Why are so many Nepali women killing themselves? A review of key issues

Abstract

For decades the maternal mortality in Nepal was the lead cause of death among women, with serious improvements in the maternal mortality ratio in the twentieth century the second most common cause has become more prominent. Suicide is now one of the leading causes of death for women of a reproductive age in Nepal.

This scoping review brings together the key available literature to identify the causes of suicide among women in Nepal. Published and unpublished studies and the grey literature published on women and suicide related to Nepal between 2000 and 2014 were searched and included in this review.This review suggested a number of explanations for high rate of suicide among women including: partner violence, alcoholism and polygamy, the culture of silence, early age marriage and prolonged child bearing and dependency on men for financial security.

This paper highlights some challenges and suggests ways forward in the improvement of mental health in Nepal.

Keywords: Mental health, Suicide, Stigma, violence and abuse

Introduction:

Mental health remains a neglected issue by many low-income countries and was not included in the Millennium Development Goals (MDGs). The MDGs are seen by many as the stepping stone to better health and development in low and middle-income countries [1].However, over the past couple of years, there has been a greater global recognition of its significance and, consequently, calls have been made for its inclusion in the post-2015 sustainable development goals [2]. Mental ill health is increasingly recognised as an important public health concern in low-income countries. Policies surrounding healthcare have often focused on the physical wellbeing of a patient without considering their psychological health. This is despite studies showing that mental health problems account for 14% of the global burden of disease[3].

Over 800,000 people die by suicide every year or every 40 seconds a person dies by suicide somewhere in the world [4]. For every successful suicide there are many more people who attempt suicide and fail. Significantly, a prior suicide attempt is the single most important risk factor for suicide in the general population. Research has shown the importance of the interplay between biological, psychological, social, environmental and cultural factors in determining suicidal behaviours [4].

In Nepal "mental health receives insignificant attention" at all levels of society [5] from the government, the media to the general public. This is reflected in the limited provision of resources towards mental healthcare. Although there are no definite national statistics on the prevalence of mental disorders in the country, one recent study indicated 37.5% prevalence in rural communities [6]. Although this indicates mental health as a significant issue, less than 1% of the health expenditure in Nepal is allocated to mental health [7]. There is still no national mental health programme or a division specialised in the Ministry of

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Health to implement the national health policy that was formulated in 2006 [8]. The Government of Nepal has attempted to include mental health services as a basic primary health care component. However, it still remains inaccessible to most of the population at primary care level [8]. There is only one psychiatric hospital which is located in capital, and therefore inaccessible to most of the rural population. Additionally, mental health illness and those affected by it are still highly stigmatised [9]. Moreover; there are few trained health workers to deal with mental health problems in Nepal. Only 2% of medical and nursing training is dedicated to mental health, and most qualified doctors and nurses work in the cities [10]. There are only 32 psychiatrists and 68 psychiatric nurses for the whole country, all based in urban psychiatric units [10,11]. Very few referrals to higher levels of care are made from rural primary health centres and health posts [10,11], and health workers in such units generally have had no mental health training.

There is a wealth of literature investigating the link between mental illness and suicide risk, suggesting, for example that 90% of suicide cases are related to mental health problems such as depression and alcohol abuse [12]. Women of reproductive age suffer the highest rates of suicide and mental health problems in Nepal [13-15]. The number of suicides within this group has increased from 22 per 100,000 in 1998 to 28 per 100,000 in 2008.Suicide is now the leading causes of death for women of a reproductive age in Nepal [12].

This article aims to increase awareness of the public health significance of suicide and suicide attempts, to make suicide prevention a higher priority on the public health agenda and develop comprehensive suicide prevention strategies in Nepal. Therefore, this article explores (a) the pattern and cause of suicide among women; (b) the range of explanations of why women of reproductive age have high levels of suicide; (c) how suicide effects family, friends and the wider community; and (d) recommendations for future policies and practice to improve mental health in Nepal.

Methods

This scoping review includes published and unpublished studies reported between 1994 and 2014 and other reports related to Nepal. The sources searched to identify studies included electronic databases such as Medline, CINAHL, Science Direct, and Scopus. WHO webpages and the Nepal Ministry of Health& Population web pages were also searched. The resulting papers were only read for key explanation for the high female suicide rate not detailed appraisal was conducted for this scoping study.

Key Findings

Profile of sufferers

There is a gender difference in suicide rates in Nepal. For women the most at risk group is those aged between 10 to 24 years, whereas for men it is those over the age of 35 [12]. There are higher rates of suicide in unmarried women compared to those who are married [12], this is likely to be because of the social pressure on women to marry. Therefore, if women do not achieve this, emotions of shame and insecurity maybe felt as a husband provides an income and house for the women. Castes and ethnic inequalities are still common in Nepal. This leads to social exclusion for individuals in lower castes and ethnic groups, making them high-risk groups [13]. For example, Dalit are more likely to have suicidal thoughts or suffer from depression than any other ethnic group [14].The feelings of worthlessness compared to others in society and lack of opportunities present for them, bring with them the increased chance of mental health problems. Geographically, those living in rural areas suffer more than those in urban areas. This is due to the remoteness and inaccessibility for amenities such as education, healthcare and the potential for higher incomes. Finally, those living with an abusive husband are more likely to commit suicide [15-16].

High suicide among women: Possible explanation

Patriarchal society in Nepal:

Nepal remains as strongly patriarchal society, with women suffering from low status [17]. Citizenship rights "are still accorded to women through male relatives, rather than in their own right" [18].This means that women lack the freedom to produce their own identity through ownership rights. The patriarchy in Nepal is evident from birth with the birth of a boy being more celebrated compared to the disappoint felt about having a girl [19]. Therefore underpinning Nepalese society and

relationships is the idea of male superiority and power [13]. The MOHP (2007) found that 21% of Nepalese men believe that a husband "is justified in beating his wife". Hence in Nepal there are strong power relations present, which influence the way that men interact with women. This impacts women's mental health in a multitude of ways. Low economic and social status means that women are vulnerable to domestic abuse. They depend on husbands or male family members to provide shelter, food and financial support. The lack of access to employment and education for women can make them feel trapped into their dependency on their husbands. This can lead to women committing suicide in order to escape their situation.

Violence and abuse:

The influence of violence on attempted and committed suicide is well documented in many countries such as India [20], Bangladesh [21] and Nepal [16].. Ronsmans and Graham [22] argued that there is a strong relationship between domestic violence and mental health problems in women. It is particularly relevant in Nepal as 80% of women reported suffering from domestic violence [16]. Violence and abuse come from a number of forms including those of a sexual, physical and psychological nature. Sexual abuse is high in Nepal; in a clinical setting 50-70% of female patients had a history of sexual abuse, including husbands and extended family members [23].

Women can feel trapped within their abusive situations both physically and emotionally. A culture of silence is present in Nepal, whereby women are unable to speak about the violence that they suffer at home [12]. However, there can be severe psychological consequence for women in this context such as stress, depression, anxiety disorders and suicide [24].Through suppressing these negative emotions women are more likely to suffer from mental illness and experience suicidal thoughts. Pradhan et al. [12] argue that suicide is not only viewed as an escape from the physical abuse that they are exposed to but also an escape from the resounding emotional turmoil that women experience too. This culture of silence means that many suicides and suicide attempts go unreported, making it difficult to gage the exact extent to which this is a problem. This extends to speaking about mental health problems stemming from abuse. People fear stigmatisation associated with psychological distress and that admitting to it could bring shame on their family too [12]. Underreporting of violence can stem from the fear of further beating and making the long-term situation worse [25]. Once a year women can speak about their home situation, women are then permitted to write a song of Tiji. In the past these have been used as platforms where women can express the negative emotions that they may be experiencing due to their current life events [26]. After this day it is classed as sinful to sing such songs. This is classed as the one break from the culture of silence in Nepal.

Violence often occurs in the home. This space is considered a private area in an individual's life where they should feel safe and secure. However, if abuse is experienced this space becomes an area of hostility [12]. The psychological implications of this are that women no longer have a place where they can relax and feel safe. Living in fear about what may occur in the future creates emotional turmoil for an individual. Women of a reproductive age, especially those who are younger, are particularly. Niaz and Hassan [19] found that younger women suffer most from violence in the home, as they may not have developed psychological coping methods to handle the situation.

The main problem is that abuse, in some communities in Nepal, is an accepted part of a relationship [27]. Sexual and physical violence in Nepal can start at an early age, especially as it is common for women to be married off when they are young. Therefore, it is something that they have grown up experiencing, or have seen in the wider community. However, violence from an early age increases the probability of mental health problems or suicide in the future [23]. Changing the social norms surrounding violence and the culture of silence are important targets to help improve the mental health of women in Nepal.

High rate of male migration:

Nepal has a high proportion of male migrant workers, and being a migrant worker can lead to mental health problems [28]. However, migration of husbands and partners can have an impact on the mental health and suicide risk of the women staying behind [29].

Relationship with husband:

The characteristics of a husband are deemed as being highly influential in a woman's mental health. Depression in women is often associated with having a negative or harmful relationship with their husband [30]. In "developing countries it is often the impact of a husband's substance abuse that leads to an increased risk of suicide in female counterparts"[12]. Several studies have shown that alcohol abuse from a husband has negative connotations for the wife's psychological health [30]. Alcohol-related problems include conflicts and violence; these again create an unstable environment for women and children to live in. Polygamy has a negative impact on the mental health and suicidal thoughts of a woman [13]. Although polygamy was made illegal in Nepal in 1997, it still exists [30]. Women who are married to a polygamist have higher rates of suicide due to the associated emotions including feelings of unworthiness and inadequacy as the husband finds another wife, and insecurity of their own position in the family. However, separation or divorce initiated by a husband can also lead to depression. This is exacerbated if the husband leaves the wife with children and no financial support. Such situations have led to women committing suicide to escape the difficult position [31].

Expectations and limitations:

In every culture there are different societal norms and expectations placed upon both women and men. In Nepal the expectation is that women will marry and bear children, especially male ones. Early marriage results in girls leaving school in order to be a housewife, therefore reducing their opportunity to an education which could lead to better employment and independence in the future. For those still in school the threat of early marriage if their grades are poor puts extra pressure on girls to succeed [12]. The stress borne in both of these situations contributes to high levels of mental health problems in young women of a reproductive age.

Early marriage results in a prolonged period of time that women bear children in Nepal [19]. This can be further prolonged if they are trying for a boy [32]. The constant pressure to produce a male child, shame of having a girl and exhaustion from multiple childbirths has a negative impact on women's psychological health [33]. Additionally, if women have children at a very early age they are at risk of having long-term physical problems, and potential problem with subsequent pregnancies and childbirth. This in turn contributes extra stress for the women in the future when they try to conceive again. The additional problem with having the first child at a young age means that some young women are neither physically nor psychological fully developed to cope. Although there is the pressure to have children, the greater risks with pregnancies are those that are unwanted. Unsafe abortions due to fear of shame, still contribute to maternal deaths in Nepal [24]. Although abortion was legalised in 2002 and became incorporated in national policy in 2004, it still affects the mental health and wellbeing of a woman.

A major limitation for women in Nepal is a lack of access to personal financial security; this is particularly relevant if they are widowed, separated or if their husband has migrated to find employment [12]. Being left leaves the responsibility of care for the family primarily on the wife. The combination of women having lower education due to early marriage, plus their low social status means that sustainable and well-paid employment can be difficult to find [13]. Illicit jobs such as sex work become alternative sources of income. However, this has the adverse consequence of physical violence and is an insecure form of income [12]. Living in poverty, barriers to jobs and risk employment can create an environment that is detrimental to women's mental health.

Stigma:

Mental health remains highly stigmatised in Nepal. This contributes to the culture of silence surrounding psychological problems. Especially in rural area it is assumed that if an individual has a mental illness it is because of evil spirits [13], inherently revolving around the negative actions of the individual. This can cause a lack of acceptance from the family, as they are worried about being associated with the individual [18]. Therefore expressing emotions or admitting to suicidal thoughts is deemed unacceptable [12]. This is true in many developing countries, and leads to underreporting of the mental health problems across the whole population [34]. This stigma is also associated with discrimination within local communities, thereby

denying access to social gatherings and sometimes employment if their mental illness is disclosed. However, the stigma and shame associated with poor mental health mean that despite having depressive emotions they are unable to express them. The feared and experienced stigma associated with having a mental health problem increases the chances of suicide.

Effect on others

Although suicide is a personal act it affects the family, friends and community whether the individual has attempted or completed suicide. It is thought that one suicide substantially affects six people surrounding it [15]. Therefore it is important to consider the implications that the high rates of suicide in women of a reproductive age has on others. Dependants are particularly vulnerable to the death of their mother [35].If the manner of death is known then children can suffer from the stigmatisation by association with the deceased. There are negative effects of poor maternal mental health on the children whilst the woman is alive too. Women who are suffering from depression are less likely to breastfeed [30]. It has also been shown that poor mental health in the mother can lead to poor infant growth, lower cognitive ability and slower social development of the child [36-37]. Additionally, if a member of an individual's family has committed suicide it increases the chances of future suicides by associates and reduces their mental health level [12]. Therefore addressing the suicide rates in women of a reproductive age will reduce the negative implications of the wider community and their dependants.

Discussion and Conclusions

Although it is women who should be targeted it is important to include men in any future action against poor mental health [17]. Many of the problems stem from the relationship between husband and wife, especially those that are violent or oppressive. Although it should be encouraged to make women feel empowered, for projects to be sustainable men must also be more accepting and supporting such changes. This can be achieved through activities such as involving them in pre and postnatal classes.

In Nepal poor mental health still goes unrecognised in many clinics and by medical professionals. The limited training that they receive and the few financial resources assigned to mental health reflect the disregard of psychological wellbeing. However, improving a mother's mental health can also improve that of her children. Increasing the awareness of psychological problems by both the general public and medical professionals could help illnesses to be recognised earlier so the woman can seek help. By increasing public knowledge and acceptance around mental health the culture of silence may slowly reduce so that women can talk about the situations that they are in. We must create platforms where women can safely to express their feelings around mental health, perhaps in the form of women's groups.

For any recommendation to be achieved on a large scale the importance of mental health in government planning and financial distribution should be raised. We need to train more staff on mental health issues, sensitise all staff and create mental health clinics to provide proper care. However, Nepal is a low-resource country making it difficult to redirect resources. Yet, training programmes and increasing awareness could be a positive initial step in reducing the problem of maternal mental health. This is particularly important for midwives and those involved in pre and postnatal check-ups. Full training of these medical professionals could help to assess whether a woman may need extra support.

The epidemiological data need to be carefully examined, as they may not reflect the reality of the situation. The WHO predicts that there may be 20 times more attempted suicides than the current figures suggest. Stigma, lack of understanding, the illegality and the culture of silence all contribute to this problem. Though there has been a start at exploring mental health in Nepal this needs to be expanded. It has been widely established that there is a dearth of mental care in Nepal [38,39].Future policies and interventions should focus on women of reproductive age in particular. This will also reduce the number of people who are affected by an individual committing suicide. We need more research studying the causes of poor mental health as well as more research into ways to improve it. Societal barriers such as the strong patriarchy, low status of women and barriers to entry of jobs and education need to be addressed. This will result in women having

more equality, and more social, cultural and socio-economic freedom. This is particularly important due to the strong relationship between domestic violence and depressive symptoms, greater freedom in the wider society may help women leave violent exploitative relationships. Mental healthcare needs to be recognised as a significant element of medicine and have increased resources available to it. This will not only improve the psychological state of their population, but also the physical health of Nepalese women and children.

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