



March 2020

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Recommended Citation

Seale-Feldman, Aidan. 2020. Historicizing the Emergence of Global Mental Health in Nepal (1950-2019). *HIMALAYA* 39(2).

Available at: <https://digitalcommons.macalester.edu/himalaya/vol39/iss2/7>



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Acknowledgements

The author thanks Dannah Dennis, Erik Linstrum, and Kedar Marhatta for reading and discussing early drafts of this text and two anonymous reviewers who provided insightful comments. Special thanks to David Citrin for editorial support, Christopher Anderson and Joan Duffy at Yale Divinity School Library Special Collections, and Joel Hafvenstein, Executive Director of The United Mission to Nepal, for granting permission to reproduce the images included in this article. This research was made possible through support from the Wenner-Gren Foundation, the UCLA Center for the Study of Women, the UCLA International Institute, and the Foundation for Psychocultural Research.

Historicizing the Emergence of Global Mental Health in Nepal, 1951-2019

Aidan Seale-Feldman

This article traces a genealogy of mental health governance in Nepal as it was constituted in and through an assemblage of historical events, local politics, personal relationships, and trends in the field of global health development. The relation between health development and local politics in Nepal is explored across four periods in the history of global health: 1) the early health development programs of disease eradication after the end of the Rana oligarchy (1951-1970); 2) the turn to primary health care during the Panchayat (1970-1990); 3) the rise of non-governmental organizations and the People's War (1990-2010); and 4) the return to health systems development in the post-conflict and post-earthquake period (2010-present). By drawing on a combination of archival research and a cross-disciplinary review of the literature on global mental health, this article tracks the changing projects of mental health development programs in Nepal over

the past century. In doing so, it becomes possible to observe the shifting trends in the problematization of mental health and the management of psychic life in Nepal from 1951 to the emergence of global mental health.

Keywords: critical global health, global mental health, psychiatry, development, Nepal.

पागल

जुर साथी म पागल !
यस्तै छ मेरो हाल ।

म शब्दलाई देख्दछु !
दृश्यलाई सुन्दछु !
बासनालाई संबाद लनिछु ।
आकाशभन्दा पातालका कुरालाई छुन्छु ।
ती कुरा,
जसको अस्तित्व लोक मान्दैन
जसको आकार संसार जान्दैन !

Mad

Surely, my friend, I am mad,
that's exactly what I am!

I see sounds,
hear sights,
taste smells,
I touch things thinner than air,
things whose existence the world denies,
things whose shapes the world does not know.
*Laxshmiprasad Devkota*¹

A Poet in Ranchi

In 1939, the celebrated Nepali poet Laxshmiprasad Devkota had a nervous breakdown (Rubin 1980). He travelled to the Ranchi mental asylum in Jharkhand, India, where he stayed for four months. His poem *Pagal* (Mad), one of the most famous in the Nepali language, was written after this experience. Why did Devkota go to an asylum in India? This question serves as a point of departure from which to begin to sketch the changing therapeutic landscape of the Nepal Himalayas over the past century. What is the history of mental health governance in Nepal? How did Nepal become a site for the production of knowledge for the field of global mental health, providing data, case studies, and evidence, and serving as a node through which key experts within the network of global mental health have circulated? This story, I argue, is as closely linked to historical events and local politics in Nepal as it is to shifting trends in the field of global health development.

In this article, I describe the emergence of global mental health in Nepal in light of a longer history of health development since the 1950s. In doing so, I focus on four periods in the history of global health as outlined by historian Randall Packard (2016), and show how each played out in relation to health development and local politics in Nepal: 1) the early health development programs of disease eradication after the end of the Rana oligarchy (1951-1970); 2) the turn

to primary health care during the Panchayat (1970-1990); 3) the rise of non-governmental organizations (NGOs) after the People's War (1990-2010); and 4) the return to health systems development in the post-conflict and post-disaster period (2010-present). The impact of the changing history of health governance on experiences of affliction remains beyond the scope of this historical essay, the aim of which is to outline the shifting trends in the problematization of mental health in Nepal from 1951 to 2019.

The Early Health Development Programs: Modernization, Cold War Politics, and the Eradication of Infectious Disease (1951-1970)

From its emergence as a nation state in 1768 through the end of the Rana oligarchy in the 1950s, Nepal was never colonized. The possibility of maintaining sovereignty was, in part, due to the alliance that Jung Bahadur Rana, then Prime Minister, cultivated with the British East India Company. In exchange for territory lost during the earlier Anglo-Nepali War (1814-1816), Rana provided soldiers and personally led an army to aid the British in the suppression of the Sepoy Rebellion, a massive Indian revolt against British rule, in 1857. The outcome of this uprising, which the British won, transferred colonial power from the British East India Company to the British government. The alliance with the British continued throughout the century of Rana rule. In return, the British Raj formally recognized Nepal as a sovereign nation in 1923 (Joshi and Rose 1966). Along with the absence of British colonization in Nepal was the absence of colonial infrastructure; the infrastructures of colonial medicine such as disease eradication programs, hospitals, and mental asylums that were developed in India were not present in Nepal.

Part of the apparatus of colonialism, both in the British and French empires, included psychiatry (Ernst 1991; Keller 2001; Linstrum 2016). In India, mental asylums were established by the nineteenth century, with segregated institutions for British colonists and Indians (Ernst 1991). In 1925, the Ranchi asylum was opened. It was not only the largest mental hospital in India, but also the largest psychiatric institution in South Asia at that time, serving the Indian population in the regions of Bengal, Bihar, and Orissa (Ernst 2013). In part because of the absence of colonial psychiatry in Nepal, Devkota, the cosmopolitan Nepali poet who peppered his poetry with references to Greek goddesses and English literature, sought out psychiatric treatment at Ranchi in the Indian state of Jharkhand. Up to the 1950s, those few who chose to seek psychiatric treatment would, like Devkota, have had to travel across the border to an asylum in India. Others would have sought treatment

from *dhami-jhakris/matras* (male or female shamans), *gurus* (spiritual masters), pilgrimage, and through Ayurvedic and Tibetan medicine (Cameron 2019; Craig 2012; Desjarlais 1992; Hitchcock and Jones 1976). These healing modalities continue to be utilized today alongside and in tandem with Western biomedical treatment (Harper 2014; Subedi 2018).

The development of biomedical infrastructure in Nepal began in the 1950s. In 1951, after over one hundred years of sovereign rule that some have likened to a form of internal colonization (Regmi 1978; Whelpton 2005), the Rana oligarchy was overthrown by Nepali Congress opposition groups that had been assembling across the border in India. Soon after, Nepal opened its borders to foreigners and international development projects for the first time. The 1950's thus marked an era of massive international development aid to the newly democratic Himalayan nation (Mihaly 1965). The focus of these early development programs were road, irrigation, factory, and school construction, as well as establishing scholarships for higher education study abroad. In the field of health, the emphasis was on hospital construction and disease eradication programs, particularly malaria. Mental health and psychiatry were absent from this first phase of international development.

The vast foreign interest in Nepal's development must be placed in a broader context of the post-World War II period, when a number of European countries including the Soviet Union, as well as the United States (US) and Japan, began to radically expand foreign aid abroad in the wake of decolonization and independence movements in Asia and Africa and the emergence of a new Cold-War politics. Of the many countries that provided development aid to Nepal in the 1950s, the U.S. was the first and largest donor. In 1951, the US created the United States Operations Mission (USOM), which later became the United States Agency for International Development (USAID). The initiative was part of President Harry Truman's 'Point IV' program, a turning point in post-war American foreign policy that created financial support for foreign development projects. From the American perspective, supporting development in Nepal, located between China and India, was not merely a benevolent act but also served strategic, anti-communist purposes (Mihaly 1965: 2).

During this same period, the World Federation for Mental Health (WFMH) was founded in London, with the explicit goal of promoting modernization in the British ex-colonies by identifying psychological impediments among the population. As historian Erik Linstrum notes, a highly influential manual entitled *Cultural Patterns and Technical Change* (1953), drafted by a committee led by anthropologist Margaret Mead, "recommended easing the frustrations

of rapid change by turning to group therapy, encouraging the subjects of development to share their difficulties with each other" (2016: 204). Despite the conceptualization of the management of psychic life as key to successful economic development and modernization, such interventions were limited to the British commonwealth, of which Nepal was not part. Instead, the earliest foreign health interventions in Nepal were shaped by an American-dominated landscape of development informed by a new Cold War politics that purposefully used rapid result 'impact-programs,' such as DDT-based malaria eradication projects, to build popular support for US-approved local governments as opposed to communist-leaning political parties (Packard 2016: 113). The use of DDT to combat malaria and demonstrate the power of US technical assistance was also the case in newly democratic Nepal, which, due to its proximity to communist China, was seen as a region of "strategic urgency" (Robertson 2018: 914). Alongside such programs, financial support was provided to build hospital infrastructure, which was not only useful but also served as a powerful symbol of modernity (Packard 2016: 232). As Judith Justice notes in her early study of foreign aid and health development in Nepal, the 1950s-1970s was defined by a "focus on disease-specific programs and expansion of Kathmandu hospital-based services" (Justice 1986: 9). Mental health and psychiatry were left out of these early interventions, which were focused on immunizations, sterilizations, smallpox, malaria, tuberculosis, and leprosy (Justice 1986: 156).

In 1959, eight years after the end of the Rana era, Nepal's first democratic elections were held. However, the newly elected government stayed in power only one year. In 1960, King Mahendra, a descendent of the original Shah monarchy, staged a coup and seized power. Citing the lack of social services and need for development and modernization, King Mahendra argued that a return to monarchy rule was in the interest of the nation, because the elected ministry "did not pay any attention to the miserable and poverty-stricken conditions of the people" (Adhikary 1995: 12). In 1962, King Mahendra drafted a new constitution, officially banning all political parties, and called the new form of government Panchayat 'guided democracy' (Ibid 1995). This marked the beginning of a thirty-year period of direct rule.

According to King Mahendra, an overarching goal of the Panchayat system was to "create a partyless healthy, clean, and advanced society" (Joshi and Rose 1966: 406). This objective was in line with the projects of foreign aid that continued in Nepal during this time, and the Panchayat period was thus also an era of rapid modernization and bureaucratization in the sectors of education, telecom-

munications, infrastructure, and health. Modernization in the field of health meant that over the thirty years that stretched between the 1950s to the late 1970s, there was a major growth of health services, including the creation of the Ministry of Health, the construction of seventy hospitals, 550 health posts, and the training of 450 biomedical doctors (Justice 1986: 9). In this way, development in Nepal also facilitated the rapid expansion of bureaucratic state power in the sphere of health (c.f., Ferguson 1994).

Much of the early development of psychiatric services in Nepal was sponsored not by foreign programs, but by His Majesty's Government. These initiatives were led by foreign-educated Nepalis during the Panchayat period and tended toward an asylum-based treatment approach. In 1961, Dr. Bishnu Prasad Sharma established the first psychiatric out-patient department at Bir Hospital. Throughout the 1960s and 1970s, additional hospital-based psychiatric services slowly increased, including the 1975 inauguration of a psychiatric ward in the Military Hospital, run by foreign-trained psychiatrist Dr. R.B. Kunwar. At least until the 1980s, those suffering from mental illness who were either abandoned or charged with crimes were confined to the psychiatric prison of Dhulikhel Jail, also known as *Pagal Khana* (mad-house) (Pach 1990: 110).²

A Turn to Primary Health Care: Alma-Ata, Community Mental Health, and the United Mission to Nepal (1970-1990)

The 1970s saw the emergence of a new paradigm for international health within the WHO. This was a shift from 'vertical' programs of disease eradication and population control, to 'horizontal' programs for primary health care, including, for the first time, mental health. In 1978, the Alma-Ata Declaration was inaugurated at the International Conference on Primary Health Care, in which health was defined as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity," and framed as "a fundamental human right."³ Reflecting the Alma-Ata goals, the 1970s–1980s ushered in a new period of donor-funded projects for the development of primary health care in the global South (Packard 2016: 227). This was also true in the case of Nepal, which created the Integrated Community Health Program (ICHP) during this time. With guidance from the WHO, the government expanded health services to rural districts, constructed health posts, and trained health workers at a range of levels in curative and preventative medicine, family planning, communicable disease surveillance, nutrition, and oral rehydration (Justice 1986: 59).

Some of the most well-known critiques of Primary Health Care development programs are based on anthropological studies of Nepal, where attempts to incorporate community participation often failed due to the disconnect between Kathmandu-based health bureaucrats and the desires and realities of rural communities (e.g., Justice 1986; Pigg 1996; Stone 1986). As Linda Stone (1986) demonstrated, health workers trained in the Primary Health Care model promoted health education over curative services, negatively viewed 'local culture' as an obstacle to health care, and espoused the importance of 'community participation,' yet never involved communities in the development of program content and scope. Likewise, Stacy Pigg (1996) described the ways in which development projects situated 'modern medicine' in opposition to 'traditional healing,' thus producing biomedicine as a powerful symbol of modernity through which claims to one's own status as *bikasit* (developed) were made. These issues would soon pose a challenge to community mental health programs, for whom 'traditional healing' would be framed as a problem to be corrected.

In the 1980s, in the context of the new Primary Health Care movement, mental health was seen as a field ripe for potential development at an international level. In an article analyzing the state of the field in the 1980s, the director of the WHO's Division of Mental Health noted that a "concern about the social and psychological consequences of rapid economic growth," in developing countries, including rapid urbanization, poverty, hunger, and apathy, had generated increasing support and desire for mental health programs and psychiatric services among government leaders (Sartorius 1983: 1). While this discourse can be traced back to earlier discussions among members of the WFMH during the 1950s, the idea that economic development and modernization were leading causes of mental illness galvanized support among donor countries for the development of mental health services at a global scale.

In the 1980s, mental health first appeared as an area of intervention for foreign development projects in Nepal. Inspired by the Alma-Ata declaration, the WHO's (1975) report on the Organization of Mental Health Services in Developing Countries, and the success of community mental health programs in Bangalore and Chandigarh, India, the United Mission to Nepal (UMN) decided to promote mental health as a new area of development (Foyle 1987). UMN is a United Kingdom-based Christian missionary organization that has been leading multi-sector development projects in the country since the early 1950s, and is well-known in Nepal for their decades of work in the health sector and hospital construction (Harper 2014).

In 1984, UMN launched the Mental Health Project, the first donor-funded mental health development program in Nepal. The project, which ran from 1984-2003, involved the development of mental health services at multiple levels, including supporting psychiatric services and training, a drug abuse prevention program, a program in the Dhulikhel Jail, and a community mental health project. The 'Community Mental Health Project' was first piloted in Lalitpur, and later expanded to four districts over a period of fourteen years (Acland 2002). The project was initially justified by a study undertaken in 1983 (Shrestha, Pach, and Rimal 1983) which found that over ten percent of people in a village south of Kathmandu were suffering from mental illness (Acland 2002). In addition to programs focused on the Nepali population, the Mental Health Project also included mental health and counseling services for foreign aid workers living in Nepal.

Archival research in the UMN Archives held in the Yale Divinity School Special Collections reveals further details on the motivation, scope, design, and activities of the early Mental Health Project. Ideas for the program were largely inspired by the model developed in the Community Mental Health Unit of the Department of Psychiatry at the National Institute of Mental Health and Neuro-Sciences (NIMHANS) Bangalore (Hickingbotham and Wright n.d.). Following this approach, mental health services were integrated into already existing community health services run by UMN at the health-post level. Documents from the 1980s indicate a priority placed on diagnosing "psychosis, epilepsy, depression, neurosis, [and] mental retardation" (Hickingbotham and Wright n.d.). The program also provided a number of psychotropic medications to participating health posts, including Chlorpromazine 50mg (anti-psychotic), Trihexyphenidyl 2mg (anti-spasmodic), Amitriptyline 25mg (anti-depressant), and Anatensol injections 25mg (anti-psychotic), in addition to Phenobarbitone 30mg (anti-epileptic), which was already available (Wright n.d.). Additionally, health workers received a ten-day training and on-the-job supervision by UMN psychiatrist Dr. Christine Wright and her senior Health Assistant. These health workers were trained in psychiatric diagnosis and treatment of mental illness, drawing on materials such as a Nepali language manual on mental health developed by UMN, as well as illustrated cards and hypothetical case descriptions (see Figures 1-4) which were used as diagnostic aids (Foyle 1987).

In these early years, psychiatric knowledge was explicitly positioned against 'non-medical help' from healers, priests, witchdoctors and visits to pilgrimage sites. As seen in

Figure 1, health workers were encouraged to provide education to community leaders about psychiatry, with the ultimate aim of replacing 'traditional beliefs and practices.' Underlined and in bold lettering, the training card states: "Your repeated efforts to give correct information would lead to change."

At the same time the identification of *bhut-pret laagne* (ghost and spirit possession), particularly among women, was acknowledged as a 'local' manifestation of 'hysteria,' which was conceptualized as a universal mental illness. The description of hysteria, now referred to as 'conversion disorder,' in the first edition of UMN's Nepali language *Manual of Mental Health for Community Health Workers* (1988), provides a brief glimpse into how cross-cultural translation was approached in this early project (United Mission to Nepal 1988). According to the *Manual*, *chopne rog* (being taken over by an external force), *deuta aeko* (god possession), and *bhut lageko* (ghost affliction) were recognized as possible local manifestations of hysterical symptoms. The explanation of the disorder, which focuses on life in the *ghar* (the husband's home), and a new bride's fear and inability to explain her problems when faced with 'new things,' is given a similarly Nepali slant. Here, a Euro-American psychiatric diagnostic model was re-contextualized for a Nepali cultural context in which high-caste Hindu kinship arrangements and resulting family conflicts became the new normative framework. Yet, at its core, the psychosomatic mechanism behind hysteria, in which unspoken conflicts are converted from the mind to the body, is assumed to be universal (Seale-Feldman 2019).

According to archival documents, the community mental health program was well-received during its inaugural year. In a handwritten draft of a report assessing the program, Dr. David Hickingbotham, one of two UMN psychiatrists running the program, wrote:

The project staff have been greatly encouraged by many aspects of this pilot study. The level of interest of the H.P. [Health Post] staff has been high, the community acceptance of the project has been widespread and the appreciation of the services provided, by the patients and their families has been heartfelt (Hickingbotham 1985).

Dr. Christine Wright, the other UMN psychiatrist, outlined the need for the program to be replicated in other districts before it could be recommended for extension into government health posts. She summed up the overall project in terms that referred to the Christian roots of the organization:



मानसिक रोगका विभिन्न लक्षण FEATURES OF MENTAL DISORDERS



H 030401/0027



Figure 1. The first card in a set of training cards that were used in UMN's Mental Health Project to aid health workers in the psychiatric diagnosis and treatment of mental disorders. Each image depicted here corresponds to an individual training card with further information.

(United Mission to Nepal:
H-03.04.01/0027, n.d.)

मानसिक रोगका विभिन्न लक्षण

अनेक स्वास्थ्य समस्या (रोग) मध्ये मानसिक रोगको कारण र उपचार सम्बन्धमा सर्वसाधारण जनतालाई ज्यादै धेरै मात्र थाहा छ । यसैकारण यसको उपचाको लागि मानिसहरू भ्रष्टाचार, तन्त्र मन्त्र, धामी भौकी र देवी देवताको सहारामा जान्छन् । यस्ता उपचारका विधिहरू अपनाउनाले बिरामीको समुचित उपचार गर्न ढिलो भै बिरामीको स्वास्थ्यमा हानि पर्न सक्छ । औषधि विज्ञान तथा आधुनिक उपचार पद्धतिको क्षेत्रमा भएका महत्वपूर्ण वैज्ञानिक प्रगतिको फलस्वरूप अब लगभग सबैसो मानसिक रोगको सस्त्रो, सुलभ, सस्तो र प्रभावकारी उपचार उपलब्ध छ । हामी सबैलाई थाहा भएको कुरो हो कि जुनसुकै रोगको पनि सुरुमै रोग निदान र उपचार अति महत्वपूर्ण हुन्छ ।

हागो समानमा धेरै आगो देसि चल्दै आएका परम्परागत चलन र वि्रवास धेरै छन् । छोटो समयमा नै फिक्कलाई बदल्न सफल छैन । शिक्षित व्यक्तिहरू तथा समानका अनुवाहकको पनि यो परम्परामा गहिरो आस्था छ । सही जानकारी दिलाउने तपाईंको निरन्तर प्रयासले यसमा परिवर्तन ल्याउन सक्छ ।

शाब्द तपाईंलाई आफ्नो कार्यक्षेत्रमा पर्ने गाउँको मानसिक रोगीको बारेमा पहिले देखि नै जानकारी छ होला । भविष्यमा कामको शिलशिलामा अरु केही मानसिक रोगी संग पनि तपाईंको भेट हुनेछ । साथै तपाईंलाई थाहा नभएका रोगीहरूको बारेमा पनि सोधलोक्य गर्नु आवश्यक छ । यो शैक्षिक सामग्रीले मानसिक रोगबाट पीडित रोगीलाई चिन् महत् गर्छ । त्यसको अतिरिक्त तपाईंले बताउन चाहेका मानसिक रोगका लक्षणहरू दर्खिलाई छर्लङ्ग गर्न पनि यसले मद्दत गर्नेछ ।

यो शैक्षिक सामग्रीको उपयोग निम्न उद्देश्यको लागि गर्न सकिन्छ:-

- समानका मानसिक रोगी पत्ता लगाउन ।
- मानसिक रोगीका परिवारलाई मानसिक रोगको बारेमा शिक्षा दिन ।
- विशिष्ट व्यक्तिहरू जस्तै: शिक्षक, प्राध्यापक, सामाजिक कार्यकर्ता, स्थानीय अनुवा, गाउँ विकास समितिका पदाधिकारीहरू र अन्य शिक्षित युवाहरूमा मानसिक रोग प्रति सही दृष्टिकोण विकास गर्न ।
- विभिन्न प्रशिक्षण शिविरको शिलशिलामा गाउँका अनुवा तथा सम्पूर्ण जनतालाई मानसिक रोगको बारेमा शिक्षित गराउन ।

H 030401/0027

FEATURES OF MENTAL DISORDERS

Of the many health problems (illness) the causes and treatment of mental illness are poorly understood by the general public. As a result people seek non-medical help from healers, priests, witch-doctor and often visit places of pilgrimage for help. People using these methods often can harm the patient by delaying proper treatment. Following major scientific development in the field of psychotropic drugs and modern techniques of treatment, simple, effective and inexpensive methods of treatment are now available for almost all the mental disorders. **As you know, in all illnesses early recognition and treatment is most important.**

The traditional beliefs and practices in our community have been there for many years. They can not be replaced in a short time. In addition, these are firmly held by the educated and the leaders of the community. **Your repeated efforts to give the correct information would lead to change.**

You may already know of some patients with mental illnesses in the villages where you are working. You are likely to see some of them in future during your work. In addition, you must actively enquire about similar patients who may not be known to you. This aid will help you in identifying people with mental illnesses. Moreover, the pictures would **facilitate the viewers to visualize the features of mental disorders you are communicating.**

This visual aid can be used for the following purposes:

- to identify mentally ill persons in the community,
- to educate the family members of the mentally ill,
- to sensitize important people like local leaders, teachers, educated youth, and members of other service agencies on various mental disorders, and
- to educate the general public and other village leaders during the Orientation Training Camps.

Figure 2. Back side of the first card in the set describing the possible uses of this visual aid.

(United Mission to Nepal:
H-03.04.01/0027, n.d.)



Figure 3. Front side of a UMN training card depicting an image of a woman suffering from ghosts, spirits, and black magic and receiving treatment from a *dhimi-jhakri* (shamanic healer).

(United Mission to Nepal: H-03.04.01/0027, n.d.)

जसमा भूतप्रेत वा आत्माको प्रभाव छ

- * केही दिनदेखि सावित्रीको व्यवहार सामान्य छैन ।
- * एक धामी भौँक्रीबाट उनको उपचार भैरहेको छ ।
- * उनको परिवारले उनमा भूतप्रेत या कुनै आत्मा चढेको छ भन्ने सोच्छन् ।
- * जादु-टुना वा भूतप्रेत लागेर भएको ठानिने रोगीको व्यवहार मानसिक रोगको लक्षण पनि हुन सक्छ ।

WHO IS POSSESSED BY BHUTAS OR SPIRITS

- * Savitri has been behaving abnormally in recent times.
- * She is being treated by a Jhankri (Witch - Doctor).
- * The family members believe that she is influenced by evil spirits.
- * Behavior attributed to black magic or evil spirits can be due to mental illness.

Figure 4. Back side of the UMN training card depicted in Figure 3 describing the overlap between behavior attributed to ghosts, spirits, and black magic, and forms of mental illness.

(United Mission to Nepal: H-03.04.01/0027, n.d.)

Has been steady and encouraging in most areas of the work, and I am often aware of the rightness of the timing for our project here in Nepal. There are many openings, and I feel, a real role at present for us in stimulating the development of services, and interest in alternative models of care. I am grateful to God for his guidance in so many new situations. Inevitably language continues to be a frustration, as do the realities of community health care—hours spent waiting for transport, walking etc! (Wright 1986).⁴

In a study of the first 15 months of the Lalitpur pilot program, Drs. Wright and Hickingbotham reported that 210 individuals (51.4% male and 48.6% female) were treated across four health posts and one mental health clinic. Patients were labeled with the diagnostic categories used in the program: psychosis, depression, epilepsy, 'mental retardation,' and 'other mental illness,' under which anxiety and 'hysteria' were included. Of the patients seen, epilepsy was the most common diagnosis, accounting for 31.9% of people, followed by psychosis (24.3%), depression (17.6%), 'other mental illness,' (16.6%) and 'mental retardation' (9.5%) (Wright and Hickingbotham 1987). The program's diagnostic terminology—in which anxiety is relegated to the category of 'other mental illness' alongside 'hysteria'—reveals the historical contingency and shifting nature of psychiatric diagnostic categories (c.f., Young 1997).

The extent of collaboration with Nepali psychiatrists in this program was initially limited to the Lagankhel Mental Hospital, which had been established in the mid-1980s and was used as a patient referral site for the program. Wright mentions her frustration at spending time in the mental hospital but not being allowed to see patients, which indicates possible tensions between foreign and Nepali psychiatrists. As she wrote in the first annual report under a heading that outlined the project's work at the Lagankhel Mental Hospital where she spent two and a half days per week: "Frustrating!—to not have clinical responsibility for patients myself" (Wright 1986). The division between Nepali psychiatry on the one hand, and donor-funded NGO-run mental health programs on the other, would continue to characterize the therapeutic landscape in Nepal for the next thirty years.

A description of the project was eventually included in the *World Mental Health Casebook* as an exemplary case study (Cohen, Kleinman, and Saraceno 2002). Out of this project the Centre for Mental Health and Counselling (CMC) was established, which later became an independent, Nepali-run NGO in 2003. According to Sarah Acland, the final program director of the Mental Health Project, "the

promotion of mental health and mental health legislation in Nepal owes a great deal to the work of religious foundations" (Acland 2002: 127). By the late 1980s, UMN had added a psychiatric out-patient clinic to their hospital in Tansen and had begun to introduce a new language of mental illness (Harper 2014: 83). In 1996, with guidance from UMN, the Nepal Mental Health Policy was drafted, calling for the creation of a mental health department within the Ministry of Health (Acland 2002). Yet, although they laid the foundation, UMN was ultimately not able to accomplish the full incorporation of mental health services at the primary care level or the creation of a mental health department in the Ministry of Health.

The Rise of NGOs: Trauma, The People's War, and NGOs for Mental Health and Counseling (1990-2010)

The 1990s marked a period of intense political conflict and transformation in Nepal. Pressure for democracy had been building over a period of thirty years, during which time King Mahendra had ruled the nation without allowing political representation. In 1990, a coalition of banned-political parties began the First People's Movement, drawing widespread participation throughout Nepali society. Meanwhile, a new political party had been gathering strength in the villages of the mid-western hills. Inspired by the tactical strategies, rural focus, and anti-imperialist philosophy of Mao Zedong, they called themselves Maoists. At first, the political parties in the capital of Kathmandu paid little attention to the growing Maoist cells. In 1996, the Maoists submitted a letter to the Prime Minister, then a Nepali Congress leader. Listed in the document were forty demands and an ultimatum: if the demands were not met, the Maoists would launch an insurgency. The letter was ignored, and the Maoists declared war against the state (Adhikari 2014).

The struggle between the state and the Maoist People's Liberation Army was long and violent. By the end of the war, over 13,000 people, including civilians, had lost their lives. Many had been raped and tortured at the hands of both the Nepal Police and the Maoists, and others had disappeared. Maoists strategically used the hills to stage their battles, moving from village to village by night. By day, the Nepal Police would follow, tracking the Maoists and brutally punishing, often torturing, and even killing, anyone suspected of providing shelter to the Maoists (Pettigrew 2013). Maoists soon became known for recruiting children in their ranks as they moved through different villages. The fragmentation of village life during this period created deep rents of distrust between people, particularly in rural communities (ibid 2013). In the midst of this violence, human rights organizations began to pay close attention

to the situation, documenting cases of torture and killings and publishing them for national and international audiences (Thapa 2011).

Occurring simultaneously with the People's War was the influx of 100,000 ethnically Nepali Bhutanese refugees into Nepal, who were resettled in the Eastern district of Jhapa by the United Nations High Commissioner for Refugees (UNHCR). This influx during the 1990s, combined with the violence of the People's War that spanned for a decade from 1996-2006, drew a new breed of international interventions to Nepal. These were peace and conflict programs funded by development and UN agencies, and in the area of health, they were psychosocial interventions for conflict-affected communities, with a particular focus on healing trauma among victim groups, such as child soldiers. As Upadhaya and colleagues (2014, 114) write, "...the emergence of mental health NGOs started only after the 1990s with the numbers increasing during the ten years of the Maoist conflict (1996-2006)." The development of mental health NGOs in the 1990s also reflects the rapid growth of the NGO sector in Nepal after the first People's Movement (Rademacher and Tamang 1993), as well as the global explosion of NGOs during the 1990s that increasingly filled gaps in government services (Fisher 1997: 440).

The therapeutic activities that take place under the label of a 'psychosocial approach' are heterogenous and increasingly incorporated into a wide range of activities, from humanitarian interventions and gender-based violence prevention programs to economic and livelihood projects (Abramowitz 2014). Today, the psychosocial approach has been taken up by policy makers and public health practitioners as an umbrella term for the broad relationship between individual mental health, society, and cultural norms (Ibid 2014). The growth of mental health NGOs in Nepal was closely linked to the availability of donor funding for psychosocial support in humanitarian and conflict-affected settings focused on healing trauma, justified in the language of human rights, and motivated by the concept of re-building stability in societies affected by war from the ground up through the rehabilitation of individuals from specific victim groups, particularly women, children, and refugees. The argument for the necessity of psychosocial intervention in Nepal was supported through reference to rates of Post-Traumatic Stress Disorder (PTSD) in populations affected by violence and displaced by war (Kohrt et al. 2008; Ommeren et al. 2002; Shrestha et al. 1998; Tol et al. 2007). Key researchers from this period would soon become leading figures in the field of global mental health.

By the time the 2003-2004 UMN annual report for the Mental Health Program had been released, the discourse of mental health had changed significantly, and reference to the Maoist insurgency began to appear. Although the goals of incorporating mental health into the health care system remained, a list of activities under the heading 'Achievements' included an increased demand for "counseling and trauma counseling training and services," the publication of a bilingual Nepali-English *Trauma Counseling Manual*, and mentioned "posttrauma-debriefing sessions held on request, with internally displaced young people, school children and in UMN-project" (Archives of The United Mission to Nepal: H-0304 2004). Trauma had emerged as a powerful new discourse in mental health development in Nepal. This trauma turn was linked not only to the Maoist insurgency, but also to the rise of trauma and PTSD as key concepts in the expanding global field of psychosocial and psychiatric humanitarian intervention (Fassin and Rechtman 2009; Watters 2010; Young 1997). Subsequently, the globalization of PTSD and trauma diagnoses in the context of humanitarian interventions have been the focus of intense controversy and critique (Pupavac 2001; Summerfield 1999).

In 2017, a review I compiled of fifty-five past and present projects listed on the websites of three leading mental health NGOs in Nepal documents the shifting trends in donor-funded mental health and psychosocial support projects since the end of the Maoist insurgency. The majority of the early projects were directly related to providing psychosocial support to conflict-affected communities, and to aid in the reintegration of 'Children Associated with Armed Forces and Armed Groups.' Since then, foreign, donor-funded projects from a myriad of countries have continued to focus on providing psychosocial support to specific groups of people based on their victim status, including survivors of gender-based violence, women and children affected by HIV/AIDS, former child soldiers, women working in the 'entertainment sector,' migrants and their families, Bhutanese refugees, and, most recently, earthquake-affected communities (c.f., Luitel et al. 2015: 4).⁵ The emphasis on services for victim groups over health system development reflects a larger trend in global health that began to move away from the Primary Health Care model in the 1990s (Packard 2016).

Unlike the first efforts during the early years of the UMN community mental health program, in the early 2000s applied research on mental health and psychosocial support in Nepal drew directly on anthropological studies of development discourse, personhood, ethnopsychology, shamanism, and the phenomenology of illness and healing

in Nepal (e.g. Desjarlais 1992; McHugh 1989; Pigg 1996). These studies were used as points of departure to design a cross-cultural psychiatry in which universal diagnostic categories were correlated to Nepali ethnopsychology and symptomology in order to promote culturally-sensitive interventions (Kohrt and Harper 2008; Kohrt and Hruschka 2010; Kohrt et al. 2005). Following Kohrt and Harper's (2008) model, these interventions would ideally take place alongside other forms of biomedical, community, and 'traditional' healing, and would promote referral across modalities. One outcome of these programs has been the creation of a new language for communicating distress with the explicit aim of destigmatizing mental illness through the association of psychosocial counseling with care of the *man* (heart-mind) (Kohrt and Harper 2008). This conceptual work would serve as a foundation for the next phase in mental health development in Nepal—the emergence of global mental health.

A Return to Health Systems Development: Global Mental Health in Post-Conflict and Post-Disaster Nepal (2010-present)

In the 1990s, The World Bank began to frame mental health as a global problem worthy of investment with the publication of an agenda-setting report, *The World Development Report* (The World Bank 1993). This report introduced the concept of 'disability adjusted life years' (DALYs), the number of years lost to disability caused by illness, arrayed by country and by type of illness, as a way to measure the 'global burden of disease.' Building on this report was the publication of the highly influential *World Mental Health Report* in 1995, the first systematic global survey of suffering related to mental, social, and behavioral problems (Desjarlais et al. 1996). Here, mental wellbeing was framed both as a universal human right and an economic concern. According to this logic, by reducing the 'burden of disease' caused by mental illness it would become possible to increase economic productivity. The new framing of mental health in terms of economic loss indicated the extent to which neoliberal market ideologies had penetrated the field of global health (McMillen 2015: 187-188; Packard 2016: 285).

In 2007, *The Lancet* commissioned the first series on global mental health. The series formed the basis of the Movement for Global Mental Health (MGMH), an international network of researchers and institutions dedicated to scaling-up mental health services and strengthening health systems in the Global South (Lancet Global Mental Health Group 2007). The first paper in the series begins with the rallying cry, "No health without mental health" (Prince et al. 2007: 859), and signals a return to the Alma-Ata goals of

supporting the development of primary health care systems, with the inclusion of mental health. The argument is structured around findings from the 2005 WHO Global Burden of Disease Report, in which "about 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychosis" (Prince et al. 2007: 859). Within the category of non-communicable diseases, the report found neuropsychiatric disorders to be the leading cause of disability-adjusted life-years worldwide, accounting for 28% of all DALYs.

When the measure of Years Lived with Disability (YLD) is used (as opposed to DALYs), the situation looks far more dire, as the WHO 2005 report found that 31.7% of all YLDs were due to neuropsychiatric conditions, with depression as the leading contributor of disability worldwide. Drawing on these metrics, the authors of the global mental health series outline priorities for mental health development in 'low- and middle-income countries': the quality of health services must be improved, psychosocial interventions must be developed and evaluated for effectiveness, health care systems must be strengthened to include mental health care, and mental health awareness must be raised (Prince et al. 2007). Following the arguments made in the *World Mental Health Report* and the *Lancet* series in which mental health is framed as a major constraint to development and economic productivity, since 2016 The World Bank has emerged as a leading source of funding and technical support for the development of mental health systems in the global South (The World Bank and World Health Organization 2016).

Since the end of the Maoist insurgency, Nepal has become a node in the new Movement for Global Mental Health (MGMH). Not only have a number of influential researchers connected to the movement worked in Nepal since the 1990s, but beginning in 2011, Nepal was selected as a site for at least four major, multi-country, multi-year global mental health projects, all implemented by the NGO Trans-cultural Psychosocial Organization-Nepal (TPO-Nepal), including the 'Programme for Improving Mental Health Care (PRIME)' project, funded by the UK Department for International Development (DFID); the 'Emerging Mental Health Systems in Low and Middle Income Countries (EMERALD)' project, funded by the European Commission and led by Kings College London; the 'Mental Health Beyond Facilities' (mhBEF) project, funded by Grand Challenges Canada and led by Makerere University School of Public Health; and the 'Problem Management Plus (PM+)' project, funded by the WHO. Through these projects, Nepal has be-

come an exemplary site of experiment and production of knowledge for the evidence base of global mental health. For example, the PM+ intervention, which ran from 2016-2019, tested the efficacy of a five-session psychological intervention using a randomized control trial (RCT) (WHO 2016) Pilot testing of the intervention was also conducted in Pakistan and Kenya, and according to the implementing agency's website in Nepal, the outcome of the RCT in Nepal would determine whether WHO will release Group PM+ globally. As anthropologist Tatsuro Fujikura (1996) has shown through his research on the village development programs of the 1950s, this is not the first time Nepal has figured as a "development laboratory."

Conclusion

Following the 2015 earthquakes when humanitarian organizations flooded the country to provide psychosocial counselling for earthquake victims, there has been unprecedented attention paid to mental health in Nepal (Seale-Feldman and Upadhaya 2015). Recent research has outlined some of the major developments in the area of mental health in the post-disaster period, indicating the ways in which the disaster served to rapidly catalyze further efforts to develop the mental health system. For example, as Chase and colleagues (2018) note, additional psychotropic drugs have been added to the free drug list and the government has created a budget for decentralized mental health care for the first time, although the integration of services has been largely limited to the earthquake-affected districts. The government has also revised the mental health policy and created positions for a mental health focal point in the WHO Country Office and the Primary Health Care Revitalization Division. The expansion of psychiatry in Nepal via Nepali and foreign development programs has also introduced new ways of conceptualizing affliction and new approaches to healing. Yet, the extent to which these conceptualizations are changing embodied experiences of affliction and suffering remains an open question.

By tracing the ways in which the therapeutic landscape of the Himalayas has changed over the past century, this article has aimed to provide an historical account of how mental health emerged as a vital new area of development. By reading contemporary developments in mental health governance in Nepal through a historical lens, it becomes possible to observe the ways in which health development in Nepal, including the recent emergence of global mental health, has consistently reflected trends in the broader field of global health from the 1950s to the present. Left out of this story of global health development is the ex-

pansion of psychiatric clinics in the private sector, which have occurred outside of the networks of the Movement for Global Mental Health (MGMH). One unexpected finding suggested by this research has been the consistent presence of Nepal as an important site in the production of knowledge for the field of global health and now global mental health, providing data, case studies, and evidence, and serving as a node through which experts within the network of global mental health have circulated. These observations suggest rich areas for further research.

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The author thanks Dannah Dennis, Erik Linstrum, and Kedar Marhatta for reading and discussing early drafts of this text and two anonymous reviewers who provided insightful comments. Special thanks to David Citrin for editorial support, Christopher Anderson and Joan Duffy at Yale Divinity School Library Special Collections, and Joel Hafvenstein, Executive Director of The United Mission to Nepal, for granting permission to reproduce the images included in this article. This research was made possible through support from the Wenner-Gren Foundation, the UCLA Center for the Study of Women, the UCLA International Institute, and the Foundation for Psychocultural Research.

Endnotes

1. English translation by Michael Hutt (Hutt 1991: 53).
2. Alfred Pach notes in his unpublished dissertation that there was a growing demand for psychiatric care in Kathmandu during the 1980s (Pach 1990: 108).
3. “The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (UNICEF and World Health Organization 1978).
4. With the exception of this mention of God, there is no indication in the archive that a Christian ideology directly influenced the design of services or that psychiatric care was used to spread Christianity.
5. Supporting agencies have included DFID, Terre des Hommes, UNICEF, UNHCR, Save the Children, USAID, Helvetas/SDC, UN Women, Physicians for Social Responsibility (Finland), Tear Australia, Himal Partner, and FELM.

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