PERCEPTIONS OF MENTAL ILLNESS AMONG NON-SPECIALIZED HEALTHCARE PROFESSIONALS IN KATHMANDU, NEPAL

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University of Bergen

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2023

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This thesis is submitted in partial fulfilment of the requirements for the degree of Master of Philosophy in Global Health at the University of Bergen.
(60 ECTS credits)

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2023

ACKNOWLEDGEMENT

Writing this research paper has been an insightful and challenging experience, and I am thankful to every single person who has contributed to it throughout this process.

To begin with, I would like to thank my supervisor, Prof. David Lackland Sam, for his consistent guidance, support, and valuable feedback. His expertise and assistance have been critical in establishing the direction of this research project and successful completion.

Furthermore, I am thankful to the University of Bergen for providing me with the research funding and additional resources that were critical to the effective execution of my research.

I would also like to express my deepest gratitude towards the ethical review boards in Nepal and Norway for granting me the ethical approval to conduct this study.

I am equally indebted to the study participants who offered their precious time and shared their perspectives for this study. Their cooperation and contribution have made it feasible to draw meaningful conclusions.

Lastly, none of this would have been possible without the constant support and encouragement of my friends and family, especially my colleague Susmita Neupane. Their confidence and fortitude in my capabilities have been my motivators. I am humbled by the collective efforts and significant contributions of every single individual involved in this research project.

LIST OF ABBREVIATIONS

PWMI	people with mental illness
APA	American Psychiatric Association
LMICs	low-and-middle income countries
SDGs	Sustainable Development Goals
MoHP	Ministry of Health and Population
DoHS	Department of Health Services
MoH	Ministry of Health
MISF	mental illness stigma framework
ICD	International Classification of Diseases
REK	Regional Committees for Health Research Ethics
NHRC	Nepal Health Research Council
GMW	General Medical Ward
ICU	Intensive Care Unit
NGOs	Non-governmental organizations

ABSTRACT

Low-and-middle-income countries (LMICs) bear three-quarters of the global mental health burden, with limited availability of mental healthcare resources. Mental healthcare delivery is critical to addressing the burden of mental illness in these contexts. A positive understanding and attitude towards mental illness among health care practitioners is essential for providing optimal medical treatment. And it is quite evident that the norms and values of the society in which healthcare professionals live have a significant impact on them since they are an integral part of that society.

According to research, many health service personnel hold stigmatizing beliefs about mental illness. The victims' behavior in seeking healthcare is immediately impacted, and the standard of healthcare service is jeopardized. Our study intends to evaluate and investigate the views of non-psychiatric medical professionals in Nepal towards mental illness, with a focus on their perspectives, predispositions, and the social acceptability of people with mental illness (PWMI).

Semi-structured interviews were conducted among medical doctors and nurses employed at several governmental and private hospitals of Kathmandu, to explore their perceptions of mental illness. The findings highlighted that the participants generally have a good grasp of mental illness and have a positive outlook towards mentally ill people. It can be concluded that, though there are certain reservations and stereotypes persisting among the professionals, they have a wide sense of understanding and acceptance towards mental illness and people with mental illness.

Keywords: mental health, mental illness, people with mental illness, Nepal, healthcare providers, stigma, stereotypes, Kathmandu

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CHAPTER I: INTRODUCTION

1.1 BACKGROUND

1.1.1 Overview of mental illness

The definition and portrayal of mental illness has been evolving over the years, with significant advancements in its assessment and understanding. It encompasses a wide spectrum of diseases impacting mental well-being, and is defined not only by its clinical elements, but also by its cultural and social elements. Because of the sociocultural influences that impact such a concept, defining a global understanding of mental disease is challenging.

The American Psychiatric Association (APA) defines mental illness as any disruption in cognition, emotion, or behavior (sometimes a combination of these) that may lead to social/familial dysfunctions(1). According to Joan Busfield's typography(2) for mental health disorders, mental disorders can be categorized into disorders of thought (psychosis, schizophrenia, et cetera), disorders of emotion (depression, anxiety, etc.) and disorders of behavior (drug and alcohol dependency).

Mental illness is one of the cross-cutting and dominant health issues around the world, contributing to 13% of the global burden of diseases measured in disability-adjusted life years(2). Despite the availability of treatments, almost two thirds of people with a recognized mental disorder never seek care from a health professional owing to stigma, prejudice, and negligence Among the total population affected by the illness, more than two-thirds reside in low-and-middle-income countries (LMICs) with less than one psychiatrist for every 200,000 people(3).

The high prevalence of mental illness in many LMICs is moderated by factors such as poverty, low socioeconomic status, unemployment, low levels of education, rapid urbanization, internal migration, lifestyle changes, and discriminatory practices toward specific population subgroups(4-6). Other studies have shown lack of priority for mental health treatment, lack of decentralization of mental health services and shortage of mental health professionals as other obstacles(7, 8). And despite the high burden, almost 70% of the mentally ill do not receive any treatment(9).

It is also crucial to understand how mental illness connects to the Sustainable Development Goal

3 (SDG 3) and its targets, which deals with promoting and ensuring optimal health and well-being for individuals of all ages. Mental health is an essential component of one's general health and well-being. Therefore, it is vital to carry out mental health research in order to understand more about the prevalence, underlying factors, and effective treatment possibilities for mental health issues. Additionally, governments may create and put into practice focused policies to enhance the quality and accessibility of mental healthcare, supporting SDG 3's objectives of providing universal health coverage and ensuring access to quality health care.

Being a socially constructed concept, mental illness is seen, labelled, and understood uniquely in different communities by different people. These beliefs, whether influenced by individual experiences, cultural norms, or media portrayals, play an important role in shaping how people with mental illnesses are treated and accepted by society. Because of sociocultural standpoints, certain societies may stigmatize mental health issues, whilst others may be more tolerant. Different perspectives about mental illness may have an impact on the type and level of care and support offered to individuals.

Various global studies have revealed that, despite increased mental health knowledge, there are still certain unfilled gaps in how mental illness is observed in our societies. Study has shown that in low and middle-income countries, four out of five people with mental illness (PWMI) do not receive effective treatment and are subject to negative and stigmatized attitude(10). Consequently, the reluctance to speak about mental illness seems to be highly associated to stigma in Eastern countries than in Western countries(11).

Stigma is the negative attitude that one has towards self or others which is attached to a personal trait of the person. Though stigma is found to be associated with numerous health disorders, it is quite prominent when it comes to mental health issues(5, 6). Stigma is made up of a number of unique entities which include stereotypes, prejudice, and discrimination. A stereotype is a preconceived notion about a specific group of people. Prejudice is defined as agreement with a stereotype that leads to a negative emotional reaction. The behavioral response to prejudice is discrimination, which may entail, for instance, avoiding a person with mental illness out of fear of the prejudice and the perception that the individual is dangerous(12).

Stigma associated with mental illness has been found to occasionally be more upsetting and crippling than the condition itself(13). Secondly, preconceptions about the functional capacity of

mentally ill persons that are embedded in our cultures give rise to social prejudice against them. This predominantly leads to self-stigma, in which people believe they are not sufficient or capable of leading a regular life, resulting in self-discrimination(7).

The prevalent stigma and stereotype associated to mental illness in the developing countries in Asia is comparatively higher than in the developed countries which requires some in-depth exploration to plan out interventions. Mentally ill people are excluded in the community, viewing them as a threat to the society. They are considered ‘crazy’ and at times, are physically and sexually abused(14).

Stigma and stereotypes related to mental health disorders is something that persists within the healthcare system as well. Healthcare professionals from all backgrounds and specialties contribute to stigmatization through conscious or unconscious bias in a number of ways, including: showing little interest in the patient's mental health history; social distance; psychiatric labeling; therapeutic pessimism; structural discrimination linked to inadequate psychiatric treatment or rehabilitation measures; and providing insufficient diagnosis information(11, 14, 15). This is seen to lead to social disapproval and discrimination which affects the treatment seeking behavior among PWMI (7). In other words, stigma serves as a barrier to both patients' willingness to use mental healthcare and healthcare providers' ability to provide optimal treatment.

In order to build therapeutic rapport and encourage patients to seek healthcare assistance, empathetic and non-stigmatizing approaches from the health professionals are necessary. Understanding the perspectives that they share makes it easier to spot potential challenges and customize measures to tackle stigma, strengthening the overall efficacy of mental health care. It also acts as a major catalyst to create focused interventions, education programs, and policy reforms(16) to successfully combat stigma by being aware of the beliefs held by healthcare workers.

1.1.2 Introduction to Nepal

Nepal is a landlocked nation in South Asia. It primarily lies in the Himalayas and is bordered by China to the north and India to the south, east, and west. With a population of 25.72 million, Nepal is a nation with a roughly 147,000 square kilometer landmass. Nepali is the primary

language spoken in the nation. Hinduism, Buddhism, Islam, and Christianity are among the religions practiced. The nation meets the World Bank's definition of a lower middle-income country(17).

The healthcare system in Nepal is made up of both governmental and private healthcare services. Despite government attempts to increase access to healthcare, particularly in rural regions, problems such as lack of infrastructure, staff, and resources still exist(16).

1.1.3 Mental health in Nepal

Formulation of mental health policy

The Mental Health Act was first established in 2006, after the National Mental Health Policy was unveiled in 1997. Its principal purpose was to offer every Nepalese with at least a basic degree of mental health treatment. These policies laid the groundwork for attempts to reduce stigma around mental illness, provide mental health services, and protect the rights of those who suffer from mental illness(18).

The plan's main components were- guaranteeing the availability and accessibility of basic mental health treatments for everybody; training personnel in mental healthcare; defending the fundamental rights of mentally ill persons; and raising mental health awareness. The integration of mental health treatments into basic health services to be offered through primary healthcare was an essential part of this program, but poor data on primary healthcare service delivery was a barrier(18). Despite multiple efforts, policy implementation remained weak, and the Mental Health Act was never enacted into legislation.

Later, in 2017, the Ministry of Health and Population (MoHP) created a mental health policy in accordance with Nepal's constitution that guaranteed every citizen of Nepal the right to mental and psychosocial health as well as the right to continue to be mentally healthy and lead a respectable life. The new draft's objectives were to ensure that everyone had access to basic mental health services; train the workforce needed to provide these services; protect the fundamental human rights of those who suffer from psychosocial disabilities and mental illness; increase public understanding of mental health; reduce stigma associated with mental illness; and develop and manage health information systems and research(19).

In accordance with the policy, each government-run hospital was required to establish a separate

mental health unit and a division for mental health under the MoHP(20). The elements of this draft strategy were significant and were expected to be effective in enhancing the country's mental health, but unfortunately the cabinet of ministers did not approve it.

The 1997 Mental Health Policy was automatically repealed since the 2019 National Health Policy included mental health-related programs, policies, and strategies. As a result, a comprehensive strategy and action plan was required to address the difficulties and issues facing the mental health industry, and the 2020 National Mental Health Strategy and Action Plan was created(19). Its goal is to enhance the mental and psychosocial well-being of Nepalese people so they may lead fulfilling lives.

The plan's guiding principles include ensuring that all people have easy access to top-notch mental health services, integrating those services into primary healthcare, maintaining participation, cooperation, and partnerships between the public, private, and non-profit sectors, and offering an inclusive mental health service that is evidence-based. One of its strategies is to manage the workforce, resources, and delivery of mental and psychosocial services. Another is to run awareness campaigns to dispel myths and superstitions about mental illness and to promote mental health. A third is to defend the human rights of those who suffer from mental illness and psychosocial disability. A fourth is to support research by incorporating data on mental health services into the existing information system(19).

The elements of this strategy appear favorable, but the fact that Nepal only has one psychiatric hospital makes it difficult to achieve its objectives. Even though there are other institutions that serve as referrals for mental care, most of them are in urban cities and have insufficient staff. The 1996 Mental Health Policy and Nepal Health Sector Programme-II both advocated for integrating mental healthcare within the basic healthcare system. However, the policy requirements cannot be implemented due to a lack of mental health governance structures at the national and district levels(21).

Additionally, this integration of services may add to the already excessive workload of healthcare professionals. Despite these obstacles, integration is still possible given a number of supportive factors, including the constitution's recognition of health as a human right, the inclusion of mental health in the national five-year health plan, and the inclusion of mental

healthcare in the Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases(22).

Current scenario

According to the National Mental Health Survey (2020)(23), the prevalence of mental illness in Nepal is 10% among the adult population. Mental illness is thought to be attributable to 18% of the burden of non-communicable diseases (NCDs). According to international estimates, 1% of Nepalese people may suffer from serious mental illnesses, while 10–20% of individuals have one or more mild mental health issues(24).

In a nation of 28 million people, where nearly 30–40%, according to current projections, has either distress, depression, or anxiety(25), neither a robust grassroots community-based effort nor an autonomous governance structure under the Ministry of Health (MoH) are in place to oversee the distribution of mental health services. The MoHP develops general health policies/plans, as well as controls, monitors, and evaluates health activities and outcomes. The Epidemiology and Disease Control Division (EDCD) of the Department of Health Services (DoHS) was selected as the focus entity to monitor mental health in Nepal in 2018. The Non-Communicable Disease and Mental Health Section manages the country's mental health programs.

The existing healthcare delivery system is structured as a tiered referral system. At the most basic level, there are community health units, health posts, urban health clinics, and primary hospitals (including primary health care centers). The country's main healthcare system does not yet include mental health services as a core component(26). Integrating mental health services into primary health care is difficult due to a combination of overworked health workers, lack of psychotropic medications, lack of awareness among the general public, and deeply ingrained stigmatized and discriminatory behavior towards the mentally ill.

Despite one in every five people suffering from mental illness, less than 1% budget is allocated to mental health and the treatment gap is estimated to be 85%(24, 27). There is one mental hospital in the country with a capacity of 50 beds. Psychiatry units at medical colleges, provincial government hospitals, and a few private hospitals provide mental health treatments. The total number of in-patient mental healthcare facilities is 25, with 500 beds(28). The majority of mental healthcare is paid for out of pocket. However, depression, psychosis, alcohol use

disorder, and epilepsy are treated for free since these were recently included in the Department of Health and Human Services' Basic Health Service Package 2075 (2018).

When it comes to mental healthcare personnel, the breakdown by profession is as follows: there are 32 psychiatrists (0.129 per 100,000 people) and 16 other medical practitioners (non-psychiatric; 0.0645 per 100,000 population), 68 nurses (0.274 per 100,000 population), 6 psychologists (0.024 per 100,000 population) and 25 (.101 per 100,000 population) other health or mental health workers. Urban and rural areas receive an unequal allocation of human resources(26).

There is no coordinating organization in place to handle public education and awareness initiatives about mental health and diseases. Mental health education for health professionals makes for 2% of medical doctors' training, and likewise, 2% of nurses' training. None of the primary healthcare physicians undergo refresher training in mental health. In the last five years, government agencies, non-governmental organizations, and professional organizations have all reinforced public education and awareness initiatives. These campaigns addressed both the general public and children and adolescents. There have also been public education and awareness initiatives aimed towards professional groups such as teachers and healthcare workers(18).

Further obstacles to achieving the objectives of the Strategic Action Plan on mental healthcare include a shortage of personnel, inadequate training, and frequent transfers of healthcare professionals, which prevents those with specialized expertise in mental health from providing ongoing treatment. There are also issues concerning inaccurate diagnosis of mental health conditions and the right people not getting the right treatment in a timely manner(29). Additionally, many people put off getting medical attention for their mental health, mostly due to stigma, prejudice, and the high out-of-pocket expenses for psychiatric treatment and medications.

1.1.4 Perception of mental illness in Nepal

Because the mind and body are regarded as separate entities(30) in Nepalese culture, mental illness is approached differently from physical illness. Mental illness is viewed as a 'spiritual malfunction' or 'weak mind,' and is blamed on spirit possession, black magic, divine wrath, and past-life crimes (*karmako phal*). Traditional healers (e.g., *dhamis, jhankris, baidangis, and*

bijuwas) have an intense faith in traditional medicine and are the primary point of contact for the majority.

Attributing to lower level of health illiteracy and awareness, several misconceptions regarding mental illness exist in the Nepalese society. People perceive mental illness as a condition resulting from ill doings in past life or due to evil spirits. It is a common understanding that typical signs of mental problems included acting violently, looking untidy, wandering aimlessly on the street, neglecting personal hygiene, laughing uncontrollably, and being unable to do regular tasks(30, 31).

Mentally ill people are seen as a threat to the society, and it is believed that they should be treated differently. Stigmatizing terms such as '*pagal'* (crazy) and '*baulaha'* (mad) are used while addressing mentally ill people. According to a study, individuals in the community are hesitant to interact with those who live with mental health issues. They are not accepted as being able to take part in social events and are often neglected. As a result, people often tend to deny treatment or discontinue their treatment fearing revelation of the mental illness (18).

There is a gradual increase in awareness of mental health in the general population and the number of people seeking treatment in mental health institutions is increasing. However, stigma and discrimination against persons with mental illnesses are substantial issues, and mental health literacy is significantly poor, leading to mental health problems being concealed, refusing treatment, and seeking alternative treatments. One of the constraints to mental healthcare has been recognized as stigma among service providers against persons with mental illnesses(32).

While stigma and scarce resources continue to be obstacles to proper care, mental health disorders are becoming more widely recognized in Nepal. In spite of the challenges and shortcomings, in recent years, Nepal's mental health system has witnessed tremendous growth and reform, reflecting a rising understanding of the value of mental health and the necessity of addressing population-level mental health issues. The government and NGOs are attempting to provide mental health services and raise awareness of the issue, particularly in metropolitan areas. Community health workers and health assistants are being trained to identify and provide basic mental health support. Research on mental health concerns is expanding, with an emphasis on stigma, prevalence, and treatment results.

1.2 LITERATURE REVIEW

Perceptions of mental illness have a significant impact on the lives of those living with such conditions, as well as impacting societal attitudes and driving the paths to care and support. The purpose of this literature review is to synthesize and analyze current research on mental illness views, focusing on the multidimensional character of these beliefs, their underlying determinants, and their consequences for people with mental illness, communities and the country. We intend to understand the complexities within mental illness perspectives by analyzing and synthesizing previous studies. This review also provides insights into areas that need more research and to identify knowledge gaps and potential intervention opportunities.

To carry out this literature review, I performed searches mainly on Google Scholar as well as other databases such as for PubMed, MEDLINE, CINAHL, et cetera. The search terms were a combination of mental illness, perceptions, Asia, Nepal, stigma, healthcare, theories, mental health, doctors, nurses and healthcare providers. The studies included are mostly research paper, observational studies, interventional studies and systematic reviews.

1.2.1 Outside Asia

Numerous studies conducted within and beyond the borders of Asia suggest that there is a pressing necessity to investigate the attitudes and perceptions of medical personnel that influence their behavior since they are actively involved in delivering treatment and care. It has been well-documented through research that psychiatrists are no different than the public in hesitating to maintain social contact with mentally ill people (5).

In a multi-site qualitative study conducted among seven countries in Africa, Asia, and Europe, it was seen that the primary care providers in Nepal believed that mental illness cannot be treated and that it cannot be cured through medical intervention (18). In a Swiss study conducted among mental health professionals, nearly all the participants expressed lower level of willingness to encounter schizophrenic patients than compared to patients with depression or no symptoms (8).

In a Finnish study(33), the nurses in primary health care settings often held the belief that those with mental illnesses should be kept isolated from the general community and did not feel safe around these patients. Another study done among mental health professionals in Europe to assess their attitude revealed that community-based staff had a more positive attitude in comparison to hospital-based professionals(9).

An American study assessing the attitudes of mental health professionals and the general public concluded that the mental healthcare providers hesitated from interacting with mentally ill patients, especially in the case of schizophrenia. Youths seeking mental healthcare in Canada felt that service providers' stigmatizing behaviors eventually prevented them from using the services(34).

Similarly, a systematic review to study mental health nurses' measured attitudes to people and practice in United Kingdom pointed out that there was some evidence that many nurses have unfavorable attitudes towards personality disorders and substance abuse(35). In a survey(36) of 516 Australian psychiatric personnel (nurses, psychiatrists, psychologists, social workers, and occupational therapists), the majority of respondents (80%) indicated that patients with borderline personality disorders posed challenges and that interacting with these patients was more difficult than communicating with other groups of patients. A similar study was done on stigma towards mental illness among health science students of Chile and Spain(37). The medical and nursing students from the study believed that individuals with mental illnesses were aggressive and unpredictable and would never be able to heal to a sufficient degree.

A study of the attitudes of psychiatric hospital staff in Israel(38) reported that mental health nurses expressed less empathy towards mentally ill patients, when compared to psychologists and psychiatrists. The nurses perceived these patients as threatening, forceful, stubborn, and more difficult to care for. According to a survey of medical students in Qatar(39), a majority believe that mental illness is a punishment from God, that PWMI should not marry, and that they would be embarrassed to have a family member with mental illness. Similar kind of affirmations were found among mental health professionals from Kuwait(40).

Recent research in Saudi Arabia(41) and Jordan(42) indicated stigmatizing views towards patients with mental problems among tertiary hospital physicians and health care professionals, respectively. With similar findings, a study from Bahrain(43) also concluded that health care providers (mainly nurses and occupational therapists) held significant stigmatizing attitude towards people with mental illness. The study emphasized intensive social contact, anti-stigma workshops and educational interventions.

1.2.2 In Asia

Some of the service users in a qualitative study from Indonesia have stated that the primary health workers were not attentive to their problems. Another patient in the same study reported that the healthcare providers did not show any concern towards his issue or treatment (19).

One of the recent studies done among medical and nursing professionals in Singapore pointed out that focusing on academic curriculum enhancement was necessary to help reduce stigma, negative attitude towards having family or friends with mental illness(10). A community-based study among primary healthcare (PHC) providers in China reported that primary healthcare providers in rural China hold pessimistic and negative attitude towards people with mental illness. As per the findings, 71.3% of respondents agreed that mentally ill patients frequently engage in impulsive and destructive behaviors and 72.9% agreed that they are burdens to the families and society(44). The study concluded that it is critical to increase PHC clinicians' awareness of mental disorders and deepen their grasp of significance of managing mental illnesses.

In a comparative study(45) carried out in a university in India, mental illness was seen negatively by a sizable number of medical and nursing students. A cross-sectional study carried out in India to examine the myths and beliefs about mental illness reported that 11.8% of the medical professionals believed that mental illness could be cured through fasting or traditional healers (9). A study from Malaysia produced similar results, where the pharmacists were very likely to reject mental illness since they believed that the condition is caused due to supernatural powers.

1.2.3 In Nepal

There is a very limited literature review available from Nepal when it comes to perception of mental illness, attributing to fewer number of studies conducted in the mental health domain. Moreover, the studies carried out so far revolve more around the mental illness stigma among the general public, caretakers or among mental health professionals/students. Very few studies discuss how the non-specialized healthcare personnel understand and view mental illness. However, to provide a general overview of how the mental health research scenario is, every relevant paper has been discussed here.

In a study assessing the knowledge of community people regarding human rights of mentally ill

people, in Pokhara, 28.6% of the population claimed that mental illness was contagious, while 40.7% thought it was an inherited condition. In addition, 36.4% of respondents thought that supernatural forces are to blame for mental illnesses, while 30% said that marriage may heal mental illness. 41% of respondents said that once acquired, mental illness is permanent(46). Likewise, one of the quantitative studies conducted to assess the help seeking behavior of psychiatric patients concluded that mentally ill patients preferred to visit traditional faith healers as they are locally available and trustworthy(14).

A cross-sectional semi-qualitative survey was conducted by Shakya DR(47) to assess the knowledge and views of intern doctors about psychiatry and mental health. The results showed that they held an accepting attitude towards mental health and mental illness. Majority of them believed that treatment for mental illness is as effective as the treatment for physical illness. But on the other hand, they also presumed that electroshock therapy was a safe and effective method of treatment for mental illness. Another study(48) was conducted by Jalan RK to assess the attitudes of undergraduate medical students towards the people with mental illness in a medical college of Western Nepal. The results indicated that the students studying clinical psychology had a negative attitude towards PWMI on the domains of social distancing, stereotyping and pessimistic prediction.

Studies by Kisa et al. and Simkhada et al. reported that health workers thought of mental illness to be life-long conditions which are incurable(49, 50). They tend to favor the treatment of physical illnesses over the treatment of mental illnesses. They have also been found to be labelling people with mental illness with stigmatizing terms such as *paagal* (mad), *taar khuskeko* (loose-wires), *paapi* (sinful), et cetera(31, 49, 51). Similarly, another study by Pathak KP(52) to assess general practitioners' knowledge, practices and obstacles in the management of dementia pointed out that the knowledge regarding diagnosis and management of dementia was unsatisfactory (<50%).

1.3 RATIONALE OF THE STUDY

According to the World Health Organization(53), a positive disposition toward mental illness among health care providers is indispensable for the provision of quality treatment. Persons with mental illnesses and their families, on the other hand, anticipate health care practitioners to treat

them as distinct people free of prejudice and discrimination(54). PWMI have highlighted that healthcare staff lack professionalism and do not view the patient as a person, which is why they hesitate to seek medical help or treatment(20). Because physicians are frequently at the forefront of a health care system as practitioners and educators, their prejudicial views may have an impact on other team members and future practitioners. It is critical in this setting to evaluate health professionals' views regarding mental illness.

Since the health professionals are a part of our community, it is likely that they may hold normative preconceptions about mental illness which directly affects their willingness to interact with PWMI. Not only in delivering care, but they themselves might be concealing their own mental issues because of the fear of being judged by society. So, it is crucial to pin down how healthcare delivery is affected by stigma so that strategies and interventions can be put into place(18).

Most of the studies conducted in Nepal have been quantitative, focusing on the community people and nursing professionals. The studies focused on the following topics: epidemiological investigations in clinical samples, non-epidemiological clinical/questionnaire evaluations of mental diseases, and psychosocial/psychotherapeutic therapies. Barely any qualitative studies specific to Nepal have been conducted, especially to get an exhaustive insight on the perspectives of medical professionals who come from non-psychiatric domain. This study with qualitative methodology provides a deeper understanding of how mental illness is perceived by nurses and doctors serving within the hospitals of Kathmandu, Nepal.

The purpose of this study is to examine and inquire into the opinions of non-psychiatric medical professionals in Nepal on mental illness, with a primary emphasis on their beliefs, biases, and societal acceptability of PWMI. Additionally, doctors and nurses are key groups of future healthcare professionals who treat people and are accountable for shaping their respective professions. The research emphasizes how being a member of society affects health workers' opinions. It seeks to validate or contribute to what current research on mental illness indicate in order to improve informed decision making and reform the healthcare system. Loopholes in the system can be detected by gaining a clear image of where the healthcare personnel stand in terms of mental illness stigma. It also helps to enhance treatment coverage and minimize inequality in mental health.

1.4 RESEARCH QUESTION

What are the perceptions regarding mental illness among non-psychiatric health professionals working in Kathmandu, Nepal?

1.5 OBJECTIVES

- To assess the understanding of mental illness among nurses and doctors working in Kathmandu, Nepal

- To explore the perceptions held by the nurses and doctors regarding people with mental illness

CHAPTER II: THEORETICAL FRAMEWORK

This study incorporates the mental illness stigma framework (MISF) to understand and explore how mental stigma is socially constructed and manifested at individual level. This framework was deemed to be appropriate for the study with the anticipation that there exists stigma of mental illness among the health workers, which was based on the literature review and the current scenario of mental health in Nepal. In this study, the framework is used to gain insights into the perspectives of the healthcare providers to understand how societal stigma of mental illness yields.

The framework portrays mental illness as a culturally positioned and socially devalued identity. People's perception and response to stigma associated with mental illness is dependent on whether the person has had a mental disorder at some point in life(55, 56). Focusing on the perspectives of those who stigmatize and those who are the sufferers, this framework provides an overview of how people comprehend, respond to and experience mental illness(57).

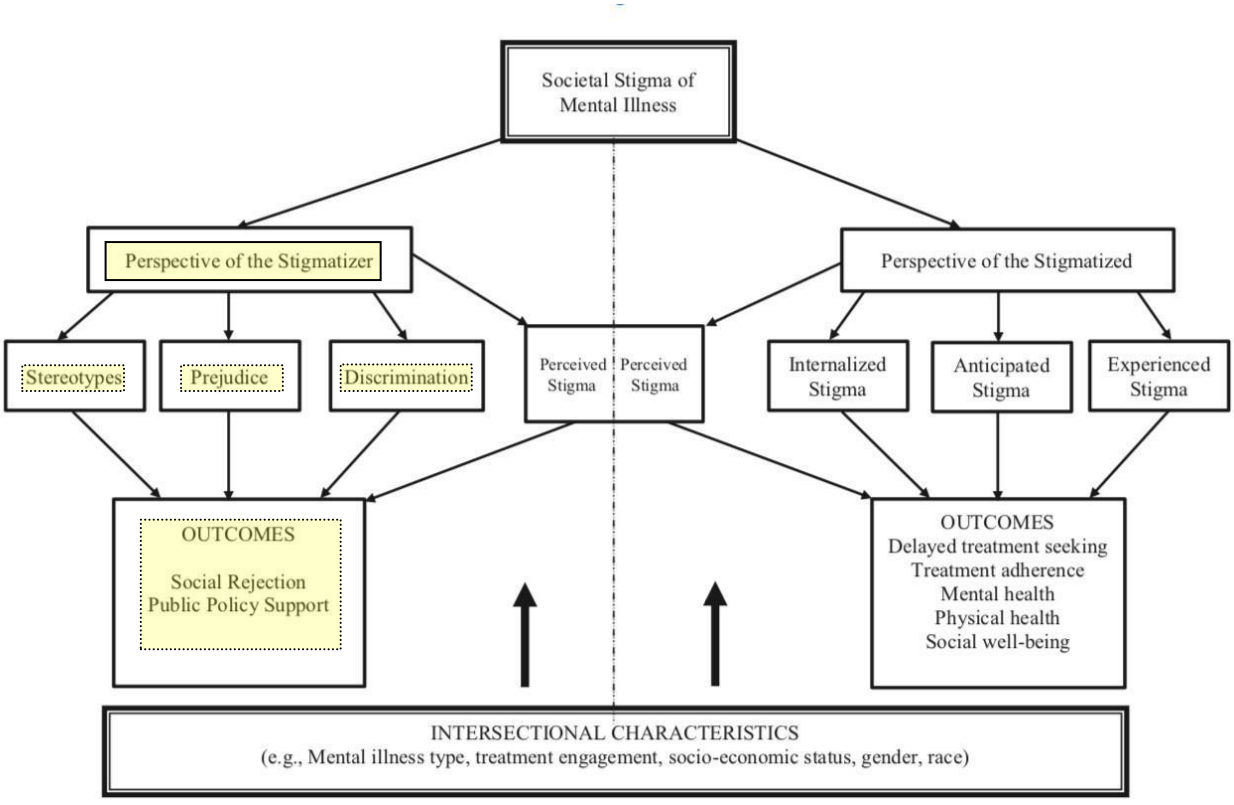

Figure 1. Mental illness stigma framework [Source: Stigma and Health, 3(4), 348-376.]

The viewpoints of those who stigmatize are classified as stereotypes, discrimination, and prejudice. Stereotypes, which cover the cognitive aspect, can be defined as having a generalized negative attitude(58) that one holds towards a group (here, the PWMI). Common prejudices that we observe towards mentally ill are outrage, pity, et cetera. The third component, i.e., discrimination comes as an outcome of prejudice and stereotypes. It is the disparity or unethical behavior that is shown towards the PWMI(57). Some common forms of discrimination are ignorance, exclusion, rejection, harassment.

MISF also entails the mechanism of perceived stigma which is a common component for both the stigmatizer and the stigmatized. It is determined by people's prior experience to mental illness which leads to having prejudices about mental illness. It simultaneously results in people not willing to acknowledge that they have mental illness and thus, refrain from seeking help. Lower literacy rate has been found to be associated with higher level of perceived stigma(59).

In this study, perceived stigma was assessed by exploring how the nurses and doctors view people with mental illness or a history of mental illness.

After reflecting on the study's findings and arguments, the theory of social constructionism was also deemed to be suited for articulating the study's findings. According to the theory, mental illness is a socially constructed phenomenon. This viewpoint holds that mental illness is a byproduct of social and cultural processes rather than an objective, innate trait of a person.

According to social constructionism, cultural ideas, values, and social norms impact how we perceive and define mental illness, and these perceptions evolve through time. Thus, our understanding of mental health and/or mental illness is impacted by these beliefs about what constitutes "normal" behavior and what is deemed aberrant or pathological(60). This theory has several important implications, one of which is the constant evolution and modification of our understanding of mental illness. This implies that as cultural beliefs and values change, so may our definitions and understanding of mental illness. So rather than it being about the disease, it's about the understanding of the disease differing from culture to culture or context to context(61).

CHAPTER III: METHODOLOGY

3.1.1 Study design

This study incorporates the qualitative case study research design as it is the most appropriate approach to thoroughly examine a given phenomenon, entity, or context in real-life settings(62). Case studies provide practical insights by providing transparency and aid in challenging preconceived beliefs and assumptions about a specific phenomenon. This is the well-suited research design since we are exploring about mental illness in depth, through the perspectives of non-specialized doctors and nurses, to facilitate suitable interventions.

3.1.2 Study setting

The study was conducted in Kathmandu district, which is also the capital city of Nepal. It is located at an altitude of around 4,600 feet (1,400 meters) above sea level. The Shivapuri and Chandragiri ranges, among others, are located on each side of the city. The city has a large and diversified population of approximately 2 million(63), comprising of people from various linguistic, racial, and religious origins.

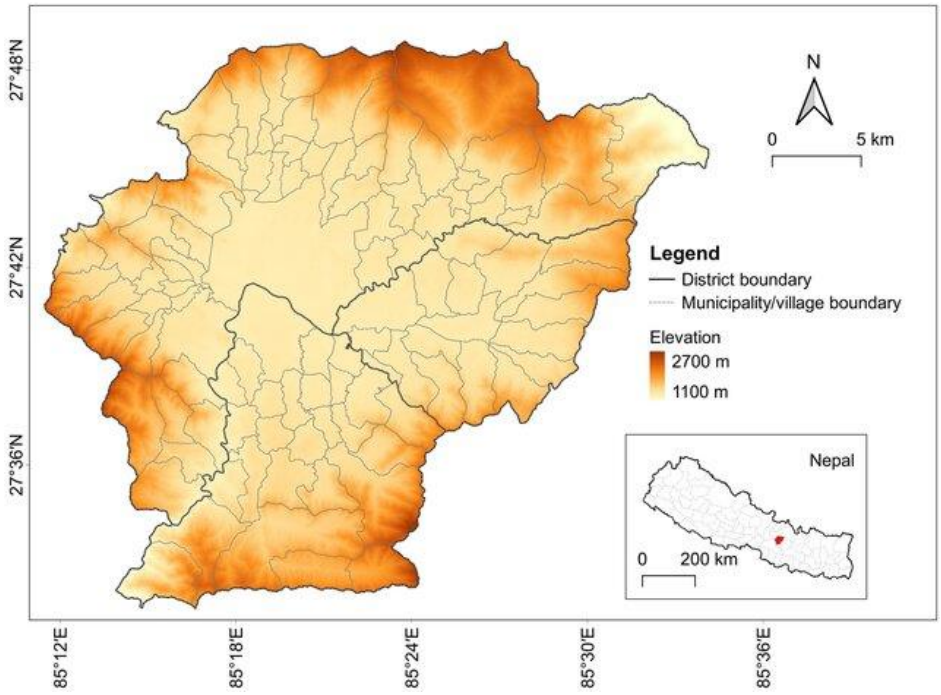

Figure 2. Physical and administrative map of Kathmandu [Source: Nepal in data]

A variety of ethnic groups live in the city, including the native Newars, Brahmins, Chhetris, Tamangs, Gurungs, and others. The major religions followed are Hinduism, Buddhism, Christianity, and Islam. Nepali is the official language spoken, however, there is a range of languages and dialects. The city's economy is broad, with important contributions from industries including tourism, trade, education, and services. A significant population lives in the capital due to the availability of amenities such as job possibilities, health care facilities, and transportation alternatives.

The reason for selecting Kathmandu as the study area is because the city is home to an extensive spectrum of healthcare facilities, including government hospitals, private clinics, specialized hospitals, and medical institutions. Being the capital and a major urban center, Kathmandu serves as a hub connecting rural and urban healthcare systems. As a result, there is a greater concentration of healthcare practitioners seeking better career opportunities and a more secure livelihood. Because of the city's diversified population, it was convenient for us to research healthcare professionals from various ethnic, cultural, and racial backgrounds, to get a deeper comprehension of healthcare practitioners' perspectives. My familiarity with the city and its healthcare system and my healthcare network also influenced the decision to select Kathmandu as the study area.

3.1.3 Sampling and participants

A combination of purposive and snowball sampling was used to recruit health professionals serving within private and government hospitals of Kathmandu. I selected the initial participants who met the criteria relevant to the objectives of my study. Further participants were contacted and recruited based on the referrals of initial contacts.

The inclusion criteria were: a) should be a licensed nurse or a doctor, b) should have completed bachelor’s degree c) should be working in private or government hospitals in Kathmandu, c) should not have a history of mental illness, d) non-specialized in mental health, e) should have a professional experience of at least a year. Mental health or psychiatric professionals were not included in the study to reduce the information and social desirability bias.

Bachelor’s degree for doctor: Bachelor of Medicine, Bachelor of Science (MBBS)
Bachelor’s degree for nurse: Bachelor in Nursing (BN) or Bachelor of Science in Nursing (BScN)

I decided to recruit only the doctors and nurses since they were more accessible and convenient to contact. Similarly, when it comes to diagnosing, treating, and interacting with patients, doctors and nurses are at the forefront of patient care. They represent the two most prominent roles in the healthcare industry, and so their expertise and experience can provide a thorough understanding of the healthcare system.

Enrollment period was from November 2022 to January 2023. The sample size was 12, which I arrived upon through the point of saturation during the data collection. Data saturation denotes the stage of a research project when further data collecting, or analysis is no longer producing new themes, insights, or data pertinent to the study objectives. To put it another way, data saturation means that the researcher has obtained enough information to fully comprehend and investigate the topic under study(64).

3.1.4 Data collection

The method for data collection was face-to-face semi-structured in-depth interviews. This is the best approach to get candid and detailed information from the respondents in a natural setting, by fostering a personal connection and rapport. Face-to-face interaction allows us to follow-up on the inquiries, get clarifications, and examine further into participant response. Also, their facial expressions and body language give their vocal responses additional meaning.

The aims and purpose of the study were integrated into a semi-structured interview guide with open-ended questions. The guide was created after a thorough evaluation of the recent existing literature(65-68) in the mental health arena and consultation with my project supervisor. The interview guide comprised of questions related to demographic information of the participants, their understanding, thoughts and beliefs about mental illness and people living with mental illness, and their willingness in interacting or associating with mentally ill patients.

Mental illness, here referred to the category based on International Classification of Diseases-10 (ICD-10) classification (organic disorders, schizophrenia, mood disorders, neurotic, stress-related and somatoform disorders, behavioral syndromes, mental retardation or other diseases of nervous system)(69). The questions from the interview guide revolved around i) how the participants defined and understood mental illness, ii) what they thought was the cause for mental illness, iii) understanding of how mental illness can be diagnosed, iv) how the illness can

be managed and if recovery was possible, v) how the society influences their perceptions, and vi) what can be done to bring change in the scenario.

The interview guide was translated into the local language Nepali before being sent to the participants. A pre-test was carried out among the study population (with two participants from comparable backgrounds) to ensure the relevance, reliability and validity of the interview guide questions. The questions were modified based on the findings and feedback from the pilot study.

The interviews were carried out in the hospitals where the participants are working. For nurses, the nursing station rooms were used, whereas for the doctors, their office rooms were used. Prior to conducting the actual interview, the objectives of the study were dictated to the participants orally and in written form. The duration of the interview lasted for around 35 minutes for each participant. Privacy and confidentiality were maintained. The responses from the participants were audio-recorded using a mobile phone. I also did note-taking side-by-side when needed.

The interview guides are available on Appendix V (in English) and Appendix VI (in Nepali).

3.1.5 Data analysis and interpretation

The audio recordings from the interview were transcribed immediately after the completion of each interview. After the transcribing was done, quality reviewing of the transcribed text was done by comparing certain portions of the text against the recorded audio and with the notes I had taken. I gave fictional names to the participants for the purpose of anonymity. The transcribed text was then translated into English. I crosschecked and edited the translation rigorously before moving on to coding and analysis. For the purpose of analysis, I used Excel as well as NVivo 12, which is a revolutionary qualitative data analysis software.

Reflexive thematic analysis (reflexive TA), as described by Braun and Clarke [34], was used to inductively code the data. I used this approach to thematic analysis since it is a versatile method for finding patterns and themes within the data. It also provides an extra layer of self-awareness and reflexivity by recognizing the researcher's participation in the analytical process.

The recursive process of reflexive TA consists of the following 6 phases: Data familiarization, systematic coding, generation of the initial themes, development and review of the themes, definition and refinement of the themes, and writing of the findings. The first stage is to immerse

oneself in the data and become thoroughly acquainted with it. I read and reread the transcribed material several times to obtain a full understanding of the text and context. I highlighted the interesting segments and started generating codes by going through each text.

I ensured that the codes aligned with the purpose and the findings of the study. For instance, the quote "*..you never know what's gonna happen when the patients are violent*" was coded as 'unpredictability'. Similarly, "…*I think as long as you love the person, you should have the patience to be with the person throughout their difficult times*.." was coded as 'support and acceptance'.

After generating codes from each transcript, I reviewed and arranged the similar codes together, making modifications to the codes where needed. Then I grouped the codes into potential themes, coming up with 12 initial themes, which reflected the participants' perspectives. These were a) PWMI are those who need help, b) Mental illness is not just depression, c) Symptoms can be physical or psychological, d) Mental illness is unpredictable, e) The family is responsible for caretaking, f) Fear towards PWMI, g) Helping PWMI to cope with the illness, h) Having mental illness in the family, i) Marriage with PWMI, j) Life can be challenging for PWMI, k) Recovery is possible, and l) Societal influence.

I revisited these themes and reflected on it, removed the redundant ones, and merged the themes that could go together. To make it more precise and relevant to the study, some of the themes were adjusted based on the research question and objectives of the study.

3.1.6 Ethical considerations

Exemption from ethical clearance in Norway and Nepal were obtained from the respective ethical committees. The ethical approvals were received from Regional Committees for Medical and Health Research Ethics (REK) in Norway and Nepal Health Research Council (NHRC), which is the national ethical body of the government of Nepal.

Prior to recruitment and participation, all respondents were briefed about the study and asked for verbal consent. All responders were briefed orally about the study's background, protocol, and goals, as well as that their information would be kept confidential and that they were not receiving any compensation to participate. Then, before conducting the interviews, I mailed them the participant information sheet and written informed consent form, which they signed and sent

it back. The participants were also provided with the freedom to withdraw from the study at any point in the process.

To maintain fairness, health personnel from both private and public hospitals were enrolled. Before audio-recording and note-taking, verbal consent was taken from the participants. To ensure anonymity, respondents have been assigned fictitious names in the transcription as well as the report writing. The information provided by the participants has not been disclosed outside the study. The audio recordings, transcriptions and field notes from the participants are stored securely with only me and my supervisor having access to it.

Positioning and reflexivity

It is important to note that me coming from similar background and sociocultural context as the participants might have influenced the data collection process. I come from a healthcare background and have several experiences with mentally ill people in the research setting. My experience as a nurse provides me an insider perspective into the healthcare industry of Nepal, allowing me to better comprehend the dynamics and experiences of healthcare professionals.

It is indisputable that I have my own biases and preconceived notions which might have had an influence over the data collection as well as the analyzing process. It is likely that my beliefs, values, and opinions might have an impact on how the findings are interpreted. However, I did not have an intention of 'testing' a certain theoretical premise while conducting the research. I was as unbiased as possible during the conversations, allowing participants to talk freely and remaining open to unanticipated points of discussion.

Since I was conducting the interviews myself for the data collection, I was aware about maintaining neutrality while interacting with the respondents. I was constantly challenging my own assumptions and being objective during the data collection, analysis and interpretation.

To address and minimize these issues, in this study, I have positioned myself solely as a researcher and not as a nurse from Nepal, having prior information and experience about mental illness.

CHAPTER IV

4.1 FINDINGS

This chapter provides the overview of the findings from this qualitative case study that was conducted in Kathmandu, Nepal among doctors and nurses with the aim to explore their understanding and perspectives about mental illness.

Twelve healthcare workers in total were questioned for the study: eight females and four males, with five of the subjects being medical officers and seven nurses. None of the participants had any specialization in mental health.

Table 1. Sociodemographic characteristics of the participants

Name of participants (fictitious)	Gender	Age	Education level	Work experience (years)	Department
Riya	F	27	Bachelor	4	GMW
Neha	F	29	Bachelor	6	ICU
Madan	M	29	Bachelor	4½	ICU
Poonam	F	22	Bachelor	3	ICU
Keshav	M	31	Master	5	ICU
Anu	F	27	Master	2	GMW
Sujata	F	23	Bachelor	2	GMW
Sunil	M	33	Master	5	GMW
Srijana	F	24	Bachelor	2½	GMW
Shiwani	F	22	Bachelor	1	GMW
Elina	F	27	Bachelor	3	GMW
Amrit	M	26	Bachelor	4	GMW

GMW: General Medical Ward

ICU: Intensive Care Unit

Their mean age was 27.22, with ages ranging from 22 to 33. They have been working in intensive care units and medical wards of different private and government hospitals in Kathmandu, Nepal.

The findings were interpreted after refining the initial themes emerging from the data analysis phase based on the research question/objectives of the study. Six major themes were finalized which were further classified into 15 sub-themes.

Table 2.Themes and sub-themes

THEMES	SUB-THEMES
Understanding of mental illness	Mental illness is not just depression.
	Mental illness is not visible.
	Stressful events cause mental illness.
	It's about the mind being exhausted.
Interactions with PWMI	PWMI can be violent and dangerous.
	It is hard to understand the mentally ill
Acceptance	It can happen to anyone.
	Recovery is possible.
Being associated to PWMI	It is the disease and not the person.
	Caretaking can be arduous.
	It is an additional burden.
	Marriage could be difficult.
Societal influence	Stigma is induced by social disapproval.
Need for change	Improving accessibility and affordability
	Awareness on mental health

Mixed responses were obtained from the participants regarding their understanding of and views about mental illness/PWMI. Since the participants come from a healthcare background, their perceptions are, to some extent influenced by their academic and professional experiences. People's understanding and perception of things are shaped through the interaction with their

sociocultural environment and they try to connect it to their pre-existing interpretation of things(23). So, it is important to emphasize that the findings are influenced by the deeply embedded societal construct among many other underlying factors.

1. Understanding of mental illness

The participants more or less had a similar understanding of what mental illness is. Majority of the participants perceived mental illness as any deviation from normal behavior and person with mental illness as someone who needs help. Here, 'normal behavior' was interpreted by the study subjects as being able to perform daily activities without any difficulty, having the ability to make decisions on their own and being able to normally cope with anxiety and stress.

Similarly, the respondents appear to have a solid grasp of the causes, prophylaxis, and treatment of mental disorders. It was widely believed that mental illness had its own physiology, much like physical disorders, and was brought on by changes in the brain functions. These changes were attributed to stress, life-altering experiences, loss of someone or something, social failings, etc. They also stressed on the fact that mental illness could happen to anyone at any time and should be treated similar to physical illness. Participants also noted that the nature of symptoms accompanying the illness created caretaking challenges for the caregivers.

1.1 Mental illness is not just depression.

The study subjects expressed that mental illness does not have a fixed presentation, but its sign and symptoms can range from being subtle to severe. While depression is assumed to be the sole mental disorder in Nepalese communities, the participants were quite aware of the range of mental illnesses and their presentations. Some participants were more specific about the categories of mental illness.

Riya (female, 27): "*I think mentally ill person is someone who needs help…it can be medical help, help in carrying out daily activities..also needs emotional support. It can range from mild to severe...from depression to psychotic illnesses such as schizophrenia. From what I know, depression is more common and has less impact on the daily life activities..with psychotic illnesses, people can be harmful towards self and also others. I have seen them being more aggressive and violent. I think it's just how the physiology of the illness is.*"

Shiwani (female, 22): "*It includes hallucination or delusion…in case of psychotic illness. It's not just about being depressed..there are many forms of mental illness. Like you see or believe in things that do not exist or that is not real, you hear voices or see things that are not present. If it's neurotic, then there's anxiety or panic disorders…also phobias.*"

1.2 Mental illness is not visible.

The majority of participants stated that, unlike physical sickness, mental illness has no observable indications or symptoms. It was seen as a problem with mental functions, which affect the mind rather than the body. The participants' shared experiences suggested that being violent or aggressive was the sole physical sign of being mentally ill. Thus, when asked about how mental illness could be diagnosed or assessed, the respondents stated that it was possible only through talking to the patients and trying to understand how they are feeling, rather than by observing them from outside. In a healthcare setting, the evaluation was performed by determining if the patients are well-oriented to time, location, and person.

Poonam (female, 22): "*With other physical illnesses, we can visually know what the issue is, but with mental illness, it cannot be seen from the outside…we have to understand their inner feelings and emotions."*

However, contradictory to this, two of the participants mentioned that there are physical symptoms as well, which is similar to having any physical illness. Common symptoms of mental illness that were reported were violent behavior, restlessness, social isolation, loss of appetite, et cetera.

Neha (female, 29): *"There are psychological as well as physical symptoms, such as being violent or screaming/shouting…some even stay isolated, not willing to talk to anyone or eat anything….not sharing one's feelings…being depressed, crying…"*

Elina (female, 27): *"I mean you can guess just from looking…if you see that someone is staying isolated or seems to be lonely..does not talk to anyone or avoids being with friends/family, then that person might be at risk of developing mental illness."*

1.3 Stressful events cause mental illness.

Regarding the study participants' perception of causative factors, there was a consensus that stressful or unexpected life experiences, which have an impact on people's emotional makeup, are the root causes of mental illness. Participants often identified external factors, such as stressful experiences (losing a loved one or a valuable object or facing an unexpected threat), as potentially having a significant negative impact on mental health and resulting in mental illnesses.

Keshav (male, 31): "…*when people cannot cope with the sudden changes in their life…like something that causes a lot of stress, then it might affect their mental health..they might go into depression or develop other mental disorders*."

Sujata (female, 23): *"Sometimes, if something unpleasant happens and you get stressed..like you cannot control your emotions…and people also keep their feelings to themselves and when it keeps piling up, the person can take it no more.. so that might also cause mental illness."*

1.4 It's about the mind being exhausted.

One of the participants had a peculiar response about the causes of mental illness. She mentioned that people contract mental illness when there is an overload on the mind, and it cannot function as it should.

Srijana (female, 24): *"I think if you are putting a lot on your mind..like thinking beyond what your mind is capable…like when we do a lot of physical work, our body gets tired..so I think the mind is also not able to process the things well when we keep putting a lot of pressure on the brain."*

2. Interactions with mentally ill people

2.1 PWMI can be violent and dangerous.

Fearfulness and repulsion towards mentally ill people were the commonly observed phenomenon among the participants. Majority of participants stated that they did not feel safe to be around mentally ill patients since they could be violent or attacking. This came from the experiences they had from the healthcare setting as well as from what they had witnessed in their social circle.

Riya (female, 27): *"I have been attacked by a mentally ill patient during psychiatric posting…it was me and my friends..we were about to assess the vital signs. Suddenly the patient snatched the tray from me. And he started chasing us.. it was a case of alcoholic psychosis. I still get scared cause sometimes you never know what's gonna happen when the patients are violent."*

Anu (female, 27): *"So you try to understand the person and be patient with them. But as they start getting violent or get out of control, you just give up..you don't have the endurance to put up with their behavior."*

Participants also expressed the fear of the unknown, backing up with their belief that PWMI can be unpredictable. They explained that since their brains do not function properly, they do not have the capacity to control their behavior or actions.

Elina (female, 27): *"When someone is mentally ill, their minds are not functioning well, and they do not have control over what they are doing. I am not trying to say that it's their fault.. the disease itself makes them violent towards self and others."*

2.2 It is hard to understand the mentally ill.

Derived from the experiences with mentally ill people, the participants exclaimed that often, they find it hard to relate with them because of the different clinical features the illness has. The subjects specifically mentioned signs such as hallucination and paranoia.

Keshav (male, 31): *"…even if you try to be close with them or talk to them, it's hard to relate to them because of the symptoms they are having. You ask something and they respond with something else..and sometimes you lose your patience.."*

3. Acceptance

3.1 It can happen to anyone.

The participants mentioned that people with mental illness are similar to any other person without mental illness and they should be treated the same as others. If appropriate medical help is sought promptly and compliance is maintained, one can get back to their regular lives and function like any other person.

Sujata (female, 23): *"….should be treated similar as other illnesses, without discrimination…and it is not a bad thing to have mental illness. It can happen to anyone at any given point of time..it*

is unpredictable and unavoidable..It is not a condition that should be viewed with discrimination."

3.2 Recovery is possible.

It was a common understanding among the study subjects that recovery from mental illness is completely attainable given that the patients comply with the treatment modules and are willing to help themselves. Participants shared that they had observed numerous instances of mental illness where individuals had recovered and returned to their regular life after receiving medical treatment and therapy.

Srijana (female, 24): *"…so there was an old guy who used to live in my neighborhood …all of a sudden, he started behaving weird. He wouldn't interact much with people, and even had problems with his wife..he used to doubt that his wife was having an affair with someone. When the situation got worse, his children took him to the mental hospital. Later..I think after few months, he was again back to normal..I know he was still taking medications and going for psychotherapy but it was a lot better than before.*"

4. Being associated to PWMI

4.1 It is the disease and not the person.

The participants believed that as with any physical illness, it was the family's responsibility to take care of the mentally ill, no matter how severe it is. Acceptance, understanding, and reinforcement of the family member's worth were critical components mentioned by the study participants. There was a belief that healthy family relationships might generate the physical and emotional support that is critical to the person living with mental illness's health outcomes.

Anu (female, 27): "*…you have to understand that they are not doing it intentionally..it's the disease that is making them act in that way…you have to understand what their needs are..which is obviously very hard."*

Sunil (male, 33): *"Once you call them family, I think it's your responsibility to take care of them, no matter what illness they have..and you have to come together as a family. I mean it is a burden in some way since you have to take care of the person, but that doesn't mean you just let them be…you have the responsibility to make sure the person is supported in all aspects."*

4.2 Caretaking can be arduous.

Despite the acceptance towards PWMI, some participants did admit that it would be challenging to look after the mentally ill. The primary concerns were about having to dedicate more time and money for the member's care. This was also about not having enough manpower to care for the sick individual, which was an issue cited by many. One member of the family had to devote all of their time to overseeing the sick person's diet, hygiene, and medications.

Neha (female, 29): *"I don't think everyone should be always invested on that one person. We also have our own routines and daily life, so it should be made sure that that is not impacted…I actually mean to say that you have to allocate some extra time to look after the person...with the income we have, it is hard to manage the finances. And there is no support from the government."*

4.3 It is an additional burden.

Having someone with mental illness was viewed as an unanticipated burden. Given the lack of emphasis placed on mental health, it was assumed to be at the bottom of the list of priorities.

There were also accounts of the families suffering several losses, including the loss of active employment. When a member of the family is sick, they lose not just that person's labor but also that of the caregiver. It was highlighted that due of their functional levels, those severe mental illness are typically harder to care for than those with other disorders.

Amrit (male, 26): "*..so, first thing, it is quite rare that they would be so aware about mental health. So if some family is dealing with financial issues or they have some conflict within the family, it is very unlikely that they will even think about seeking help for mental illness. When they are already struggling with money or their basic needs, would they be bothered about mental health? Obviously not."*

Similarly, participants also shared it being hard on the family members since they are frequently judged, shunned, and secluded from the community if someone has mental illness in the family. They emphasized on sensitization of the community people about mental illness so that it would help to change the views.

4.4 Marriage could be difficult.

There have been some reservations about getting married to a mentally ill person because doing so presents a number of difficulties for both the patient and their partner. However, the participants did say that as long as it's not severe, being married to someone who has mental illness would not be a remarkable concern.

Sujata (female, 23): "*...so the marriage I think depends on whether it is a minor illness or a major one. If it's a minor illness, then I don't think there would be a problem. But if it's something like psychosis or neurosis, then I think it will be quite tough...as it comes with many challenges. Like for example, it is easier for people to come out of depression..but if someone has bipolar disorder or schizophrenia, dementia, it's difficult for the person as well as their partners."*

Some of the participants also mentioned that as long as the person is willing to seek medical help and is complying with the treatment, it would not be an issue to marry a person with mental illness.

Madan (male, 29): *"I don't think it is a sin or a crime to get married to someone with mental illness. Mental illness can always be treated and it is not a big deal for the person to take medications or seek treatment. It is similar to taking medications for other physical illnesses, such as cancer. I do not think it matters if the person has mental illness or not as long as they are seeking help and being treated."*

5. Societal influence

Concerns regarding help-seeking, timely treatment and compliance were cited by the healthcare providers when it came to people living with mental illness. This was attributed to people not feeling safe enough in their social environment to open up about the illness.

5.1 Stigma is induced by social disapproval.

Since healthcare providers are a part of society, their values and beliefs are highly influenced by how the community perceives things. And when it comes to mental illness, the situation is even worse. Since it is a topic of stigma in the Nepalese society(27), people hesitate to talk about it, or to take it as a health emergency. This is a result of illiteracy and lack of awareness that persists in society. And this has been a leading contributor to the delay in treatment seeking behavior.

The participants, though involved in the healthcare profession, considered societal stigma as one of the main factors for influencing their perceptions about mental illness and thought it was unavoidable.

Anu (female, 27): *"The society I come from, it's extremely difficult when it comes to mental illness. The way people with mental illnesses are treated and its perception is completely different from physical illnesses. People think it is a curse to have mental illness. Like it is the result of the gods being unhappy...And even if someone is mentally ill in the family, they refrain from bringing it out in the open…they get scared that they might be isolated from the society or looked down upon…"*

Srijana (female, 24): "*The thing is, you cannot easily let go of how your mindset has been shaped. No matter how well-educated you are or how aware you are, sometimes you just get influenced by the environment around you or by how you have been brought up. And for us…like for Nepali people, given our social values and our culture, there are several myths that causes mental illness to be seen as a sin.*"

One of the participants also shared about how her schooling helped her develop sympathy and change her perspectives about people with mental illness.

Neha (female, 29): "*Before I studied nursing, I used to have negative views about PWMI. I used to think they are mad…'dimag khuskeko huncha ni (one who has lost their mind)'. Because that is how mental illness was viewed as…and still is. But when I think about it now, I feel really bad."*

6. Need for change

The majority of the respondents were concerned about mental health not receiving as much attention as needed. For instance, respondents claimed that the Ministry of Health lacks a functioning division or regulatory framework for mental health. Concerns were also raised regarding the lack of funding for mental health. Several respondents stated that the health facilities had not been responsible or attentive to the population's demands for mental health due to a lack of adequate monitoring procedures.

6.1 Improving accessibility and affordability

According to respondents, having only one mental hospital at the national level is not enough to meet the demands of the nation. They also reported that because of the mental health services being centralized in the capital city, there is lack of inclusivity for people living in the rural areas. Similarly, limited services provided through the government health facilities is another barrier to making mental health accessible.

Madan (male, 29): *"…like if you have the services available to you, people will be willing to get treated. But in case of mental health…okay, so firstly there are very few mental health institutions…we have this one government hospital..and there are private facilities, but most of them are just to make money..so what happens with the people living outside the valley? Or in far-eastern or far-western areas?*"

6.2 Awareness on mental health

Participants expressed a strong desire for improved mental health knowledge and dialogue around mental illness. Awareness raising was a common theme in response to identified difficulties, and it included various methods of imparting knowledge and stigma reduction campaigns. The approaches for stigma reduction employed by respondents were congruent with the local literature on the subject. They had a consensus regarding exposure of public to the physiology and management of mental illness by creating mass awareness about mental health.

The health providers shared how important it was for people to be made aware of the importance of mental health in order to eradicate the stigma and misconceptions associated with mental disorders. Also, they underlined the need for awareness among healthcare professionals and acknowledged that, whether consciously or unconsciously, they occasionally have a tendency to get carried away and stereotype about mental illness.

Keshav (male, 31): "*I see that we are far behind when it comes to the awareness about mental health…and we healthcare providers are no different. I will talk about myself..I used to call the mentally ill people 'baula' myself..before I entered the medical field. When I think of it now, it's so embarrassing…so I wouldn't blame the public for holding stereotypes*.."

Elina (female, 27): "*I think there's a need to address the myths and misconceptions about mental illness..especially in our community. It is sad to see how people with mental illness are treated.*

It's like a crime to be mentally ill…I think the government has to be accountable about this…like prioritizing mental health at national level and promoting mental health services. And those who are already aware…like us..we should be sharing the knowledge we have in our circle."

4.2 DISCUSSION

The findings of our study can be summarized under three main headings: 1. Understanding/perception of mental illness, 2. Perceived challenges/barriers, and 3. Need for change. Several similarities as well as discrepancies have been found between the findings of our study and several other documented studies. These will be discussed further down in relation to the existing literature from local as well as global contexts.

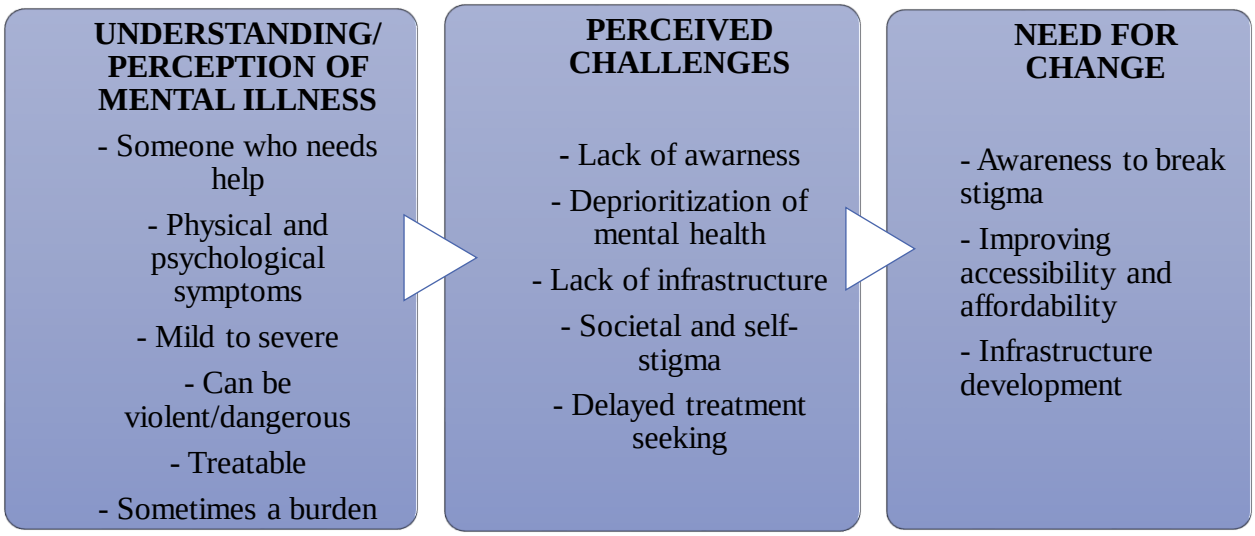

Figure 3. Summary of the findings of the study

Understanding/perception of mental illness

Many studies have been carried out globally using various measures to evaluate how health professionals view mental illness(24, 70). Not just among the general population, but even within the medical community, people with mental illnesses are subject to stigma and prejudice. And it is well-documented that the healthcare system is one of the key domains where people with mental illness encounter stigma and discrimination(71, 72). For example, persistent stigma associated with primary health care members who were expected to be frontline staff in the

delivery of treatment for mental health conditions was identified as one of the key barriers to the integration of mental health services in primary care in Zambia(73).

This study, however, has produced distinctive findings when it comes to stereotypes and stigma. Looking at the overall viewpoints of the participants on mental disorders, it is notable that the participants had positive views towards mental illness. This is in line with a meta-analysis conducted to assess changes in attitudes of healthcare professionals towards mental illness, which revealed that they had a positive outlook towards PWMI(57). Contact and familiarity with people who have had mental illness improves public perceptions, according to research(74, 75).

Except for a minority of responders, there is a good understanding of mental illness in terms of its physiology, symptoms, and management. Regarding the participants' perceptions, several encouraging discoveries have been made. They appeared to be accepting of those who suffer from mental illness and emphasized that their lives can be just as normal as anyone else's.

Higher education has been linked to fewer stigmatizing views towards those with mental illness, according to research from Lebanon(76). The duration of practice also has a greater role in acquiring a deeper understanding of the causes of mental disorders and a greater awareness of the rights of persons with mental illnesses as shown by a cross-sectional study from Qatar (77). Our study's findings were consistent with these findings, demonstrating that, with a few notable exceptions, healthcare professionals generally have a decent grasp of mental illness.

Therapeutic pessimism, which occurs when physicians are pessimistic about the probability of recovery, is also a cause of stigma in clinical settings(11). On contrary to this, our study participants revealed that mental illness can be cured if timely treatment/management is done, which also contradicts with the findings of a scoping review(78) and a qualitative study(68) conducted in Nepal.

But having said that, there are certain shortcomings too, when it comes to perceptions regarding encounters with mentally ill people. Fear of harm or threat has been a significant factor in the stigma associated with mental illnesses among Nepalese health personnel(79, 80), which is also one of the major findings of this study. Individuals who stigmatize the mentally ill have a propensity to keep their distance from them(81).

The hesitation in interacting with mentally ill is something that is supported by some other studies as well(82, 83). Primary care providers in a multi-site qualitative study(68) mentioned difficulty in managing challenging scenarios including agitation or other behavioral concerns, as well as managing patients with drug problems. This is explained by the fact that healthcare providers view PWMI as violent or destructive. However, opposing to this, the psychiatric intern doctors in a study stated that not all patients in psychiatric facilities are violent and dangerous, that these individuals do comprehend the thoughts, feelings, and actions of others, and that given the right care, they are capable of leading fulfilling lives(47).

One of the studies(84) from Nepal presented a peculiar reasoning behind the unwillingness, where the primary care providers stated that they would be looked down upon by their colleagues if they interacted with or treated mentally ill patients. This is something that was not explicitly mentioned in our study, though they did share about the societal prejudices towards mentally ill people.

The respondents also voiced concerns regarding marriage to PWMI saying that it would be quite challenging given the severity of illness. The underlying reason for this again circled back to caretaking and family life being tough. The main stressors were the cost of living and the need for additional time and manpower. Some studies(85, 86) from Nepal have shown that the caretakers of mentally ill people are generally their parents or their children. This might explain that either mentally ill people struggle finding partners or they are abandoned by their partners.

The reluctance to get associated with PWMI is also attributed to the significance of moral characterization resulting in stigma. This is more prominent in Eastern societies when compared to the Western because of the cultural differences. The differences might include the understanding of the causation of mental illness, the help-seeking behavior, treatment preferences, the support from the family and community, et cetera(59). There is a greater degree of negative perception when it comes to acceptance of mentally ill people especially in the context of Asian countries. Consequently, this creates hindrances in seeking timely healthcare, accessing/receiving quality of care, and adhering to the treatment.

Perceived challenges

The contextual challenges that the participants have identified when it comes to mental illness are mainly around the lack of infrastructures, the devaluation of mental health and the

stereotypes and stigma surrounding mental illness. Mental health being at the bottom of the priority list is the major concern, which is backed by the fact that there is no mental health legislation and extremely limited infrastructures to cater to mental health. Likewise, the lack of awareness on mental health is a barrier to busting the misconceptions about mental disorders.

The persisting societal stigma hinders treatment seeking as well as delivery of quality of care since the healthcare providers come from the same community. Stigma produces an adverse environment where people with mental illnesses feel anxious about prejudice, rejection, and unfavorable social judgement. They are frequently deterred by this fear of asking for assistance or being open about their struggles. Due to worries about their reputation for being a victim to mental illness, people may never seek treatment or stop receiving treatment(32). The societal stigma was one of the primary concerns among the health personnel as they shared that sometimes they are also biased towards the mentally ill people as they are bound by the values and norms of the society.

The challenges related to policy include failure to execute the mental health policy, the absence of a mental health act despite a fourth draft revision, and a lack of national-level engagement and participation in mental health policy creation and planning. Other limiting factors include insufficient mental health care human resources, lack of budget allocation to mental health care, lack of mental health services at the district and primary health care levels, and insufficient infrastructure for the delivery of mental health and psychosocial services(87).

There were concerns regarding mental healthcare not being accessible to all. Because of the lack of integration of mental health into primary health care and the lack of decentralization of mental health services, the people outside the capital city struggle to access and afford mental healthcare even if they are willing to. Similarly, having to pay for the services out of pocket makes it more challenging for the individuals to receive quality care.

Need for change

Existing evidence from studies worldwide indicates that there is a dire need to refute the myths regarding mental illness. Our study also advocates that it is vital for the public, especially those in the healthcare industry to be exposed to appropriate mental health education since they are accountable for the health and well-being of the people. This is also important in addressing self-stigma and help-seeking among the healthcare providers.

A four-day educational program for medical students and nurses in Nigeria(88) that offered basic knowledge on mental illnesses and treatments was proven to enhance attitudes post-assessment on three of four subscales. However, it is to be noted that one of the studies from Nepal pointed out that medical students' attitude of discrimination and maintenance of social distance did not change even after mental health education and training(48). The study suggested that adequate modification to the existing medical curriculum could bring about a change in the attitude.

The respondents from our study place a high priority on mental health and underline the necessity of raising awareness among both healthcare professionals and the general population. This contradicts with several previous studies conducted within Asia that claim healthcare professionals discriminate because they have preconceived notions about mental illness(89, 90).

It is equally essential for them to be trained with necessary skills, such as empathy and communication. Mental health education and training should be part of the curriculum for the general healthcare providers as well, and not just for mental healthcare professionals. Patients might not always have access to psychiatrists or mental health specialists, which is why it is important that even the non-specialized health personnel are familiar with managing mental health conditions. Earlier studies have demonstrated the effectiveness of psychiatry education in modifying medical students' attitudes toward mental illness(91).

A review and expansion of the current curriculum of general nurses and doctors is urgently needed(92) in order to develop the attitudes of empathy, respect, understanding, etc., and to reduce stigma toward psychiatry, which will lead to better patient care. This has been supported by one of the qualitative studies conducted in seven countries within Africa, Asia and Europe(68). The need for curriculum reform is also supported by one of the studies from Nepal(93) which assessed the Nepalese pharmaceutical students' perceptions regarding mental disorders.

Social contact intervention is deemed as an effective anti-stigma initiative to reduce stigma and stereotypes in healthcare settings. It enables the health providers to acquire empathy and a greater understanding of the effect of stigma by hearing firsthand stories of the obstacles experienced by people with mental illnesses(94). Personal contacts can help minimize anxiety and concern by demonstrating that people with mental illnesses are not harmful or unpredictable.

More than 500 experimental and observational research on social interaction have been conducted, with the majority finding a reduction in prejudicial thinking(14, 95). A qualitative synthesis of effective anti-stigma initiatives found several kinds of social interaction as one of the crucial factors(96). Researchers found a substantial change in Turkish medical students' views on three out of seven items following a contact of the students with a schizophrenic person. They were also made to watch a movie regarding people with schizophrenia(97).

The study by Kohrt B.A. suggested that getting primary healthcare providers to interact with mentally ill patients on a local level and getting them thoroughly involved in the treatment process facilitated attitudinal changes and improved clinical behavior. Similarly, the health workers who previously believed that mental illness could not be treated reported change in their assumptions after undergoing the training of social contact intervention(84). This is something that can be used as a strategy to bust the myth regarding mentally ill patients being dangerous and tackling the unwillingness to associate with them.

Health care professionals' views regarding PWMIs have improved as a result of the integration of mental health teams into primary care in LMICs in Asia, the Middle East, and Africa(98). In spite of the positive changes, there still persists mental health treatment gap in LMICs like Nepal, which can be effectively bridged by integrating mental health services into basic healthcare(99). The integrated approach promotes better access to mental health services, improved social integration, better health outcomes for patients receiving primary medical care, and increased mental health human resource capacity. Increased mental health budget allocations and the implementation of mental health acts also needs to be prioritized(100).

It has been revealed through the participants that the health system governance plays a major part in tearing down the stigma and stereotypes around mental illness. The correct execution of the mental health policy measures is required to assure access to and usage of mental health services as well as to reduce the treatment gap. And for effective healthcare delivery, good governance is necessary with strong leadership(101).

Similarly, media also plays a huge role in combating the mental illness stigma among healthcare providers. Targeted awareness campaigns can be run to disseminate information regarding mental illness can help to reduce the existing stereotypes(83). In the current scenario, social media can be utilized to launch campaigns related to mental health awareness. Collaboration

with social media influencers and content producers in the healthcare industry may increase engagement and impact.

4.2.1 Applicability of theoretical framework

We aimed at highlighting the perspectives of the stigmatizer through this study, by exploring perceptions and beliefs of healthcare providers. Components of stereotypes, prejudice and discrimination were investigated to gain a thorough outlook of factors that are ingrained among the healthcare professionals which is contributing to mental illness stigma. This is because we assumed that there was a stigma associated with mental illness among healthcare practitioners. This was somewhat justified because of some of the stereotypes persisting among the doctors and nurses, but it did not fully incorporate the interpretations of our study. The findings suggested that despite the influence of the societal view of mental illness, the nurses and doctors still place a high value on mental health, and are concerned for people living with mental illness.

Stigma appears to be generated in both high- and low-income nations by misconceptions relating to mental illness etiology, stereotypic ideas, and a lack of healthcare infrastructures to adequately support integrated mental health systems. While the prevalence of stigma may be comparable across countries, the experience of someone with mental illness in a high-income country will be different from that of someone in a low-income country where mental health systems are rudimentary, rampant human rights violations may persist, research on best practices is lacking, and local advocacy structures are non-existent(102). We can take the example of how schizophrenia was understood across the world in the past. In Western societies, it was seen as something being wrong with the brain and able to be treated with medicines. While in the other parts of the world, it was seen to be caused by spiritual factors(103).

In contrast to affluent nations or communities with various sociocultural origins, our study, which was done in an Asian setting in a developing country, had peculiar findings. Though it can be seen that some of the perceptions of the participants have been influenced by the community's values and beliefs, there are some commendable findings which show a brighter future for the healthcare industry in Nepal. The respondents believe that society has an impact on how people perceive mental illness and how it shapes their behavior. Yet, they feel that greater awareness is

needed to break down the prejudices and myths about mental illness that persist in their communities.

It was commonly believed by the participants that mental disorders are curable and anyone with mental illness could go back to their regular lives if treatment was sought on time. The health personnel were also mostly positive about being associated with mentally ill people and showed enthusiasm towards helping them get better. This points out that apart from the societal values and norms, there are other factors which may have an influence on how individuals perceive certain phenomenon. In the case of our study participants, these factors are educational level, personal and professional experiences, and ethical beliefs and values.

4.3 STRENGTHS AND LIMITATIONS

Talking about the trustworthiness of the study, it is very pivotal to discuss the major components of qualitative study, i.e. credibility, transferability, dependability, and reflexivity(104). As discussed by Guba and Lincoln (cited by Korstjens I), credibility is achieved through prolonged engagement, triangulation, peer debriefing, persistent observation, negative case analysis and member checks. To enhance dependability, the research process must be logical and transparent.
This research study presents a broad overview of how health service workers' views on mental illness are shaped by their experiences, backgrounds, or the sociocultural setting. I employed rigorous research methodology with appropriate techniques of data collection i.e. in-depth interviews and well-defined data analysis process, i.e. thematic analysis(105). This helped to elicit rich and extensive insights from the participants and examine the depth and complexity of their experiences, viewpoints, and meanings. This inductive approach also made it possible to explore the study matter in an objective and grounded manner.

In order to make sure that the participants' perspectives were accurately represented, data saturation was ensured during the data collection phase. The use of verbatim quotes from the participants in the findings section also enhances the credibility of the study. From data collection to research findings, there is a detailed account of the research process, thus aiding thick description. The study provides a detailed description of the research setting, the participants and the researcher's role. Similarly, there is a comprehensive overview of the data

collection and analysis (transcription, coding, theme generation, et cetera) to assist readers in understanding how these might have influenced the research findings.

To validate the findings from the study, member checking was carried out with one of the participants and adjustments were made accordingly. Along with that, peer debriefing was done by one of the master students, who is also carrying out qualitative research in a similar setting in Nepal.

The participants were well-assured about confidentiality and a good rapport was established so that they would not hesitate in sharing sensitive or personal information. Similarly, open-ended questions were used to minimize participant bias. Nonetheless, as health professionals, the participants are expected to have good knowledge and attitude towards mental illness in general. It is possible that they might have concealed the negative feelings or experiences towards PWMI. So, there is a possibility of social desirability bias as the participants were aware of my health/medical background. One of the other limitations is the lack of triangulation since only one method of data collection was used in the study, restricting the cross-checking and validation of findings across multiple sources.

Since only a few healthcare institutions (private and government) were included in this study, the perspectives expressed by participants may not entirely represent the perceptions of all healthcare professionals working within Kathmandu (the capital city). It also lacks the inclusion of healthcare providers serving outside the capital, thus diluting the profoundness of the findings to some extent. The other limitation is that only the doctors and nurses from the medical ward and ICU have been recruited, because of the use of snowball sampling. Furthermore, the sample size was quite small, and the study only includes the perspectives of healthcare providers and not of the service users.

Nevertheless, the findings of the study are transferrable to similar settings within Nepal or within South Asia. It is applicable to healthcare settings in areas with similar cultural, socioeconomic and political backgrounds.

4.4 IMPLICATIONS

The findings from this study have several implications and relevance for the planning and delivery of mental health services in Nepal. It sheds light on critical concerns such as mental health awareness, help-seeking and mental healthcare delivery in a low-income country that is currently under-researched. From implementing the mental health policy and restructuring the health system to facilitating the flow of factual information about mental illness, there is much to do at the local as well as the national level.

The study findings are valuable for identifying trends that apply to several healthcare settings, or among different healthcare professionals. This information can help shape targeted interventions and policies to address these trends. The findings also have significance for planning out clinical recommendations that focus on non-stigmatizing language, attitudes and practices while treating patients with mental health issues. There is also possibility for collaboration with advocacy groups, lawmakers and mental health institutions to develop targeted stigma-reduction campaigns and policies.

It is also very crucial to stress upon the study's significance to advocate for mental health education. The research findings can help shape educational initiatives that aim to challenge preconceived notions and increase mental health literacy among the non-specialized healthcare workers. This could benefit medical and nursing education by preparing the future healthcare professionals to deliver compassionate and objective treatment by incorporating mental health awareness components into curriculum.

Our study also highlights the importance of restructuring and strengthening the national mental healthcare system. First and foremost, the mental health act needs to be put into implementation. The policies that have been drafted need to be given life, with the establishment of a separate mental health body under the Ministry of Health. There is an urgency for the government to collaborate with different stakeholders to rapidly strengthen the mental healthcare system by integrating it into the country's health system.

Several long-term initiatives can include (1) redesigning the current health system to better integrate mental health into primary health care; (2) enhancing the health infrastructures in geographically challenged places; (3) investing more funds for mental health, and (4) creating

and implementing accountability and transparency measures. Non-governmental organizations (NGOs) and the commercial sector might play significant advocacy role for creating a central coordinating unit for mental health in order to accomplish this(106). The case of Afghanistan demonstrates the critical role that NGOs and outside development partners played in the establishment of a mental health department(107).

Provisions should be established for the decentralization(108) of services outside of the capital Kathmandu so that healthcare is accessible to all. This strategy to decentralize mental health care has also been advocated in other post conflict settings such as Burundi(109), Uganda(110) and Lebanon(111). It is necessary to deliver mental health services at the regional, district, and local levels with every healthcare facility having a psychiatric unit. They must be included in all tiers of general healthcare, including primary care. The allocation of mental health resources must follow the mental health policy, and a sufficient supply of vital psychotropic medications must be kept on hand.

4.5 RECOMMENDATIONS

Limited studies have been conducted in Nepal, which explore the mental health arena in relation to the healthcare professionals. Our study, because of its limitations, has not been able to capture the complete scenario. However, it opens the possibilities of a variety of scientific and public health advantages.

Through this study, we can suggest additional research to compare and contrast the opinions of healthcare practitioners and service users in order to get a holistic view and draw deeper conclusions. Deeper exploration can be done into identifying the underlying factors (gender, age, socioeconomic status, et cetera) that influence the perceptions of healthcare providers.

Similarly, comparative studies can be carried out to assess the degrees of stigma and stereotypes in various healthcare settings (such as public vs. private hospitals) or geographic areas. This can help identify contextual elements that promote stigma and guide focused interventions. There is also room for comparing the views and perceptions of non-psychiatric professionals with that of psychiatric professionals.

There is also potential to employ a mixed methods approach which offers a comprehensive exploration of the mental health scenario. It also enhances the credibility, validity and

applicability of the study findings. I also believe that more meaningful insights can be drawn by combining various methods and techniques for data collection, such as observation, document reviews and interviews. This can help to investigate how healthcare providers perceptions impact patient outcomes, help-seeking, treatment adherence and overall well-being.

A further study with healthcare staff from different backgrounds (such as primary healthcare providers, community health workers, health assistants, et cetera) is needed to get a detail nationwide picture that can be implemented in future academic and professional practice.

4.6 CONCLUSION

It can be concluded from the findings that healthcare professionals (nurses and medical officers) working in the health institutions in Kathmandu (Nepal) hold an overall good understanding about mental illness, its physiology and management. They perceive mental illness as any other physical illness meaning that equal amount of care, support and acceptance is needed for people with mental illness.

However, despite being trained as health professionals and holding good knowledge and experience with mentally ill people, there is some influence of their community's values and norms over their perceptions. How the society views the mentally ill as violent and dangerous was also reflected in their sharing since there was some hesitation in being associated to PWMI. Moreover, there were concerns regarding caretaking and allocating extra resources for the mentally ill person.

Whilst the study suggests that the healthcare scenario is quite favorable when it comes to mental health and mental illness, there is opportunity for enhancing the knowledge and comprehension of health practitioners when it comes to some of the misconceptions around mental disorders. This can be accomplished through a combination of teaching, training, and awareness-raising campaigns.

The findings suggest the need for increased mental health awareness, revision of curriculum for health providers and exercise various interventions to tackle the stereotypes and prejudices among health personnel and public. To emphasize the importance of mental health at the national level, policy implementation, monitoring, budgeting, and coordination across many sectors are essential.

REFERENCES

1. Association AP. What is Mental Illness?2018. Available from: https://www.psychiatry.org/patients-families/what-is-mental-illness.
2. Busfield J. Mental Illness: Wiley; 2011.
3. Organization WH. India: Mental Health Atlas 2011. Geneva: World Health Organization. 2011;3:2016-17.
4. Rathod S, Pinninti N, Irfan M, Gorczynski P, Rathod P, Gega L, et al. Mental health service provision in low-and middle-income countries. Health services insights. 2017;10:1178632917694350.
5. Cía AH, Stagnaro JC, Aguilar Gaxiola S, Vommaro H, Loera G, Medina-Mora ME, et al. Lifetime prevalence and age-of-onset of mental disorders in adults from the Argentinean Study of Mental Health Epidemiology. Social psychiatry and psychiatric epidemiology. 2018;53:341-50.
6. Alloh FT, Regmi P, Onche I, van Teijlingen E, Trenoweth S. Mental Health in low-and middle income countries (LMICs): Going beyond the need for funding. Health Prospect: Journal of Public Health. 2018;17(1):12-7.
7. Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to improvement of mental health services in low-income and middle-income countries. The Lancet. 2007;370(9593):1164-74.
8. Mendenhall E, De Silva MJ, Hanlon C, Petersen I, Shidhaye R, Jordans M, et al. Acceptability and feasibility of using non-specialist health workers to deliver mental health care: stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. Social science & medicine. 2014;118:33-42.
9. Mukherjee S, Mukhopadhyay D. Stigma towards mental illness: A hospital-based cross-sectional study among caregivers in West Bengal. Indian Journal of Public Health. 2018;62(1):15-20.
10. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bull World Health Organ. 2004;82(11):858-66.
11. Knaak S, Mantler E, Szeto A, editors. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthcare management forum; 2017: SAGE Publications Sage CA: Los Angeles, CA.
12. Corrigan PW. Target-specific stigma change: a strategy for impacting mental illness stigma. Psychiatr Rehabil J. 2004;28(2):113-21.
13. Thornicroft G. Shunned: Discrimination against people with mental illness: Oxford University Press; 2003 01 Feb 2013.
14. Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O, et al. Mental health-related stigma in health care and mental health-care settings. The Lancet Psychiatry. 2014;1(6):467-82.
15. Heim E, Kohrt B, Koschorke M, Milenova M, Thornicroft G. Reducing mental health-related stigma in primary health care settings in low-and middle-income countries: a systematic review. Epidemiology and psychiatric sciences. 2020;29:e3.
16. Amatya R, Chakrabortty P, Khattri J, Thapa P, Ramesh K. Stigma causing delay in help seeking behavior in patients with mental illness. Journal of Psychiatrists' Association of Nepal. 2018;7(2):24-30.
17. Nepal Country Brief: Building a Peaceful Prosperous and just Nepal [Internet]. World Bank Group. 2016. Available from: https://www.worldbank.org/en/country/nepal/brief/nepal-country-results-brief.
18. Angdembe M, Kohrt BA, Jordans M, Rimal D, Luitel NP. Situational analysis to inform development of primary care and community-based mental health services for severe mental disorders in Nepal. Int J Ment Health Syst. 2017;11:69.

19. Kohrt BA, Turner EL, Gurung D, Wang X, Neupane M, Luitel NP, et al. Implementation strategy in collaboration with people with lived experience of mental illness to reduce stigma among primary care providers in Nepal (RESHAPE): protocol for a type 3 hybrid implementation effectiveness cluster randomized controlled trial. Implement Sci. 2022;17(1):39.
20. Service HN. Govt drafts new mental health policy. The Himalayan Times. 2017.
21. Upadhaya N, Jordans MJD, Pokhrel R, Gurung D, Adhikari RP, Petersen I, et al. Current situations and future directions for mental health system governance in Nepal: findings from a qualitative study. Int J Ment Health Syst. 2017;11:37.
22. Singh R, Khadka S. Mental health law in Nepal. BJPsych Int. 2022;19(1):24-6.
23. Subba S. Sociocultural Construction of Illness. Kathmandu, Nepal: Ms Usha Kiran Subba[Google Scholar]. 2007.
24. Shyangwa P, Singh S, Khandelwal S. Knowledge and attitude about mental illness among nursing staff. J Nepal Med Assoc. 2003;42:27-31.
25. Kohrt BA, Hruschka DJ, Worthman CM, Kunz RD, Baldwin JL, Upadhaya N, et al. Political violence and mental health in Nepal: prospective study. The British Journal of Psychiatry. 2012;201(4):268-75.
26. Dr Kapil Dev Upadhyaya VC, Shekhar Saxena. WHO-AIMS Report on Mental Health System in Nepal. Kathmandu, Nepal: WHO and Ministry of Health; 2006.
27. Nepal R, Doranga S, Timsina P. Knowledge and attitude on mental disorder among adults in Putalibazar Municipality of Syangja district of Nepal. Progress in Health Sciences. 2021;11:NA.
28. Rai Y, Gurung D, Gautam K. Insight and challenges: mental health services in Nepal. BJPsych International. 2021;18(2):E5.
29. Jordans MJ, Luitel NP, Kohrt BA, Rathod SD, Garman EC, De Silva M, et al. Community-, facility-, and individual-level outcomes of a district mental healthcare plan in a low-resource setting in Nepal: A population-based evaluation. PLoS medicine. 2019;16(2):e1002748.
30. Kohrt BA, Harper I. Navigating diagnoses: Understanding mind–body relations, mental health, and stigma in Nepal. Culture, Medicine, and Psychiatry. 2008;32:462-91.
31. Upadhyaya KD. Mental health & community mental health in Nepal: major milestones in the development of modern mental health care. Journal of Psychiatrists' Association of Nepal. 2015;4(1):60-7.
32. Koschorke M, Oexle N, Ouali U, Cherian AV, Deepika V, Mendon GB, et al. Perspectives of healthcare providers, service users, and family members about mental illness stigma in primary care settings: A multi-site qualitative study of seven countries in Africa, Asia, and Europe. PLoS One. 2021;16(10):e0258729.
33. Ihalainen-Tamlander N, Vähäniemi A, Löyttyniemi E, Suominen T, Välimäki M. Stigmatizing attitudes in nurses towards people with mental illness: A cross-sectional study in primary settings in Finland. Journal of Psychiatric and Mental Health Nursing. 2016;23(6-7):427-37.
34. Sheikhan NY, Henderson JL, Halsall T, Daley M, Brownell S, Shah J, et al. Stigma as a barrier to early intervention among youth seeking mental health services in Ontario, Canada: a qualitative study. BMC Health Services Research. 2023;23(1):86.
35. Dickens GL, Schoultz M, Hallett N. Mental health nurses' measured attitudes to people and practice: Systematic review of UK empirical research 2000-2019. J Psychiatr Ment Health Nurs. 2022;29(6):788-812.
36. Cleary M, Siegfried N, Walter G. Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. International Journal of Mental Health Nursing. 2002;11(3):186-91.
37. Masedo A, Grandón P, Saldivia S, Vielma-Aguilera A, Castro-Alzate ES, Bustos C, et al. A multicentric study on stigma towards people with mental illness in health sciences students. BMC Medical Education. 2021;21(1):324.

38. Bodner E, Cohen-Fridel S, Mashiah M, Segal M, Grinshpoon A, Fischel T, et al. The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. BMC Psychiatry. 2015;15:2.
39. Zolezzi M, Bensmail N, Zahrah F, Khaled SM, El-Gaili T. Stigma associated with mental illness: perspectives of university students in Qatar. Neuropsychiatric disease and treatment. 2017:1221-33.
40. Al-Awadhi A, Atawneh F, Alalyan MZY, Shahid AA, Al-Alkhadhari S, Zahid MA. Nurses' attitude towards patients with mental illness in a general hospital in Kuwait. Saudi journal of medicine & medical sciences. 2017;5(1):31.
41. Saad SY, Almatrafi AS, Ali RK, Mansouri YM, Andijani OM. Stigmatizing attitudes of tertiary hospital physicians towards people with mental disorders in Saudi Arabia. Saudi Medical Journal. 2019;40(9):936.
42. Dalky HF, Abu-Hassan HH, Dalky AF, Al-Delaimy W. Assessment of mental health stigma components of mental health knowledge, attitudes and behaviors among jordanian healthcare providers. Community Mental Health Journal. 2020;56:524-31.
43. Al Saif F, Al Shakhoori H, Nooh S, Jahrami H. Association between attitudes of stigma toward mental illness and attitudes toward adoption of evidence-based practice within health care providers in Bahrain. PLoS One. 2019;14(12):e0225738.
44. Ma Z, Huang H, Nie G, Silenzio VMB, Wei B. Attitude towards Mental Illness among Primary Healthcare Providers: A Community-Based Study in Rural China. Biomed Res Int. 2018;2018:8715272.
45. Poreddi V, Thimmaiah R, BadaMath S. Medical and nursing students' attitudes toward mental illness: An Indian perspective. Invest Educ Enferm. 2017;35(1):86-94.
46. Koirala D, Silwal M, Gurung A, Gurung R, Paudel S. A study to assess the knowledge regarding human right of mentally ill patient among community people in Kaski, Pokhara, Nepal. Journal of Gandaki Medical College-Nepal. 2019;12(2):40-5.
47. Shakya D. How intern doctors view ‘psychiatry and mental health’? Journal of Psychiatrists' Association of Nepal. 2018;7(1):32-9.
48. Jalan R. Attitudes of undergraduate medical students towards the persons with mental illness in a medical college of western region of Nepal. Journal of Nepalgunj Medical College. 2018;16(1):48-53.
49. Kisa R, Baingana F, Kajungu R, Mangen PO, Angdembe M, Gwaikolo W, et al. Pathways and access to mental health care services by persons living with severe mental disorders and epilepsy in Uganda, Liberia and Nepal: a qualitative study. BMC psychiatry. 2016;16(1):1-10.
50. Simkhada B, Sharma G, Pradhan S, Van Teijlingen E, Ireland J, Simkhada P, et al. Needs assessment of mental health training for Auxiliary Nurse Midwives: a cross-sectional survey. Journal of Manmohan Memorial Institute of Health Sciences. 2016;2:20-6.
51. Angdembe M, Kohrt BA, Jordans M, Rimal D, Luitel NP. Situational analysis to inform development of primary care and community-based mental health services for severe mental disorders in Nepal. International journal of mental health systems. 2017;11:1-16.
52. Pathak KP, Montgomery A. General practitioners' knowledge, practices, and obstacles in the diagnosis and management of dementia. Aging Ment Health. 2015;19(10):912-20.
53. Global atlas of the Health Workforce [Internet]. WHO. 2016.
54. Pelzang R, editor Attitude of Nurses towards Mental Illness in Bhutan2011.
55. Bos AE, Pryor JB, Reeder GD, Stutterheim SE. Stigma: Advances in theory and research. Basic and applied social psychology. 2013;35(1):1-9.
56. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, et al. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological medicine. 2015;45(1):11-27.

57. Lien Y-Y, Lin H-S, Tsai C-H, Lien Y-J, Wu T-T. Changes in Attitudes toward Mental Illness in Healthcare Professionals and Students. International Journal of Environmental Research and Public Health. 2019;16(23):4655.
58. Chapagai M, Dhungana S, Tulachan P, Ojha S. Attitudes towards Psychiatry and Mental Illness among medical students in a university hospital. Journal of Institute of Medicine. 2015;37(3).
59. Krendl AC, Pescosolido BA. Countries and Cultural Differences in the Stigma of Mental Illness: The East–West Divide. Journal of Cross-Cultural Psychology. 2020;51(2):149-67.
60. Glozah FN. Exploring Ghanaian adolescents' meaning of health and wellbeing: a psychosocial perspective. Int J Qual Stud Health Well-being. 2015;10:26370.
61. Shipley J, Luker J, Thijs V, Bernhardt J. The personal and social experiences of community-dwelling younger adults after stroke in Australia: a qualitative interview study. BMJ Open. 2018;8(12):e023525.
62. Creswell JW, Poth CN. Qualitative inquiry and research design: Choosing among five approaches: Sage publications; 2016.
63. Mesta C, Cremen G, Galasso C. Urban growth modelling and social vulnerability assessment for a hazardous Kathmandu Valley. Sci Rep. 2022;12(1):6152.
64. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52(4):1893-907.
65. Sichimba F, Janlöv AC, Khalaf A. Family caregivers' perspectives of cultural beliefs and practices towards mental illness in Zambia: an interview-based qualitative study. Sci Rep. 2022;12(1):21388.
66. van Ginneken N, Chin WY, Lim YC, Ussif A, Singh R, Shahmalak U, et al. Primary-level worker interventions for the care of people living with mental disorders and distress in low- and middle-income countries. Cochrane Database Syst Rev. 2021;8(8):Cd009149.
67. Slewa-Younan S, Krstanoska-Blazeska K, Blignault I, Li B, Reavley NJ, Renzaho AMN. Conceptualisations of mental illness and stigma in Congolese, Arabic-speaking and Mandarin-speaking communities: a qualitative study. BMC Public Health. 2022;22(1):2353.
68. Koschorke M, Oexle N, Ouali U, Cherian AV, Deepika V, Mendon GB, et al. Perspectives of healthcare providers, service users, and family members about mental illness stigma in primary care settings: A multi-site qualitative study of seven countries in Africa, Asia, and Europe. PLoS One. 2021;16(10):e0258729.
69. Organization WH. International Statistical Classification of Diseases and Related Health Problems. Geneva: World Health Organization; 2015.
70. Chang S, Ong HL, Seow E, Chua BY, Abdin E, Samari E, et al. Stigma towards mental illness among medical and nursing students in Singapore: a cross-sectional study. BMJ open. 2017;7(12):e018099.
71. Horsfall J, Cleary M, Hunt GE. Stigma in Mental Health: Clients and Professionals. Issues in Mental Health Nursing. 2010;31(7):450-5.
72. Thornicroft G, Rose D, Mehta N. Discrimination against people with mental illness: what can psychiatrists do? Advances in Psychiatric Treatment. 2010;16(1):53-9.
73. Kapungwe A, Cooper S, Mayeya J, Mwanza J, Mwape L, Sikwese A, et al. Attitudes of primary health care providers towards people with mental illness: evidence from two districts in Zambia. African journal of psychiatry. 2011;14(4):290-7.
74. Angermeyer MC, Matschinger H. The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders. Soc Psychiatry Psychiatr Epidemiol. 1996;31(6):321-6.
75. Corrigan PW, Green A, Lundin R, Kubiak MA, Penn DL. Familiarity with and social distance from people who have serious mental illness. Psychiatr Serv. 2001;52(7):953-8.

76. Abi Doumit C, Haddad C, Sacre H, Salameh P, Akel M, Obeid S, et al. Knowledge, attitude and behaviors towards patients with mental illness: Results from a national Lebanese study. PloS one. 2019;14(9):e0222172.
77. Ghuloum S, Mahfoud ZR, Al-Amin H, Marji T, Kehyayan V. Healthcare Professionals' Attitudes Toward Patients With Mental Illness: A Cross-Sectional Study in Qatar. Front Psychiatry. 2022;13:884947.
78. Gurung D, Poudyal A, Wang YL, Neupane M, Bhattarai K, Wahid SS, et al. Stigma against mental health disorders in Nepal conceptualised with a 'what matters most' framework: a scoping review. Epidemiol Psychiatr Sci. 2022;31:e11.
79. Neupane D, Dhakal S, Thapa S, Bhandari PM, Mishra SR. Caregivers' attitude towards people with mental illness and perceived stigma: a cross-sectional study in a tertiary hospital in Nepal. PLoS One. 2016;11(6):e0158113.
80. Mahato PK, van Teijlingen E, Simkhada P, Angell C, Ireland J, Mahato P, et al. Qualitative evaluation of mental health training of auxiliary nurse midwives in rural Nepal. Nurse Education Today. 2018;66:44-50.
81. Lauber C, Nordt C, Falcato L, Rössler W. Factors influencing social distance toward people with mental illness. Community mental health journal. 2004;40:265-74.
82. Lauber C, Rössler W. Stigma towards people with mental illness in developing countries in Asia. Int Rev Psychiatry. 2007;19(2):157-78.
83. Upadhyaya K. Mental health, mass media and stigma reduction. Journal of Psychiatrists' Association of Nepal. 2013;2(2):52-3.
84. Kohrt BA, Turner EL, Rai S, Bhardwaj A, Sikkema KJ, Adelekun A, et al. Reducing mental illness stigma in healthcare settings: Proof of concept for a social contact intervention to address what matters most for primary care providers. Soc Sci Med. 2020;250:112852.
85. Rai S, Gurung D, Kaiser BN, Sikkema KJ, Dhakal M, Bhardwaj A, et al. A service user co-facilitated intervention to reduce mental illness stigma among primary healthcare workers: Utilizing perspectives of family members and caregivers. Fam Syst Health. 2018;36(2):198-209.
86. Shamsaei F, Cheraghi F, Bashirian S. Burden on Family Caregivers Caring for Patients with Schizophrenia. Iran J Psychiatry. 2015;10(4):239-45.
87. Upadhaya N, Jordans MJD, Pokhrel R, Gurung D, Adhikari RP, Petersen I, et al. Current situations and future directions for mental health system governance in Nepal: findings from a qualitative study. International Journal of Mental Health Systems. 2017;11(1):37.
88. Iheanacho T, Marienfeld C, Stefanovics E, Rosenheck RA. Attitudes toward mental illness and changes associated with a brief educational intervention for medical and nursing students in Nigeria. Academic Psychiatry. 2014;38:320-4.
89. Chou H-J, Tseng K-Y. The Experience of Emergency Nurses Caring for Patients with Mental Illness: A Qualitative Study. International Journal of Environmental Research and Public Health. 2020;17(22):8540.
90. Tan GTH, Shahwan S, Goh CMJ, Ong WJ, Wei K-C, Verma SK, et al. Mental illness stigma's reasons and determinants (MISReaD) among Singapore's lay public – a qualitative inquiry. BMC Psychiatry. 2020;20(1):422.
91. Nayak A. Changing medical students' attitudes to psychiatry through newer teaching techniques. Mens sana monographs. 2015;13(1):180.
92. Poreddi V, Thimmaiah R, Math SB. Attitudes toward people with mental illness among medical students. Journal of Neurosciences in rural practice. 2015;6(03):349-54.
93. Panthee S, Panthee B, Shakya SR, Panthee N, Bhandari DR, Bell JS. Nepalese pharmacy students' perceptions regarding mental disorders and pharmacy education. Am J Pharm Educ. 2010;74(5).

94. Tergesen CL, Gurung D, Dhungana S, Risal A, Basel P, Tamrakar D, et al. Impact of Service User Video Presentations on Explicit and Implicit Stigma toward Mental Illness among Medical Students in Nepal: A Randomized Controlled Trial. Int J Environ Res Public Health. 2021;18(4).
95. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. BMC medicine. 2019;17:1-15.
96. Knaak S, Modgill G, Patten SB. Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. The Canadian Journal of Psychiatry. 2014;59(1_suppl):19-26.
97. Altindag A, Yanik M, Ucok A, Alptekin K, Ozkan M. Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. Psychiatry and Clinical Neurosciences. 2006;60(3):283-8.
98. Assad T, Okasha T, Ramy H, Goueli T, El-Shinnawy H, Nasr M, et al. Role of traditional healers in the pathway to care of patients with bipolar disorder in Egypt. International Journal of Social Psychiatry. 2015;61(6):583-90.
99. Stein DJ, Benjet C, Gureje O, Lund C, Scott KM, Poznyak V, et al. Integrating mental health with other non-communicable diseases. Bmj. 2019;364.
100. Imran N, Azee M, Javed A. Child and adolescent psychiatry in Pakistan: current scenario and future direction. World Child Adolesc Psychiatry. 2018;15:16-8.
101. Marais DL, Petersen I. Health system governance to support integrated mental health care in South Africa: challenges and opportunities. Int J Ment Health Syst. 2015;9:14.
102. Stuart H. Reducing the stigma of mental illness. Global Mental Health. 2016;3:e17.
103. Borch-Jacobsen M. Making psychiatric history: madness as folie a plusieurs. Hist Human Sci. 2001;14(2):19-38.
104. Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. European Journal of General Practice. 2018;24(1):120-4.
105. Barnett-Page E, Thomas J. Methods for the synthesis of qualitative research: a critical review. BMC medical research methodology. 2009;9(1):1-11.
106. Upadhaya N, Luitel NP, Koirala S, Adhikari RP, Gurung D, Shrestha P, et al. The role of mental health and psychosocial support nongovernmental organisations: reflections from post conflict Nepal. Intervention. 2014;12(Supplement 1):113-28.
107. Ventevogel P, van de Put W, Faiz H, van Mierlo B, Siddiqi M, Komproe IH. Improving access to mental health care and psychosocial support within a fragile context: a case study from Afghanistan. PLoS Medicine. 2012;9(5):e1001225.
108. Jordans MJD, Luitel NP, Tomlinson M, Komproe IH. Setting priorities for mental health care in Nepal: a formative study. BMC Psychiatry. 2013;13(1):332.
109. Ventevogel P, Ndayisaba H, van de put w. Psychosocial assistance and decentralised mental health care in post conflict Burundi 2000 – 2008. Intervention. 2011;9:315–31.
110. Baingana F, Mangen PO. Scaling up of mental health and trauma support among war affected communities in northern Uganda: lessons learned. Intervention. 2011;9:291–303.
111. Hijazi Z, Weissbecker I, Chammay R. The integration of mental health into primary health care in Lebanon. Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict. 2011;9(3):265-78.

APPENDICES

I. PARTICIPANT INFORMATION SHEET

Purpose of the project and why you are being invited to participate

Would you like to participate in a research project aimed at understanding the perceptions of non-psychiatric health professionals regarding mental illness and the factors contributing to it? We are looking for medical professionals who do not specialize in mental health, has never experienced mental illness, and regularly encounters patients. So, we have decided to recruit you as a study participant since you fit into our selection criteria.

What does the project entail?

The research study will follow a qualitative study design, and a face-to-face semi-structured in-depth interview to gain your insights on the study matter. The interview should not take more than 30 minutes. The questions will revolve a bit around your personal demographic information and mainly your views and thoughts on mental illness and people with mental illness. For the purpose of documenting the findings, our conversation will be recorded, and some notetaking will also be done. The recording will only be used for research purposes and will be confidential.
As part of the project, we will collect and register data on you. Your personal information and the information that you provide based on your thoughts and perceptions about mental illness will be registered.

Possible advantages and disadvantages

There are not any benefits or risks directed at you from this study. Your participation in the study will contribute towards scientific knowledge and how negative views about mental illness can be corrected. You will not be harmed in any way throughout the research process. However, it is possible that you may experience some discomfort talking about this topic.

Voluntary participation and right to withdraw consent

Participation in the project is voluntary. If you would like to participate, please sign the consent form at the end of this document. You can withdraw your consent at any time without giving a reason. There will be no negative consequences for you or your treatment if you do not want to participate or if you choose to withdraw at a later stage. If you withdraw your consent, your

information will not be used in any further research. You can request access to the data held on you, and this will be provided within 30 days. You can also apply for your data to be deleted. The right to have your data and material destroyed, deleted, or returned does not apply if the material or data is anonymized or have already been published. Access may also be restricted if the data has been included in analyses already performed.

If you want to withdraw at a later stage or have questions about the project, you can contact the project manager (see the contact details at the end of this document).

What happens to the data held onto you?

The data registered about you will only be used as described under the purpose of the project and is planned for use in the year 2022/2023. Use and storage time can only be extended after approval from the Regional Committee for Medical and Health Research Ethics and other relevant authorities. You have the right to access the information that is registered about you and to have any errors in this information corrected. You also have the right to information about the data security measures that apply to the processing of the data. You can lodge a complaint about the processing of your data to the Norwegian Data Protection Authority and the institution's Data Protection Officer.

All data will be processed without names and personal identification numbers or other directly identifiable information (= coded data). A code links you to your data through a list of names. Only the project manager, Professor David Lackland Sam and the student, Puja Tripathi will have access to this list.

Publishing results is a necessary part of the research process. Data in published research will be de-identified to preserve the privacy of individual participants, but we have a duty to inform you that we cannot rule out individuals being identified.

After the research project is completed, the data held on you will be stored for five years for control purposes.

Finances

Also, please be mindful that you will not be compensated monetarily or in any other way for your contribution to the project.

Approvals

The Regional Committee for Medical and Health Research Ethics has considered the research ethics in the project and given its approval.

The University of Bergen and the project manager (Professor David Lackland Sam) are responsible for privacy and data protection in this project.

Contact details

If you have questions about the project or want to withdraw your participation, you can contact:

Professor David L. Sam; tel: +47 91872815; Email: David.sam@uib.no

Puja Tripathi; +47 46552435; Ptr006@uib.no

If you have questions about data protection in the project, you can contact the Data Protection Officer (Personvernombud) at the University of Bergen: Janecke.Veim@uib.no +47 55582029.

II. PARTICIPANT INFORMATION SHEET (IN NEPALI)

सहभागी जानकारी पाना

परियोजनाको शीर्षक: Perceptions regarding mental illness among non-psychiatric healthcare professionals in Kathmandu, Nepal

परियोजनाको उद्देश्य र तपाइँलाई किन सहभागी हुन आमन्त्रित गरिएको छ

कृपया तपाईं मानसिक रोग बारे गैर-मनोवैज्ञानिक स्वास्थ्यकर्मीहरूको धारणा बुझ्ने उद्देश्यले गर्न लागिएको अनुसन्धान परियोजनामा भाग लिन चाहनुहुन्छ? हामी मानसिक स्वास्थ्यमा विशेषज्ञ नभएका, मानसिक रोगको अनुभव नभएका र नियमित रूपमा बिरामीहरूसँग सम्पर्कमा आउने स्वास्थ्यकर्मीहरू खोजिरहेका छौं। तसर्थ, हामीले तपाइँलाई अध्ययन सहभागीको रूपमा समावेश गर्ने निर्णय गरेका छौं।

परियोजनामा के समावेश छ?

यो अनुसन्धानमा qualitative study design प्रयोग गरिनेछ भने विधिको रूपमा Case study गरिनेछ। तपाईंको धारणाहरू प्राप्त गर्न semi-structured interview लिइनेछ । अन्तर्वार्ता 30 मिनेट भन्दा बढी हुने छैन। यस अन्तर्वार्तामा तपाईंको demographic जानकारी र मुख्य रूपमा मानसिक रोग प्रति तपाईंको विचारहरू सम्बन्धित प्रश्नहरू हुनेछन्। अन्तर्वार्ता documentation गर्ने उद्देश्यका लागि हाम्रो कुराकानी रेकर्ड र नोटिङ गरिनेछ। रेकर्डिङ यस अनुसन्धानका लागि मात्र प्रयोग गरिनेछ र गोप्य राखिनेछ।

सहभागिताको अवधि र सम्पर्कको आवृत्ति

डाटा सङ्कलनको भागको रूपमा, सहभागीहरूसंग एक पटक अन्तर्वार्ता लिइनेछ, प्रत्येक अन्तर्वार्ता लगभग ३० मिनेटको लागि। यस अध्ययनमा सहभागीहरु संग कुनै फलो-अप अन्तर्वार्ता वा सम्पर्कहरू हुने छैन।

सम्भावित फाइदा र बेफाइदाहरू

यस अध्ययनबाट तपाईलाई कुनै फाइदा वा जोखिम छैन। अध्ययनमा तपाईंको सहभागिताले मानसिक रोगको वैज्ञानिक ज्ञान र अध्ययन क्षेत्रमा योगदान पुर्याउनेछ।

व्यक्तिगत सहभागीहरूको गोप्यता जोगाउनको लागि प्रकाशित अनुसन्धानमा डाटा पहिचान गरिने छैन, तर हामी तपाईंलाई सूचित गर्न चाहन्छौं कि हामी व्यक्तिहरूको पहिचानलाई अस्वीकार गर्न सक्दैनौं। अनुसन्धान परियोजना पूरा भएपछि तपाईंसँग लिइएको डाटा नियन्त्रण उद्देश्यका लागि पाँच वर्षको लागि भण्डारण गरिनेछ।

आर्थिक वा अन्य क्षतिपूर्ति

कृपया सचेत रहनुहोस् कि परियोजनामा तपाईंको योगदानको लागि तपाईंलाई आर्थिक रूपमा वा अन्य कुनै पनि तरिकाले क्षतिपूर्ति दिइने छैन।

नैतिक स्वीकृति

चिकित्सा तथा स्वास्थ्य अनुसन्धान नैतिकताका लागि Regional Committees for Medical and Health Research Ethics (REK), Norway का साथै Nepal Health Research Council (NHRC), Nepal ले परियोजनालाई स्वीकृति दिएको छ।

University of Bergen, Norway र परियोजना प्रबन्धक (Prof. David Lackland Sam) यस परियोजनाको गोपनीयता र डेटा सुरक्षाको लागि जिम्मेवार छन्।

सम्पर्क

यदि तपाइँसँग परियोजनाको बारेमा कुनै प्रश्नहरू छन् वा तपाइँको सहभागिता अन्त्य गर्न चाहनुहुन्छ भने तपाइँ सम्पर्क गर्न सक्नुहुन्छ:

Prof. David Lackland Sam; इमेल: david.sam@uib.no

पूजा त्रिपाठी; ९८४९४४१६८८; इमेल: Ptr006@uib.no

Nepal Health Research Council, Kathmandu, Nepal; 977-1-4254220; nhrc@nhrc.gov.np

यदि तपाइँसँग परियोजनामा डेटा सुरक्षाको बारेमा कुनै प्रश्नहरू छन् भने तपाइँ University of Bergen का डाटा सुरक्षा अधिकारीलाई सम्पर्क गर्न सक्नुहुन्छ: Janeke.Veim@uib.no

III. INFORMED CONSENT

Project title: Perceptions of mental illness among non-specialized healthcare professionals in Kathmandu, Nepal

Researcher: Puja Tripathi

- I have read and understood the information provided about this research project in the participant information sheet.
- I consent for the researcher to take notes and to record audio during the interview. It can be translated and transcribed by the researcher.
- I am aware that I may withdraw myself or any information that I provide for this project at any time.
- If I withdraw, I understand that all relevant information from this project will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research on completion (please tick one): Yes No

Participant's name and signature

……

Participant's contact details

……

……

IV. INFORMED CONSENT (IN NEPALI)

सूचित सहमति पत्र

परियोजना शीर्षक: काठमाडौं, नेपालमा कार्यरत गैर-विशेष स्वास्थ्यकर्मीहरू बीच मानसिक रोगको धारणा

अनुसन्धानकर्ता: पूजा त्रिपाठी

- मैले सहभागी जानकारी पानामा यस अनुसन्धान परियोजनाको बारेमा प्रदान गरिएको जानकारी पढेको र बुझेको छु।
- अन्वेषकलाई अन्तर्वार्ताको क्रममा टिपोटहरू लिन र अडियो रेकर्ड गर्न म सहमत छु। यो अनुसन्धानकर्ता द्वारा अनुवाद र ट्रान्सक्राइब गर्न सकिन्छ।
- मलाई थाहा छ कि म आफैं वा मैले यस परियोजनाको लागि उपलब्ध गराएको कुनै पनि जानकारी फिर्ता लिन सक्छु।
- यदि मैले फिर्ता लिन्छु भने, म बुझ्छु कि यस परियोजनाका सबै सान्दर्भिक जानकारीहरू नष्ट हुनेछन्।
- म यस अनुसन्धानमा भाग लिन सहमत छु।
- म अनुसन्धान पूरा भएको रिपोर्टको प्रतिलिपि प्राप्त गर्न चाहन्छु (कृपया एउटामा टिक गर्नुहोस्): हो होइन

सहभागीको नाम र हस्ताक्षर

.....

.....

सहभागीको सम्पर्क विवरणहरू (आवश्यक भएमा मात्र)

.....

V. INTERVIEW GUIDE

Greetings**!**

Thank you for agreeing to participate in this interview. So, as mentioned earlier, the title of this research study is 'Perceptions of mental illness among healthcare professionals in Nepal'. The study aims at discussing the perspectives of healthcare professionals regarding mental illness and the factors contributing to it.

We will be conducting a face-to-face semi-structured in-depth interview to gain your insights on the study matter. The interview should not take more than 30 minutes. The questions will revolve around a bit of your demographic information and then your views and thoughts on mental illness and people with mental illness. Whatever response you provide will be a great contribution towards scientific knowledge and correcting the negative views about mental illness. If you do not wish to respond to any questions, it is completely fine.

For documenting the findings, our conversation will be recorded, and some notetaking will also be done as necessary. The recording will only be used for research purposes and will be confidential.

Before starting, I would like to request your permission to audiotape our conversation.

(*Some rapport building questions were asked before beginning the interview.*)

1. To start, could you please tell me a bit about yourself? Your name, qualification and how long you have been in this profession?
2. How often do you encounter patients (per month/week)? >> Adult patients?
3. When I say mental illness, what comes to your mind? How do you define it? Can you say a bit more about why you think of it that way?
4. What do you think causes mental illness? Do you think it is hereditary?
5. What kind of symptoms/characteristics do PWMI show?
6. How is mental illness similar or different from physical illness?
7. How do you think they should be treated? Why do you think so?
8. How easy or difficult is it to interact with someone with mental illness?

9. What do you think about recovery from mental illness? How do you think the illness can be treated?

10. What experiences do you have with mentally ill people? Any instances that you remember (positive or negative)? What happened? How did you deal with it?

11. If someone is mentally ill, how does it affect the family?

12. How would you feel and react if someone in your family is mentally ill?

13. What do you think of their ability to perform their daily tasks, such as studying or working?

14. Would you want to be friends with someone who is mentally ill? Why do you think so?

15. How do you feel about marrying someone who has mental illness? How appropriate or inappropriate do you think it is? Could you please explain a bit more?

16. To end, do you have anything else that you would like to share?

Thank you again for contributing to this study. I would like to get back to you if there is anything else that I need from your side. Also, I will reach out to some of you to get your feedback and comments once the findings of the study are finalized.

VI. INTERVIEW GUIDE (IN NEPALI)

अन्तर्वार्ता गाइड

अभिवादन!

यस अन्तर्वार्तामा सहभागी हुन सहमत हुनुभएकोमा धन्यवाद। तसर्थ, पहिले नै उल्लेख गरिएझैं यस अनुसन्धान अध्ययनको शीर्षक 'नेपालका स्वास्थ्यकर्मीहरूमा मानसिक रोगको धारणा' हो। अध्ययनको उद्देश्य मानसिक रोगको बारेमा स्वास्थ्यकर्मीहरूको दृष्टिकोण र यसमा योगदान गर्ने कारकहरूबारे छलफल गर्नु हो। हामी मानसिक स्वास्थ्यमा विशेषज्ञता नभएका, कहिल्यै मानसिक रोगको अनुभव नगर्ने, र नियमित रूपमा वयस्क बिरामीहरूसँग सम्पर्कमा आउने चिकित्सकहरूको खोजी गरिरहेका छौं। त्यसोभए, हामीले तपाइँलाई अध्ययन सहभागीको रूपमा भर्ती गर्ने निर्णय गर्यौं किनभने तपाइँ हाम्रो चयन मापदण्डमा फिट हुनुहुन्छ।

अध्ययनको विषयमा तपाईको विचारहरू प्राप्त गर्न हामी आमनेसामने अर्ध-संरचित गहन अन्तर्वार्ता लिनेछौं। अन्तर्वार्ता ३० मिनेटभन्दा बढी समय लिन हुँदैन । प्रश्नहरू तपाईको जनसांख्यिकीय जानकारीको केही वरिपरि घुम्नेछ र त्यसपछि मानसिक रोग र मानसिक रोग भएका व्यक्तिहरूमा तपाईको विचार र विचारहरू। निष्कर्षहरू दस्तावेजीकरण गर्ने उद्देश्यको लागि, हाम्रो कुराकानी रेकर्ड गरिनेछ, र आवश्यक रूपमा केही नोटिङ पनि गरिनेछ। रेकर्डिङ अनुसन्धान उद्देश्यका लागि मात्र प्रयोग गरिनेछ र गोप्य हुनेछ।

कृपया ध्यान दिनुहोस् कि अध्ययनबाट तपाईलाई कुनै हानि वा फाइदाहरू निर्देशित छैनन्। निष्कर्षहरूले थप अनुसन्धान अध्ययनहरूलाई मार्गदर्शन वा सिफारिस गर्न मद्दत गर्नेछ। तपाईले प्रदान गर्नुभएको प्रतिक्रियाले वैज्ञानिक ज्ञान र मानसिक रोगको बारेमा नकारात्मक विचारहरू सच्याउन ठूलो योगदान गर्नेछ।

यस अध्ययनमा तपाईको सहभागिता पूर्णतया स्वैच्छिक हो। यदि तपाइँ कुनै पनि समयमा अध्ययनबाट फिर्ता लिन चाहनुहुन्छ भने, तपाइँ त्यसो गर्न स्वतन्त्र हुनुहुन्छ, र त्यहाँ कुनै परिणाम हुनेछैन। तपाईंले प्रदान गर्नुभएको डाटा नष्ट गरिनेछ र तपाईंको फिर्ता पछि अध्ययनमा प्रयोग गरिने छैन। तपाइँमा राखिएको डाटामा पहुँच अनुरोध गर्न सक्नुहुन्छ, र यो 30 दिन भित्र प्रदान गरिनेछ। तपाईं पनि मेटिने परियोजना मा आफ्नो डाटा लागि आवेदन गर्न सक्नुहुन्छ।

यदि सामग्री वा डाटा अज्ञात छ वा पहिले नै प्रकाशित भइसकेको छ भने तपाईंको डाटा र सामग्री नष्ट, मेटाउने वा फिर्ता गर्ने अधिकार लागू हुँदैन। पहुँच पनि प्रतिबन्धित हुन सक्छ यदि डेटा पहिले नै प्रदर्शन गरिएको विश्लेषणहरूमा समावेश गरिएको छ। तपाईंबाट सङ्कलन गरिएको जानकारी अनुसन्धान उद्देश्यको लागि मात्र प्रयोग गरिनेछ र वर्ष 2022/2023 भित्र प्रयोग गरिनेछ। तपाईंबाट प्राप्त व्यक्तिगत जानकारी र अन्य डेटा कोडहरू प्रयोग गरेर गुमनाम गरिनेछ। परियोजना प्रबन्धक, प्रोफेसर David Lackland Sam र विद्यार्थी पूजा त्रिपाठीले मात्र यो डेटा पहुँच गर्न सक्नेछन्।

तपाइँसँग तपाइँको बारेमा दर्ता गरिएको जानकारी पहुँच गर्ने र आवश्यकता अनुसार कुनै पनि गलत जानकारी सुधार गर्ने अधिकार छ। तपाईंसँग डाटाको प्रशोधनमा लागू हुने डाटा सुरक्षा उपायहरूको बारेमा जानकारीको अधिकार पनि छ। अनुसन्धान परियोजना पूरा भएपछि, तपाइँमा राखिएको डाटा नियन्त्रण उद्देश्यका लागि पाँच वर्षको लागि भण्डारण गरिनेछ। नतिजा प्रकाशन अनुसन्धान प्रक्रिया को एक आवश्यक भाग हो। प्रकाशित अनुसन्धानमा डाटा व्यक्तिगत सहभागीहरूको गोपनीयता जोगाउनको लागि डि-पहिचान गरिनेछ, तर हामी तपाईंलाई सूचित गर्ने कर्तव्य हो कि हामी व्यक्तिहरूलाई पहिचान गर्न इन्कार गर्न सक्दैनौं।

सुरु गर्नु अघि, म हाम्रो कुराकानी अडियोटेप गर्नको लागि तपाइँको अनुमति अनुरोध गर्न चाहन्छु।

(अन्तर्वार्ता सुरु गर्नु अघि केही सम्बन्ध निर्माणका प्रश्नहरू सोधिनेछन्।)

1. सुरु गर्नको लागि, के तपाईं मलाई आफ्नो बारेमा केही बताउन सक्नुहुन्छ? तपाईको नाम, योग्यता र तपाई यस पेशामा कति समयदेखि हुनुहुन्छ ?

2. तपाइँ कति पटक बिरामीहरूसँग भेट्नुहुन्छ (प्रति महिना वा हप्ता दिन)? >> वयस्क बिरामीहरू?

3. जब म मानसिक रोग भन्छु, तपाईको दिमागमा के आउँछ? तपाइँ यसलाई कसरी परिभाषित गर्नुहुन्छ? तपाईं किन यसरी सोच्नुहुन्छ भन्ने बारे थोरै भन्न सक्नुहुन्छ?

4. तपाईको विचारमा मानसिक रोगको कारण के हो ? यो वंशाणुगत हो कि होइन ?

5. मानसिक रोग भएका व्यक्तिहरूले कस्तो प्रकारका लक्षण/विशेषताहरू देखाउँछन्?

6. मानसिक रोग कसरी शारीरिक रोग भन्दा समान वा फरक छ?

7. उनीहरूलाई कस्तो व्यवहार गर्नुपर्छ जस्तो लाग्छ? किन यस्तो लाग्छ ?

8. मानसिक रोग भएको व्यक्तिसँग कुराकानी गर्न कत्तिको सजिलो वा गाह्रो छ?

9. मानसिक रोगको उपचारको बारेमा तपाई के सोच्नुहुन्छ? यसको उपचार कसरी गर्न सकिन्छ जस्तो लाग्छ ?

10. मानसिक रूपमा बिरामी व्यक्तिहरूसँग तपाइँको अनुभव कस्तो छ? तपाईंले सम्झनुभएको कुनै उदाहरण (सकारात्मक वा नकारात्मक)? के भएको थियो? तपाईंले यसलाई कसरी व्यवहार गर्नुभयो?

11. कोही मानसिक रोगी भएमा परिवारमा कस्तो असर पर्छ ?

12. तपाईंको परिवारमा कोही मानसिक रूपमा बिरामी भएमा तपाईंले कस्तो महसुस गर्नुहुन्छ र प्रतिक्रिया दिनुहुनेछ?

13. यसले उनीहरूको दैनिक कार्यहरू, जस्तै अध्ययन वा काम गर्ने क्षमतालाई कसरी असर गर्छ वा गर्दैन जस्तो लाग्छ?

14. के तपाई मानसिक रोगीसँग साथी बन्न चाहनुहुन्छ? अलि बढी व्याख्या गर्न सक्नुहुन्छ?

15. मानसिक रोग लागेको व्यक्तिसँग विवाह गर्दा तपाईंलाई कस्तो लाग्छ? कृपया अलिकति व्याख्या गर्न सक्नुहुन्छ?

16. अन्त्यमा, मानसिक रोग बारेमाअरु केहि थप्न चाहनुहुन्छ?

यस अध्ययनमा योगदान गर्नुभएकोमा पुन: धन्यवाद। यदि तपाइँको तर्फबाट हामीलाई चाहिने अरु केहि छ भने म तपाइँलाई फेरि सम्पर्क गर्नेछु। साथै, अध्ययनको निष्कर्षलाई अन्तिम रूप दिइसकेपछि म तपाईंको प्रतिक्रिया र टिप्पणीहरू प्राप्त गर्न तपाईंलाई सम्पर्क गर्नेछु।

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: C l/

2 November 2022

Ms. Puja Tripathi

Dr. David Lackland SAM

Principal Investigator

University of Bergen

Norway

Ref: Approval of thesis proposal

Dear Ms. Tripathi and Dr. SAM

This is to certify that the following protocol and related documents have been reviewed and granted approval through the expedited review process for its implementation.

Protocol Registration No/ Submitted Date	316/2022 MT 4 July 2022		Sponsor Protocol No		
Principal Investigator/s	Ms Puja Tripathi Dr. David Lackland SAM		Sponsor Institution		
Title	Perceptions of mental illness among non-psychiatric healthcare providers in Kathmandu, Nepal				
Protocol Version No	NA		Version Date		
Other Documents	l. Data collection tools 2. Informed consent form 3. Approval from University 4. Work plan		Risk Category	Minimal risk	
Co-Investigator/s					
Study Site	Kathmandu, Nepal				
Type of Review		Expedited	Timeline of Study 2 November 2022 to June 2023	Frequency of continuing review	
		Full Board			

	Review Date: 31 October 2022	Duration of Approval 2 November 2022 to 2 November 2023 This approval will be valid one year	

Tel: +977 1 4254220, Fax; +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.gov.np, E-mail: nhrc@nhrc.gov.np

Government of Nepal
Nepal Health Research Council (NHRC)

Estd. 1991

Ref, UI

Total budget of research	NRs 2,50,000.00
Ethical review processing fee	NRs 10,000.00

Investigator Responsibilities

Any amendments shall be approved from the ERB before implementing them
Submit the support letter from the regulatory authorities in Nepal like DDA, FWD, DoHS, before implementing the study
Submit progress report every 6 months
Submit final report after completion of protocol procedures at the study site
Comply with all relevant international and NHRC guidelines
Abide by the principles of Good Clinical Practice and ethical conduct of the research

If you have any questions, please contact the Ethical Review M & E Section at NHRC,

Thanking you,

Dr. Pradip Gyanwali
Member Secretary

Tel: +977 1 4254220, Fax; +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.gov.np, E-mail: nhrc@nhrc.gov.np

Region:	Saksbehandler:		Vår dato:	Vår referanse:
REK vest	Ingvild Haaland	Telefon:	29.06.2022	475239

David Lackland Sam

Prosjektsøknad: OPPFATNINGER AV PSYKISKE LIDELSE BLAND HELSEPERSONELL I NEPAL

Søknadsnummer: 475239 Forskningsansvarlig institusjon: Universitetet i Bergen

Prosjektsøknad vurderes som utenfor helseforskningslovens virkeområde.

Søkers beskrivelse

The project entails qualitative research which aims to explore the perceptions of healthcare professionals on mental illness in Nepal. The participants will be health personnel serving at hospitals in the capital city (Kathmandu) who do not specialize in mental health. Face-to-face semi-structured interviews will be conducted as part of the data collection process.
The interview guide will incorporate questions revolving around beliefs, prejudices and social acceptance of healthcare providers towards people with mental illness.
The study aims at getting a clear picture of where the healthcare personnel stand in terms of perception towards mental illness, to identify the loopholes and reduce inequities in mental health. It will validate or add to the existing studies and help strengthen the healthcare system in Nepal.

With reference to your application regarding the abovementioned project. The Regional Committee for Medical and Health Research Ethics (REC Western Norway) reviewed the application in the meeting 08.06.2022, pursuant to The Health Research Act § 10.

REKs vurdering

The Medical Health Act applies to all medical and health research on human beings, human biological material or personal health data. Such research also includes pilot studies and experimental treatments. Medical and health research is defined as activity conducted using scientific methods to generate new knowledge about health and disease (§§2 and 4).

The English title of the project is: PERCEPTIONS OF MENTAL ILLNESS AMONG HEALTH PERSONNEL IN NEPAL

REK vest

Besøksadresse: Armauer Hansens Hus, nordre fløy, 2. etasje,

Haukelandsveien 28, Bergen

| **E-post**: rek-vest@uib.no

Web: https://rekportalen.no

Project manager: David Lackland Sam

Research responsible institution: University of Bergen, Norway

The project will investigate perceptions of healthcare professionals on mental illness in Nepal. Health personnel serving in Kathmandu not specialized in mental health, will be interviewed by face-to-face interview about beliefs, prejudices and social acceptance regarding mental health.

REC Western Norway evaluates the project as being exempted from review by the Regional Committee for Medical and Health Research Ethics, in Norway.

REC Western Norway remarks that the project should be reported to the data protection officer at the responsible institution.

Vedtak

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. §§ 2 og 4, og søknaden skal derfor ikke behandles av REK.

Klageadgang

Du kan klage på REKs vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes på eget skjema via REK portalen. Klagefristen er tre uker fra du mottar av dette brevet. Dersom REK opprettholder vedtaket, sender REK klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering, jf. forskningsetikkloven § 10 og helseforskningsloven § 10.

Sincerely

Nina Langeland
Prof., Dr.med
Chair of the Committee

Ingvild Haaland
Senior adviser

Kopi til:

Universitetet i Bergen

Puja Tripathi