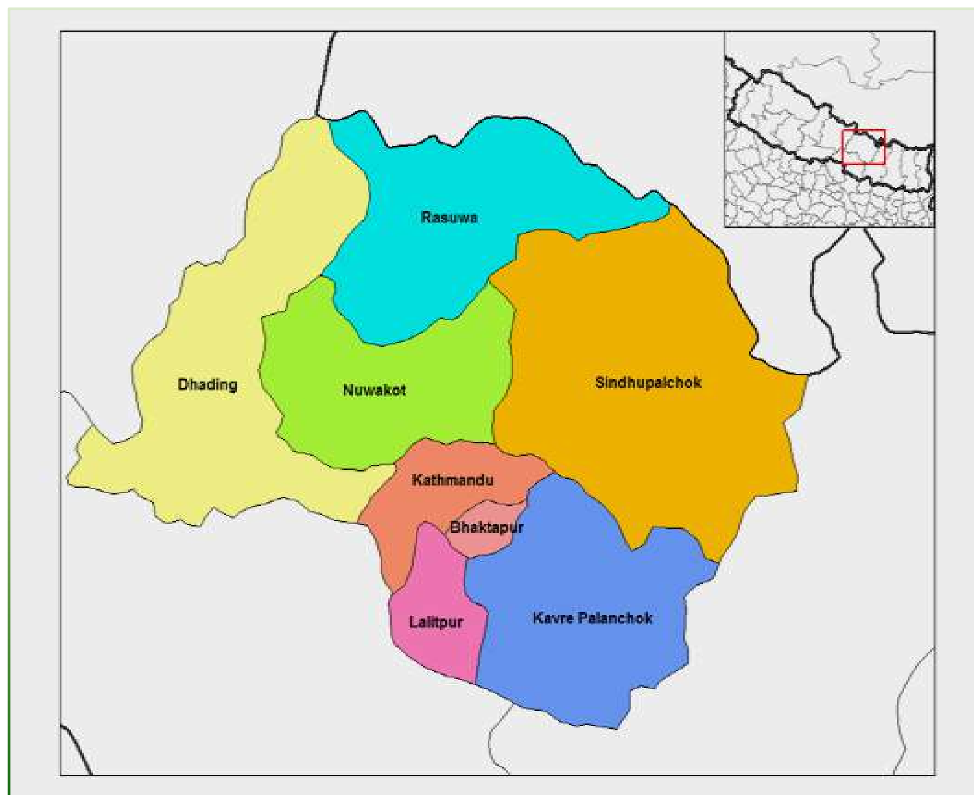
Interactions of Poverty and Mental Health:
A Case for Local Perspectives and Community Health Care in Lalitpur, Nepal

Leah Davison

For eight weeks from April to June 2016, I conducted ethnographic fieldwork in Lalitpur, Nepal. The findings were outlined in my MSc dissertation titled *Interactions of Poverty and Mental Health: A Case for Local Perspectives and Community Health Care in Lalitpur, Nepal.* Lalitpur is an urban district situated in the Kathmandu Valley of Nepal –a country with minimal spending on mental health.



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While completing my MSc in international development I was given the opportunity to undertake primary research that examined the links between mental health and poverty. Given my interest and background in studying poverty I jumped at the opportunity to examine the mechanisms through which poverty and mental illness interact in low income countries. The motivation for the research arose from the fact that many studies in low income countries provide evidence that factors such as experiencing insecurities or vulnerabilities have greater associations than income levels on one's mental health or well-being.

There is common consensus that an association between ill mental health and one's experience of poverty exists. The relationship between the two is predominantly described by two theories. The theory of social causation explains the development of mental health disorders as the OUTCOME of poverty and, for example, deprivation associated with living in poverty.On the other hand, the drift or selection hypothesis suggests that mental health issues may LEAD to impoverishment through lack of employment or associated high health costs, for example.This is the cause effect debate and it illustrates that the relationship between poverty and mental health is both complex and uncertain.

The Global Mental Health Movement (GMHM) is often criticised for promoting a bio-medicalised and universalist approach to mental health care interventions, while development studies have been criticised for inadequate representation of poor people's understandings and perceptions of their own situations. One of my main research objectives was thereforeputting the lived realities of those living with mental health issues and the voices of those living in poverty at the forefront of my research.

I collaborated with Chhahari Nepal for Mental Health (CNMH), an NGO with a strong presence in the Lalitpur area. CNMH ascribes to a social medical model that emphasises holistic community led care when helping those in distress. Their social support services are person centered. Utilising ethnographic research methods such as participant observation and semi-formal interviews I attempted to better understand how socioeconomic factors could create vulnerability to mental illness and distress. The research focused on the experiences of four families who are clients of CNMH.

A number of common themes and trends emerged from the study. The concept of poverty was most commonly recognised as economic deprivation. Many were quick to associate the term with a lack of purchasing capacity, including the ability to regularly purchase medication for the member of their family that was mentally ill. Understandings and behaviours associated with mental illnesswere culturally specific. They were embedded in the belief that to be mentally ill in Nepalese society is to be 'pagal' – loosely translated as mad. And being 'mad' was often thought to be the consequence of a wrongdoing. Utilising traditional healers to cure this 'madness' through ceremonial acts and offerings was therefore common practice. This leads to the theme of stigma. As expected, I found stigma related to mental illness was common place in Lalitpur. It visibly generated social exclusion for those suffering from mental illness as well as their families on a whole. In Nepal this stigma is largely related to the inaccurate understandings of how one develops mental illness (Kohrt and Harper, 2008: 471). Recognising that social exclusion was commonplace drew out that a wider understanding of deprivation than that of economic scarcity existed in the community.A broader idea of well-being was more commonly understood as one's ability to take part in a community and make their own choices. It was also true that caring for a mentally ill person had a major impact on the well-being of entire families —both economically and socially. There are direct and indirect costs of mental illness on both an individual's, and a family's earning capacity and general well-being. This is commonly referred to as the vicious cycle between poverty and mental health.

It was clear that CNMH played a large part in generating a sense of community amongst mentally ill or distressed people and their families. This in turn positively contributed to the well-being of mentally distressed or ill clients and their families as a whole. This social network was of great value and acted as an alternative to the community that mentally ill clients and their families had been socially excluded from.

In conclusion, I found the presence of mental health issues or distress lead to financial and social burdens on individuals, their families as a whole and wider society. Though poverty may increase one's vulnerability to mental illness or distress, or act as a risk factor, it is difficult to draw direct correlations between its causal effect on mental well-being. What was clear, was the direct and positive effect of access to a social network for mentally ill clients and their families. It was also clear that vulnerabilities are exacerbated by the government's lack of spending and support for progressive mental health policy that recognises the positive consequences of community health care. The government should therefore take steps towards creating national policies that prioritise mental health care, and in particular emphasise community approaches that are culturally relevant. It is also essential to encourage open dialogue on mental health to reduce stigma attached to it.

Lalitpur, Nepal (photo taken by a CNMH client)

Kohrt, B.A. and Harper, I. (2008). Navigating Diagnoses: Understanding Mind-Body Relations, Mental Health, and Stigma in Nepal. *Cult Med Psychiatry,* 32, p. 462-491.