Nepal
WHO Special Initiative for Mental Health
Situational Assessment

I. CONTEXT

The Federal Democratic Republic of Nepal is a landlocked country in South Asia, between China and India. Nepal has diverse geography that includes the Tarai or flat river plain in the south, central hill regions, and mountainous Himalayas in the north. The country has a federal parliamentary republic and is made up of 7 provinces (Pradesh) with the nation's capital located in Kathmandu. The population of Nepal is divided between a concentration in the southern-most plains of the Tarai region and the central hilly region.[2] Major economic activities include tourism, carpets, and textiles. Most of the labor force in the country is in agriculture (69%), followed by services (19%) and industry (12%).[2]

Financial support from family members employed overseas is a major source of income for almost 56% of Nepali.[12,13] Remittances from foreign work equate to nearly a quarter of Nepal's income.[13] The majority of migrant workers travel to Malaysia and gulf countries, such as Qatar, Saudi Arabia, UAE and Kuwait. Despite the enormous contribution they make to their households and home country, migrant workers are vulnerable to poor mental health due to labor exploitation, poor working conditions, and abuse, such as forced labor and trafficking.[12] Additionally, there can be profound impacts related to family separation and migrant work for the workers as well as the spouses[14] and children[15] they leave behind.

According to World Bank Data, Nepal ranks 4th of 8 in the South Asia Region for life expectancy and 5th of 8 for infant mortality.[16] Maternal mortality is at 239 deaths per 100,000 live births.[8] Antenatal care coverage is at 84%.[8] Nearly a quarter of women over 15 years old in Nepal report being a victim of intimate partner violence (IPV).[8]

The most common substances used in Nepal are opiates, cannabis and tranquilizers.[17] Nepal is yet to adopt a comprehensive policy on regulation and control of alcohol Nepal has a low HIV seroprevalence.[10]

The SARS-CoV-2 (COVID-19) pandemic has highlighted the limitations of existing mental health services in the country and increased mental health care needs, exemplified by substantial increase in death by suicide.[19,20] Efforts to address this acute need are reported to include the development of a COVID-19 Mental Health and Psychological Support Intervention Framework and the implementation of a *National Mental Health Strategy and Action Plan 2020* by the Ministry of Health and Population.

Table 1: Demographics

Demographic information	
Population	29,675,000[1]
Under 14 years	*8,328,000*[1]
Over 65 years	*1,754,000*[1]
Rural population	79.4%[2]
Literacy	67.9%[3]
Languages	Nepali (official)[2]
Ethnicities	Chhettri 16.6% Brahman-Hill 12.2% Magar 7.1%, Tharu 6.6%, Tamang 5.8%, Newar 5%* [2]
Religions	Hindu 81.3% Buddhist 9% Muslim 4.4%[2]
GDP per capita	1,071.10 USD[4]
Electricity	93.9%[5]
Sanitation	95.0%[6]
Water	79.0%[6]
Education	82.8% complete primary school[7]
Health information	
Life expectancy	71.7 years at birth[1]
Infant mortality	32 deaths per 1,000 live births[1]
Maternal mortality	239 deaths per 100,000 live births[8]
Leading causes of death	COPD (16%), Ischemic heart disease (12%)
Healthcare Access and Quality Index	40.0 (36.5 to 44.4)[9]
HIV seroprevalence	0.10%[10]
Health Expenditure	
Total	2.4% of GDP[11]
Per Capita	USD 25.40[11]

**Ethnicities under 5% not reported;*
COPD: Chronic Obstructive Pulmonary Disease
USD: United States Dollar

Nepal has several strengths and challenges to consider in its mental health care system. There is increasing public awareness of mental health and a long history of traditional healing methods for mental health ailments. Nepal has had gradually increasing multisector involvement in the mental health field and prioritization by the government, including a recent National Mental Health Strategy and Action Plan 2020 . There is strong support from NGOs, and several global initiatives that have been piloted in Nepal. Integrated approaches to care have been adopted to expand mental health services.

Challenges include a deep-rooted stigma and misconception about mental illness as well as lack of human and financial resources for mental health. Additionally, delivery of mental health care in secondary care is not strong, and the technical and managerial capacity of municipal and provincial governments is low. Mental health is not a priority in the medical education curriculum of universities, and health care is not oriented towards a chronic care model that demands regular follow up.

The main institutions that deliver basic health services are 135 public hospitals, 2,168 non-public health facilities, 196 primary health care centers and 3,806 health posts.[21] Primary health care services are also provided by 12,532 Primary Health Care Outreach Clinic sites.[21] A total of 16,428 Expanded Programme of Immunization clinics provide immunization services.[21] These services are supported by 51,420 Female Community Health Volunteers.[21]

II. METHODS

The Rapid Assessment used a modified version of the Program for Improvement Mental Health Care (PRIME) situational analysis tool[22] to assess the strength of Nepal's mental health system. The assessment was carried out from April to May 2021. We expanded the tool to include multi-sector entry points for mental health promotion and services, a focus on vulnerable populations, and stratification of relevant sociodemographic and health indicators across the life-course. The PRIME tool assesses six thematic areas: 1) socioeconomic and health context, 2) mental health policies and plans, 3) mental disorder prevalence and treatment coverage, 4) mental health services, 5) cultural issues and non-health sector/community-based services, and 6) monitoring and evaluation/health information systems. The complete situational analysis tool for Nepal is available for review in **Appendix 1.**

Desk Review

The majority of data on socioeconomic status, population health, policies/plans, and the mental health-related readiness of health and other sectors came from secondary sources, including a detailed review of available mental health policies and plans and other government documentation, the World Bank, Demographic and Health Surveys, published peer-reviewed and grey literature, and the Global Health Observatory. We also accessed the Ministry of Health and Population (MOHP) Health Management Information System to assess treatment coverage, staffing complements, and facility numbers. Finally, national-level estimates of the prevalence and rate of priority mental health conditions, stratified across the life course, were derived from the 2019 Global Burden of Disease Study (GBD)[23] and the fact sheets of the National Mental Health Survey Nepal.

Key Informant Interviews

We used qualitative data to inform our description of the strength of the mental health system. Participants were sampled purposively, and interviews followed structured guides. We aimed to identify at least one participant from each of the following groups: people with lived experience of a mental illness, advocates for mental health, clinicians and implementers of mental health programs, and mental health system policymakers. The final sample included three implementers and designers of innovative MH programs.

Facility Checklists

We also conducted visits to health facilities to document key indicators related to readiness to provide mental health services. We used an adapted version of the WHO Service Availability and Readiness Assessment (SARA) instrument.[24] Facilities were sampled purposively. We aimed to sample at least one facility from each group of the following groups: specialist mental hospitals, psychiatric units within general hospitals, and primary care clinics. The final sample included one specialist mental hospital, two psychiatric units in general hospitals, one community mental health center, one mental health outpatient clinic, and one primary care clinic.

Analysis

It was not possible to calculate treatment coverage in Nepal as estimates of numbers of patients treated for mental health conditions were not available. For the qualitative analysis, we used simple, deductive thematic coding to align interview content with the sections of the situational analysis tool, outlined below. We also abstracted and summarized data from each facility checklist.

III. RESULTS

Mental Health Policies and Plans

Political Support

The government of Nepal has gradually increased its political commitment to mental health services in recent years, culminating with the establishment of a specific mental health desk within the Ministry of Health and Population's Department of Health Services. Mental health care has been included in the list of basic health services in Sub-Section 4 (e) of Section 3 of the Public Health Services Act, 2075. Furthermore, the Public Health Service Regulations have expanded the type of mental health services to be included in the Basic Health Service and Emergency Health Service Packages. In addition, the National Health Policy, 2019, section 6.17.5, has a strategy to expand mental health services integrated into overall health systems.

The public funds allocation for mental health is approximately 0.05 USD per capita, with an estimated USD$1.5m annual budget for mental health interventions. Notably, this budget does not include costs for human resources or hospital operations.

Mental Health Policy and Mental Health Plan 2020

Nepal has a single, over-arching health policy, with sub-sections related to particular conditions. Mental health is mentioned in section 6.17.5. There is no standalone mental health policy in Nepal. The National Mental Health Strategy and Action Plan (2020) provides a more comprehensive description of Nepal's plans for mental health care. This strategic Action Plan describes the provision of free primary care mental health services for all parts of the country. Described below are key components incorporated within the National Mental Health Strategy and Action Plan 2020.

The prioritization of mental health has significantly increased in the last decade. The role of NGOs and INGOs in the promotion and development of mental health is highly appreciated. They have pushed the government to prioritize mental health. Since then, even government started taking it into priority.

- MH program implementer

Table 2: Components of National Mental Health Policies and Plans

		Policy*	Plan
Components	PHC integration	n/a	
	Decentralization		
	Hospital integration		
	Maternal	n/a	
	Child/adolescent	n/a	
	HIV	n/a	
	Alcohol/substance use	n/a	
	Epilepsy	n/a	
	Dementia	n/a	
	Promotion/prevention	n/a	
	Suicide	n/a	
Equity	Gender	n/a	
	Age/life course	n/a	
	Rural/urban	n/a	
	Socio-economic status	n/a	
	Vulnerable populations	n/a	

Present; Partially included; Absent

*This policy refers to the overarching heath policy in Nepal

Key Components of the Policy and Plan

Integration of mental health at Primary Health Care level

The Action Plan calls for integration of mental health services across all tiers of the public health care system. The Community Mental Health Care Package 2074 (2017) intends to support meeting this objective.

Strengthening mental health at Secondary Health care level

The Action Plan supports the provision of specialized mental health services in secondary level hospitals and above. Use of health insurance and telemedicine are seen as accessory modalities to support these services. Currently, telemedicine is only used to support primary care through remote monitoring and supervision.

Service user engagement in policy development and planning

The signing of the UN Convention on the Rights of People with Disabilities and the launch of service user organizations in Nepal have increased service user involvement in advocacy activities, but their involvement in policymaking processes remains limited.[26] Service users identify lack of education and technical knowledge, concerns about stigma and discrimination with disclosure, the need to prioritize income generation, and rurality as barriers to participation in policymaking activities.[26] Formation of grassroots level service user groups, receiving training and capacity-building on mental health, and redoubling efforts to reduce stigma and discrimination associated with mental disorders were among the strategies identified to increase involvement.[26]

Legislation

Nepal is yet to adopt a national mental health act. The Act Relating to Rights of Persons with Disabilities, 2074 (2017) provides for every citizen's right to health, rehabilitation, social security, and recreation. Section 35 and 36 of the Act ensure additional service facilities for people with mental or psychosocial disabilities[27] in line with UN Convention to the rights of Persons with Disabilities. The National Mental Health Strategy and Action Plan 2020 states "Government agencies will take the initiative to protect the rights and interests of senior citizens, the helpless, single women and persons with disabilities in a bid to help them overcome mental problems."[28]

The National Mental Health Strategy and Action Plan 2020 calls for the protection of basic human rights for people mental health problems and psychosocial disabilities. Among its propositions, the Strategy puts forward advocacy activities and initiatives to remove elements of existing laws that are discriminatory; calls for legal protections of basic human rights; will provide guidelines for health institutions, rehabilitation homes, communities, and families for the rehabilitation people with mental disorders; assures coordination across sectors for identification and access to care of people in need of substance use disorder treatment and rehabilitation, and it promotes the collaboration of mental health service users in the implementation and dissemination of its provisions and laws.

Prevalence and Treatment Coverage of Priority Mental Disorders

The Nepal National Mental Health Survey (NMHS) was carried out between January 2019 and January 2020 in all seven provinces of Nepal.[29] Among adults, 10% reported any lifetime mental disorder and 4.3% had a current mental disorder. About one quarter (23%) of adults sought some type of treatment for their mental disorder.

GBD 2019[23] estimated the prevalence of major depressive disorder (MDD) in Nepal to be 3.6%, compared to 2.6% for the South Asia region and 2.5% globally. Women, compared with men in Nepal, have a higher prevalence of MDD (4.3% vs 2.8%) and older populations have a high prevalence of MDD (7.6%). Estimates of the prevalence of epilepsy, schizophrenia, alcohol use disorders, and bipolar disorder in Nepal are comparable to regional and global estimates. Alcohol use disorders are much more prevalent among men (2.4%) than women (0.1%). The estimated prevalence of drug use disorders (0.4%) is comparable in Nepal to regional estimates (0.5%) and lower than global estimates (0.8%). Men in Nepal have a higher suicide rate than women (20.7 vs 3.3 suicide deaths/100,000 population).[23] Though more systematic data collection is needed there is indication of a 14% increase in the rates of suicide last year(than the previous year as per the records of Nepal Police)during the COVID-19 epidemic.

Table 2: Prevalence and Treatment Coverage of Selected Mental Disorders

		Prevalence (UI)					
		NMHS*		GBD 2019†		Total† (UI)	Treated**
Schizophrenia	Overall	0.1%‡	0.1-0.3%	0.3%	0.2-0.3%	75,921	60,031-93,424	--
	Female			0.2%	0.2-0.3%	36,760	28,884-45,123	--
	Male			0.3%	0.2-0.3%	39,161	30,993-48,088	--
	Young adults (20-29)			0.3%	0.0-0.4%	16,886	10,952-23,929	--
	Older age (70+)			0.2%	0.0-0.3%	2,212	1,693-2,779	--
Bipolar Disorder	Overall	0.1%‡	0.1-0.3%	0.4%	0.0-0.5%	113,333	87,029-144,797	--
	Female			0.4%	0.3-0.5%	58,526	44,615-74,956	--
	Male			0.4%	0.3-0.5%	54,807	41,806-69,897	--
	Young adults (20-29)			0.5%	0.3-0.7%	28,497	18,742-40,950	--
	Older age (70+)			0.4%	0.3-0.5%	4,213	2,929-5,837	--
MDD	Overall	1.0%‡	0.8-1.4%	3.6%	3.1-4.1%	1,043,324	899,164-1,211,858	--
	Female			4.3%	3.7-5.0%	661,970	568,510-771,157	--
	Male			2.8%	2.4-3.2%	381,354	326,522-445,672	--
	Young adults (20-29)			3.5%	2.4-4.9%	190,838	132,263-268,261	--
	Older age (70+)			7.6%	5.7-9.8%	83,412	62,708-107,268	--
Epilepsy	Overall	*n/s*		0.4%	0.1-0.7%	112,143	26,159-203,883	--
	Female			0.4%	0.1-0.6%	55,365	12,669-99,987	--
	Male			0.4%	0.1-0.8%	56,778	13,258-104,084	--
	Young adults (20-29)			0.4%	0.1-0.7%	19,683	4,401-37,674	--
	Older age (70+)			0.6%	0.1-1.1%	6,739	1,631-12,330	--
Alcohol abuse	Overall	4.2%‡	3.6-4.8%	1.2%	1.0-1.4%	346,284	293,068-410,707	--
	Female			0.1%	0.1-0.2%	18,760	14,561-23,966	--
	Male			2.4%	2.0-2.8%	327,523	277,319-386,767	--
	Young adults (20-29)			1.8%	1.3-2.6%	99,150	68,225-140,011	--
	Older age (70+)			1.3%	1.0-1.8%	14,280	10,660-19,261	--
Drug abuse	Overall	0.2%‡	0.1-0.3%	0.4%	0.3-0.5%	122,082	94,484-154,795	--
	Female			0.4%	0.3-0.6%	67,482	52,089-85,850	--
	Male			0.4%	0.3-0.5%	54,600	40,895-72,961	--
	Young adults (20-29)			1.0%	0.7-1.5%	56,503	36,774-81,974	--
	Older age (70+)			0.1%	0.0-0.1%	612	387-879	--
Suicide Deaths§	Overall	*n/s*		11.6	8.1-15.0	3,528	2,474-4,550	--
	Female			3.3	2.4-4.4	533	389-702	--
	Male			20.7	13.6-27.0	2,995	1,976-3,920	--
	Young adults (20-29)			16.6	10.7-23.1	1,411	886-1,984	--
	Older age (70+)			19.9	14-34.7	380	153-380	--

**Estimates from Nepal Mental Health Survey (NMHS); †Estimates from Global Burden of Disease study 2019; ‡Adults 18+ years; §Rate of suicide deaths per 100,000 population; **No available data for treated prevalence. MDD: Major depressive disorder; n/s: not specified; UI: Uncertainty interval.*

The NMHS yielded prevalence estimates in the adult population for alcohol use disorders of 4.2%, markedly higher than GBD estimates. NMHS estimate of MDD prevalence was 0.1%, which is much lower than the GBD estimate.

Mental Health Services

Governance

Public mental healthcare in Nepal is coordinated and delivered by the Department of Health Services (DoHS), under the overall leadership of the Ministry of Health and Population (MoHP). Within the DoHS, mental health care is the responsibility of the NCD and Mental Health Section of the Epidemiology and Disease Control Division (EDCD). This section is the program focal agency for mental health and is responsible for planning and organization of services, coordination with other Government and nongovernment sectors, and implementation of national plans and programs. Additionally, the Curative Service Division of DoHS governs the secondary and tertiary care mental health interventions and the Management Division of DoHS manages the Health Information System and drug supply. Similarly, the National Health Training Center will oversee the identification of training needs, development and accreditation of training curricula, and organization of trainings. These divisions deliver mental health-related services in an integrated fashion, along with general health services, and in close collaboration with the NCD and MH Section of EDCD.

Human Resources

Nepal has an estimated 144 psychiatrists plus 3 child psychiatrists. Of these, 110 are in private practice. There are an additional estimated 75 psychiatric nurses and 30 psychologists in private practice. Almost all specialists are concentrated in major urban areas. There are also an estimated 700 lay counsellors working in the public sector. Specialist Psychiatry training is available from several institutions, while clinical psychology training is available only in one institution. As a result, there is around 15- 20 psychiatrist added every year while only 2-3 clinical psychologists are produced. There are, however, no training programs in Nepal for sub-specialties such as addiction, child mental health, or geriatric mental health.

Table 3: Human Resources for Mental Health

		#	Rate per 100,000
Generalist	Doctor	28,477[30]	96.0
	Nurse	27,040[31]	91.1
	Pharmacist	3761[32]	12.7
Specialist	Neurologist	25	0.1
	Psychiatrist	147	0.5
	Clinical psychologist	35	0.12
	Psychiatric Nurse	75	
	Lay counsellors	~700	2.4

Due to lack of specific specialists, the patients are also not getting specialized care. We do not have specialists dealing with specific substances of abuse, for example treating only alcohol use disorder.
- MH program implementor

Healthcare Facilities for Mental Health

Nepal has one specialist public-sector psychiatry hospital as well as four private-sector psychiatry hospitals. Hospital-based mental health care is mainly delivered from 19 medical colleges and several of the 364 private general hospitals and 27 government hospitals. There are two public-sector facilities for alcohol/substance use rehabilitation, any many more run by non-governmental organizations. There are also 3 outpatient facilities for children and adolescents.

Table 5: Healthcare facilities for Mental Health

		Total Facilities	Facilities/ 100,000	Total Beds	Beds/ 100,000
Inpatient	Mental hospital	10*	0.03	*n/s*	*n/s*
	General hospital psychiatric unit	18	0.06	350	1.18
	Forensic Hospital	*n/s*	*n/s*	*n/s*	*n/s*
	Child/adolescent facility	*n/s*	*n/s*	*n/s*	*n/s*
Outpatient	Hospital mental health	29	0.10	*n/s*	*n/s*
	Community-based/PHC /non-hospital mental health	*n/s†*	*n/s†*	*n/s†*	*n/s†*
	Alcohol/drug/other facility	2**	0.01	*n/s*	*n/s*
	Child/adolescent	3	0.01	*n/s*	*n/s*

**Many hospitals provide mental health care in general inpatient facilities. This number is not reflected here. There are 19 medical colleges, 364 private hospitals, and 27 zonal and regional hospitals that provide inpatient care.*
***Run by the government. This number represents dedicated alcohol, drug, and substance use facilities. Many psychiatric facilities will provide care for alcohol and substance use.*
n/s: not reported
† Total number of community-based/PHC/non-hospital mental health facilities and beds are not available; however, these services are present throughout Nepal.

Primary Care Integration

Nepal has adapted the mhGAP tools to fit its context, in the form of the Community Mental Health Care Package 2017. Per this model, care for common mental disorders including depression, anxiety, alcohol use disorder, Epilepsy and child/adolescent mental and behavioral disorders are intended to be managed at the primary care level. The

National Mental Health Strategy and Action Plan 2020 calls for mental health resources in a number of governmental agencies including primary care.

Mental Health Integration into Other Public Health Programs

Mental health is yet to be meaningfully integrated into other priority public health programs such as HIV/AIDS, tuberculosis, or maternal and child health programs. Mental health intervention in the national HIV program is limited to voluntary counseling and testing in the form of pre- and posttest counselling.[33] Additionally, the opioid substitution therapy (OST) program is integrated in the HIV program. The Global Fund to Fight AIDS, Tuberculosis and Malaria has been covering the costs of medical and psychosocial support services for OST patients in Nepal since 2011.[34] The National Child Health Strategy includes the prevention of tobacco, alcohol and substance use and provision of socio-emotional skills in schools; however, these interventions are yet to be implemented. Despite a great scope, mental health interventions have not yet been integrated into maternal health programs or the tuberculosis program.

The inclusion of mental health in the NCD agenda has, to a certain extent, helped to advance mental health in the mainstream NCD discussion. The Multisectoral Action Plan for the Prevention and Control of NCDs 2013-2020 had a separate focus area on mental health. Similarly, mental health has been included in the next edition of the NCD action plan. Mental health and NCDs are governed together by the same focal point, and several other related systems level initiatives are often combined, such as update of essential drug list, drug procurement & supply, or management of health information. At the same time, separate parallel programs on PHC strengthening are being implemented. Usually, the implementation of mhGAP interventions follows the same districts where the WHO Prevention of Essential Non-Communicable Diseases (PEN) package has been implemented in the previous year. The same health care providers trained on PEN will also be trained on mhGAP. While the impact of this is yet to be studied, these sequential trainings are expected to complement each other and enhance the quality of primary care services.

Psychotropic Medications

A set of psychotropic medications, including antipsychotics, antidepressants, anxiolytics, mood stabilizers, and antiepileptics are available at health facilities of all levels across Nepal; although patients frequently pay out of pocket due to frequent stock out and inconsistent supply. Mental health medications can be prescribed by registered medical doctors; however, Health Assistants employed in primary health care can also prescribe after receiving a training and following certain government protocols.

Psychosocial services

There is limited availability of psychological services in Nepal outside of a few tertiary care hospitals and private hospitals and clinics. The small number of clinical psychologists in these settings provide a wide range of psychotherapies. In addition, basic psychological interventions are also delivered through NGO programs in selected districts and population groups.

Health Information System

Health information related to mental health in Nepal has been integrated in two different formats depending on the type of the health facility: The information from the hospitals and Primary Health Care Centers are recorded based on the diagnoses made by the medical doctors. This means that all the diagnoses can potentially be recorded and reported from the hospitals. Whereas for the Basic Health Centers, health workers will have to choose from a set of 15 pre-coded diagnosis options which includes most of the priority MNS conditions.

The health workers at Basic Health Centers do not have adequate knowledge and skills to make diagnoses from the list. Recent projects to integrate mental health at primary care level have prioritized different sets of clinical conditions, some of which are not covered in the diagnostic check list. This has resulted in under reporting of the information. Similarly, the data quality from the hospitals does not meet desired standards. The information is not routinely calculated and periodically reviewed. The more challenging is suicide related information, which is often scattered in vital statistics, hospital records and the police records.

Community

Sociocultural Factors

Traditional healers

Mental disorders have been attributed to supernatural and religious causes.[35–37] While there are no specific faith-based sites in Nepal, faith healers and traditional healing systems are engraved in all forms of cultural and

religious practice in Nepal from Hinduism, Buddhism, to Indigenous cultures. A Christianity-based mental health support system has also been introduced in Nepal. Traditional healers in Nepal use their spiritual role to create religious explanatory frameworks when treating an individual's psychological and sociological existential crises.[36] Within this psycho-sociological foundation, the traditional healer manipulates unconscious symbols of the body and self as culturally relevant psychotherapy. There are three main types of traditional healers in Nepal: *dhami-jhankri* (amalgam term for two separate traditional healer types), *lama* (Buddhist monk and healer), and *mata* (female healer). Community members choose traditional healers based on the healer's status within the community, genealogical or symbolic familiarities, sensitivities to local socio-economic issues, level of discrimination among the poor, emotional availability, genuine appearance, and mastery over the supernatural. Additionally, many community members seek services from traditional healers due to economical and access barriers to modern medicine and perceived fear of "injection" and "saline" treatment.[38]

Stigma

In both rural and urban communities there is stigma towards mental illness, though things have changed in the past decade. There is also discrimination against persons with mental illnesses. It is difficult for them to find jobs or partners if they disclose mental illness. It is seen as an illness that has no treatment. Stigma also causes dropout in the treatment of mental health problems. In one study, Female Community Health Volunteers, reported that people felt ashamed to go to health facilities for mental health treatment due to fear of discrimination, which is why people drop out.[39]

Currently [one of] the strongest pillars providing support to persons with mental health are families of persons with mental illness. Even though awareness about mental illness is not there in an adequate level in the general population, the family never abandons their members in their difficult times. - MH program implementer

Non-Health Sector Activities

There is little multisectoral involvement in mental health care. Since mental health is an emerging priority in Nepal, stakeholders in other sectors have yet to fully integrate mental health services into their programs. Still, the social protection programs such as prevention of GBV, child protection, or disability management are increasingly integrating mental health components in their projects. Similarly, sectors such as migrant worker health and education are gradually including mental health into program plans.

Education: Many private schools have school counselors, but public or government schools do not. The MoHP, however, has initiated a school nurse program where efforts are underway to integrate a package of school mental health interventions. The Women and Social Committee of the House of Representatives has instructed the government to include mental health awareness and suicide prevention in the health curriculum of primary and secondary schools.

Other challenges [in the Nepal mental health system] are lack of mental health in school curriculums and lack of promotion of school mental health. - MH program implementor

Justice: Mental health activities in justice system include occasional orientation of advocates and lawyers on mental health and crime and periodic mental health assessment and treatment of inmates of prison. In addition, mental health assessment and support for children detained for criminal offense has been initiated.

Social Welfare: The government has started supporting NGOs to work with people who with mental disorders who are experiencing homelessness. The government uses a private-public partnership (PPP) model to release applications for funds to NGOs.

Refugee services: MH was a priority in Bhutanese refugee camps in the Eastern Nepal, but was phased out as repatriation was completed. .

Migrant workers: Systematic action is yet to be taken. Except for a few destination countries, pre-assessment of MH is not done. Similarly, there is no systematic assessment and support to the migrant workers returning to the country.

Advocacy

There are many active NGOs in Nepal doing work related to mental health, including one run by people with lived experience of mental health conditions. NGOs are playing a major role in advocacy and demanding rights based mental health care. NGOs have also been active in providing services for child protection, gender-based violence, people with developmental disorders (such as autism and Down syndrome), inpatient treatment and

rehabilitation for alcohol and substance use disorders, or homeless people with mental disorders. There are more than 50 drug rehabilitation centers registered as NGOs in Nepal that engage in regular advocacy efforts, even though many are poorly aligned with rights-based standards of care (e.g., involuntary admissions, use of restraints).

Awareness-raising, Promotion, and Prevention

Awareness-raising, mental health promotion, and mental disorder prevention activities are delivered by the government and several NGOs. These activities include regular radio programs, distribution of leaflets and pamphlets for mental health awareness, as well as dissemination of audiovisual information through social media. These efforts do not occur systematically, but are typically centered around specific projects or celebration of global advocacy events such as International Suicide Prevention Day or the World Mental Health Day.

Several organizations run help-line services for mental health in general and suicide prevention, specifically, though few of them operate 24 hours daily.

IV. CONCLUSION

Nepal is a landlocked country in South Asia, between China and India that has a large rural population. The majority of health care capacity, including mental health, is concentrated in major cities. Foreign employment is a major source of income for many Nepali households, yet the mental health of foreign and migrant workers is not well assessed. There is increasing awareness and investment in mental health from both the general public and the government in part due to experience with the acute stressors and mental health needs associated with emergencies such as the 2015 Nepal earthquake and the COVID-19 pandemic. Nepal has a history of strong support from NGOs. Despite these strengths, Nepal still faces challenges in its mental health care system. Scarce human resources and financial investment for mental health persist; nor is it a priority in medical education curriculums.

Nepal has a single, over-arching health policy in which mental health is included as a subsection. There is no standalone mental health policy in Nepal. In 2020, Nepal published the National Mental Health Strategy and Action Plan 2020, which addresses integration of mental health in primary care and the need to strengthen mental health services at the secondary health care level. Strengthening mental health services at the secondary and tertiary care levels, through training of specialist providers and financial investment, is a noted aim. While there are efforts underway to implement mhGAP in the primary care setting, there is limited provision of psychosocial services outside of a few tertiary care hospitals and private clinics.

Nepal has a strong traditional health care system. Faith healers and traditional healing systems are embedded in all forms of cultural and religious practices in Nepal. Traditional healers in Nepal use their spiritual role to create religious explanatory frameworks when treating an individual’s psychological and sociological existential crises. Traditional and faith-based healers are important stakeholders in the mental health care system of Nepal.

Nepal has little mental health integration into non-health sectors. Social protection programs such as prevention of gender-based violence, child protection, and disability management are increasingly including mental health components. Migrant worker health programs have recently begun to focus on mental health. Finally, stigma and discrimination associated with mental health conditions continue to shape disclosure and willingness to utilize mental health services. Attention to these issues and to the human rights of people with mental health conditions must be an integral part of expanding access to care from all types of care providers and services.

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