Qualitative evaluation of mental health training of auxiliary nurse midwives in rural Nepal

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Word count - 5481

Acknowledgement

We like to thank all ANMs who took part in the interviews. All UK volunteers who contributed to the training and Green Tara Nepal for the logistical support during the fieldwork and, last but not least, the Health Partnership Scheme for funding the project.

Abstract

Background and Objectives: Mental illness is increasingly recognized as a global health problem. However, in many countries, including Nepal, it is difficult to talk about mental health problems due to the stigma associated with it. Hence a training programme was developed to train auxiliary nurse midwives, who otherwise are not trained in mental health as part of their pre-registration training in rural Nepal, on issues related to maternal mental health. After training programme a selection of auxiliary nurse midwives were interviewed to establish their views on the training, its usefulness and ways to improve it.

Methods: This qualitative study reports on the analysis of interviews conducted with auxiliary nurse midwives who participated in the training programme. The interviews addressed issues associated with the training programme as well as perceptions around mental health in rural Nepal. Transcripts were thematically analysed.

Results: Three themes emerged from analysis: (1) issues related to training; (2) societal attitudes; and (3) support for women. The 'training' theme describes the benefits and limitations of training sessions. 'Societal attitudes' describes society's attitude towards mental health which is largely negative. 'Support' describes the positive behaviour and attitude towards pregnant women and new mothers.

Conclusion: The study supports the need for continued training for auxiliary nurse midwives who are based in the community. This gives them the opportunity to reach the whole community group and potentially have influence over reduction of stigma; offer support and diagnosis of mental ill-health. There is still stigma around giving birth to a female child which can lead to mental health problems. It is imperative to increase awareness and educate the general public regarding mental health illnesses especially involving family members of those who are affected.

Keywords: maternal mental health, auxiliary nurse midwives, training, stigma, education

Background

Mental health has slowly risen in importance on the global agenda. Untreated mental health disorders accounts for 13% of the total global burden of disease. Unipolar depressive disorder is the third leading cause of disease burden accounting for 4.3% worldwide, 3.2% for low-income countries and 5.1% for high-income countries (World Health Organization 2011). Projections for the year 2030 estimate that

worldwide, unipolar depression will be the leading cause of disability (Alonso, 2012). The results of WHO World Mental Health Surveys, the largest cross-national community-based epidemiological surveys on mental disorders carried out across 28 countries, revealed that mental disorders are a common risk in younger people (Alonso, 2012). Mental disorders not only cause long-term disability and dependency but also contribute to mortality (Prince et al. 2007). However, mental health problems are difficult to discuss in rural Nepal due to the associated stigma attached to it (Regmi et al. 2004, Hall et al. 2016). Although the overall suicide rate is higher in men compared to women (Hawton 2000), the suicide rate in women of childbearing age is much higher than that of men in the same age group (Oates 2003). Mental health issues in pregnant women and new mothers in rural Nepal are often not recognized and hence often ignored by community-based maternity care providers.

In order to improve mental health services in primary-care settings in low and middle-income countries (LMICs), it is important to develop community mental health services, including appropriate training and supervision (Saraceno et al. 2007). Training, employing and supporting nurses can help improve mental health services in LMICs (Ghebrehiwet and Barrett 2007). One key barrier to improving mental health care in primary-care settings is the low numbers of skilled health workers who are trained in providing (maternal) mental health care (Saraceno et al. 2007). In Nepal, there is the added problem that the profession of midwifery is in its infancy (Bogren et al. 2013; Boren et al. 2016). A needs assessment of mental health training for Auxiliary Nurse Midwives (ANMs) in Nepal, showed a lack of training on mental health issues related to pregnancy and childbirth (Simkhada et al. 2016). ANMs are the key maternity care providers in large parts of rural Nepal and their overall training which is only eighteen months covers all aspects of basic nursing and midwifery.

A group of Nepali and UK researchers, educationalists and development experts collaborated to design a series of maternal mental health training for community-based maternity care providers. The project was fund as part of the Health Partnership Scheme (HPS), which is part of the UK Department for International Development (DfID). The project targeted Nawalparasi, a district bordering India in the south of Nepal. The training lasted one year starting in early 2016 and finishing in early 2017.

The target population of the training project comprised community-based health-care practitioners, mainly ANMs working in local birthing centres and a smaller number of nurses working in larger health facilities (there are no doctors in rural villages). These ANMs are otherwise not trained in mental health as part of their pre-registration training. The training focused on promoting mental health as part of everyone's lives and on building skills to recognise mental health issues in pregnant women and new mothers. The training was conducted jointly by UK volunteers and Nepali-language speaking trainers. The training was held in a classroom, covering theory and practice. We conducted six different training

sessions with one-third of the ANMs from the entire district attending one day each time a course was conducted. Each time, the course was repeated three times to allow the maximum number of participants to attend without over-depleting the workforce in each of their workplaces. Every session was attended by the same 70 to 80 trainees over a one-year period.

Each session was designed by the multi-disciplinary and multi-national team and built upon the sessions previous to it. Sessions included various activities for teaching and learning including role play, group activities, group presentations, and discussion. At the end of each session or during these sessions, an evaluation was conducted to establish what participants had learnt from the sessions. Table 1 lists the details of the programme of the six training days. This THET-funded programme paid for UK health volunteers to come to Nepal for about ten days each to conduct training with ANMs. Each session, two or three UK volunteers conducted the training using their skills as experts in the field of mental health, maternity care and/or health promotion. Overall 15 volunteers came to Nepal including NHS (National Health Service) midwives, mental health nurses, and health visitors as well as university lecturers in nursing, public health and health promotion.

Insert Table 1

The aim of this paper is to explore how the ANMs perceived the training; what they learned; what was missed; their perception of maternal mental health problems in community and women's care needs when mental health issues are present.

Materials and Methods:

Study design

To evaluate this educational intervention and to improve knowledge of, and attitude towards mental health issues in pregnant women and new mothers among community-based health workers, qualitative semi-structured interviews were conducted. As this study is exploratory in nature, qualitative analysis was most suitable (Forrest Keenan & van Teijlingen 2004). This qualitative study is part of a larger mixed-methods study. Mixed-methods approaches, by their nature of combining quantitative and qualitative research methods and data, are often pragmatic (Mackenzie Bryers et al. 2014). The qualitative part is interpretivist in nature, i.e. the conception of shared reality arises from the interactive process between researcher and participants and their temporal, cultural and structural contexts (Vogt et al. 2012).

Sampling and setting

Purposive sampling was used based on availability of participants for telephone and face-to-face interview. The inclusion criteria were: ANMs who took part in all six rounds of training; and who worked at a birthing centre during training and at the time of the interviews. Although there were many participants who met the inclusion criteria, data saturation was reached with 15 ANMs. In a qualitative study, the inquirer makes knowledge claims based on constructivist perspectives coming from experiences shared by the participants (van Teijlingen et al. 2011). The researcher collected open-ended data with the aim to develop themes (Creswell, 2003). Semi-structured interviews were conducted in Nepali in early 2017 by the first author mostly face to face and some by telephone. Interviews were recorded with permission, transcribed and translated into English (Kirkpatrick & van Teijlingen 2009).

Data collection and analysis

Fifteen interviews were conducted with ANMs from birthing centres of Nawalparasi district who attended six rounds of mental health training provided by the volunteers from the UK. The longest interview was of 19 minutes and 35 seconds and the shortest was 7 minutes and 31 seconds. Data were analysed using a thematic analysis framework (Braun and Clarke 2006). All transcripts were read a number of times and coded systematically by the first author, who identified a number of themes which were, which were independently checked by the second author and then revised to generate the final themes. Quotes are provided below to illustrate themes (Keenan Forrest & van Teijlingen 2004), with only numbers as identifiers, e.g. 'ANM 8'. Figure 1 outlines the thematic analysis.

Ethical Considerations

Ethical approval was granted by the UK university and the Nepal Health Research Council. Participants were informed that the participation was voluntary and they could withdraw at any time during the interview. The interviewer explained the research and obtained verbal consent before starting each interview.

Insert Figure 1

Results:

Three broad and overlapping themes emerged: (1) issues related to mental health training; (2) societal attitudes; and (3) support for women. Training covers the benefits and limitations of the training intervention; societal attitudes raises stigma and gender differences associated with the mental health problems whereas support describes the (need for) positive behaviour and attitudes towards women with mental health problem in the community.

Issues related to mental health training

The first theme comprises sub-themes around: (a) importance of mental health training in the field of maternal health; (b) communication; (c) identifying mental health problems; (d) developing a positive mental health state; and (e) limitations in the training.

Importance

Almost all participants said that mental health training had been helpful so they could counsel women and their family. They stated that they now counsel pregnant or postpartum women with mental health problem at their birthing centres, for example,

"Through counselling we have helped two cases feel better." (ANM 4)

The ANMs said that after the training they have become capable of providing initial counselling to every woman during antenatal visits and to post-partum women after delivering their babies.

Along with counselling women, they also counselled their family members. Counselling family was seen as helpful when family members didn't seem to be able to provide help for the women who were struggling.

> *"We call such cases separately and provide them counseling. If they come with their husband and mother in law then we ask their mother in law to take care of their daughter in law." (ANM 3)*

Participants stated that speaking to family members was helpful to change the negative attitudes of the family towards mental illness.

Almost all participants mentioned that if they couldn't help women through counselling, they referred them to tertiary-level government hospitals. However, several expressed their concern about the lack of suitable referral places for people with serious issues who require prompt treatment. The local primary health posts do not have mental health support:

> *"When we identify serious cases then there should be such place where we can refer them and where they get prompt treatment soon after their visit. For example, in Primary Health Care centre (PHC) if there is a psychiatric doctor then it would be easier for us to refer there and they would also get prompt treatment." (ANM 2)*

Interpersonal communication and counselling

Many participants stated that the training had helped them to develop their interpersonal communication. They felt, for example, that they had learnt to listen more to women and understand their problems better.

> *"After taking training, we speak less and make them speak more. Previously we used to speak more and they used to speak less but we were not able to link their problem with mental health problem." (ANM 12)*

The majority reported they had learnt how to counsel. The term 'counseling' used by the participants here refers to improved learning and communication skills as the training did not specifically teach professional counselling. Although many mentioned they had learnt about counselling in previous training, the role play done during the maternal mental health training was new to them and considered very helpful.

> *"Previously it was difficult for us to counsel but this training has taught us how to do counseling." (ANM 7)*

Learning about mental health problems

Most participants mentioned that before their training they didn't think a lot about mental health but training helped them to understand the importance of mental health of women during pregnancy and in the post-partum period. They would make comments like:

> *"We used to focus more on physical health problem rather than mental health problem but after training we knew that mental health is also important so we have been addressing mental health problem since then." (ANM 11)*

Many found the training helpful as it taught them to identify women with mental health problems.

> "*Previously when the women with mental health problem visited us we couldn't identify them. But later after taking training it has become crystal clear about what happens if there are mental health problems among pregnant women.*" *(ANM 15)*

Some participants found that the training helped them to develop their own positive state of mind. They became aware of and learnt to develop important qualities in themselves like patience, empathy, dealing with their own worries.

"It has become very useful. Our mental state is also not always consistent so we might get aggressive at times so we learnt to handle ourselves along with the women and the family members." (ANM 11)

Some participants expressed that it is quite difficult to encourage women to open up and talk about their problem. However, this training taught them about making women feel comfortable to speak up. They thought this was one of the biggest strengths of the training.

"It is quite difficult as they do not open up to such problem and also hide their problem and after we keep on asking them constantly they finally accept their problem." (ANM 2)

Some also mentioned that one of the strengths of this training was that it helped them to handle and deal with women with more complex issues. They understood now that that women might need special care as during this period their mental state is somewhat 'disturbed', for example:

"The strength of the training was that I learnt how to handle the pregnant women during their stress. Some women become very violent, quarrel and once labour pain starts they start panicking, shouting and biting. So, we learnt how to handle such cases. (ANM 5)

The counselling that the ANMs provided proved to be very helpful and thus protected some pregnant women from negative views and behaviour from their family. The following ANM recalls women who attend the birthing centre with stories of ill treatment by their family, something they claim to address at least in some way:

"….our technique of counseling has changed a lot after training and there are good impressions." (ANM 14)

Limitations of training

Participants identified several limitations to our training: all those trained thought that similar training should be provided to all health workers at the health post, i.e. to both permanent and temporary health staff. Participants expressed that other staff at the health post also encounter people with mental health issues. In the absence of trained ANMs other staff encountering mental health issues would lack skills to manage:

"I recommend every health workers to take the training because when a women visits, they will be able to identify the case. Also, women with mental health problems don't come to health workers thinking he/she might have taken the training, they go randomly to any health worker." (ANM 8)

Refresher training and longer training sessions

A few participants said that a refresher course was needed as they might forget things they had learnt.

> *"I think there should be refresher training because sometime while working we might forget some points so through refresher training it will be easy for us to remember." (ANM 4)*

Some also thought it best if the training was provided for a longer period than the current six days.

Support for women

Providing love, care and support

Most participants mentioned that the women with mental health conditions need love, care and support. Whenever the ANMs come across such women, they call her family members especially mother-in-law and husband and counsel them to provide the woman with love and care. Few participants expressed that some families who are educated understand the need of providing rest and care to pregnant and post-partum women.

> *"…there was one case and her whole family had helped her. Everyone in her family was educated so they helped her." (ANM 3)*

Others mentioned their wider education role in the community, for example providing advice to family:

> *"For some family members, we provide information then they are found to be supportive. We have informed the family members to keep them [= the person with mental health problems] happy, talk frequently and not to leave them alone." (ANM 2)*

One positive effect noted by ANMS was that where family was supportive of pregnant and post-partum women, they would bring them to the ANMS at the health post for a check- up.

> *"As they come here with their husband or with mother-in-law so it seems like they have supported." (ANM 1)*

Support by community or health workers

Some participants said that few people in their community have become aware of the risk of mental health conditions in pregnant and post-partum women and so they support such women. ANMs gave examples where neighbours and villagers helped such women. Health workers and

female community health volunteers were found to be more helpful and supportive to women under such circumstances.

> *"There are various types of people in the community; among them some people understand the mental health problem and are supportive too. Among those who are supportive they want to bring the change." (ANM 9)*

Societal attitudes

Mental illness as stigma

Many participants expressed that those women with mental health problem were often considered as mad in their communities. They were also considered to be a burden and it was often perceived they would not contribute anything to society. So, there is a stigma related to mental health conditions in the community.

> *"Community people do not understand mental health problem and we also can't tell it directly. They think that mad people suffer from mental health problem." (ANM 12)*

Commonly held views in rural Nepal make it difficult to raise and discuss any mental health issues. Interviewees said that in their communities it is very difficult to speak about mental health conditions. They linked this to the community being predominantly made up of low caste and poorly educated:

> *"It is very difficult here in* (this*) … community because they do not disclose their mental health related problem". (ANM 1)*

Women do not feel comfortable to open up and speak about their problems in front of others, especially family.

> *"When they come with their family members they do not disclose anything but when we take them inside for a checkup if they confront their problem" (ANM 2)*

Unfair treatment

Pregnant and post-partum women with mental health condition are generally not treated with kindness and care in the community. The ANMs expressed that there are only a few families who support women with mental health problems. Generally, most people take this problem negatively and, from a health perspective, treat them inappropriately.

"Community looks at such cases maliciously along with unfair treatment so they take it negatively." (ANM 3)

Some participants also said that the community tries to keep a distance from women with mental health conditions and think that they should be isolated and that people shouldn't talk with them.

"She should be kept alone and isolated, if she goes to other places then she will talk unnecessary so she should not be helped" (ANM 12)

Baby girls

Some participants expressed that women may suffer mental health problems due to giving birth to a girl. Stories were told about women crying and getting depressed after repeatedly giving birth to girls, as this is considered to be a bad omen by their family.

"… where daughter was born for the third time and soon after delivery the woman started crying in her bed." (ANM 6)

ANMs mentioned that in their rural communities having a son is important and the family expects a son. But if a woman already has daughters, she can become fearful and stressed if she gives birth to a girl again which can lead to mental health problems.

"The pregnant women might take stress thinking that her family desired a son but she gave birth to a daughter and it may end up with mental health problem." (ANM 6)

Some women also get stressed by fearing that her family will blame her for giving birth to a girl.

However, there were positive signs too, as it is becoming easier to speak about mental health problems. Several participants reported that the community is now changing and people have started to be more positive about women suffering from mental health problems. They have started to speak about mental health problems in the community.

"They take it as normal. Most of the people take it normally as they relate such case with their past experience during their pregnancy." (ANM 11)

Discussion

This paper evaluates a mental health training intervention and explores the wider societal issues related to maternal mental health. The three overlapping themes raised were around the training itself, societal issues around mental health and support for women in the community.

The training on mental health was perceived to be a good start and was, in many ways, viewed as successful. The participants have pointed out the importance of the topic, their learning, the strengths and limitations of the training sessions and their growing realization of what else they need. The latter included notions of appropriate referral pathways, which is a separate problem as Nepal, like many other low-income countries, lacks skilled mental health professionals. Nepal needs national policies (and funding) to overcome the large shortage of mental health workers and services (Brucker et al. 2011). It is important to invest in setting up mental health services in primary care, especially in rural areas. However, this is unlikely to be sustained unless it is accompanied by the development of community mental health services, to allow for training, supervision and continuous support for primary care workers (Saraceno et al. 2007).

Overall, the maternal mental health training appears to have been more than simply information sharing. ANMs have been resourceful and have tailored what they have learnt from UK volunteers to suit their local situation. For example, the volunteers shared practical as well as several theory aspects and helped the ANMs realize that women need private time to be given a chance to disclose mental health issues.

These ANMs, like the nurses in Malawi (Chorwe-Sungani 2013), lacked knowledge and skills to handle mental health issues but felt confident enough to identify and counsel them after receiving the mental health training. The training helped ANMs realize how useful it was to learn about the mental health conditions in women, and how to identify and provide counseling in primary care settings like birthing centres. However, they need such training more often and for longer periods as ‘refresher’ training so that they don’t forget the concepts.

This article highlights the importance of training, how it equips the ANMs with skills to listen to problems of pregnant and post-partum women as well as how they now counsel women at birthing centres. A study of health visitors in general practice also highlighted the importance of training and counselling to treat postnatal depression (Holden et al. 1989).

Research has shown that midwives have a pivotal role to play in perinatal mental health and are also willing to take on a more developed role in mental health but they often find themselves ill-equipped to deal with women with mental illness, lack training, knowledge and confidence (McCauley et al. 2011,

Ross-Davie et al. 2006). Thus, proper and appropriate training of midwives, in Nepal the ANMs, enables them to assess mental health needs of women and refer them for timely intervention. Our participants mentioned that they needed refresher trainings to boost their confidence in counselling skills. A quasi-experimental study conducted to test confidence of social workers in providing substance misuse counselling showed that those who received training over a period of time demonstrated an increased in confidence from pre-to post training (Prescott et al. 2002). Patients counselled by such health workers generally achieve better results than by those staff who received shorter one-off training sessions (Prescott et al. 2002).

It is widely recognized that there are difficulties in raising mental health problems, and not just with childbearing women, but in rural societies in Nepal (Simkhada et al. 2015, Hall et al. 2016). Hence there is a double challenge for people with mental ill health, on one hand they struggle with signs and symptoms resulting from the condition and on the other hand they are challenged by the stereotypes and prejudice resulting from misconceptions about mental ill health (Corrigan and Watson 2002). Unfortunately, such discrimination still exists towards people suffering mental health problems, resulting in people keeping such problems secret (Byrne 2000). Stigma is mostly of two types: public stigma (the prejudice and discrimination endorsed by the general population that affects a person) and self-stigma (the harm that occurs when the person internalizes the prejudice) (Hinshaw 2007). The findings from our study mainly focus on public stigma but it is equally important that future researchers focus on self-stigma.

ANMs reported self-stigma among women with only daughters who feared producing more girls in subsequent pregnancies. The results were similar rural Bangladesh (Gausia et al. 2009). Preference for a son, also exists in other countries for example in Egypt (El-Gilany and Shady 2007). Women in a rural patriarchal society like in our study are likely to encounter mental health problems related to the gender of unborn child.

In order to act against such stigma present in society, anti-stigma campaigns, educating the general public and students and protest campaigns using email alerts are being used around the world (Rusch et al. 2005). Some participants mentioned that the way some people look towards mental health problems and people suffering from such illnesses is changing, however it is limited to only few people and health care workers (especially ANMs). In order to reduce stigma related to such mental illnesses in Nepalese society it is very important to raise awareness and education across the general population.

This study has several limitations: first the evaluation is based on self-reporting only. There has been no observation of ANM practice or feedback from community members. Secondly, the sample size is small

and area of study is confined to only few villages.

Conclusion

The training had an impact on the ANMs sampled who expressed a need and desire for further and more training. They perceived the need for a referral pathway for women in need of further mental health treatment and support. Stigma against women suffering from mental health problems still exists and self-stigma related to giving birth to a female child is a problem in Nepal. ANMs supported the idea of anti-stigma activities.

Maternal mental health is a specific sub-field that is important for nurses and midwives to engage with. In countries where mental health is stigmatised and the role and position of women is lower than that of men, training ANMs cannot just be focused on the knowledge and skills needed to identify and treat (or refer) mental illness. ANMs also needs skill to raise such sensitive issues with the wider society, especially the woman's family.

Conflict of interest

The authors declare no conflict of interest.

References

Alonso, J., 2012. Burden of Mental Disorders based on the World Mental Health Surveys. Rev Bras Psiquiatr. 34, 7-11.

Bogren, M.U., Berg, M., Edgren, L., van Teijlingen, E., Wigert, H., 2016. Shaping the midwifery profession in Nepal - Uncovering actors' connections using a Complex Adaptive Systems framework. Sex Reprod Healthc. 10, 48-55.

Bogren, M., van Teijlingen, E., Berg, M., 2013. Where midwives are not yet recognized: A feasibility study of professional midwives in Nepal. Midwifery. 29 (10), 1103-1109**.**

Bruckner TA., Scheffler RM, Shen G, Yoon, J., Chisholm, D., Morris, J., Fulton, B.D., Dal Poz, M.R., Saxena, S., 2011. The mental health workforce gap in low- and middle-income countries: A needs-based approach. Bull World Health Organ. 89 (3), 184–194. https://doi.org/10.2471/BLT.10.082784

Byrne, P., 2000. Stigma of mental illness and ways of diminishing it. Adv Psychiatr Treat. 6 (1), 65-72.

Chorwe-Sungani, G., 2013. Nurses' knowledge and skills in providing mental health care to people living with HIV/AIDS in Malawi. J Psychiatr Ment Health Nurs. 20, 650-654.

Corrigan, PW., Watson, AC., 2002. Understanding the impact of stigma on people with mental illness. World Psychiatry. 1(1): 16-20.

Creswell, J., 2003. Research Design: Qualitative, Quantitative and Mixed Methods Approaches 2nd edn. London: SAGE.

El-Gilany, AH., Shady, E., 2007. Determinants and causes of son preference among women delivering in Mansoura, Egypt. East Mediterr Health J. 13 (1), 119-128.

Forrest Keenan, K., van Teijlingen, E., 2004. The quality of qualitative research in family planning and reproductive health care. J Fam Plann Reprod Health Care. 30 (4): 257-59.

Gausia, K., Fisher, C., Ali, M., Oosthuizen, J., 2009. Antenatal depression and suicidal ideation among rural Bangladeshi women: a community-based study. Arch Womens Ment Health. 12 (5), 351-358.

Ghebrehiwet, T., Barrett, T., 2007. Nurses and mental health services in developing countries. Lancet. 370, 1016-17.

Hall, S. E., Watson, T. S., Kellums, M. L., Kimmel, J., 2016. Mental health needs and resources in Nepal. Int J Cult Ment Health. 9(3), 278-284.

Hawton, K., 2000. Sex and Suicide – Gender differences in suicidal behaviour. Br J Psychiatry. 177 (6), 484-485.

Hinshaw S. The Mark of Shame: Stigma of Mental Illness and an Agenda for Change, 2007. New York, Oxford University Press.

Holden, J.M., Sagovsky, R., Cox, J.L., 1989. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. BMJ, 298, 223.

Kirkpatrick, P., van Teijlingen E., 2009. Lost in Translation: Reflecting on a Model to Reduce Translation and Interpretation Bias. Open Nurs J. 3(8), 25-32.

MacKenzie Bryers, H., van Teijlingen, E., Pitchforth, E., 2014 Advocating mixed-methods approaches in health research, Nepal J Epidemiol **4**(5), 417-422. http://www.nepjol.info/index.php/NJE/article/view/12018/9768

McCauley, K., Elsom, S., Muir-Cochrane, E., 2011. Midwives and assessment of perinatal mental health. J Psychiatr Ment Health Nurs. 18(9), 786-795.

Oates, M., 2003. Suicide: the leading cause of maternal death. Br J Psychiatry. 183 (4): 279-281.

Prescott, P., Opheim, A., Bortveit, T., 2002. The effect of workshops and training on counselling skills. J Norwegian Psychol Assoc. 5, 426–31.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., Rahman, A., 2007. No health without mental health. Lancet. 370, 859-77.

Regmi, S.K., Pokharel, A., Ojha, S.P., Pradhan, S.N., Chapagain, G., 2004. Nepal mental health country profile. Int J Psychiatry. 16 (1-2), 142-149.

Ross-Davie, M., Elliott, S., Sarkar, A., Green, L., 2006. A public health role in perinatal mental health: Are midwives ready? Br J Midwifery. 14(6): 330-334.

Rüsch, N., Angermeyer, M. C., Corrigan, P.W., 2005. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. Eur Psychiatry. 20: 529–539.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., Underhill. C., 2007. Barriers to improvement of mental health services in low-income and middle-income countries. Lancet. 370, 1164-74.

Simkhada, B., Sharma, G., Pradhan, S., van Teijlingen., Ireland, J., Simkhada, P., Devkota, B., 2016. Needs assessment of mental health training for Auxiliary Nurse Midwives: a cross-sectional survey. J Manmohan Mem Inst Health Sci. 2, 20-26.

Simkhada, P., van Teijlingen E., Winter, RC., Fanning, C., Dhungel, A., Marahatta SB., 2015. Why are so many Nepali women killing themselves? Review of key issues. J Manmohan Mem Inst Health Sci. 1 (4), 43-49.

van Teijlingen E., Simkhada, B., Porter, M., Simkhada, P., Pitchforth, E., Bhatta, P., 2011. Qualitative research methods and its place in health research in Nepal, Kathmandu Univ Med J. 9 (4), 301-305.

Vogt, W.P., Gardner, D.C., Haeffele, L.M. 2012. When to use what research design. New York: The Guilford Press.

World Health Organization. Global burden of mental disorders and the need for a comprehensive,

coordinated response from health and social sectors at the country level. 2011. Available from: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf