

[ORIGINAL RESEARCH ARTICLE]

Mental Health Treatment Patterns for Anxiety and Depression among Women in Nepal

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Abstract

The main objective of this article is to assess different patterns of treatment for anxiety and depression for women in Nepal. There is increasing global consciousness about mental health issues; however, there remain considerable research and practice deficiencies as far as Nepali women are concerned. The justification of the study is to determine the main challenges women face in accessing mental health care in Nepal and to assess the quality of care provided to women. The study used data from the most recent survey, the 2022 NDHS, and a stratified sampling technique to assess the response of a nationally representative sample of 7,442 women categorized based on socio-economic status and region. The factors that have been determined are age, education, wealth, ethnicity, and regional divisions. The treatment-seeking behavior and the service utilization were determined through descriptive statistics. The study reveals that women who were elderly, educated, and wealthy enjoyed better treatment for depression than

marginalized and those in rural areas. Lack of structures and financial constraints prevented professional care and drug usage. The majority of the participants depended on care from their close relatives. The study confirms that culturally appropriate approaches should be used for depressed Nepalese people. The changes should involve investment in infrastructure in rural areas, integrating mental health into primary care, and achieving cost reduction by subsidization. Thus, The intervention must be evaluated in future studies to determine if improvements in equity and mental health outcomes are to be made successfully.

Keywords: anxiety, depression, healthcare access, treatment utilization, mental health treatment.

INTRODUCTION

Depression and anxiety are common health problems, especially among women of Nepal, owing to particular cultural, economic, and environmental constrain. It also faces poor mental health care access, prejudice, and a low supply of mental health care workers. Therefore, there is a need to fully focus on the psychological health needs of the people trying to solve these problems.

Anxiety and depression represent a high burden of diseases in the world, and the WHO puts them among the top contributors to disability (WHO, 2023). In the case of Nepal, these mental health challenges are common, particularly among women, because of gender violence, poverty, social isolation, and caregiving. It is lamentable to note that women experience more anxiety and depressive disorder compared to men. Marital and disability status of individuals are linked with mental health disorders (Pandey et al., 2023). Issues related to mental health services in Nepal can only be addressed through strategic changes and better Interprofessional practice. Conventional and allopathic approaches to healthcare are also integrated into Nepal's healthcare system (Buerkner & Walsh, 2023). Mental health issues remain a challenge for women in Nepal with high levels of anxiety and depression. Such challenges are more often magnified because of underlying gender-based discrimination, poverty, domestic violence, and other socio-cultural aspects (Mamidanna et al., 2024). Despite a high need for mental health treatments, people in Nepal have little capacity to obtain and utilize such care effectively.

Studies indicate that the mental health of women in Nepal is often neglected and remains a public health unmet burden (Pham et al. 2021). Depression, anxiety, and other forms of psychological distress are more prevalent among women due to burdens such as gender discrimination, poverty, and domestic violence (Kohrt & Worthman 2009). Belittling feelings due to events associated with loss, inferiority, shame, or even confinement tend to be predictive of depression. In developing nations, anxiety and depression affect as much as 20 percent of the patients, even those in primary healthcare settings (Salter & Hall, 2022).

New-onset depression or anxiety among prostate cancer patients receiving androgen deprivation therapy: they fail to recommend treatment; disparities in treatment set a record that 50 percent of those diagnosed do not receive documented treatment. Primary care providers frequently prescribe psychotropic medications (Tsao et al., 2022). Selective serotonin reuptake inhibitors and benzodiazepines are among the medicines used for anxiety, but the one-year usage of the treatment is comparatively low because of early discontinuation (Fischer et al., 2024). However, in patients with both depression and anxiety, it appears that response to Antidepressant treatment is mainly non-specific, and the predictors of poor response include higher baseline severity and worse sleep quality.

The healthcare professionals' competencies and the efficacy of services provided for the given mental health issues were satisfactory. Additional concerns identified were elevated staff turnover, shortages of specific medications, and perceived disadvantages from some specialists (Luitel et al., 2020). Medical management incorporates medications, such as antidepressants, but they are more frequently employed along with psychological therapies. As reported by studies, cognitive behavioral therapy and other psychotherapy techniques like problem-solving therapy have been successful in treating anxiety and depression in Nepalese women (Luitel et al., 2017). Wealthy women tend not to suffer from anxiety and depression than less wealthy women (Gnawali et al., 2024).

Women who have separated or divorced from their marriages have shown higher levels of stress and anxiety. Thus, it is essential to manage these situations appropriately.

Regardless, these women experience problems in receiving aid in mental healthcare facilities. Anxiety and depression levels are exceptionally high among women within the age groups of 15-49 (Pandey et al., 2024). Nevertheless, while there is literature on mental health treatment algorithms, information specific to Nepali women diagnosed with anxiety and depression is still needed. Treatment outcomes are one of the many aspects that require further inquiry, especially in the case of these women and men in interventional techniques where healthcare professionals are not divined (Shawon et al., 2024).

It is essential to analyze the impact of socio-cultural factors on the mental health care of Nepali women. There are deficiencies in research about culturally relevant therapies to improve treatment effectiveness for anxiety and depression in this community. This study is significant since it deals with issues of mental health treatment concerning women in Nepal, which Nepali women dominate. This study will assess potential treatment options for anxiety and depression to benefit future mental health policy direction in Nepal. Expanding mental health services for women will have a cascade effect on families and communities at large.

This study attempts to obtain the most relevant therapeutic choices for anxiety and depression in women in Nepal. The scope takes into consideration cultural ideas and traditions. The outcomes of this research will lead to the development of inexpensive treatments for women from varied geographical and economic backgrounds.

DATA AND METHOD

Sample Design

Sub-wards are the primary sample unit for the 2022 Nepal Demographic and Health Survey (NDHS) based on the 2011 Census. Rural and urban households were used to categorize all 36,020 sub-wards in the country. After implementing administrative changes in 2015, Nepal was split into 77 districts and seven provinces, totaling 753 local municipalities, 293 of which were in urban areas and 460 in rural areas. Between 2011 and 2015, urban municipalities increased from 58 to 217.

In the 2022 NDHS design, a two-stage stratified sampling strategy was used. Fourteen sample strata were obtained by dividing the provinces into urban and rural strata. In the initial round, 476 primary sampling units (PSUs) were chosen, including 248 urban and 228 rural units. From these PSUs, 14,280 households (7,440 urban and 6,840 rural) were randomly chosen to participate in one-on-one interviews. Households were geo-coded for interviews at various times, and segments with populations greater than 300 were further divided.

Sampling Procedure and Sample

A modified sample frame from the 2011 population and housing census was utilized by NDHS in 2022. All seven provinces were separated into urban and rural areas, providing 14 sample strata. The sampling procedure comprised implicit stratification and proportionate allocation in each stratum. The sample frame was arranged based on administrative units, and a probability proportional to size technique was employed. Altogether, 476 primary sampling units were selected, comprising 248 in urban areas and 228 in rural regions.

A household enumeration was done in each PSU to create a sampling frame. Wards with over 300 houses were partitioned geometrically, and one section was picked using probability proportional to size. Each cluster had 30 homes picked for 14,280 households (7,440 urban and 6,840 rural). Surveys were carried out by 14,845 women and

4,913 men. Data from 12,355 people (7,442 women and 4,913 males) with mental health status from the NDHS 2022 are examined. Other sites include further information on the sampling.

Statistical Analysis

For data analysis, SPSS version 20 was used to describe and analyze the statistical analysis of the 2022 Nepal Demographic and Health Survey. Appropriate in light of the survey has been weighted analysis. Categorical data were summarized as a proportion (with a 95% confidence interval), and numerical data were summarized as a mean (with a 95% confidence interval). Binary logistic regression analyses were conducted separately for depression and anxiety disorders, with status in regards to age, sex, marital status, location, province, ethnicity, religion, and literacy as covariates. Significance was tested at a $p < 0.05$ level.

RESULTS AND DISCUSSION

Results

Table 1 displays the socio-demographic features of women respondents. The average age was 29.8 (SD=9.7) years, of which 48.3 percent were aged between 20-34 years, 33.8 percent were between the ages of 35-49 years, and 17.8 percent were below 20 years. The ethnic composition showed Janajati (36.9%), Brahmin/Chhetri (27.7%), Dalit (15.0 %), and Madhesi/others (20.4%). Most of the study populations were Hindus, constituting 83.0 percent of the population. However, 17 percent of the respondents belonged to other religions.

Table 1

Socio-demographic Profile of Respondents

Background Characteristics	Women (N)	(%) (95% CI)
Age (years)		
Mean \pm SD	-	29.8 \pm 9.7
<20 years	1,322	17.8 (16.9 to 18.8)
20–34 years	3,581	48.3 (47.0 to 49.6)
35–49 years	2,507	33.8 (32.7 to 35.0)
Caste/Ethnicity		
Brahmin/Chhetri	2,049	27.7 (25.3 to 30.1)
Dalit	1,115	15.0 (13.3 to 16.9)
Janajati	2,735	36.9 (34.1 to 39.8)
Madhesi /others	1,511	20.4 (17.8 to 23.2)
Religion		
Hindu	6,151	83.0 (80.8 to 85.0)
Other	1,259	17.0 (15.0 to 19.2)
Marital status		
Unmarried	1,632	22.0 (20.8 to 23.4)
Married or living together	5,533	74.7 (73.3 to 76.0)
Divorced or not living together	245	3.3 (2.89 to 3.80)
Wealth index		
Lowest	4,228	57.0 (53.5 to 60.5)

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Highest literacy status	3,183	43.0 (39.5 to 46.5)
Illiterate	1,944	26.2 (24.6 to 28.0)
Literate	5,467	73.8 (72.0 to 75.4)
Province		
Koshi	1,241	16.7 (15.4 to 18.2)
Madhesh	1,512	20.4 (19.1 to 21.8)
Bagmati	1,493	20.2 (18.5 to 21.9)
Gandaki	704	9.5 (8.35 to 10.8)
Lumbini	1,360	18.4 (17.0 to 19.8)
Karnali	458	6.2 (5.62 to 6.79)
Sudurpashchim	641	8.6 (7.96 to 9.39)

The findings of the study indicated that most individuals were either married or living together (74.7%), with a considerable number being unmarried (22.0%) and a small number being divorced or separated (3.3%). As for the distribution of wealth, 57.0 percent of the respondents were in the lower wealth group, whereas 43.0 percent were in the upper wealth group. Further, 73.8 percent of the population was literate, and 26.2 percent were illiterate, showing that there exists a positive reading culture amongst educated people.

According to the data, the majority of the respondents were from the provinces of Madhesh (20.4%) and Bagmati (20.2%), while a significant number of them also came from the provinces of Lumbini (18.4%) and Koshi (16.7%). More respondents came from the provinces of Gandaki (9.5%), Sudurpashchim (8.6%), and Karnali (6.2%).

Table 2

Treatment Options for Women Experiencing Anxiety or Depression Symptoms

Background Characteristics	Ever told had anxiety (%)	Ever told had depression (%)	Took medication (%)^a	Received therapy (%)^b	Number of women
Age Groups					
15–24	2.35	2.05	0.6	1.75	2,611
25–34	4.15	3.35	0.9	0.9	2,292
35 and above	5.07	3.68	1.86	1.85	2,507
Caste/Ethnicity					
Brahmin/Chhetri	4.5	4.4	1.6	2.2	2,049
Dalit	4.4	3.1	1.1	1.4	1,115
Janajati	2.7	2.3	1	0.8	2,735
Madhesi/ Muslim/others	10.3	5.2	2.2	3.0	1 500
Literacy status					
Illiterate	4.9	2.9	1.9	1.1	1,944
Literate	10.4	7.6	2.3	4.1	5467
Wealth quintile					
Lowest	2.7	2.3	0.6	0.8	1,344
Highest	4.2	3.9	1.7	1.6	1,479
Total	3.9	3.0	1.2	1.5	7,410

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Province					
Koshi	3.4	2.7	1.1	2.2	1,241
Madhesh	3.9	2.1	0.9	1.1	1,512
Bagmati	3.5	3.6	1.3	1.1	1,493
Gandaki	3.7	2.3	0.4	0.5	704
Lumbini	4.5	3.5	1.6	2	1,360
Karnali	6.2	4.5	2.6	2	458
Sudurpashchim	2.8	2.8	0.7	1.8	641

^aTook medication recommended by health care practitioner for anxiety or depression in the prior 2 weeks

^bReceived therapy from a health care practitioner for a mental health concern in the last two weeks

Table 2 shows how Nepalese women are treated for anxiety and depression. Anxiety symptoms were evident in 3.9 percent, whereas depression symptoms were prominent in 3.0 percent. Over the last two weeks, 1.2 percent of respondents used drugs, and 1.5 percent received therapy.

It was found that the older groups of women aged 35 years and above were the most anxious (5.07%) and depressed (3.68%). Moreover, 1.86 percent of them claimed to have taken prescribed medicines, while 1.85 percent went for counseling. The youngest women aged 15-24 years had the least medication utilization, which was at (0.6%) but slightly increased when it came to counseling (1.75%) as compared to women aged 25-34 years.

Madhesi Muslims exhibited the highest levels of anxiety (10.3%) and depression (5.2%); 2.2 percent of these individuals were under medication, and 3.0% attended therapy sessions. Janajati women exhibited the lowest rates of anxiety (2.7%) and depression (2.3%), with a mere 1.0 percent medicated and 0.8 percent in treatment respectively. Individuals' social rank and income level impact their capacity to get mental health care. Educated women reported higher levels of anxiety (10.4%) and depression (7.6%) than illiterate women. Women in higher socio-economic strata were more likely to suffer from anxiety (4.2%) and depression (3.9%), as well as take medication (2.3%) or therapy (4.1%), than those in the lowest income quintiles.

In addition, geographical differences were observed since a more significant proportion of ladies from Karnali Province reported higher levels of anxiety (6.2%) and depression (4.5%), as well as higher rates of medication (2.6%) and counseling (2.0%) usage. In contrast, the least amount of medication (0.4%) and counseling (0.5%) was reported in Gandaki Province. The table shows how background characteristics influence the diagnosis and treatment of mental diseases. It reveals that anxiety and depressive disorders are more typically identified and treated among older, educated, and wealthier women, members of various ethnic groups, and those living in specific locations.

Table 3

Health Care-Seeking Behavior and Providers for Women with Anxiety or Depression Symptoms: Nepal, DHS 2022

Background Characteristic	Ever sought help (%)	Health care provider	
		(%)	Other (%)
Age groups			
15–24 age group	18.3	3.0	97.0
25–34 age group	20.1	6.5	93.5
35 age group and above	17.6	10.6	89.4
Caste/Ethnicity			
Brahmin/Chhetri	17.5	11.8	88.2
Dalit	17.1	7.4	92.6
Janajati	18.9	4.9	95.1
Madhesi/ Muslim/ Other	44.2	7.6	192
Literacy status			
Illiterate	17.5	7.3	92.7
Literate	19.8	6.1	93.9
Wealth index			
Lowest	14.0	4.0	96.0
Highest	18.5	10.7	89.3
Total	18.6	7.0	93.0
Province			
Koshi	19.1	4.8	95.2
Madhesh	19.1	2.8	97.2
Bagmati	15.4	12.6	87.4
Gandaki	19.0	5.1	94.9
Lumbini	20.6	8.6	91.4
Karnali	18.4	11.5	88.5
Sudurpashchim	19.6	6.4	93.6

Table 3 shows that 18.6 percent of women reported that they had ever sought help due to anxiety or depression, 93.0 non-healthcare, and 7.0 healthcare providers. The proportions of people participating in care seeking were highest for the age category of 25–34 years (20.1%), 15–24 years (18.3), and 35+ (17.6%). Participants pointed out that older women seek help from healthcare providers at a higher percentage (10.6 %) than younger women.

Among the various ethnicities, the group of Madhesi, Muslims, and others showed the most care-seeking behaviors (44.2%), but most relied on non-health providers. The health-seeking behavior of Brahmin/Chhetri women was the highest among all groups, as they reported a rate of 11.8% in seeking assistance from healthcare providers. Slightly more educated women (19.8%) than uneducated women (17.5%) sought care. It should be noted that although more healthcare-seeking services were sought by literate women (6.1%), illiterate women had a higher percentage of seeking such services (7.3%).

Economic considerations greatly impacted women’s healthcare, with higher wealth quintile individuals (18.5%) more likely to go for treatment than the lowest (10.7%). It

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was also evident that there were differences in help-seeking behavior regarding anxiety or depression across regions, as relatively more women in Bagmati Province wanted assistance (12.6%) than those in Madhesh Province (2.8%). Lumbini and Karnali provinces recorded moderate assistance-seeking patterns at 8.6 percent and 11.5 percent, respectively. Out of the total, only 20.0 percent of women showed a willingness to seek help for social anxiety and depression suspiciously not related to health care. Age, ethnicity, level of education and wealth, and even province affected women's willingness to seek help.

Table 4

Determinants of Diagnosis of Anxiety among Nepalese Women: A Logistic Regression Analysis

Predictor Variables	Odds Ratio (OR)	95% Confidence Interval (CI)	p-value
Age Group (ref: 15–24 years)			
25–34 years	1.85	1.52 - 2.26	<0.001
35 and above	2.16	1.78 - 2.63	<0.001
Ethnic Group (ref: Brahmin/Chhetri)			
Dalit	0.97	0.72 - 1.32	0.85
Janajati	0.59	0.45 - 0.76	<0.001
Madhesi/Muslim/Other	2.82	2.12 - 3.76	<0.001
Literacy Status (ref: Illiterate)			
Literate	1.75	1.48 - 2.07	<0.001
Wealth Quintile (ref: Lowest)			
Highest	1.58	1.23 - 2.02	<0.001
Province (ref: Koshi Province)			
Madhesh	1.16	0.88 - 1.54	0.29
Bagmati	0.97	0.71 - 1.32	0.85
Gandaki	1.02	0.74 - 1.41	0.91
Lumbini	1.33	0.98 - 1.81	0.07
Karnali	1.91	1.31 - 2.79	0.001
Sudurpashchim	0.81	0.56 - 1.19	0.28

Note: Odds Ratio = exposed to a risk factor and compared to a non-exposed group; Confidence Interval (CI) = the interval of values within which the true odds ratio would lie in 95 out of 100; A p-value = 0.05 indicates evidence for the significance of the predictor variable.

The study population mainly consisted of women aged 15–24 years, who had the lowest mean age across all age categories diagnosed with anxiety adjusted for women in those age groups quartiles, well above the mean age of diagnosis 25–34 years (OR 1.85 and 2.16, $p > 0.001$). The effect of ethnicity was also significant in that Brahmin/Chhetri women categorized as Madhesi/Muslim/Other had greater odds of being diagnosed with the disorder compared to Janajati women (OR=2.82, $p < 0.001$), who had lower diagnosis rates when compared with Brahmin/Chhetri women (OR known =0.59, $p < 0.001$). The educational background of the subjects was also known, where literate women were more likely diagnosed with anxiety than non-literate women (OR=1.75, $p < 0.001$). The

multilayered diagnosis of anxiety was also economic in scope since women of the wealthiest quintile were more likely diagnosed with the anxiety disorder than women of the poorest quintile (OR =1.58, $p < 0.001$).

The severity of anxiety disorders varied among women in different regions; Karnali Province had a higher diagnosis rate than Koshi Province (OR =1.91, $p = .001$), but there were also no differences in the other provinces.

DISCUSSION

The study's findings give critical information on the socio-demographic features of Nepalese women presenting symptoms of anxiety and depression aged 18 to 29, as well as their treatment-seeking views. The socio-demographic analysis yielded an overall mean age of respondents as 29.8 years, and nearly half (48.3%) were aged between 20 and 34 years. These values correspond to previous studies on the younger adult population most affected by mental health (Garipey et al., 2022). Likewise, the study by McDonald and Vajravelu (2024), which covered COVID-19 behaviors, noted that younger people (18–29 years) showed different patterns of compliance to health measures due to their involvement in health and health-related community activities.

Unequal access to mental health care is evident from the ethnic mix of the sample, with the most considerable number of participants being Janajati women, followed by women of Brahmin/Chhetri and Dalit races. This demographic orientation corresponds with Dhital et al. (2023) observations that mentioned different ethnic nationalities in Nepal experience and treat mental health problems differently because of the influence of socio-cultural dynamics. Women of Brahmin/Chhetri utilization, accessibility, and ethnicities are likely to encounter different expectations and care accessibility, which can lead to differences in mental health outcomes (Nina & Richards, 2023). Similar to the findings among South as well as East Asian youth, Janajati women endure distinct social stressors, which leads to more incredible incidents of anxiety and depression (Dissanayake et al., 2023). In that, these youth experience high levels of anxiety traits but fewer diagnoses of it.

Dalit women are sometimes pushed to the brink and consequently do not get properly diagnosed or even obtain mental health care, comparable to other tendencies in the existing studies for other minority ethnic groups. Women seeking mental health care have greater vulnerability and morbidities. Cultural minority women are less likely to be diagnosed with depression than their white British counterparts, yet rates of severe mental health concerns are greater among black women than physical health problems (Catalao et al., 2022). Social determinants, which include racism and poverty, are also presented by mineralized groups and are harmful to their mental health; however, some of them show a lower prevalence of some disorders, which is referred to as a mental health paradox (Phimphasone-Brady et al., 2023).

Regarding their mental health treatment, the statistics show that just 3.9 percent of the women surveyed claimed to have been diagnosed with anxiety and just 3.0 percent with depression. Strikingly, in the past two weeks, only 1.2 percent had taken any medication prescribed to them, whereas only 1.5% had any counseling. This low uptake of treatment is in line with other studies that show significant underutilization of mental health services, particularly for women (Choudhry et al., 2023). In an example of this trend, women above the age of 35 reported more excellent diagnosis and treatment rates, which suggests that age, individuals may become more attuned to mental health issues with age, possibly because they have greater access to healthcare (Poudel et al., 2022).

Furthermore, education and economic status results reinforce the socio-economic factors affecting mental health care. Among the respondents, 73.8 percent were literate, and literate women were more likely to seek help than illiterate ones. This finding is similar to that of the Bhandari et al. (2023) study, which revealed that higher education could improve mental health literacy and treatment-seeking behavior. Also, the wealth quintile analysis showed that the higher the wealth group of women (18.3%), the better access to treatment, which means that there are still some economic difficulties in accessing mental health services.(Shrestha et al., 2023).

Significant provincial variations in treatment-seeking behavior were also evident, particularly with the women of Karnali Province exhibiting the highest level of treatment for anxiety and depression. In contrast, women from Madhesh Province were the least likely to seek healthcare assistance. Differences in the health delivery system could cause these differences, the perception of mental illness in society and the availability of services. Age, gender, family structure, existence of long-term health problems, and loneliness were some of the significant determinants of depressive symptoms (Maharjan & Shrestha, 2022).

This research aimed to examine specific socio-demographic parameters that impact the possibilities of anxiety therapy among women in Nepal and discovered quite a lot of them. A considerable number of women, particularly those aged 25-34 years and over 35 years, were shown to be more at risk of anxiety. Again, ethnicity was a key determinant, as women of the Madhesi/Muslim/Other ethnic identification group had more excellent anxiety disorder diagnoses than those of the Brahmin/Chhetri and the Janajati ethnic groupings. The second persuasive feature was literacy since more literate women had a higher chance of being diagnosed with anxiety as compared to the illiterate ones. Women earning the greatest levels of education were also more likely to suffer from mental problems or stress disorders than the rest. Furthermore, the regional context influenced healthcare presentation, with women from Karnali Province being more likely to be diagnosed with anxiety disorders than women from Koshi Province, highlighting the need for specialized mental health treatments. Overall, these results show the characteristics of age, ethnicity and, level of education, financial position, and geography, among others, that impact the mental well-being of women in Nepal.

Anxiety disorders are among the most prevalent and devastating mental conditions. In their most untreated stage, they are likely to begin in early life and carry risks of chronic physical disorders in the future, such as high blood pressure and heart disease (Javaid et al., 2023). Furthermore, those women from Madhesi, Muslim, and other ethnic groups were more likely to get therapy than Brahmin/Chhetri women, illustrating the varied nature of mental health concerns that encompass cultural and ethnic backgrounds.

The findings highlight the pressing need to work towards strategies to bridge the mental health management gaps for women in Nepal. More focused interventions, such as awareness campaigns on mental health literacy, should be directed towards the lower levels of education enrolled in these younger women to help improve their treatment-seeking behavior.

Furthermore, enhancing access to mental health services in underrepresented provinces is critical to meeting the mental health treatment requirements of women from all social demographic categories.

CONCLUSION

The present research aims to explore patterns in the management of anxiety and depression among Nepali women, focusing on surveys from the 2022 DHS. Analysis shows considerable gaps in socio-demographic characteristics with women of older age, those who have had formal education, and of a higher economic power benefiting from the treatment. There were also differences both by ethnic and regional affiliation with some ethnic groups and provinces having higher treatment rates. The reliance on informal care alongside low use of professional services shows there is a problem with infrastructure, more so the deficient one in rural areas. The results of this study underscore the importance of efficient and culturally and geographically appropriate mental health care.

For these reasons, a considerable agenda of tasks lies in front of policymakers aiming at increasing and incorporating mental health services in primary health care, especially in rural settings. There is a particular need for mobile clinics and culturally appropriate training of local health workers in sexual and reproductive health. Grant support and outreach slogans addressed to sensitive groups of people can reduce organizational and financial obstacles. Furthermore, developing private and public partnerships and increasing gender-related mental health programs can also increase service fairness.

Future work should assess the impact of these interventions to identify ways that the approaches can be optimized and monitored to guarantee long-term positive changes in women's mental health in Nepal. This research participates in the stream of prior works to minimize the gap in mental health treatment and inform policy in cultural and geographical sensitivity.

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