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Mental health service delivery in rural Nepal: opportunities and challenges with insights from Jumla (Karnali Province)

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ABSTRACT

Introduction: Mental disorders are among the leading contributors to Nepal's disease burden, with depressive and anxiety disorders ranking among the leading causes. However, access to care is grossly unequal. Mental health professionals and services are concentrated in urban centers, whereas rural areas such as Jumla suffer severe shortages of trained providers, medicines, and functional referral systems. Stigma, cultural beliefs, and reliance on traditional healers further delay help seeking from formal services, while many individuals remain untreated even when services do exist. Financial constraints, lack of awareness, and limited health-system capacity widen this treatment gap. Such challenges bring into sharp focus the need to understand barriers to service delivery and to identify feasible, culturally grounded strategies for integrating mental health care within rural primary health systems.

Methods: We conducted a narrative synthesis of Nepal-specific literature, implementation reports, and qualitative studies. Sources included published surveys, primary-care evaluations, reviews of stigma and policy, and local JKAHS reports.

Results: Promising approaches include supervised task-sharing, culturally tailored community engagement (including partnerships with traditional healers), adaptation of WHO's mhGAP training, and use of digital decision-support tools. Key recommendations for Jumla include reinforcing health-system supports (reliable medication supply, private counseling space, referral networks), piloting offline-capable e-mhGAP apps, and engaging community stakeholders (FCHVs, local leaders, healers) in co-designing stigma reduction and referral programs. Evidence from Jumla's recent mental-health conference and local studies underscores readiness for integrated models.

Conclusion: Implementation research and monitoring are needed to ensure the feasibility, acceptability, and effectiveness of these interventions in Karnali.

Keywords: Jumla, Karnali Province, Mental health, Rural Nepal, Service delivery

INTRODUCTION

Globally, mental health problems are a serious public health concern, accounting for 7.4% of disability adjusted life years (DALY).[2] In the context of Nepal, about one in seven Nepalese has a mental disorder. Among them, depressive disorders and anxiety disorders are the top two contributors to the total prevalent cases. The proportional contribution of mental disorders to total DALYs is also growing in Nepal.[1] But the main burden is compounded by inequities in access: psychiatrists and psychologists are concentrated in urban centers, leaving rural and mountainous populations (like Jumla) underserved.[2] Even if the health service is available, people are still unable to utilize those resources due to the existence of barriers like; lacking financial means to afford care, fear of being perceived as weak for having mental health problems, fear of being perceived as crazy, having no one to help in seeking mental health care, and being too unwell to ask for help.[3] Moreover, there remains a general lack of awareness about available mental health services and appropriate help-seeking behavior, further limiting timely care. Culturally, people initially tend to seek help not from professionals but from traditional healers like (dhami, jhankri).[4,5] This indicates that the treatment gap is likely to be even more pronounced in areas where formal mental health services and knowledge of mental health are nonexistent.

METHODS

We conducted a narrative synthesis, with an emphasis on Nepal-specific literature, implementation reports, and qualitative studies. Sources included: published community surveys, primary-care integration evaluations, scoping reviews of stigma and policy, and local JKAHS reports. Searches (PubMed, Google Scholar, NepJOL)employed relevant terms (Nepal, rural mental health, Jumla). Selection was for direct relevance to Karnali/Jumla and implementable interventions. This is not a systematic review; it synthesizes heterogeneous evidence (pilot studies, qualitative mapping, conference reports) to offer practical conclusions. Because of limited published data on mental health service delivery in Karnali, the review relied on implementation reports and qualitative accounts. Service delivery in different parts of Nepal is included in this study.

RESULTS

Mental health care in rural Nepal, and especially in Jumla, is held back by many challenges—shortages of trained staff and medicines, stigma in families and communities, and weak referral systems. Despite this, there are clear opportunities. Training local health workers with mhGAP, using offline digital tools, and working together with trusted traditional healers can make services more accessible. Simple approaches like single-session counseling and psychoeducation are practical where

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follow-up is difficult. Bringing mental health into maternal-child health programs, nutrition services, and schools also offers natural entry points. Recent local initiatives, such as Jumla's community mental health conference, show that the district is ready to pilot integrated, community-based models.

DISCUSSION

Burden and service landscape in rural Nepal

Population surveys in Nepal find substantial prevalence of depression, anxiety, self-harm, and alcohol/substance problems.[3,6] For example, community surveys cite high rates of maternal depression and female suicidality in the hills. But specialist services are extremely scarce outside Kathmandu: Nepal has only about 0.2 psychiatrists and 0.06 psychologists per 100,000 people. Psychiatric beds and inpatient facilities are likewise concentrated in urban centers. Consequently, rural people rely on primary health centers and community programs.[6] However, Nepal's mental health policies and budgets are weak; mental health receives <1% of the health budget, and plans are poorly implemented.[7]

Barriers to care

Stigma (interpersonal and structural): At the interpersonal level, shaming by family and community, exclusion by others, and reduced marriage or employment opportunities discourage disclosure and treatment seeking by those with mental disorders. Structural stigma includes low policy salience, discriminatory policies and practices, and weak protection of rights in health and social systems.[7] Conceptual research using the "what matters most" methodology identifies how stigma in Nepal is also interwoven with cultural values of family honor, productivity, and social status, such that interventions must be context-specific and co-designed with communities to be effective.[8]

Cultural care pathways and traditional healers: Nepalese qualitative research identifies that traditional healers (dhami and jhankri) are generally the initial point of contact for individuals experiencing mental health issues due to them being affordable, trusted, and integrated into society. Pluralistic routes will often be employed by families, moving between biomedical and traditional services depending on effectiveness perception.[4,8]

Workforce training gap: Health workers at frontline facilities in Nepal, including doctors, nurses, health assistants, and ANMs, frequently report insufficient mental-health training and self-doubt about being able to deliver care. There is evidence to indicate that short-term training increases knowledge, but that the skill reverts to baseline levels without ongoing supervision and refresher training. Without critical system supports such as an assured supply of psychotropic drugs, diagnostic equipment, and privacy space for counseling, training alone will not likely be translated into long-term service delivery.[9,10]

Health-system constraints: Health-system limitations are the prevailing barrier to integrating mental health in Nepal's rural primary care. Data have indicated the frequency of shortage of psychotropic drugs, lack of private counseling facilities, and overburdening of frontline workers. Referral systems are also poorly functioning, as patients often miss specialists even after being referred to district hospitals. Limited funding and structural stigma also discourage prioritizing mental health in planning and resource allocation. In Karnali, as in much of the rural countryside, these systemic constraints severely hinder effective service delivery. [7,10]

Promising Service Delivery Strategies

Primary care training: Evidence from Nepal and other low-resource settings shows that non-specialist health workers can deliver good quality care for common mental disorders when supported by mhGAP-based training and supervision. Pilots in Nepal demonstrate that after systematic mhGAP training (typically 9–14 days for clinicians and counselors), primary health workers reported improved knowledge, confidence, and case-detection and screening rates.[9,11]

Digital mhGAP decision support (e-mhGAP): The WHO's e-mhGAP electronic application has been piloted in Nepal to support frontline workers and health workers value the e-mhGAP prototype for diagnostic advice and prompting them to management steps.[12]In remote locations like Karnali, expanding e-mhGAP will require offline capability, local language interfaces, and charging solutions for devices. In 2020–21, Nepal launched **1166**, the first nationwide suicide prevention hotline, under the Ministry of Health and Population which is free and accessible from all major networks, including remote areas. Follow up calls are made and callers are invited for health support and counselling.[18]

Community Participation: Linkage with traditional healers: Evidence from rural Nepal shows that integrating traditional healers into referral networks and training them to recognize severe symptoms can improve timely access to mental health services and enhance community trust in biomedical care.[4] Building respectful partnerships, rather than the replacement of traditional practices, represents a culturally sensitive approach to expanding mental health service delivery in Nepal.

Single-Session Therapy and Psychoeducation: In rural Nepal, poor digital infrastructure limits telecommunication-based care. Single-session therapy ensures that clients receive immediate, focused care in the first visit, addressing key symptoms and providing an actionable plan even if follow-up is unlikely. Similarly, Psychoeducation equips clients with knowledge, problem-solving skills, and coping strategies in a brief format, making it both practical and culturally adaptable.[13]

Integration with MCH, nutrition, and schools: In maternal/child health, nutrition, and school programs, integrating mental health has multiple entry points in rural Nepal. Antenatal consultations, immunization services, and nutrition centers provide routine opportunities for screening mothers for depression or anxiety; in Karnali Province, about a third of mothers of malnourished children had severe mental distress.[14] Maternal stress counseling in nutrition centers and life-skills training in schools can provide early intervention, improve coping, and refer families to care.

One-stop crisis management center : Initiatives to provide mental health services to a specific population have already been started through the establishment of a one-stop crisis center. Public hospital-based one-stop crisis management centres (OCMCs) were established under the Ministry of Health and Population in 2011 to prevent GBV and provide appropriate services to its survivors. These services include immediate medical treatment, psychosocial counselling, legal counselling, safe home, security and rehabilitation, education and empowerment. [17]

Implementation Risks & Challenges

Implementation of training: Training can only provide a short-term advantage. Without system reinforcement, knowledge is lost. Previous experiences in Nepal showed that, when there is little knowledge about mental health, staff resort to dealing with only physical complaints.[15] Planning thus has to provide sustainable supply chains and clinic space from the onset.

Limitations of technology: Telehealth and E-mhGAP require devices, power, and connectivity. Jumla has low bandwidth and frequent power outages. Any digital solution will have to be offline-capable and work on low-end hardware. Pilots must consider costs for hardware (smartphones/tablets, solar chargers) and IT support.

Stigma and demand gaps: Low demand can be maintained despite improved detection through stigma. Counselling must be offered in acceptable cultural terms (e.g. "stress reduction") and confidentiality ensured. Structural stigma (e.g. absence of protective legislation) makes care linkage inadequate for guaranteeing follow-through. Uptake and dropout barriers will have to be tracked.

Workforce well-being: Non-specialist staff in mental health positions may experience increased stress and workload. Supervision should include assistance to the providers' mental well-being and workability. Training must include burnout prevention.

Equity considerations: Interventions must be extended to the disadvantaged groups (e.g. the poor, ethnic minorities, remote villages). Pilots must stratify data by gender and caste, and adjust outreach (e.g. utilizing female FCHVs to access women).

This descriptive synthesis draws on Nepalese literature at present available (published papers, local studies, conference reports) and thus may not capture unpublished experience or more general regional data. It is unsystematic and may be subject to selection bias. Karnali/Jumla data remains limited, based on some JKAHS research and reports, and pilot as opposed to larger trials. Much of the recommendation (e.g. for e-mhGAP or integration models) relies on provisional data in relation to feasibility. Therefore, each of the proposed strategies will be tested with intense assessment and revised as new evidence comes up.

CONCLUSION

Rural Nepal's mental-health treatment gap is large but not unbridgeable. Decades of international and Nepal-specific evidence, including systematic review evidence, illustrate that multi-component, context-adapted interventions can make integration feasible. In Karnali/Jumla, local promising evidence and initiative (e.g., the 2024 community mental health conference) indicate a desire to act.[16] Better utilization of the available human resources, psychiatric nurses, psychosocial counselors, and public health professionals is what should be focused on, since they already have mental health knowledge but remain underutilized within government systems. A blended package of supervised task-sharing, steady system inputs (medicines, space, referral), community partnerships (including traditional healers), and digital supports (offline e-mhGAP) is most promising. By intentional local replication and continuous learning, Jumla may pilot models which, if scaled up, offer lessons for implementation at other far-flung districts, progressing towards Nepal's universal mental health care for all.

DECLARATIONS

Author Contributions

SP conceived the study topic, conducted the literature search, synthesized the evidence, and drafted the manuscript. AP contributed to data collection from local reports, assisted in literature review, and helped in drafting sections of the paper. DS provided critical inputs on methodology, reviewed the draft for intellectual content, and assisted with the interpretation of findings. PS contributed to refining the discussion, editing, and providing contextual insights on mental health in rural Nepal. RA provided minor assistance in formatting and reference management. All authors read and approved the final manuscript.

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Ethical Approval

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Consent/Assent

Not applicable

Data Availability Statement

This review article is based entirely on previously published literature and publicly available data sources on mental health service delivery in rural Nepal, with a particular focus on Jumla (Karnali Province). No new primary data were generated or analyzed. All data supporting this work can be found within the cited references.

Conflicts of Interest

Authors declare no conflict of interest.

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