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Mental Health and Development Programme

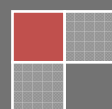
LEADS Nepal

Baseline Study Report



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Executive Summary

LEADS Nepal, BasicNeeds (BN) partner in Nepal implements community based mental health and development programme in Baglung and Myagdi districts using the model innovated by BasicNeeds. The purpose of the baseline study was to review the existing mental health situation in the programme districts and to help draw appropriate programme activities to address the needs of people with mental disorders and epilepsy or their carers. This will enable LEADS to identify the service delivery systems of the government health institutions, resources and human capacity as well as service demands from the community. It will also be useful to monitor progress in implementing MHD Model, providing community services, and involving users, families and health service providers in mental health promotion, prevention, care and rehabilitation.

The baseline study found that about 20-25 percent of all outpatients attending primary health care services are showing some sort of mental or behavioral disorders. The prevalence of mental disorder is very common among poor, illiterate, marginalized Dalits and women. As most individuals with severe mental disorders and their family members are targets for stigma and discrimination, they hesitate to come forward for appropriate treatment. Even the individuals with neurotic disorders do not like to consult psychiatrists because of the stigma attached. There is inadequate awareness of the problems among decision makers, social leaders and the general population about the mental disorders and its consequences. A negligible portion of the population has free access to essential psychotropic medicines; however, there is no specific data on how many people are receiving them for free.

The complete absence of a government mental health service is a major problem faced by the population in these districts on mental healthcare. There is no trained manpower in government health institutions, and district based private medical clinics which offers monthly mental health clinics by psychiatrist is significantly expensive and that is not affordable by poor and socially excluded groups of people. The treatment of mentally ill person becomes high burden most of the times beyond the financial capacity, and this burden solely rests upon the family. The approximate financial burden that falls on a family when one of its members becomes mentally ill is around 25000 Nepalese rupees (equivalent to nearly GBP 200) per year (Arun Jha 2007). Most people in the districts think that mental illness means becoming crazy or lunatic, being possessed by spirits or losing control of oneself. Although healthcare professionals are becoming more aware of mental health problems, the majority of rural people in Baglung and Myagdi still believe that mental illness is caused by bad fortune. No mental health services available and very limited knowledge about mental health makes people visiting the traditional/religious healing methods which are actively practiced, specifically in the field of mental health.

In Baglung and Myagdi, Self Help Groups (SHG), there are potential SHGs for integrating people with mental disorders or their carers. Most of these SHGs are formed with a purpose of strengthening group recognition and gaining power in the community, and has been a unique approach to gain financial security especially among women. The approach combines access to low-interest financial services with a process of self management and mutual support system who are SHG members. With the growing numbers of Non Government organizations (NGOs) with various purposes, SHGs are formed in almost all villages. Being in the group has been like a culture and almost all villages have some types of community groups. SHGs are functional mainly by extending financial services to the poor and marginalized members, and contribute to the alleviation of rural poverty. SHG members reflect a diverse membership covering different

social and economic categories, including the poor which includes Scheduled Castes (SC), Scheduled Tribes (STs), Widows. SHGs uniquely stand to support their members on issues of social justice affecting women.

There is no community access to the communication and information on mental health. Neither government nor NGOs working in those areas have community awareness programmes on mental health. People with mental illness are therefore living without any information, access to the service and they are forced to attend traditional healers because there are no other options. Increasing public awareness on mental health is one of the major important needs.

Based upon our findings, we recommend several actions. The National Mental Health Policy needs improvement by addressing training needs of the health workers as well as social needs of the people with mental disorders for broadening mental health service access from rural health institutions. Social awareness of mental health, making mental health a cross cutting issue from government and NGOs and activities focusing on empowering women in taking decisions such as treatment, vocational training and income generating activities, as well as integrating into the SHGs are urgent attentions to be paid. Strengthening capacity of Local Health Management Committees (LHMC) and service users such as SHGs is another crucial recommendation. Their stronger role in advocacy and empowerment only can create an increased demand for quality health services and for influencing central level policy on mental health. Mental health service is very limited in comparison to the demands and government's priority requires to make mental health services available at the regional, district and peripheral levels. Mental health resources have to be distributed in accordance with the mental health policy, and adequate supply of essential psychotropic drugs should be maintained. Finally, it is very important to have places to incorporate mental health data to mainstream the mental health information and data into the national health information system.

Acronyms

AHW	Auxiliary health Worker
ANM	Auxiliary Nurse Midwife
BNPPD	BasicNeeds Policy and Practice Directorate
BN	BasicNeeds
CFUG	Community Forest Users Groups
CMH	Community Mental Health
CO	Community Organizations
DAO	District Administration Office
DDC	District development Committee
DHO	District Health Office(r)
DLGSP	District Local Government Support Programme
DPHO	District Public Health Office(r)
DoHS	Department of Health Services
EPI	Expanded Programme on Immunization
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
HMIS	Health Management Information System
HP	Health Post
LEADS	Livelihoods Education and Development Society
LDF	Local Development Fund
LHMC	Local Health Management Committee
MCHW	Maternal and Child Health Worker
MFG	Micro Finance Groups
MG	Mothers Groups
MHD	Mental Health and Development
MoU	Memorandum of Understanding
NGO	Non Government Organization
NRCS	Nepal Red Cross Society
PHC	Primary Health Care
PHCC	Primary Health Care Centre (an institution under the district hospital headed by a medical officer)
PHC/ORC	Primary Health Care/Outreach Clinics (basic health service delivery centres in rural villages)
SHG	Self Help Groups
SHP	Sub Health Post
SC	Schedule Castes
ST	Schedule Tribes)
SWC	Social Welfare Council
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization
WRH	Western regional Hospital

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2. Introduction

2.1 LEADS

LEADS Nepal, BasicNeeds (BN) partner in Nepal is a non-governmental and non-profit making social organization established in 2009, registered in Kaski District Administration (DAO) Office and affiliated to the Social Welfare Council (SWC) Kathmandu; working to address the needs and promote the rights of people with mental disorders and physical disability, their family, carers and neighboring society, and those who are living in need, hardship or distress seeking the fulfillment of their rights, empowerment and livelihood..

LEADS regards mental health and disability as a social issue and is process orientated, with a focus on empowerment and rights, provides or refers to recovery and rehabilitation services, as well as increasing opportunities for livelihoods education and income generating. It works within the community to promote attitude change and increased knowledge about mental health disability.

LEADS implements community-based programme using the BN's model for mental health and development to promote recovery for people with all kinds of mental illnesses and engage them or their family members in the livelihoods activities to ensure a life in the community for all. LEADS closely works in partnership with all level government health institutions through building capacity of health personnel to improve the delivery of mental health services reaching to the more vulnerable and marginalized community.

LEADS's Mental Health and Development (MHD) Programme supports the meaningful participation of people with mental disorders and their carers in all aspects of the mental health system including the planning, design, implementation, policy formulation and evaluation of mental health services.

The approach that this project will take is based on MDH model developed by BN. The 5 main elements of the model are:

1. Capacity Building
2. Community Mental Health(CMH),
3. Sustainable Livelihoods,
4. Research,
5. Management and Administration.

The model has proved to be effective because it deals with the needs of people with mental disorders from a holistic perspective, as well as promoting access to treatment and also provides for the fulfillment of social, economic and cultural needs.

By the end of the project period, LEADS expects to achieve the following scope of mental health services.

- Promoting mental well-being
- Tackling stigma, discrimination and social exclusion

- Preventing mental health problems
- Providing care for people with mental health problems and providing comprehensive and effective services through the government health services
- Rehabilitating and integrating into society
- Nepal's mental health policy is improved and effectively implemented through health institutions addressing the needs of people with mental disorder.

LEADS Vision, Mission, Goal, and Objectives

Vision: “A society where people with mental disorders and disability, as well as those who are poor and marginalized can live and work successfully in the community, enjoy equal social opportunities and benefits, rights and respects to fulfill their potential”

Mission: LEADS works in the western region of Nepal with and for people with mental disorders and disabilities (including women, those from Dalit, ethnic & disadvantaged communities), seeking the fulfillment of their human rights & empowerment. Its mission also focuses to improve access to psychiatric treatment in the community through integrating into existing primary health care system to promote “rights to be treated and treated right”. It focuses to transfer vocational skills to people with mental disorders and disability, their families for their better livelihoods attaining financial stability to reduce poverty.

Goal: To improve the quality of life of people with mental disorders and disability, both for now and in the future, by addressing their physical and social needs and promoting their inclusion in family and community life.

Objectives:

1. Promoting and developing the inclusion and empowerment of beneficiaries.
2. Increasing the opportunities for beneficiaries to access education, vocational training and longer term income generation and livelihoods possibilities.
3. Developing LEADS' programmes to improve services and meet new needs.
4. Developing the organizational capacity to support its wish to expand, and have greater influence locally, regionally, and nationally.
5. Developing LEADS' sustainable capacity (which includes working more closely with local communities and local government) to ensure greater mainstreaming of community mental health and disability issues and services.

2.2 BasicNeeds (BN)

BasicNeeds, is a UK registered charity (1079599) whose objective is to relieve persons who are in need, hardship or distress and in particular (without prejudice to the generality) persons suffering from mental illness and their families and carers. In pursuance of this objective BasicNeeds purpose is “*to enable people with mental illness or epilepsy to live and work successfully in their communities*”.

BasicNeeds is a mental health rights organization that focuses on initiatives that directly involve poor people with mental illness and their families, being primary beneficiaries of such initiatives. BasicNeeds, through partnership, implements a field generated integrated model known as the Mental Health and Development (MHD), the main implementation strategy of BasicNeeds programmes.

The BasicNeeds mental health and development model seeks to improve access to psychiatric treatment in the community through integration into the existing primary health care system. Support is provided for mentally ill people or people with epilepsy and their families to attain financial stability that can be sustained through illness.

BasicNeeds builds knowledge and generates evidence about the needs of mentally ill people and uses it to influence local and national policies and practices. BasicNeeds empowers mentally ill people and their families to participate in all areas of project implementation ensuring their voice is at the centre of development.

2.3 Baseline Study

According to the Memorandum of Understanding (MoU) signed between BasicNeeds and LEADS Nepal, Baglung and Myagdi districts of western region of Nepal was selected to implement the mental health and development model. Baseline report of the MHD programme was prepared by developing a frame work and outline and was finalized in consultation with BN office in Bangalore. The baseline report plan, an instrument for detailed baseline report was then prepared by LEADS and study was carried out in Baglung and Myagdi districts.

3. Methodology

3.1 Purpose of the study

The purpose of the Baseline Study was to review the existing mental health situation in Baglung and Myagdi districts, and to help draw appropriate programme activities to address the needs of people with mental disorders and epilepsy. This included identifying the service delivery systems of the government health institutions, resources and human capacity as well as service demands from the community. To fulfill the above purposes following research questions were considered throughout the study:

1. What are the mental health policy and legislation, and initiatives from district health offices for mental health service provisions
2. What is the situation on accessibility of mental health services in the districts including the psychiatrist service; (for people with mental illness and economic condition)
3. What are the mental health services provided in primary health care,
4. What are the human resources available for mental health services including infrastructures?
5. What is required for mobilizing/integrating people with mental illness into existing or new SHGs

3.2 Data collection, literature review and FGD

The community based MHD model is to be implemented in Baglung and Myagdi districts. This study was carried out using various methodologies to obtain and collect the relevant data and information. A survey format was used to obtain the data and information of district health services including mental health, infrastructure and health personnel situation. Focused Group Discussions (FGD), one in each district was conducted. Participants of the FGD were district

health officers, public health officers, health institution in charges, nurses and clinical staff in the district hospitals. There were 37 participants in Baglung and 31 in Myagdi in the discussions.

Secondary data were gathered from the hospital and public health office records. Periodic reports published by Department of Health (DoH), District Health Offices and NGOs were also source of information. Private medical practioners in the districts who provide mental health clinical services were also interviewed to assess the demand on the mental health services in the districts.

FGDs were conducted with government health workers including public health officers to capture the 'service providers' perspective' on the mental health services and capacity of health workers on delivering mental health services. A discussion tips was used for the FGDs, which was used to guide the discussions. There were a total of 2 FGDs held and they each consisted of groups of 30-35 persons per group, during which a facilitator lead the discussion, while a report taker documented the discussions. The FGD sessions were carried out concurrently and lasted about 2 hours. The participants were divided into four groups in order to obtain views of health workers from different locations.

The information and statistics of government health institutions were drawn from the secondary sources such as record book of health information management system maintained by the district health offices. This was limited to the infrastructure and staff positions available at present to observe service provision situation on mental health. Concerned statistics assistants and medical record assistant were consulted to solicit their views and ideas at various stages of report preparation and their comments and suggestions have been incorporated.

3.3 The data collection process and data sources

The district health/public health offices were consulted for the information and up to date records on health services available from the district and periphery level especially on the mental health. Annual reports of the two health offices in Baglung and Myagdi, medical records, and Department of health services, Ministry of health annual report was the sources of information. Consultation meetings with district health officer, medical officers, public health officers and other clinical and public health staff were also conducted to gather information on the district situation. Data collection was a partnership process to ensure access to accurate and comprehensive information.

3.4 Data cross-checking

The data received were scrutinized and further clarification was requested for inconsistency on data received. Further, to ensure the quality of the data in the final report, data received from district health offices were cross-checked with other secondary sources of data such as the health services fact sheets.

Literatures were reviewed regarding the national situation on mental health services, policies and practices. Websites of the department of health services was accessed for detailed information on Nepal's policy in mental health, and other international organizations such as WHO were accessed.

Pre assessment of LEADS staff was conducted during the MHD model training to assess their capacity of LEADS staff on mental health and development to implement the MHD model.

4. Findings

4.1 Background

Nepal is a small Himalayan country situated between its two big neighbors China and India with a population of 28.2 million people (UNDP 2008) of whom 90% live in rural areas and main language used in the country is Nepali. Nepal has three geographic regions; the mountainous Himalayan belt (including 8 of the 10 highest mountain peaks in the world), the hill region and the plains region. Nepal contains the greatest altitude variation on earth, from the lowland Terai, at almost sea-level to Mount Everest at 8848 metres. Nepal is divided into five development regions and seventy-five districts.

The main ethnic group includes Indigenous Nepalese, Indo-Nepalese and Tibeto-Nepalese. Religious groups include Hindu, Buddhist, Muslim and Christian. The country is a lower middle income group country based on World Bank 2004 criteria. As per GDP, and population living below the poverty line and per capita income, Nepal still remains one of the poorest countries in the world. Frequent natural disasters and past 10 years violent conflicts in Nepal have further added hardship to life. Forty percent of the population is under the age of 15 and 6% of the population are over the age of 60 (UNO, 2008). The life expectancy at birth for males is 62.1 and 64.2 for females (WB, 2008). The literacy rate for men is 61.6% and 26.4% for women (WHO, 2006). Average per capita income is US\$ 400 (UNDP 2008). According to the human development index Nepal ranks 138 out of 177 countries (UNDP 2008). The 1996-2006 armed conflict created over 200,000 IDPs. Despite the peace process, many have still not returned to their homes, fearing further reprisals. Analysts say the failure of IDPs to return is mainly because the Maoists have not promised to guarantee people's safety and refuse to return seized property. Most have lost their original livelihoods in farming or animal husbandry and do not want to return to their empty homes. The problem has been compounded by weak governments, unable to effectively support reintegration and rehabilitation.

The proportion of the health budget to GDP is 5.3 (WHO, 2001). There are 18.82 hospital beds per 100,000 populations (DoH, 2008) and 1 doctor per 10,000 people (UNDP 2008). HIV prevalence rate in the country is 0.5 %. In terms of primary care, there are 268 physician-based primary health care clinics in the country (e.g., district hospital, health centers and primary health centre) and 3,179 on-physicians based primary health care clinics (DoHS, 2007).

4.2 Mental Health Situation in Nepal

Studies in Nepal have shown that 25-30 % of the general population has one or more mental disorders (Kopila Nepal 2009). Approximately 20-25 percent of all outpatients attending primary health care services are showing some sort of mental or behavioral disorders often presented as multiple physical complaints (Sonal Singh 2008). As most individuals with severe mental disorders and their family members are targets for stigma and discrimination, they hesitate to come forward for appropriate treatment. Even the patients with neurotic disorders do not like to

consult psychiatrists because of the stigma of mental disease. There is inadequate awareness of the problems among decision makers, social leaders and the general population about the mental disorders and their consequences.

Less than 1% of all health expenditures are directed towards mental health (0.14). In terms of affordability of mental health services, a negligible portion of the population has free access to essential psychotropic medicines; however, there is no specific data on how many people are receiving them for free.

Very few epidemiological studies have been done to find out the incidence and prevalence of mental disorders in Nepal. It is estimated that the total prevalence rate of all psychiatric disorders put together exceeds more than 20 % of the total population.

The breakdown of the various types of mental illness, neurological condition, learning disability (or mental retardation) and other conditions as an estimated prevalence in the general population as follows:

S.N	Disorder Prevalence	Percentage
1.	Psychosis	1-2
2.	Neurosis of all kinds	10
3.	Depression	4-6
4.	Seizure disorders (epilepsy)	1
5.	Mental retardation	3-5
6.	Alcohol use disorders	3-5
7.	Narcotic and other substance use disorders	0.5
8.	Others (PTSD, psychogeriatric etc)	1

There is no mental health legislation as yet, and the National Mental Health Policy formulated in 1997 is yet to be fully operational. Key components of the mental health policy are:

- to ensure the availability and accessibility of minimum mental health services for all the population of Nepal;
- to prepare human resources in the area of mental health;
- to protect the fundamental human rights of the mentally ill; and
- to improve awareness about mental health.

There is an essential drug list for different levels of health institutions. Health institutions with specialists (e.g., Central level hospitals) have more essential drugs available than do primary health clinics, in which there are only limited drugs available from the essential medicines list. In psychotropic, these medicines include Antipsychotics, Anxiolytics, Mood Stabilizers and Antiepileptic drugs. There is no emergency/disaster preparedness plan for mental health but there is such plan for general health.

Mental ill health is not much talked about because of the stigma attached. The roles of the legal and insurance systems are almost negligible. The financial burden rests upon the family. The traditional/religious healing methods still remain actively practiced, specifically in the field of mental health. The service, comprising little more than two-dozen psychiatrists along with a few

psychiatric nurses and clinical psychologists (mainly practicing in modern health care facilities) has started showing its impact--however this is limited to specific urban areas. The majority of the modern health care facilities across the country are devoid of a mental health facility. The main contextual challenges for mental health in Nepal are the provision of adequate manpower, spreading the services across the country, increasing public awareness and formulating and implementing an adequate policy

Primary health care nurses, non-doctor/non-nurse primary health care workers are not allowed to prescribe. In addition to that, primary health care doctors are allowed to prescribe for certain psychotropic medicines such as anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic.

The total number of human resources working in mental health facilities, including the private sector, per 100,000 populations is 0.59. The breakdown according to profession is as follows:

- 32 psychiatrists (0.129 per 100,000 population),
- 16 other medical doctors(not specialized in psychiatry)0.0645 per 100,000 population),
- 68 nurses (0.274 per 100,000 population),
- 6 psychologists (0.024 per 100,000 population),
- no social workers, no occupational therapists,

The only mental hospital in Kathmandu is a 50-bedded hospital, currently running 45 beds with a plan to run 50 beds in the future. The services are mainly used by middle and lower social class patients. The hospital admits around 750-800 patients in a year and sees about 23,000 outpatients (including follow-ups). The hospital contributes to the mental health care of severely mentally ill patients. In the future, the hospital could play an important role in training staff about the process of implementing mental health services in primary health care. Additionally it could run post-graduate courses in psychiatry.

4.3 Strengths, Weaknesses and challenges of the Mental Health System in Nepal

Strengths:

The country has a national mental health policy and human resource development is gradually taking place in the country. In addition, there is a good network within the general health service system where mental health can be integrated. There is a gradual increase in awareness of mental health in the general population and the number of people seeking treatment in the mental health institution is increasing. Psychotropic drugs are widely available. In the essential drug list psychotropic medicines are included up to the primary health centre. Some private medical colleges and NGOs are providing psychiatric services. There is a good family system, which takes responsibility for their sick family members at home.

Weakness:

Financial constraints exist and the majority of the people in the country are poor and therefore, cannot afford treatment. There is only one mental hospital in the country, which is not enough to address the huge need for inpatient care. Mental health services are not easily available in the rural areas and in remote places. There is a stigma around mental health. The infrastructure of

mental health services is poor and the human resources are not sufficient. There is no mental health legislation as yet. There are no human rights issues addressed for mental health patients. The government has not allocated an adequate budget for mental health services. No consumer association exists in the country to focus and advocate for satisfied initiation of government mental health services. The country' mental health information system is poor. There is no separate division for mental health under the Ministry of health.

Challenges:

- Lack of adequate mental health professionals and treatment facilities.

As already pointed out there are very limited mental health professionals and treatment facilities. Nepal has a population of over 28 million. If we calculate we will find out that we have one psychiatrist for every 700,000 people and one psychiatric bed for every 80,000 population. This is far from what actually is needed. Almost all of these services are centered only on the main cities. Moreover a significant proportion of the population lives in remote hills, from where a visit to one of these towns takes several days of walking and this involves unaffordable cost to the poor and needy people with mental health problems.

- If we look at the situation of other supportive professionals like psychiatric nurses, trained social workers, occupational therapists, and clinical psychologists, the situation is even bleaker.
- Psychiatric nurses: There are only a 68 psychiatric nurses in all over the country; as a result general nurses without proper mental health training and skills run most psychiatric wards.

4.4 Government attitude and policy

The law in Nepal continues to define mental illness as madness. In the civil code, the legal definition of mental illness is not clarified, but the language of the legislation refers to someone with broken mind or madness. This attitude is reflected in everyday practice where people with mental illness are described as mad.

- There is no law in Nepal to protect someone with mental illness. The bleak situation is shown by the following two laws. The electoral rolls act of 1995 denies the right to vote to someone with mental illness.
- The Local Administration Act of 1972 gives the power to the Chief District Officer to detain mentally ill people in jail either for their own safety or for the safety of the community. There is no provision for a person to be first to be examined by a psychiatrist before the detention. This leaves plenty of room for abuse of this law. Today there are more innocent mentally ill people in the jails of Nepal, than there are in the psychiatric wards. The conditions in jails are very poor and the patients are generally not offered any treatment in the jails. The law has no provision about when to let them out of the jail.

Although the government has adopted a national mental health policy in 1997 and subsequently agreed to include mental health as an element in primary health care, mental health continues to have a low priority on the national health agenda. This is proven by the fact that only 0.14%

of the national health budget is spent on mental health and the government keeps no official record of the mental illness prevalence rates of the country

1. Denial of the problem

At least 25% of the population suffers from some form or degree of mental illness at any given time. Despite that the government, policy makers, the so-called intellectuals, the general public and even our medical colleagues are not aware that mental health needs immediate attention. In order to tackle this challenge we need to have advocacy groups that can raise awareness in the policy makers.

- Insurgency

The whole nation was affected by the war between the government forces and the rebels. Thousands have already lost their lives, many have been injured and many more people have undergone or witnessed torture, kidnapping and maltreatment by armed groups. This might have led to many cases of mental illness and other stress related conditions but are far from being prepared to handle these cases.

2. Poverty

As Nepal is one of the poorest nations in world we find that lots of people are not able to afford the psychotropic medication for long periods. Poor economic condition is one of the main reasons why people don't approach our health services. We also see many of our patients discontinue medications because of the un-affordability. The cost of the medications often prevents us from using certain medications.

4.5 Programme Area at a Glance

The western development region comprises of 3 zones and 16 districts and the Dhaulagiri zone has been considered one of the most affected during the 1996-2006 armed conflict which created over 10,000 IDPs (NRCS 2007) mainly from the rural villages. Despite the peace process, many have still not returned to their homes, fearing further reprisals. Most have lost their original livelihoods in farming or animal husbandry and do not want to return to their empty homes. Some IDPs have ended up in the larger towns and cities, where they live in impoverished conditions and are often exploited. The zone is considered to be one of the region's poorest area with about 89 percent of the population living in rural settings. The decade-long armed conflict crippled the economy of this area hardening the life of many people. The agriculture sector is the main contributor to economic growth but was severely affected by political unrest.

The area still has a poor health delivery system. Maternal mortality is a huge problem, and significantly high numbers of women are dying every year from pregnancy-related complications due to lack of skilled birth attendants and emergency obstetric centers. HIV/AIDS prevalence is increasing in the area. The reason behind this is mainly the migration for labor work abroad and India.

The mental health and development programme is being implemented in Baglung and Myagdi districts which are the remotest mountain districts. Agriculture, livestock and non-timber forestry products particularly, the high value herbal collection is the main income source of the people in these districts. Cottage industry, off-season vegetable growing, goats and sheep rearing for meat products are some of the activities. These two districts do

not produce enough food grains to eat and as such, food grains has to be dependent on terai districts.

Both of the districts have poor motorable road network. Only the Baglung headquarter is connected with pitched (tarmac) road and Myagdi district headquarter is still lacking road connections. It takes several days of walking to reach some of the villages from the district headquarters in the both districts. Economic activity in the districts is limited; therefore almost 90 percent of the economically active male and significantly high female populations go to several Indian States and Arabian countries for employment.

It is also strikingly clear that, districts under the Dhaulagiri zone are worst in all forms of indicators, socio-economic, poverty and human development indicators, than that of the other districts under western development region. The real challenge in these districts is that it does not have a dependable connectivity with other districts and no air links. It takes days of walk to reach a motorable road heads and to the district headquarters from the VDCs.

4.6 Situation and Needs of people with mental illness in the districts

Both Baglung and Myagdi districts are located in a very remote and hilly area. The majority of its population depends on agriculture and farming. The complete absence of a government mental health service in the area is a major problems faced by the population in these districts on mental healthcare. The approximate financial burden that falls on a family when one of its members becomes mentally ill is around 25000 Nepalese rupees (equivalent to nearly GBP 200) per year (Arun Jha 2007). Most people in the districts think that mental illness means becoming crazy or lunatic, being possessed by spirits or losing control of oneself (Jha 2007). Although healthcare professionals are becoming more aware of mental health problems, the majority of rural people in Baglung and Myagdi still believe that mental illness is caused by bad fortune.

Mental ill health something that people do not talk about, and individuals generally hide the problems because of the stigma attached. The treatment of mentally ill family member becomes high burden most of the times beyond the financial capacity, and this burden solely rests upon the family. No mental health services available and very limited knowledge about mental health makes people visiting the traditional/religious healing methods which are actively practiced, specifically in the field of mental health.

There is no trained manpower in government health institutions, and district based private medical clinics which offers monthly mental health clinics by psychiatrist in both district is significantly expensive and that is not affordable by poor and socially excluded groups of people.

4.6.1 Myagdi

The Myagdi district with its headquarter in Beni Bazaar has 39 Village Development Committees (VDC) is highly mountainous district and deeply dissected by rivers. It is 290 K.M. far from Kathmandu and 80 km from Pokhara to the west. Parbat and Kaski (in the east), Baglung (south), Rukum (west) and Dolpa and Mustang (north) are neighboring districts. It is located at

782 m. to 8167 m. height (Dhaulagiri-I) from sea level. The geographical pattern is structured by 8 percent plain valley, 56 percent high hill and 36 percent Himalayan Mountain. 36 percent of total land of the district area lies in high Himalayan zone.

According to the sources available from central statistical department, 2064 BS total number of population showed 132594 (62014 male and 70580 female), and among the total population, 106544 (92%) living in the rural remote area. Life expectancy is 59.7 year, Literacy rate is 43.1 percent (Female 28 percent Male 58.2 percent).

Myagdi is a home place of various casts and indigenous group. Most of them are from Mongolian stream specially Magar (45 percent out of total pop.), Gurung, Chhantyal, Thakali, and others are Brahman, Chhetry, Damai, Blacksmith, Sarki etc. Nepali is mother tongue of 98.3 percent people. Myagdi has less than 60 KM rough road extensions and no direct link of road transportation to the highways. Foot trails networks dominate district.

4.6.2 Baglung

Baglung District, a part of Dhaulagiri zone covers an area of 1,784 km² and has a population of 312,130. (Female 168612, Male 143518), and 92.5 population are living in rural locations. Literacy rate of the district is 59.82 (Male 71.28 and Female 48.36). Baglung is surrounded by Parbat, Myagdi, Rukum, Ropla, Pyuthan and Gulmi districts. It looks like Nepal in shape. It has 59 Village Development Committees and one Municipality. It has many rivers and streams. It is a hilly district, most of the population settled in the sides of the rivers. Fertile planes situated in the either sides of the rivers are used for farming. Headquarter of Baglung (Baglung Bazaar) is also situated in the bank of the holy river- Kaligandaki. Like Nepal, Baglung is also diverse in religion, culture, ethnicity, altitude, temperature etc. Hinduism and Buddhism are the major religions. Magar, Chhetri, Brahman, Newar, Gurung, Chhantyal and Thakali are the main ethnic groups living in Baglung. Highest temperature in the lowest altitude of Baglung rises up to about 37.5 degrees Celsius in summer and the lowest temperature at Dhorpatan falls up to about -15 degrees Celsius in winter. Altitude of Baglung varies from about 650 meters at Kharbang to about 4,300 meters in Dhorpatan. Hinduism (83.69%) is the major religion followed by Buddhism 15.28, Muslim 0.16, Christians 0.09 and others.

Baglung is rich in herbal medicine plants. Rice, corn, millet, wheat and potato are the major crops. There were many mines in use in Baglung in the past; Iron and Copper mines being the most prevalent. But they are not in use for long time because of the lack of care of the government. There are numerous slate mines in use in Baglung.

4.7 Public attitude towards mental illness in Baglung and Myagdi districts:

- Majority of the people in the area still have high trust and belief on the traditional healers and practice primitive type of health practice. Generally, they consider mental illness not as illness but as a moral weakness caused by supernatural forces like Bhoot [ghost], Boksi [witches], Mohni [black magic], Paap[sins of previous lives] or as a result of celibacy. Those people who are aware about mental illness also don't believe that mental illnesses are treatable. The patients, who have recovered fully from mental illness, also continue to be stigmatized. It is not unusual for them to be shunned by employees, friends and the society at large.

- The traditional way of managing mental illness was to seek the assistance of traditional faith healers like Dhama and Jhankri. Even now many people and not only those in the rural and remote areas continue to consult the traditional healers. These traditional healers often treat psychiatric patients with special rituals some of which might be quite brutal like beating or marking with hot iron rod with the aim of eradicating the so called evil spirit and they are often successful in treating minor and self limiting illness. Due to this more serious psychiatric and neurological patients also go to consult faith healers. These causes not only delay in seeking treatment but also exhaustion of scarce resources in these ineffective treatments.

The attitude of the society towards mental illness continues to be negative. As a consequence even common problems go undetected and those who are diagnosed live in the dread of being discovered due to the stigma attached to it. As a result, only a minority of the mentally ill ever comes to the attention of the mental health services. Even those who reach, they reach late.

- This problem of ignorance and misconceptions about mental illness can be handled by the use of mass media, education of teachers who might pass the information to their students and also by educating the village leaders. The fact that most of the mentally ill are first taken to the traditional healers can be taken as an opportunity. These healers can be trained for harm reduction and possible referral to health institutions.

4.8 Conditions for provision of mental health services in the districts

The vulnerability of people living in the programme area to mental illness is exacerbated by poverty, violence, gender-based violence, the post conflict situation and substance abuse. Past conflict has been a contributing factor to the increased incidence of mental illness. Hill districts area are particularly affected by the high suicide rate and high levels of mental disorders. However, the nearest mental health services are in Pokhara. People with mental disorders face stigmatization and exclusion from daily family and community life in many different ways. They are often ignored and excluded from social events. This adds to the exclusion that also exists in relation to gender and caste. At worst they may be chained or locked in rooms, violating their human rights. Mental disorders also create a double obstacle to securing the right to work: an untreated person with a mental illness cannot hold a job, and the carer of that person is occupied full-time as a custodian.

The prevalence of mental disorder is very common among poor, illiterate, marginalised women. A contributing factor is gender discrimination. Women do not have property rights, their freedom is limited, their literacy rates are lower than men's, they are often undervalued and treated appallingly in a strongly male dominated society. Levels of gender-based violence (GBV) are high towards all women but those with mental disorders are particularly vulnerable.

The main problems in these districts remains even growing and while consulting people with mental illness, government officials, and private service providers, main priorities identified were:

- (i) Access to treatment and affordable drugs

- (ii) Access to psycho-social counseling
- (iii) People with mental disorders having opportunities to participate in an income generating activity.

4.9 Mental Health Services available in Western Region:

4.9.1 Government

1. Western Regional Hospital (WRH), Ramghat,
2. Manipal College of Medical Sciences (MCOMS), Phulbari

4.9.2 Private hospitals and nursing homes providing mental health clinical services

1. Fishtail hospital and Research centre Pvt. Ltd, Gairapatan
2. Charak Hospital and Research centre Pvt. Ltd, Naya Bazar
3. Fewacity hospital and Research centre Pvt. Ltd, Srijanachok
4. Model healthcare hospital, New road
5. Padma Nursing Home, New road

4.10 Health Facilities in the districts

S/N	Health Facilities	Myagdi	Baglung
1	District hospital	1	1
2	Primary health center	1	3
3	Health posts	8	9
4	Sub-health posts	31	49
5	Private clinic	17	29
6	Aurvedic health care center	3	5
7	Number of PHC/ORCs	105	190
8	Number of FCHVs	369	1007
9	Number of Private Hospitals	0	2

Source: District Health Office Report Baglung and Myagdi 2008/9

4.11 Human Resources Situation as of March 2010

Post Name	Myagdi			Baglung		
	Sancti oned	Filled	Vacant	Sancti oned	Fille d	Vacant
Medical Officer	3	1	2	9	3	6
District Supervisor	3	3	0	5	5	0
Staff Nurses	4	1	1	12	8	4
Health Assistants	12	11	1	14	12	2
Public Health Nurse	1	1	0	1	1	0
AHW's	43	38	5	68	64	4
ANM's	13	9	2	23	19	4
VHW	31	17	14	59	42	17

MCHW	31	31	0	47	43	4
Office Helper (including driver)	23	47	0	32	69	0

Source: District Health Annual report Baglung and Myagdi, 2008/9

4.12 Existing Self Help Groups (SHG) in the districts

Self-Help Groups (SHGs) are the important platform for people with mental disorders after starting their treatment or for their carers. The study was an attempt to explore the existing SHGs in Baglung and Myagdi districts those potential for integrating people with mental disorders or their carers. Self-help groups are geared for mutual support, information, and growth. Self-help is based on the premise that people with a shared condition who come together can help themselves and each other to cope, with the two-way interaction of giving and receiving help considered advantageous. Self-help groups are peer led rather than professionally led.

In Baglung and Myagdi, Self Help Groups (SHG) are formed with a purpose of strengthening group recognition and gaining power in the community, and has been a unique approach to gain financial security especially among the women. The approach combines access to low-interest financial services with a process of self management and mutual support system who are SHG members. With the growing numbers of Non Government organizations (NGOs) with various purposes, SHGs are formed in almost all villages. In the later years, government has also been recognizing the strengths and performances of such SHGs and started to implement government programmes through active SHGs. Mothers Groups are the examples that government health awareness programmes are generally implemented through Mothers Groups. Linked not only to health programmes but also to wider development programmes, SHGs are seen to confer many benefits, both economic and social. SHGs are also the community platforms from which women become active in village affairs, stand for advocating women's rights, empowerment and take action to address social or community issues such as the abuse of women, alcohol, water supply etc.

4.12.1 Castes System and SHGs

Nepalese society is split by a hierarchical caste system that has traditionally discriminated against those at the bottom – the Scheduled Castes and Indigenous Tribal Castes. Within broad caste categories too there are divisions. But, most of the groups formed are mixed groups from all castes focusing towards wider village development which make participation from all castes a condition of the programme. The experience of women from different castes and sub-castes coming together from their separate toles and being part of village meetings, build the confidence of the usually marginalized and begin to break down some prejudices. Because of the SHG initiative and determinations, they are beginning to bridge the divisions, through mixed caste membership in the groups, and in others through joint actions across groups of different castes.

4.12.2 Approaches of SHGs

Being in the group has been like a culture and almost all villages have some types of community groups. However there are barriers inherent in the conditions of membership to a group formed to mediate financial transactions – through regular meetings, savings and loan repayments.

Such conditions are difficult for women who migrate for seasonal wage employment, and households with variable or uncertain incomes. Both are economic characteristics of the poor and very poor. They can and do lead to 'self-exclusion' if not exclusion by group members.

SHGs are functional mainly by extending financial services to the poor and marginalized members, and contribute to the alleviation of rural poverty. SHG members reflect a diverse membership covering different social and economic categories, including the poor which includes Scheduled Castes (SC), Scheduled Tribes (STs), Widows. SHGs uniquely stand to support their members on issues of social justice affecting women. These SHGs take issues such as domestic and sexual violence, prevention of child marriage, property rights of women and issues on double marriage.

SHGs work together to address issues that affect not only their own members, but others in the larger community. Functional SHGs involve in community actions for improving community services such as improving water supply and access from the Dalit community, education, health care, veterinary care, village road, trying to stop alcohol sale and consumption, contributing finance and labor for new infrastructure, protecting natural resources and acts of charity (to non-members).

4.12.3 Potential for integrating people with mental disorders into SHGs:

Following are the potential community groups where people with mental disorders or their carers can be integrated.

I. Mothers Groups (MG)

In almost all of the VDCs in Baglung and Myagdi districts, there are several forms of informal self-help groups such as '*dhukuti*', mothers group, and many other groups with specific objectives. These types of SHG groups are composed of not only pro-poor focused, but mostly lower middle or middle class people are involved. Another most popular informal self-help group is *Aama Samuha* (mothers' group) formed at the ward level mobilized by Female Community Health Volunteers (FCHVs). Mothers' group is mainly formed and activated by the local women with one or more objectives that could be related to income generation aspect and/or removing social evils and bring about positive changes in the society. Women empowerment is the main objective of the most mothers' groups. These mothers' groups organize campaigns against alcoholism, injustice to women, girl trafficking, and other social evils. They also mobilize their savings and provide credit to the needy members. However, these are not necessarily targeted at the poor. They used to be widely practiced in the hills and mountains of Western Development Region. Therefore Mothers Groups are the most potential groups to integrate the people with mental disorders or their carers.

II. DHUKUTI Groups

The '*Dhukuti*' system is a very old form of self-help group in Baglung and Myagdi; it has been in operation for more than 4 decades. Closely affiliated and well-acquainted persons form a group and start contributing a specified amount at specified intervals of time. In each collection meeting, the cash collected is given to one of the needy members for use as per the rules set unanimously by the group. Rules are found generally unwritten, but agreed by all in the

inception meeting. The member who has used the amount will also continue contributing the time bound amount till all the members get chance to use the money raised in each sitting. The essence of this practice is that with small installments contributed by all group members one needy member can use a huge sum of money that can accomplish a larger activity generating a lasting source of income. It is a self-help approach to development of members. Those who use the fund at the earlier opportunity can turn over the money and get benefited more through the time value of money. In this system, members do not need to pay interest as such, but depending on the rules they make, early seekers of the sum have to get little less money than what is collected in total and the last holder of the chance may just collect his/her total deposit and/or little more money left by the early seekers.

III. Community Organizations (CO)

The Local Development Fund (LDF) under the district development committee (DDC) and District Local Government Support Programme (DLGSP) initiated local communities to get local people organized into Community Organizations (COs)/SHGs in various settlements within the Village Development Committee (VDC). COs are organized for separate groups for men or women or both. The COs also mobilizes compulsory and other types of savings. Generally they charge 10-12% interest per annum to the borrowers under their lending schemes. COs conduct regular meetings in which members apply for loans and also collect due installments. COs determine the interest rates and other terms and conditions of loans if they lend money using their own savings. If a member demands more money than the CO can provide from its savings, the member would have to fill a separate application form addressed to the Local Development Fund (LDF). The CO recommends the loan and forward to the LDF for approval.

IV. Community Based Micro Finance Groups (MFGs)

The microfinance schemes have expanded and became more popular among the rural poor in these districts after withdrawal of commercial banks from rural areas because of security reasons. Diversification has come from the commercialisation of leading NGOs and their transformation into rural microfinance banks. They compete with pre-established public Regional Rural Development Banks, using the Grameen Bank methodology as many of the smaller Nepali microfinance institutions.

The community based MFGs provide a wide range of savings and loan to their members. They tend to serve the poor, with a stronger emphasis on the disadvantaged. They commonly require compulsory savings, but also offer individual or group saving schemes, deposits, festival and educational savings services. Loans provided has a minimum term of 3 months and can be extended for more than 18 months, covering specific purposes, such as health, agriculture, microenterprise, housing, or, in some cases, emergency or social reasons. In addition, self-Help Groups can be linked to commercial banks, an approach taken by the Banking with the Poor Program implemented by the Rastriya Banijya Bank (RBB). Despite the institutional challenges and necessary methodological adjustments to be made, RBB has lent directly to self-help groups under this program.

V. Community Forest Users Groups (CFUGs)

Community Forest Users Groups (CFUGs) are the community mixed groups all over the Baglung and Myagdi districts initiated earlier by the Livelihoods Forestry Programme (LFP), a project supported by DFID, and later handed over to District Forest Office (DFO). CFUG

concept and its achievements has been the most successful among the different community group modalities towards institutionalizing the issue of social inclusion at local level.

There are a total of 1012 CFUGs in Baglung, Myagdi and Parbat managing a total of about 51231 ha of community forests which involves more than 90 thousands household users. The holding of decision making positions by poor, dalits, disadvantaged Janajatis and women is the unique examples in the CFUGs. The key position holding by women, dalits, disadvantaged Janajatis and poor in the CFUG is high. For example, percentage of Dalits in CFUGs committees is 21%. (Yadav K Kumar 2009). Most importantly, well being assessment is the basis for all CFUG members for ensuring the identification of poor and excluded households for justified flow of programme inputs into target groups. Meaningful participation of the CFUG members in the meeting while taking decisions, and level of access of over resources and services including Income Generating Activities (IGA) are the mandatory terms of conditions. Livelihoods & Forestry Programme (LFP) has been supporting the process of CFUGs in the area since 2001. The process is being facilitated jointly by District Forest Office, LFP, partner NGOs and other SHGs.

4.13 Capacity of LEADS for implementing MHD Programme:

LEADS has professional competent and qualified staff team in the field of social development and training. Majority of its staff members have significantly long experience with various international development organizations and have gained practical experience to work with poor and marginalized community. Three among its 11 members of staff were trained in mental health and development model by BasicNeeds, two were trained from RINPAS Ranchi, India on mental health. The social Mobilisers and other junior staff members are trained on MHD model by staff trained by BN. Therefore all of the LEADS staff members are oriented comprehensively in the MHD model. Four among 11 staff members have practiced MHD model in the field in Kaski and Syangja.

Capacity assessment was conducted during the training in Bangalore and also in LEADS training programme to staff and Social Mobilisers. Questionnaire answered by the participants before and after the training is on the appendix.

The knowledge on mental health was improved after the training. Six staff were included in the capacity assessment among them were 3 senior management and 3 middle level managers. The first question were responded by linking with illiteracy, poverty and gender voilences as causes of mental illness and majority responded that mental illness can happen to everybody, but vulnerability is to the excluded group of people. Mental illness as perceived by majority of respondents is curable but that needs especial attention and care with availability of appropriate treatment facility. Similarly second question was responded with kinds of mental health problems, such as losing control over own mind, becoming aggressive, sleeplessness, and anxiety.

All of the staff members were involved in the CBR work including treatment services of epilepsy, and have extensive experience on working with community groups. They think that CBR and working with people with mental disorder is not much different. Staffs have experience in

forming groups and working with them. Existing Self Help Groups or other community groups are the best place to integrate people with mental illness.

Policy issue was not much responded and it was noticed that staff need exposure in the mental health policy context. Majority of staff members think that a mental health service is very limited in Baglung and Myagdi, and the service available is only Pokhara. People with mental illness have to travel to Pokhara for clinical treatment at private hospitals. Service provision from the district hospitals in mental health is significantly less.

Working with government health staff makes sometime challenging to be able to meet their expectation. Also, it is not easy to arrange their time for training and most challenging is to involve and motivate them in the programme.

The MHD model training has enhanced staff capacity on understanding about the important part of social development in the model. Enhancing group capacity, empowerment, and involving people with mental illness and carer in the livelihoods activity was main priority expressed by the staff. Therefore, LEADS staff have shown proven capability of successfully implementation of MHD model with innovative ideas and knowledge to improve the quality of life of individuals, and in reducing stigma through community awareness

5 Limitation of the study

This report does not intend nor it has capacity to check the validity of the primary sources of the data received, and the data presented in this report therefore reflect the information provided and confirmed by the responsible people in the district health offices. In both of the district health offices, there is no official record of how many people with mental disorder and epilepsy are treated. Rather this kind of treatment is recorded in the “other” section which includes the mental health.

All health institutions in Baglung and Myagdi were not visited but the information on mental health services and infrastructures were gathered from the in charges those who were in the district. Therefore the data and information are dependent on their responses.

Statistical data covered in this report are from the health institutions, but generally health institutions use a HMIS (Health Management Information System) which does not cover mental health portion of the service. Therefore, average numbers of people visiting health institutions for mental health service is the assumed numbers obtained from the health post in charges.

6 Discussion

Nepal has a short and slowly developing history of psychiatry. Recent political turmoil has crippled Nepalese healthcare in rural areas. Although the final quarter of the 20th century saw some development of psychiatric services in Nepal, the majority of Nepalese people remain deprived of such services even today. There is no national health programme or Mental Health Act. Psychiatric services are hospital based and most are centralized in the capital.

There are no morbidity data for mental illness. Around 1% of the population has severe mental illness and 10-20% milder mental health problems (Jha 2007). A survey of two developing

towns in western Nepal in 1998 revealed a high point prevalence (35%) of 'conspicuous psychiatric morbidity' (Jha 2007). About 2% of people with that degree of morbidity have been reported to suffer from incapacitating illnesses requiring continuous support. The current situation would certainly be different as a decade-long Maoist insurgency has caused immense social upheaval.

Both Baglung and Myagdi districts are located in a very remote and hilly area. The majority of its population depends on agriculture and farming. The complete absence of a government mental health service in the area is a major problem faced by the population in these districts on mental healthcare. The approximate financial burden that falls on a family when one of its members becomes mentally ill is around 25000 Nepalese rupees (equivalent to nearly GBP 200) per year. Most people in the districts think that mental illness means becoming crazy or lunatic, being possessed by spirits or losing control of oneself (Jha 2007). Although healthcare professionals are becoming more aware of mental health problems, the majority of rural people in Baglung and Myagdi still believe that mental illness is caused by bad fortune.

Mental illness is something that people do not talk about, and individuals generally hide the problems because of the stigma attached. The treatment of a mentally ill family member becomes a high burden most of the times beyond the financial capacity, and this burden solely rests upon the family. No mental health services are available and very limited knowledge about mental health makes people visit the traditional/religious healing methods which are actively practiced, specifically in the field of mental health.

There is no trained manpower in government health institutions, and district based private medical clinics which offer monthly mental health clinics by a psychiatrist in both districts is significantly expensive and that is not affordable by poor and socially excluded groups of people.

Primary health care nurses, non-doctor/non-nurse primary health care workers are not allowed to prescribe. In addition to that, medical officers (doctors) are allowed to prescribe for certain psychotropic medicines such as anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic.

There is not at all the community access to the communication and information on mental health. Neither government nor NGOs working in those areas have community awareness programmes on mental health. People with mental illness are therefore living without any information, access to the service and they are forced to attend traditional healers because there are no other options. Increasing public awareness on mental health is one of the major important needs.

The prevalence of mental disorder is very common among poor, illiterate, marginalized Dalits and women. A contributing factor is gender discrimination. Women work double hours than the men, but they do not have property rights. Their literacy rates are lower than men's, they are often undervalued and treated appallingly in a strongly male dominated society. Levels of gender-based violence (GBV) are high towards all women but those with mental disorders are particularly vulnerable.

7 Recommendation

Based on the findings of the study, the following remedial measures are recommended to increase access, availability and utilization of mental health services

- 7.1 HMIS forms used by the government health institutions from Sub Health Post to the regional hospitals should have places to incorporate mental health data to mainstream the mental health information and data into the national health information system.
- 7.2 There is no any kind of research on the prevalence of mental health problems in these districts. Therefore, a research on this would give very important on assessing the mental health situation.
- 7.3 Government health workers in the SHP to the district hospitals needs mental health training so that they could offer services or advises to the people living in remote area. The mental health policy needs improved by addressing social needs of the people with mental disorders, as well as broadening mental health service access from rural health institutions.
- 7.4 Social awareness on mental health should be a priority programme from government or NGOs. Making mental health a cross cutting issue would benefit general population in accessing knowledge and information on mental health.
- 7.5 There is a general trend that men leads the family and has decision making power controlled him, and women usually not allowed to come out of the house alone. The MHD Programme should give priority to women in its all stages such as treatment, vocational training and income generating activities, as well as while integrating into the SHGs.
- 7.6 Improving the confidence of health workers is an urgent priority. There is a need to assess the impact on the quality of mental health services to enhance quality of care and maintain staff motivation.
- 7.7 Local health management committees (LHMCs) are to be empowered and oriented on mental health.
- 7.8 Capacity building of service users including SHGs in advocacy and empowerment for increased demand from users for improving and influencing central level policy on mental health.
- 7.9 Mental health care facilities should be developed and have an active and dynamic interaction with the communities they serve. Mental health services have to be made available at the regional, district and peripheral levels. They have to be integrated into general health services at all levels including primary health care. Mental health resources have to be distributed in accordance with the mental health policy, and adequate supply of essential psychotropic drugs should be maintained.

8 Conclusion

The mental health service availability in Baglung and Myagdi is almost impossible till now from the government health services, and if available in Pokhara is only purely medical treatment. The MHD model is innovative as it takes a holistic approach addressing not only health needs but also poverty, empowerment and social inclusion. It achieves this through a rights-based approach including the development of self-help groups, the promotion of livelihoods and self-advocacy. It is also innovative, as it will integrate mental health into an existing community based rehabilitation programme. The application of the MHD model in the context of rural Nepal, (post conflict, inaccessible mountainous region) will generate new learning as will the integration of mental health services into the primary health care system.

The number of psychiatrists and other mental health professionals has been steadily growing in Nepal. A few extra psychiatric wards and postgraduate psychiatric training programmes have been started but a lot remains to be done to reach to the rural area. Mental healthcare in rural district like Baglung and Myagdi needs efforts focused on raising awareness, making existing services available to the general public from SHP to the district hospital.

References

1. Annual report of Department of Health 2007/08
2. 1st Quarter report of Myagdi and Baglung district health office
3. District Public Health Office Kaski annual report 2007/08
4. Centre for Mental health and Counseling (CMC) Nepal Annual Report 2007/08
5. WHO-AIMS report on Mental Health System in Nepal 2006
6. Report of KOSHISH, Mental Health Self Help Organizations
7. Mental Health Problems Increase In Nepal's Refugee Camps, news in daily newspaper Kantipur
8. Nepal mental health country profile, TU Teaching Hospital Kathmandu.
9. 25% people develop mental disorder at some stage: Study paper published in Kantipur national daily
10. Statistical data from Baglung and Myagdi district public health offices.
11. International review of Psychiatry: Vol 18, Number 6, Dec 2006, Informa healthcare (Dr Lumeshowr has one article in this book)
12. Ministry of health Nepal (1995). National Mental Health Policy. Teku, Ministry of Health.
13. Nepal mental health country profile. Regmi SK, Pokharel A, Ojha SP, Pradhan SN, Chapagain G. Tribhuvan University Teaching Hospital, Kathmandu, Nepal. regmi_ktm@yahoo.co.uk
14. Political violence and mental health: a multi-disciplinary review of the literature on Nepal. Tol WA, Kohrt BA, Jordans MJ, Thapa SB, Pettigrew J, Upadhaya N, de Jong JT.
15. Jha Nepalese psychiatrists' struggle for evolution, Psychiatric Bulletin (2007), 31, 348^350. doi: 10.1192/pb.bp.107.014571
16. HealthNet TPO, Amsterdam, Netherlands. wtol@healthnettpo.org
17. Political violence and mental health: a multi-disciplinary review of the literature on Nepal.
 - a. Tol WA, Kohrt BA, Jordans MJ, Thapa SB, Pettigrew J, Upadhaya N, de Jong JT
18. Yadav K K: Changing social dynamics at decision making level in community forestry users groups Nepal

19. www.surgeongeneral.gov
20. Self Help Groups in India: A study of the lights and shades, APMAS, (Andhra Pradesh Mahila Abhivruddhi Society)
21. State of Microfinance in Nepal, Rural Microfinance Development Centre Ltd., Putalisadak, Kathmandu Nepal
22. Allan Oginga: Rural Poverty, Livelihoods & Mental Health, BasicNeeds
23. ARUN JHA, Nepalese psychiatrists' struggle for evolution Psychiatric Bulletin (2007)
24. Community Based Psycho-Social Support: Kpoila Nepal's experience, Mental Health and CBR Workshop 13 February 2009

Appendices:

1. Mental Health and Development (MHD) Model Training to LEADS Nepal Pre and Post Test Questions

1. What do you think about people with mental illness?
2. What do you know about mental illness
3. What do you think about working with people with mental illness? How can you provide service to them?
4. What do you think about including people with mental illness into existing community groups? How do you think you will do that?
5. What information do you have about mental health related policy in Nepal?
6. What information do you have about mental health services in Baglung and Myagdi districts?
7. Do you expect any special challenge in implementing the Mental health and Development Programme?

2. Topics Guide for Focus Group Discussion

1. Welcome, Introduction (both individuals and on LEADS Mental Health and Development Programme)
2. Objectives of the Group Discussions, Agendas shared
3. What are the key activities carried out from the health institution?
4. What is the average OPD visit per day, and top 10 diseases treated from the health institution?
5. Is there mental health service available in your health institution?
6. If yes, how do you provide services?
7. How many individuals come with some sorts of mental illness symptoms among those OPD visitors?
8. Do you have psychotropic medicines supplied from the government? If so, names of the medicines.
9. Where do you refer to people with mental illness if the institution is not able to treat, or do not have medicines?
10. Do you record people with mental illness in the HMIS register? If yes, code number in the HMIS, if no, how they are recorded in the HMIS?
11. What do you think the prevalence of mental illness in this area? What could be the reasons of mental illness?
12. Have you ever got training on mental health? Are you confident in diagnosing the mental health problem?
13. Are there any private hospitals or clinics offering mental health treatment services? Do people visit those hospitals or clinics?
14. Do you think the treatment services offered from the private clinics are affordable for most of the individuals?
15. What do you think about government policy on mental health? Is it satisfactory or needs much more attentions on improving policy?
16. Do you think mental health is a public health issue? What do you think government health workers role in advocating for making mental health services available from all health institutions?
17. Is infrastructure and equipments in your health institution adequately supplied? What lacks for the quality service delivery?
18. What about LHMC role? Are they active and strengthened enough to voice and demand from the government?

3. List of Health Personnel Interviewed:

Myagdi District			
SN	Name	Designation	Health Institution
1	Dr Lal Bahadur Malla	Medical Superintendant	Myagdi district hospital
2	Dr Binod Panta	Medical Officer	PHCC Darbang Myagdi
3	Dr Kalia Sapkota	Medical Officer	Myagdi District Hospital
4	Dr Rupesh Shrestha	Medical Officer	Myagdi District Hospital
5	Mr Lok Nath Poudel	Sr. AHW	Takam health Post Myagdi
6	Ms Indu Subedi	Staff Nurse	Myagdi District Hospital Myagdi
7	Ms Lila Gautam	Sr ANM	Myagdi District Hospital Myagdi
8	Mr Kusma Raj Poudel	Sr AHW	Singha health Post Myagdi
9	Mr Sobha Natha upadyaya	Sr AHW	Pakhapani Health Post Myagdi
10	Mr Deepak Raj Sharma	Sr AHW	Bhurung tatopani Health Post Myagdi
11	Mr Jadu Nandan Raut	Sr AHW	Sikha health Post
Baglung District			
1.	Dr Tarun Poudel	Medical Superintendant	Baglung District Hospital
2.	Dr Laxman Bastola	Medical Officer	Baglung District Hospital
3.	Dr Jeevan Thapa	Medical Officer	Burtibang PHCC
4.	Mr Arjun Kumar Adhikari	District Health Officer	DHO Baglung
5.	Mr Prem KC	Health Assistant	Sarkuwa Health Post
6.	Mr. Tuk Nath Sharma	Sr Health Assistant	Rangkhani Health Post
7.	Mr. Mukunda Sharma	Statistical Officer	DHO Baglung

8.	Mr Jeevan Kumar Shakya	Sr Health Assistant	District Hospital Baglung
9.	Ms Guma KC	Sr ANM	District Hospital Baglung
10.	Ms Shanti Sharma	Sr Health Assistant	Kusmi Sera PHC
11.	Mr Narayan Prasad Poudel	Sr AHW	Tityang Sub Health Post
12.	Mr Rajendra Mahato	Health Assistant	Dhamja Health Post
13.	Chhote lal Shah	Health Assistant	Righa Health Post
14.	Bilash Chandra Poudel	Sr AHW	Malika Sub Health Post
15.	Indra Bahadur Thapa	Sr AHW	Laharepipal Sub Health Post
16.	Ram Bilash Yadav	Sr Health Assistant	Taman Health Post

Number of people served by level of health facilities Baglung

SN	Indicators	064/65 1 st QTR	FY 065/66 1 st QTR	FY 066/67 1 st QTR
	Hospital	3525	2176	2630
	PHCC	492	652	777
	HP	271	409	334
	SHP	175	324	341
	PHC/ORC	12	15	12

Source: Annual Report DHO

Top Morbidity among inpatients Baglung

Rank	Top 10 Morbidity among Inpatients	Number	Mortality
1	Enteric Fever	131	--
2	Pneumonia	130	--

3	<i>AGE</i>	94	--
4	<i>COPD</i>	89	--
5	<i>Sever Pneumonia</i>	88	--
6	<i>Fever</i>	82	--
7	<i>APD</i>	59	--
8	<i>UTI</i>	44	--
9	<i>ARI</i>	32	--
10	<i>HTN</i>	23	--

Source: Annual Report DHO

Government Health Services (SHP to the District Hospitals)

1. EXPANDED PROGRAM ON IMMUNIZATION
2. NUTRITION PROGRAM
3. CB-IMCI / ARI / CDD PROGRAM
4. FAMILY PLANNING PROGRAM
5. SAFEMOTHERHOOD PROGRAM
6. FCHV PROGRAM
7. *PHC / ORC PROGRAM*
8. National Tuberculosis Control Program
9. LEPROSY CONTROL PROGRAM
10. MALARIA/ FILARISIS/ HIV AIDS CONTROL PROGRAM
11. CURATIVE SERVICE
12. HEALTH EDUCATION / TRAINING PROGRAM