Editorial

OPEN ACCESS

Received: Feb 28, 2019

Accepted: May 18, 2019

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Conflict of Interest

No potential conflict of interest relevant to this
article was reported.

Author Contributions

Conceptualization: Jimba M. Formal analysis:
Fujimura MS. Investigation: Jimba M, Fujimura
MS, Dhital R. Supervision: Jimba M. Writing -
original draft: Jimba M, Fujimura MS, Dhital R.
Writing - review & editing: Jimba M, Sharma R,
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Mental health initiative after the 2015 disaster in Nepal

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ADVERSITIES OF NATURAL DISASTERS ON HEALTH SYSTEM

Natural disasters occur in many parts of the world, resulting in various geophysical, meteorological, and climatological events. According to the World Health Organization (WHO), these natural disasters kill about 90,000 people every year,¹ and the economic cost of these events is huge. The result from natural disasters, however, is not only the lost lives and assets. They are also detrimental to health systems by killing health workers, damaging health facilities, and transportation systems. Disasters also severely affect the mental health of the population affected.² The challenge to address mental health in a post disaster setting with a damaged health system is much higher in low- and middle-income countries (LMICs).³

BURDEN OF MENTAL HEALTH PROBLEMS IN LMICS

Globally, LMICs account for 80% of mental health problems and mental illnesses account for 8.8% of the total burden of disease in these countries.⁴ The key risk factors for mental health problems include poverty, social disparity, childhood adversity, and violence.⁵ These risk factors are typical challenges which people living in LMICs face daily, and subsequently their mental health worsens in the aftermath of disasters.

Despite such disease burden, in most LMICs, mental health remains a less prioritized area when it comes to health financing and resource allocations. For example, the mental health budget allocation is less than 1% of the national health budget in most low-income countries.^{6,7} Moreover, the existing allocation is focused only on the treatment. The preventive aspects of mental health are largely ignored, such as focusing on the communities, person-centered care, integrating mental health into the routine health care.⁷ A lack of proper mental health policy and established structure could also interfere with the timely response to mental health and psycho social support (MHPSS) in the communities after the disasters in LMICs.^{2,3}

REFORMS IN GLOBAL MENTAL HEALTH

Over the past decade, the global mental health community had consistently highlighted these gaps in mental health and advocated for reform of mental health policies worldwide.⁷ As a result, WHO launched a Mental Health Gap Action Program which focuses on scaling up the care for mental, neurological, and substance use disorders in LMICs.⁸ The WHO also launched a Comprehensive Mental Health Action Plan (2013–2020) which consists of broad targets of implementing interventions at different levels of communities to promote specialized care for mental health.⁹ The comprehensive action plan also emphasized the continuum of care covering the preventive, curative, rehabilitative, and re-integrative aspects of mental health.⁹

Built upon the advocacy and the action plans, the Sustainable Development Goals (SDG) also included mental health into its health-related goals.¹⁰ The SDG Goal 3 has set specific targets to address the existing gaps in mental health that focuses on “ensuring the healthy lives for all at all ages”. The SDG target 3.4 aims at “prevention, treatment, and promotion of mental health and wellbeing to reduce the premature mortality from non-communicable diseases by one third”.¹⁰ The mental health component is incorporated among other targets which highlight the universal access to quality care and essential medicines. Although the SDG targets have been successful to address the gaps in mental health care in LMICs, it still calls for a deeper understanding.⁷

NEW PUBLIC HEALTH NORM AFTER DISASTERS

The recent reforms in global mental health could have also played a role in improving the post-disaster responses on delivering MHPSS in LMICs. In spite of the devastation triggered by disasters, a new and improved public health norm can rise after the adverse events: preparing to mitigate disasters and rebuilding by design.¹¹ Effective post-disaster actions sometimes bring about a new change, leading to strengthened health systems.

As outlined in the WHO report ‘Building back better: sustainable mental health care after emergencies’, disasters can provide an opportunity to improve the mental health system of the country in the long run.¹² The report has provided the examples from different disaster-affected settings from LMIC such as Indonesia and Sri Lanka. Both countries lacked proper mental health policies prior to the 2004 Tsunami. However, both countries introduced new mental health initiatives after the disaster which proved to be successful and sustainable. For example, Indonesia has strengthened and expanded the primary mental health care services across different districts and still continues the expansion. In Sri Lanka, ever since a mental health policy reform was introduced, the community mental health workers were trained and their activities have been sustained till date.¹² The lessons from Nepal after the 2015 earthquake could provide an additional insight on how a new public health norm can arise after a disaster in LMICs.

NATURAL DISASTERS AND EARTHQUAKE IN NEPAL

Nepal is a low-income country that faces natural disasters such as flood, landslide, fires, and avalanche, which affects thousands of lives every year.¹³ The frequent natural disasters compounded with the lingering political instability from a decade long conflict

had detrimentally affected the health system in Nepal over the years.¹⁴ In April 2015, an earthquake with a magnitude of 7.8 struck Nepal near the capital where around 9,000 people died. Among 14 severely hit districts, 83.5% of 793 public health facilities were heavily damaged, while greatly affecting the health system at all levels.¹⁵ The government declared a state of emergency, calling on support for rescue and relief following the earthquake. In response, many organizations were quick to provide psychological first aid to the earthquake victims. However, the Ministry of Health and Population (MOHP) in Nepal had not yet properly implemented mental health policies and was not able to provide standard protocols for MHPSS immediately after the earthquake.¹⁶

MENTAL HEALTH SITUATION BEFORE THE 2015 EARTHQUAKE IN NEPAL

Prior to the 2015 earthquake, mental health had not received adequate attention in Nepal. Though the national mental health policy was first introduced in Nepal in 1996,¹⁷ it was not implemented properly. Since the dialogues on global mental health started worldwide, efforts were made to prioritize mental health at a national level in Nepal as well with the support and advocacies of the WHO and other non-government organizations (NGOs).¹⁸ The government of Nepal endorsed a multi-sectoral action plan for 2014 to 2020 on prevention and control of non-communicable diseases (NCDs) which also included mental health,¹⁹ however, it was not implemented properly. NGOs had played more prominent roles than the government in implementing MHPSS by adopting the best evidence-based practices.²⁰ NGOs also played a key role in developing a pool of frontline health workers trained in mental health and community psychosocial workers. However, prior to the earthquake, the activities introduced by NGOs had not been scaled up at a national level and was not sustainable, mainly due to the lack of commitment from the government.²⁰

Moreover, the country faced a severe shortage of mental health professionals with 0.22 psychiatrists and 0.06 psychologists per 100,000 population.²¹ Though major general hospitals and university teaching hospitals have a designated psychiatric and mental health unit within their institution in Nepal, the country has only one dedicated specialized government hospital exclusively providing mental health care service.²¹ This government mental health hospital faced a high flow of patients, inadequate human resources and insufficient funding which severely compromised the quality of care.

Prior to the 2015 earthquake, the post disaster MHPSS services were poorly coordinated in previous disasters such as landslides, flood, and civil war.²² The lack of a focal point for MHPSS or a mental health unit was identified as a barrier for coordinated and sustainable MHPSS responses in Nepal.²²

LESSONS FROM A POST-EARTHQUAKE NEPAL

Despite the lacking policy implementation and human resources, the process of improving mental health system has been accelerated after the 2015 Earthquake in Nepal. It happened partially after the 3rd World Conference on Disaster Risk Reduction in Sendai which took place a month prior to the Nepal's disaster.²³ The introduction of SDG in 2015 and the advocacy from the WHO and other NGOs also influenced its progress.

A recent study after the 2015 earthquake on post-earthquake MHPSS responses in Nepal suggested that the activities had extraordinarily improved the process of building mental health system in Nepal.²⁴ The funding for mental health from the government and NGOs increased remarkably after the earthquake which was almost non-existent previously. The MOHP, with the support from the WHO and other NGOs, helped in establishing a coordinated response and reporting systems for MHPSS. By following the Inter-agency Standing Committee (IASC) cluster approach, MHPSS was provided through a bottom-up approach, improving responses in the community levels to the specialized care. MHPSS was included in the comprehensive disaster response teams at all 14 severely affected districts in Nepal during the recovery period.²⁴

Immediately after the earthquake, the government had declared a state emergency and called for international and national support which helped in increasing the global attention as well as in resources to provide immediate MHPSS. The immediate disaster response after the earthquake followed the IASC guideline on cluster approach and included different areas such as basic support for nutrition, health, water and sanitation, and shelter, etc. Moreover, the immediate medical response was provided across the earthquake-affected regions of the county by over 150 international and national emergency medical teams, which also included around 20 MHPSS experts.²²

One month after the earthquake, in the early recovery phase, a mental health sub cluster was formed by the MOHP with the support from WHO. It provided the standard post-disaster MHPSS as outlined by the WHO and IASC and improved the coordination between different partner organizations providing MHPSS.²²

In the early recovery to late recovery phases, the key NGOs working in mental health helped in increasing the pool of primary health care providers trained in mental health treatment by two-fold.²⁴ These NGOs also worked together with the government to train the female community health volunteers and other volunteers at the grassroots level on psychological first aid, reaching out to thousands of people in the communities.²⁴ The comprehensive disaster response had also strengthened the health system by establishing a standard referral mechanism for specialized care, and enabling regular supervision of the MHPSS programs by the mental health professionals which were also in line with the SDG targets of reducing the gaps for mental health care.²⁴ Though some of the activities were initiated on an ad-hoc basis,²² the coordination improved gradually during the recovery period leading to some long-lasting impact on building the mental health system in Nepal.²⁴ Indeed, all actions were in line with the SDG targets of reducing the gaps for mental health care.

After the earthquake, in the rehabilitation and reconstruction phase, such efforts positively affected MOHP to establish a new mental health structure in a new federal republic of Nepal, under the NCDs and Mental Health Section in Epidemiology and Disease Control Division, Department of Health Services in 2018. The mental health section initiated the plans to introduce new policies related to prevention, treatment and rehabilitation, improving quality of care and logistics management of equipment and medicines, and strengthening research, monitoring, and evaluation for mental health, and among many others.²⁵ Moreover, the coordination between the NGOs and the government had been improved and the efforts were made to integrate mental health into the primary care. Efforts were also made by this newly formed initiative to establish and strengthen mental health units in the district level hospitals and allocate psychiatrists at provincial levels.

Although still in the initial phases, Nepal's holistic efforts in promoting mental health in a post-disaster period could be a model case for other resource-limited countries. As a resilient country, Nepal is now building a sustainable mental health foundation, and it sets a successful example that a new public health norm can surely take place amidst the adverse events.

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