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Mental Health as a Global Development Challenge: A Critical Analysis of the Case in Nepal

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Abstract

This paper builds on primary literature to provide a critical analysis investigating mental health as a global development challenge in the context of Nepal. First, the Nepalese mental healthcare context is introduced and reviewed. Second, challenges for mental healthcare progress in Nepal are examined, and solutions are suggested. Third, this analysis considers the critical role of Nepalese traditional healers in the solution to its mental healthcare challenge. Further, community development is discussed in the context of mental healthcare, and finally, suggestions are devised for global mental health promotion.

Keywords: Nepal, mental health, traditional healers, healthcare

Mental Health as a Global Development Challenge: A Critical Analysis of the Case in Nepal

The Covid-19 pandemic has highlighted the importance of mental health promotion for global development. In addition to the severe negative impacts on the physical health of populations globally, the pandemic has had profound implications for mental health (Hossain et al., 2020). While a comprehensive mental health epidemiology of Covid-19 is lacking, Covid-19 has been described as both a physical pandemic and a mental health epidemic (World Health Organization [WHO], 2022a).

To illustrate, one clear trend has been the dramatic 25 percent rise in rates of depression and anxiety globally linked to the impacts of social isolation, job loss, and challenges accessing community and social support (WHO, 2022a). Additionally, the pandemic exacerbated existing social inequities, whereby women and people with pre-existing physical health conditions were more likely to be affected by mental health disorders (WHO, 2022a). Furthermore, according to the WHO (2022a), mental healthcare services, including vital suicide-prevention care, have been among the most disrupted services during the pandemic, shedding light on disparities and gaps in care.

The case for improving mental healthcare in global development is clear. One of the most critical outcomes of psychiatric disease is suicide, with estimates upwards of 90 percent (Arsenault-Lapierre et al., 2004; Bertolote & Fleischmann, 2002). Although most people with mental disorders do not commit suicide (Brådvik, 2018), a recent metanalysis found that mental disorders were significant predictors of suicide, with estimates of 2 to 8 percent for dysthymia and 8 to 14 percent for major depressive disorder (Moitra et al., 2021).

Suicide is one of the leading causes of death among young adults, and individuals with severe mental illness die an average of two decades earlier than

those without these challenges (WHO, 2019). In addition to the association between mental health and suicide, globally, mental health problems account for 7.4 percent of disability-adjusted life years and 22.9 percent of years lived with disability (Whiteford et al., 2013). Thus, mental health reaches beyond individual private considerations and needs to be on the agenda for national and global development. A major recognition of the importance of mental health for global development, mental health is the inclusion in the Sustainable Development Goals (SDG) (United Nations - Department of Economic and Social Affairs, 2022), subsumed under the third goal. Mental health is included in target 3.4, with the reduction in suicide mortality rate as the associated outcome indicator.

The definition of mental health has evolved substantially and continues to change. Mental health is understood as an important part of overall health. Early conceptualizations merely viewed health as an absence of illness; and, therefore, mental health as an absence of mental illness (Larsen, 2022). Manderscheid and colleagues (2010) go beyond this definition by positing wellness and illness as two separate dimensions. In their definition, they include the development of autonomy as a dimension of wellness – a notion that lends itself to individualist perspectives.

To Galderisi and colleagues (2015), a globally applicable definition of mental health needs to capture a wide variety of social and cultural backgrounds. In contrast to earlier definitions, these authors define the concept in more depth than simply describing it as an absence of mental illness. An attempt to create a culturally inclusive in-depth definition of mental health is articulated in the following:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and

> modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium. (Galderisi et al., 2015, pp. 231-232)

According to this conceptualization, mental health encapsulates a complex, dynamic process of functioning in society. Contrary to this conceptualization, however, mental health does not play a central role in the SDGs (2022). Instead, adopting a narrower definition in this framework, mental health is subsumed in one of the targets of SDG goal three, and the associated indicator is the suicide rate. This appears to reflect a return to an earlier definition of mental health as merely an absence of mental illness (Larsen, 2022). This critique has been reinforced by Votruba and Thornicroft (2018), who forcefully argue for a distinct, clear mental health target with its associated indicators in the SDG framework.

Stafford-Smith et al. (2016) also advocate for a separate mental health target that is well integrated with the existing framework to maximize implementation success and avoid jeopardizing progress on alternative SDGs. A useful indicator in this realm might be the treatment gap, the percentage of people with a mental disorder that is left untreated. Cross-country summary research estimates that for most mental disorders in most countries, more than 40 percent of the population does not get adequate treatment (Kohn et al., 2018). This consideration is particularly important in Low and Middle-Income Countries (LMIC) where the disease burden attributed to mental health is high, resources are limited, and accurate data is scarce (Rathod et al., 2017).

Nepal offers a unique window of opportunity for researchers and practitioners interested in assessing the impact of SDG goal three on mental

health promotion. Like in other LMICs, mental health resources in Nepal are scarce and, when available, are largely concentrated in major urban centers (Luitel et al., 2015). This treatment gap has both theoretical and practical significance. Theoretically, a large treatment gap allows researchers to easily identify and distinguish measures for improving treatment outcomes. From the practical standpoint, the presence of a treatment gap highlights the urgent need to implement measures to close treatment gaps to improve mental health outcomes in Nepal.

In this paper, we critically examine mental healthcare challenges in Nepal in the context of the SDGs. To honor the uniqueness of the Nepalese context, traditional modes of healing are introduced as important determinants of healthcare delivery. We conclude with suggestions for enhancing mental healthcare in the context of community and social development in Nepal.

Mental Health in the Context of Nepal – Challenges and Solutions

An analysis of how to improve mental healthcare delivery in Nepal must begin with a thorough understanding of the local context. While an exhaustive description of the social context of mental healthcare delivery in Nepal is beyond the scope of this paper, in the following, we outline some key developments that have impacted mental health services and access to these services over the last few decades.

Currently, Nepal faces a complex mental healthcare challenge. The mental healthcare system is comprised of multiple care providers operating at the federal, provincial, and local levels, each of which plays a unique role in providing services (Ministry of Health and Population, 2022). Specialist mental health services such as psychiatrists are limited to major hospitals at the provincial level and there are no specialized mental healthcare institutions specifically for children and the elderly (Luitel et al., 2015). Additionally, a large portion of the population

lives in rural areas in Nepal, while most of the treatment resources are concentrated in urban areas (WHO, 2022b)

Historically, system change has been slow in Nepal. In 2020, health expenditure amounted to only 2.4 percent of the national Gross Domestic Product (GDP), of which mental health expenditure is a subcategory (Government of Nepal Ministry of Finance, 2020). According to WHO (2022b), Nepal's mental health expenditure is 0.05 USD per capita – a fraction of the total health expenditure of 25.40 USD per capita. The decade-long civil war in Nepal, which ended in 2006, affected every sector of health services delivery and healthcare infrastructure (Luitel et al., 2015). Further, healthcare infrastructure was a strategic target of the war efforts in Nepal, severely damaging its emerging mental health infrastructure (Luitel et al., 2015).

Since the end of the civil war, Nepal has focused on decentralizing its primary healthcare system to fulfill a primary goal of the first National Health Policy in 1991 (Ministry of Health & Population, 2012). This approach is targeted at improving healthcare access for rural populations as healthcare services had previously been centralized and access had been largely focused on serving city populations.

The creation of 3,129 Sub Health Posts (SHPs) that serve as the first low-barrier contact points of the population appears promising in this respect. Mental health services are now being integrated into their repertoire to minimize barriers to access (Luitel et al., 2015). However, according to Luitel and colleagues' (2015) analysis, one major criticism of the SHPs is their inability to dispense necessary psychotropic medication to help-seeking individuals. Also, challenges remain in training health assistants in SHPs on evidence-based, culturally embedded mental health service delivery (Luitel et al., 2015; Rathod et al., 2017).

Further gaps are evident in the government's mental healthcare service delivery. Nepal developed its first mental health policy in 1996, which commits the government to provide essential mental health services to the population (Luitel et al., 2015). A comprehensive review of its implementation by Upadhaya in 2013 identified several challenges, of which two of the most urgent ones are analyzed in the following. The first objective of the policy, to provide minimum mental health services to the population, lacks implementation regarding the most vulnerable and oppressed communities, according to Upadhaya (2013). Upadhaya (2013) further identifies that although most regions in Nepal have seen increased availability of mental health services for the population partly due to the policy, the availability of mental health services has overlooked the far-western and remote hill regions of the country. Furthermore, while Nepal's Ministry of Health and Population provides free medication for medical conditions, it does not offer common psychotropic medication free of charge, frequently leaving lower caste and socio-economically disadvantaged individuals and communities underserved (Upadhaya, 2013). Taken together, these efforts have helped Nepal achieve significant improvements in health levels and standard of living since the end of the conflict, however, some challenges remain, particularly in the availability and accessibility of mental health services. To address the pertinent gaps in mental health service delivery, the Community Mental Health and Psychosocial Support Programme, a national Non-Governmental Organization (NGO) was established in May 2003 (Centre for Mental Health & Counselling-Nepal, 2022). The program aims to integrate mental health and psychosocial services into district hospitals, health posts, and primary health centers (Centre for Mental Health & Counselling-Nepal, 2022). It targets community mental health through awareness training and community education in 16 rural communities. In 2020, the program had achieved significant reach, providing mental health services to more than

8500 people in 192 municipalities (Centre for Mental Health & Counselling-Nepal, 2022).

Efforts directed at mental health care have also been made at the community level, often considered a strength in LMICs such as Nepal (Rathod et al., 2017). For example, Female Community Health Volunteers (FCHVs), were introduced in 1988 by the Government of Nepal (Ministry of Health and Population, 2022a). The FCHVs provide a critical linkage of communities to healthcare services such as dispensing commodities and providing referrals (Khatri et al., 2017). Currently, there are more than 50,000 FCHVs with more than 89 percent operating in rural communities (Ministry of Health and Population, 2022a). Importantly, as FCHVs are not trained mental health professionals, their effectiveness in improving outcomes is dependent on their ability to detect individuals in distress and refer them to the appropriate resources. The possibility of FCHVs to detect victims of gender-based violence (GBV) has shown promising results regarding FCHVs' willingness to provide services as well as community acceptance (Betron et al., 2020). GBV is a worldwide pandemic, particularly in low-and-middle-income countries and in humanitarian crises St John and Walmsley (2021) indicate that "survivors are left with a combination of post-traumatic stress disorder, depression, and anxiety," which lead to further morbidity and mortality (p. 792399). While few interventions have been developed for this population specifically, Khatri and colleagues (2017) point to the need for a comprehensive reorganization of the fragmented role of FCHVs to improve their effectiveness in health promotion.

Traditional healers are the preferred first contact for mental healthcare in Nepal (Gupta et al., 2021a). Hence, their role needs to be considered when reorganizing mental healthcare solutions. The advantages of traditional healers may complement those of psychiatric and psychological practitioners in line with a biopsychosocial-spiritual model of care (Pham et al., 2020). The

biopsychosocial-spiritual model of care acknowledges that it is critical to understand patients' spiritual symptoms to improve health outcomes (Katerndahl, 2008). Crucially, Katerndahl (2008) found that spiritual symptoms are correlated with life satisfaction and healthcare usage and describe a complex interconnection between psychological and spiritual symptoms that cannot be ignored. The following section briefly examines the role of traditional healers in the mental healthcare context of Nepal.

Traditional Healers in the Mental Healthcare Context of Nepal

The global mental health discourse carries an inherent inconsistency: it is often pointed out that the cultural context matters for effective mental healthcare but fails to implement local knowledge in practice, instead favoring purely biomedical perspectives (Chase et al., 2018). The DSM-5 (Diagnostic and Statistical Manual; American Psychiatric Association, 2013) introduced the *cultural formulation interview* as a 16-item semi-structured instrument to elicit cultural understandings of mental illness and care and adapt the treatment accordingly (Aggarwal & Lewis-Fernández, 2015). More specifically, the instrument aims to obtain information on cultural perceptions of the problem, support, help-seeking, and coping from the patient's perspective (Aggarwal & Lewis-Fernández, 2015). While the inclusion of the cultural formulation interview is an important step, it does not address bigger-picture concerns of how culture permeates mental healthcare systems and practices (Gopalkrishnan, 2018).

Traditional healing is embedded in many cultural practices worldwide to facilitate healing within communities. They are the most popular first point of contact for mental health concerns for the Nepali people within their communities, with 28 percent of patients utilizing them as their first resource (Gupta et al., 2021a). A recent scoping review examining the role of traditional healers in most major regions of Nepal found that even within the boundaries of

Nepal there exists great diversity in traditional healing practices (Pham et al., 2020). Traditional healers utilize a wide variety of diagnostic tools that "[…] included pulse checks, social interpretation, and magico-religious divination, recitals, and offerings" (Pham et al., 2020, p. 7). They often combine diagnosis and treatment.

To understand the role played by traditional healer more clearly, it would be important to shed light on the five realms of the self in Nepali ethnopsychology: 1) *ijjat* (social status), 2) *dimaag* (brain-mind), 3) *man* (heart-mind), 4) *saato* (spirit), and 5) *jiu* (body) (Kohrt & Harper, 2008). These five realms are interconnected and deeply ingrained in the understanding of mental health and how it is communicated in the communities of Nepal (Kohrt & Harper, 2008). In all ethnopsychologies, the realms of self are intricately linked and interconnected – imbalances in one aspect potentially throw other realms off balance, too. However, Gurung, Lohorung Rai, Newars, and other ethnic groups in Nepal have differing mind-body conceptions, the examination of which is beyond the scope of this paper (Kohrt & Harper, 2008).

Traditional healers explain suffering mainly through the lens of the *saato* (spirit) and speak to the need to connect with symbolic and spiritual forces (Korth & Harper, 2008; Pham et al., 2020). Korth and Harper (2008) explain that disruptions of the *saato* cause distress. For example, traditional healers diagnose how fear and shock can disrupt the *saato* and even result in *saato gayo* (the loss of the spirit from the body). Further, when the *saato* has left the body, it is more vulnerable to supernatural forces that may enter the body and is more susceptible to physical illness (Korth & Harper, 2008).

Some critical implications can be drawn from the brief analysis of traditional healing and bodily realms in Nepal. Crucially, psychiatrists and psychosocial workers interpret the suffering in terms of different facets of the

bodily realms than traditional healers (Korth & Harper, 2008). Having alternative explanations for illness without interconnection is challenging both individually and on a systems level. Individually, it makes help-seeking difficult and tedious: if individuals are not satisfied with a given explanation, they need to seek a different care provider which is associated with renewed wait for treatment, potentially long travel time, and travel costs. Additionally, help-seeking decisions are mediated by supernatural beliefs that influence when and which care provider is sought, particularly in individuals with schizophrenia (Gupta et al., 2021a).

In the context of Nepal, traditional healers stand to provide care alongside other mental healthcare providers such as psychologists and psychiatrists (Gupta et al., 2021b). For Gupta (2021b), individuals seek out diverse care providers with no systematized referral system, potentially further complicating help-seeking. For instance, a study in Nepal demonstrated that longer, more complex pathways to care are associated with longer durations of untreated disease in individuals with schizophrenia (Gupta et al., 2021a). This situation may be further exacerbated by potential rivalries between healthcare providers: a dualistic competitive view of either traditional or Western modes of care is against the need to meet the holistic healthcare needs of Nepalese people. Further, such a conception overlooks the inherent strength of traditional healing that is embedded in cultural practices and belief systems (Pham et al., 2020) and their shared complementary goal with Western psychiatric practice to improve mental health outcomes. In general, practitioners and policymakers are faced with the complex challenge of avoiding the so-called category fallacy (Kleinman, 1987) of imposing Western psychiatric diagnoses in contexts with low cross-cultural validity.

Interesting parallels can be drawn between Nepal and Cambodia, which also saw major impacts of war on population health, including mental health (Somasundaram et al., 1999). Cambodia's path of starting mental healthcare

facilities in an environment with predominantly traditional modes of healing has striking similarities with the Nepalese context. In Cambodia, the implemented program aimed at minimizing interference with traditional healing practices and, on the contrary, encouraged their usage (Somasundaram et al., 1999) alongside newly introduced healthcare provision following a Western model. While Somasundaram et al. (1999) are hesitant to make concrete suggestions, a fruitful theme in Cambodia's case was the recognition that both traditional healers and Western model care providers each carry their unique strengths, which may be complementary and improve overall population mental health outcomes.

This section presented a brief introduction to faith healer practices and traditional perceptions of mental health as well as Nepalese ethnopsychology. Future work is needed to investigate concrete implementations that harness both traditional and non-traditional modes of care. In the following section, Community Development (CD) is introduced as an under-investigated practical approach to introducing mental healthcare within local communities.

Community Development Approaches to Mental Health in Nepal

Community Development (CD) in the context of mental health is often ill-defined and broad: ranging from interpretations of CD as "individual self-help to radical collective action" (McCabe & Davis, 2012, p. 508). In this paper, we adopt O'Donnell and Karanja's (2000) transformative view of CD, which posits transformation as a central concept of community practice. These authors further advance that this approach to CD "best encapsulates the process by which people come to know their own internal spirit and strength in order to develop alternative visions of themselves and their community" (p. 75). Like other forms of community practice, CD aims to strengthen social ties within the community. Social connectedness has been demonstrated as a key protective factor for mental health (Saeri et al., 2018).

However, CD has been largely neglected as a method for promoting community mental health. Research by McCabe and Davis (2012) identifies three core barriers to achieving CD that promotes mental health. They assert that community models of mental health are often rooted in narratives of pathologies and not community strengths. Furthermore, these researchers challenge the notion of CD as a value-free approach, it overlooks structural inequities and barriers to mental health. Finally, policy objectives need to be aligned in that CD is an iterative reflective process aimed at the long term, while mental health interventions often target the short term.

Community developers can more effectively support community-level mental health if they aim to directly overcome these barriers with the view of bridging gaps between CD and mental health. They need to openly discuss and align the underlying objectives of CD to the needs of the local communities. For example, community developers must view mental health as a concern for CD and become equipped with the necessary knowledge and skills to address mental health in vulnerable communities (McCabe & Davis, 2012).

Recognizing community strengths for mental well-being and rooting CD in these assets appears to be another avenue of achieving community mental health promotion from the bottom up. This idea is in line with the asset-based CD approach, the Asset-Based Community Development (ABCD) model (Kretzmann & McKnight, 1993). ABCD emphasizes community strengths and assets. Instead of building communities from the top down, this model stresses community strengths and building strong communities from the inside out by giving community members a central role in the development process (Kretzmann & McKnight, 1993). Interestingly, one may view Nepal's efforts of using NGOs to fill crucial gaps in the mental healthcare system as a deficiency-based approach. An ABCD approach to CD that instead includes and builds upon the strengths of local communities may stand to improve mental health outcomes.

For CD to be effective in the Nepalese context, it needs to overcome challenges of cross-cultural validity. As Laing (2009) points out, classical models of community practice, such as those developed by Rothman (1974) lack cultural sensitivity or altogether exclude the cultural forces that shape communities. A recent comparative review concluded that Facilitation for Empowerment and Social Transformation, a theory of community development based on Freire and redesigned and introduced in Nepal in 1996, is an "effective tool to help the community people experience the possibility of having meaningful development change through mutual collaboration and actions, promoting the effective and sustainable use of local resources" (Malla, 2021, p. 23). This model requires in-field quality studies, and its effectiveness, mental health specifically, has not been evaluated (Malla, 2021). Further, deciding on the single most applicable model of community practice in mental healthcare in Nepal is challenging as, to our awareness, there is no current research on the effectiveness of alternative or local CD models directed at mental health in Nepal.

Conclusion and Future Directions

In sum, this paper investigated the state of mental healthcare in Nepal from an SDG-informed perspective. We identified diverse mental healthcare providers and pathways to care and devised suggestions for strategic improvements, such as the utilization of FCHVs and further integration and harmonization of providers.

In Nepal, CD approaches offer promise but are yet to be integrated into mental healthcare promotion. One challenge persists in harmonizing diverse culturally shaped interpretations of suffering and subsequent solutions and treatments. In Nepal, traditional healing practices coexist with Western modes of care, such as psychiatry. This paper recognizes the potential to commit the category fallacy (Kleinman, 1987) and suggests potential remedies for the

integration of traditional and non-traditional modes of healing as a remedy. Further, we outlined potential synergies in Nepal as illustrated by the case of Cambodia (Somasundaram et al., 1999).

On the global level, mental health is increasingly understood as important in sustainable development as it is therefore gaining more recognition and investment (Scorza et al. 2017). Three-quarters of the 1 billion people with mental disorders live in LMICs, and their number is projected to increase (Patel et al., 2016). Although effective and low-cost interventions are available, governments often lack the funding to address mental disorders in LMIC countries (Iemmi, 2019). The inclusion of mental health in the SDGs as an official development goal was a major milestone for global mental health. However, there remain challenges to the integration of mental health targets into programs supporting other SDGs (Scorza et al., 2017; Stafford-Smith et al., 2016). Finally, further effort is required to devise more detailed mental health indicators and targets to channel efforts into the most effective measures and to understand how this might be integrated and evaluated in the context of Nepal.

References

Arsenault-Lapierre, G., Kim, C., & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: A meta-analysis. *BMC Psychiatry, 4*, 37. doi: 10.1186/1471-244X-4-37.

Bertolote J.M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry, 1*, 181–185.

Betron, M., Thapa, A., Amatya, R., Thapa, K., Arlotti-Parish, E., Schuster, A., Bhattarai, J., Limbu, S., Chiweshe, M. T., Rishal, P., & Dhital, R. (2020, November 13). Should female community health volunteers (FCHVs) facilitate a response to gender-based violence (GBV)? A mixed methods exploratory study in Mangalsen, Nepal. *Global Public Health, 16*(10), 1604–1617. https://doi.org/10.1080/17441692.2020.1839929

Brådvik, L. (2018). Suicide risk and mental disorders. *International Journal of Environmental Research and Public Health,17*, 15(9),028. doi: 10.3390/ijerph15092028. PMID: 30227658; PMCID: PMC6165520.

Centre for Mental Health & Counselling-Nepal. (2022). Community mental health and psychosocial support programme (January 2022 – December 2025): CMC Nepal. *CMC-Nepal.* http://www.cmcnepal.org.np/wp-content/uploads/2021/09/Annual-Report-2020.pdf

Chase, L. E., Sapkota, R. P., Crafa, D., & Kirmayer, L. J. (2018). Culture and mental health in Nepal: An interdisciplinary scoping review. *Global Mental Health, 5*(36). https://doi.org/10.1017/gmh.2018.27

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015, June). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231–233. https://doi.org/10.1002/wps.20231

Government of Nepal Ministry of Finance. (2020). *Budget speech of fiscal year 2020/21.*

https://www.mof.gov.np/uploads/document/file/Budget%20Speech%202020_20201118033431.pdf

Gupta, A. K., Grover, S., Thapaliya, S., Shrestha, S., Sawant, S., & Shoib, S. (2021a). Pathways to care and supernatural beliefs among patients with psychotic disorders in Nepal. *Middle East Current Psychiatry, 28*(1). https://doi.org/10.1186/s43045-021-00143-3

Gupta, A. K., Joshi, S., Kafle, B., Thapa, R., Chapagai, M., Nepal, S., Niraula, A., Paudyal, S., Sapkota, P., Poudel, R., Gurung, B. S., Pokhrel, P., Jha, R., Pandit, S., Thapaliya, S., Shrestha, S., Volpe, U., & Sartorius, N. (2021b). Pathways to mental health care in Nepal: A 14-center nationwide study. *International Journal of Mental Health Systems, 15*(1). https://doi.org/10.1186/s13033-021-00509-4

Hossain, M. M., Tasnim, S., Sultana, A., Faizah, F., Mazumder, H., Zou, L., McKyer, E. L. J., Ahmed, H. U., & Ma, P. (2020, June 23). Epidemiology of mental health problems in COVID-19: A review. *F1000Research, 9*, 636. https://doi.org/10.12688/f1000research.24457.1

Iemmi V. (2019). Sustainable development for global mental health: A typology and systematic evidence mapping of external actors in low-income and middle-income countries. *BMJ Global Health,*4**,** e001826.

Katerndahl, D. A. (2008, September 1). Impact of spiritual symptoms and their interactions on health services and life satisfaction. *The Annals of Family Medicine, 6*(5), 412–420. https://doi.org/10.1370/afm.886

Khatri, R. B., Mishra, S. R., & Khanal, V. (2017, July 21). Female community health volunteers in community-based health programs of Nepal: Future perspective. *Frontiers in Public Health, 5*, 1-4. https://doi.org/10.3389/fpubh.2017.00181

Kleinman, A. (1987, October). Anthropology and psychiatry. *British Journal of Psychiatry*, *151*(4), 447–454. https://doi.org/10.1192/bjp.151.4.447

Kohn, R., Ali, A. A., Puac-Polanco, V., Figueroa, C., López-Soto, V., Morgan, K., Saldivia, S., & Vicente, B. (2018). Mental health in the Americas: An overview of the treatment gap. *Revista Panamericana de Salud Publica = Pan American Journal of Public Health, 42*, 1-9 e165. https://doi.org/10.26633/RPSP.2018.165

Kohrt, B. A., & Harper, I. (2008). Navigating diagnoses: Understanding mind–body relations, mental health, and stigma in Nepal. *Culture, Medicine, and Psychiatry, 32*(4), 462–491. https://doi.org/10.1007/s11013-008-9110-6

Kretzmann, J. P., & McKnight, J. L. (1993). Building communities from the inside out: A path toward finding and mobilizing a community's assets. *Evanston, IL: Institute for Policy Research*, 1–11. https://resources.depaul.edu/abcd-institute/publications/Documents/GreenBookIntro%202018.pdf

Larsen, L. T. (2021, April 26). Not merely the absence of disease: A genealogy of the WHO's positive health definition. *History of the Human Sciences, 35*(1), 111–131. https://doi.org/10.1177/0952695121995355

Laing, B. Y. (2009). A critique of Rothman's and other standard community organizing models: Toward developing a culturally proficient community organizing framework. *Community Development, 40*(1), 20–36. https://doi.org/10.1080/15575330902918931

Luitel, N. P., Jordans, M. J., Adhikari, A., Upadhaya, N., Hanlon, C., Lund, C., & Komproe, I. H. (2015). Mental health care in Nepal: Current situation and challenges for development of a district mental health care plan. *Conflict and Health, 9*(1), 1-11. https://doi.org/10.1186/s13031-014-0030-5

Malla, P. (2021). Practices of community development in Nepal: A comparative narrative review. ISSRA *Journal of Arts, Humanities and Social Studies, 01*(01), 23–28. https://doi.org/10.5281/zenodo.5600583

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2010). Evolving definitions of mental illness and wellness. *Preventing Chronic Disease, 7*(1). https://pubmed.ncbi.nlm.nih.gov/20040234/

Moitra, M., Santomauro, D., Degenhardt, L., Collins, P. Y., Whiteford, H., Vos, T., & Ferrari, A. (2021). Estimating the risk of suicide associated with mental disorders: A systematic review and meta-regression analysis. *Journal of Psychiatric Research, 137*, 242-249. doi: 10.1016/j.jpsychires.2021.02.053.

McCabe, A., & Davis, A. (2012). Community development as mental health promotion: Principles, practice and outcomes. *Community Development Journal, 47*(4), 506–521. https://doi.org/10.1093/cdj/bss026

Ministry of Health and Population. (2022a). Female Community Health Programme. Ministry of Health and Population - *Female Community Health Programme*. https://www.mohp.gov.np/eng/program/reproductive-maternal-health/female-community-health-programme

Ministry of Health and Population. (2022b). Ministry of Health and Population. *Government of Nepal - Ministry of Health and Population*. https://www.mohp.gov.np/eng/

Nepal Health Research Council. (2020). National mental health survey, Nepal-2020. http://nhrc.gov.np/wp-content/uploads/2020/09/Factsheet-Adults-1.pdf

O'Donnell, S. M., & Karanja, S. T. (2000, June 2). Transformative community practice. *Journal of Community Practice, 7*(3), 67–84. https://doi.org/10.1300/j125v07n03_04

Patel, V., Chisholm, D., Parikh, R., et al. (2016). Addressing the burden of mental, neurological, and substance use disorders: Key messages from disease control priorities, 3rd edition. *The Lancet, 387*, 1672–85.

Pham, T., Kaiser, B. N., Koirala, R., Maharjan, S. M., Upadhaya, N., Franz, L., & Kohrt, B. A. (2020, May 22). Traditional healers and mental health in Nepal:

A scoping review. *Culture, Medicine, and Psychiatry, 45*(1), 97–140. https://doi.org/10.1007/s11013-020-09676-4

Rai, Y., Gurung, D., & Gautam, K. (2021). Insight and challenges: Mental health services in Nepal. *BJPsych International, 18*(2). https://doi.org/10.1192/bji.2020.58

Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017, January 1). Mental health service provision in low- and middle-income countries. *Health Services Insights, 10*, 117863291769435. https://doi.org/10.1177/1178632917694350

Regmi, S. K., Pokharel, A., Ojha, S. P., Pradhan, S. N., & Chapagain, G. (2004). Nepal mental health country profile. *International Review of Psychiatry, 16*(1–2), 142–149. https://doi.org/10.1080/09540260310001635186

Rothman, J. (1974). *Planning and organizing for social change: Action principles from social science research.* Columbia University Press. https://scirp.org/reference/referencespapers.aspx?referenceid=583501

Saeri, A. K., Cruwys, T., Barlow, F. K., Stronge, S., & Sibley, C. G. (2017). Social connectedness improves public mental health: Investigating bidirectional relationships in the New Zealand attitudes and values survey. *Australian & New Zealand Journal of Psychiatry*, *52*(4), 365–374. https://doi.org/10.1177/0004867417723990

Scorza, P., Poku, O., & Pike, K. M. (2018, March 22). Mental health: Taking its place as an essential element of sustainable global development. *BJPsych International, 15*(4), 72–74. https://doi.org/10.1192/bji.2017.22

Somasundaram, D. J., van de Put, W. A., Eisenbruch, M., & de Jong, J. T. (1999, April). Starting mental health services in Cambodia. *Social Science & Medicine, 48*(8), 1029–1046. https://doi.org/10.1016/s0277-9536(98)00415-8

Stafford-Smith, M., Griggs, D., Gaffney, O., Ullah, F., Reyers, B., Kanie, N., Stigson, B., Shrivastava, P., Leach, M., & O'Connell, D. (2016, July 18).

Integration: The key to implementing the Sustainable Development Goals. *Sustainability Science, 12*(6), 911–919. https://doi.org/10.1007/s11625-016-0383-3

St John, L., & Walmsley, R. (2021). The latest treatment interventions improving mental health outcomes for women, following gender-based violence in low-and-middle-income countries: A mini review. *Frontier Global Women's Health, 16*(2),792399. doi: 10.3389/fgwh.2021.792399. PMID: 34977864; PMCID: PMC8716596.

The Lancet Global Health. (2020, November). Mental health matters. https://doi.org/10.1016/S2214-109X(20)30432-0

The World Bank. (2020). Rural population (% of total population) - Nepal. https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?end=2020&locations=NP&start=2020&view=map

Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems, 2*(1), 3. https://doi.org/10.1186/1752-4458-2-3

United Nations - Department of Economic and Social Affairs. (2022). Goal 3 | Department of Economic and Social Affairs. Retrieved September 19, 2022, from https://sdgs.un.org/goals/goal3

United Nations. (2020, May). Policy Brief: COVID-19 and the need for action on mental health. https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf

Upadhaya, K. (2013). National mental health policy – 1996, what has been achieved: A review. *Journal of Psychiatrists' Association of Nepal*, *2*(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4331482/

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., Charlson, F. J., Norman, R. E., Flaxman, A. D., Johns, N., Burstein, R., Murray, C. J., & Vos, T. (2013). Global burden of disease attributable to

mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet, 382*(9904), 1575–1586. https://doi.org/10.1016/s0140-6736(13)61611-6

World Health Organization. (2020). Nepal - special initiative for mental health, situational assessment. https://cdn.who.int/media/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---nepal---2022.pdf?sfvrsn=714028db_3&download=true#:~:text=There%20is%20no%20standalone%20mental,all%20parts%20of%20the%20country.

World Health Organization. (2022a). *COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide.* https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

World Health Organization. (2022b). *Nepal WHO special initiative for mental health situational assessment.* https://cdn.who.int/media/docs/default-source/mental-health/special-initiative/who-special-initiative-country-report---nepal---2022.pdf?sfvrsn=714028db_3&download=true

World Health Organization. (2017). Mental health atlas 2011: Nepal. Retrieved September 19, 2022, from https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2017-country-profiles/npl.pdf?sfvrsn=21f5c9fe_1&download=true