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# Understanding the psychosocial and mental health needs of Haruwa and Charuwa bonded labourers in South-Eastern Nepal

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## Table of Contents

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<b>Table of Tables</b> .....	<b>3</b>
<b>Acknowledgements</b> .....	<b>3</b>
<b>Executive Summary</b> .....	<b>4</b>
<b>1 Introduction</b> .....	<b>6</b>
1.1 Context of mental health in Nepal.....	6
1.2 Haruwa and Charuwa: Bonded and forced labour.....	7
1.3 Migration.....	8
1.4 The Freedom Fund's hotspot in South-Eastern Nepal.....	8
1.5 Psychosocial and mental health needs.....	9
<b>2 Methods</b> .....	<b>10</b>
2.1 Design.....	10
2.2 Measures.....	11
2.2.1 Demographic profile of socio-economic situation.....	11
2.2.2 General Health Questionnaire (GHQ- 12).....	11
2.2.3 Hopkinson Symptom Checklist (HSC-25).....	11
2.2.4 PTSD Checklist—Civilian Version (PCL-C).....	11
2.2.5 Trauma event list.....	11
2.2.6 WHO Disability Assessment Scale (DAS)-II.....	11
2.2.7 Alcohol Use Disorders Identification Test (AUDIT).....	12
2.3 Procedure.....	12
2.4 Participants and districts.....	12
2.5 Statistical analysis.....	12
<b>3 Results</b> .....	<b>13</b>
3.1 Participant profile.....	13
3.2 Loan agreement, labour, and pay.....	13
3.3 Perceived quality of relationships, needs and sources of support.....	15
3.3.1 Anxiety and depression.....	16
3.3.2 Traumatic events experienced and PTSD symptoms.....	17
3.3.3 Alcohol use.....	18
3.3.4 Overall psychological distress.....	18
3.3.5 Functioning, disability and health.....	18
<b>4 Discussion</b> .....	<b>19</b>
4.1 Poverty.....	19
4.2 Loans, work and pay.....	19
4.3 Migration.....	20
4.4 Psychological difficulties.....	20
4.5 Stigma, underreporting and access.....	22
4.6 Traditional healers.....	23
<b>References</b> .....	<b>24</b>

## **Table of Tables**

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Table 1. Age and family demographic stratified by district .....	12
Table 2. Demographic, education, and socio-economic profile stratified by district .....	13
Table 3. Loan conditions agreed between participants and their landowner.....	13
Table 4. Specifics of the loan agreement .....	14
Table 5. Type of work contracted to pay back loan .....	14
Table 6. Quality of relationships reported in % of frequency rating .....	15
Table 7. Self-identified main problems reported by participants.....	15
Table 8. Help sought for psychological needs .....	15
Table 9. Traumatic events experienced by the participants .....	17

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## Executive Summary

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In the southeastern Terai regions of Nepal a traditional form of bonded labour termed 'Haruwa and Charuwa' continues to exist despite being officially outlawed by the Nepalese government. Haruwa means 'ploughman' and Charuwa means 'cattle herder'. For the overwhelming majority of these agricultural working families, their working conditions and socio-economic circumstances constitute a form of modern slavery. In this paper, modern slavery is used as an umbrella term to describe human trafficking, slavery, servitude and forced labour.

The severe impact of modern slavery on individuals' mental health and psychosocial well-being has been evidenced internationally. However, current understanding of the psychosocial and mental health needs of forced labourers is only recently emerging and has never been investigated within Haruwa and Charuwa families. The Freedom Fund is a philanthropic organisation, which aims to eradicate modern slavery internationally. This paper was commissioned by the Freedom Fund and was a collaboration between the Freedom Fund, Helen Bamber Foundation (for the first field visit), an independent contractor (UK clinical psychologist) and the Centre for Mental Health and Counselling – Nepal (CMC). It aimed to understand the psychosocial and mental health needs from the Haruwa and Charuwa families' perspectives, using a mixed methods survey. Participants were recruited by partner Nepali NGOs within the Freedom Fund's South-Eastern Nepal hotspot program, and data was primarily collected by CMC staff. The original design of the study was suspended due to the devastating April 2015 Earthquake in Nepal and data was therefore collected through two field visits.

### ***Participants described high levels of general psychological distress***

The main findings were as follows:

1. Poverty and lack of basic needs were found to be both precipitating and perpetuating factors for debt bondage.
2. Participants described high levels of general psychological distress, depression, anxiety, Post-Traumatic Stress Disorder (PTSD) and impairment in day-to-day functioning:
  - 46% of respondents reported clinically significant anxiety symptoms
  - 61% reported clinically significant depression symptoms
  - 47% reported some level of suicidality
  - 18% reported clinically significant PTSD symptoms.
  - Almost one-quarter of respondents reported evidence of severe psychological distress.

These findings are in line with other international research into the mental health consequences of modern slavery. Gender was associated with higher rates of psychological distress in all cases apart from depression symptoms.

3. Stigma surrounding mental health was found to be high and this may have interfered with reporting culturally sensitive issues.

Key recommendations:

1. The program should follow-up with the current research participants and assess whether their well-being improves in line with increasing prospects of moving out of bonded labour (i.e. through their involvement in community freedom groups and other Freedom Fund partner activities in the area).

2. Future research in this area could include a control group of dalit (so-called low caste) agricultural workers to compare with those in a situation of debt bondage. This would generate greater understanding of the unique impact of bonded labour on well-being.
3. As there are limited resources available for training NGO staff, initially, it is recommended that training should focus on staff members working directly with the affected communities. This should include: raising staff awareness and understanding of mental health issues within a psychosocial framework; how to reduce stigma in staff around mental health; and how to sustain staff well-being while they help participants make changes to their socio-economic situation.
4. As a next phase of psychosocial support, it is likely to be helpful to strengthen community integration, involvement and social cohesion, building on existing systems of social support and resilience (Newlin & Webber, 2015). However, participatory feasibility research is required before such training should be developed to ensure cultural sensitivity. The finding of this present report that family and community are the participants' preferred source of support for psychological needs should be capitalised upon.
5. It could be helpful to train selected members of the community in identifying mental health problems using community validated and user-friendly instruments (Jordans, Kohrt, Luitel, Komproe, & Lund, 2015) to support them to refer severe mental health presentations to specialist services. However, before this training takes place, it would be important to learn from CMC's previous work, about available services, including mapping the referral pathways. It may be necessary to give more in-depth training to psychosocial counsellors who can be available in the absence of other services. This is to prevent damaging relationships with participants and local NGO partners due to raising expectations of the availability of support (P. Mahat, personal communication, July 16, 2016).
6. In the future, if more specialised intervention training to address specific mental health problems is considered appropriate for the Haruwa-Charuwa community, it should closely build and learn from previous mental healthcare initiatives in a Nepali context (Jordans, Luitel, Pokhrel, & Patel, 2016). In addition, any intervention would need to be deliverable by non-specialist professionals, but with sufficient training and on-going supervision (Jordans et al., 2016). The intervention should be guided by the needs and voices of the Haruwa-Charuwa community, as well as being piloted and its effectiveness systematically evaluated (Helen Bamber Foundation, 2015). The literature also suggests that such targeted psychological interventions focusing on specific mental health problems (e.g. PTSD) would be most appropriate for individuals in families who are survivors of bonded labour (Helen Bamber Foundation, 2015).

# 1 Introduction

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## 1.1 Context of mental health in Nepal

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Nepal is one of the poorest countries in the world and is ranked among the lowest category countries on the human development index (United Nations Development Programme (UNDP), 2015). From 1996 – 2006 the country endured a decade long civil war between the Maoist Communist Party of Nepal and the government of Nepal's security forces. Nepal is still recovering in the wake of this recent conflict and civilians were subject to human rights abuses from both sides (Singh, Dahal, & Mills, 2005). The psychological sequelae of civil war are vast (Thapa & Hauff, 2005). Health services that might have been created in rural areas during the war tended to be centralised in urban areas, thus further limiting the support (including mental health) to rural communities (Tol et al., 2010). Steps are being taken to overcome inequalities in healthcare provision and access, but the gap between demand and service provision remains large. As highlighted in figure 1, there is a serious human resource issue in mental healthcare in Nepal to serve its overall current national population of an estimated 28 million people. (Jordans, Luitel, Tomlinson, & Komproe, 2013; Luitel et al., 2015). Finally, the South East Terai of Nepal is particularly affected by gaps in statutory services, which includes healthcare provision (P. Mahat, personal communication, July 16, 2016).

- Human resources
- **Mental health services are coordinated by difference institutions in the centre e.g. mental hospital, management division**
  - **Limited human resource on mental health: 60 psychiatrists (an estimated 25% are reported to be out of country); 25 psychiatric nurses; 16 clinical psychologists; 400-500 para-professional counsellors (trained by NGOs); 867 general doctors/PHC workers who have received short mental health training**
  - **Most of the psychiatrists, psychiatric nurses and psychologists are working in private sector and in big cities**
  - **Community health volunteers are not trained on mental health issue**

Figure 1: Mental health human resources in Nepal (taken from a research article on "Mental health care in Nepal" by Luitel et al. (2015) p.7)

Encouragingly, further information provided by the Psychiatric Association of Nepal at a conference in August 2016 indicates 120 psychiatrists have graduated from Nepal and abroad; 68 psychiatric nurses; 20 clinical psychologists (P. Mahat, personal communication, August 22, 2016).

Traditional healers offer a much more available source of support, with research estimating that for every 650 people of the population there is 1 traditional healer (Kohrt & Harper, 2008). Research suggests that traditional healers understand distress and mental health issues as affecting the soul, which can occur through the paranormal e.g. witchcraft and spirits, but there are divides within Nepali culture about the effectiveness of such interventions (Kohrt & Harper, 2008).

## 1.2 Haruwa and Charuwa: Bonded and forced labour.

The 2016 Global Slavery Index estimated that in Nepal, 234,600 individuals (0.8% of Nepal's population, which ranks as 7<sup>th</sup> highest in Asia-Pacific) live in conditions of modern slavery (Walk Free Foundation, 2016). Outlined in figure 2 below (taken from Centre for Social Justice, 2013 p.31), this paper understands modern slavery as an umbrella term describing the following:

<b>Human trafficking</b> <ol style="list-style-type: none"><li>1. Recruitment, transportation, transfer, harbouring or receipt of persons;</li><li>2. By means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person; (where a child is involved, the above means are irrelevant)</li><li>3. For the purposes of exploitation, which shall include (<i>non-exhaustive</i>):<ol style="list-style-type: none"><li>a. Prostitution;</li><li>b. Other sexual exploitation;</li><li>c. Forced labour;</li><li>d. Slavery (or similar);</li><li>e. Servitude etc.;</li><li>f. Removal of organs.</li></ol></li></ol>	<b>Slavery</b> <p>The status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised (129 Convention; approved in defining Art 4 ECHR: <i>Siladin v France</i> (ECHR, 2005)).</p> <b>Servitude</b> <p>An obligation to provide one's services that is imposed by the use of coercion, and is to be linked with the concept of 'slavery' described above (<i>Siladin v France</i>, ECHR (2005)).</p> <b>Forced labour</b> <p>All work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily.</p>
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**Figure 2: Modern slavery understood as trafficking, slavery, servitude and/or forced labour (taken from Centre for Social Justice, 2013 p. 31)**

The flat Terai regions of Nepal are the agricultural heartlands of the country and within the southeastern districts of Nepal, agricultural labour is, for the majority of the population, the main source of income. A recent study estimated that there are 70,000 households working as Haruwa-Charuwa labourers in this region of Nepal (International Labour Organization (ILO), 2013). Haruwa means ploughman or tiller, and Charuwa means cattle herder. The roles are often divided by gender and age with men ploughing and women, children and the elderly herding livestock. Domestic servitude is also common among women, children and the elderly in Haruwa and Charuwa families. It has been estimated that 95% of Haruwa and Charuwa families are living in conditions of bonded i.e forced, labour (ILO, 2013).

The primary reason that poor individuals become bonded labourers is through financial obligation to wealthier landowners. Poor individuals without collateral, mainly from dalit families, turn to landowners or money lenders for financial assistance. The loans that are procured are offered at high interest rates (more than 36% per annum; ILO, 2013). Wages are often below the district's minimum wage or labour is paid for with insufficient food supplies, seeds or small plots of infertile land to farm, which results in malnutrition and expanding debt (Freedom Fund, 2014).

In situations where children have to work due to conditions of the loan, there is a likelihood that the children's educational attainment is at risk. Thus educational levels in this community are historically low. Working hours are especially long during the planting and harvesting months with little flexibility to obtain other sources of income. The relationship between the money lender and the Haruwa and Charuwa families is often characterised by increasing threats of requiring them to pay back the loan in full immediately, threats to seize their assets, and threats of violence and in some cases these threats turn into lived experiences (Freedom Fund, 2014).

### 1.3 Migration

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International migration within the Terai dalit community to India and the Gulf countries has increased year on year in the last two decades, and most noticeably in the last decade (Centre for the Study of Labour and Migration (CeSLaM), 2014). While the hill districts of Nepal have the greatest proportion of families containing a family member who is or has been an international migrant, the Eastern Terai (14.2%) region has the second highest rate (CeSLaM, 2014). In particular, international migration is especially high in the district of Dhanusa (60,001-80,000; CeSLaM, 2014)

The overwhelming motivation for international migration is to find work, often in low seasons of agricultural work due to lack of availability and pay. Agricultural work is the main occupation before and after foreign employment (CeSLaM, 2014). Although for some families in Nepal migration can create additional sources of income and widen prospects, recent reports have found that Nepali migrant workers can experience a range of human and civil rights violations (including situations amounting to human trafficking) throughout their foreign employment careers, without sufficient legal representation and support (Open Society Foundations (OSF), 2014).

For the Haruwa and Charuwa community, if financial support to facilitate migration is sourced via a loan then the family members at home often experience high loan repayments, which have to be repaid through Haruwa and Charuwa labour (H. Joshi, personal communication, June 20, 2016). The majority of Nepali migrant workers are men, that said, women are reported to also migrate internationally for employment and in such cases are potentially more at risk of harm due to gender inequality, isolation associated with domestic servitude and illegal migration channels (OSF, 2014). Large loans to fund economic migration and unsafe migration are therefore ever increasing issues for Haruwa and Charuwa families (Reflections on issues raised by the Nepal Scoping Visit, Institute of Development Studies, 2016).

### 1.4 The Freedom Fund's hotspot in South-Eastern Nepal

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In late 2014, the Freedom Fund launched its hotspot strategy in three South East districts of Nepal with the aim of liberating Haruwa and Charuwa bonded labourers, eradicating future enslavement of this community and helping those who have decided to migrate to try to mitigate the risks. Tackling the root causes of this form of modern slavery through economic empowerment, social mobilisation, legal support, rights to land, housing and education are the beginnings of supported social change in South East Nepal. At the centre of this multifaceted approach are the Haruwa and Charuwa community themselves; change is conceived as a by-product of both increased capacity of the community in conjunction with systemic change at the provincial and national level (Freedom Fund, 2014).



## 1.5 Psychosocial and mental health needs

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Psychosocial and mental health research is growing in rural Nepal although it is still fairly limited especially with regard to modern slavery and in particular traditional forms of bonded labour. Kohrt et al. (2009) revealed that high rates of common mental health problems (anxiety and depression) were found amongst adults living in rural Nepal especially among low caste individuals. Furthermore, dual diagnosis is common, especially between depression and alcohol abuse (for a review see; Agyapong, 2013), which has also been evidenced in Nepal (Neupane & Bramness, 2013). Importantly, in Kohrt et al. (2009) research, caste was independently associated with severity of anxiety, but not depression whilst controlling for life stresses and personal resources.

Post-traumatic stress symptoms have been more commonly assessed in displaced populations and/or torture survivors in Nepal (Mills, Singh, Roach, & Chong, 2008; Thapa & Hauff, 2005) and survivors of human trafficking both in Nepal (Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008) and internationally (Hossain, Zimmerman, Abas, Light, & Watts, 2010).

Investigations into the psychological sequelae of trafficking have mainly focused on persons trafficked for sexual exploitation (Oram, Stöckl, Busza, Howard, & Zimmerman, 2012). However, research is now beginning to investigate health consequences of exploitation for labour purposes also (Turner-Moss, Zimmerman, Howard, & Oram, 2014). Post-traumatic stress symptoms are especially important to consider in the eastern Terai regions due to several factors: The effects of the civil war; gender-based violence occurring in rural Nepal (Kohrt et al., 2009); migration for employment being associated with human rights abuses (OSF, 2014); and the toxic nature and circumstances around Haruwa and Charuwa forced labour (Freedom Fund, 2014; ILO, 2013).

***The conditions surrounding the labourers are likely to lead to a high level of mental health need.***

Cross-cultural mental health research requires sensitivity to how communities understand and talk about psychological distress. Research into common phrases to describe psychological suffering in Nepal reveals limited usage of western terminology e.g. depression (Kohrt & Hruschka, 2010). This makes the use of culturally 'sensitive and specific' measures that have been empirically validated (where possible) especially important (Chen, Ganesan, & McKenna, 2013). More broadly, previous research has revealed that mental health problems in Nepal are highly stigmatised, understood at times within a spiritual framework and often associated with adverse implications for the individual and their family's status within the community (Kohrt & Harper, 2008). Such cultural frameworks of distress will naturally shape help-seeking behaviour as well as shaping the families' decisions about whom to approach for support. For example, women are more likely to be viewed as vulnerable to witchcraft in Nepal (Sapkota et al., 2014), which will likely guide possible treatment decisions by the individual and their family (Kohrt & Harper, 2008). A clear understanding of the Haruwa and Charuwa families' understanding and conceptualisation of psychological distress has not been investigated to date.

In summary, research to date suggests that the conditions surrounding the Haruwa and Charuwa labourers are likely to lead to a high level of mental health need when understood within a psychosocial framework. However, in what form such difficulties are most prevalent has yet to be empirically assessed. A better understanding of such needs alongside the communities' views and understanding of psychosocial and mental health issues will pave the way to offer meaningful support in the future. This must all be understood and framed within the limited mental health resources (e.g. hospitals and trained health care workers) available to individuals living in rural Nepal (as described in section 1.1).

## 2 Methods

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### 2.1 Design

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The study utilised a cross-sectional design to assess the psychological distress and psychosocial needs of Haruwa and Charuwa adult labourers, across three districts in South Eastern Nepal: Dhanusa, Saptari and Siraha. NGOs working directly with Haruwa and Charuwa communities in the Freedom Fund's South Eastern Nepal hotspot were informed about the project and they independently identified participants for the study: An opportunistic sample was utilised.

Four separate focus groups, which were facilitated by the CMC team were conducted. Two were completed with current Haruwa-Charuwa labourers (total N=30) and two were completed with local NGO staff (total N=18).

The UK psychologist conducted five semi-structured interviews with staff members in the first field visit. These were designed in the field to utilize human resources due to issues regarding effective translation. They focused on understanding the Haruwa-Charuwa context and psychosocial issues they faced. Alongside this, the UK psychologist conducted six in-depth neuropsychiatric interviews, which were originally intended to cross-validate questionnaire measures of distress on a small sub-sample of participants. However, due to significant translation issues this data was not included, as it was not deemed reliable by the team.

The initial focus group and semi-structured interview data confirmed that the Haruwa-Charuwa were living in highly disadvantaged socio-economic situation, facing high levels of discrimination at the individual, community and political level. Associated with this,

psychosocial and mental health symptoms including those understood in western societies as depression, anxiety, post-traumatic stress and alcohol abuse were reported. Also, mental health problems (especially severe mental health presentations) were reported as highly stigmatized.

All of the above were undermining their ability to

live meaningful and fulfilling lives. Low levels of service availability and service use were identified and traditional healers were reported as the most available and accepted form of support. The emotional burden of this work on local NGO field staff was also reported as being high. These results from the first two focus groups led to items being added and adapted on the traumatic experiences list to fit the context.

The Centre for Mental Health and Counselling-Nepal (CMC) staff also completed one-to-one interviews which were accompanied by measures of anxiety, depression, post-traumatic stress disorder (PTSD), traumatic incidences, alcohol use, overall distress and day-to-day functioning. All data analysed in the results section of this report comes from the one-to-one interviews, and the Haruwa and Charuwa labourers who took part in these interviews are referred to as 'participants'. Further neuropsychiatric interviews completed by CMC were also excluded due to translation and reliability issues.

The CMC staff were aware of the local context, and local NGO staff facilitated translation where Maithili was the participant's first language and they could not speak Nepali fluently. Of note, in most cases participants understood Nepali. CMC is a national level not-for-profit organization working in both mental health and psychosocial support since 2003. They are involved in integrating mental health and psychosocial counselling into existing health

***The study utilised a cross-sectional design to assess the psychological distress of Haruwa and Charuwa adult labourers.***

services and schools through inter-sector collaborations. CMC staff also offer direct psychotherapeutic services.

All data was intended to be collected over two weeks, however, the devastating earthquake of April 2015, resulted in the research being stopped and suspended. The focus groups, semi-structured interviews and 37 one-to-one interviews were collected before the earthquake, and 66 interviews were conducted after the earthquake.

## 2.2 Measures

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All instruments with the exception of the demographic and trauma events list, were translated into Nepali. The demographic and trauma events list questions were instead translated verbally in session with the translator.

### 2.2.1 Demographic profile of socio-economic situation

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Demographic profile regarding information on the participants' loan, nature of work, monthly wage and social relationships, was collected across the three districts using a semi structured interview schedule devised by the authors.

### 2.2.2 General Health Questionnaire (GHQ- 12)

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Levels of psychological distress were measured using the GHQ-12 which has been shown to be a reliable and valid measure of general psychiatric well-being (Goldberg & Hillier, 1979). Each of the 12 items on the scale assesses the severity of psychological distress over the past three weeks, scores range from 0-36 and a score of above 20 indicates severe problems with psychological distress (Gupta et al., 2008). The measure has been validated in rural Nepal (Koirala, Regmi, Sharma, & Khalid, 1999).

### 2.2.3 Hopkinson Symptom Checklist (HSC-25)

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The HSC-25 is a symptom inventory which measures symptoms of depression and anxiety, rated on a scale of 1 (not at all) to 4 (extremely). The HSC-25 has 10 items for anxiety symptoms and 15 items for depression symptoms (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The HSC-25 has been used in previous studies examining depression and anxiety in Nepali populations affected by conditions of modern slavery (Tsutsumi et al., 2008). Scores above 1.75 indicate significant levels of anxiety and/or depression (Thapa & Hauff, 2005).

### 2.2.4 PTSD Checklist—Civilian Version (PCL-C)

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The PCL-C was utilized to measure PTSD symptoms. The PCL-C has 17 items that correspond with symptoms for Post-Traumatic Stress Disorder. Each symptom is rated on a 5-point scale from not at all (1) to extremely (5). The scale has been validated in Nepal and scores above 50 indicate significant PTSD symptoms (Thapa & Hauff, 2005). Participants were also asked what their most terrifying traumatic event was (Thapa & Hauff, 2005).

### 2.2.5 Trauma event list

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A modified list of traumatic experiences from the Harvard Trauma Questionnaire as adapted by Thapa and Hauff (2005) was utilised for this study. The final list was adapted following the focus groups and comprised of 15 traumatic events.

### 2.2.6 WHO Disability Assessment Scale (DAS)-II

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The WHO DAS-II is a generic assessment instrument for health and disability based on the conceptual framework of the International Classification of Functioning, Disability, and Health (ICF). The short form (12 items) was used where scores go from 0 (no difficulty) to 4 (extreme difficulty or cannot do). The final score was calculated as a percentage of the total (as recommended by WHO). The instrument was translated by CMC for the study with

permission of the WHO, but the measure has been previously used in a Nepali context (Thapa & Hauff, 2012).

### 2.2.7 Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT is a 10-item screening tool developed by the WHO to assess alcohol consumption, drinking behaviours, and alcohol-related problems. A medium level of alcohol problems is indicated by a score between 8-15, and 16 or over represents high levels of alcohol problems. Scores above 20 suggest dependency. The measure has been translated for use in Nepal (P. Mahat, personal communication, July 16, 2016).

## 2.3 Procedure

All participants were interviewed in a private room. The details and ethical procedures (e.g. data protection, confidentiality and right to withdraw) were verbally explained to the participants and given that the majority were illiterate, informed consent was verified via fingerprint. Individuals then completed the demographic interview followed by the psychological distress and functioning measures. Due to the literacy level of the sample group all questions were read out by the interviewer and filled in by the interviewer on behalf of the participant. On average each interview lasted one hour. Travel costs were reimbursed and snacks were provided for participants.

## 2.4 Participants and districts

Participants in the interviews consisted of 90 adults (over 18 years of age) currently working as Haruwa and Charuwa labourers who were being assisted by local partner NGOs of the Freedom Fund's South- Eastern Nepal hotspot program. Participants lived in Dhanusa, Saptari or Siraha. See table 1 for mean age, family size and number of children. 13 participants were removed from the analysis: 12 due to such individuals not currently being in a situation of bonded labour and one because they had no demographic data available.

**Table 1. Age and family demographic stratified by district**

	Saptari	Siraha	Dhanusha	Total
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
<b>Age</b>	45.71 (11.76)	42.52 (11.23)	42 (11.28)	43.33 (11.41)
<b>Family size</b>	8.54 (3.66)	7.26 (3.16)	7.68 (2.64)	7.80 (3.17)
<b>Number of children</b>	2.71 (1.67)	2.94 (1.31)	2.71 (1.85)	2.79 (1.61)

## 2.5 Statistical analysis

Due to missing responses on some questions in the demographic questionnaire, percentages are reported based on the total number of responses on that question rather than total number of participants. Statistical differences in frequency were reported using chi squared, but in cases where assumptions were violated then Fischer's exact test was used. T-test was used to compare means. A well-known statistical technique known as bootstrapping was applied to look at the parameters of the sample (known as confidence intervals). The results have compared differences between males and females on the questionnaire measures because this data was complete, and gender has been consistently shown to predict the degree of psychological distress in Nepal.

### 3 Results

#### 3.1 Participant profile

All participants were Hindu and dalit (from one of the historically discriminated castes) or from an indigenous group: dalit Madheshi (96%), other dalit (2%), and Janajati (indigenous groups; 2%). The majority of the participants were married (92%), with remainder of the sample either widowed, separated or not married (6%, 1% and 1% respectively). Most of the participants had no formal education (96%), but a small minority had 1-3 years of formal education (2%) or between 9-15 years of education (2%). See table 2 for further descriptive statistics and demographic profile stratified by district.

**Table 2. Demographic, education, and socio-economic profile stratified by district**

		District			Total
		Saptari	Siraha	Dhanusha	n (%)
		n (%)	n (%)	n (%)	
<b>Sex</b>	Male	17 (19)	9 (10)	12 (13)	<b>38 (42)</b>
	Female	11 (12)	22 (25)	19 (21)	<b>52 (58)</b>
<b>Literate</b> (i.e self-reported they can read and write)	Y	9 (10)	9 (10)	11 (12)	<b>29 (32)</b>
	N	19 (21)	22 (25)	20 (22)	<b>61 (68)</b>
<b>Family type</b>	Nuclear	5 (6)	9 (10)	8 (9)	<b>22 (24)</b>
	Joint (i.e. including married son's family)	23 (25)	22 (25)	23 (25)	<b>68 (76)</b>
<b>Legal owner of their house</b>	Family	3 (3)	5 (6)	1 (1)	<b>9 (10)</b>
	Landowner	3 (3)	1 (1)	2 (2)	<b>6 (7)</b>
	Government	22 (25)	25 (28)	28 (31)	<b>75 (83)</b>
Total population		28	31	31	90

#### 3.2 Loan agreement, labour, and pay

The most frequently reported reasons for loans were for migration abroad (30%), health care (23%), food (19%) and marriage (17%). While the majority of participants reported having a written agreement of the loan (76%) only 9 participants mentioned that they had a copy of this (see table 3). 73 (82%) participants reported that they took their loan from the landlord either themselves or jointly with their partner. The remainder 16 (18%) participants reported that the loan was taken out either by their partner or parent-in-law, all of whom were female with the exception of one.

Typical loan duration was 25 months (see table 4) and work undertaken to pay the loan was typically fieldwork (41%) or domestic work (40%) – see table 5.

**Table 3. Loan conditions agreed between participants and their landowner**

Nature of loan agreement		N	%
<b>Reason for loan</b>	Food	17	19
	Healthcare	21	23
	Migration abroad	27	30
	Marriage	15	17
	Assets (land, building a house, farming)	7	8
	Repaying old loan	1	1
<b>Was there a written agreement developed</b>	Y	68	76
	N	18	20
	Don't know	2	2
<b>If yes, do they have a copy</b>	Y	9	13
	N	58	85

**Table 4. Specifics of the loan agreement**

	mean	SD	Min	Max
<b>Length of time since current loan was taken</b> (months)	25.76	32.38	1	240
<b>Size of loan</b> (Lakhs Nepali rupees) *	1.21	1.14	.02	5
<b>Remaining debt owed</b> (Lakhs)	1.06	1.11	.02	5
<b>Amount of loan that participant had so far paid off</b> (%)	3.58	115.42	-857.14	93
<b>Interest rate</b> % per annum	46.45	11.62	12	60
<b>Legal interest rate frequency</b> (below 16% per annum)			1%	

\* 1 Lakh = 100,000 Nepali Rupees = \$ 932

Participants on average had their current loans for two years so far, and had borrowed on average 1 lakh rupees (\$932). On average they had only managed to pay off a small percentage of their debt (4%). The overwhelming majority of participants were paying illegally high rates of interest.

**Table 5. Type of work contracted to pay back loan**

	Female n (%)	Male n (%)	Total n (%)
<b>Field work (e.g. haruwa or charuwa)</b>	11 (12)	30 (33)	<b>41</b>
<b>Domestic or domestic + field work</b>	37 (41)	3 (3)	<b>40</b>
<b>Cannot or unable to work</b>	2 (2)	0	<b>2</b>
<b>Other</b>	1 (1)	5 (6)	<b>6</b>

With regards to family involvement, 72 (82%) participants stated that their family also worked for the landowner to pay back the loan, of whom 38 (53%) stated that their partner had to work, and the rest reported either their partner and children, or just their children had to work for the landowner. Only 14 (16%) stated that their family were not involved. On average, participants reported that they worked 6.27 (SD 1.22) days a week, and 9.16 (SD 2.11) hours a day. They reported their family members worked on average 6.47 (SD 1.02) days a week and 8.85 (SD 2.04) hours a day.

Approximately half of participants also had a family member who migrated abroad to help repay the loan (n=44, 49%). While 36% of these participants reported no associated problems, 23% reported that having their family member abroad either had negative consequences on their health or increased their workload. A further 38% reported that it impacted them in more than one way including their health, workload, relationships or engagement in the community.

In terms of other employment, 75 (83%) stated that during the off-season they were allowed to work for other people, and 38 (51%) of these participants reported that they had to ask their landowner's permission. 11 (12%) participants said that they were unable to work for other people.

The majority of the participants (62%) were paid in cash and in kind (i.e. raw rice), followed by just payment in kind (27%), cash only (3%), and the remaining (8%) receiving no payment at all. For those who received monetary payment the average daily wage was NRs. 249 (SD 89.81) (\$2.32) and the majority of the participants were paid below the minimum wage (64%), most of whom were females (68%). Participants who only received payment in kind received on average 6.17kg of raw rice per day, which is less than the weight of rice for those paid in cash and kind (6.84kg). Thus those paid merely in kind received the lowest form of pay. 61% of the participants reported that they were struggling with payments on their loans.

### 3.3 Perceived quality of relationships, needs and sources of support

The following section shows psychosocial variables as reported by the participants followed by mental health measures and measures of functional disability. The majority of participants reported satisfactory, good or very good relationship with their landowner (with the latter two categories being reported mainly by women). Similar findings were also reported for their relationship with the community at large, and with their own family, and no discrepancy between sexes was observed (see table 6),

**Table 6. Quality of relationships reported in % of frequency rating**

	Very bad	Bad	Satisfactory	Good	Very good
Relationship with landowner/ landowner's family	0	9	48	29	12
Community at large	1	12	42	37	8
Own family	0	4	37	49	10

**Table 7. Self-identified main problems reported by participants**

Main categories of self-identified problems	%
Economic	11
Work	0
Psychosocial	4
Health	31
2 or more problems	43
None	9

**Table 8. Help sought for psychological needs**

Sources of help	%
Family	22
Community	19
Landowner	8
Services	6
More than one source	22
Self/believes its unhelpful to seek support from others	20

Out of the entire sample only 10% mentioned they utilised healthcare services e.g. a health post or visiting the doctors for psychological needs, and only one of these participants was male. Similarly, no participants reported visiting traditional healers for psychological needs. Importantly, family members and the community were seen as systems of support for the participants although 20% of individuals would rely on themselves or believed seeking support from others was not helpful.

### 3.3.1 Anxiety and depression

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On the HSCL-25, clinically significant anxiety symptoms (i.e. symptoms indicative of meeting diagnostic criteria) have been indicated in a Nepali context by scores above 1.75. The mean anxiety score for the participants was 1.87 (SD = 1.87) on the anxiety subscale of the HSCL-25. 46% of participants reported symptoms above this cut-off. The difference between females (29/90) and males (12/90) above this cut off was a statistically significant difference ( $\chi^2 (1) = 5.18, p = .02$ ). Thus women were significantly more likely to report anxiety symptoms than men.

For the depression subscale the cut-off score is the same on the HSCL-25. The mean depression score for all participants on the depression subscale of the HSCL-25 was 1.95 (SD= .71). 61% of participants reported symptoms above this cut-off, however no statistical difference on rates of clinically significant depression symptoms was observed between females (35/90) and males (20/90;  $\chi^2 (1) = 1.99, p = .16$ ). Therefore, there was no significant difference in the likelihood of reporting depression between sexes. Furthermore, 47% of all participants reported some level of suicidality and there was no statistical difference between females (25/90) and males (17/90;  $\chi^2 (1) = .98, p = .75$ ). Within this group, eight women reported moderate (n=6) or extreme (n=2) levels of suicidality compared to three men who reported moderate levels of suicidality. No male participants reported extreme levels of suicidality.



### 3.3.2 Traumatic events experienced and PTSD symptoms

**Table 9. Traumatic events experienced by the participants**

	Lifetime (%)	Most terrifying event (%)
Self or family experienced serious ill health	82	12
Lack of food / water to the point of starvation	71	14
Self or family threatened with violence	35	11
Self physically assaulted	23	8
Witnessing someone being badly injured or killed	22	2
Self or family threatened with kidnapping or death	20	0
Unexpected death of a family member	18	11
Forced marriage	16	0
War or combat experience	16	0
Forceful removal from shelter or property	12	4
Family member or close relative kidnapped	8	1
Self kidnapped	6	2
Witnessing rape or sexual assault	2	1
Experiencing rape or sexual assault	1	0
Sexual harassment	0	0
<b>Experienced at least one event</b>	98%	
<b>Mean number of traumatic events</b>	3.34 (SD 1.93)	

Nearly all participants experienced at least one traumatic event with the average being approximately three.

On the PCL-C, clinically significant PTSD symptoms in a Nepali context have been indicated by a score above 50. The overall mean PTSD symptoms reported was 32.76 (SD=16.35) and 18% of participants had scored above this cut-off. There was a statistically significant difference between females (15/90) and males (1/90;  $\chi^2(1) = 10.322, p > .01$ ). For participants with clinically significant PTSD symptoms (N=15/90) a range of experiences was identified as their most terrifying event, however, an unexpected death of a family member was the most frequent response (N= 4/15). In the whole sample, seven self-identified most terrifying events were unable to be included in Table 9 as they did not fit the categories of the trauma list.

### 3.3.3 Alcohol use

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Only two female individuals reported drinking alcohol on the AUDIT therefore only male scores were reported. The mean score for male participants was 2.76 (SD= 4.37). With a cut-off point of 8 as recommended by the WHO guidelines, there were 4 (4.4 %) who indicated problems with drinking, all of whom were men. Although this was statistically significant between sexes ( $p = .03$ ), the statistic is inconsequential given the low sample size.

### 3.3.4 Overall psychological distress

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The mean GHQ scores for this sample (16.07, SD 6.33) indicated evidence of psychological distress (GHQ >15). A score of above 20 on this scale indicates severe psychological distress. There were more females (17/90= 19%) with a score of above 20 than males (5/90= 6%), and this difference was statistically significant ( $\chi^2 (1) = 4.536, p = .033$ ).

### 3.3.5 Functioning, disability and health

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The mean overall score on the WHO DAS-II was 7.46 (SD = 8.70). Compared to an Australian population study who cite scores of 10-48 as evidence of 'clinically significant disability' (Andrews, Kemp, Sunderland, Von Korff, & Ustun, 2009) there were significantly more females (22/90 = 24%) who scored 10 or above compared to males (5/90 = 6%;  $\chi^2 (1) = 8.88, p = .003$ ).

## 4 Discussion

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### 4.1 Poverty

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The main reasons participants acquired a loan was for basic needs (food and medical treatment) and to fund migration abroad to increase earning potential. The top most frequent traumatic events and subjectively terrifying events were related to: ill health in a context of limited access to health care due to cost; food insecurity; and unexpected deaths of family members. Similarly, self-identified key problems were related mainly to economic security and health issues. Food and financial insecurity has been shown in global mental health research to be related to common mental health problems in low and middle-income countries (Hadley & Patil, 2006; Sorsdahl et al., 2011). Taken within a psychosocial framework of well-being, meeting the basic needs of the Haruwa-Charuwa community and improving their social and economic status may benefit their mental health, as such issues are possibly affecting the extent of psychological distress reported (Kohrt et al., 2009).

### 4.2 Loans, work and pay

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Overall the loans taken are of a substantial amount, averaging approximately 1 lakh rupees, which is over a year's salary if the worker were earning minimum wage in Nepal (Danish Trade Union Council for International Development Cooperation, 2014). Although on average, respondents had had their current loan for 2 years, the average amount they had paid off was only 4%. 99% of the loans were at illegally high interest rates and in the majority of cases, the participants did not have a copy of the agreement. Furthermore, most struggled with repayments, which is likely to be related to the finding that the majority were paid less than minimum wage or were paid in kind (e.g. 6kg of raw rice).

This suggests that despite the long hours already being worked at low wages to attempt to pay off the loan (especially during the season), and that 82% of participants stated that their family (including children) are also working for the landowner to pay back the loan, this form of debt bondage is locking individuals and families into poverty across generations.

#### *Recommendations*

The Freedom Fund's current initiatives to empower self-help groups to form microfinance schemes and collective loan systems to improve financial stability, food security and access to healthcare, alongside lobbying government to enforce land rights and minimal wages, may impact on the psychosocial well-being of Haruwa and Charuwa families. In addition, it is worth noting that the scale of the loans being taken by households, and the common events that result in loan requests (e.g. migration and marriage) may be issues that the program could help participants to consider collectively.

An important step with regards to evaluation will be to follow-up on the participants of the current research and to assess whether their well-being improves as a function of these social variables and the increasing prospects of coming out of debt bondage.

Future research projects in this area should include a control group of dalit agricultural workers to compare to those in a situation of debt bondage to understand the unique impact of debt bondage on well-being.

### Limitation

A limitation of the current research was that the length of time that the individual had been a Haruwa and Charuwa bonded labourer was not collected, nor was the previous number of loans recorded. Future research should include such information because previous research has shown psychological distress is related to the length of time people are in a situation of modern slavery (Helen Bamber Foundation, 2015).

## 4.3 Migration

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Funding migration abroad for work accounted for 30% of the reasons for taking the loan. Working abroad is a large motivation for migration across Nepal and especially in border districts such as those in the South East Terai (CeSLaM, 2014). For some in this study, however, having a member working abroad negatively affected the family members who remained at home, including and in particular their workload and health, but this was not unanimous. Support to participants whose family members are abroad and support to mitigate the risks of labour migration are important issues for the Haruwa-Charuwa (P. Mahat, personal communication, July 16, 2016).

### Limitation

We were unable to analyse who had migrated in the family and if money was being sent home or not, which is likely to affect the impact of migration on Haruwa-Charuwa families.

## 4.4 Psychological difficulties

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Overall the sample reported significant levels of psychological distress and impairment in functional ability. In the majority of measures it was women who were more likely to report symptoms above a clinically significant threshold. In particular, while traumatic experiences were experienced by both sexes, women were more likely to report symptoms indicating post-traumatic stress and it was a death of a family member that was the most frequently reported associated event in these individuals. Gender has been indicated as a predictor of psychological distress across a number of studies in Nepal (Kohrt et al., 2009; Thapa & Hauff, 2005). Depression symptoms, however, were equally observed among male and female participants and this was also true of rates of suicidality. Suicidality is an important issue to consider as among Nepali women it is one of the main causes of death, furthermore, it has been suggested to be linked to experiences of domestic violence (Karki, 2012).

### **Women more likely to report symptoms above a clinically significant threshold.**

The reporting of such high rates of distress is in line with previous research highlighting high rates of depression and anxiety in rural Nepal, post traumatic stress among survivors of human rights abuses and modern slavery in Nepal (Kohrt et al., 2009; Mills et al., 2008; Tsutsumi et al., 2008) and survivors of modern slavery internationally (Helen Bamber Foundation, 2015).

It was expected that women would show low levels of alcohol use, but it was not predicted that such low rates of alcohol use would be observed also in the male participants in the quantitative part of the research. Alcohol emerged in the qualitative element of the study as an important issue in male participants' health status and was understood by some staff in line with a 'self-medicating' theory of alcohol use (Agyapong, 2013). See section 4.5 for discussion of this.

The overall impression is that these participants are in a highly distressing situation, are distressed by it and it is compromising their ability to live a meaningful life. It is also clear that, given the on-going causes of their psychological distress, an isolated intervention would likely be unsustainable and invalidating to the participants' distress unless wider healthcare, legal, welfare and community support systems are mobilised.

A recent review of mental health support for survivors of modern slavery shows that meaningful targeted interventions are helpful for alleviating distress in *survivors* of modern slavery, and that many of these combine specific psychological support with legal, economic and vocational support (Helen Bamber Foundation, 2015). However, the number of such interventions is quite limited.

The limited evidence base of targeted mental health interventions has therefore focused on *survivors* of modern slavery (Helen Bamber Foundation, 2015), but the overwhelming majority of Haruwa-Charuwa labourers in the Eastern Terai are currently in bonded labour (Freedom Fund, 2014; ILO, 2013).

### *Recommendations*

Programs of psychosocial support in Southeastern Nepal are likely to be successful if they are multi-layered and holistic (Kohrt et al., 2010). As there is limited resource for training, initially, it is recommended that training should focus on the NGO staff working directly with the participants. For example, this could focus on raising staff awareness and understanding of mental health issues as understood within a psychosocial framework, how to reduce stigma in staff around mental health, and how to sustain staff well-being while they help participants make changes to their socio-economic situation.

As a next phase of psychosocial support, it is likely to be helpful to strengthen community integration, involvement and social cohesion, building on existing systems of social support and resilience (Newlin & Webber, 2015). However, participatory feasibility research is required before such training should be developed to ensure cultural sensitivity. The finding of this present report that family and community are the participants' preferred source of support for psychological needs should be capitalised upon.

It could also be helpful to train selected members of the community to identify mental health problems using community validated and user-friendly instruments (Jordans, Kohrt, Luitel, Komproe, & Lund, 2015) to support them to refer severe mental health presentations to specialist services. However, before this training takes place, it would be important to learn from CMC's previous work, about available services, including mapping the referral pathways. It may be necessary to give more in-depth training to psychosocial counsellors who can be available in the absence of other services. This is to prevent damaging relationships with participants and local NGO partners due to raising expectations of the availability of support (P. Mahat, personal communication, July 16, 2016).

***Training should focus on the  
NGO staff working directly  
with the participants.***

In the future, if more specialised and targeted intervention training to address specific mental health problems (such as PTSD) is considered appropriate for the Haruwa-Charuwa community, it should closely build and learn from previous mental healthcare initiatives in a Nepali context (Jordans, Luitel, Pokhrel, & Patel, 2016). Also, such interventions need to be deliverable by non-specialist professionals, but with sufficient training and on-going supervision (Jordans et al., 2016). Additionally, they should be guided by the needs and voices of the Haruwa-Charuwa community, piloted and their effectiveness systematically evaluated (Helen Bamber Foundation, 2015). The literature also suggests that such

targeted psychological interventions focusing on specific mental health problems would be most appropriate for families who are survivors of bonded labour (Helen Bamber Foundation, 2015).

### *Limitation*

The methodology for recruitment for the study was opportunistic and with a small sample size. Therefore there are limitations to its generalizability and how representative the sample was of the population as a whole. High rates of missing data undermined the findings of the demographic interview and an ability to compare participants' socio-economic status with their mental health.

## 4.5 Stigma, underreporting and access

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A common theme from the qualitative data was that stigma surrounding mental health (especially severe mental health problems) was high and that this interfered with help-seeking behaviour. Furthermore, mental health professions in Nepal regard alcohol problems as one of the more urgent mental health issues to be addressed, based on their clinical experience (Jordans et al., 2013). However, alcohol problems were surprisingly low among male participants. This is possibly due to fear of reporting alcohol use, which may have been exaggerated by the presence of an interpreter from within their community. Similarly, other potential sensitive issues including domestic violence, threats from landowners and sexual harassment may also have gone unreported for this reason.

Participants also stated that their relationships with the landowner, community and family at large were largely positive. While for some this is likely to be the case, the social and psychological profile of the participants suggests the true nature of their relationships, especially with the landowners, were not captured. It has been noted in other contexts of bonded labour that in the early stages of an intervention, participants tend to perceive the landlord as their benefactor, and sometimes as being the only source of financial help during a crisis (G. Baumann, personal communication, April 29, 2016). When reporting on relationships therefore, it is suggested that financial assistance is what bonded labourers tend to consider, rather than the penalty of subsequent bonded labour and ensuing threats or intimidation.

### *Recommendations*

Participant involvement in future research and intervention development, alongside using language that is meaningful to participants that minimises stigma would be helpful in increasing access and overcoming cultural barriers to support (Kohrt & Harper, 2008; Kohrt & Hruschka, 2010). This is also important at all levels of an integrated intervention (from social to family to individual work) and how organisation members talk about mental health among one another.

Raising staff awareness and understanding of mental health problems within a psychosocial framework as described in section 4.4 will hopefully also facilitate a destigmatising discourse within the community regarding mental health.

For future research, in order to help overcome the possible limitation of underreporting when interviewing participants, data could also be collected from informants (e.g. neighbours or family members) and greater training and selection processes of translators.

Lastly, greater attention to defining and clarifying terms consistently across interviews would also be helpful.

## 4.6 Traditional healers

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On a pragmatic level, traditional healers are far more available than health professionals, however, they also operate within a framework unfamiliar to conventional health professionals e.g. the spiritual domain (Kohrt & Harper, 2008). While the focus group discussions suggested that traditional healers were visited and deemed to be helpful, the individual data found no reporting on the use of traditional healers. It is possible traditional healers are sought in cases of severe mental health problems e.g. psychosis, and this study did not focus on such presentations. Furthermore, overt disparity in cultural beliefs may have affected the interviewing dynamic. For example, the Haruwa and Charuwa families may have been hesitant to report to healthcare professionals and translators interviewing them (more aligned to a western medical practice) that they continue to have faith in traditional healers or have visited them in the past. Alternatively, the price of consultation with a traditional healer may have been a factor.

### *Limitation*

Understanding of help-seeking behaviour was limited in this study. Further qualitative research to learn about what factors lead a family to a) seek treatment for psychological distress, and b) how a decision is made about what form of support is utilised, would be important in developing psychosocial support in this community.

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