



Rapid Mental Health and Psychosocial Support Situational Assessment Services, Identified Needs, and Recommendations following the April and May 2015 Earthquakes in Nepal



May 22, 2015

1. Goals

The primary goal of this rapid mental health and psychosocial support (MHPSS) situational assessment was to obtain an understanding of existing services and identified needs following the earthquake that occurred on April 25, 2015. Towards the end of the assessment period, on May 12, 2015, another earthquake struck, exacerbating the MHPSS needs of the population. The results will inform the program design of International Medical Corps' (IMC) MHPSS initiatives to address existing gaps in services. Data collection focused on assessing the availability, quality and accessibility of existing mental health and psychosocial support services, as well as community-based components of mental health and wellbeing amongst populations affected by the earthquakes.

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2. Methodology

The rapid MHPSS situational analysis was conducted by IMC's Emergency Mental Health and Psychosocial Support Coordinator for Nepal (Claire Whitney) from 27 April - 19 May 2015 as a component of a multi-sectoral assessment carried out by the IMC Emergency Response Team (ERT). The assessment tools were adapted from the UNHCR/WHO publication (2012), "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises".

A desk review of current policy documents included:

- Nepal earthquake sitreps and reports (e.g. UNRCO, OCHA, WHO):
<http://www.humanitarianresponse.info/operations/nepal>

- Nepal’s National Mental Health Policy (1997): <http://www.nepalmentalhealth.org/banner/2.html>
- WHO-AIMS Report on Mental Health in Nepal (2006): http://www.who.int/mental_health/evidence/nepal_who_aims_report.pdf
- “Mental Health Care in Nepal: Current Situation and Challenges for Development of a District Mental Health Care Plan” (2015; Luitel, Nagendra et al): <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4331482>
- “A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal” (2012; Government of Nepal, Office of the Prime Minister and Council of Ministers): <http://asiafoundation.org/resources/pdfs/OPMCMGECUGBVRResearchFinal.pdf>

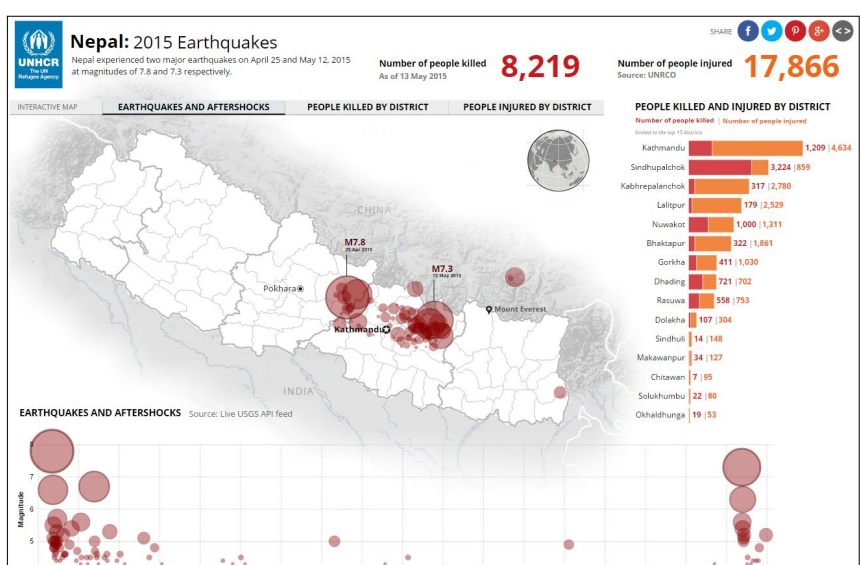
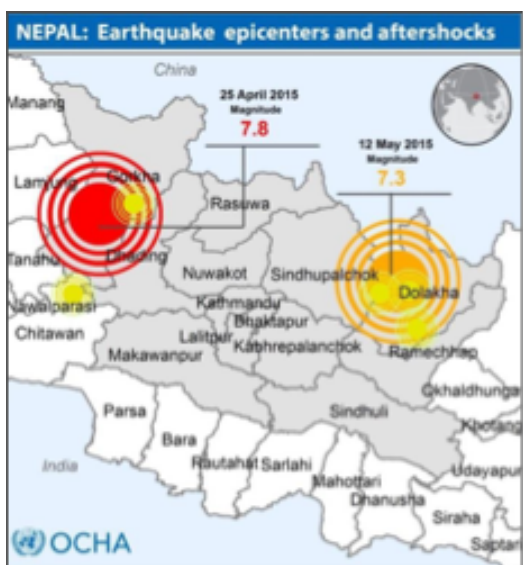
Interviews, Focus Group Discussions, and Site Visits:

MHPSS assessment data was collected from discussions with key informants (e.g. the Director of the Mental Hospital in Kathmandu, the Chief Medical Superintendent of the Gorkha District Hospital, the WHO Regional Advisor for Mental Health in SEARO Region) and with international organizations working on MHPSS in Nepal; as well as from PSS and MH coordination meetings in Kathmandu. Field visits were conducted to the affected districts of Gorkha and Dhading, and 5 focus group discussions were held with community members. In Gorkha, where the epicenter of the earthquake was, there were 4 focus group discussions/psychoeducation sessions held in two villages in Sirdibas VDC (144 participants were reached, with nearly equal representation of males and females, and an age range of 16-60). In Dhading, a focus group discussion was held in Dhading Besi, which included some displaced from other VDCs (23 participants, 14 male and 9 female, with age range of 20-70).

3. Background and Context

3.1 Nepal Earthquakes

On April 25, 2015, a M7.8 earthquake struck Nepal. Over 4.2 million were affected, 8,477 dead, 17,866 injured, 2.8 million displaced, and 5,429 houses damaged. On May 12, 2015, a M7.3 earthquake struck, causing 156 fatalities and 1,926 injuries. The total number of mortalities to date is 8,633. Dozens of districts were affected, of which 11 were highlighted as priorities; IMC’s two assigned districts are Dhading and Gorkha.



3.2 Mental Health Policies and Strategies in Nepal

Nepal has a National Mental Health Policy, which was adopted in 1997. The policy mentions several policy components and sub-strategies, including a) availability and accessibility of mental health services through integration with general health care, b) strengthening human resources through mental health training (for generalists and specialists), c) formulating legislation to protect the rights of people with mental illness, d) mental health awareness at the community level. The policy also includes a plan of action with assigned responsibilities and actions at all level (central, regional, district). However, the policy's framework has not yet been implemented, a division of Mental Health has not been created, and the government's budgetary allocation for mental health is extremely limited (less than 1% of the health budget). There has been discussion about revisiting the policy and advocating for its implementation to build and strengthen mental health services and capacity, subsequent to the earthquakes. Additionally, advocacy-based organizations such as Nepal Mental Health Foundation and KOSHISH have had ongoing efforts to move mental health forward at the national level. Treatment of major mental illness and substance abuse is primarily limited to the capital (Kathmandu) and select urban areas.

Nepal also has a "Contingency Plan for Mental Health and Psychosocial Support (NEPAL)" which has been published in 2009 by the MHPSS working group. This plan is based on the global IASC (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which have also be translated into Nepali. The contingency plan outlines key points and actions from the guidelines relevant to Nepal and has been endorsed by various local and international organizations working in Nepal.

4. Assessment Results

4.1 MHPSS Coordination and Assessments

There is a Psychosocial Support (PSS) working group coordinated by UNICEF, which developed out of the Protection Cluster. There is also a Mental Health (MH) working group coordinated by WHO, which developed out of the Health Cluster. Discussions have been held to propose merging the two into an MHPSS working group. Both groups have initiated a mapping of actors and current/intended services, using a simple 4Ws table that is updated regularly. Rapid assessments are being completed by IMC, LWS, and MSF. As of yet, there is minimal coordination for crosscutting themes within health, protection, and nutrition sectors.

4.2 Mental health care access

There is sufficient access to inpatient and outpatient mental health care in Kathmandu, including basic PSS/case management support services, counseling/psychotherapy, and inpatient/outpatient psychiatry services provided by NGOs such as the Centre for Mental Health and Counselling (CMC), KOSHISH, Center for Victims of Torture (CVICT), Kopila, Maryknoll, and the Mental Hospital. Nationwide, there are approximately 0.22 psychiatrists and 0.06 psychologists per 100,000 population,¹ mostly centered in the capital; which is below the global WHO recommendations of 22.3 mental health professionals per 100,000 population in low-

¹ "Mental Health Care in Nepal: Current Situation and Challenges for Development of a District Mental Health Care Plan" (2015; Luitel, Nagendra et al) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4331482>

income countries.² There are 18 outpatient mental health facilities available, 3-day treatment facilities, and 17 community-based inpatient psychiatry facilities in addition to the mental hospital in Kathmandu, but no separate facilities for children and adolescents.³ There is very limited access to mental health care outside of Kathmandu; the majority of health care facilities across Nepal do not have any MHPSS services. Psychological support is a notable gap, although some of the countryside towns have local NGOs providing basic PSS support. Access to psychotropic medications varies dramatically. In cities and larger towns, they are more widely available; in most of the countryside, there is limited or no access to psychotropics. Psychotropics on the national level list of essential medications that are free of charge and should be available at all health facilities include: antipsychotics (Chlorpromazine), tranquilizers (Diazepam), benzodiazepines (Alprazolam; Diazepam). Antiepileptics (Phenobarbitone, Carbamazepine) are available and free of charge as well. However, not all health facilities have these medications, and alternate psychotropics require purchase, and can be costly.

There is an initiative to improve access to MHPSS services, led by the Programme for Improving Mental Health Care (PRIME) consortium, being implemented in Chitwan District by TPO Nepal, in collaboration with HealthNet TPO and with support from the Ministry of Health.

4.3 Mental Health Services and Psychosocial Activities in Target Affected Areas

In Gorkha and Dhading, short-term psychosocial services are available in the central part of each district via local NGOs; however, there are no MHPSS services available in the countryside and remote villages, where MHPSS concerns are the most pronounced, and services the most needed.

- In Gorkha, a local NGO (Centre for Mental Health and Counseling, CMC) provides periodic, short-term psychosocial support for those in need. There are no psychiatric services available in the district. An assessment at Gorkha District Hospital showed health staff are not trained in mental illness and emotional distress; hospitals/clinics do not have access to psychotropic medications. The nearest outpatient and inpatient psychiatry service providers are in Chitwan (Chitwan Medical College, Department of Psychiatry) and Pokhara (BG Hospital, private psychiatric hospital) (approximately 2-2.5 hours by road). Regarding basic psychosocial support for children, both Save the Children and Good Neighbor International intend to set up Child-Friendly Spaces.
- In Dhading, two local NGOs (CMC and Integrated Community Development Campaign) provide periodic, short-term psychosocial support. According to key informants, hospitals/clinics do not have medical staff trained in mental illness and emotional distress, and psychotropic medications are not available. Outpatient psychiatric services have been provided on a monthly basis by a mobile mental health team at a roadside hospital, coordinated by the Mental Hospital in Kathmandu. After the earthquake, the Mental Hospital arranged for psychiatry services to be available via a mental health tent attached to the district hospital, which intends on providing services there for at least one month. The nearest inpatient psychiatry facility is the mental hospital in Kathmandu which was not damaged or affected by the earthquake but is difficult to reach (>2 hours by road). Regarding basic psychosocial support for children, both Save the Children and World Education intend to set up Child-Friendly Spaces.

² "The mental health workforce gap in low- and middle-income countries: a needs-based approach" (2010; Bruckner, Tim et al) <http://www.who.int/bulletin/volumes/89/3/10-082784/en>

³ WHO-AIMS Report on Mental Health in Nepal (2006):
http://www.who.int/mental_health/evidence/nepal_who_aims_report.pdf

4.4 Current problems and stressors among earthquake-affected populations

During field visits to affected areas in Gorkha and Dhading, key informants and focus groups were asked about current problems and stressors affecting people in their community. The results are shown below. It is essential to note that while there are similar stressors identified by various communities within these districts, the most-affected communities expressed much more dire need for basic services, and appear to have more pronounced psychosocial distress.

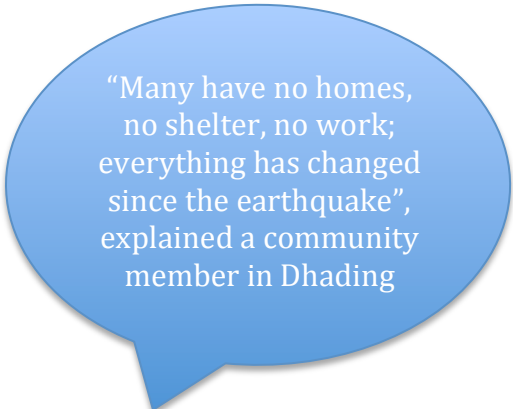
Stressors Related to Basic Needs	Stressors Related to Livelihood	Stressors Related to Social Needs	Psychosocial Distress
<ul style="list-style-type: none"> • Shelter (e.g. lack of tents and inability to rebuild homes; monsoon season approaching) • Physical Health and WASH (e.g. illness due to hygiene and sanitation concerns) • Food and Nutrition (e.g. food insecurity and inadequate food aid in remote areas) • Clothing and blankets in remote villages 	<ul style="list-style-type: none"> • Livelihoods and livestock lost during the earthquake and landslides • No source of income and resulting stress of providing for the family 	<ul style="list-style-type: none"> • Loss of social support systems (e.g. family or loved ones deceased, or missing) • Separation of loved ones (e.g. family separation due to displacement or medical evacuation to other areas) 	<ul style="list-style-type: none"> • Loss and bereavement regarding loss of loved ones and belongings • Fear and anxiety (e.g. that another earthquake will occur; that they will not be able to protect loved ones; frightening aftershocks) • Sadness, hopelessness, and uncertainty about the future; difficulty imagining how to move on, especially with monsoon season approaching • Anger and irritability in reaction to stressors • Decreased sleep, appetite, and concentration, affecting participation/ completion of daily activities • Despair and suicide in a number of reported cases

Identified at-risk groups:

- Those who are injured
- Those whose family members/loved ones died
- Those who have become helpless/hopeless
- Those who are poor/marginalized
- The elderly and pregnant women

Ongoing stressors and problems (predating the earthquake):

- Poverty and related economic stressors
- Limited access to needed resources
- Domestic violence and other forms of gender-based violence
 - A national study on gender-based violence indicated that approximately half of women (48%) reported a lifetime experience with GBV, with over two thirds (69%) reporting psychological problems including fear, depression, and tension; this has been linked to significant rates of suicidal ideation (29%) and suicide attempts (4%) amongst GBV survivors.⁴
- Consequences following the armed conflict that ended in 2006, including deaths, disappearances, and human rights abuses
- Human trafficking
- Substance abuse (e.g. alcoholism)



“Many have no homes, no shelter, no work; everything has changed since the earthquake”, explained a community member in Dhading

⁴ “A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal” (2012; Government of Nepal, Office of the Prime Minister and Council of Ministers): <http://asiafoundation.org/resources/pdfs/OPMCMGECUGBVResearchFinal.pdf>

4.5 Prevalence of Mental, Neurological, and Behavioral problems

Data collected from a WHO study in 2006 captured the diagnostic breakdown of patients receiving psychiatric services: outpatient facilities treated anxiety related disorders (56%), mood disorders (21%), schizophrenia (12%), other disorders (6%) and substance abuse (4%). Community-based inpatient facilities treated anxiety related disorders (47%), mood disorders (26%), schizophrenia (14%), other disorders (10%), and substance abuse (3%). Mental hospitals treated schizophrenia (34%), mood disorders (21%), anxiety related disorders (15%), other disorders (26%), and substance abuse (4%).⁵ There is no data on mental health problems available as of yet from the affected areas. Rates of common mental disorders, such as anxiety disorders and depression, often double in the context of humanitarian emergencies from a baseline of about 10% to 20%; those with severe mental disorders (2-3%) are especially vulnerable in these contexts and require access to care.⁶ Primary health care centers are an important entry point for identification of those with mental health problems.

4.6 Local Concepts of Psychological Distress and Mental Illness, and Ways of Coping

Community members openly shared that they have observed others experiencing stress, grief, and potential depression following the initial earthquake. Key informants have reported that those experiencing psychosocial distress often experience somatization/physical complaints (e.g. tension, pain, gastric problems, dizziness); upon probing, there is generally a psychological/psychosocial underpinning. Community members and key informants identified the following psychological signs and symptoms in response to the earthquake: loss and grief/bereavement, fear/anxiety, sadness/crying, anger/irritability, uncertainty about the future, and hopelessness/despair, many of which have been linked to decreased appetite, difficulty sleeping, nightmares, difficulty completing daily activities, isolation, and suicide. It is important to note that suicide is illegal in Nepal, which likely prevents reports of suicidal ideation for crisis intervention. Additionally, suicide is believed to be the leading cause of death amongst women of reproductive age.⁷ Pertaining to mental illness, those in focus group discussions in target districts expressed their belief that mental illness cannot be found in their communities. This could be due to a number of reasons, including a lack of understanding of mental illness, as well as associated stigma. Identified methods of coping with distress include: social support, cultural and religious traditions, meditation, yoga, homeopathic treatments, and traditional healers (“witch doctors”).

Reports of distress among specific groups		
<p>Distress among Children</p> <ul style="list-style-type: none"> ○ Fear <p>What are community members doing to reduce the upset/ distress of children?</p> <ul style="list-style-type: none"> ○ Words of comfort; no need to worry; “be in open places” 	<p>Distress among Women</p> <ul style="list-style-type: none"> ○ “Many have no homes, no work, no shelter; everything has changed” ○ Lost their homes; need for shelter ○ For those with homes, fear of going inside ○ Difficulty accessing what is needed (e.g. hygiene) <p>What are community members doing to reduce the upset/ distress of women?</p> <ul style="list-style-type: none"> ○ Praying for help to make things better 	<p>Distress among Men</p> <p>Lost their homes; need for shelter</p> <ul style="list-style-type: none"> ○ Lost their livelihoods; need for work ○ Concern about how to save the family ○ Concern about how to access shelter or buy a home <p>Where do men who are upset/ distressed seek help?</p> <ul style="list-style-type: none"> ○ No ideas how to cope with these conditions ○ Without resources

⁵ WHO-AIMS Report on Mental Health in Nepal (2006): http://www.who.int/mental_health/evidence/nepal_who_aims_report.pdf

⁶ World Health Organization & United Nations High Commissioner for Refugees. *Assessing Mental Health and Psychological Needs and Resources: Toolkit for Major Humanitarian Settings*. Geneva: WHO, 2012.

⁷ Given the stigma associated with suicide, it is difficult to ascertain if this is factual; belief is widespread.

What kinds of mental health or stress-related problems do people have in this community?	What is the cause of this problem?	What is being done to help people with this problem?	What more could be done to help people with this problem?
Depression	Difficult life; many stressors; loss	No initiatives before the earthquake; now ad-hoc PSS support temporarily available	Availability of ongoing MHPSS services; capacity-building of medical staff to recognize emotional distress and mental illness; development of referral mechanisms
Fear/unease	Earthquake and ongoing tremors	Community-based support; ad-hoc PSS support temporarily available	
Alcoholism	Depression; addiction	No initiatives or services (nearest substance abuse treatment center is in Kathmandu)	
Domestic Violence	Aggressive behavior by partner or family member	Occasional police involvement; no services available	Availability of services/support for women; capacity-building of medical staff to be able to support/respond if needed and to refer to services for survivors of violence
Physical complaints (e.g. tension; gastric problems)	Emotional distress	Quick discussion from medical staff	Capacity-building of medical staff to recognize and address somatization of emotional distress; availability of support services

4.7 Actors Currently Active in MHPSS

All local and international organizations that have been providing MHPSS services in Nepal previously have mobilized to also provide support to earthquake-affected populations, in addition to the populations to whom they are providing ongoing support.⁸ The key local actors that have expanded their activities in the wake of the earthquake include TPO, CMC, CVICT, and the mental hospital; coordinated outreach has included roving MHPSS support as well as conducting trainings in Psychological First Aid (PFA) throughout affected districts. In addition, several organizations such as UNICEF, Save the Children, and others are organizing child-friendly spaces in affected districts. The table below shows current MHPSS activities and services in line with the IASC MHPSS intervention pyramid (see Table and Figure below).

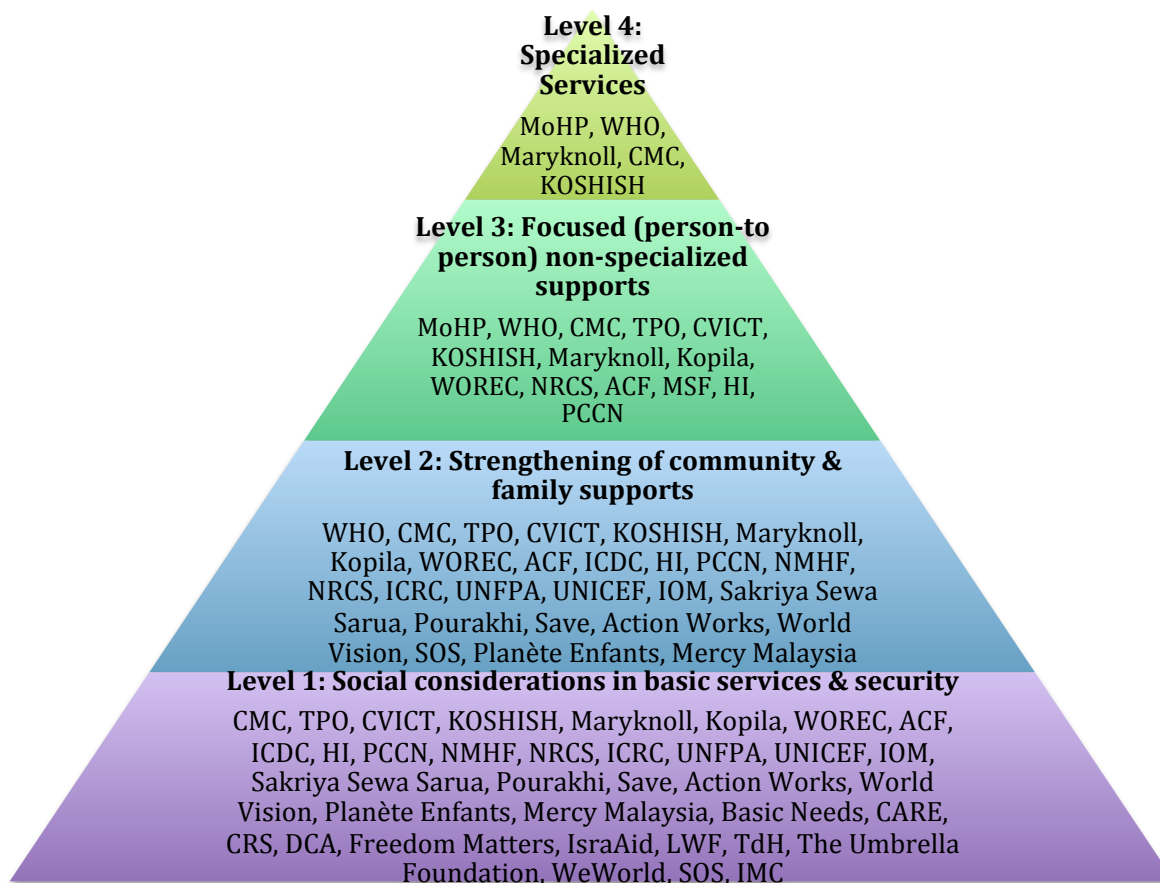
	Level 1: Social considerations in basic services & security	Level 2: Strengthening of community & family supports	Level 3: Focused (person-to person) non-specialized supports	Level 4: Specialized Services
<i>Local Actors</i>				
Centre for Mental Health & Counseling (CMC)	√	√	√	√
Center for Victims of Torture (CVICT)	√	√	√	

⁸ The MHPSS services and emergency outreach efforts continue to develop on a daily basis; the below information is based on all known active projects at the date of publication.

	Level 1: Social considerations in basic services & security	Level 2: Strengthening of community & family supports	Level 3: Focused (person-to person) non-specialized supports	Level 4: Specialized Services
Integrated Community Development Campaign (ICDC)	√	√		
Kopila	√	√	√	
KOSHISH	√	√	√	√
Maryknoll	√	√	√	√
MoHP/Mental Hospital (Kathmandu)			√	√
Nepal Mental Health Foundation (NMHF)	√	√		
Nepal Red Cross Society (NRCS)	√	√	√	
POURAKHI	√	√		
Sakriya Sewa Sarua	√			
Transcultural Psychosocial Organization (TPO)	√	√	√	
Women's Rehabilitation Center (WOREC)	√	√	√	
<i>International Actors</i>				
Action Contre la Faim (ACF)	√	√	√	
Action Works	√	√		
Basic Needs	√			
CARE	√			
Catholic Relief Services (CRS)	√			
Danish Church Aid (DCA)	√			
Freedom Matters	√			
Handicap International (HI)	√	√	√	
International Committee of the Red Cross (ICRC)	√	√		
International Medical Corps (IMC)	√			
International Organization of Migration (IOM)	√	√		
IsraAid	√			
Lutheran World Federation (LWF)	√			
Mercy Malaysia	√			
Médecins Sans Frontières (MSF) – Belgium			√	
Médecins Sans Frontières (MSF) – Spain			√	

	Level 1: Social considerations in basic services & security	Level 2: Strengthening of community & family supports	Level 3: Focused (person-to person) non-specialized supports	Level 4: Specialized Services
Post-Crisis Counseling Network (PCCN)		√		
PLAN	√			
Planète Enfants	√	√		
Save the Children	√	√		
SOS Children's Village (SOS)	√	√		
Terre des Hommes (TdH)				
The Umbrella Foundation				
United Nations Population Fund (UNFPA)	√	√	√	
United Nations Children's Fund (UNICEF)	√	√		
WeWorld	√			
World Health Organization (WHO)		√	√	√
World Vision	√	√		

Concentration of activities and organizations per level on the IASC MHPSS intervention pyramid



5. Summary and Recommendations

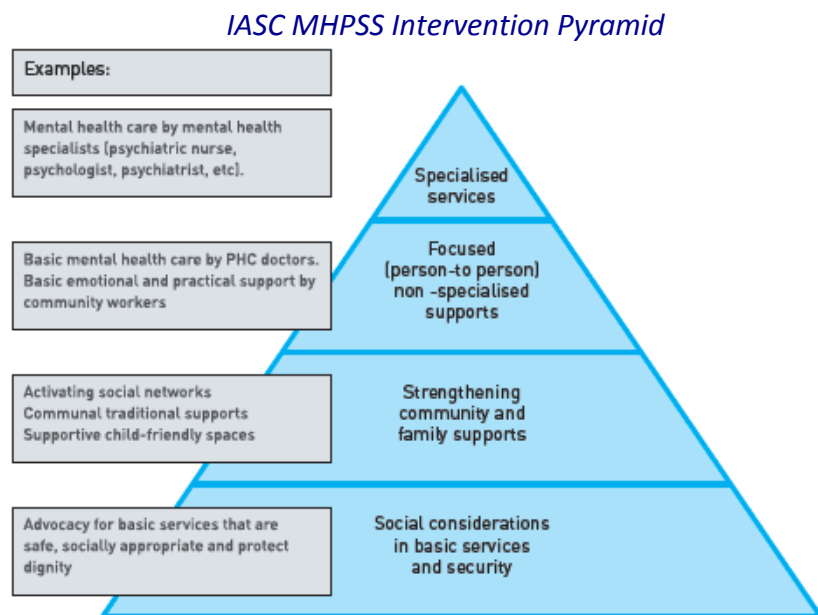
5.1 Summary

Prior to the earthquakes, Nepal was a recently stable country with some notable foundations of MHPSS support services, including a national mental health policy, comprehensive MHPSS services in the capital, and varying levels of MHPSS services in other urban and rural areas. However, the mental health policy has not been implemented, and there is a dearth of MHPSS services outside the capital (Kathmandu), especially in the areas of psychotherapy, inpatient and outpatient psychiatric care, and access to needed psychotropic medications. Nevertheless, key local actors and organizations have been making strides to increase access to and availability of MHPSS services.

In light of the earthquakes and resulting loss and displacement, there is an immediate need to ensure that those interacting with affected populations are trained in the provision of basic support and referrals (e.g. via training in Psychological First Aid). Furthermore, there is a significant and continued need to revisit the national mental health policy plan and to advocate for its implementation to ensure that mental health services are strengthened and decentralized, and that the majority of communities have sufficient access to all levels of care in mental health and psychosocial support.

5.2 Recommendations

Global standards outlined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings include recommendations on different levels of mental health and psychosocial intervention using a pyramid approach, with basic needs and social considerations at the foundation, and increasingly advanced services to the top with specialized mental health services. The following recommendations take each designated level of MHPSS services into account.



5.2.1 Improve the psychological wellbeing and recovery of the earthquake-affected population

In consideration of the multidimensional impact of the earthquake and resulting loss, displacement, psychosocial stressors, and psychological distress, significant efforts should be made to reach out to and support the communities that were affected. This is especially necessary given the remote locations of many affected villages and the widespread lack of basic services and support. Initiatives should be undertaken with local partners to organize outreach into these affected areas and help fill critical gaps in access to basic resources as well as other vital support services and to promote psychosocial support and wellbeing on individual, family, and community levels. Activities could range from trainings in Psychological First Aid to

group discussions on stress management and positive coping mechanisms, to activities that bring families and communities together, to strengthen social support systems. Several local NGOs have been coordinating responses; further collaboration is needed to ensure that all affected villages are reached and supported.

5.2.2 Improve the capacity of local organizations and actors to respond to MHPSS needs of the earthquake-affected population

The integration of MHPSS considerations and services as part of the emergency response could be further strengthened with local non-specialized actors, such as TPO, CMC, CVICT, Kopila, ICDC, and others who are conducting outreach to affected communities and offering psychosocial support and Psychological First Aid (PFA) trainings. Workshops could be offered on relevant components of the IASC Guidelines (which have already been translated and adapted to the Nepali context), PFA and ways of supporting positive coping mechanisms among affected populations. There is also a need to establish referral pathways among different organizations and service providers, which include referrals of people with mental health and psychosocial problems. At this time, IMC has already supported two LNGOs (ICDC and Kopila) in the provision of Psychological First Aid (PFA) trainings to community-based service providers such as community health workers, teachers, and other community service providers in Dhading and Kathmandu. IMC will continue to support PFA trainings, and will also organize a training of trainers for a collaborative cascade training plan with other NGOs.

5.2.3 Improve the coordination of mental health and psychosocial support services and activities

The IASC MHPSS Guidelines recommend a unified MHPSS coordination group to facilitate the communication and coordination between actors working on MHPSS, as well as to link activities and crosscutting initiatives with other sectors (e.g. health, protection, nutrition). Following the earthquake, two separate working groups were created; a PSS group developed out of the Protection Cluster, and a MH group developed out of the Health Cluster. The coordination of information and program planning would be greatly improved with a harmonized MHPSS working group; in the meantime, efforts should be undertaken to ensure there is sufficient communication and coordination between the two groups.

5.2.4 Improve access to mental health services by strengthening MHPSS service availability in the primary health care system

Global best practices delineated in the IASC Guidelines emphasize the benefits integrating MHPSS services into primary health care settings. The integration of mental health into general health care is also a goal outlined in the 1997 Nepal Mental Health Policy; there is an opportunity now to advocate for government implementation of this policy, as well as designation of an official MHPSS government representative. While some health care settings, including the mental hospital and hospitals offering psychiatric services, as well as a few district hospitals that had been selected and supported by LNGOs, have staff trained in MHPSS and have access to psychotropic medications, substantial efforts must be made to ensure that MHPSS services are decentralized and widely available in health facilities across the country, especially in more rural areas where communities were more affected by the earthquakes. The WHO has published mhGAP-Humanitarian Intervention Guidelines (mhGAP-HIG) that are aimed at general health care staff and provide clinical guidance on the pharmacological and psychosocial management of mental, neurological and substance use priority conditions. These guidelines and overall model of MH PHC integration may also be useful to consider in the Nepal context and some initial discussions about this are currently taking place.

5.2.5 Improve access to psychotropic medications and capacity of prescribers, especially in the primary health care system

According to the national health policy, all medications on the national essential drug list – which includes psychotropic medications (antipsychotics (Chlorpromazine), benzodiazepines (Alprazolam; Diazepam tablet and injections), Antiepileptics (Phenobarbitone, Carbamazepine)) – should be available and free of charge in all general health facilities. However, there are widespread reports that psychotropics are not available in a vast number of health care settings. Efforts must be undertaken to ensure the availability of psychotropic medications according to national guidelines and free of charge, and that general health staff who are authorized to prescribe receive the needed training in the identification and clinical management of patients with priority mental health and neurological conditions. Furthermore, advocacy should be taken to make additional psychotropic medications available in health care settings which are included on the WHO Essential Drug List and especially those that have been recommended for inclusion in the Interagency Emergency Health Kit (IEHK: Amitriptyline (tablets), haloperidol (tablets and injections), diazepam (tablets and injections), biperiden (tablets), and phenobarbital (tablets)).⁹

5.2.6 Advocate for MHPSS support considerations in long-term planning

In addition to immediate services and support for those affected by the earthquake, there should be ongoing advocacy for inclusion of MHPSS services in longer-term programming for these populations as they begin rebuilding their lives. Mental health and psychosocial considerations are a vital part of the recovery process. While access to MHPSS services may exist in more urban areas, there is a need to ensure that these services are available and accessible to those who are most in need of support. Recommendations include the following: 1) Support for awareness-raising campaigns on MHPSS considerations at the community level to help identify, refer, and support people with mental health and psychosocial problems; 2) Promote community-based psychosocial support initiatives, such as group and community-oriented discussions on wellbeing and positive coping mechanisms; 3) Provision of basic training and capacity-building for community-level workers in identification of people with mental health problems in order to provide basic psychosocial support and referrals to health/mental health facilities; 4) Address critical gaps in availability and affordability of psychotropic medications; 5) Ensure that the most vulnerable and in need have access to MHPSS services, in collaboration with national and international MHPSS actors, coordinated through the current Mental Health and Psychosocial Support working groups.

5.2.7 Advocate for training and capacity building of MHPSS staff in survivor-centered support and case management

Given the prevalence of gender-based violence in Nepal, it is essential that MHPSS service providers are trained in survivor-centered approaches, and are aware of referral pathways for GBV-focused services to ensure this information is shared with survivors.



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⁹ van Ommeren M, Barbui C, de Jong K, Dua T, Jones L, et al. (2011) If You Could Only Choose Five Psychotropic Medicines: Updating the Interagency Emergency Health Kit. PLoS Med 8(5): e1001030. doi:10.1371/journal.pmed.1001030