Nepal

General Information

Nepal is a country with an approximate area of 147 thousand sq. km. (UNO, 2001). Its population is 25.724 million, and the sex ratio (men per hundred women) is 104 (UNO, 2004). The proportion of population under the age of 15 years is 40% (UNO, 2004), and the proportion of population above the age of 60 years is 6% (WHO, 2004). The literacy rate is 61.6% for men and 26.4% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.2%. The per capita total expenditure on health is 63 international $, and the per capita government expenditure on health is 19 international $ (WHO, 2004).

The main language(s) used in the country is (are) Nepali. The largest ethnic group(s) is (are) indigenous Nepalese, and the other ethnic group(s) are (is) Indo-Nepalese and Tibeto-Nepalese. The largest religious group(s) is (are) Hindu, and the other religious group(s) are (is) Buddhist, Muslim and Christian.

The life expectancy at birth is 59.9 years for males and 60.2 years for females (WHO, 2004). The healthy life expectancy at birth is 52 years for males and 51 years for females (WHO, 2004).

Epidemiology

Wright et al (1989) interviewed patients attending a primary care center for psychiatric illnesses using the Self-Reporting Questionnaire. Psychiatric morbidity was detected in one-quarter of all patients screened; more women were affected. Sharma (1975) examined 226 subjects with cannabis abuse and an equal number of matched (age, sex, education) normal controls. Compared with the controls, the cannabis users had a poor work record, poor social and family relationships, a lack of interest in sex and a general loss of initiative and efficiency. Regmi et al (2002) screened 100 women 2-3 months post-delivery and 40 control women using the Edinburgh Postpartum Depression Scale (EPDS). All those who screened positive for depression and 20% of the negatives also underwent a structured interview to assess depression by DSM-IV criteria. Predictive errors were minimized by using an EPDS score 13 to define depression. Using this threshold, there was no difference in depression prevalence between postpartum women (12%) and the control group (12.5%). Van Ommeren et al (2001) used standardized tools to interview 418 tortured Bhutanese refugees and 392 non-tortured Bhutanese refugees. Tortured refugees were more likely to report 12-month ICD-10 posttraumatic stress disorder, persistent somatoform pain disorder and dissociative (amnesia and conversion) disorders. In addition, tortured refugees were more likely to report lifetime posttraumatic stress disorder, persistent somatoform pain disorder, affective disorder, generalized anxiety disorder and dissociative (amnesia and conversion) disorders. Tortured women, compared with tortured men, were more likely to report lifetime generalized anxiety disorder, persistent somatoform pain disorder, affective disorder and dissociative (amnesia and conversion) disorders. Shrestha et al (1998) did a case-control study on a random sample of 526 tortured Bhutanese refugees and an equal number of non-tortured refugees matched for age and sex. The tortured refugees, as a group, suffered more DSM-III-R PTSD symptoms and had higher Hopkins Symptom Checklist-25 (HSCL-25) anxiety and depression scores and more musculoskeletal system- and respiratory system-related complaints than the non-tortured refugees. Buddhists were less likely to be depressed or anxious, and males were

less likely to experience anxiety. Van Ommeren et al (2002) found that the number of PTSD symptoms, independent of depression and anxiety, predicted both number of reported somatic complaints and number of organ systems involving such complaints. Emmelkamp et al (2002) evaluated 315 Bhutanese refugees and found that the total number of coping strategies was correlated with anxiety and depression. Negative coping, in contrast to positive coping, was related to all symptom outcome measures. Received social support was more strongly related to symptoms than perceived social support. The findings from the first sample were replicated in the second sample of 57 Nepalese torture victims. In a case-control study that involved 68 cases and 66 controls in a Bhutanese refugee camp, Van Ommeren et al (2001) found that recent loss, early loss, childhood trauma and pulse-rate were predictors of case status during an epidemic of medically unexplained illness consisting of somatoform symptoms, acute anxiety and dissociation (which included visual and auditory hallucinatory experiences in 60% and 28% of cases, respectively). Karki et al (2001) found that 86.5% of patients (n=37) attending the emergency ward with severe organophosphorus poisoning (OPP) had consumed it with the intent of committing suicide.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1997.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The mental health policy is a part of the general health policy. Psychiatrists, psychologists, psychiatric nurses, lawyers and civil servants were involved in its development. The policy aims to provide minimum mental health care facilities for all by the end of the current National Five-Year Plan by integrating mental health services into the general health services of the country, develop human resource facilities in mental health, protect the fundamental rights of the mentally ill, improve awareness about mental illness and promote better mental health in the community.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1994.

National Mental Health Programme

A national mental health programme is absent.

It is in accordance with the national mental health policy of the country.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1986.

Supply of 5 essential psychotropics has been ensured in the lowest level of the health delivery system of the country.

Mental Health Legislation

Under the Civil Law there are some sections having legal provisions concerning insanity. A separate mental health legislation, that protects the basic human rights of the mentally ill, has been drafted and is now awaiting the approval of the parliament.

The latest legislation was enacted in 1964.

Mental Health Financing

There are budget allocations for mental health.

The country spends 0.08% of the total health budget on mental health.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, tax based and grants.

The Government and NGOs like the World Health Organization, United Mission to Nepal etc. are important funders of mental health care services. Despite this, the family of the mentally ill has to spend around 25 000 Nepalese rupees per year (USD 320) as direct services costs.

The country has disability benefits for persons with mental disorders. Chronic mental illness has been classified as one of the mental disabilities and these patients have equal rights as other disabilities according to the Disability Act.

Mental Health Facilities

Details about mental health facilities at the primary care level are not available. Mental health is not an integral part of primary health care, but treatment of severe mental health disorders are available in ten districts where community health programmes with the support of NGOs are going on.

Regular training of primary care professionals is not carried out in the field of mental health. Primary care physicians and health workers are trained in mental health. Subsequent refresher training and supervision by psychiatrists has been attempted in some regions. A system of referral has been established. Local faith healers have been involved in the referral network. Successful integration of mental health care in primary health care has already occurred in 7 out of 75 districts.

There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.08
Psychiatric beds in mental hospitals per 10 000 population	0.02
Psychiatric beds in general hospitals per 10 000 population	0.02
Psychiatric beds in other settings per 10 000 population	0.04
Number of psychiatrists per 100 000 population	0.12
Number of neurosurgeons per 100 000 population	0.04
Number of psychiatric nurses per 100 000 population	0.08
Number of neurologists per 100 000 population	0.08
Number of psychologists per 100 000 population	0.08
Number of social workers per 100 000 population	0.04

At least 40 beds (10 in the governmental and 30 in the private sector) are earmarked for drug dependence treatment. All mental health professionals are stationed in urban and semi-urban areas.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Apart from usual services, NGOs run mental health services for homeless psychotic patients and refugees and day care centres for drug users.

Information Gathering System

There is mental health reporting system in the country. A morbidity form is available for outpatients and is filled by primary health centres.

The country has data collection system or epidemiological study on mental health.

Programmes for Special Population

The country has specific programmes for mental health for refugees.

Orientation programmes have been organized for school teachers. Special clinics for children, psychosexual disorders, headache and drug abuse treatment are available at a few centres.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam.

The drugs listed above are in the essential drug list for health posts and sub-health posts. More psychotropic drugs are available in the district and primary health care level.

Other Information

A national level Non-communicable Disease Prevention and Control Committee has been formed in the Ministry of Health. Eight non-communicable diseases (including mental disorder) have been prioritized. An overall national focal point for non-communicable diseases and a coordinator for each of the eight non-communicable diseases have been identified and a national Non-communicable Diseases Policy and strategies have been formulated. Activities for each of the eight non-communicable diseases are being planned.

Additional Sources of Information

•DoHS (1998-99) Annual Report – National Health Policy.

•Emmelkamp, J., Komproe, I. H., Van Ommeren, M., et al (2002) The relation between coping, social support and psychological and somatic symptoms among torture survivors in Nepal. Psychological Medicine, 32, 1465-1470.

•Essential Drug List and National Formulary (Government document).

•Karki, P., Hansdak, S. G., Bhandari, S., et al (2001) A clinico-epidemiological study of organophosphorus poisoning at a rural-based teaching hospital in eastern Nepal. Tropical Doctor, 31, 32-34.

•Ministry of Health (1995) National Mental Health Policy.

•Regmi, S., Sligl, W., Carter, D., et al (2002) A controlled study of postpartum depression among Nepalese women: validation of the Edinburgh Postpartum Depression Scale in Kathmandu. Tropical Medicine & International Health, 7, 378-382.

•Regmi, S. K., Pokharel, A., Ojha, S. P. (2004) Nepal mental health country profile. International Review of Psychiatry, 16, 142-149.

•Sharma, B. P. (1975) Cannabis and its users in Nepal. British Journal of Psychiatry, 127, 550-552.

•Shrestha, N. M., Sharma, B., Van Ommeren, M., et al (1998) Impact of torture on refugees displaced within the developing world: symptomatology among Bhutanese refugees in Nepal. JAMA, 280, 443-448.

•Tausig, M., Subedi, S. (1997) The modern mental health system in Nepal: organizational persistence in the absence of legitimating myths. Social Science & Medicine, 45, 441-447.

•Van Ommeren, M., de Jong, J. T., Sharma, B., et al (2001) Psychiatric disorders among tortured Bhutanese refugees in Nepal. Archives of General Psychiatry, 58, 475-482.

•Van Ommeren, M., Sharma, B., Komproe, I., et al (2001) Trauma and loss as determinants of medically unexplained epidemic illness in a Bhutanese refugee camp. Psychological Medicine, 31, 1259-1267.

•Van Ommeren, M., Sharma, B., Sharma, G. K., et al (2002) The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: examination of comorbidity with anxiety and depression. Journal of Traumatic Stress, 15, 415-421.

•Wright, C., Nepal, M. K., Bruce-Jones, W. D. (1989) Mental health patients in primary health care services in Nepal. Asia-Pacific Journal of Public Health, 3, 224-230.