

Implementation Challenges of Nepal's National Mental Health Strategy 2020–2025: Governance, Financing, and Stigma Barriers.



Authors and affiliation

Independent team - Sahayatri Consults

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Background

राष्ट्रिय मानसिक स्वास्थ्य रणनीति तथा कार्ययोजना, २०७७

नेपाल सरकार स्वास्थ्य तथा जनसंख्या मन्त्रालय मानवीय मन्त्री स्तरिय,
२०७७ प्रति १४ को निर्णय अनुसार



नेपाल सरकार
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- ✓ Mental health has emerged as a critical global public health concern.
- ✓ Ministry of Health and Population (MoHP) has been developed and implemented the National Mental Health Strategy and Action Plan (NMHS-AP) 2020-2025
- ✓ The aim is to address the needs of the population and the priorities outlined in the National Health Policy 2019.

Objectives of the strategy assessment

- ✓ To assess the progress made in the strategies and action plan.
- ✓ To identify challenges, and barriers in the implementation process.
- ✓ To gather insights and way forward from stakeholders

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Methodology



Qualitative dominated mixed-methods (June–December 2025): Ethical approval from NHRC.



Qualitative: 155 participants (45+ KIIs, 8 FGDs in 10 districts, 7 provinces).



Quantitative: HMIS data (cases, workforce, budget); facility observations.



Rights-based lens: UNCRPD, WHO QualityRights Toolkit.



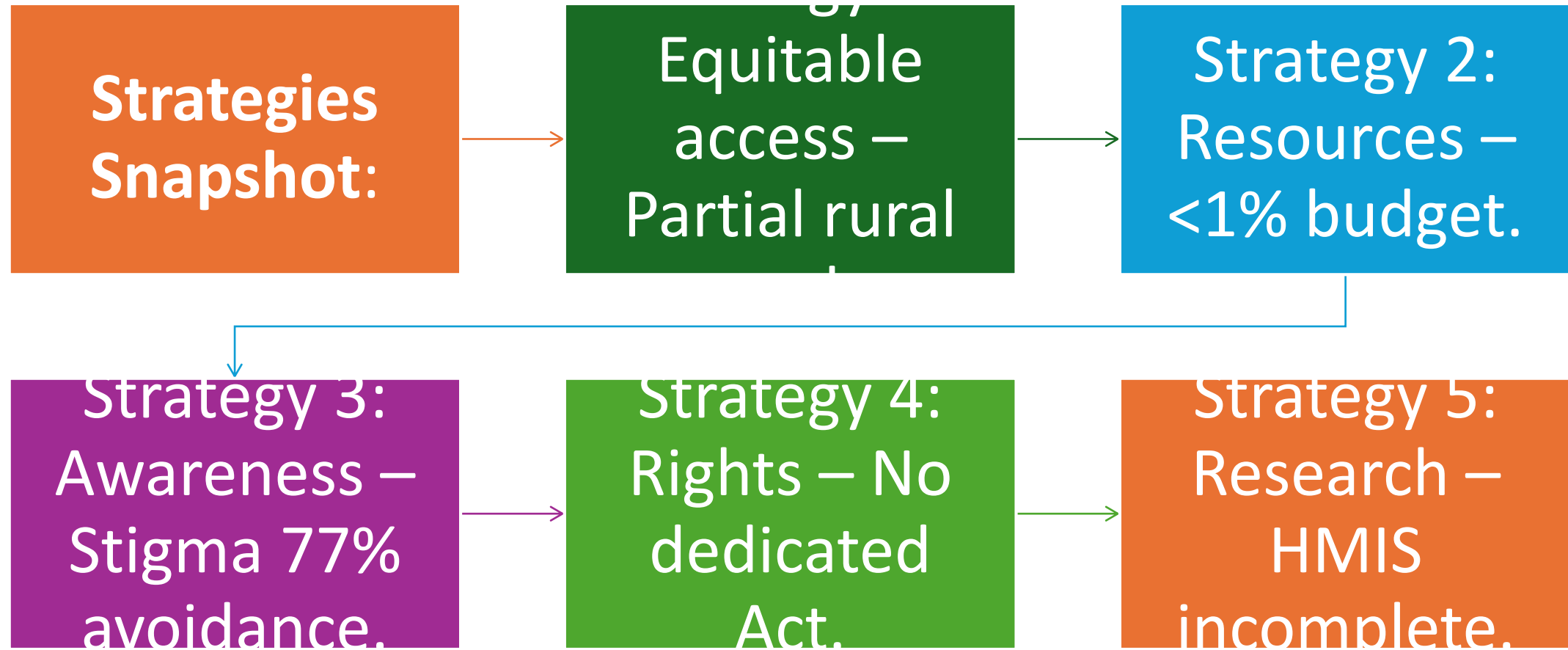
Validation & sharing: Aug 3 & 29 Dec, 2025 (federal stakeholders).



Limitations

- . The short timeframe limited the ability to conduct longitudinal trend analysis;
- . Resource constraints restricted exploration to some extent, which may affect generalizability;
- . Limited availability of relevant information.

Key results



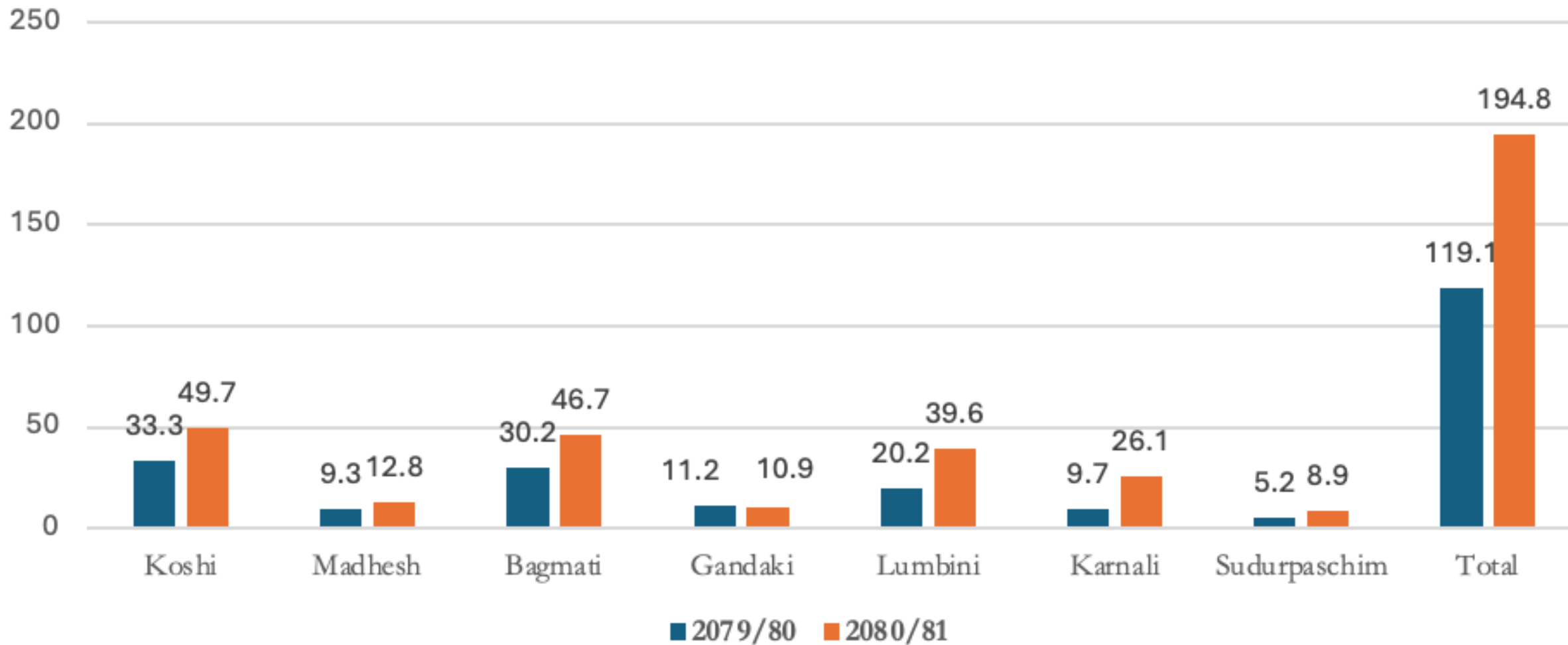
Strategy 1 - Eccess and coverage

Indicator (Strategy 1)	Baseline	Target	Progress to date	Notes
1.1 Municipalities operating community mental health programs	100 (FY 2076/77)	500	77 districts implementing programs	No record of exact number of municipalities.
1.2 Hospitals/academies providing specialized mental health services	10	40	62	Mostly urban; limited days per week; multidisciplinary staff gaps.
1.3 Hospitals/academies providing super-specialized services	3	23	25	Mostly urban; limited days; staffing gaps; ~500 inpatient beds reported.
1.4 Municipalities with child & adolescent mental health programs	1	150	753	Covered via school-based curriculum/SEL/mental health first aid and school health nurses.
1.5 Municipalities with suicide prevention programs	–	753	753 (reported)	Often limited to single events; sustained programming limited.

Strategy 1 - Access and coverage

1. Significant expansion of services and a 63% increase in reported mental health cases in HMIS largely due to improved detection and expanded reporting.
2. Service availability remains urban-centric; rural access is constrained by staffing, medicine stock-outs, and weak referral pathways.
3. Services are treatment-focused; prevention and promotion receive limited resources and implementation.

Number of mental health cases under treatment in 1000



Strategy 2 - Mechanism, resource and workforce

Indicator (Strategy 2)	Baseline	Target	Progress to date	Notes
2.1 Separate mental health mechanism at federal/provincial/local levels	8	500	25	1 focal at federal; 1 focal in each province; focal persons in 17 districts.
2.2 Local levels allocating a separate mental health budget	15	500	753 (reported)	Not verified against AWPB; often limited to 1 annual event.
2.3 Hospitals with sanctioned & filled specialist positions	7	50	9 hospitals in 4 provinces	Permanent consultant psychiatrists: 16; temporary: 20 (reported).
2.4 Personnel trained in mental health	500	7000	4994	~71% of target; post-training supervision limited.

Strategy 2 - Mechanism, resource and workforce

1. Separate budget lines at local level are reported widely, but verification against AWPB is limited and funding remains insufficient (mental health reportedly <1% of health budget).
2. Mechanisms/focal persons exist mainly at federal/provincial levels; targets for decentralized mechanisms are far from met.
3. Training scale-up is substantial, but supervision/mentoring and specialist workforce are major gaps.

Strategy 3 — Awareness, stigma reduction, suicide prevention

Indicator (Strategy 3)	Baseline	Target	Progress to date	Notes
3.1 Types/number of information disseminated through mass media	4	15	<15 (exact not tracked)	Insufficient nationwide coverage/monitoring.
3.2 Schools operating school mental health programs	20	700	1386	Activities reported as limited; strong expansion overall.
3.3 Journalists oriented on mental health & suicide prevention	50	500	282	Training on sensitive reporting (media mobilization).
3.4 Local levels with mental health self-care groups formed	20	500	N/A	Mostly NGO-supported; no national list.
3.5 Municipalities with mental health promotion/disability management committees formed	20	500	753	Formed under Disability Rights Act; mental health underemphasized.

Strategy 3 — Awareness, stigma reduction, suicide prevention

- School mental health programming expanded strongly; curriculum integration reported up to grade 8.
- Mass media dissemination and journalist orientation remain below target; stigma persists (especially in rural contexts).
- Suicide prevention efforts exist (e.g., **1166 helpline**), but trends remain concerning and sustained local programming is limited.

Strategy 4 — Human rights & rehabilitation

Indicator (Strategy 4)	Baseline	Target	Progress to date	Notes
4.1 Discussions held with legislators on rights of persons with mental health/psychosocial disabilities	2	20	7	Often supported by I/NGOs; still below target.
4.2 Local levels operating mental health rehabilitation services	0	150	N/A	Government has not established; some NGO-run services exist.
4.3 Rehab centers meeting minimum standards and operating with permission	0	150	N/A	No national minimum standards guideline developed.
4.4 Hospitals providing treatment & rehabilitation for substance abuse	2	25	25	300+ rehab centers registered under MoHA also provide rehab services; OST centers expanding.
4.5 Prisons providing MHPSS services to inmates	4	50	36	36 jail health staff received mhGAP training; overcrowding/quality concerns noted.

Strategy 4 — Human rights & rehabilitation

- Policy attention improved and Supreme Court directives are a key milestone, but **integrated mental health legislation** is still absent.
- Rehab services and minimum standards for rehab centers remain major gaps; many services are provided by NGOs/private sector.
- Prison mental health coverage expanded, but quality and regularity concerns remain.

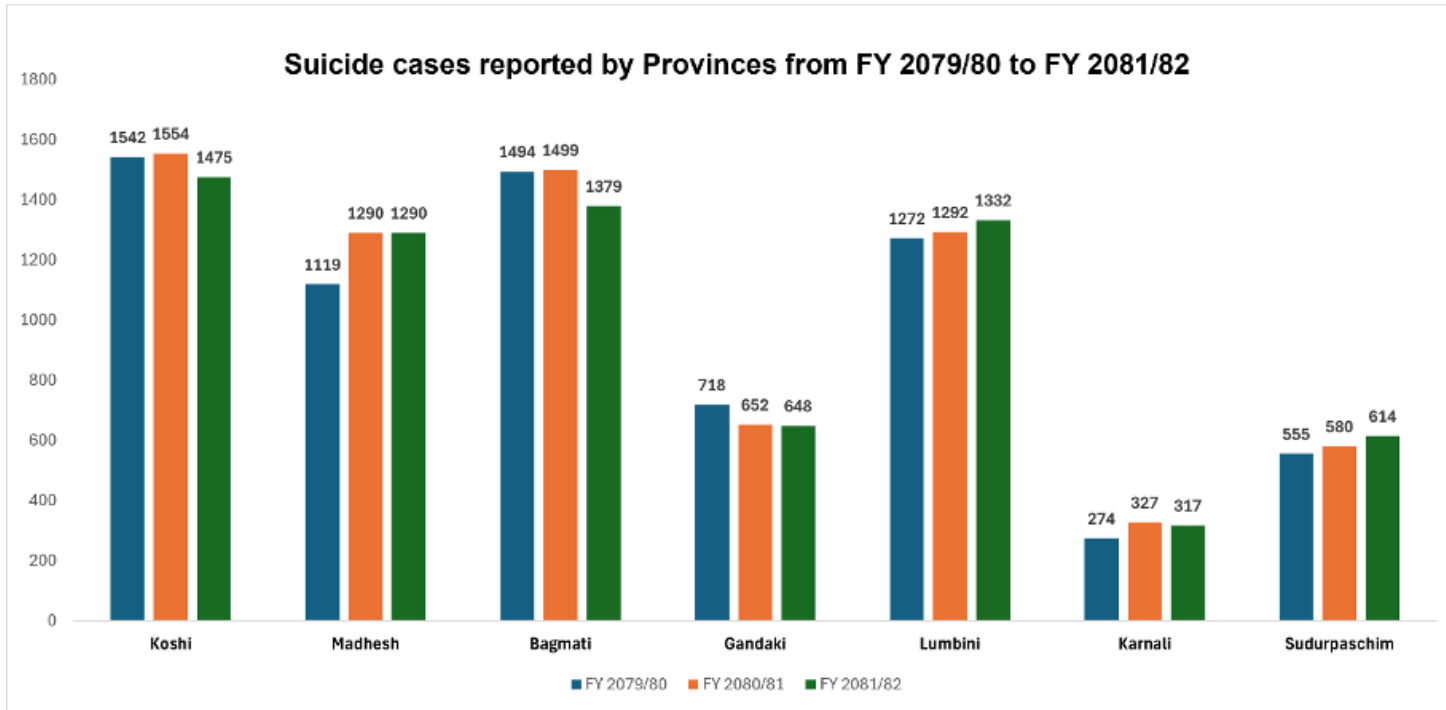
Strategy 5 — Information systems, suicide surveillance, research

Indicator (Strategy 5)	Baseline	Target	Progress to date	Notes
5.1 Health institutions regularly reporting mental health services	50	500	1150	Expanded reporting network; concerns about training/quality reporting.
5.2 Health institutions maintaining records/reporting suicide-related events	0	753	2	Pilot suicide registry in Ilam and Mahakali; new piloting Baglung.
5.3 Studies related to community mental health	1	20	13 (national level)	275 MH studies received NHRC ethical approval (2019–2025), including partners.
Indicator (Strategy 5)	Baseline	Target	Progress to date	Notes

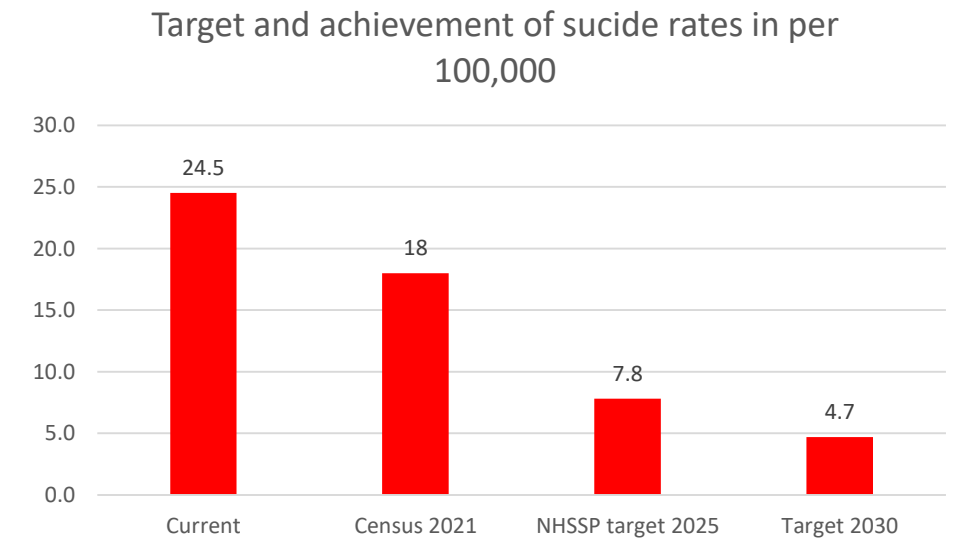
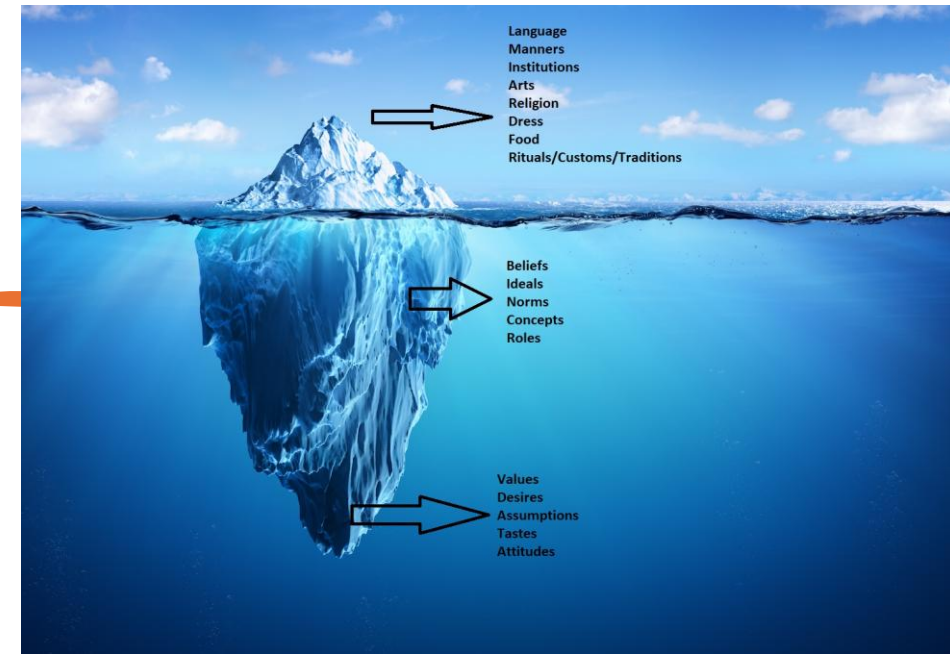
Strategy 5 — Information systems, suicide surveillance, research

- Routine reporting expanded substantially, but data quality and completeness are uneven.
- Suicide and self-harm surveillance is a critical gap; only small pilots exist.
- Research output is increasing, but funding and systematic use of evidence in programming remain limited.

Key results



Source: Nepal police



Source: NJAR Report 2080/81

Strengths

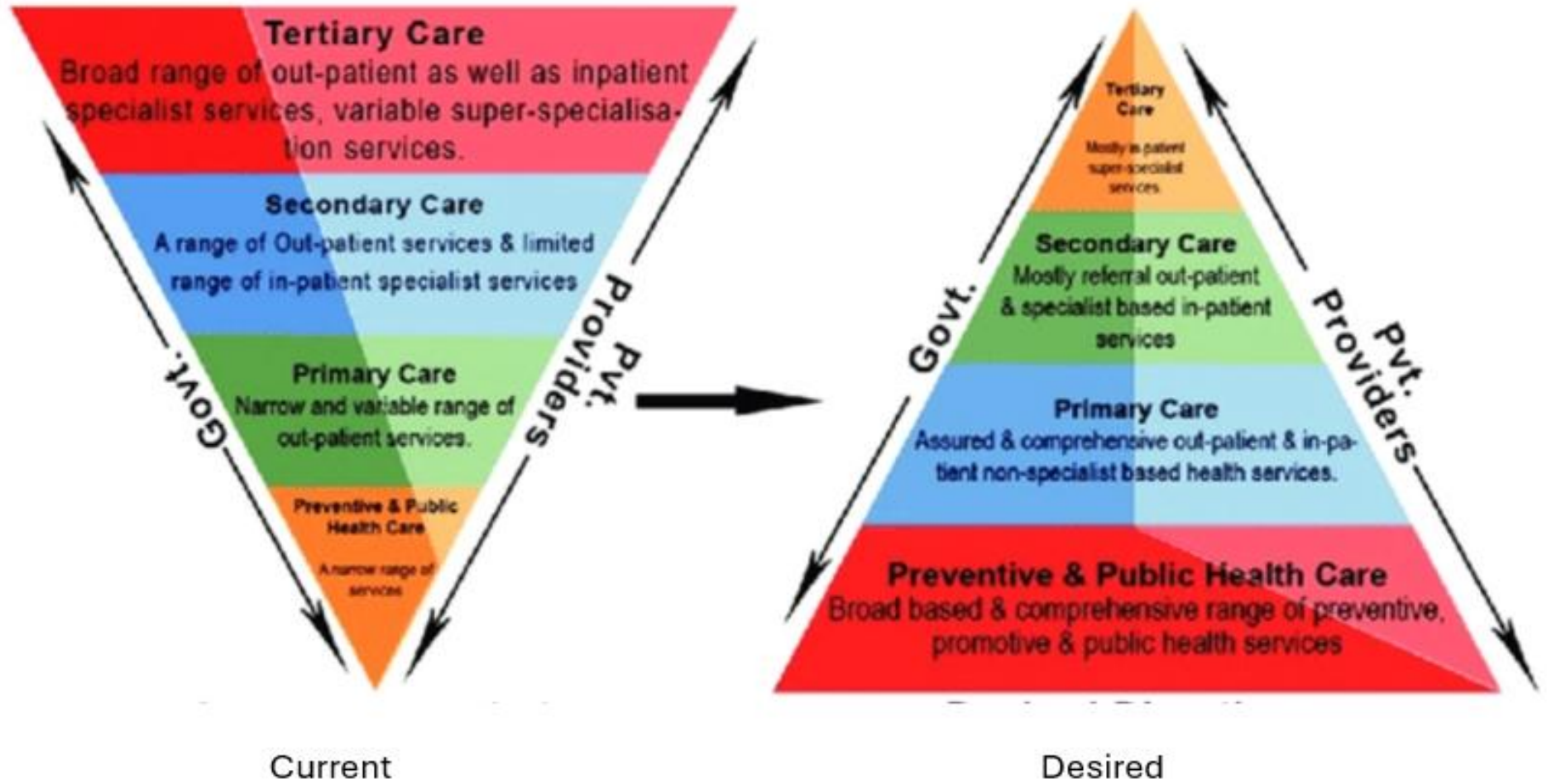
- Significant progress in service integration and coverage
- Strategic workforce arrangement including task shifting
- Aligned mental health in the school curriculum up to grade 8
- Effective partnership with development partners
- Developed mental health policies and strategies at sub-national level
- Supreme court directed to develop dedicated mechanism
- Established recording and reporting system

Conclusion

1. Prioritize awareness and mental health promotion at the top in the next strategy
2. Launch nationwide MHPS promotion campaigns with basic stress and emotion management adapting lifecycle approach
3. Implement community-based self-assessment and screening tools with referrals to psychosocial and psychological services.
4. Integrate MHPSS into compulsory subjects for grades 9–12
5. Expand community mental health services/digital innovations ensuring HRH.
6. Integrate MHPSS into health insurance ensuring medical supplies and special care.
7. Analyze routine service data, conduct research and utilize in the programming
8. Develop and implement multisectoral mental health strategic plan up to 2030

Reverse the 'pyramid of inverse care system' for improved health outcomes: Lahariya, Chandrakant.(2020)

Specialist and Super-specialists
Specialists & MBBS doctors
MBBS doctors and public health team
Public health team & Community Health Officers



Acknowledgement

Gratitude to all the participants involved in the assessment



Dr. Jeeban Ghimire is a public health expert (Ph.D. in Public Health) with over 20 years of experience leading large-scale, donor-funded projects for major organizations like FHI, UNFPA, JSI, FCDO, Abt Associates, Save the Children and ADRA. He specializes in health systems strengthening, nutrition, and policy assessment. A recognized researcher and evaluator, he is dedicated to inclusive, rights-based development and high-level policy assessment & dialogue.