**Project report submitted to HelpAge International Myanmar**

**Mental Health Care Burden on Family, Community and Health Care Professionals in Myanmar: A Qualitative Assessment**

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# Executive Summary

**Introduction**

Mental health is crucial to a person’s well-being, healthy family and interpersonal relationships. Mental health problems include disorders such as depression, psychoses, self-harm/suicide, epilepsy, dementia, disorders due to substance use, and mental and behavioural disorders. The Global Burden of Disease ranked Anxiety disorders and Depressive disorders as 9th and 10th respectively for causing the most disability in Myanmar in 2017.

A very limited number of studies attempted to explore the perceptions and challenges in the provision and utilization of mental health services. A qualitative study was conducted among Healthcare service providers, Caregivers of mentally disabled persons, and Community leaders to explore the barriers and challenges in providing and utilizing mental health services in Myanmar.

**Methodology**

In-depth interviews and Key Informant interviews were conducted among 27 health care providers, 65 caregivers, and 12 community leaders who were selected from six townships covering different geographical regions in Myanmar (hilly, central, coastal, and delta areas). Interview guides were prepared separately for each type of respondent from a thorough review of the literature. The interviews were conducted by experienced researchers from the University of Public Health, Yangon. Ethical approval for the study was obtained from the University Institutional Review Board. All the interviews were conducted in Myanmar language and recorded after obtaining their written consent.

All interviews were transcribed and translated into the English language by the researchers. The transcripts were used for their content analysis by generating inductive and deductive codes. These codes were entered in Atlas.ti-8 software to classified into the code groups. These codes and code groups were categorized into themes for data analysis. A total of six themes emerged from the coding.

Of the 27 healthcare professionals interviewed, 11 were general practitioners and 8 were psychiatrists, and the majority had more than 10 years of service experience. Among the 65 caregivers of mental health patients, most of them were parents or spouses of the patients, the majority were females, aged less than 50 years, up to high school level of education, engaged in farming or having their own business. Half the 12 community leaders who participated in the study were graduates and engaged in the community and social services.

**Results**

*Mental health status*

According to healthcare providers, in Myanmar, the major mental health problems for which the patients sought treatment were Anxiety, Depression, Bipolar disorder, mood disorders, schizophrenia, substance abuse, and other psychotic disorders. Mental health cases were commonly reported by men and youths, and the most commonly cited factors that were affecting mental health negatively were alcohol and substance use. The health care providers observed an increase in the number of mental illnesses cases being reported in recent years. Most of the patients only utilized the services at severe stages of their illnesses.

*Factors contributing to mental health*

According to all participant groups, the major cause contributing to mental illness was substance abuse by people, work-related stress, family issues, failed businesses, debt due to the treatment of chronic diseases like HIV and cancer, genetic factors, lack of job opportunities for the youngsters, and inappropriate alcohol licensing policies. The participants also mentioned the poor implementation activities to regulate the sale of alcohol, as well as the availability of drugs as the reasons for substance abuse and related addictions. Some caregivers expressed that lack of sleep, overthinking and lack of appetite can also cause be the indications of mental disorders. Some community leaders believed that congenital anomalies and physical abnormalities by birth, a curse from God, and abuse of addictive drugs and substances were causing mental illness.

*Perceptions of stakeholders on mental health*

Most of the caregivers believed that only allopathic medicines and consultations with doctors were important to treat the illness. Few caregivers practised alternative therapies suggested by religious leaders and monks along with mainstream medication. Service providers and Community leaders mentioned that there was a lack of awareness about mental health in the community, lack of acceptance by own family members, differential and inhuman treatment by family, and superstitions and stigma by society hampering treatment-seeking behaviours. Providers explained that many families did not accept that their family members had a mental illness and that they did not avail referrals for diagnosis, and neither did they comply with long term treatment. The need for counselling to family members was emphasized by a few physicians.

The healthcare providers were opined that the existing facilities to treat mental illness were insufficient. Many public health facilities did not have mental health specialists, counsellors or essential medications to provide treatment services, and have reported high patient load in most mental health facilities. According to mental health professionals, most practitioners typically give less importance to mental health than to other illnesses, and often under-report the mental patient load. Providers also explained their lack of knowledge and capacity to screen, diagnose, and treat, and on the absence of formal referral systems were affecting mental health care provision. This lack of knowledge among providers often results in under-diagnosis or over-treatment of the illness. Unavailability of medicines, high patient-load, non-appointment of psychiatrists in health facilities, lack of punctuality and absenteeism of providers were reported as major challenges in the provision of services as per demand. Many health care providers expressed the need for training health care workers at all levels in the country. The service providers also apprehended that lack of daycare centres and special schools to look after the mentally ill patients hindered the quality of care for patients, and few mentioned that such care centres might induce stigma. Ensuring economic security by providing job opportunities to families of mental health patients, might improve treatment compliance, outcomes, and quality of life.

Though most of the caregivers appreciated the quality of amenities and services provided in public health facilities, some expressed concerns about the inadequacy of infrastructure, long waiting periods, and the quality of medicines provided in public hospitals. Another concern of caregivers was the lengthy treatment course combined with the difficulties in sustaining regular patient follow-up at the clinics. Nevertheless, positive behaviours and patience shown by healthcare professionals were shown to influence caregivers to adopt similar approaches and to positively influence patient follow-ups in the clinics. Those caregivers emphasized the importance of patient-friendly and discrimination-free environments in the hospitals, as well as empathy, showed by the providers towards the caregivers. Some caregivers emphasized the positive experiences they have had in providing care to patients when patients were willing to undergo treatment and adhere to medications, when patients showed empathy towards them, and when efforts were made to control their behaviour and to reduce their stigma against mental health patients. Some caregivers also mentioned they received support from other family members, relatives, and friends. A few of the caregivers felt that taking care of a mentally ill family member as a family obligation.

*Experiences related to mental health*

The care provided to patients usually includes support on basic personal needs, timely provision of medicines, and handling of aggressive, destructive, anti-social and self-abusive behaviours. Some caregivers reported feeling compelled to take more severe measures for patients who would become more aggressive, such as confining them, tying their hands and legs, giving sedatives, or even threatening them with pain-inducing objects. Many caregivers experienced helplessness or even depression while caring for such patients. Many families find it difficult to seek treatment because of social stigma and financial burden associated with the treatment.

Caregivers reported that longer duration of treatment, higher vigilance, supervision, accompanying and safeguarding patients during clinic visits, and the inability to leave patients alone at home were all causes for job terminations and loss of employment opportunity, and the plight of mental patients caused depression and sleeplessness to caregivers. The community leaders explained that mentally sick people often engaged in violence and crimes, which affected the community and its social aspects.

*Challenges regarding mental health*

Caregivers reported several challenges in terms of providing care for mental health. Caregivers often lacked support from their family members, and also witnessed superstitions and differential attitudes of family members to patients, as well as stigma and discrimination from society. Also, a lack of awareness of mental health-related signs and symptoms and on availability of services in the area was a major challenge for providing care and services. Caregivers also reported the challenges in accompanying patients for services, supporting in their daily personal needs, and assuring patient’s compliance with treatment. In addition to difficulty in promoting adherence from the patient side, a major challenge was also the inadequate supply of medicines and the lack of counselling and education to caregivers. Caregivers often had difficulties handling more demanding patients, and often witnessing harassment faced by patients. Managing caregivers’ health care and mental health conditions at the same time as caring for such patients was extremely difficult. Lastly, caregivers reported that in some cases their own mental and physical health deteriorated, and they experienced the loss of employment and job opportunities contributing to increased economic burden and debt and reduced quality of life.

**Recommendations to improve mental health**

The recommendations that were given by the study participants to improve the mental health situation in Myanmar were the following:

* Improving the quality of treatment through capacity building;
* Assuring the availability and affordability of treatment and other special services for mental health;
* Improving the infrastructure in healthcare facilities;
* Increasing and strengthening coordination with NGOs to build a conducive environment for treatment-seeking;
* Promoting inter-departmental coordination for identification of cases and reducing burden and stigma;
* Filling the vacancies and recruiting additional human resources to reduce patient-load;
* Organizing campaigns to increase health awareness to the public and training to mental health professionals;
* Promoting health lifestyle including alcohol and drug de-addiction programs and reducing stress among youths and children;
* Promoting health education for the community to reduce stigma and treatment prognosis, early diagnosis, substance abuse, and the importance of family for children through inter-sectoral and departmental coordination;
* Improving the legal framework and enforcement of laws on alcohol and drugs;
* Improving socio-economic conditions of population through employment generation and skill development, and economic support to patients through resource pooling at townships and community level insurance;
* Mobilizing youths and manpower to be volunteers in most of these activities; and
* Generating evidence periodically on mental health status, challenges in providing the services, and on barriers to avail services for future planning.

# 1 INTRODUCTION

## 1.1 Background

Myanmar is a South-East Asian country with an estimated population of 53 million in 2017 and has a triple burden of diseases such as communicable diseases, non-communicable diseases and accidents/injuries/mental health issues. According to Global Burden of Disease (GBD) estimates, in 2017 Anxiety disorders and Depressive disorders were ranked 9th and 10th respectively in the top 10 causes of years lived with disability by the people in the country. (1)

## 1.2 Burden of Mental health problems in Myanmar

The estimated prevalence of Anxiety disorder of Myanmar in 2017 was 3.38%, Depressive disorder and other mental health disorders were 2.29% and 1.95% respectively. (1) Mental health is crucial to a person’s well-being, healthy family and interpersonal relationships. Mental health and physical health are closely related. (2) Mental, neurological and substance use disorders are highly prevalent and they account for a large burden of diseases globally. These include depression, psychoses, self-harm/suicide, epilepsy, dementia, disorders due to substance use and mental and behavioural disorders in children and adolescents. (3)

Mental disorders are generally characterized by some combination of abnormal thoughts, emotions, behaviour, and relationships with others. As per the Global Mental Health Report in 2018, one in four persons was expected to be affected by mental or neurological disorders at some point in their lives. (4) Mental disorders account for about 450 million people currently and they are among the leading causes of ill-health and disability worldwide. These include 300 million people with depression, 60 million people with bipolar affective disorder, about 23 million people with schizophrenia and 50 million people with dementia. (4,5)

Despite the high burden of mental disorders, health systems have not yet adequately responded, leading to a gap between the need for treatment and its provision all over the world. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder. In high-income countries, between 35% and 50% of people with mental disorders are in the same situation. (5)

People with mental illness require social support and care, besides the support from health-care services. Families and friends who give care to people with mental disorders (MDs) are also affected in a variety of ways and degrees. As a consequence, poverty, discrimination and stigma, lack of support from others, diminished social relationships, depression, emotional trauma, and poor or interrupted sleep, are all associated with caregiver burden. (4,6)

In addressing the burden of mental disorders, health-care services play a critical role. Most mental disorders can be successfully treated. However, nearly two-thirds of people with a known mental disorder never seek help from a health professional. According to WHO, stigma, discrimination, and neglect prevent care and treatment from reaching people with mental disorders. (4,7) Perception and attitude of health professionals towards mental illness have an impact on their decisions in daily practice. Moreover, health professionals’ negative attitudes may be a factor in the low rate of engagement of patients with serious mental illness with healthcare services. (8)

Religious leaders in ethnic minority communities are often the first point of contact for mental health needs. (9) A growing literature recognizes the roles of clergy in identifying and addressing mental health needs in their congregations. (10)

## 1.3 Rationale of the study

Though estimates of the prevalence of mental illnesses are high as above, limited studies have attempting to assess the perceptions and challenges in providing and utilizing mental health services for people having mental illness in Myanmar. Thus, this study aims at exploring the perceptions of health care providers, caregivers, and communities towards mental illness. The result of this study will help to assess and better understand the burden of mental health problems and barriers for availing the services in Myanmar. Understanding the current mental health situation and the challenges faced by the service providers, caregivers of mental health patients and perceptions towards the mental health problems by community members is important to devise appropriate strategies, to provide appropriate services to patients, and to plan better health promotion plans to reduce barriers and scale-up the utilization of mental health services.

# 2 OBJECTIVES

The objective of this study was to assess the burden of the persons who provide care to mental health patients in selected townships of Myanmar.

## 2.1 Specific objectives

The specific objectives of the project were to:

* Assess experiences, perceptions, and burden of family and community in providing mental health care in selected townships of Myanmar.
* Explore the experiences and barriers in delivering mental health care services by health care professionals in selected townships of Myanmar.
* Provide suggestions to minimize the burden of care providers and to improve the utilisation of mental health services in Myanmar.

# 3 METHODOLOGY

## Study design

A qualitative study was carried out to assess the perceptions on mental health, experiences, and burden of healthcare professionals, communities and families. Individual in-depth interviews (IDIs) were conducted to explore the burden of caregivers in providing care to patients with mental disorders. Key informant interviews (KIIs) were conducted among selected health care providers and community leaders to explore the challenges, experiences, and perceptions to provide services for mental disorders. The data collection for this study was done from August 2018 to July 2019 by a team of six researchers from the University of Public Health, Yangon who have experience and skills in conducting qualitative research.

## Study setting

The Republic of the Union of Myanmar is located in South-East Asia and shares borders with Bangladesh, India, China, Laos, and Thailand. According to the Population and Housing Census 2014, the total population of Myanmar was 51,419,420. As per the Myanmar Information Management Unit, there were 330 townships in Myanmar as of December 2015.

The present study was conducted in six selected townships of Myanmar, of which two townships were from the delta region and one township each from the coastal and hilly regions. Two of the selected townships had community mental health clinics. Most of the selected townships in Myanmar had psychiatrists, except townships with community mental health clinics where psychiatrists were not recruited. In those townships where there were no psychiatrists, the clinics were operational for two days a month. The population by each township ranged from 100,000 to 450,000.

## Study population

The study population included mental healthcare providers, caregivers for mental health patients and community leaders from each township. The inclusion and exclusion criteria used to select the study participants were listed below.

**Inclusion criteria:**

* **Health care providers** included psychiatrists, medical superintendents, district health officers, township medical officers, psychiatric nurses, and general practitioners.
* The **caregivers** were the persons who used to take care of patients at home and/or accompanying the patients for clinical consultations for at least 6 months. Persons offering supportive care to mental patients undergoing treatment for depression, psychosis, epilepsy, addiction disorders, and children and adolescents having mental and behavioural disorders.
* **Community leaders** who had frequent engagements with the community and were involved in an administrative role and/or community-based organizations were included in the study.

**Exclusion criteria:** healthcare providers who were on leave during the data collection period, and caregivers having communication difficulty.

## Respondent selection and sample size achieved

In this study, a purposive sampling approach was adopted to identify and recruit study participants. The researchers contacted the psychiatrists and healthcare professionals in each of the selected townships and sought their help to identify the caregivers and community leaders for the study. The sample size was determined by data saturation when there was no new information obtained from the informants.

From each township, 9 to 12 caregivers and two community leaders were interviewed. The health care professionals who participated in this study included eight psychiatrists, three medical superintendents, two district health officers, two township medical officers, one psychiatric nurse, and eleven general practitioners. These health workers were from different geographical regions in Myanmar (hilly, central, coastal, and delta areas), from the community mental health projects in two townships, and one tertiary mental health hospital.

A total of 27 health care providers, 65 caregivers, and 12 community leaders were interviewed for this study.

## Interview guide / tool

The interview guide for each type of respondent was developed through a review of the literature. The interview guide included open-ended questions and probes to understand the meaning of mental disorders by the respondents, causative factors of mental disorders, experiences, burden, and barriers to the community to take care of persons with mental disorders, and their suggestions to reduce mental disorders and to improve the mental health services. Pilot interviews were conducted in Thone Gwa Township, Myanmar, to ensure that the questions were relevant. Data from the pilot study were not included in this study. The interview guide prepared in English was translated into Myanmar language for data collection.

## Data collection

The interviewers and note-takers were trained to conduct in-depth interviews, and oriented on the objectives and confidential nature of this study. The interviews were conducted in Myanmar language by the interviewer with the help of the note taker. The average duration of the interview was an hour, and the audio recording was done after obtaining the consent. The venue for all interviews was carefully chosen to ensure that there were no distractions. Notes related to the interviews such as date, time and duration of the interview, as well as information on participant demographics were obtained. Field notes were taken by another team of researchers. After the completion of each interview, the interviews were summarized and read back to the participants for validation.

## Data analysis

The data were analysed using a Framework Analysis. All the interviews were recorded and transcribed verbatim on the same day. Interviewers familiarized themselves with the data by repeated listening and reading. All the transcribed interviews were read by the researchers who did the analysis. The verbatim was translated into English transcripts, and the transcripts were used for their content analysis. Both inductive and deductive codes were developed for each topic/issue and ensured that no new codes were emerging. These transcripts were further coded by using **Atlas.ti-8** software. The emerged codes were evaluated against the research objectives and were classified into the code groups. Then, the codes and code groups were categorized into themes. These themes were used for data analysis.

## Ethical approval

Ethical clearance for the study was obtained from the Institutional Review Board of University of Public Health, Yangon (ITERB 2018/Research/32). At the outset of the study, the objectives and procedures of the study were explained to all participants. Written informed consent was obtained from all participants. The research team members carried out the interviews and initial analysis, and the personal identifiers of participants were removed to maintain anonymity and confidentiality.

# 4 RESULTS

The present study was conducted to understand the experiences, perceptions, and burden caused by mental health illness to families and communities, to explore the experiences and barriers for health care professionals to deliver mental health services in six selected townships of Myanmar and to identify ways to reduce this mental health burden.

The study was conducted among 105 informants – 27 health care providers, 65 caregivers, and 12 community leaders. This chapter presents the general characteristics of study participants and the common categories emerged under different themes.

## 4.1 Profile of the respondents

A total of 27 healthcare professionals participated in this study, and their profile is given in Table-1. There were eight psychiatrists, three medical superintendents, two district health officers, two township medical officers, one psychiatric nurse, and 11 general practitioners. Most of them were older than 39 years (range 30 to 70 years) and had more than 10 years (range 7 to 34 years) of service experience.

Table-1. Profile of health care professionals (n=27)

|  |  |  |
| --- | --- | --- |
| **Characteristics** | **Frequency** | **Percentage** |
| **Age**  30 to 39 years  40 to 49 years  50 to 59 years  ≥60 years | 7  8  8  4 | 25.9  29.6  29.6  14.8 |
| **Sex**  Male  Female | 15  12 | 55.6  44.4 |
| **Health care professionals**  Psychiatrist  Medical superintendent  THO/ TMO/DHO  Psychiatric Nurse  General practitioners | 8  3  4  1  11 | 29.6  11.1  14.8  3.7  40.7 |
| **Duration in service (years)**  ≤10 years  11 to 20 years  21 to 30 years  >30 years | 6  8  10  3 | 22.2  29.6  37.0  11.1 |

The background characteristics of the caregivers for mental health patients are depicted in Table-2. Slightly over half of the caregivers were aged up to 50 years and were female, and had less than high school level education. Many of the caregivers were engaged in farming or their own business. Nearly half of the caregivers were the parents of patients.

Table-2. Background characteristics of caregivers (n=65)

|  |  |  |
| --- | --- | --- |
| **Characteristics of caregivers** | **Frequency** | **Percentage** |
| **Age** |  |  |
| ≤50 year | 38 | 59.38 |
| >50 years | 27 | 42.19 |
| **Sex** |  |  |
| Male | 28 | 43.75 |
| Female | 37 | 57.81 |
| **Education level** | |  |
| Illiterate | 1 | 1.56 |
| Can read and write | 7 | 10.94 |
| Primary school | 27 | 42.19 |
| Middle school | 12 | 18.75 |
| High school | 6 | 9.38 |
| Graduate | 5 | 7.81 |
| Missing | 7 | 10.94 |
| **Occupation** | |  |
| Dependent | 16 | 25.00 |
| Manual worker | 8 | 12.50 |
| Own business | 18 | 28.13 |
| Government staff | 1 | 1.56 |
| Farmer | 21 | 32.81 |
| Seller | 1 | 1.56 |
| **Caregivers’ relation to patient** | | |
| Parents | 32 | 50.00 |
| Offspring | 5 | 7.81 |
| Sibling | 10 | 15.63 |
| Spouse | 12 | 18.75 |
| Relatives | 5 | 7.81 |
| Friends | 1 | 1.56 |

The profile of the community leaders who participated in this study is given in Table-3. From each township, two community leaders were selected with the help of medical officers. All key informants were males in the age range of 28 to 70 years. One respondent from the Delta region was a monk. Half of them were graduates, and others had up to the high school level education. During the interviews, one-third of the community leaders reported being actively engaged in social welfare services.

Table-3. Profile of community leaders (n=12)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ID No.** | **Township** | **Age** | **Sex** | **Education** |
| A | Community mental health clinic (+) | 48 | Male | High School Level |
| B | Community mental health clinic (+) | 63 | Male | Middle School Level |
| C | Community mental health clinic (+) | 53 | Male | High School Level |
| D | Community mental health clinic (+) | 58 | Male | High School Level |
| E | Delta region | 28 | Male | BA (English) |
| F | Delta region | 39 | Male | Master |
| G | Coastal region | 70 | Male | LLB |
| H | Coastal region | 60 | Male | Graduate |
| I | Central Region | 49 | Male | High School Level |
| J | Central Region | 53 | Male | BA |
| K | Hilly region | 38 | Male | LLB |
| L | Hilly region | 63 | Male | BA (History) |

The data obtained through key informant interviews and in-depth interviews were subject to thematic content analysis through inductive and deductive coding approaches. The transcripts were coded manually and used Atlas.ti-8 software for further analysis in tune with the research objectives. A total of six themes emerged from the content analysis, which is presented in Table-4.

Table-4. Major themes emerged in content analysis

|  |
| --- |
| Theme 1. Mental health status |
| Theme 2. Factors contributing to mental health |
| Theme 3. Perception of stakeholders on mental health illness |
| Theme 4. Experiences related to mental illness by stakeholders |
| Theme 5. Challenges regarding mental health |
| Theme 6. Recommendations to improve mental health illness |

## 4.2 Services provided through Community Mental Health Centres

During the thematic analysis of qualitative data, an attempt was made to understand various services provided to beneficiaries through community mental health centres (CMHCs). The interviews with health care providers informed that the CMHCs in the selected townships were established in February 2012, and started as a mental health project in Khayan, Thonegwa by Sayar U Win Aung Myint (Deputy Medical Superintendent) and Sayar U Kyi. From the beginning of the project, the centres were offering specialized consulting services.

*“CMHC was started as a mental health care project in Khayan, Thonegwa. At that time, it was not regular care. In February 2012, it was like one mental health specialist used to tour and offer consultation services in Khayan township. It started in the era of Sayar U Win Aung Myint (Deputy Medical Superintendent) and Sayar U Kyi. CMHCs were started in Kyauk Tan and Kort Hmu followed by Hlaing Thar Yar.” (Respondent- Health care provider)*

Over the years, these CMHCs have offered easy access to mental health services and prompted patients and family members to complete the treatment course. These centres were also able to procure drugs and dispense them at affordable prices at the periphery level.

The clinical team in the CMHCs consists of four psychiatrists including consultants, sanitary staff, two trained nurses and three nurse aids. The physician has to offer consultations to patients. The nurses dispense drugs, register cases, and prepare reports. Services are offered three days a week, and each doctor provides consultations for 30-40 patients during operational days. In certain CMHCs, like the one in Hlaing Thar Yar, the patient load is sometimes very high, reaching about 400 patients a day, which means that each doctor has to examine about 50 to 100 patients a day.

*“Clinic opens 3 days a week, and patient load per day will be 30 to 40, of which about 4 cases will be of Alcoholic related illness.” (Respondent - Health care provider)*

*“In Hlaing Thar Yar, the number of patients reached 400 some days, so each doctor has to see 50 to 100 patients. It is not suitable for the ward if only 6 doctors are placed at the CMHC”. (Respondent- Health care provider)*

“*Most of the follow-up cases are appointed only if they are very severe. Normally, we give appointments monthly, and weekly for very severe cases.” (Respondent- Health care provider)*

## 4.3 Theme 1. Mental health status

According to the healthcare providers interviewed, the major mental health problems for which the patients approached them were mood disorders, schizophrenia, substance abuse, and psychotic disorders. Sometimes female patients approached them with anxiety and ‘fit’ (epilepsy) because of anger. Substance abuse was relatively low in most townships as compared to that in cities like Taunggyi and Mandalay. The code groups that emerged under the theme of mental health status are given in Table-5.

Table-5. Theme 1. Mental health status

|  |
| --- |
| THEME 1. MENTAL HEALTH STATUS |
| * Prevalence of mental Health Illness |
| * Symptoms of poor mental health |
| * Consequences of poor mental health |

**Prevalence of mental Health Illness**

According to the mental healthcare service providers, it was found that Anxiety, Depression, Bipolar mania and Schizophrenia were the most common mental health disorders in the study areas, followed by cases of alcohol withdrawal and substance abuse symptoms.

*“Anxiety neurosis is the most common mental health disorder, and the second one is alcoholic addiction. In some cases, Psychosis / Schizophrenia among patients was found.” (Respondent- Health care provider)*

According to another health care provider, Alcohol-related cases were the most prevalent, followed by drug abuse.

*“In terms of issues related to inpatients, the majority were related to alcohol abuse (50 to 60%), and drug abuse (20 to 30%). Others are mental health illnesses including depression and mania (bipolar disorder). In terms of outpatients, most issues were related to mania, depression, alcohol addiction, and substance use. Schizophrenia was also present among certain patients, whereas Insomnia and sexual disorders (as a result of insomnia) were rare” (Respondent- Health care provider)*

Mental health cases were commonly reported by men and the most commonly cited factors affecting mental health negatively were alcohol and substance use. Depression was more common among female patients, maybe because of their inability to share their problems with their husbands. Some females had issues related to lack of sleep, headache, and dizziness symptoms before their examination.

*“Among men common issues are related to alcohol and narcotics use. Depression and exaltation (severe mood disorder) are more common among women” (Respondent- Health care provider)*

The health care providers observed an increase in the number of mental illnesses cases reported over the years. Even though mental health cases increased over the years, it was low as compared to the increase in non-communicable diseases.

*“Cases of mental health illnesses have been increasing compared to the previous years, however, it has not yet reached 10 per cent of the total population, and although the rate is increasing, it is not as high as that of NCD. Diabetic and hypertension are common than mental health illnesses” (Respondent- Health care provider)*

For youth, the main cause of mental illnesses was the addiction to alcohol and substances whereas, for older people, who usually have to depend on working family members, family issues and financial instability was the main cause of mental health illnesses.

*“Youths don’t know about those problems; they make a plan for their life but not the elderly people. Older people can’t live however they want and they have more family problems and financial problems.” (Respondent- Health care provider)*

**Symptoms of poor mental health**

A large number of respondents also mentioned different symptoms ranging from feelings of anxiety, depression, aggressiveness, stress, frustration, disappointment, and despair. In some cases, symptoms went from panic attacks, verbal abuse, to reduced desire to live. Alcoholic patients had symptoms such as turbulences, insomnia, and even hallucination in some cases. Mental health disorders were also associated with other chronic diseases such as epilepsy, epileptic Psychosis, TB, and HIV, as reported by a Health care provider respondent.

As most of the patients visited the caregivers only at a severe stage, they majorly found psychosis, manic and mood disorder cases in hospital settings.

Some women experienced sustained states of depression and hopelessness, while others mentioned experiencing a poor state of mental health that had passed when circumstances changed.

“*At the extreme end were attempts of suicide or suicidal ideas like jumping from the house window and uncontrollable crying/hitting and screaming.” (Respondent- Health care provider)*

**Consequences of poor mental health**

The consequences of dealing with mental health problems for caregivers, particularly, the stress was reported as such: because the patients did not change clothes or take showers by themselves and sometimes shout out at the caregivers., that had an impact on the well being of the caregivers themselves.

“*Sometimes she says she is going to pee and then passes urine in her trousers.” (Respondent - caregiver)*

There was also a loss of self-identity among the patients and they were unable to locate their house.

*“However he went outside saying that he was going home. But he didn’t remember the house he has been in before.” (Respondent - caregiver)*

Few women patients have had serious problems which affected their social life. for example, regarding eroticism and increased libido leading sometimes to pregnancy.

According to the caregivers, the mental health patients used to cause disturbances to the caregivers, healthcare providers, and the community they live in by getting involved in quarrels at night, in domestic violence with spouses and parents, being rude and yelling at others. Some of the patients also exhibited anti-social behaviours such as nudity which made it difficult for the caregivers, providers, and community to handle.

*“She pressed the head of the child with the pillow and she also said she would give the child away to my father and mother. Whenever his disease gets severe, he punches everyone nearby. He also drives motorcycle if someone prohibits it he destroys it.” (Respondent - caregiver)*

*“During a quarrel with parents or with the spouse, he hits someone with no reason suddenly.” (Respondent - caregiver)*

*“Sometimes they go naked to the forest in front of groove. Some patients defecate on the floor after it has been cleaned. So to clean the floor again, we need workers.” (Respondent - caregiver)*

The family members have lost their job opportunities and experienced loss of income because they had to give their time for taking care of mental health patients. Sometimes the caregiver could not perform well at their workplace or have had to miss work altogether as they have to put the efforts into handling their family patients.

Many of the patients could not engage in paid vocational activities as they need to take periodic rests in their workplace and are sometimes unable to control their cognitive functions. Some patients have a long treatment making it impossible to work.

“*She is taking rest for 3 months*” *(Respondent - caregiver)*

“*He can’t work as before and easily get tired.” (Respondent - caregiver)*

Many mental health patients exhibited a lack of desire to interact with others and suffered from lack of sleep and loss of appetite. Commonly, they wanted to stay alone and do whatever they want.

*“She was in the blankness and replied nothing when I talked to her” (Respondent - caregiver)*

## 4.4 Theme 2. Factors contributing to mental health

The major factors contributing to poor mental health conditions reported by study participants were discussed below and the code groups identified under the theme is given in Table-6.

Table-6. Theme 2. Factors contributing to mental health

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| THEME 2. FACTORS CONTRIBUTING TO MENTAL HEALTH |
| * Substance abuse by the people |
| * Stress at work and family problem |
| * Low socioeconomic status |
| * Poor regulations on alcohol/substance abuse |
| * Positive family history |

**Substance abuse by the people**

From the responses elicited through in-depth and key informant interviews, it was evident that male patients used to get treatment for symptoms related to alcohol dependence. Caregivers and healthcare providers mentioned that many patients stop consuming alcohol upon insistence from their family, but used to develop various withdrawal symptoms. Many started taking alcohol as part of the socialization process, and many youths started this habit as an experiment with alcohol.

*“Then they drink the whole day. Later their family members tell them to give up alcohol. So they* quit *alcohol but it is followed by withdrawal symptoms*.” *(Respondent- Health care provider)*

*“They thought that if you cannot drink, you might not get in the social environment. Young people are also experimenting to drink alcohol.” (Respondent - caregiver)*

**Stress at work and family problem**

Mental health problem, particularly, depression was mentioned by respondents as the result of family issues such as the death of the spouse. Depression leads to alcohol consumption and becomes a social problem in men. In women, the depression was mainly due to the death or separation of their husbands.

*“Depression can be seen in women when their husbands are dead or divorced.” (Respondent- Health care provider)*

Lack of job opportunities and permanent employment have resulted in economic vulnerabilities and debt trap. Also, the excess workload was the main contributing factor to the increase in mental health problems. Stress due to increased competition during educational performance and examination has led to the rise in the prevalence of mental health illness among students.

*“Most patients are from the clothing industry for which they have to work from early morning to late night” (Respondent- Health care provider)*

**Low socioeconomic status**

Low socioeconomic status was cited as a cause for mental illness by the healthcare providers. There were patients who have started alcohol consumption and committed suicide due to the excessive burden of debt.

“*Because of the socio-economic problem, people develop Mental illness. They work the whole day. In the evening, they drink. Moreover, they are low in education status. They think their stress is released after drinking.” (Respondent- Health care provider)*

**Poor regulations on alcohol/substance abuse**

In most of the townships, the unregistered alcohol shops buy alcohol from the registered shop and sell. it Easy availability and lower cost of alcohol have become a leading cause of mental illness.

*“Alcohol use dependency is the most* common *psychiatric related problem and alcohol can easily be bought, it costs only 50 or 100 kyats” (Respondent- Health care provider)*

A healthcare professional explained that the role of armed forces by providing prohibited drugs has resulted in the excessive use of banned drugs by the labour population and addiction to it by children.

*“We have to give poppy plants to the workers first before we can ask them to work in the rubber plantations. There is also this thing called Myin Say (Myin means horses and Say means drugs) which are transported via armed forces. This group is also known as the group for peace. All of the armed forces sell Myin Say. Initially, they target the children who are poor and give them to use for free. When those children become addicted, they are forced to carry the drugs, as dealers. They are persuaded that they will get one tablet free if they can sell 10 tablets*.” (Respondent*- Health care provider)*

**Positive family history**

According to health care providers, some of the mental health problems have a family history.

*“It is partly due to genetics. It can be found as 6 in every 100 children.” (Respondent- Health care provider)*

## 4.5 Theme 3. Perception of stakeholders on mental health illness

The perceptions of caregivers of mental health patients, community leaders and healthcare service providers on mental health illness are provided under this theme in Table-7.

1. **Perception of mental health illness by the caregivers**

**Perception of cure of Mental illness**

Most of the caregivers correctly perceived that only doctors can cure mental illness. When probed about the practices of witchcraft as a causative or curative mechanism for mental illness, they had recused the idea.

*“Psychiatrists can treat mental illness.” (Respondent - caregiver)*

“*Sorcery and witchcraft cannot cause mental health illness.” (Respondent - caregiver)*

*“At first, I think because of that. I thought it was not because of that later on and so I am here.” (Respondent - caregiver)*

They thought the illness was related to mind and there was nothing that the family could do. So, the best way for the family was to go to the hospital. Many did not believe that traditional healers, herbalists and exorcists could cure or treat mental illness, and believed that such persons could not make any difference.

*“Traditional shaman (Bhanenaw Sayar) cannot cure this case. They are not professionals and have no skills to treat this, but the professional psychiatrists can. They have experiences and professionalism.” (Respondent - caregiver)*

Table-7. Theme 3. Perception of stakeholders on mental health illness

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| THEME 3. PERCEPTION OF DIFFERENT STAKEHOLDERS ON MENTAL HEALTH ILLNESS |
| I. Perception of mental health illness by Caregivers |
| * Perception of cure of Mental illness |
| * Understanding of Mental illness |
| * Perception of Cause of Mental illness |
| II. Perception of Mental Health Illness by Community leaders |
| III. Perception of Mental Health Illness by Health care providers |

**Understanding of Mental illness**

The caregivers assumed that someone who behaves abnormal or thinks abnormal has mental health illness. They also thought that symptoms like loss of consciousness was abnormal and must be a mental health issue.

The caregivers perceived that it was due to distress and that there was a need to keep open-minded and share feelings with others. If not, it would become aggravated and finally explode. They assumed that this was not a shameful disease and should be accepted by others in the community.

*“Mental illness is out of control of mind due to too many worries and anxiety.” (Respondent - caregiver)*

According to caregivers, insomnia and thinking all the time and finally losing his mind are the symptoms. They used to think it was due to the instability of mind and body.

“According *to Buddhist monks, they always say that mindfulness is very basic and critical in life. Even for me, I also have a lot of thoughts concerning family and everything. I can’t even control my mind sometimes. So, I think my sister also cannot control her mind like this.” (Respondent - caregiver)*

About the prognosis, they did think it could be relieved in a short time, and with compliance with treatment, it could be cured completely.

*“Some persons get relief in a short time and some get completely healed.” (Respondent - caregiver)*

When asked about the ways to relieve mental health illness, they opined that warmth and care, especially from the family could help the patient. Few caregivers did not have sufficient knowledge regarding mental health.

*“If her husband treats her warmly and cares about her, it can relieve her suffering more. I think just like that.” (Respondent - caregiver)*

*“I have no idea.” (Respondent - caregiver)*

**Perception of Cause of Mental illness**

Caregivers and the community believed that mental health was associated with spiritual issues like being enchanted, bewitched, and/or possessed. The other causes listed by the caregivers were stress, change in weather, overthinking, lack of sleep for a long time, drug usage and impairment in body metabolism and circulation.

*“For example, she is cold while others feel hot in summer.” (Respondent - caregiver)*

*“Some of my neighbours said that if a child is sick, it is due to the extraordinary traditional issue or being enchanted.” (Respondent - caregiver)*

*“As for me, I don’t think it is related to black magic or witchcraft things. But our elderly said that it is due to no regulation of body metabolism and circulation.” (Respondent - caregiver)*

*“I think it was because of the weather and stress. May be due to overthinking all the time.” (Respondent - caregiver)*

*“I think it happened after she has been forced to break with her first boyfriend.” (Respondent - caregiver)*

Few caregivers did not know the causes of mental illness and they assumed that it is due to diverse factors like muscle weakness, the impact of physical injury, poisoning, or doing certain things (daily habits) at the wrong time.

*“I have no idea. I think it was because of muscle weakness and behave abnormally.” (Respondent - caregiver)*

*“Think her mental disorder is due to the impact of cow kick in her young age.” (Respondent - caregiver)*

*“I think the restaurant owner in Malaysia put the drugs in his food or drinks and that is why he becomes abnormal after his return.” (Respondent - caregiver)*

*“We think she took a bath or shampoo wrong time so that causes her brain something defect. And then, people say that it might be due to black magic so we saw some exorcists before but it didn’t go well.” (Respondent - caregiver)*

1. **Perception of Mental Health Illness by Community leader**

The community leaders perceived the mental health illness as an abnormal state of mind. Various causes for mental illness perceived by community leaders were related to blood and bowels. Some even thought it as a congenital disease, physical abnormality present at birth, and psychotic disorder as a result of using illegal drugs.

They comprehended mental illness as a condition when a person was being detached from reality, and might not be behaving and acting normally.

*“Being in an abnormal state of mind, I would say” (Respondent - Community leader)*

*“I have heard that mental health is due to blood-related or bowel disorder. Some may be congenital” (Respondent - Community leader)*

Also, many of them thought of socio-economic problems due to failed business, affordability, and job terminations have led to mental health problems. Many older community leaders believed that the pursuance of higher education by the younger generation has damaged their nervous system resulting in increased mental illness among the youths.

*“In my opinion, I think he studied a lot and hurt the nervous system when he was a Grade student.” (Respondent - Community leader)*

*“Well, the failed business, as I mentioned.” (Respondent - Community leader)*

*“For some, there are these married couples who sell pork. The cost of licensing is quite expensive. They worked in Kyauk Tan for many years. But after some time, they can no longer afford it. Their job terminated because of some other businessmen.” (Respondent - Community leader)*

According to the community leaders, the cases were on the rise due to increased alcohol consumption because of a lack of job opportunities for the youngsters, and inappropriate alcohol licensing policies.

“*I think that’s partly because of the lack of job opportunities. Licensing to sell alcohol officially is no longer undertaken. Only the already authorized ones can sell. There is no new license in our town” (Respondent - Community leader)*

This was mainly leading to increased use of recreational drugs and children refusing to obey rules.

*“That is related to recreational drugs and alcohol. Children become disobedient” (Respondent - Community leader)*

When asked about the relationship between mental health and traditional beliefs, they opined that they were related to one’s education level and the society they live in. There was a lack of awareness about mental health among the community as they did not get any education on the subject and had to read books related to these topics. This lack of knowledge did make them believe in superstitions and not getting appropriate consultations from the hospital.

*“It is mainly linked to one’s educational level and society. Besides, the lack of general knowledge and not willing to read books compound this. If people start to read more books and have a certain level of education, these speculations will fade away. Since there is a low educational level in the village, there will still be these beliefs” (Respondent - Community leader)*

While talking about the differential treatment by the society towards mental health patients, particularly the alcohol addicts, the community leaders responded that such discriminations were rare and they have not heard or seen that it in their community.

*“It’s kind of rare here.” (Respondent - Community leader)*

When asked about the recent trends in mental health conditions, they assumed that the mental health illness among the community has amplified. They reported that even though the government was getting taxes and funds, there were offences and violence in the community by mentally sick people and the government has not been able to control the crimes. These crimes have affected all areas like health, commercial, politics, and social aspects.

*“They [mental health illness] haven’t lowered in number. I must say they have added up. These health issues not only affect the alcoholics but also the community – lack of sleep, for example. It is affecting not only health but also commercial, politics and social aspects.” (Respondent - Community leader)*

1. **Perception of Mental Health Illness by Healthcare providers**

The health care providers opined that the accessibility of service was very poor and to reduce the caseload in the hospitals, the mental health services should be made easily available and accessible to all.

*“If the patients can get easier access to mental health service at everywhere” (Respondent- Health care provider)*

The service providers further apprehended that the lack of daycare centres to look after the mentally ill patients and special schools were the greatest hindrance in giving care to the patients. Also, they felt that even if such centres were established, the caregivers of patients would feel shy to visit centres because of the stigma existing in society. One of the health care providers explained that the caregivers have had the misperception that visiting such centres means that one of their family might be abnormal and could be stigmatized by society.

*“Something like the daycare centre. Not systematically founded as in other countries. The main fact is that they cannot go to those centres (Like special training schools for autism, training schools for children with disabilities) even if there is.” (Respondent- Health care provider)*

The healthcare providers perceived that there was an increase in the prevalence of mental health disorders, which were mainly due to excessive consumption of alcohol and inefficient policies on alcohol and substance sale.

*“Reason for increase Alcohol drinking is common and it is prominent” (Respondent- Health care provider)*

In addition to social stigma as a barrier to avail healthcare services, healthcare provider opined that few families were financially weak and could not afford the cost for medicines and transportation. Ensuring economic security, by providing job opportunities to families with a mental disorder, would improve treatment outcomes and quality of life. The absence of family support could result in poor compliance as the patients have to be cared for constantly.

*“Some people don't have much money. Moving to Yangon is difficult.” (Respondent- Health care provider)*

*“There may be social, financial and other difficulties for them. Some patients don’t need to worry about money but they have no attendant” (Respondent- Health care provider)*

*“This is because of the social problem, so it will be good for the administration to provide employment for them to work” (Respondent- Health care provider)*

The health care providers apprehended that the caregivers might not go to referral centres for diagnosis, not comply with long term treatment, or even accept that their family member has mental illness. The service providers felt that there was a need for intensive counselling to family attendants so they accept the health condition. Many caregivers used to bring patients to the hospital only after the appearance of severe symptoms. For minor mood swings or changes, patients had to seek treatment. The providers perceived that conducting awareness programs on mental illness, alcohol, and substance abuse was a major preventable strategy to reduce the prevalence of mental cases.

The Service providers opined that movies that emphasize mental health might help in combating the social stigma and by increasing mental health knowledge regarding the community. The religious and traditional misconceptions of mental illness could be reduced by creating awareness.

*“There is not good in the movie in our country that if there is a mental illness patient, they put to go and stay outside the village. They also believed the mental disorder patients are due to the punishment from religious or traditional.” (Respondent- Health care provider)*

Many health care providers expressed the need for training health care workers at all levels in the country. A multiplier training model was suggested by one health professional. As per him, providing training for Treating Medical Officers (TMOs) will result in a cascade training of TMOs training their lower cadre staffs working with them. The health workers would be capacitated to monitor patient follow-ups and referrals.

*“My idea in the training is that we start training to TMO and BHS respectively. And then they take accountability to the capacity they have and monitor the follow-up. We can link with the BHS who then teach back to community health workers.” (Respondent- Health care provider)*

*“I think the psychiatrists will be better to provide training to TMOs. Then, multiplier training to BHS and volunteers. The staffs lower than BHS level cannot give treatment so far, yet they can able to monitor the patient follow up and referral criteria.”*

## 4.6 Theme 4. Experiences related to mental illness by stakeholders

The code groups generated from the experiences of Caregivers, Community leaders and Healthcare professionals related to the management of mental health were given in Table-8.

1. **Experiences during caregiving to mental health patients**

**Duration of caregiving**

The interviews with caregivers of mental health patients have shown that that the duration of caregiving varied for each caregiver, ranged between 20 days to 4 years.

*“It’s been 20 days of looking after him.” (Respondent - caregiver)*

*“I have been taking care of her for the past 4 years.” (Respondent - caregiver)*

In the process of caregiving, one of the responsibilities of caregivers was to visit the healthcare facility and avail the treatment for the patient. According to caregivers, the frequency of visits to health care facilities varied between every fortnight to once a month.

*“One time in 2 weeks and some time, 1 time for 1 month.” (Respondent - caregiver)*

Table-8. Theme 4. Experiences related to mental illness by stakeholders

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| THEME 4. EXPERIENCES RELATED TO MENTAL ILLNESS BY STAKEHOLDERS |
| I. Experience of caregiving to mental health patients |
| * Duration of caregiving |
| * Preference for treatment |
| * A positive experience by the caregiver |
| * Experience in getting treatment |
| * Negative experience by the caregiver |
| * Experience using alternate therapy |
| II. Experiences of Community leaders |
| III. Experience in treating by Health care professionals |
| * Training experience |
| * Referrals |
| * Feedback from patients |
| * Superstition belief |

**Preference for treatment**

On probing about the experiences of availing services from public and private sectors, some of the caregivers have opined that the services offered in the public sector were substandard due to inadequate infrastructure and poor quality of medicines and they did prefer the private sector.

“*The drugs from the public sector are so bitter and so she doesn’t want to take. We only did go there only three times.” (Respondent - caregiver)*

“*Here we face the area for consultation of patients and sometimes also need to find the chair when we arrived. More comfortable in ABC clinic. and they give one doctor with one chair separately. The patients need privacy to consult with the doctor and here there is no privacy for patients and so crowded.” (Respondent - caregiver)*

**Positive experiences**

From the interviews with the caregivers, it was understood that not all caregivers had difficulty in taking care of the patients. Those who had better financial stability made it easier for them to purchase medicines and procure other requirements. This financial stability helped the caregivers and patients to lead a better life compared to families with financial problems.

*“It’s not difficult in taking medication and buying the drugs.” (Respondent - caregiver)*

Many caregivers shared their positive experiences in dealing with the patients. Many patients were willing to undergo treatment, ready for medication, did understand the situation of caregivers, and tried to control their behaviour. These patients have lessened caregivers’ burden and also helped them to lead quality lives with lesser confinements and restrictions.

*“She agrees to accompany and she also sleeps at night. Her hand had been relieved and it’d been fine.” (Respondent - caregiver)*

*“She takes medicine regularly.” (Respondent - caregiver)*

Some caregivers felt it was their duty to take care of their family members [patients]. In many cases, other family members and relatives offer support to caregivers to take care of patients, which eased out their inconvenience to provide care.

*“Gets depression and so we have to support her.” (Respondent - caregiver)*

*“I give him medicine myself to take daily, both day and night. I never fail to do this even if I am busy.” (Respondent - caregiver)*

*“We just went there ourselves with the help of relatives.” (Respondent - caregiver)*

**Experience in getting treatment**

Many caregivers appreciated the quality of amenities and services available in public health care facilities. Some of the interviewees appreciated the manner in which the doctors and nurses dealt with the patients. Many caregivers reported that the behaviour and patience shown by healthcare professionals have influenced the caregivers to adopt such approaches while taking care of the patients. Some of the caregivers explained the patient-friendly attitude and non-discriminating environment in the hospitals. Few of them even opened up on their experience of buying medication and drugs which was quite favourable to the caregivers and also shared their experiences where the doctor understood the difficulties of the caregiver in getting the patients to the hospital and the doctor shared his contact number to avail medication for the patients. These positive traits in health care settings have been valued positively by the caregivers and helped to ease out their adversities and difficulties in providing care to the patients.

*“When we got there, the nurses are so very warmly and they tell very sweetly to the patients. After seeing that, I realized that we will need to be patient.” (Respondent - caregiver)*

*“It’s not easy to bring her to the clinics when she has epilepsy. So, Dr. Aung Myo Thant gave his phone number. It doesn’t have difficulties in taking medication and in buying.” (Respondent - caregiver)*

*“It’s not difficulties in buying the medication, does not have discrimination in the environment” (Respondent - caregiver)*

**Negative experiences faced by the caregivers**

During the interview with the caregivers, they expressed their difficulties and sadness experienced in the process of providing care to the patients. They also revealed the viewpoints and prejudice of the community towards the family of mental health patients. This lack of empathy in society has led to an increased burden to the family members by worsening their emotional stability in addition to the challenges in caregiving.

*“The other’s lack of sympathy and empathy and the others have a low opinion and make underestimate.” (Respondent - caregiver)*

Some of the respondents have spoken about their difficulties to provide support on patients’ basic needs such as bathing, eating, and sleeping continuously. They also mentioned the difficulties to make patients take medicines on time and to ensure the adherence to medicines by patients. They also explained of adverse anti-social behaviours of the patients like self-injuring, hitting and harming others, and the difficulties to handle such behaviour. These acts compelled the caregivers to take measures like confining them or tying their hands and legs or giving sedatives. Some caregivers felt that using threats or pain-inducing objects like a knife or stick were required to make patients eat or avoid other anti-social behaviours such as shouting, harming others, etc. The caregivers also narrated about their experiences in managing ad dealing with patients having unpredictable mood swings and aggressive behaviours.

Many caregivers have spoken about their strivings to monitor the activities (such as run away from the house) of patients round the clock. The necessity for accompaniment and safeguard during travel outside the home to control the behaviour of the patient was also highlighted in the interviews. The caregivers also emphasized that they could not leave the patients alone at home because of their unpredictable behaviours, and the necessity of taking the patients along while they had to go out or for work.

*“Sometimes she doesn’t take shower for a month and have to drag her to take one.” (Respondent - caregiver)*

*“If they are good, they talk normally but if they’re bad they know nothing. Sometimes, they become restless and they hit someone while they watch TV. So, we had to give them medication.” (Respondent - caregiver)*

*“We have to tie and close him up in the room when he became worse and rough.” (Respondent - caregiver)*

*“We need to keep eye on him because he can leave when he wants. So, if he wants to go outside like a tea shop, he has to go with an extra man. She shouts out loud until she gets sweating. And then she becomes normal and after that she becomes calm. She opened up her food with the knife and so we have to make her scared. She is scared of the stick. Sometimes I had to hit her as she did not listen to me.” (Respondent - caregiver)*

*“I take him sometimes. He stayed at home when he was young but now he can’t be left alone anymore.” (Respondent - caregiver)*

The caregivers also explained their challenges in taking care of the patients as well as managing routine professional life and social life like visiting monasteries and celebrating festivities. The mental health illness in the family and the habits of the patients have adversely affected the social and professional life of the caregivers.

*“I had prepared medication for him when I have to go on donation, monastery, and festival. But he hides the medication and didn’t take it on his own.” (Respondent - caregiver)*

*“It’s only he can’t work. I have to do all of the housework and so I get mad.” (Respondent - caregiver)*

The caregivers have experienced helplessness inevitability on occasions of caregiving to patients. This has happened specifically when caregivers had introspected the cause of the disease, the burden it caused to the family, and the pain they had to undergo when they witness the harsh treatment of the patient either by themselves or by health care professionals.

*“I feel sad but not angry because this is our fate.” (Respondent - caregiver)*

*“The nurses tied him in iron beds. Two arms were tied and I didn't dare to go and see it. The cables were clipped, he was in pain and was tied like a cow” (Respondent - caregiver)*

**Experience using alternate therapy**

Other than using the main/allopathic medication for mental illness, the caregivers also reported about the use of alternative medicines and their experiences in using them. In many cases, alternative medicine was practised along with mainstream medication like the herbal therapies suggested by religious leaders and monks. Many suggested that it was not effective in treating the mental health practices and they had to switch to the mainstream medication from psychiatrists.

*“We cure with herbal medicines and she became worse. And then we did cure with the monk and donation. And finally, we have to go to ‘ABC’ clinic and from there we go to ‘BCD’ hospital.” (Respondent - caregiver)*

1. **Experiences of Community leaders**

On interviewing community leaders, some of them have spoken about their experiences with mental health patients in their community. Some leaders felt that the number of mentally challenged patients in their community has reduced over the years. A few of them expressed that lesser visibility of mentally ill patients in the community might have been due to the lack of visible symptoms, or many patients might have been confined in their houses, or the difficulty in separating mentally ill persons from others.

*“They also felt that there are several psychotic patients during the previous years. They become mentally disturbed. But for now, there are only a few like those who are a bit abnormal.” (Respondent- Community leader)*

*“It’s hard to notice the depressed patient just from checking his appearance. I have seen 4 or 5 patients who have psychosis and disorientation in the community.” (Respondent - Community leader)*

Many community leaders affirmed that they knew the cause of mental illness and mentioned the factors such as alcohol abuse, stress, and family problems as the cause. Many leaders also believed that mental retardation and physical handicap might cause mental problems.

*“Well, I have seen 2 patients who become psychotic as a result of alcohol drinking and those who become stressed and behave abnormally because of the family’s living.” (Respondent - Community leader)*

*“Mental retardation and those who are handicapped are also mentally disturbed sometimes.” (Respondent - Community leader)*

During the interview, many community leaders narrated their encounters with mentally ill patients, the severity and the consequences of this illness on the society and family. Some recounted their experience of witnessing events such as patient setting fire on their own house, committing suicide due to excessive drinking, and being estranged by family. Many leaders related these experiences to stress and financial issues. Many respondents witnessed the extremely violent behaviour of patients towards their family members and to the community and religious sentiments.

“*He beat his own parents and decapitates the Buddha’s head.” (Respondent - Community leader)*

*“He hanged himself and took his own life away while staying alone and drinking at home. Another patient who is a staff at a company hanged himself too because he was thought to have some financial issues.” (Respondent - Community leader)*

*“Some are quite serious in such a way that he burned a house.” (Respondent - Community leader)*

Few community leaders have revealed that the mental health illness might be due to the hopelessness or while patients presume themselves as a social or financial burden to their family due to chronic conditions like AIDS and cancer. In such circumstances, some patients might get mentally stressed and take up extreme steps of ending one’s own life.

*“Who hanged himself in front of the community centre. He was diagnosed with cancer and when he realized that, he became depressed and hanged himself. Maybe that’s also partly because they no longer want to be the burden for their family.” (Respondent - Community leader)*

*“Some people wander around wearing nothing, sleep wherever they want, become violent and they can stand without eating anything. They only eat once every 2-3 days” (Respondent - Community leader)*

Few interviews with the community leaders showed that they did not have much experience in dealing with mental health patients. Many of them said that they believed that mental health illness was due to separation from their family and also due to the curse as they were born with it.

*“They have these problems because they are shunned by their family and for some, they are born with it” (Respondent - Community leader)*

During the interviews, few community leaders shared their experience on the role of a family member or mental health patients and they are running away from the responsibility of taking care of the patients. The reason for this negligence was a kind of discrimination against their family member or the embarrassment it causes to the family members. This neglect by the caregivers has resulted in further neglect of this patient by the immediate neighbourhood and society and has worsened their plight in terms of treatment and normal wellbeing. According to leaders few family members even don’t bother to give the patients the daily medicines already distributed by the community or the health care officials.

*“Lack of family support- About 75% of those whom I have met do not take any responsibility. We have to collect the medication in Pathein once a month. And we distribute to the patients and ask them to take medication regularly. Even though we emphasize the importance of compliance on medication, they fail to take it regularly. So, what can we do? These are some of the problems. For some parents, they just tell us that they don’t know what to do and for some, they avoid their child at all costs. Since the own parents neglect the patient, it’s not surprising that the neighbourhood does the same. If we send them, we have to ask the parents to take them back and we even tell the date to pick them up and our contact numbers. However, it doesn’t usually happen*.” (Respondent *- Community leader)*

The community leader also experienced that the family members treat the patients differently. Some neglect the patients by assyming that some other family member is taking care of them, and escape from responsibility. According to the community leader, there is a need to support the patients and to look after them empathetically to calm them.

They also shared that this lack of attention happens only in few communities and the people in the society end up mocking the patients which further deteriorates their condition.

*“What they do is laugh at the patient and tell them that they are crazy and avoid them as much as possible. That’s why patients get even worse. I am sure that the condition can be controlled if both the family and the neighborhood support the patients as much as they can.” (Respondent - Community leader)*

A few of the community leaders have spoken about the crucial role of community in supporting the mentally ill patients by sending the patients to the health care centers with the help of community volunteers, hospital administration and by the police.

*“One or two patients who are sent to the hospital by the community recovered after coming back” (Respondent - Community leader)*

*“They just live their own without disturbing the neighborhood. If the condition gets worse and begins to disrupt the society, they are sent to the hospital with the hospital administrative and the police” (Respondent - Community leader)*

*“If they become aggressive, cause troubles with weapons and have conflicts with the family when they are detached, we have to inform the police. We have to keep things under control if the condition gets worse. If not, we usually console the parents to keep things on track.” (Respondent - Community leader)*

1. **Experience in treating by Health care professionals**

Most of the Interviewees shared their experience related to the treatment provided to the mentally ill patients on consultations. Many general practitioners participating in this study used to treat such patients with vitamin supplementation and diazepam, as they lacked knowledge on treating mental health patients. According to a few clinicians, neurological cases were often misunderstood with mental cases by people and upon differential diagnoses, they used to refer such cases to the specialists. They also have mentioned the importance of obtaining patient case history for proper diagnoses. Some of the service providers mentioned the importance of using screening tools to identify mental health patients in the community.

*The most cases I experienced are neurological diseases that have misunderstood with mental cases. After assessing the case history, we consider it a neuro case and refer to the neuro medical department.” (Respondent- Health care provider)*

*“We treat simple management. Vitamin supplementation and diazepam are given to cover withdrawal symptoms.” (Respondent- Health care provider)*

*“I treat them in their home as an initial treatment. If they are not relieved, they are referred to psychiatrists and hospitals.” (Respondent- Health care provider)*

*“We also screen the patients during medical tours.” (Respondent- Health care provider)*

Some of the health care providers conveyed their experience of treating the patients or prescribing the medicine though the patient was not physically present. Some of them dispensed medicines through attendants/caregivers of the patients who could communicate well. They supported this practice and empathized with the caregivers on their difficulty in getting the patients to the clinic, they advised the caregivers to bring the patients to the facilities if the conditions of the patient didn't improve.

*“Attendant comes to the clinic and asks for drug- Yes, it is sometimes hard to take the patient with. But I carefully advise them to take patients if their status does not improve or can’t be controlled. If the patient gets better and the attendant can communicate properly, I give the prescription.” (Respondent- Health care provider)*

Many of the service providers have experienced rude behaviors of the patient during their interactions. At times the patient gets agitated and becomes restless while explaining their case and family history to the clinician, and forces clinicians to wrap up the conversation faster. This further deteriorates the chances of understanding the illness and its cause by the physician.

*“According to their culture, the patient doesn’t like to answer the history which we have to rely mostly upon. They also don’t like it if we ask about a family history of mental illness. They think we are taking too long intentionally. They just want to be examined and assessed very shortly and get the medicine they want in a short time. Some even say “don’t ask me here and there, doctor. Please give the medicine as you want.” (Respondent- Health care provider)*

Other difficulties experienced in the treatment were the inability of the doctor to prescribe medicine for a longer duration demanded by the patients and the annoyance for multiple hospital visits.

*“The other problem is they want the drug for 2 months and we can give them only for 2 weeks. These are the major problems.” (Respondent- Health care provider)*

Many clinicians have communicated that they had to adhere to several guidelines for the treatment of vulnerable patients like pregnant ladies. They have experienced difficulties in following such guidelines to these types of patients.

*“If the patient is pregnant with depression, we have to follow the WHO guideline. In this case, it is a problem to decide the suitable drug for the patient*.” *(Respondent- Health care provider)*

During the interview many of the Health care providers shared their experience related to patients and family’s concerns related to providing care. They felt that caregivers were voluntarily asking for patients admissions in the hospital in order to reduce their burden at home and to prevent the embarrassment of taking care of the patient with symptoms that were not critical. Most of them experienced stigma and embarrassment expressed by caregivers or family members of the patient as they wanted health care providers to keep their information confidential.

*“Most of the family members and attendants are worried about their patients. SO, they voluntarily request for admission of the patient. In fact, we already know that the symptoms do not need hospitalization as the vital signs are good*.” (Respondent*- Health care provider)*

*“They do not want other people to know about their condition. They feel embarrassed.” (Respondent- Health care provider)*

Few health care providers spoke about their experience of turning away the mental health patient during consultation mainly because of a lack of knowledge and skills to treat such patients.

“*I will not treat patients with depression. I ask about background history and condition at home. I inquire for any conflict or problem between family members but I do not treat* them” *(Respondent- Health care provider)*

**Training experience**

Doctors during their interview spoke about their experiences of attending training at induction and mid-career level, especially in the public sector. Such trainings are intended at acquiring the necessary skills to treat patients having alcohol withdrawal symptoms, epilepsy, and psychiatric emergencies.

*“As soon as I transferred to Magway in 2013, we received a mental health training conducted by Dr. Win Aung Myint for a year project in the region. They gave training at two levels. One was for the public health side and was intended at training BHS, and HAs. Topic included alcohol, epilepsy, and psychiatric emergency.” (Respondent- Health care provider)*

Few of the specialists spoke about their experience of providing training to various health care workers, NGOs, doctors, and nurses, and the community to provide psychosocial support and intervention to the patient with epilepsy and other mental related illness. They also provide theme based training to the health workers on the occasion of important days like world mental health day

*“For example, the commonest topic is about the drug. Usually, give it to NGO. For epilepsy, psychosocial support and intervention training is avaialable for doctors and nurses. If it is a special day such as world mental health day and its theme is depression, training for depression will be done.” (Respondent- Health care provider)*

**Referrals**

Most of the respondents during the interview shared their experience in treating as well as referring the patients to the specialist mental health centers. The referral was done mainly due to their lack of experience and skills in treating such patients, knowledge about the nearest specialty center and also based on the severity of the illness. This referral was done after counseling the patient-caregiver regarding its importance.

*“Since there is a community mental health clinic at Kyauk Tan, we refer them to the clinic.” (Respondent- Health care provider)*

*“Suicidal features were present so we refer him to the mental hospital.” (Respondent- Health care provider)*

*“Explain and counsel the family members for mild cases and refer to psychiatrists for specific treatment. If the symptoms are severe, we just refer to the hospital. We send some patients who walk alone to the hospital with the help of authority” (Respondent- Health care provider)*

Few of the respondents shared their experience of involving in various surveys and other programs which are important for understanding the prevalence of mental health illness, screening and also referring the cases to the concerned specialists.

*“Experience in attending survey related to the Prevalence of Depression, epilepsy, and psychosis. We undergo a survey and case referral if found.” (Respondent- Health care provider)*

**Feedback from patients**

Many interviewees shared their experience of prescribing medicines to the attendants without the patient based on the feedback obtained from the attendants on the patient’s health. They also counsel regarding some drugs available FOC and provide medicines FOC to them. This was mainly done by empathizing with the caregiver, understanding the transportation difficulties they face, etc.

*“They give feedback that they get the drugs with FOC and the patients do not need to wait and patient attendance can take drugs.” (Respondent- Health care provider)*

*“Previously we get a variety of drugs with a low amount. Now they change their trend. They only give two varieties out often with a large amount. Other drugs have to be bought.” (Respondent- Health care provider)*

**Superstition ad beliefs**

Many caregivers shared their experience of the practice of superstitious beliefs for treatment. They felt that they were helpless and couldn’t convince the patients to not depend on false practices. They also gave an insight into how it is still prevailing in rural society and its hindrance to the treatment and recovery of the patient. They also put a light on their experiences of providing health education to the community stressing to eradicate such practices.

*“They go to pagan and they said to remove the bad spirit from the body. I cannot say anything and I don’t have any power and I can give only advice to them. Not usual human, even monk happened like that. I have seen the pagan among community or wards. I saw a lot and now even if it reduces I think it will still present among the rural community. Sometimes they believe that they need to remove the spiritual barrier upon the patients. If not, they don’t need to take medication. I also give health education to them as much as I can.” (Respondent- Health care provider)*

## 4.7 Theme 5. Challenges regarding mental health

During probing, the caregivers shared their challenges in taking care of mentally sick patients. They encountered various issues inside their immediate environment or coming from the outside.

Table-9. Theme 5. Challenges regarding mental health

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| THEME 5. CHALLENGES REGARDING MENTAL HEALTH |
| I. Barriers to caregivers |
| 1. Barriers to caregivers – Internal |
| * Lack of a support system |
| * Economic barrier |
| * Burden to caregivers |
| * Lack of awareness regarding Mental health |
| * Poor compliance with the treatment |
| * Superstition belief and use of alternate therapy |
| * Discontinuation of medicine by the patients |
| 1. Barriers to caregivers – External |
| * Social Stigma |
| * Inefficient consultation |
| * Lack of infrastructure and Manpower |
| * Inadequate supply of medicine |
| * Lack of service |
| * Lack of funding |
| * Lack of counselling |
| II. Barriers to Health care providers |
| 1. Challenges of health care providers |
| * Inability to diagnose and treat |
| * Lack of knowledge regarding mental health illness |
| * Lack of priority to mental health |
| * Underreporting of mental health cases |
| * Lack of training for health care workers |
| * Poor punctuality of health staffs |
| 1. Barriers pertaining to the health system |
| * Administration barrier |
| * Lack of infrastructure |
| * Lack of sufficient manpower |
| * Inadequate supply of medicine |
| * Lack of incentives to health care workers |
| * Lack of Intersectoral coordination |
| * Lack of referral system |
| 1. Other barriers |
| * Lack of research activities pertaining to mental health |
| * Lack of voluntary organizational support |

1. **Barriers to caregivers: Internal**

**Lack of a support system**

Many of the caregivers mentioned about the lack of support from their family members as a major hindrance in procuring and providing treatment services to the patients. The scarcity of attendants to look after the patients at times have resulted in improper uptake of medications at home, and delayed procurement of drugs from hospitals.

*“Have had no stock of drugs at home, as there was no one to accompany her to the clinic, as I have to go to the farm for harvesting. Also, the doctors said not to let her go alone.” (Respondent - caregiver)*

They also mentioned that due to lack of support the family had to break apart. Many of the family members through supported financially disowned the mental health patients causing stress and isolation.

*“I also didn’t get any support from her father and we’re also separated for about 3 years.” (Respondent - caregiver)*

*“He was admitted to hospital for 4 times, 2 times at Ywar Thar Gyi psychiatric hospital. Now as he must be admitted to the hospital, I asked for money from my husband (stepfather). He gave me 100,000 MMK but he said he could not take charge of him because he is not his son. As I have another son completing education, I am very stressed” (Respondent - caregiver)*

**Economic barrier**

Caregivers face a financial problem as they cannot afford to spend money on drugs and travelling. Few are employees and not rich enough so they are worried about how to live because their salaries are too low to afford the treatment. Also, factors such as increased transportation costs and expensive medicines have furthered their problems.

*“Transportation costs about 35,000. It also costs about 300,000 MMK for drugs and buying charges.” (Respondent - caregiver)*

*The caregivers also fail to follow up visits due to financial or social problems. “Two times within one year.” (Respondent - caregiver)*

These increased costs and financial burden of caregivers have resulted in them borrowing money and selling valuable properties for the sake of the wellbeing of their family members. They borrowed money in the rainy season and repay the debt in the summer.

*“I had to borrow a loan to treat the patient” (Respondent - caregiver)*

*“Drugs from there are so expensive; also have to sell out home.” (Respondent - caregiver)*

Many of the caregivers were worried and reluctant to take their patients to the hospital due to increased cost for accessory services such as food and stay. They cannot afford to take treatment from other hospitals if the doctors refer them to the psychiatric hospital due to their financial weakness.

*“I had difficulties to go to the hospital and with expenses for the meal. Although we can get the medicine for free, sometimes we have to buy it and I am afraid I do not have enough money for that.” (Respondent - caregiver)*

*“We can’t afford to move to another hospital” (Respondent - caregiver)*

**Burden to caregivers**

The caregivers stated that they had to take care of the sick dependents though they were suffering from other severe illnesses as there was no other alternate choice.

*“I also have heart disease and so it is not good. I also take care of myself and also of her.” (Respondent - caregiver)*

Caregiving was a difficult job as there was a requirement of a person to look after the patient constantly.

*“It is necessary to keep someone in rotation to watch for the patients at night time and sometimes caregivers can’t focus on their job.” (Respondent - caregiver)*

The financial burden further elongated even after the demise of the patient to the caregiver.

*“When my husband passed away, I had to sell things and I owed money.” (Respondent - caregiver)*

Some of the acts of mental health patients had led to embarrassment to the caregiver and resulted in apologizing in public.

*“While waiting under the sun, there was such a whole mess with him crawling and struggling around and I am the one to guard him safe. Sometimes, I have to apologize for her to the people who don’t know about her suffering.” (Respondent - caregiver)*

**Lack of awareness regarding mental health**

During interviews, most of the beneficiaries claimed that they were not aware of mental health and did not know about the source for treatment as they have no experience in dealing with mental illness in the family. The majority of the caregivers also claimed that they had to find an alternate mode of transportation as they had no clue where to avail of the service.

*“We have to go by taxi because we don’t know how to get there” (Respondent - caregiver)*

*“It had never happened in this family and don’t know where to go.” (Respondent - caregiver)*

*“I’m so annoyed and so worried about her future. I have no idea what I should do.” (Respondent - caregiver)*

**Poor compliance with the treatment**

Caregivers had to face difficulty from the patient in giving medication to them as they denied frequently taking medicines.

*“Sometimes she did spit out” (Respondent - caregiver)*

Some caregivers even accepted that they were unable to procure medicines on time due to their busy schedules.

*“Drugs are out after taking one year and I also do forget to buy it” (Respondent - caregiver)*

Patients assumed they are normal and denied to take medications.

*“The reason why he didn’t take medication is that he assumed he is good.” (Respondent - caregiver)*

The other major challenge was to convince the patient to go to the health care facilities, for that they had to lie and give some other reason. Also, they had to use various innovative methods to make patients take medicine.

*“He didn’t want to come here. My sister-in-law and I took him saying that it was to measure the blood pressure. He didn’t want to take medicine and didn’t want to go to the hospital. So we took him without saying anything.” (Respondent - caregiver)*

*“It is difficult to give medication. I asked for help from the doctors and so they prescribed to mix with soy milk and let him take. He doesn’t take medication at first.” (Respondent - caregiver)*

**Superstition belief and use of alternate therapy**

The Caregiver also spoke about curing with herbalists and exorcists. The reason they gave for such practices was financial instability and going to the hospital would be expensive. They even mentioned that the cases got worse after consulting the monks and that they wasted a lot of time on it.

*“I cure with the traditional practitioners because I have no money and it relieved for a while. And it relapses again. Myanmar traditional practitioners cost too much.” (Respondent - caregiver)*

*“We have to bring the monks from North Okkalarpa who cured that kind of patient. He became worse and even tries to break the pot and so we have to tie him up.” (Respondent - caregiver)*

Many health care providers have felt that there is a severe lack of awareness among the community, especially among caregivers regarding mental health. They consider scientific treatment as a final option after several failed experiences of alternate methods and superstitious beliefs. This lack of awareness has led to people going ahead with various superstitious practices for the cure. Taboo or stigma among community members who see the patient’s behaviour as strange behaviour, lead to discriminating them and further deteriorating their problem**.**

*“We have experienced a lot of patients coming to us after seeing the exorcist” (Respondent- Health care provider)*

*“When we treat and consult one patient, there are many people who are eager to get treatment even when we said that we will treat all of them.” (Respondent- Health care provider)*

**Discontinuation of medicine by the patients**

Few providers felt that there is poor interpersonal communication between patients and doctors especially in mentally ill cases where communication and psychosocial behaviour are severely affected. This scenario may lead to poor treatment choices by doctors and poor compliance with treatment by the patients.

*“Mental health service is weak because interpersonal communication gap problem between patient and doctor become enlarged” (Respondent- Health care provider)*

1. **Barriers to caregivers – External**

**Social Stigma**

Many of the caregivers felt extremely stigmatized as the people in the neighbourhood do not understand the severity of the problem and mock the patients and their families.

*“One thing I feel sad about is that people tease him as he is used to taking off his trousers when he feels stressed. Some people make bad comments to our family and it makes me sad.” (Respondent - caregiver)*

*“Sometimes there is gossip talk behind the patients. Some people do not make friend with the patients and make isolation.” (Respondent - caregiver)*

**Inefficient consultation**

Caregivers faced issues from the side of health professionals as they were unavailable for consultation on the day of the appointment.

*“When I get here, the doctor is not here.*” *(Respondent - caregiver)*

*“They give an appointment date to come to the office. When the day arrives, he comes here with his friend but he can’t wait for the doctor and returns.” (Respondent - caregiver)*

**Lack of infrastructure and Manpower**

The caregiver spoke about the difficult terrain and the geographical conditions which worsen their burden of taking the patient to the hospital.

*“The roads are so rough and more severe in the rainy season.” (Respondent - caregiver)*

They find that there is a lack of infrastructural arrangements in health care settings making the whole thing not patient-friendly.

“*Here we face the area for consultation of patients and sometimes also need to find the chair when we arrived. More comfortable in Hlaing Thar Yar and they give one doctor with one chair separately. The patients need privacy to consult with the doctor and here there is no privacy for patients and it is so crowded.” (Respondent - caregiver)*

**Inadequate supply of medicine**

The major hurdles during the treatment process for the caregivers along with the accessibility issues are insufficient drugs at the health centre.

*“If the drugs stock out, we get into trouble. It’s also far from our home to get there. If drugs are out, she gets mad.” (Respondent - caregiver)*

**Lack of service**

Caregivers also experienced a lack of facilities especially human resources for the treatment.

*“There were no psychiatrists in B……....” (Respondent - caregiver)*

*“There is no close-by health centre. There was a midwife and it is assigned one centre for 6 villages. It’s also far from our village.” (Respondent - caregiver)*

**Lack of funding**

There is no external financial support from different organizations or charity which affects empowerment.

*“They have not supported financially. We have not received any kind of funding.” (Respondent - caregiver)*

**Lack of counselling**

The doctor says nothing about the condition of the patients to the caregivers because they are unable to gauge the extent and intensity of the disease and plan the treatment.

“I *ask them about her but they don’t respond.” (Respondent - caregiver)*

**Barriers to Health care providers**

1. **Challenges of health care providers**

**Inability to diagnose and treat**

The health care providers had difficulty to diagnose and treat the patients with mental illness since they were not specialized in the field of psychiatry.

*“I don’t know because there is a lot of different patients. Some patients have a family problem. Some have financial problems. I don’t know it is a mental health disease or not.” (Respondent - health care provider)*

*“I have a problem when I prescribe drugs. Recently, the patient has a pregnancy, I can’t choose the drugs” (Respondent - health care provider)*

**Lack of knowledge regarding mental health illness**

Many of the health care providers were working as general practitioners and knew only symptoms of major diseases, like insomnia, stuffiness of the body, neck stiffness, anxiety, psychosis and alcohol addicted disorder, etc. They had to refer to the psychiatrists when they had a case. Few confronted that they lacked sufficient skills and were outdated regarding mental health illness. As they had encountered only a few cases in their practice and lacked experiences they found it difficult to treat. Consequently, they had no idea to reduce and prevent mental health problem

*“When I found depression patients, I referred to psychiatric.” (Respondent - health care provider)*

*“As I am a GP and also an old doctor, so if there is a new case of patients coming to me, I also need to learn from medical books for that new cases.*” *(Respondent - health care provider)*

“*We also need to know the update of drugs because there are a lot of pharmaceutical companies who are approaching us.” (Respondent - health care provider)*

**Lack of priority to mental health**

Most of the practitioners felt that the management of physical health problems is of greater importance than mental health issues. The government will not use the program data for planning purposes.

*“Recently, we have not used any mental health data for programme planning. We just compile the data and report it to the central unit. Furthermore, mental health is not in the priority list of public health problems so far.” (Respondent - health care provider)*

**Underreporting of mental health cases**

Most of the providers admitted that they had reported fewer cases than what they had seen, as it was not the public health programme priority.

*“in recent years, mental health cases are increasing than in previous years, though less than 10 per cent of the total population have these problems. The official rate of increase in mental health cases is not as high as the increase in NCDs. There might be under-reporting of mental health cases, as we have this data only from their clinic visits.” (Respondent - health care provider)*

**Lack of training for health care workers**

Interviewed health care providers expressed that they had a deficit in knowledge due to the lack of training and the lack of skills updating, therefore they could not treat the cases and had to refer to a higher level. They also felt that they just had theoretical knowledge of mental health. They also revealed that even the peripheral health workers and support staff lacked the training of handling mental health cases.

*“We have not received mental health training for more than 6 years. So, the juniors will only have theory-based knowledge in curriculum and are not adapted to get on-site training.” (Respondent - health care provider)*

*“I cannot treat patients mostly before I receive training. I only refer them as I cannot diagnose and treat” (Respondent - health care provider)*

*“10 staff members hadn’t received any mental health training.” (Respondent - health care provider)*

**Poor punctuality of health staffs**

The health practitioners were temporarily appointed and psychiatrist was not available all the time. This made it difficult in availing of the treatment and increase in the caseload on the day of consultation.

*“Some staffs are late. But it is difficult to deal with that because some are specialists.” (Respondent - health care provider)*

1. **Barriers of the health system**

**Administration barrier**

Rotational plans for the specialists and other health care workers reduced their availability at the health centres. As a result of the rotational plan, the doctors miss out on the previous data of the patients and do not have knowledge regarding the follow-up cases. That consumes more time in consultation and leads to inefficient treatment as stated by health providers.

*“I think it is just a rotational plan and it does not mean that only SAS will come here.” (Respondent - health care provider)*

*“This project comes after I have arrived for 1-2 years. I can check in the register book.” (Respondent - health care provider)*

**Lack of infrastructure**

Health care providers told that there was a lack of infrastructural facilities in the hospitals. There were no designated wards for mental health inpatients that previously existed and now being assigned to other departments. As a result of which the patients had to be treated in the outpatient clinic and referred if necessary to the speciality hospital for admissions. There were other infrastructural barriers such as lack of basic needs like water, electricity and sanitation measures.

*“Previously there was an inpatient ward when the psychiatrist was assigned. After a period of no psychiatrist in Magway, the ward has been occupied by renal, pediatric department and blood bank respectively. Now, we have just left the outpatient clinic.” (Respondent - health care provider)*

*“Mostly they complain about water, electricity and toilet problem” (Respondent - health care provider)*

**Lack of sufficient manpower**

Many interviewees had the opinion that many health facilities were undermanned and lacked specialist care for mental health. Due to a lack of manpower, early diagnosis and treatment have become impossible. Also, quality care has been compromised.

*“If there is one psychiatrist in the clinic, it is more convenient for the patients to come and treat regularly and early diagnose.” (Respondent - health care provider)*

*“Challenge to look after the huge amount of inpatients due to insufficient manpower sometimes.” (Respondent - health care provider)*

**Inadequate supply of medicine**

Many of the respondents threw light on issues relating to the adequacy of drugs important for mental health patients like sedatives and anti-psychotic drugs. They felt that drugs were adequate for inpatients but were not sufficient for outpatients for FOC. They also felt that the shortage was mainly due to controlled drugs from the FDA and other regulatory bodies. They felt that drugs were easily available in major cities compared to townships thus acting as a barrier to provide service. They also felt that the quality of service was hampered as they were unable to prescribe the drug for a longer duration for a single patient since there was a reduced stock. These problems are being faced more by general practitioners.

*“We can provide adequately to inpatients but not guarantee to outpatients.” (Respondent- Health care provider)*

*“There is no sedative or antipsychotic drug in hand from the public health side.” (Respondent- Health care provider)*

*“Because I think they don’t have drugs or they can’t treat the patients.” (Respondent- Health care provider)*

*“We could easily buy [the drugs] in the previous year. We cannot buy this year. We have to order from the company directly or request from friends. They are the controlled drugs from the FDA and so they cannot be bought in Kyauk Tan pharmacies. We can get in Yangon with a controlled drug signature and from the company. But it is delayed from the company” (Respondent- Health care provider)*

*“We disperse the drug items to patents in smaller quantities, so most of the patients have to buy drugs when the given quantity is exhausted. We will give the drugs to a patient for 1 month. If the drugs are consumed fast, we give it to them only for 5-7 days*.” (Respondent*- Health care provider)*

*“The caregivers have a lot of complaints when they don’t get drugs for more than 2 weeks supply but they don’t want to bring patients to the clinic” (Respondent- Health care provider)*

**Lack of Intersectoral coordination**

Many of the health care providers opined that there was a severe gap between the public sector and private practitioners in terms of sharing information, knowledge regarding disease patient, and coordination which resulted in reduced quality care towards the patient.

*“There is a gap between pubic hospital and GPs and no proper collaboration between us. That is not good for the medical field and services.” (Respondent- Health care provider)*

**Lack of referral system**

Many of the interviewees felt that there is a lack of uniform formal referral systems in place which is affecting the quality of treatment. According to them, referral happens very informally through verbal mode and sometimes through letters. And generally, GP's are ignored in this process. Many practitioners were also scared to refer as they were not confident of their diagnosis.

*“Mostly, the patients are referred by verbally, but some are referred by letters. I don’t refer back to GP. Because I think they don’t have drugs or they can’t treat the patients.” (Respondent- Health care provider)*

*“I don’t have a referral form because I am afraid of the wrong diagnosis.” (Respondent- Health care provider)*

1. **Other barriers**

**Lack of research activities on mental health**

Few of the health service providers believed that there is still not sufficient data on the status of mental health illness in the country which is hindering it from attaining maximum priority and also determining the ways to go ahead.

*“We cannot say mental illness and general psychiatric disorders are increasing in numbers. On the other hand, alcohol use disorder and substance use and related disorders are increased. Therefore, we assume mental health disorder is increasing in the general population. But we cannot give details because we don’t have data.” (Respondent- Health care provider)*

## 4.8 Theme 6. Recommendations to improve mental health illness

1. **IMPROVE QUALITY OF CARE TO THE PATIENT**

**Manpower**

During interviews, various stakeholders recommended some measures for improving mentally ill patients. Few of them spoke about improved manpower level especially of the specialist in CMHC for patients to avail specialist mental health services. They also suggested that specialist services should be made available at every township so that it is accessible.

*“In the absence of CMHC: Whoever comes to CMHC will not get treatment. To substitute it, we should post psychiatrist in respective hospital, the problem will be solved” (Respondent- Health care provider)*

*“There should be psychiatrists in the most accessible area. And psychiatrists should be assigned to each township level” (Respondent- Health care provider)*

Table-10. Theme 6. Recommendations to improve mental health illness

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| THEME 6. RECOMMENDATIONS TO IMPROVE MENTAL HEALTH ILLNESS |
| 1. Improve the quality of care to the patients |
| * Manpower |
| * Affordability and availability of treatment and special care |
| * Training of health care professionals in treating mental health illness |
| * Improving health care facilities |
| * Need for interdepartmental coordination |
| * Caseload reduction strategy |
| * The need for voluntary organization |
| 1. Prevention strategies |
| * Increasing health awareness campaign towards community |
| * Mental health awareness for doctors |
| * Healthy lifestyle promotion |
| * Health Education for the community and strategies |
| * Health education for reducing alcohol and substance abuse |
| * Legislative method to prevent substance abuse |
| * Emphasis on various programs and surveys |
| * Improving the socio-economic condition of the population |
| 1. Rehabilitation Strategies |
| * Economic empowerment |
| 1. Sources of support |
| * Voluntary organization support |
| * Economic support |
| * Volunteers and Manpower support |
| * Transportation facilities |

**Affordability and availability of treatment and special care**

Some stakeholders suggested that if the cost of care was reduced, the status of mental health patients would improve, especially those from lower socio-economic status. The cost of care could be reduced using some innovative model in collaboration with doctors, government and rich people who could empathize with the patient and family.

*“Some patients cannot afford treatment. The cost is at least 20,000 to 30,000 MMK, approximately 5,000 or 6,000 for each visit and such patients are limited as their family is facing financial difficulties. If we can solve this together by cooperating with the doctors, I am convinced that the families will feel relieved.” (Respondent- Caregiver)*

Few caregivers suggested that it would be very helpful if special schools for mentally ill kids were made available and affordable. This would help the patient by reducing discrimination at school and also reduce the burden on the caregiver.

*“Also it would be better if the specialty school can be extended in more places and to reduce the school admission fees. Also opening the school full time would help the child to improve.” (Respondent- Caregiver)*

**Training of health care professionals in treating mental health illness**

During the interview of the health care providers, many of them suggested that there should be increased training activities for doctors at entry-level and midcareer so that they are updated with skills and knowledge to confidently diagnose, treat or refer the patients of mental health. They also suggested that more drugs should be made available at peripheral levels for the treatment.

*“I think refresher course for 1-2 days in a year is enough. 1 day for 3 hours is enough. I forget about the drugs when related patients do not come for a long time.” (Respondent- Health care provider)*

*“I have confidence. I dare to speak to the patients, don’t be afraid, you will be ok. Previously I was afraid of treating alcohol withdrawal patients,. I was scared that something could go wrong with treatment. In training, psychiatrists taught us that alcohol withdrawal is not so much a problem. There is no problem until they hit their environment.” (Respondent- Health care provider)*

*“I would like to suggest to organize more training and to give permission for buying controlled drugs more conveniently.” (Respondent- Health care provider)*

Some of the providers also suggested providing training to doctors on updated guidelines for treatment that is very easy to be followed

*“I learned guideline including delirium, alcohol abuse, psychosis, schizophrenia” (Respondent- Health care provider)*

*“To give training is good. It should be done in every township. Because I have the experience in a psychiatric hospital when I was a Part (I) student in Medical school. So I am not in touch with the psychiatric case. Now they give training and guideline. I just need to follow their instruction and so I think it is very good.” (Respondent- Health care provider)*

Few of the stakeholders suggested that training must be provided to peripheral health workers and social workers who are the link to the community. Training them would increase awareness in the community and the management of the cases at the grass-root level.

“*We should teach BHS to gain mental health knowledge. Training is necessary to get more awareness. “E.g., if a patient has a complaint of insomnia, they should aware of mental health problems. The case must be filled in the form provided by DHIS.” (Respondent- Health care provider)*

*“Social worker means counselling up to the village level to deal with family members and also help to get leave from the job and return back to work after. Social workers have an important role in the community. Actually, in the community team, social workers should be more than nurses because they are case managers. They link the people and also clinic and place and manage the whole case. They are like a guide and so their role is very important at the community level.” (Respondent- Health care provider)*

“*Health talks and information sharing activities should be provided about mental health to the level of basic health staffs.” (Respondent- Health care provider)*

**Improving health care facilities**

During the interview with the stakeholder, many of them suggested that infrastructural improvements should be done in the health care facilities. This should be done by establishing a mobile community mental health team in every hospital to take community-level actions. Few caregivers also suggested that it would help them immensely if doctors visited the home of the patient.

*“Every hospital with psychiatric unit should have a community mental health team including good structure and proper budget.” (Respondent- Health care provider)*

*“It’ll be better if the doctors or psychiatrists could procure home visits to meet and consult with the patients.” (Respondent- Caregiver)*

*“The central level should need to arrange the mobile team and community mental health team and developing of psychiatric*.” *(Respondent- Health care provider)*

Few of the health care providers also suggested the exclusive budget for CMHC to reduce their dependencies at a higher level. They also recommended for clarity in assigning staff and making the roles and responsibilities of health care providers clear.

*“Would likely to have separated budget for the CMHC clinic.” (Respondent- Health care provider)*

*“Would likely have a tentative community clinic team. Currently, duty roster is circulated from the MS office and there are some difficulties in assigned staff.” (Respondent- Health care provider)*

They also recommended that there should be improved coordination with NGOs. The NGOs at the local level come forward and work closely with the health care providers for the betterment of the community.

*“Would need more support from the local sector (NGO) to provide necessary support” (Respondent- Health care provider)*

**Need for interdepartmental coordination**

Various stakeholders recommended that there should be increased coordination and connection between health workers at all levels especially to identify the source of the disease. Treatment will also be improved due to improved referral channels within the department. They also suggested that coordination with other departments, parents, and community is vital in tackling the cause of the disease.

*“Connection between health care professionals is very important and if there is a connection we can overcome the barrier and we need to find the source of disease. If we found the source, we need to control the source by cooperation with other departments also.” (Respondent- Health care provider)*

*“Parents, guardians, those from administration and health sectors should come forward and pull our heads together to come up with a solution, such as sharing the expenses or referring to Ywar Thar Gyi Mental Hospital, if the guardians allow.” (Respondent- Health care provider)*

**Caseload reduction strategy**

Many stakeholders suggested that it is important to reduce the number of patients per doctor in the hospital to efficiently treat individual patients. To make this happen they suggested various ideas like prescribing drugs for a longer period and follow up once in a month or two, Increase the number of specialists who can easily diagnose and treat.

*“If possible, they should give drugs for one or two weeks to the patients and the patients follow up for only one time per month or two months that may reduce the patients in the clinic.” (Respondent- Health care provider)*

*“If there is one psychiatrist in the clinic, the patients are more eager to come and be treated regularly and early diagnosed.” (Respondent- Health care provider)*

**The need for voluntary organization**

Few of the stakeholders emphasized the need for voluntary organizations to play an important role in taking care of mental health patients. Mainly for the patients who couldn’t be taken care of at home because of affordability issues or lack of acceptance by society and family

*“I would recommend having some organizations that can take care of mentally ill people. There are few organizations working for mentally ill people.” (Respondent- Health care provider)*

*“There should be an organization to take care of the mentally ill like homes for the elderly. Some families can afford and accept to treat mentally ill persons. But society does not accept it. Mentally ill persons are not allowed to live in the ward.” (Respondent- Community leader)*

1. **PREVENTION STRATEGIES**

**Increasing health awareness campaign towards community**

During the interview, few stakeholders recommended that awareness activity to the community through health care providers should be increased. Since health care providers are the best source of information and are in direct contact with the community it would be easier to disseminate the information, create awareness and give health education related to various issues of mental health.

*“Health care providers are more important than public. They are the most responsible persons. Health definition also includes the physical and mental wellbeing and therefore health care providers need to give health education to the community. I have never seen health education related to mental health given to the community. Even they can use the contact among health care providers or contact via messenger blot/group for sharing information, but they don’t.” (Respondent- Health care provider)*

Many of the stakeholders spoke about awareness campaigns such as the celebration of World Mental Health Day and its theme of depression. During this period training and awareness were given to health workers and public respectively regarding depression. This was conducted by experts in the field of mental health.

“*They preached the theme of World Mental Health Day, ‘Depression, Let’s talk’. We invited Sayar Win Kyaw Thu and talked to BHS. CME should be done. As more people become aware, mental health care will become more successful*.*” (Respondent- Health care provider)*

**Mental health awareness for doctors**

Few of the stakeholders especially doctors suggested that there should be more information and awareness given to the doctors and GP at the peripheral level regarding the specialist services of the doctors and treatment at a higher level. This according to them leads to better referral and makes it easier for patients to access services.

*“Medical doctors need to know update information of mental health services like which date and time are psychiatrists in Township hospital and some kind of information like if psychiatrists are present one time per week in Shwe Kaw Hmue social network. If we know about that kind of information, we can easily refer patients there and they give their services free of charge.” (Respondent- Health care provider)*

**Healthy lifestyle promotion:**

Many stakeholders including community leaders recommended that healthy lifestyle like exercises should be promoted and awareness be given, that would help reducing stress among youth and children.

*“In Myanmar, doing exercise in the early morning should be encouraged as other countries. We must motivate people to participate more.” (Respondent- Community Leader)*

*“We want young people to participate in healthy lifestyle adoption.” (Respondent- Health care provider)*

*“It is needed to have healthy behaviors in school health education.” (Respondent- Health care provider)*

**Health Education for the community and strategies**

Most of the stakeholders stressed the importance of health education to be conducted and increase awareness within the community regarding the cause and effect of mental health illness. It is mainly focused on reducing stigma and treatment prognosis, early diagnosis, substance abuse and the importance of family for children.

*“We give Health Education to the patient’s family. It is the main thing.” (Respondent- Health care provider)*

*“The main thing is health education. They have to accept psychiatric cases are not mad. So we can treat them easily.” (Respondent- Health care provider)*

*“We should give health education about an early diagnosis that can help the patient to get better to the community.” (Respondent- Health care provider)*

*“As the parents, we should need to make our children friendlier and have happy time within the family. That may prevent going outside and doing the wrong thing like smoking and alcohol drinking. Educate the community about side effects of alcohol abuse including mental health problems.” (Respondent- Health care provider)*

Few stakeholders suggested that Health education regarding mental illness to the community could be given by involving health ministry using mass media. Various NGOs, doctors and health care workers, community leaders, religious leaders, teachers, and parents can also educate regarding mental illness. It also needs to be included in the curriculum of schools.

*“There should be health education on smoking and alcohol hazard at school. This kind of education session was mainly done by Mother and Child Association.” (Respondent-Health care provider)*

“*Health education should be given by the religious leader example monks or father from the Christian religion. They go and approach their religious believe leader.*” *(Respondent- Health care provider)*

*“It can always show the side effects of alcohol on TV or Skynet. I think we should also share some mental health brochures about alcohol in most places.”*

*“Health education should be done in basic education high schools, dhamma [Buddhist] schools, school health programs, and adolescent health programs to obtain mental health awareness. It will be fine if we add about mental health in tablets. We already train how to use the tablet to gain information. Facts should be collected whatever the reason.” (Respondent- Health care provider)*

**Health education for reducing alcohol and substance abuse**

Many practitioners also spoke about how they got involved in health education especially for the prevention of alcohol abuse. They explained and made people aware of the negative consequences of alcohol addiction on health and the burden it causes to the individual, family as well as society.

*“But for an alcohol addiction problem, I can give health education such as if you drink more, you will suffer from liver disease and something like this. I explain about the side effects of alcohol such as low capacity, no promise, the problem in job, marital status problem, the problem with children, brain damage, liver damage, nerve damage, poor personality, ruining job, causing the family problem.”*

**Legislative method to prevent substance abuse**

Various stakeholders during the interview stressed and recommended that legislative provisions and law enforcement should be tightened to curb the menace of spurious and illegal sale of alcohol and substances. These have resulted in increased cases of mental health illness and addiction and also created a disturbed society. They also suggested ways to jncrease prices of the alcohol especially by increased taxes and duties and to reduce use. They also suggested banning the sale of alcohol and substances to the under-aged

*“It should not be sold alcohol with poor quality. This poor quality of alcohol is cheaper than purified drinking water. I want to control that kind of alcohol. After they drink this kind of alcohol, they suffer from the disease.” (Respondent- Community Leader)*

*“The main thing needed is to control alcohol consumption by law enforcement. Law is just a state if there is no enforcement.” (Respondent- Health care provider)*

*“I just want to increase the alcohol taxation, and restrict the selling of alcohol to underage and at night.” (Respondent- Caregiver)*

*“By increasing tax in other countries, these items are not imported. So it becomes not easy to sell. Arrest the bars with no license.” (Respondent- Community Leader)*

**Emphasis on various programs and surveys**

Few programs should be promoted like MHGAP which is run under the guidance of WHO for training GP and basic health staff to treat minor mental illness and referral systems. This system also reduces the burden on tertiary sectors and plays an important role in early identification and prevention of mental health illness.

*“Now mental health gap action program (MHGAP) by WHO guidance is running and in training. If GP can treat minor common mental illness, it will get a referral system. If basic health staff can treat temporally, secondary and tertiary patients, centers will not be crowded. It is like prevention. To get to this goal, we need to establish community mental health and MHGAP.” (Respondent- Health care provider)*

**Improving the socio-economic condition of the population**

Some stakeholders also recommended that there should be more concentration on providing employment opportunity and ensuring economic stability which in return reduces stress, alcohol abuse, and mental health problems

*“Providing employment opportunity to the lower socioeconomic class.” (Respondent- Health care provider)*

*“As the government, it is good to give them a job. Generally, they do not have a job and so they become depressive resulting in drinking alcohol” (Respondent- Community Leader)*

1. **REHABILITATION STRATEGIES**

**Economic empowerment**

During the interview of various stakeholders, few of them threw light on how the community identified and supported the patient with illness and not having family or caretaker. They did this by pooling money and using this resource for the treatment and rehabilitation of the patient.

*“If there was a patient in town and if he had no more family member to take care of him, the people in the town would contribute by collecting money to have a handy amount.” (Respondent- Community Leader)*

Few of them spoke about the role Social Welfare department of the government and few NGOs played in the rehabilitation of handicapped and mentally unstable patients of low socioeconomic status. They empower such people economically by providing vocational training.

*“The social welfare service takes care of handicapped patients.” (Respondent- Health care provider)*

*“They divide the patients into two groups: one with handicapped and one with mental retardation. After that, if the patients are handicapped but still strong enough, we recommend them to attend some courses. That’s done not only by the social welfare service but also by other non-government organization” (Respondent- Community Leader)*

1. **SOURCES OF SUPPORT FOR MENTAL HEALTH ILL PATIENTS**

**Voluntary organization support**

When interviewed the stakeholders they revealed that they had support from many Voluntary Organisations that provide services like ambulance, food, money, and transportation. This made caregivers use the health systems and reduced their burden. Some organizations help women to act against harassment and offer mental and physical support to them.

*“Myanmar has Red Cross Society, fire control department, and ogranizations for women. Previous government utilized these orginzations to provide maternal and child health services”. (Respondent - Community leaders)*

*“I heard the some new that one NGO do the separate epilepsy project” (Respondent - Community leaders)*

*“It’s called Shwe Maw Hoon which was founded by the general U Khin Nyunt. It’s a charity group in Kyauk Tan. The group members restrain the patient and send them to the mental hospital by ambulance*.” *(Respondent - Community leaders)*

Along with the support to the patient's family, the NGOs also provide infrastructural support by providing hospital buildings for consultation as privacy is much needed in treating mentally ill patients.

*“For the social service regarding healthcare, the groups named Shan Myar and Myittar Shin do volunteering by building hospitals. These are the service regarding healthcare.” (Respondent - Community leaders)*

**Economic support**

On interviewing the caregivers, it was seen that they get lots of support from the hospital. There are some donations, regulated with the help of the community and these donations help to stable the clinic. They have also received donations as a birthday celebration.

“*There is also a charity fund at Kyauk Tan Township to help the poor patients. They support 10000 MMK per poor patient.” (Respondent- caregiver)*

Most of the drugs are provided free of cost at the Community Clinic in order to encourage compliance by the patients. The drugs are given mainly to the poor, old ages and monks. Also, few investigations are provided free of charge for the inpatients at the hospitals.

*“We provide some drugs but some drugs are to be bought. But the community clinic is FOC*.” *(Respondent- health care provider)*

*“Charities at the township is provided by Quarter Youth association. They identify and motivate potential patients to avail treatment from our center, and send people to take care [attendants] of the patient in their clinic visits.” (Respondent- health care provider)*

*“It can provide free of charge for all investigation (especially imaging procedures) for inpatients” (Respondent- health care provider)*

**Volunteers and Manpower support**

Caregivers also expressed that they get sufficient aid at hospitals. For the patients where accessibility is not easy the patients are allowed to sleep at the clinic and get consultation the next day.

*“They are our patients previously treated as depression, now in recovery condition. They come one day ahead to help us and we provide the bed to sleep at the clinic” (Respondent- health care provider)*

Some poor patients were also referred to the clinic for necessary procedures and support by the volunteers in the community. These volunteers are strong enough to be able to control the aggressive patients and those involved in anti-social activities. These volunteers were easily accessible and they also supported the transportation facilities.

*“They are composed of people who are strong and able to guard the mentally ill restless aggressive patients on the way to the hospital. No, they are just a volunteer team and we just need t call them. And we need to pay for the car fuel charges.” (Respondent- health care provider)*

**Transportation facilities**

If the patient needs transportation, the volunteers contact the charity association and the patient is given some money.

*“For some patients in Yangon, they are taken in a car to Kyauk Tan.” Respondent- health care provider)*

# 5 CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

This section includes the conclusions reached from the study, its major limitations and the recommendations to improve mental health status in Myanmar. The major challenges in providing mental health services identified through this study by respondent groups are the following:

**Healthcare providers**

* Major mental health problems in Myanmar were Anxiety, Depression, Bipolar mania, mood disorders, schizophrenia, substance abuse, and other psychotic disorders. An increase in the number of mental illnesses cases was observed over the years.
* Men and youths seek treatment for mental health problems more than females. Alcohol and substance abuse were the major causes of their mental illness.
* Many families were not willing to accept that their family members have a mental illness, does not avail referrals for diagnosis, or comply with the long term treatment.
* The existing facilities to treat mental illness are insufficient to treat a high volume of patients. There is a need for training to screen, diagnose, and treat cases as well as establishing a formal referral system. It is critical to ensure the availability of medicines and psychiatrists in health facilities and reduce the absenteeism of providers.

**Caregivers of mental health patients**

* Most of the caregivers have belief in allopathic medicines
* Contributing factors of mental illness included alcohol and substance abuse, work-related stress, family issues, failed businesses, debt to treat chronic diseases like HIV and cancer, genetic factors, lack of job opportunities, and poor implementation of alcohol/drug-related policies.
* Social stigma, longer duration of treatment, accompanying patients for clinic visits, and job losses aggravated the financial burden to the caregivers.
* Lack of awareness on mental health in the community, lack of acceptance by own family members, differential and inhuman treatment by family, and superstitions and stigma by society hamper treatment seeking.
* Offering basic personal need support, timely provision of medicines, handling of patients who are aggressive, destructive and have self-harm behaviours were reported as challenges.
* Punitive measures adopted by caregivers include confining, bonding, sedatives, and threatening. Many caregivers experienced helplessness or depression as well as deterioration of their physical health.

**Community leaders**

* Some community leaders believed that congenital anomalies and physical abnormalities by birth, being a curse from God, and psychotic disorder as a result of using illegal drugs were causing mental illness.

**Limitations of the study**

* Lack of representation from private providers, traditional practitioners, and the general public using those services, and those not seeking services for mental health problems
* The community leaders, as well as beneficiaries (caregivers), were selected with the help of healthcare service providers – the possibility of bias in response
* Most of the interviews were very short and the answers were similar to quantitative survey and not much probing was done
* The interviews with Community leaders were more about their experiences with mental health issues and did not capture the community level perceptions and challenges
* Some vital information and explanations might have been lost during transcription and translation.

**Recommendations to the mental health situation in Myanmar**

* Improving the quality of treatment through capacity building;
* Assuring the availability and affordability of treatment and other special services for mental health;
* Improving the infrastructure in healthcare facilities;
* Increasing and strengthening coordination with NGOs to build a conducive environment for treatment-seeking;
* Promoting inter-departmental coordination for identification of cases and reducing burden and stigma;
* Filling the vacancies and recruiting additional human resources to reduce patient-load;
* Organizing campaigns to increase health awareness to the public and training to mental health professionals;
* Promoting health lifestyle including alcohol and drug de-addiction programs and reducing stress among youths and children;
* Promoting health education for the community to reduce stigma and treatment prognosis, early diagnosis, substance abuse, and the importance of family for children through inter-sectoral and departmental coordination;
* Improving the legal framework and enforcement of laws on alcohol and drugs;
* Improving socio-economic conditions of population through employment generation and skill development, and economic support to patients through resource pooling at townships and community level insurance;
* Mobilizing youths and manpower to be volunteers in most of these activities; and
* Generating evidence periodically on mental health status, challenges in providing the services, and on barriers to avail services for future planning.

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