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Assessment of community needs and perception of mental health in rural Nepal

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Abstract

Background: Mental health disorders are a major global burden, with countries like Nepal experiencing high prevalence and significant treatment gaps. Community perceptions critically shape health-seeking behaviours, yet research in rural Nepal is limited. This study explores knowledge, perceived risk factors, care options and help-seeking attitudes related to mental illness and suicide in Saudiyar, a rural village in Dang district, Nepal, with no regular formal mental health services. It is part of a needs assessment by Health Foundation Nepal (HFN) to inform planning of community mental health interventions.

Methods: This cross-sectional study was conducted in 2018 in Saudiyar, Dang. Using purposive and convenience sampling, 119 participants from 11 community groups were surveyed with a semi-structured Nepali-language questionnaire. Topics included mental health knowledge, perceptions, risk factors, suicide exposure and care preferences. Complete case analysis and descriptive statistics were used to summarise findings using the Statistical Package for the Social Sciences (SPSS)

Results: A total of 95.8% of participants had heard of mental illness, with the radio as the main source of information. Stress and worry (57.1%), alcoholism (53.8%), and depression (28.6%) were identified as key mental health issues. Low self-esteem, poverty, and family problems were seen as major risk factors for mental illness and suicide. While 38.2% had known someone who died by suicide, only 4.5% reported personal experience with mental illness, and 10.2% reported a family member being affected. Doctors (75.7%) and medication (88.8%) were seen as helpful treatments, alongside yoga (78.2%) and Bhajan (religious songs – 59.7%). Nearly all participants (99.2%) supported establishing community-based mental health services.

Conclusion: TOur study identified a community's perception of stress, alcohol use, poverty-related hardship, family conflict and low self-esteem as major contributing factors for mental illnesses and suicide. While biomedical treatment was widely valued, most participants found religious and spiritual practices helpful for mental health.

Keywords

Nepal, perception, health-seeking behaviour, suicide, self-esteem, biomedical treatment

INTRODUCTION

Mental illnesses are a significant global health burden, with low- and middle-income countries (LMICs) bearing a disproportionate share of unmet mental health needs (Lund et al., 2010; James et al., 2018). In Nepal, recent studies estimate the prevalence of mental health disorders to range between 13% and 22% in adults and children, with suicidal ideation affecting up to 11% of adults and 9% of children (Risal et al., 2016; Jha et al., 2019). Despite this significant burden, mental health

services remain concentrated in urban centres, with limited access to trained professionals and a persistent reliance on traditional healers as primary sources of mental health care (Lund et al., 2010; Luitel et al., 2015). As a result, an estimated 80 to 90% of people with mental illnesses in developing countries, including Nepal, do not receive adequate services (World Health Organization, 2008; Luitel et al., 2017).

One critical barrier to effective mental health service delivery in LMICs is the limited integration of community perspectives into programme design and policy development. Scientific knowledge on mental health is often not translated into public understanding, leading to widespread stigma, misconceptions and low service utilisation (Conner et al., 2010; Ahmedani, 2011; Salve et al., 2013; Benti et al., 2016). Understanding how communities perceive mental illness, its causes and treatment options is essential for informing culturally relevant interventions and improving health-seeking behaviour (Adewuya and Makanjuola, 2008; Chase et al., 2018).

In the Nepali context, studies exploring community perceptions of mental illness remain scarce, particularly in rural settings where access to care is lowest. A recent qualitative study by Adhikari and colleagues highlighted the importance of community awareness and perceptions of mental health in treatment planning of children in rural Nepal (Adhikari et al., 2015). Yet broader evidence on how rural communities understand mental illness, suicide and treatment – especially from multiple stakeholder perspectives –remains limited.

Health Foundation Nepal (HFN), a non-profit organisation based in Nepal and the US, has been implementing community-based mental health programmes in the Dang district of Nepal since 2018. At the time of initiation of mental health programmes, the district – home to more than 600,000 people – lacked formal psychiatric services. As a part of programme planning, HFN conducted a comprehensive mental health needs assessment in Saudiyar, a rural village in the Dang district. To our knowledge, this is the first study exploring community mental health needs and perceptions. From a diverse set of stakeholders, we assessed community knowledge of mental illness, perceived risk factors and causes –including those related to suicide – as well as available care options, coping strategies and care-seeking behaviours.

METHODS

Study design and setting

This was a cross-sectional descriptive study conducted in Saudiyar, a rural village in the Dang district of western Nepal. Dang is one of the largest districts in Province 5, with a population exceeding 600,000. At the time of the study (2018), the district had no formal psychiatric services. The study was undertaken as part of a broader community mental health programme led by HFN, a non-governmental organisation operating in Nepal and the US.

Eligibility and consent

Participants were eligible if they were 15 years or older and belonged to one of the designated community groups. For participants under the age of 18, written parental consent was obtained in addition to participant assent. Written informed consent was obtained from adult participants.

Sampling and participants

Participants were selected from 11 stakeholder groups to ensure a comprehensive understanding of community mental health perspectives (Table 1). The participants included higher secondary students (boys, n=14), higher secondary students (girls, n=14), local health workers (n=10), local religious leaders (n=10), including female community health volunteers (FCHVs, n=10). Adolescents, adults and older people represent the general population accessing these services. Among the adult and older people population, we

targeted community members who were either the head of the family (father-in-law) or made care-seeking decisions in the family (married women or mothers-in-law). These groups were identified due to their influential roles in community health promotion and care decision-making in rural areas of Nepal.

A total of 119 participants were recruited using purposive and convenience sampling to ensure diverse representation rather than statistical generalisability. First, eligible individuals from each group were listed with support from local health centers and community leaders. Approximately 10 to 15 individuals per group were invited to participate. Adolescents were represented by gender (14 boys and 14 girls), and political leaders were slightly overrepresented (n=11) due to local availability. Recruitment continued until the target sample size for each group was reached.

Data collection instrument

A survey questionnaire, translated in the Nepali language, was used for data collection. The questionnaire was developed in consultation with mental health professionals from psychiatry and public health backgrounds. The questionnaire included variables relating to sociodemographic characteristics, sources of mental health information, participant perceptions of existing mental illness in their communities, risk factors for mental illnesses, community exposure to suicide, mental health histories, care-seeking behaviours and perceptions, ways to treat mental health illnesses, and services to improve mental health.

Data collection procedure

Data collection was carried out by well-trained HFN staff residing in the community. Data was collected between April and June 2018. All responses were recorded on paper forms and subsequently reviewed for completeness and consistency by the research team and entered into an Excel format. To maximise the sample size for analysis, we did not exclude any rows with missing data.

Data management and analysis

Completed questionnaires were manually reviewed for data quality (MRB, RP, MA and BA), and any inconsistencies were identified and verified during this process through mutual consensus among the research team. Participants were asked to rate their mental health on a scale from 0 to 10, where 0 represented the poorest and 10 represented the best mental health. Participants were asked about how to treat mental illnesses, through an open-ended questionnaire. Data was analysed using complete case analysis, where percentages and descriptive statistics were calculated based on the number of respondents for each specific variable. Due to variability in item-level response rates, the denominator (n) differed across variables. Missing responses were entered into International Business Machines Corporation's SPSS version 21 for analysis (IBM Corp., 2012). Descriptive statistics (frequencies, percentages and means) were used to summarise the community's mental health needs and perceptions.

Ethics

The Institutional Review Committee (reference number: 352 (6-11-E)2/074/075) at the Institute of Medicine, Kathmandu, Nepal provided ethical approval for this study.

RESULTS

Sociodemographic characteristics

Among the respondents, 53.4% were male. The majority of respondents (74.8%) belonged to the *Brahmin/Chhetri* ethnicity. One-third of participants were educated at a higher secondary level. All participants were Hindu by religion. 71.4% of the participants were married; 50.8% lived in the nuclear family, followed by 43.2% in a joint family (Table 1).

Table 1. Sociodemographic characteristics of the study population

Characteristics	Classification	Number	Percentage %
Sex (n=118)	Male	63	53.4
	Female	55	46.6
Ethnicity (n=119)	*Brahmin/Chhetri*	89	74.8
	Indigenous	22	18.5
	Dalit	4	3.4
	Others	4	3.4
Educational level (n=115)	Illiterate (those with no formal education)	13	11.3
	Primary (Grades 1 to 5)	19	16.5
	Secondary level (Grades 6 to 10)	35	30.4
	Higher secondary (Grades 11 and 12)	40	34.8
	University (bachelor's and above)	8	7.0
Religion (n=119)	Hindu	119	100
Marital status (n=119)	Single	30	25.2
	Married	85	71.4
	Widow/widower	4	3.4
Family type (n=118)	Nuclear (parents and son/daughter)	60	50.8
	Joint (parents, grandparents, son/daughter)	51	43.2
	Extended (parents, grandparents, son/daughter, uncles/aunts and cousins)	3	2.5
	Other*	4	3.4
Population groups (n=119)	Higher secondary students (adolescent boys)	14	11.8
	Higher secondary students (adolescent girls)	14	11.8
	Local health workers	10	8.4
	Local religious leaders	10	8.4
	Married men	10	8.4
	Local political leaders	11	9.2
	School teachers	10	8.4
	Adult married women	10	8.4
	Adult mothers-in-law	10	8.4
	Adult fathers-in-law	10	8.4
	Female community health volunteers (FCHVs)	10	8.4

(*Those who were not covered by the definition of a single, joint and extended family, such as single-person households, non-related cohabitants or other non-traditional living arrangements).

Sources of mental health information

The participants were asked whether they had heard about mental illnesses and about the sources of their information. Almost 95.8% of participants had heard about mental illness and 4.2% responded that they did not know about mental illnesses. The most common sources of mental health information were the radio, TV and health workers (Table 2).

Perception of existing mental illnesses in the community

Similarly, participants were asked if they believed that people in their community suffer from four special mental problems or illnesses. Among the 119 participants, 57.1% believed that people suffer mainly from stress (57.1%), alcoholism (53.8%), and depression (28.6%) (Table 2).

Table 2. Participant perception, awareness and types of mental illnesses in the community

Characteristics	Number	Percentage %
Mental illness (n=119)		
Stress/worrying	68	57.1
Alcoholism	64	53.8
Depression	34	28.6
Other mental problems	10	8.4
Have you heard about mental illness? (n=119)		
Yes	114	95.8
No	5	4.2
Where did you hear from? (n=119)		
Radio	81	68.1
TV	52	43.7
Health workers	34	28.6
Newspaper	24	20.2
Internet	21	17.6
Friends	15	12.6
Relatives	10	8.4
Books	12	10.1
Parents	10	8.4
Teacher	8	6.7
Other	27	22.7
Risk factors for mental illness (n=119)		
Poverty	46	38.7
Low self-esteem	38	31.9
Relationship issues in family	38	31.9
Don't know	7	5.9
Drug addiction	6	5.0
Health issues	5	4.2
Illiteracy	5	4.2
Others (social problem, workload, breakup, physical disability)	5	4.2
Loss of loved ones	3	2.5
Lack of counselling	3	2.5
Community exposure to suicide (n=110)		
Witnessed and known the person who committed suicide	42	38.2
Have not witnessed, but only heard of suicide	41	37.3
Witnessed but don't know the person who committed suicide	27	24.5

Community perception on the risk factors for mental illness

The study participants were asked an open-ended question on the reasons for suffering from mental health problems. Poverty and subsequent family problems were believed to be the major reasons for mental health illness. Study participants defined poverty in terms of unemployment and indebtedness. Almost one-third of participants reported that low self-esteem was the reason for mental health problems. They described tension, worrying too

much, overthinking, solitude, and that the inability to cope with modernisation could lower self-esteem in people. Relationship issues in the family were also reported by 31.9% of participants. Family issues were described as distance from children, second marriage, domestic abuse, the pressure of having children, extramarital affairs, family conflicts, and a lack of mutual understanding in the family. Other risk factors include illiteracy, health issues, drug addiction, lack of counselling, loss of loved ones, social problems, workload, breakup, and physical disability. However, nearly 6% of participants did not know the risk factors for mental illness (Table 2).

Community exposure to suicide

When the participants were asked if they had seen or known any people who committed suicide, 38.2% of them reported that they had witnessed or known someone who committed suicide. Only 37.3% reported that they have not witnessed but only heard of people committing suicide (Table 2). The 110 participants who reported either witnessing or hearing about suicide were asked about the possible reasons for attempting suicide through an open-ended question. Stress, worrying and depression (38.2%) were the most frequently cited reasons, followed by poverty (16.4%). Multiple responses were allowed to answer the question. Considering the challenges in differentiating stress, worrying and depression by the participants, they are grouped in one category as a root cause of suicide, just like poverty and low social-esteem (Table 2).

When asking participants if they were ever diagnosed with mental illness, 104 (95.4%) reported that they had never been diagnosed, and 5 (4.6%) reported getting a diagnosis. The average score among 66 respondents was 7.7 ± 1.7, with scores ranging from 3 to 10. About 11 out of 108 respondents (10.2%) revealed family members with mental illness, and with depression as the most common illness (Table 3).

Table 3. Mental health histories, treatment approaches and services access in the community

Characteristics	Response	Number	Percentage %
Mental illness ever diagnosed (n=109)	Yes	5	4.6
	No	104	95.4
Healthy scale (0–10) n=66	Mean ± SD= 7.7 ±1.7 (Range: 3-10)		
Mental illness in family members (n=108)	Yes	11	10.2
	No	97	89.8
Mental illness in family member and relationship (n=11)	Depression (wife)	5	45.5
	Depression (mother)	1	9.1
	Tension (father)	2	18.2
	Addiction (husband)	1	9.1
	Depression (daughter)	1	9.1
	Depression (sister)	1	9.1
Care-seeking behaviours and perceptions			
Have you ever discussed your mental health issues with a medical professional? (n=113)	Yes	38	33.6
	No	75	66.4
Do people in your community seek medical care for mental health problems? (n=97)	Yes	50	51.5
	No	47	48.5
Can doctors help people with mental illness? (n=103)	Yes	89	86.4
	No	14	13.6
Will people take medications for their mental illness? (n=113)	Yes	78	69.0
	No	35	31.0
Do you think the people with mental illness benefit from medication? (n=116)	Yes	103	88.8
	No	12	10.3

Characteristics	Response	Number	Percentage %
Ways to treat mental illness (n=112) (multiple choices possible)			
Counselling and medication	-	40	35.7
Love, care, affection and support	-	13	11.6
Sharing problems with other	-	10	8.9
Keeping busy	-	9	8.0
Music, travel, sports	-	9	8.0
Meditation and yoga	-	9	8.0
Diet and exercise	-	4	3.6
Lower use of alcohol and drugs	-	4	3.6
Self-satisfaction	-	4	3.6
Prayer and staying in silence	-	3	2.7
Spending quality time with family	-	3	2.7
Don't know	-	4	3.6
Access to mental health services (n=115)			
Care available at the nearest hospital or clinic	-	79	68.7
Care not available at the nearest hospital or clinic	-	36	31.3

Care-seeking behaviours and perceptions about treatment

To assess the care-seeking behaviours and perceptions about treatment, participants were asked questions about themselves and their beliefs about the community's perspectives on mental illness. Only 33.6% reported that they had discussed mental health issues with medical providers in the past. Almost 88.8% reported that people with mental illness might benefit from medications (Table 3).

Community perceptions about the treatment options for mental illness

Among 112 participants who responded to this question, 35.7% identified counselling and medication as ways of treating mental illness. A significant number of participants suggested psychosocial intervention and self-care as treatment options. 11.6% report that love, care, support and affection from friends and family, besides medication would be needed to get better (Table 3).

Knowledge about the availability of mental health services

Participants were asked if they knew the nearest hospital or clinic to receive mental health services. Out of 115 participants, 68.7% reported yes, and 31.3% did not know about the availability of mental health care in the nearest hospital or clinic. (Table 3).

Community perceptions of mental health services

Participants were asked about the role of different activities in coping with stress through multiple questions. Yoga (78.2%), *Bhajan* (religious songs) (59.7%), meditation (36.1%), and mindfulness activities (31.9%) were the top choices for participants. Similarly, almost all (96.6%) believed that psychosocial counselling and psychotherapy are helpful to people with mental illness. While asking whether starting mental health services in their community will be helpful, almost all (99.2%) responded 'yes' (Table 4).

Table 4. Services to improve mental health.

Community perception of mental health services		Number	Percentage %
Activities to cope with stress (Yes) (n=119)	Yoga	93	78.2
	Bhajan (religious songs)	71	59.7
	Meditation	43	36.1
	Mindfulness activities	38	31.9
	Exercise	33	27.7
	Music	29	24.4
	Others (playing, travelling, psychosocial counselling)	4	3.4
Psychosocial counselling and psychotherapy helpful to people with mental stress (n=118)	Yes	114	96.6
	No	3	2.5
	Don't know	1	0.8
Starting mental health services in your community helpful for people (n=118)	Yes	117	99.2
	No	1	0.8

DISCUSSION

This study provides valuable insight into community perceptions of mental health in a rural area of Nepal where formal psychiatric services are previously unavailable. Using a cross-sectional design, we engaged a diverse group of community members – including general population representatives and community leaders representing health workers, FCHVs, schoolteachers, politicians, faith healers and religious leaders. The survey questionnaire captured the knowledge and perceptions of community members about mental illnesses – the causes, treatments and care-seeking patterns.

Consistent with global evidence, community members identified stress and worrying (57.1%), alcohol use (53.8%), and depression (28.6%) as the most prevalent mental issues. These findings are consistent with existing literature suggesting anxiety, depression and alcohol use disorders as the major mental health issues globally and in Nepal (Risal et al., 2016; GBD 2017, Disease and Injury Incidence and Prevalence Collaborators, 2018; Jha et al., 2019). These perceptions align with international epidemiological patterns where common mental disorders, particularly mood, anxiety and substance-use disorders, account for the largest share of mental health burden in both high- and low-resource settings (World Health Organization, 2017). Our findings also mirror data from similar LMIC contexts such as Vietnam and Tanzania, where stress, depression and substance use were perceived as prominent mental health concerns (van der Ham et al., 2011; Benedicto et al., 2016).

Importantly, this study highlights the role of social determinants – particularly poverty, low self-esteem and family conflict – as key community-identified contributors to mental illness and suicide. These perceptions are aligned with the global mental health literature, emphasising the critical interplay between socioeconomic adversity and psychological distress (Lund et al., 2010).

Poverty, described in terms of unemployment and indebtedness, was cited by over 38.7% of participants as a leading cause of mental health issues. Notably, low self-esteem was also considered to be a contributing factor for suicide, which reflects global evidence on the role of self-esteem on suicidal rates (Chatard, Selimbegović and Konan, 2009). However, this finding needs to be interpreted cautiously. In low-income contexts, such as Nepal, where approximately 25% of the population lives below the national poverty line, self-reliance is often culturally expected, even when individuals face substantial mental stress and anxiety due to economic

hardship. This cultural expectation may obscure the psychosocial toll of poverty, reinforce stigma and limit help-seeking behaviours (Ortega and Alegría, 2002; Kohrt, Mendenhall and Brown, 2016).

Family-related stressors were reported by 31.9% of participants as mental health risk factors. These findings are consistent with research from South Asia that shows familial relationships often act as both a source of support and psychological strain (Manoranjitham et al., 2007). Our findings are particularly significant as they suggest that people have a solid understanding of the role of family conflict and relational disputes on mental health. However, these social determinants of mental illness have not received much attention in planning preventive and curative mental health services in Nepal.

Suicide emerged as an important health issue in the Saudiyar community of Nepal. Although national suicide rates remain moderate – estimated at approximately 9.8 per 100,000 per year (Bhandari et al., 2024) – our study found that over one-third of participants reported personally knowing someone who committed suicide. This finding suggests that the visibility and personal impact of suicide within the community are high. Such lived experiences may amplify community awareness and concern, highlighting the need for targeted suicide prevention strategies.

Encouragingly, our findings suggested a growing openness toward mental health care within the community. While only 51.5% of participants in our study believed that community members would be willing to seek mental health services, 86.4% believed that medical doctors can treat people with mental illnesses, and 88.8% believed in the effectiveness of medications. These findings contrast sharply with earlier national estimates indicating that nearly 90% of people with mental illness in Nepal do not seek professional care (Luitel et al., 2017).

However, we acknowledge that the optimistic findings from our study may be influenced by significant representation of community leaders and health workers in the sample size. While this may have introduced bias, this also presented a significant opportunity for community-based mental health promotion. Evidence from various settings highlights the influential role of community leaders in shaping public perceptions of mental illness and treatment, both positively and negatively (Johnsen et al., 1997; Kim and and Campbell, 2022). Programmes that strategically engage community leaders can foster greater acceptance and uptake of mental health services as these leaders serve as trusted gatekeepers in most rural settings and help to bridge gaps between the community and formal health system (Castillo et al., 2019).

In addition to biomedical treatment, a significant portion of the community reported strong endorsement of eastern mindfulness practices such as yoga (78.2%), *bhajans* (59.7%), meditation (36.1%), and music (24.4%) as important strategies for coping with stress. These findings are particularly relevant for global mental health, where growing attention is being paid to the integration of culturally embedded, non-pharmacological approaches into care systems (Kelly, 2008; Dalky, 2012; Varambally and Gangadhar, 2012). In Nepal's majority-Hindu context, practices like *bhajan* and yoga are not only familiar but socially acceptable and potentially low-cost interventions. Their incorporation into mental health programmes may offer locally acceptable avenues to reduce stigma and increase engagement.

Limitations of the study

This study has several limitations. First, the study was conducted in a single rural village in Dang district, which may limit the generalisability of the results to other regions of Nepal with different socio-cultural and health system contexts. Second, the sample size was relatively small and determined pragmatically rather than statistically powered, potentially affecting the robustness of the quantitative estimates. Third, the inclusion of a substantial proportion of community leaders and health workers – who may have more favourable views toward mental health care

– could have introduced selection bias, potentially skewing responses toward greater awareness and acceptance of mental health services. Also, a notable limitation of this study is the presence of variable-specific non-response, which led to differing sample sizes across analyses. This could introduce response bias, particularly if non-respondents differed systematically from respondents. While available case analysis preserves the integrity of each variable's results, it may reduce comparability across variables and limit the generalisability of some findings. Future studies should consider strategies to minimise missing data and explore the use of multiple imputation techniques to address potential bias. Lastly, the use of self-reported data may be subject to social desirability and recall bias, particularly in sensitive areas such as suicide, mental illness and care-seeking behaviours. Nonetheless, this study provides critical baseline data for an under-researched setting and identifies entry points for community-driven mental health interventions in rural Nepal.

CONCLUSION

This study offers critical insights into the mental health perceptions, needs and care-seeking behaviours of a rural Nepali community in the Dang district, a setting historically underserved by formal psychiatric services. Community members identified stress, alcohol use and depression as key mental health challenges, and highlighted poverty, low self-esteem and family conflict as important social determinants. Encouragingly, there appears to be growing acceptance of both biomedical and culturally rooted coping strategies, including yoga, meditation and spiritual practices. Although our findings may reflect the perspectives of a relatively informed sample – including community leaders and health workers – they also underscore the vital role of these actors in promoting mental health literacy and service engagement.

For mental health systems in low-resource settings, especially in South Asia, our findings suggest that integrating culturally congruent approaches with conventional care and leveraging local leadership can enhance community-level responsiveness to mental health needs. As global mental health efforts seek to close treatment gaps and build context-specific care models, evidence from rural settings like Saudiyar can inform strategies that are culturally grounded, community-led and responsive to local needs.

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Authors' contribution: The concept of research involved contributions from SP, SD, MRA, BA, MRB, RP and HN. The design of the research was developed with input from BA, SP, RP, MRA, MRB and SG. For the literature search, contributions were made by RP, MRA, MRB and SP. Data collection was carried out by HN and SG. Data analysis was performed by MRB, RP, SRM, BA, and MRA, with BA contributing extensively. Data interpretation involved RP, MRB, BA, SRM and MRA. Drafting of the manuscript was undertaken by SG, MRB, BA, SRM, SP, MRA, SD, RP and HN. The manuscript was reviewed for important intellectual content by SRM, SD, BA, SP, MRA, RP, MRB, SG and HN. Final approval of the version ready for submission was given by BA, SRM, SG, SP, RP, SD, MRB, MRA, and HN. All authors agreed to be accountable for all aspects of the work. Correspondence with the journal will be handled by SG, SP, BA, SRM, RP, MRB, SD, MRA and HN.

Ethical approval: The Institutional Review Committee (reference number: 352 (6-11-E)2/074/075) at the Institute of Medicine, Kathmandu, Nepal provided ethical approval for this study.

Conflicts of interest: A few data collectors were residents of Saudiyar. All authors are affiliated with HFN, either as an employee, board member or previous board member.

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Informed consent: Informed consent was obtained from all participants. For participants under the age of 18, written parental consent was obtained in addition to participant assent. Written informed consent was obtained from all adult participants.

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