Quest Journal of Management and Social Sciences
Volume 3 Issue 1: 76-85
ISSN Print: 2705-4527
ISSN Online: 2705-4535
Web: https://www.quest.edu.np

What Determines Indigenous Peoples' Mental Health Awareness? A Descriptive Cross-Sectional Study From Nawalpur District

Ranjana Koirala[1*], *Tilarupa Bhattarai*[1]

[1] Maharajgung Nursing Campus, Institute of Medicine, Tribhuvan University, Nepal

[*] Corresponding Author (ranjanakoirala2070@gmail.com)

Received: 16 January, 2021
Revised: 4 May, 2021
Accepted: 18 May, 2021
Published: 10 June, 2021

How to cite this paper:

Koirala, R., Bhattarai, T. (2021). What determines indigenous peoples' mental health awareness? A descriptive cross-sectional study from Nawalpur district. *Quest Journal of Management and Social Sciences, 3(1)*, 76-85.

Abstract

Background: The health status of indigenous people including Tharu is very poor. Despite several studies on indigenous communities, no previous studies were found about mental illness and its awareness among the Tharu people in Nepal.

Objectives: This study aims to find out the awareness of mental illness among adults of the Tharu community. Within the objective the present study specific to identify the level of awareness on mental illness and to identify an association between selected socio-demographic characteristics and level of awareness on mental illness.

Method: The study was based on the descriptive cross-sectional design and was conducted in 3, 4, 6, 8, and 15 wards of the Madhyabindu municipality of Nawalpur District as the majority of the Tharu's household are located in these wards. This research administered a structured questionnaire to assess awareness of Tharu adults on mental illness. Data were collected in September and October 2018. The collected data were analyzed by using descriptive statistical methods where the researcher calculated mean, standard deviation, percentage, and frequency. Chi-square test was used for inferential statistics.

Result: Our analysis revealed that the socioeconomic status of the Tharu community is based on agriculture. The overall level of awareness of respondents, 35.5 % had adequate awareness of mental illness whereas 34 % had moderate awareness and 30.5 % respondents had inadequate awareness of the mental illness. The level of awareness of mental illness is statistically significant with the age of respondents, gender, marital status, education status, and occupation status.

Conclusion: Based on the findings of the study, it concluded that nearly one-third of Tharu adults have an adequate level of awareness regarding mental illness. Further, the awareness level of Tharu adults tends to vary according to age, sex, education, occupation, and marital status.

Implication: The findings of this study imply that mental awareness among the indigenous community is still low and the findings of the study could be used by a mental health organization to plan and implement mental health-related awareness programs in an indigenous community.

Keywords: Community mental health, Mental health awareness, the Tharu community, Terai belt, Nepal

Paper Type: Research paper

JEL Classification: C21, I1

Introduction

Globally, mental health problems are one of the most serious public health problems and serious public health concerns (Luitel et al., 2015). World Health Organization (WHO) explained that one in four people in the world will be affected by mental or neurological disorders at some point in their lives and around 450 million people are currently suffering from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide (WHO, 2001). Four out of five people with severe mental illness in low and middle-income countries receive no effective treatment (Kohn et al., 2004). It indicates, globally mental health problems are being serious public health concern that accounts for 7.4% of disability-adjusted life years (DALY) and 22.9% of years live with a disability (YLD) (Whiteford et al., 2013).

World Economic Forum (2011) estimated the cost of the global burden of mental illness in 2010 was $2.5 trillion. This cost is projected to rise above $6 trillion by 2030, an amount three times greater than overseas development assistance spent by all nations between 1990 and 2010. Around 20% of the world's children and adolescents have mental disorders or problems. Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people. Mental and substance use disorders are the leading cause of disability worldwide. About 23% of all years lost because disability is caused by mental and substance use disorders. Available mental health services in South-East Asia tend to be urban-centered and hospital-based, with the result that 80%-90% of the population has no access to treatment. The number of people who commit suicide is higher than the number who die because of road accidents, terrorism, and HIV/AIDS (Uprety & Lamichhane, 2016). The World Health Organization (2001) says that over 90% of suicide cases relate to mental disorders and that more than two-thirds of all suicides are preventable. There is a huge scarcity of resources to address the mental health needs of the population in South Asia. The negative social attitudes towards mental health, massive underestimation of the suffering of mentally ill people, lack of political empathy, and the lack of mental health leadership are the real challenges.

Mental illness is maladjustment in the living. It produces a disharmony in the person's ability to meet human needs comfortably or effectively and function within a manner (Sreeevani, 2016). Mental illness is common and ubiquitous and cuts across all sections of society throughout the globe, irrespective of its socio-economic status: rich or poor; educated or illiterate, and gender status (Shyangwa et al., 2014). In the Nepalese context, a few studies related to mental illness and awareness are available. Shyangwa et al. (2014) observed that the prevalence rate of some common psychiatric disorders was high in the community of eastern Nepal (14.0%). Another survey conducted by Shrestha (1998) in the Kathmandu Valley in 1983 shows the prevalence rate of mental illness at 14.0%. Although Nepal has made remarkable progress on improving maternal health and reducing the child mortality rate, still much more needs to be done in mental health (Shyangwa et al., 2014).

Awareness and health knowledge are interrelated and lack of knowledge about mental illnesses poses a challenge to the mental health care delivery system. In India, a study found that mental health awareness among adolescents is very low (Shrivastav et al., 2016). A study carried out in Nigeria found poor knowledge about the cause of mental illness among the respondents. Negative views of mental illness were widespread, with as many as 96.5%, believed that people with mental illness were dangerous because of their violent behavior. Most would not tolerate even basic social contacts with a mentally ill person: 82.7% reported they would be afraid of having a conversation with a mentally ill person and only 16.9% would consider marrying one (Gureje et al., 2005). In central Africa, Yongsi (2015) assessed that recognition of common mental disorders and knowledge of mental illness among the general population was quite poor (32.6 %). A study carried out by Yeapandlow (2009) in Malaysia indicated that the majority of the respondents didn't have good knowledge of mental illness as well as ethnic background, religion, education level, and residential location were a few demographic

characteristics found to be significantly related to either the respondent's knowledge or attitude towards mental health issues. Similarly, a comparative study conducted in India showed that result among the rural participants, 78% had poor knowledge of mental illness whereas among respondents of urban areas 82% had good knowledge about mental illness (More et al., 2012). In a co-relational comparative study on knowledge and attitude towards mental illness and health among the urban and rural communities in Nepal, Singh et al. (2013) found that adults residing in urban had more knowledge about mental illness than adults of rural communities.

In Nepal, although there are no accurate data on the prevalence of mental illness, small-scale studies have indicated the prevalence to be as high as 37.5% in rural communities and approximately 30% of the population of Nepal suffers from psychiatric problems (Uprety & Lamichhane, 2016). According to Nepal police data (2074/75), 5346 people committed suicide and around 14-15 people died every day by committing suicide on average. Raoof (2012) explained that 90% of people committing suicide were predicted to have some type of mental disorder. In Nepal, mental health services are also not organized, over 90% of the population who needs mental health services has no access to treatment, and mental health services are only concentrated in big cities, with 0.22 psychiatrists and 0.06% psychologists per population of 100, 00. Only 2% of medical and nursing training focuses on mental health issues (Uprety & Lamichhane, 2016). The available services are centered in urban areas, which are costly and inaccessible to the majority of the population. Nepal, a country of about 28 million populations has only one government-run Mental Hospital. There are approximately only 50 psychiatric clinics and 12 psychological counseling centers, besides these medical colleges, are also providing psychiatric services (WHO, 2006). It indicates that there are no adequate provisions of mental health services to people.

Mental Health and Indigenous People

Many studies explained that mental illness is high among indigenous people. According to the national census, mental disability is heavily concentrated among the Terai indigenous people (Central Bureau of Statistics [CBS], 2012). Dislocation, epidemics, depopulation, and subjugation have put indigenous peoples everywhere at high risk of depression and anxiety (Alex, 1999). Not only in Nepal, but the mental health of indigenous people found to be endangered in other parts of the world also. Povey et al. (2016) observed that in Australia, Aboriginal and Torres Strait Islander tribes experience much higher rates of psychological distress compared with non-indigenous Australians. Similarly, Black et al. (2015) found that the occurrence of very high psychological distress was nearly triple the rate in indigenous people. There are high rates of suicide, alcohol abuse, and domestic violence in indigenous people. Some regions have indigenous population suicide rates that are up to 12 times higher than those of non-indigenous populations (Pan-American Health Organization & WHO, 2016).

Indigenous people suffer from high rates of various neuropsychiatric and behavioral problems, yet relatively no data exist concerning the mental health status and treatment needs of indigenous peoples including in the context of Nepal. Further, literature seems unavailable in the case of mental health issues and their knowledge and practice regarding mental illness on Nepalese indigenous community and people.

The Tharu tribal groups are highly prone to various types of disease. Most individuals belong to lower-class families and lack of education and awareness of mental health make them vulnerable (Rajput et al., 2014). However, awareness and prevalence data about the mental illness of indigenous people and Tharus are not available. Tharus are well-known farmers of the Terai whose economy is based on agriculture and forest (Bhandari, 2013). Low income, unproductive labor, lack of autonomy, landlessness, illiteracy, etc. are still the main identity of the Tharu ethnic people (Sharma, 2006). Only a few Tharu people have started other professions recently. Tharu's priority is food and clothes, second – investment in ritual ceremonies, third – health, and fourth education (Thakulla, 2017). Rural and backward communities are not much aware of education and health. Awareness about health in Tharu

youth is 51.03 % (Barma, 2011). It indicates that health awareness among the Tharu people is very less due to various reasons.

The health status of the indigenous people, including Tharu is very poor (Rajpoot et al., 2016). The Tharu people suffering from chronic illness ranges from 8.3% to 9.7% (Subba et al., 2014). Indigenous people in Nepal have a limited tendency to understate their disease symptoms because of limited medical or paramedical consultation due to the lack of resources and opportunities for consultation (CBS, 2012). Rather, Tharus follow their goddess called 'Bhuyian' and many other gods; the gods are believed to have the ability to heal disease and sickness (Verma, 2010). According to traditional legends, gods are given a 'Bhakal,' a promise of something to god on condition that the sickness is cured in any events of misfortunes, plagues, and horror dreams (Mishra et al., 2017). Tharus would approach shamans as a doctor, known as Guruba; the shaman uses Buddhist medicines to cure illness and also try to appease gods through incantations, beating drums, and offering sacrifices (Verma, 2010). The Tharu people believe sickness comes when the gods are displeased, and the demons are at work (Mishra et al., 2017).

While reviewing available literature, awareness of mental illness is found below in the general population. But, no study related to awareness of mental illness among the Tharu people could be found by a researcher. Therefore, a researcher is interested in assessing the awareness of mental health among Tharu adults. The general objective of the study is to find out the awareness of mental illness among adults of the Tharu community in the Nawalpur district.

Very little relevant literature is found in the context of Nepal on awareness of mental illness among the community people and literature on the mental illness awareness among adults of the Tharu community is very rare. However, some research was found on knowledge and attitude of mental illness among the community people. The findings of this study may guide health organizations and policymakers to plan and implement a program to raise awareness on mental illness to the people of the Tharu community. This study might be useful as a supporting document to those who are interested in a similar kind of research.

This paper is organized into the following sections. Section II presents the research methodology selected for this study; Section III presents results and discussion of the study, and the final section concludes the study with necessary recommendations/policy implications.

Research Method

Study Site, Population, and Sampling

The population for the study was the functional head of the family from each Tharu household. The Tharu population was included 20% of the total sample size from each selected ward of Madhyabindu Municipality i. e. 40 Tharu adults (household) from each ward. Inclusion criteria were: both male and female head of the family aged 21 to 59 years living in Madhyabindu municipality ward no 3, 4, 6, 8 &15 and available at the time of data collection were included for the study. The Tharu people are indigenous to the southern belt of the Terai of Nepal (Guneratne, 2002) and they are the second-largest indigenous ethnic group of Nepal (CBS, 2012). The Tharus are probably the oldest group to inhabit the Terai region and have difficulty to fulfill their daily needs (Joshi, 2016). Apart from Nepal, some Tharu people also live in the Indian states of Uttarakhand, Uttar Pradesh, and Bihar (Verma, 2010). According to the census 2011, the Tharu population of Nepal is 17,37,470 which accounts for 6.6% of the total population of Nepal (CBS, 2012).

A descriptive cross-sectional design was adopted for this study. The setting for the study was ward numbers: 3, 4, 6, 8, and 15 of the Madhyabindu municipality. The majority of Tharu households are located in these wards. The Madhyanindu municipality is located in the central Terai of Nepal in the Nawalpur District. It has 14 wards. The total population of Madhyabindu municipality is 54,140 and the total household in this area is 11,943. According to a municipal officer of the Madhyabindu

municipality, among total household, 35% of households (4140) belongs to Tharus. To determine the sample size, the following formula was used (Panta, 2016) for a similar study.

$$n= z^2pq/e^2$$

Where, n= sample size required for the study, z= value corresponding to 5% level of significance which will be equal to = 1.96, p= Prevalence or proportion of an event of key indicator to be estimated, which is equal to 78 % = 0.78 as per More et al.(2012), q= 1-p = 0.22, e=allowable error that can be tolerated = 6%=0.06. Calculating this, the total population for the study becomes 183.04. While adding a 5% non-response error, the minimum sample size for the study was 194. However, 200 was taken as a sample size for this study.

Data Collection and Analysis

A structured questionnaire was developed to assess the awareness of Tharu adults on mental illness. The research instrument consisted of two parts - socio-demographic information of respondents (i.e. age, sex, marital status, educational status, occupation, and religion) and questions related to mental health awareness. Pretesting of the questionnaire was conducted in 10% of the sample size which was conducted in Kawasoti Municipality of Nawalpur district. Collected data were analyzed by using descriptive statistical methods where the researcher calculated mean, standard deviation, percentage, and frequency. Chi-square test was used for inferential statistics.

Data Analysis and Result

This section presents the results obtained from the study. Descriptive statistics (such as frequency, percentage, mean and standard deviation) were used to describe the socio-demographic variables and awareness regarding mental illness. A Chi-square test was performed to identify the association between the respondent's awareness regarding mental illness.

Socio-demographic Characteristics of the Respondents

For this study age, sex, occupation, education, income, and religion (as in Table 1) are taken as socio-demographic variables. This study found that nearly one-third (32.5%) of the respondents belonged to the age group of 21-30 years and 51 % were female and most of the respondents were Hindu (98%). Majorities (83%) of the respondents were married and 56% were living in a joint family. Among the total respondents, 71.5% could read and write and among them, 45.5 % studied up to secondary level. As Benti et al (2016) poor perceptions were common among the elderly, less educated, private workers, those unable to access mental health information, and those with no family history of mental illness. A similar experience was observed in Australia as Povey et al. (2016) argued tribes experience much higher rates of psychological distress compared with non-indigenous Australians. Therefore, there is a great need in creating awareness of mental illness and focus should be given to the people with low socioeconomic status and poor education to eradicate the negative attitude of people (Santhiya et al., 2016).

Table 1: Respondents' Socio-demographic Characteristics (n=200)

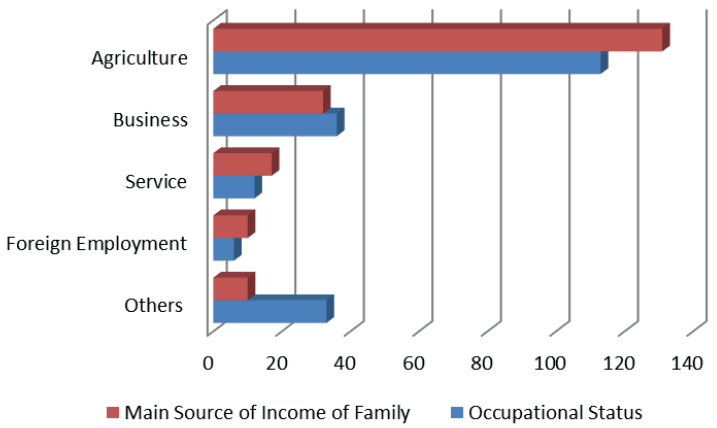
Characteristics	Number	Percentage
Age groups		
21-30	65	32.5
31-40	56	28.0
41-50	39	19.5
51-60	40	20.0
		Mean =37.95 years, SD =12.01years

Gender		
Male	98	49.0
Female	102	51.0
Marital Status		
Married	166	83.0
Unmarried	25	12.5
Widow/widower	9	4.50
Types of Family		
Nuclear	88	44.0
Joint	112	56.0
Religion		
Hinduism	196	98.0
Christianity	4	2.0
Literacy Status		
Can read and write	143	71.5
Cannot read and write	57	28.5
Level of Education (n=143)		
Primary	**22**	**15.3**
Lower Secondary	20	14.0
Secondary	65	45.5
Higher Secondary	25	17.5
Bachelor	11	7.7

Income Related Characteristics of the Respondents

Regarding the occupation, more than half of the respondents (56.5%) were involved in agriculture and 65.5% of respondents' main source of income was agriculture (Figure 1). One-fifth of respondents (20.5%) had food sufficiency for less than 6 months in a year from their main source of income. Respondents' main source of receiving information regarding mental illness was a personal experience (63%) and media (40%) and 73% of respondents met with mentally ill people. It indicates that the socio-economic condition of the Tharu community is based on agriculture and they are not well educated. Singh et al. (2013) found that adults residing in the urban community have more knowledge (33.6%) than adults of a rural community (26.9%).

Figure 1: Respondents' Income Related Characteristics



Source of Receiving Information Regarding Mental Illness

Figure 2 illustrates that almost all respondents received some information about mental illness, among them the major source of information was from experience through family and society (63%) followed by mass media (40%), neighbors/relatives (37%), health personnel (9.5%) and training (0.5%). Respondents agreed that almost all (100%) had easy access to health facilities and there was no availability of any kinds of mental health project in their locality. Similar findings were observed in Risal (2011) which mentioned relatively low levels of awareness about mental disorders in Nepal. In Ethiopia, 37.3% had a poor perception of mental illness, and lack of mental health information was found to be associated with poor perception of mental illness (Benti et al., 2016). As Singh et al. (2013) suggested, the development of information booklet and various mass media helps to enhance adult's attitude towards mental illness.

Figure 2: Respondents' Source of Receiving Information Regarding Mental Illness

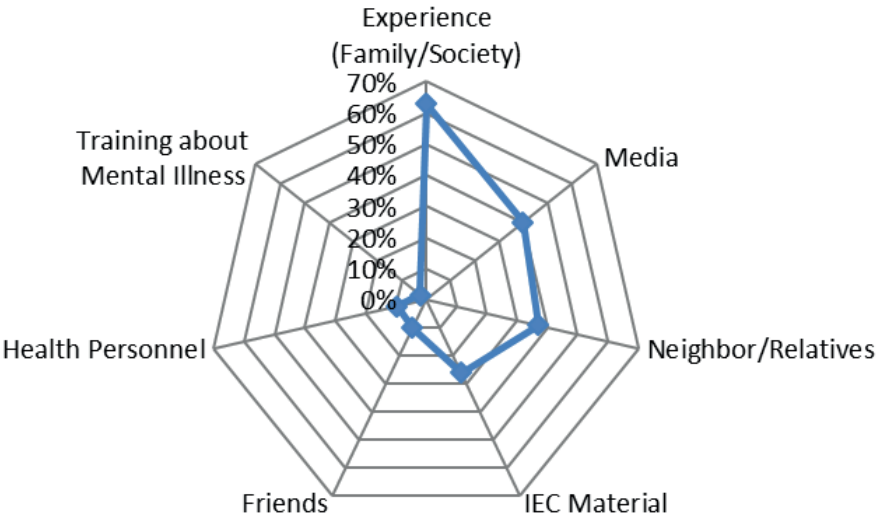
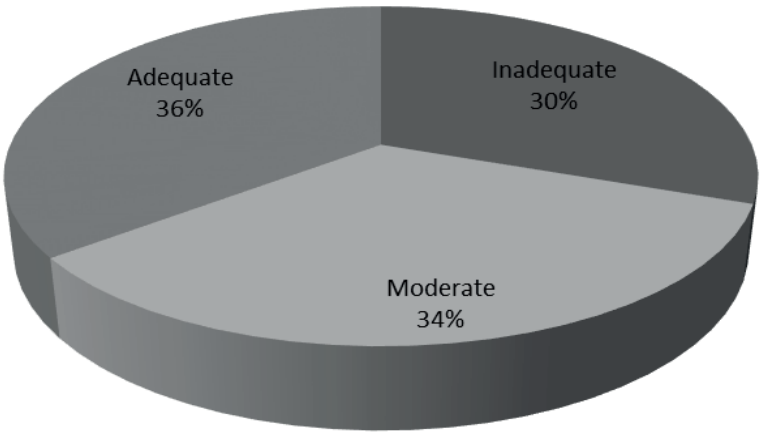


Figure 3. Respondents' Level of Awareness on Mental Illness



Awareness of Mental Illness

Talking about the level of awareness of respondents, 35.5 % had adequate awareness of mental illness whereas 34 % had moderate awareness, and 30.5 % of respondents had inadequate awareness of mental illness (Figure 3). This finding is contradictory to the study done in Puducherry of India among the general community population by Santhiya et al. (2016), which showed that 50% had adequate knowledge, 35.5% had moderately adequate knowledge and 14.5 % had adequate knowledge regarding mental illness. Similarly, in other studies Santhiya et al (2016) found that that 14.5 % had inadequate knowledge, 35.5% had moderate knowledge and 50% had adequate knowledge regarding mental illness. Yongsi (2015) and Ganesh (2011) also concluded that knowledge of mental illness among the general population was quite poor (32.6 %).

Association of Respondents' Level of Awareness on Mental Illness

Table 2 indicates that the level of awareness of mental illness is statistically significant with the age of respondents ($p<0.000$), gender (0.030), marital status (0.045), education status (0.000), and occupation status (0.004). Younger age group, male respondents and married had higher awareness level, similarly, educated people and people involving besides agriculture like service, business, and foreign employment had higher awareness level. Similar findings were observed in another cross-sectional study done in Pokhara, Nepal by Parajuli et al. (2015) where the level of knowledge was statistically significant with the educational status and occupation of respondents ($p<0.05$). Singh et al. (2013) found a positive correlation between knowledge and attitude towards mental illness and health in an urban and rural community. In this regard, Benti et al. (2016) emphasized the requirement of mental health education on possible causes, treatment, options, and possible outcomes of treatment to the community.

Table 2: Level of Awareness on Mental Illness by Selected Demographic Variables

Variable	Level of Mental Health Awareness			Total	Chi-square (p-value)
	Inadequate	Moderate	Adequate		
Age (Completed years)					
21 – 40	22(18.18%)	41(33.88%)	58(47.94%)	121 (100%)	0.000
41 – 60	36(45.57%)	12(15.19%)	31(39.24%)	79 (100%)	
Gender					
Male	22(22.44%)	38(38.78%)	38(38.78%)	98 (100%)	0.030
Female	39(38.24%)	30(29.41%)	33(32.35%)	102 (100%)	
Marital Status					
Unmarried	2(8.00%)	8(32%)	15(60.00%)	25 (100%)	0.045
Married	56(44.80%)	45(25.71%)	74(42.29)	175 (100%)	
Literacy Status					
Can read and write	23(16.08%)	40(27.97%)	80(55.95%)	143 (100%)	0.000
Can't read and write	35(61.40%)	13(22.81%)	9 (15.79%)	57 (100%)	
Occupation Status					
Agriculture	41(36.61%)	32(28.57%)	39(34.82%)	112 (100%)	0.004
Others*	17(19.32%)	21(23.86%)	50(56.82%)	88 (100%)	

**Others occupation status indicates business, service, labor, foreign employment.*

For the way out, Yongsi (2015) suggested the need for a strong emphasis on education to increase mental health awareness. Similarly, Ganesh (2011) suggested the need for a strong emphasis on public education to increase mental health literacy among the general public to increase awareness and positive attitude of people towards mental illness. In the Nepalese context, Risal (2011) observed a shortage of mental health professionals and opined that primary health care should remain the single largest sector for mental health care in low and middle-income countries like Nepal.

Conclusion

The present study aimed at finding out the awareness of mental illness among adults of the Tharu community in the district of Nawalpur. A descriptive cross-sectional study design was used. Data was collected using a structured interview schedule among 200 participants residing in Madhyabindu Municipality. This study found that the majority of the Tharu people belong to joint family, their socioeconomic status is mainly based on agriculture and they are relatively less educated. Concerning the level of awareness, 35.5% of the respondents had an adequate level of awareness on mental illness whereas 34 % had moderate awareness and 30.5 % of respondents had inadequate awareness of the mental illness. The study concludes that Tharu adults have an adequate level of awareness regarding mental illness. The awareness level of Tharu adults tends to vary according to age, sex, education, occupation, and marital status. The findings of the study could be used by a mental health organization to plan and implement mental health-related awareness programs, especially for the indigenous community. The study is not free from limitations, such as it only dealt with limited indigenous people (only Tharu) from a few wards of middle Terai of Nepal. Thus, it can only be generalized revealing the similar socioeconomic context of other Nepalese settings.

Conflict of Interest

Author had no conflict of interest while preparing this paper.

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