nepal.

Poverty and mental health will be viewed from an interdisciplinary perspective taking into account the role of psychology, sociology and development.

2.1 Conceptualization of Poverty

The word "poverty" is ambiguous as it has different cultural, social and economical implications. Lack of access to basic needs such as food and clean water, housing, education, health, and stable source of income are common markers in defining poverty. The general definition of poverty by the World Bank "deprivation of well-being" has raised many questions with regards to what deprivation and well-being mean. On an in depth analyses of Poverty Dynamics, Addison *et al.* (2010) argues that the next step in poverty research lies at the identification of intersection of dynamics and cross-disciplinary to understand and tackle poverty. Firstly, they emphasize on the necessity of comprehending the dynamics of poverty. Then, they discuss the importance of shifting measures of poverty from "income and consumption to more multidimensional concepts" (p. 2); and thirdly, bridging the gap between disciplines through an over arching approach that uses mixed method (qualitative and quantitative).

On the other hand, Foster (1998) bases the measurement of poverty on the comparison of resources to needs with regards to the identified poverty threshold. An absolute poverty line "is a fixed (group-specific) cutoff level that is applied across all potential resource distributions" while a relative poverty line implies to "a current data to generate the current poverty threshold" (p. 336). Evaluating the measurement of poverty standard, absolute versus relative, Foster poses the question of how one can be sure of the validity of the standard. He explains that there is no specific cutoff that defines the absolute line as being low and relative lines as high. He argues "in an isolated

period, it is not possible to tell whether a given threshold is relative or absolute, nor is the distinction particularly important, since the same numerical cutoff, however originally derived, must lead to the same level of poverty" (p. 337). Furthermore, along with Addison *et al.* (2010), Foster's taxonomy allows for an intermediary position between absolute and relative poverty line, and as Khan (2005) puts it, "poverty is not a still photograph but part of a process" (p. 1).

Barrientos (2008) and Hulme (2008) approach poverty from the context of social protection, or as they called it a 'quite revolution'. Even if there is an emergent consensus on social protection and its effective response to poverty and vulnerability in developing countries, Barrientos and Hulme argue that corruption and scares resources has been a barrier as the paradigm of social protection continue shifting onto national and international policy schemes. They also argue that social protection depends on the increasing extent on income transfers combined with access to basic services and/or productive employment and asset building (p. 5). This shows that social protection is today focusing more on productivity, which is economics, rather than the social aspect. Both scholars further explain that developing countries' social protection idea is shared with an understanding that poverty is not a one directional dilemma, but rather multidimensional and continual.

Rural-urban and international migration as well as brain drain, results of globalization, also play an immense role in the levelizing of poverty, in which growth (whether in population or income bases) is an important channel manipulating the poverty line (Goldberg and Pavcnik, 2004). As seen above and discussed by many other scholars, including Deaton (2003) and Ravallion (2003), the measurement of poverty and its multidimensionality is essential, as it rises many issues. Poverty is mostly seen through an economic perspective with the emphasis of income and material ownership. However, it can also be understood in different dimensions. In sociology it is seen from the conditions of power, inequality, lack of security and community's values. In psychology, on the other hand, it is seen from satisfaction and state of the mind (people's state of happiness with what they have). Hence, because of the different criteria used to define poverty by different scholars, it is necessary that the comprehensive definition of poverty stated by the World Bank be used for the purpose of this study; which is "low incomes and the inability to acquire the basic goods and services necessary for survival with dignity. Poverty also encompasses low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one's life" (World Bank, 2010). For the purpose of this study, findings on women's perception of poverty will be looked at in relation to above

World Bank definition of poverty.

2.2 Conceptualization of Mental Health

Mental health could be classified as a new phenomenon, especially in developing countries, in terms of diagnosing psychosis and neurotic disorders. Stigmatization and discrimination towards the affected or the mentally ill has made the concept to become a taboo in many societies. There are many debates that arise on how to define not only mental health but also health and illness. As stated above, according to the WHO, health is defined as "state of complete physical, mental and social well-being, and not merely the absence of disease" (WHO, 2001). Although, what does this mean? Does it mean that the definition of health depends on societal and cultural context? What does 'not merely the absence of disease means? Does it mean that a person can be sick/ill but also healthy at the same time? These questions are important in rising, as the definition of health is general and physicians, biologists, and chemists might incorporate the presence of disease/pathogens in their definition of health. In his book, *What is Health?* Burry (2005) states that besides the bold statements made by organizations such as the WHO, that the essential definition of health by the medical model refers to "the absence of disease" (p. 2). In his analysis, he links mental health to the biological make up of the individual; he further explains that the medical model identifies mental disorders as the result of an organic disturbance, excluding the idea of a "failure of character or from a weak will" (p. 16). Mental illness involves behavioral changes and is prone to negative judgments, because the very definition of the problem is linked to self and/or behavior.

According to the WHO, on the other hand, "mental health is not just the absence of a mental disorder. It is the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2007). Considering that mental health can be affected by our day-to-day activities, the WHO definition gives a well rounded but general description. It can also fit Miranda and Patel and Desai and Issac's explanation of mental health. As discussed by Mollica *et al.* (2004) mental health is greatly affected by complex emergencies such as civil unrest and genocide.

According to Bourchovitch and Mednick (2002), the word health comes from Old English and refers to the state of being "sound or whole". Further dissecting the word "health", they stated that

it was "associated not only with the physiological functioning, but with mental and moral soundness and spiritual salvation as well" (p. 175). At the centre of both disciplinary and scholarly perspective of mental health, it can be seen that the well being of the mind and the capacity of threshold to challenges, is a common characteristics of most definitions.

2.2.1 Policy and Infrastructure Implementation of Mental Health in Nepal

Healthcare in Nepal is delivered through hospitals in urban areas, health centers and health posts in rural areas (Jha, 2007). The total number of physicians in Nepal is estimated to be 3200 (4 per 100,000 population) (Jha, 2007). Formulated in 1996, Nepal's mental health policy contains four components, which are (1) Ensuring availability and accessibility of minimum Mental health services to all the Nepali population; (2) Preparing manpower in areas of Mental health; (3) Protecting the fundamental human rights of the mentally ill; and (4) improving Mental Health awareness (WHO, 2006). Yet, Nepal still shows a slow development of psychiatry (Jha, 2007). Beside policy implementation, there is only one mental health hospital in Nepal which is located in the capital city Kathmandu, with 0.20 beds per 100,000 population (Jha, 2007 and WHO, 2006), making accessibility challenging to the majority of the rural dwellers. Out of 18 outpatient mental health facilities, non-are reserved for children, and these facilities service 297.9/ 100,000 of the general population, which includes 3 day treatment and 17 community-based psychiatric inpatient units (general and teaching hospitals) treating 0.766/ 100,000 and 1.00 bed/ 100,000 population respectively (WHO, 2006). With very little human resources available on this field (0.59/ 100,000 population to be exact) there is a disproportionate distribution between rural and urban areas (Jha, 2007 and WHO, 2006). There are 0-1 psychiatric nurses per 100,000 population (WHO, 2001); majority of the professionals working for Ministry of Health, Ministry of Education (Government teaching hospitals), Ministry of Homes (Police hospitals), Ministry of Defense (Army hospital) and private sector medical college teaching hospitals (WHO, 2006, pp. 2).

According to the 2006 WHO assessment, only 0.17% of all health expenditure was spent on mental health in Nepal; with substantial amount spent on the Mental Hospital. Without a social insurance scheme in place, Nepalese patients have to personally pay for, antipsychotic and antidepressant medications, which cost 9 Nepalese Rupees (NRPs) daily or roughly 8 percent of the daily wage of a day laborer (WHO 2006). According to Jha (2007), when one member of the family becomes mentally ill, the approximate financial burden is about 25,000 NRPs. Even though it was stated on the WHO assessment that there is no clear data on how the budget is spent, it is obvious that little to no money is spent on prevention and control mechanisms especially in the rural and underserved

areas. There is no national morbidity data for mental illnesses in primary or secondary care (Jha, 2007). In the assessment it was also found that 47% of the diagnosis were related to neurotic, stress related and somatoform disorders, while 26% was related to mood disorders.

2.3 Impact of Social Support on Mental Health

Social support is vital to human survival. Lehtinen's *et al.* (2005) argues that mental health is an intrinsic value that has attribution to qualities in the abstract of society, culture, philosophical, and religious framework. They argue that cultural settings reflecting cultural norms influence the identification of values and the acting of those values. In support of the vitality of values and culture, Burry (2005) makes clear that there seems to be a misunderstanding when approaching mental health in relation to interpersonal and social dynamics. Referring to Rogers and Pilgim's (2003) work, Burry explains that mental health is an aspect of health inequalities, as its occurrence is determined by social factors and it could have diverse meanings depending upon the social and ethnic groups. Many psychological studies undertaken during the late 1970s show the value of social interaction. Investigating the outcome of isolation, Dr. Stuart Grassian, a psychiatrist and an expert on psychiatric effects of solitary confinement, states that a minimal environmental stimulation and social interaction can cause sever psychiatric harm (Grassian, 1983).

As a result, the capacity for social relationship plays a role in the aspect of good mental health. One positive factor that can prevent the onset or recurrence of mental illness is social support (Lehtinen *et al.* 2005). It is a known fact, and a necessity, that humans seek (and need to seek) interaction with other people. Lehtinen *et al.* (2005) states the strength of social interaction also matters for fulfilled development of an infant. As adults, part of our daily routine is our job; thus, our work contributes to our mental stability. "It gives structure, and rhythm to our daily life, it gives the possibility for self-fulfillment, it strengthens our self-esteem and it provides conditions…" (Lehtinen *et al.* 2005, p. 52). Many studies have also revealed that unemployment and dissatisfaction in the work force could lead to health problems, such as hypertension, anxiety and distress. In accessing the importance of employment in respect to mental health, Marrone and Golowka (2000) state that unemployment is worse than the stressors of employment to mental health. They argue that the result of long-term unemployment encompasses depression, feeling of worthlessness, self-pity, self-absorption, poverty, higher risk of substance abuse and greater chance of isolation (Marrone and Golowka, 2000, p. 188). They also noted that employment creates an avenue for people to expand their social network, meet more people, thereby expanding their

support group. They stress on the idea that employment will help in eliminating social barriers of stigma.

Results from a prospective cohort study, conducted by Glass *et al.* (1993) examined the impact of social support on outcome after first stroke. This supports Marrone and Golowka's argument. The findings showed that despite the severity of initial injury, patients with high social support recovered more rapidly and to a higher extent than those with less social support. On the other hand, House *et al.* (1988) criticizes the fact that many studies have reported a positive correlation between social support and health and/or its buffering effect in the presence of stress (House *et al.*, 1988, pp. 553). They argue that even though there is extensive evidence linking social relation to health that it is problematic as designs used for these kinds of studies are largely cross-sectional and/or retrospective using self-reported data. Nonetheless, it is inevitable that all human beings need to interact with their kind, as isolation is not an option for full human development and survival. Accordingly, House *et al.* (1988) did not deny nor neglect the importance of social support, as they state that social relationships generally have advantageous effects on health. However, they question whether there is a direct link between the two (social support and health) or its buffer effect and the kind of support; "Social relationships appear to have general beneficial effects on health, not solely or even primarily attributable to their buffering effects and there may be aspects of social relationships other than their supportive quality that account for these effects" (pp. 553). In support of House's *et al.*'s argument, Dalgard *et al.* (1995) practically comes to the same conclusion. A 10 year follow up study in Oslo conducted by Dalgard and colleges shows that, when exposed to negative life events, social support does have a positive effect on mental health by buffering the risk of development of a mental disorder. However, this only applies to those who have feelings of powerlessness and lack of control over their own lives.

In summary, many studies have shown the association between mental illness and social determinants such as poverty, gender disadvantage and poor-physical health (maternal and child). Challenging living situations will ultimately lead to stressful life experiences; poor physical health and violence are also some of the recognized risk factors for mental disorders. Research on depressive and anxiety disorders has consistently shown that marginalized/poor people are at greater risk of suffering from mental illness. Women are more prone to be the victims of mental illness, because of social circumstances/pressure and workload. Stewart, *et al.* (2001) states that in order to understand women's health, it is vital to consider the biological, socio-cultural and personal contexts of their lives. Majority of women have many responsibilities besides house

chores; today women have become the hunters and gatherers. As stated by the United Nations (2005), women continue to experience a disproportionate share of the global poverty burden; which greatly undermines their health. Many women and girl children also have no access to safe drinking water, thus they are forced to travel far for water collection and are also burdened with food preparation and fuel collection (Stewart et. al. 2001). Stigma is another factor that worsens mental illness, where victims (including the career) are forced to isolation and are emotionally abused by the society. In most developing countries, mental health services have both financial and man power shortages (WHO, 2007). As further elaborated by the WHO (2007), much of the available resources are spent on treatments and care rather than on developing an integrated mental health system; they suggest the integration of mental health into primary health care and making it accessible in general hospitals and developing a community based mental health services. In order to prevent mental illness, collaboration of multi-sectoral organizations and advocacy against discrimination towards the mentally ill is necessary (WHO, 2007).

CHAPTER 3
METHODOLOGY

As stated earlier, the aim of this study is to investigate the interaction of poverty and mental illness in women in a Hagam VDC. For recap, the objectives and research questions will be restated below.

The specific objectives are to:

I. Understand rural women's perception of poverty and insecurity and its effect on mental health in Hagam;
II. Identify existing mental illnesses in the community of Hagam;
III. Ascertain the relationship between poverty and mental illness;
IV. Explore women's coping mechanisms against development of mental illness.

Research question:

I. How do women in Hagam view poverty and what is its effect on their mental health? What does poverty mean to women in Hagam?
II. What are the common mental illnesses in women in Hagam?
III. What is the perception of health workers on mental health and how does this affect information flow in the community?

3.1 Research Design

This is a mixed method study that analyzes women's understanding of poverty and mental health, and weather life stressors, poverty, expose women to mental illness. A mixed method is when both quantitative and qualitative research techniques and approaches are combined into a single study (Johnson and Onwuegbuzie, 2003). The research utilized a semi-structure interview corresponding to research questions I and III and objectives I, III, and IV; and Self Rating Questionnaire (SRQ) corresponding to research question II and objective II.

As mentioned above, the study was conducted in two villages, Yanglakot and Bisinghar, of Hagam VDC. However, no comparison between the two villages was made as sample size was small.

3.1.1 Justification of Design

This research method is appropriate to adequately investigate the subject matter by giving participants the opportunity to explain their understanding of the subject matter, poverty and mental health. As it was noted by Bowling (2002), semi-structured interviews will allow interviewees the flexibility to explain their point of view and beliefs, while the questionnaire will allow the researcher to obtain specific information from participants.

Qualitative research allows one to explore various dimensions and understanding of the social world of participants and significance of the meanings that participants generate (Mason, 2002). An interpretivists approach was taken during the study, where participant's interpretations and perceptions were the primary data source (Mason, 2002). For instance, specific indicators of poverty and mental health, which are the main focus of this research, were not primarily identified as participant's perceptions and understanding of the terminologies was significant to the study. As can be seen on the SRQ sheet (Appendix VI), the questionnaire consists of 25 questions. The first 20 are designed to predict neurotic disorders, by the following 4 detecting for psychoses and the 25th for epilepsy. This research followed the simple SRQ guidelines of cut off scores in order to evaluate pre-existing mental health conditions in the community; the cut-off score for neurosis was 7 between questions 28-47, at least one positive response for psychosis (Q 48-51) and question 52 detects for epilepsy (Jha, 2009).

3.2 Study Area

This study was carried out in two villages in Hagam VDC, Yanglakot and Bisinghar. Hagam VDC is one of the project areas of PHASE Nepal in Sindhupalchowk district. Situated in the north-eastern boarder of Nepal, Sindhupalchowk has its headquarter at Chautara and has 79 VDCs, one district hospital, and eleven health posts (PAHSE Nepal, 2011c). Hagam VDC is 4-5 hours walk from the nearest road Jalbire (PHASE Nepal, 2011c). Community programs were launched in Hagam and Fulpingkot in 2006 and 2007 respectively to provide basic health care and education (PAHSE Nepal, 2011c). It was also stated that Hagam is estimated to have 800 households with 6 members per household. Working to improve people's life in the community, the organization's health worker works both from the government sub-health post (SHP) in Bisinghar, twice a week, and the organization's out reach center (ORC) in Yanglakot, four days a week. The ORC and SHP are about an hour apart, walking distance. Presently, there is only one PHASE health worker working in both locations and is the only available worker in any case of emergency for the Yanglakot community. For the purpose of this study, three health workers were interviewed; 2

working for PHASE Nepal and one government employee. One of the two PHASE Nepal health worker is currently located in Kathmandu office.

The study was conducted within six weeks total; six days were spent on the field and the remaining time was spent in Kathmandu office, where data analyzing and recording took place.

3.3 Theoretical Considerations

Sultana (2007) explains the dilemma and difference of implementing institutional ethics formality in the global north and south. She states that even if literacy and equality is still an issue in the global north, its intensity cannot be compared to the global south. Conducting international fieldwork could be problematic, as it poses many issues in relation to positionality and power difference. Even if the origin of the researcher is from the global south, researchers positionality will pertain higher class and educational variation, such as "material, social, and political differences" (Sultana, 2007, pp. 375). A third party also took part in this research, a translator. While conducting interviews on the field, a female (from Kathmandu) translator was used. All participants were women, thus it was necessary to use a female translator to ensure reliable data and avoid positionality barriers that may have surfaced due to gender inequality.

A translator has a direct influence on the information accessed from the informant; appropriate word choice and the context in which words are used are important during translating responses to the researcher. This has a major impact on the study; it has an indirect effect in limiting the 'power' of the researcher over the study. Considering Temple and Young's (2007) analysis on the role of interpreters, a translator is not only a translator; they become an analyst and cultural broker as assumptions are made while in search for equivalent meaning (pp. 171). During this study, considering the issue of correct transfer of information between the researcher and translator, the translator was explicitly asked to make sure that the prospective participants understood all the information before participating in the study. This was important because participation was supposed to be voluntary without discrimination by age or socioeconomic status. Interviewees were also allowed to leave the interview at any point in time. To avoid beneficence, participants were not provided with any form of reward. Confidentiality was a priority, thus, variables were used for all participants.

3.4 Ethical Considerations

Before undertaking the fieldwork ethical approval was obtained through the University of Sheffield, Geography Department. Before each interview, participants were given a written information sheet describing the project, their responsibilities and rights followed by a consent form (Refer to appendix I, II and III).

3.5 Description of Methods

The research was conducted through semi-structured interview, to gather qualitative data, and self-rating questionnaire (SRQ) to collect quantitative data. The SRQ, prepared for Nepal, was previously used in a community survey of a village in south Lalitpur by K.P. Adhikari and B.D.B. Dension (1999) for United mission to Nepal (Jha, 2009; refer to appendix VI). All semi-structured interviews were recorded and transcribed at the end of each day. The interpreter was asked to translate each question to Nepali and back to English, for each participant, to allow the researcher to ask follow up questions as needed. Accordingly, all transcriptions were made by the researcher. However, the SRQ was verbally translated to Nepali by the translator and answers were also recorded by the translator (this had limitations on the research and further explanation can be found chapter 5). However, it was highlighted that the person administering the SRQ requires some mental health training (Jha, 2009). Thus, results of this study could be invalidated as the researcher is not qualified or trained in the utilization of the questionnaire in conducting a quantitative study. Nonetheless, it is noteworthy to mention that usage of this questionnaire was suggested and approved by PHASE staff.

3.5.1 Sampling Criteria

Initially, it was proposed that a purposive sampling would be used to select participants, as the research targeted for particular criteria (women of reproductive age); followed by snowballing, where group of women (participant) will help recruit others in the target group (Bowling, 2002). However, while on the field circumstances led to the use of convenience sampling. Convenience or accidental sampling is a type of sampling where prospective participants are selected for the study because of availability and/or convenience (Bowling, 2002). All participants were selected to be interviewed while waiting to be seen by a PHASE health worker in the ORC and SHP. The remote service PHASE Nepal had set up, allowed the researcher to interview women from both villages including during home visits in Yanglakot. Purposive sampling was used to select the health workers interviewed.

3.6 Data Analysis

Firstly, semi-structured interview was administered followed by SRQ questionnaire. All participants completed both interview and SRQ, while two participants did not have the time to complete the SRQ. During analyzing the semi-structured interviews, the researcher followed a selection of sets of steps discussed by Mason, (2002) and Taylor-Powell and Renner (2003). First step discussed was the importance of familiarizing oneself with data before analysis begins; and this was done followed by evaluating and identifying key questions relating to the research question, analysis was focused by topic. Information was then categorized into themes (Attride-Stirling, 2001) and organized into coherent category. Lastly, interpretation of data was made after summarizing and connecting pattern between and within categories.

All conducted questionnaires were first organized and entered into a table. An ordinal-level measurement was used during this process. The reason being, even if the questionnaires were yes/no, some participants responded with 'sometimes'. Responses were thus identified with "Y", "N" and "S" for yes, no and sometimes respectively. According to Blaikie, N. (2003), quantitative research consists of variables, where different values, characteristics of objects, events or people can be measured by a uniform numerical scale (pp. 23). The concept of variables, as simple numbering/ categorizing such as, 1, 2, 3 or A, B, C were not used in order to indicate that the variables do not imply to any difference in magnitude nor does it mean it is equally spaced out (Blaikie, 2003). Then, individual participant were analyzed and probable diagnosis was made. Next, percentage calculation was used to find out the proportion of participants who answered in certain way and percentage of participants with similar conditions. Percentages were simply calculated before interpreting data; careful and unbiased judgments were then made during analysis to reduce the number of multiple interpretations to a single data. Tables, graphs and statistical calculations were also used in order to identify any correlation and differences. Odds ratio, 95% confidence interval and p-value were calculated using SPSS. Odd ratio (OR) is a statistical analysis that generates useful information in understanding the relationship between cause and effect (Acock, 2008).

There are many ways in which quantitative and qualitative methods are combined; the common ones are triangulation and complementary (Bowling and Ebrahim, 2005). Triangulation is the technique of combining two or more methods in a study; in this case findings from one type of study can be checked against the findings of the other (Jick, 1979; and DeMarrias and Lapan, 2004). Complementarity is on the other hand, a way in which the strength of one method is used to improve the performance of the other (Bowling and Ebrahim, 2005, pp. 233). For the purpose of

this research, complementarity was used in mixing both qualitative and quantitative data collected. This is important, as it gives an explanatory, reliable, holistic and contextual portrayal of the units being studied (Jick, 1979). In this case, the qualitative data analysis will support the quantitative data in explaining findings.

3.7 Limitations of Study Design

Methods used were time consuming, especially because it was time of harvest and women had limited time to spare. This was also one of the factors that did not allow the researcher to conduct household interviews, as majority of the women were busy with agricultural work. The major weakness of the semi-structured interview was that questions were not comprehendible to the participants, thus administering follow up questions was a challenge. On the other hand, results cannot be generalized to other communities, as the sample size was small and only represents women of Yanglakot and Bisinghar. Generally, qualitative research aims to explore and understand specific communities social structure (Mason, 2002).

A limitation was also observed in using the SRQ questionnaire, as questions were subjective and indicators from the questionnaire might have been culturally specific and liable to misinterpretation by participants. Due to the fact that interviews were conducted in the ORC and SHP, it was seen that most participants were describing their reason for visiting the health center. The subjectivity of the questionnaire and the limited knowledge of mental health among the women of Hagam might have skewed the quantitative analysis made.

CHAPTER 4

RESULTS

The aim of this study is to investigate the effect of poverty on the mental health of women in Hagam VDC. Data collected was analyzed to answer the research questions accordingly. This chapter is divided into parts; the sub-headings focus on the four fundamental themes of the study that shaped this research. It should be noted that during analysis the word 'mental health/ illness' refers only to neurosis, psychosis and epilepsy.

4.1 Characteristics of Participants

Table 1, shows the general characteristics of participants; 28 community women and three key informants were sampled. Two of these women did not complete the SRQ and were therefore excluded from the quantitative assessment. The age of respondents ranged from 17-88 with the majority being in the 17-38 year category. As shown on table 1, illiteracy rate is high among the women of Hagam, where 85% had received no education. Most are married and the main occupation is farming.

Table 1: Characteristics of samples in Hagam VDC

Number of participants (N)	28
Mean age	35
Marital Status	
Married	92%
Single	4%
Dependent	4%
Participants who attended School	
None	~ 85%
Primary	~15%
Secondary	None
Post-Secondary	None
Occupation	
Farming	50%
Small scale business	7%
Farming, small scale business and/or others	43%

*This table excludes key informants.

Table 1 also shows that 92% of women interviewed are married and most live with their extended family. The average number of children per household was 3. The main forms of livelihood are agriculture and cattle razing; others are involved in small businesses such as selling goods and sewing. Among all 28 women, only 4 have had primary education and these women did not show any hierarchy in their response.

4.2 Qualitative Results

4.2.1 Perception of Poverty

Generally, it was difficult for the participants to explain the concept of poverty in their own words. Most women defined poverty as not having enough food, clothing, money, and land, while two women linked poverty to the general community; *"people living in these hilly and remote area are all poor"* (Female, 50- Yanglakot); some respondents however couldn't explain poverty stating that everyone is equal and happiness is determined by the individual. One the other hand, two women associated poverty with having to work hard, living in pain and having to encounter obstacles regularly.

Based on their definition of poverty, participants were asked if their definition of poverty applied to them, and most categorized themselves as poor, while few said that because they are not starving they are not poor. In addition, many women stated that they consider themselves poor because of the responsibilities they have and the size of their farmland. Below are some of the responses;

> *"It's hard to raise children, we do not have family planning here. And our neighbors have problems as well"* (Female, 39- Yanglakot).
>
> *"Working in people's house is poor"* (Female, N/A- Yanglakot).
>
> *"I suffer and work a lot so I am poor"* (Female, 88- Bisinghar).
>
> *"I am poor because I do not have enough food and clothing and I have a small farm"* (Female, 53- Yanglakot).
>
> *"I have to buy food, I don't have enough food to grow so I am poor"* (Female, 21- Yanglakot).

On the contrary, most participants responded positively towards their work environment regardless of the difficulty. Very few women found their daily activities challenging, thus reported unpleasant work environment. These groups of women were seen to link good employment with education, *"I*

didn't go to school, so I can not find jobs and this is what I have to do for living" (Female, 88-Bisinghar).

4.2.2 Perception of Mental Health

The research showed that there is very little knowledge of mental health in the community. Majority of participants were not aware of what mental health meant and the few who had heard of the concept could not explain it. They generally referred to it as madness or going mad. Although, three women defined mental health as:

> *"If one is unconscious or cannot talk well, then person is mentally ill"* (Female, 27-Yanglakot).
>
> *"If one thinks for too long then they start having mental problems"* (Female, 17-Yanglakot).
>
> *"Some kind of problem in the brain"* (Female, 32- Yanglakot).

From the findings, relationship between women's perception of mental health and education could not be established, as only one participant from the above respondents had primary level education. However, it was found that there was no correlation between education and their response, since only 1 participant out of the 3 had primary level education. Moreover, most participants, even if they were not aware of mental health, they knew few people in the community who were "mad".

> *"Mad people and us are all one, I don't differentiate but if people run to him they say dirty person coming and they run away"* (Female, 17- Yanglakot).
>
> *"Yes, had seen two people, one is doing better now and she became mad after seeing her neighbors dead body. The other had head injury and became mad*" (Female, 32-Bisinghar).

4.2.3 Coping Mechanisms Against Mental Illness

As important as emotional support is to the human existence, people have different ways of dealing with life's challenges. The common coping mechanism that surfaced during the analysis was spending time with friends and consulting them about their problems. It was found that most respondents were not deprived of social interaction. However, very few stated they didn't have enough spare time; taking care of their children, household chores and agricultural work were the reasons that kept the women from socializing. *"My husband tells me to not take too much stress"*

(Women, 34- Yanglakot) was the common response given. Five respondents said they do not get emotional support from their husbands; 25% of the women, do not discuss their problem with anyone, *"when I feel low, I just sit at home and cry"* (Women, 72-Yanglakot). The remaining 75% participants reported emotional support from friends and family members.

4.2.4 Health Worker's Understanding of Mental Health

The aim of interviewing key informants (KI) was to explore the perception of health workers on mental health and how this affects information flow in the community, thus 3 health workers were interviewed. As explained in earlier chapters, two health workers presently work in Hagam VDC, while one is located in Kathmandu office. The two health workers in Yanglakot and Bisinghar are over worked, as they are the only health care providers in the community.

> *"I have many responsibilities; antenatal, delivery, family planning, awareness program, arrange meetings, dental care, school health program, exhibition program, community health program etc…for this village, I am the only person on call for cases of emergency"* (Female, KI).

Only one informant was very knowledgeable on the subject, the other 2 had a general understanding but lacked the appropriate vocabulary to explain themselves. The key informants also stated that because of the lack of knowledge about mental health in Hagam VDC, most people usually associate the illness with supernatural forces and thus they sacrificed animals to gods. When the question of whether mental health is treatable and if it responds more to traditional or modern medicine was posed, all key informants cited that it can be treated in Katmandu and that modern medicine is better than traditional medicine. They all have emphasized on the importance of providing emotional support especially from loved ones.

> *"Should be treated well, should be given a lot of love from family and community, community shouldn't tell the person that he/she is mad. They need more support"* (Female, KI).

A common response that surfaced during the interview was that stressful life conditions would ultimately lead to mental illness. They identified neurosis to be the most common mental illness in Hagam VDC. KI #2, who has worked for PHASE Nepal for four years, stated that depression was most common in married women; also noting that this is because of the responsibilities women have not only as a wife but also as a mother and family caregiver. On the other hand, KI #1 cited men above the age of 15 to be more vulnerable than women and children. Further explanation was

not provided as to why men above the age of 15 are at higher risk. When asked for types of symptoms they look for in diagnosing a patient with mental illness, key informants' responses were:

> *"Dizziness, unclear vision, sudden loss of consciousness and unclear speech"* (Male, KI).

> *"Abnormal behavior, body ache, loss of appetite, mostly stressed and suicidal thoughts"* (Female, KI).

> *"Lack of attention, neglecting daily activities such as bathing, brushing teeth and the avoidance of eye contact during conversation"* (Female, KI).

The above responses show that the health workers are, to certain degree, aware of the common symptoms to diagnose neurosis, psychosis and epilepsy. Stigma was also one of the aspects that could further perpetuate ones sickness, according to the key informants. *"When I see a mad person on the street then I go to the family and speak with them and advise them to not leave the sick person alone, because he/she might get hurt or might hurt others"* (Male, KI). The research has also shown that there are inadequate mental health services available in Hagam VDC. As can be seen from the responses below, the health workers improvise and work with what is available. Patients that have shown symptoms of depression, stress or loss of appetite are given vitamins, sleeping pills and support to calm them down. When asked how information on mental health is distributed in the community, key informants stated that only those patients that show symptoms of mental illness are advised. They also cited that mental health is not a priority issue in Hagam VDC.

> *"In this village there is no service/treatment available. However, if a depressed person come in to the ORC then is given support and is usually told to revisit and if not improved is usually referred to Kathmandu mental hospital…"* (Female, KI).

> *"No service is available but sometimes they are given sleeping tablet. But we do not want them to get use to the medicine so we don't give it out as much. Then they are sent to Katmandu"* (Female, KI).

From the key informants, it was found that majority of the community compare themselves with urban people and consider themselves as poor. Key informant #2 cited that most parents want to provide sufficient medical care, education, food and clothing to their children and because it is impossible for many households to provided what is a necessity they usually see themselves as poor. The same key informant also estimated that 25% of women in Hagam have depression and stress related mental illnesses, while KI #3 estimated 10% of women. Other contributing factors stated by the key informants were stress from divorce, death and a chronic illness in a family member.

4.3 Quantitative Results

4.3.1 Burden of Mental Illness in Hagam VDC

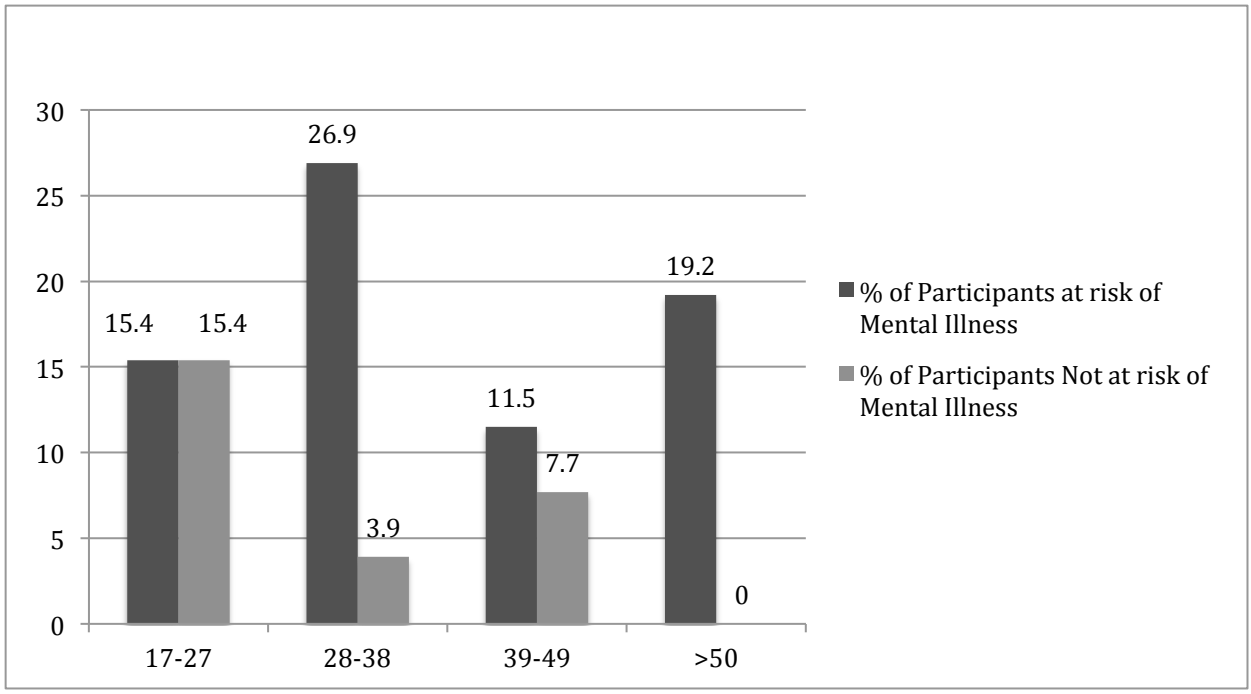
Table 2: Distribution of women's vulnerability to mental illness in Hagam VDC		
Sequence	Number (N)	%
Neurosis	3	11
Psychosis	3	11
Epilepsy	--	--
Neurosis + Psychosis	10	39
Neurosis + Epilepsy	2	8
Neurosis + Psychosis + Epilepsy	1	4
None	7	27
Total	26	100

Table 2, shows percentages of women who are vulnerable to the different mental illness that were assessed using the SRQ questionnaires. In order to explore the effect of poverty on women's mental health, cross-reference was made between the SRQ results, and responses from the semi-structured interviews (Questions 3, 4 and 7; Appendix VI). As shown, 27% are not vulnerable to mental illness; majority of the participants, 39%, are however at risk of neurosis and psychosis.

Table 3: Age distribution of vulnerability of respondents to mental illness		
Age and number of participants (N)	Number of participants at risk of Neurosis, Psychosis and/or Epilepsy (N)	Number of participants not at risk of Neurosis, Psychosis and/or Epilepsy (N)
17-27 (8)	4	4
28-38 (8)	7	1
39-49 (5)	3	2
>50 (5)	5	0

73% of women were found to be at possible risk of mental illness. Thus, in order to see if these results were affected by age, women who completed the SRQ (N=26) were divided into four age groups and the distribution of vulnerability to mental illness displayed (Table 3).

Figure 1: Risk of mental illness amongst respondents



As seen in figure 1 above, women 28-38 years have the highest risk followed by those above 50 years. The number of women in the 17-27 age groups, who were vulnerable to mental illness together with those who were not at risk of developing this condition, was similar. It should be noted that all women above 50 years sampled were vulnerable to mental illness.

4.3.2 Correlation between Poverty and Mental Health

Respondents were classified based on whether they consider themselves poor and their vulnerability to mental illness displayed in Table 4.

Table 4: Association between poverty and mental health

	Poor	Not Poor	Total
At risk of Mental Illness	16	3	19
Not at risk of Mental Illness	4	3	7
Total	20	6	26

OR= (16x3)/(4x3) = 4

95% Confidence interval = [0.58, 27.82]

P value = 0.16

The above table shows the strength of association between poverty and mental health. Furthermore, an odd ratio of 4 was found which indicates that people consider themselves poor have 4 times the risk of developing mental illness when compared to those who did not consider themselves poor. Referring to the P value, which is 0.16, it can be seen that it is not statistically significant, as the value is not less than 0.05. The small sample size is a possible reason why the odds ratio is not statistically significant.

In summarizing all the findings, it was found that women in Hagam VDC relate poverty to not having sufficient food, clothing, land and money. In terms of mental health, however, majority of women were not aware of the illness and it was found that the common term used in identifying a mentally ill person was “mad person”; this illustrates the stigma attached to mentally ill in the community. It was also found that majority of the women cope with life stressors by confiding in their loved ones. Neurosis and psychosis were identified to be the common mental illnesses that women are vulnerable to. All health workers were found to be familiar with mental health, however, their knowledge in relation to information availability in the community could not be analyzed effectively since distribution of information could be constrained by the current number of workers, which were 2 during the field research.

CHAPTER 5
DISCUSSION

In support of the hypothesis, the major findings of the study show that women who reside in environments with a low socio-economy (Hagam VDC) are prone to mental illness. It was also discovered that women in Hagam had very little understanding of poverty and mental health. In terms of social support; however, majority of the women had stable social support network. This was not demonstrated to reduce the risk of developing mental illness. Furthermore, the possibility of casual relationship between poverty and mental illness cannot be ruled out, as findings have demonstrated. Odds ratio of 4 showed the association of poverty and risk of developing mental illness, however, the P value was found to be statistically insignificant. Interpretation of these results will be discussed below, following the structure of main themes of the study.

5.1 Women's Perception of Poverty

Bhatta and Sharma (2006) stated that food insecurity, malnutrition, illiteracy and social exclusion are important indicators of poverty in Nepal. This research did not disregard the general definitions of poverty given by many western scholars; however, the aim was to understand women's perception of poverty in the community without imposing any kind of indicators. The term poverty is mainly defined using economic indicators; this study was on the other hand set out to explore women's perception and to see what poverty meant to women of Hagam. Findings were in support of Bhatta and Sharma's assessment that women's perception of poverty in Hagam VDC is the insecurity that exists in reference to food, land, and capital.

Even though explaining poverty was challenging to participants, most defined poverty as not having enough food, clothing and money in times of need. Deaton (2003) and Ravallion (2003) argue that power, inequality and lack of security are some of the indicators of poverty from a sociological perspective. However, no further correlation could be made, as responses from defining poverty did not lead the researcher to ask further questions regarding such indicators. On the other hand, few women (N=3) stated that labeling oneself as poor depends on the individual's state of mind, which relates to the psychological perspective of poverty. One of these women nonetheless, was found to be at risk for a mental illness. This indicates that not all poor people will have a negative attitude towards their life, and not all will be at risk for mental illness because of their socio-economic status. Few participants (N=2) reported that poverty meant having to work hard, live in pain and encounter obstacles regularly; these responses could fall into the three disciplinary perspectives discussed earlier. Having to suffer, work hard and live in pain can be used as economic, sociological and/or psychological indicators in defining poverty. 'Working hard'

relates to income; thus, falling under the economic definition of poverty. Whilst, living in pain and encountering suffering regularly can fall under both sociological and psychological perspective of what poverty means.

Findings also showed that a correlation between women's perception of poverty and their attitude towards their working environment could not be established. This is because a majority of the participants expressed positive attitudes towards their working environment, yet they identified themselves as being poor. Hence, having a positive attitude towards occupation is not necessarily associated with good living conditions. Furthermore, some women linked their occupation to their level of education. Majority of the women (~85%) are uneducated and many were found to have linked their occupation (93% farming) to illiteracy. Only four respondents had primary level education, however no difference was found in their responses in terms of their occupation or their understanding of poverty. Based on these findings, it could be said that people who attained a higher-level of education have a greater chance to secure employment that could entertain their interests, possibly leading that individual to personal satisfaction. This confirms Marrone and Golowka's (2000) study of the effect of unemployment. Majority of the participants had a job, where many were dissatisfied. Although, Marrone and Golowka listed depression, self-pity and self-isolation as a result of unemployment, dissatisfaction of an occupation could also lead to daily stress impinging an individual's general happiness.

For the purpose of this study, the World Bank definition of poverty was used, as it is general and encompasses many aspects of disparity that exists between the well off and the poor. Considering women's perception of poverty as a base line, it can be said that poverty to women of Hagam is the inability to acquire the basic human needs; which fits into the World Bank's definition of poverty.

5.2 Women's and Health Worker's Perception of Mental Health

As mentioned earlier, the person administering the SRQ is expected to have had previous training on its use. However, with PHASE Nepal and PHASE UK's approval, the researcher administered the SRQ in order to predict possible vulnerability in women of Hagam. Thus, numbers and assessment shown here is by no means a diagnosis. It should also be noted that results cannot be generalized as the sample size is small and findings only represent women in Hagam.

Health workers understanding of mental health was assessed to see its effect on information flow in the community. Referring to the three descriptions of mental health given by the key informants, it can be said that one has a better understanding in comparison to the other two; regardless, however, it was found that there is an awareness of mental health by the health workers. These three health workers are the only health service providers in Hagam VDC. Hagam VDC has an estimated 800 households with 6 members per household. This indicates that the work over load on the health workers is immense, with a proportion of 1 health worker per 1,600 populations. Consequently, it is important to note that these health workers are not psychiatrists nor are they specifically trained to diagnose and treat mental illness. As one key informant stated, they usually learn on the job. Even though, health workers were found to be aware of mental health, information transfer in the community was inadequate. As stated above, the disproportionate ratio of health workers in respect to Hagam population further perpetuates the lack of information flow. The community awareness program that is undertaken twice a week by the PHASE Nepal health worker does not incorporate a mental health curriculum, as it is not a priority in the community. Though, there are other means of information transfer that could be used; for instance, posters, radio, TV, formal and informal mass community gatherings, sensitization of health interventions organized by government and non-governmental organizations are not applicable. For these sources of information to be utilized effectively the health care workers need to first establish that there is an unmet mental health needs in the community. Due to the lack of mental health professionals, it will be challenging to execute every health related problem efficiently.

Furthermore, there is a perception that mental health is a western disease, because of the number of people affected by it. In opposing, it should be taken into account that developing countries mostly do not have the necessary manpower and capital to encourage research and implement needed strategies and infrastructures in all communities. Accordingly, this plays a factor on the diagnosis and treatment of mental health in Nepal. Globalization also has a role in terms of manpower, as trained workers migrate to the west and neighboring countries in search of better life opportunity. Therefore, it would be imprudent to conclude that mental health is a western disease.

Findings also elucidated that perception of mental health amongst women in Hagam community was low. Majority of the women were found to have associated mental illness to madness. According to Bourchovitch and Mednick (2002) health is the state of being “sound or whole”. They also stated that health is associated with mental and moral soundness and spiritual salvation. Centering participants understanding of mental health, it can be seen that the well being of the mind

and the capacity of threshold to challenges, is a characteristic that can relate to Bourchovitch and Mednick's (2000) definition of health in relation to mental health.

For the purpose of this study the WHO definition of mental health was used, as it gives a holistic picture and can be generalized. From the findings, participants perceived 'madness' as the form of mental illness. Some of the characteristics of madness identified by the participants included the person's inability to cope with normal life stressors, achieve daily activities and to behave out of the social norm. Thus, it can be argued that these characteristics are in line with the WHO definition of mental health.

5.3 Correlation between Poverty and Mental Health

39% of women in Hagam were found to be at risk of neurosis and psychosis. During complementarity analysis it was found that these participants had emotional support and enjoyed their occupation, nonetheless, they still identified themselves as poor. Few of these participants enjoyed their daily activity and did not think they were poor. In addition, the study shows that 73% of the women were found to be at possible risk of neurosis, psychosis and/or epilepsy. Parallel to job dissatisfaction and life stressors, it can be said that women residing in Hagam VDC are prone to mental illness. Three women had reported that everyone was equal regardless of their positive attitude towards poverty; however, one of them was found to be vulnerable to psychosis and epilepsy and the other two were not at risk of mental illness. As Mollica *et al.* (2004) argued, there are factors such as, civil unrest and genocide that could facilitate the onset of mental illness. Even though civil unrest and genocide are extreme phenomena, it is a fact that people who are exposed to unsustainable ways of living could be affected as much as people who have witnessed civil unrest or genocide. It is a fact that not all individuals who were exposed to the sever circumstances react to the trauma the same way, nor do all women who live in low socioeconomic environments. Some will have higher thresholds and better ways of dealing with the problem than others do.

5.4 Coping Mechanism

"Being unwanted, unloved, uncared for, forgotten by everybody, I think is a much greater hunger, a much greater poverty than the person who has nothing to eat." ~ Mother Teresa

The quote stated above, emphasizes the magnitude of social support to human kind. As Lehtinen *et al.* (2005) states that the one factor that can avert the onset or recurrence of mental illness is social support. Accordingly, findings of this study have shown that women's common stress coping mechanism is to socialize and/or seek emotional support; 75% of respondents reported to consult their friends and husbands, while few had little to no time to spare for socializing.

As discussed by Marrone and Golowka (2000), employment creates an avenue to expand the social network. Accordingly, women who are part of small-scale businesses, such as selling goods, cited that they are at times accompanied by friends at their work place. This also applies to women whose occupation is farming, where in most cases people work together. This creates an opportunity for women to expand their social networks according to Marrone and Golowka.

The impact of social support on stroke and unemployment shows the buffering influence social support has on general life stressors. Findings from this study on the other hand, did not show any difference between those women who had support and those who did not. It was found that even women who have adequate social life and family support were at risk of neurosis, psychosis and/or epilepsy. As a result, the research cannot support scholars such as Rogers and Pilgim, Marrone and Golowka, Glass *et al.* and Dalgard *et al.*'s findings. Stigma was also found to be another factor that could have contributed on the minimum awareness of mental health in Hagam.

5.5 Limitation

As previously mentioned, many practical and theoretical limitations were encountered. One of the major issues was explaining the concept of mental health and poverty to participants. Most participants found it hard to explain, as they were not familiar with the idea and had limited vocabulary to give an elaborated response. Language was also another barrier; despite the use of a translator, some participants were Tamang, a type of caste, and spoke Tamang with only basic knowledge of Nepali. This was another key hindrance, as they were more than one problem affecting respondents' answer. The translator used many examples in order to explain questions, which posed as a leading question and suggested ideas to participants to simply answer yes or no; because of language barrier, researcher had no control over this fact. As stated above, in order to ask follow up questions the translator was asked to translate one question at a time, English to Nepali and vise versa. However, as information saturation was being reached, in day 5 and 6, the translator started asking most of the questions at ones with out translating responses and

summarizing all the answers at ones. This was brought to the translator's attention, as the researcher was limited from asking further questions and important information from the respondent might have been forgotten. Whether recognized or not, as much as a translator, interpreters also become researchers as they make assumptions about equivalence words (Temple and Young, 2004), and are on the frontline of the research making an important mark on the study and retrieving the needed information from participants.

CHAPTER 6
CONCLUSION

As discussed above, depending on the discipline, poverty and mental health can be approached and defined from different perspectives. This paper has investigated the effect of poverty on mental health in women of Hagam VDC. It has concentrated on the individual level of understanding of poverty and mental health. Conclusive results from this study have showed that women who reside in Hagam VDC are prone to mental illness supporting the initial hypotheses. However, these results are not conclusive, as it can be argued that the researcher did not have training to administer the SRQ questionnaire. Unexpected findings that surfaced during the study were the lack of link between social support and risk of mental illness and the lack of correlation between poverty and job satisfaction. Women were also found to have limited understanding and vocabulary to explain their perception of poverty and mental health. Nonetheless, it was found that women's description of poverty, which was the insecurity of food, clothing and money, supported Bhatta and Sharma's indicators of poverty in Nepal.

The findings have the following implications for action to be implemented with regards to stigma and improving women's health in Hagam VDC. During quantitative analysis no obvious correlation was established between poverty and mental health. However, during complementarity analysis, it was found that regardless of women's awareness of poverty and mental health, women of Hagam are vulnerable to neurosis, psychosis and epilepsy.

In summary, women in Hagam VDC suffer from diseases that are preventable because of the truncated access they have to resources. Inadequate healthcare delivery and lack of modern technologies continue to compound the poverty and aid dependency issue. Along these lines, in order to improve the distribution and illiteracy, the most effective undertaking would be to structure policies and infrastructure to increase the availability and proliferation of education and health care that benefits the country.

Moreover, it is important to note the advantages of the MDGs. The MDGs are by no means the solution to all health and poverty related problems, but it creates a pavement to start somewhere. Achieving the MDGs will help empower women and so effectively improve health (mental health included) and reduce poverty. The MDGs will not be a silver bullet to the countries health and poverty issues, but rather another tool to add to existing prevention efforts. Hence, in order to increase confidence and decrease gender inequality, the government needs to enhance their

involvement and provide more support to PHASE Nepal (and other organizations) in working to empower the community.

Accordingly, the essence of this vast problem must be understood and tackled by implementing a sustainable intervention that truly benefits the needy. In addition, this research further promotes more research with bigger sample size examining whether there is a direct link between poverty and mental health in Hagam VDC. Comparison between different social classes is also necessary to validate results. Questionnaires used also need to be simplified so that participants understand the context and respond accordingly.

Following the completion of this study the following recommendations are being made:

1. The Health Sector Development Plan (HSDP) needs to be implemented in order to increase access, decrease inequality and allow health workers to perform their duties effectively.

2. In order to reduce the stigma attached to mental health, community awareness has to be raised. However, as findings have shown, in terms of Hagam and the manpower currently available, it seems impossible for at least few years. Thus, all political and personal opinions aside, intense participation of government and multilateral organization is needed along with schools and community leaders. Upper class students could be given a project as initiative to raise awareness in their community and report back to school; community leaders can also prepare weekly meetings to raise awareness on health.

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