

Strengthening Mental Health Systems in Decentralized Settings: A Qualitative Study of Policy, Governance, and Community Foundations for Sustainable MHPSS Services in Nepal

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Abstract

Background

Strengthening mental health systems in decentralised settings requires coherent policy, functional governance, and community engagement. This study examined how these system-level processes and community structures shape the accessibility and sustainability of mental health and psychosocial support (MHPSS) services within Nepal's federal health system.

Methods

A qualitative study was conducted as part of the endline evaluation of the PARBARDHAN project across seven municipalities in Sudurpaschim and Karnali Provinces, two of Nepal's most geographically remote and under-resourced regions. Data were collected through fourteen in-depth interviews and seven focus group discussions with municipal leaders, health coordinators, primary-level health workers, peer support group members, and self-help group members. Thematic analysis was used to examine stakeholder perceptions regarding policy alignment, government engagement, systemic gaps, and community capacity for sustainable MHPSS.

Results

Four themes emerged: (1) alignment with local policy and systems facilitated integration; (2) increased government engagement and ownership strengthened responsiveness; (3) persistent systemic gaps including unreliable psychotropic medicine supply, delays in disability certification, absence of institutionalised financing, and lack of supervision constrained continuity; and (4) community groups demonstrated growing autonomy, but sustained progress required formal recognition and predictable budgets.

Conclusions

Policy alignment, government engagement, and community mobilisation have advanced MHPSS integration, but structural gaps hinder equitable and sustainable delivery. Strengthening supply chains, institutionalising financing and supervision, and incorporating community groups into municipal health planning are essential.

Background

Mental health disorders are a leading contributor to the global burden of disease, accounting for 125.3 million disability-adjusted life years (DALYs) worldwide in 2019 [1], with depression alone affecting an estimated 280 million people and anxiety disorders impacting 301 million people [2]. The burden is

especially pronounced in low- and middle-income countries (LMICs), which together are home to 85% of the world's population and account for more than 80% of all mental health disorders. Projections indicate that by 2030, depression will become the third leading cause of disease burden in low-income countries and the second leading cause in middle-income countries [3]. In South Asia, rapid demographic and lifestyle changes have contributed to a marked increase in mental health disorders, placing a significant strain on health systems that are largely unable to meet the growing demand for care. As a result, more than 75% of affected individuals in this region remain without access to adequate treatment [4].

In Nepal, mental health is an emerging public health concern, with evidence showing that 10% of adults have experienced a mental disorder during their lifetime and 4.3% are currently living with symptoms of a mental disorder [5]. At the regional level, Nepal ranks second among South Asian countries in psychiatric morbidity, with an estimated prevalence of 307 cases per 1000 population [6]. The mental health situation in Nepal is further shaped by the country's high rates of migration. Nepal is one of the leading labour-sending countries in South Asia, with more than 300,000 Nepalese working abroad, primarily in the Gulf states and Malaysia [7]. This large-scale outmigration has significant social implications, including family separation, economic pressures, and shifting community dynamics, all of which can exacerbate psychosocial stress and vulnerability to mental health problems among migrants [8, 9]. Migration in Nepal not only affects the health and well-being of those who move abroad but also imposes substantial psychosocial burden on family members left behind, who are reported to experience elevated rates of depression, reproductive health issues, loneliness, and marital conflict compared with families of non-migrants [10].

Given this growing mental health burden, the Nepalese government has undertaken substantial policy and system-level measures to enhance accessibility and sustainability of MHPSS services. The Constitution guarantees free basic health services and equal access for all citizens, and subsequent statutes notably the Public Health Service Act, 2075 (2018) [11] and the Public Health Regulations, 2077 (2020) [12] formally include mental health among basic and emergency services to be delivered at federal, provincial, and local levels. The 15th Five-Year Plan (2019/20–2023/24), along with the National Health Policy (2019), further commits to expanding mental health services in alignment with constitutional rights and to integrating them into primary health care [13]. The 2020 National Mental Health Strategy and Action Plan offers a detailed roadmap for implementation, emphasising equitable access, workforce development, community participation, rights-based service delivery, and integration across all levels of government [14].

Within this policy environment, the PARBARDHAN project supported the operationalisation of national mental health commitments at the municipal level by assisting local governments to develop and implement municipal mental health strategies across participating municipalities in Sudurpaschim and Karnali Provinces. These locally tailored strategies were integrated into municipal planning processes and guided the implementation of community-based and primary-care-linked MHPSS interventions, thereby translating national policy provisions into functional local-level action.

Despite these progressive policy commitments, significant challenges continue to impede the accessibility and sustainability of MHPSS in Nepal. Service provision remains highly centralised in urban areas, with rural and remote communities facing persistent shortages of trained personnel, essential psychotropic medicines, and functional referral mechanisms [15, 16]. Primary health care facilities often lack adequately trained staff and supervisory support, while limited financial resources and fragmented implementation further constrain the scale-up of community-based services [17]. In addition, mental health remains underprioritised within the broader health system, resulting in weak intersectoral coordination, insufficient monitoring, and vulnerability to donor dependence for programme continuity [18]. These gaps underscore the pressing need to translate policy commitments into actionable, system-level reforms that ensure equitable, decentralised, and sustainable service delivery.

A midterm evaluation of the PARBARDHAN project identified early progress in community-level MHPSS integration but highlighted persistent challenges in medicine supply, disability certification, and municipal budget allocation [19]. However, whether these gaps persisted or were resolved by the project's end remained unexplored, underscoring the need for an endline assessment. Little is known about how local governments, health facilities, and community structures translate policy mandates into functional MHPSS services, or how these efforts influence service sustainability. Furthermore, while community-based models, self-help groups, and local partnerships are increasingly recognised as essential for long-term service continuity, their actual contribution to system strengthening remains underexplored.

This qualitative study examines how policy provisions, health system governance and community structures are perceived to shape the accessibility and sustainability of MHPSS services in Sudurpaschim and Karnali Provinces of Nepal. By engaging municipal leaders, health coordinators, frontline workers, psychosocial counsellors, and community groups, the study analyses how MHPSS interventions are integrated into local health systems, the nature of government ownership and intersectoral collaboration, existing structural gaps across health system building blocks, and the community and governance foundations necessary for sustaining services. Findings provide direct evidence to inform mental health system design at provincial and national level, and contribute to the global evidence base on decentralised MHPSS system strengthening in low- and middle-income countries.

Methods

Study design

This study employed a qualitative research design to explore how policy-level commitments and system-level actions shape the accessibility, delivery, and sustainability of MHPSS services in two of Nepal's most underserved provinces. The design allowed an in-depth examination of stakeholder experiences, implementation challenges, and contextual factors influencing the integration of MHPSS services within local health systems.

Study setting

The study was conducted across seven municipalities located in Sudurpaschim Province and Karnali Province, two of Nepal's least developed and most geographically remote regions. Three municipalities were selected from Kailali District in Sudurpaschim Province, and four from Salyan District in Karnali Province, where the PARBARDHAN project was being implemented. These municipalities were chosen because they had ongoing MHPSS interventions, functional coordination mechanisms, and local governments that had allocated financial, human, and structural resources to strengthen mental health service delivery. The PARBARDHAN project, implemented by CMC-Nepal and Felm, aims to enhance the mental health and psychosocial wellbeing of migrant workers, their left-behind families, and persons with disabilities through community-based and disability-inclusive MHPSS programming.

Sudurpaschim Province, situated in Nepal's far west, is characterised by rugged terrain, limited health infrastructure, and persistent socioeconomic challenges. The province consistently reports higher levels of poverty and lower health-service utilisation compared with national averages, contributing to pronounced disparities in access to mental health care [20]. Karnali Province — Nepal's largest by area but sparsely populated — is similarly marked by difficult geography, limited road connectivity, and chronic underinvestment in health and social services. It has historically recorded some of the poorest health indicators in the country, including limited availability of specialised mental health providers and services [21]. These structural constraints make both provinces priority areas for strengthening community-based MHPSS systems.

Participants and sampling

Participants were selected using purposive sampling to ensure inclusion of individuals with direct knowledge of mental health policy, service delivery and programme implementation. In total, 14 in-depth interviews (IDIs) and 7 focus group discussions (FGDs) were conducted. IDIs were completed with elected municipal representatives (mayors/chairpersons, $n = 5$), health coordinators ($n = 5$), health facility in-charges ($n = 2$) and Chief Administrative Officers ($n = 2$). FGDs were conducted with peer support group members (3 FGDs, 8 participants per FGD) and self-help group members (4 FGDs, 8 participants per FGD) (Table 1). Sample size was determined by thematic saturation. Data collection and analysis proceeded iteratively. After 10 IDIs and 5 FGDs, no new codes emerged. Two additional IDIs and two additional FGDs confirmed saturation, with no novel themes identified. The final sample of 14 IDIs and 7 FGDs was therefore considered sufficient for thematic saturation.

Data collection

Interview Guide Development

Semi-structured interview guides were developed specifically for this study with separate guides prepared for IDIs and FGDs. The guides were developed based on the objectives and research questions of the study, the PRBARDHAN project's logical framework and a literature review of MHPSS implementation in decentralised settings [22]. The interview guides were not adapted from any previously published interview instruments. Guides were drafted in English, translated into Nepali, and back-translated to ensure conceptual equivalence. Three pilot interviews (one municipal representative, one health coordinator, one SHG member) were conducted in a non-participating municipality (Dhangadhi Sub-metropolitan) to test question clarity and flow. Pilot interview data were not included in the final analysis. The English versions of the IDIS and FGD guides are provided as Supplementary Files 1 and 2.

Data were collected between 3 and 20 February 2025, following ethical approval from the Nepal Health Research Council, using a combination of IDIs and FGDs. Semi-structured interview guides were employed to ensure consistency across interviews while allowing flexibility. IDIs were conducted in private offices at municipal buildings or health facilities, lasting 45–65 minutes (mean: 52 minutes). FGDs were conducted in community spaces (schools, health post waiting areas, or SHG meeting rooms), lasting 90–120 minutes (mean: 105 minutes). Each FGD had 6–10 participants; groups were stratified by participant type to ensure homogeneity and comfort. No repeat interviews or member checking was performed.

IDIs explored policy implementation, system-level barriers, resource allocation, and sustainability efforts, whereas FGDs focused on the experiences of frontline workers and community-level actors who interact with the MHPSS system on a daily basis. Interviews were conducted in the local language, audio-recorded with informed consent, and supplemented by field notes. Data collection continued until thematic saturation was reached and no new information emerged.

Data analysis

All interviews were audio-recorded, transcribed verbatim in Nepali, and anonymised. A random 20% of transcripts were checked against audio recordings for accuracy by a second researcher (AG). Thematic analysis followed Braun and Clarke's (2006) six-phase framework: (1) familiarisation through reading and re-reading; (2) initial coding; (3) generating initial themes; (4) reviewing themes; (5) defining and naming themes; (6) writing the report.

Two researchers (HG and GB) independently coded the first three transcripts line-by-line using inductive coding. Codes were compared, discrepancies discussed, and a consensus codebook developed. The remaining transcripts were coded by HG using the final codebook, with weekly debriefing sessions with GB and AG to resolve new codes. Coding was performed manually using Microsoft Excel. NVivo was not used due to limited access, but manual coding logs were maintained. Themes were triangulated across respondent groups (municipal vs. community vs. health facility) to identify convergent and divergent perspectives. Negative cases (views that contradicted dominant themes) were documented and reported.

Trustworthiness

Several strategies were used to ensure rigour. Triangulation across different respondent groups helped validate the findings. Peer debriefing within the research team supported consistency in interpretation. Reflexive notes were maintained throughout the process to minimise researcher bias.

Ethical considerations

Ethical approval for the study was obtained from the Nepal Health Research Council (Ref. 1088, dated 13 January 2026). All participants were informed about the purpose of the study, voluntary participation, confidentiality, and the right to withdraw at any time. Written or verbal consent was obtained before each interview. This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ). Given the sensitive nature of mental health discussions, interview guides avoided re-traumatising language. Participants were offered the option to pause or withdraw at any point without consequence. No mental health crisis occurred during data collection; however, a referral pathway to local psychosocial counsellors was established in each municipality in the event a participant required support.

Patient and Public Involvement

Patients and the public were not involved in the design, conduct, reporting or dissemination plans of this research. The study participants (municipal leaders, health coordinators, health workers, and community group members) were research participants, not involved in the research design or process. No patient or public contributors were engaged in shaping the research questions, study methods, analysis, interpretation, or writing of this manuscript.

Results

Four interconnected themes emerged from the analysis, reflecting how policy environments, system capacities, and community structures shaped MHPSS implementation and sustainability.

Table 1
Participant characteristics by data collection method and category

Participant category	Data collection method	Number
Elected municipal representatives (Mayor/Chairperson)	IDI	5
Health coordinators	IDI	5
Health facility in-charges	IDI	2
Chief Administrative Officers	IDI	2
Peer support group members	FGD	3 FGDs / 8 participants each
Self-help group members	FGD	4 FGDs / 8 participants each

Theme 1: Alignment with and Integration into Local Policy and Systems

Participants described strong alignment between project activities and municipal health priorities, with integration into existing structures viewed as central to facilitating smooth implementation and avoiding duplication.

Alignment with Local Health Policy

Municipal representatives and health officials consistently viewed the project as aligning with existing local health priorities, with several municipalities incorporating mental health into their annual plans. Participants perceived this policy convergence as strengthening ownership and facilitating integration into routine governance.

"Tikapur Municipality has also prioritised mental health while making policies and plans. Similarly, CMC has collaborated with Tikapur Municipality in this sector, which has been a great support." (IDI, Health Facility In-charge)

"The municipality itself has begun including mental health in their annual planning. This is a very positive sign." (IDI, Municipality Representative)

System Integration for Efficiency

The project deliberately used existing government and community platforms — such as health posts, community groups, and the Red Cross — thereby avoiding parallel structures and improving efficiency.

"The project worked together with health posts and the Red Cross, so there was no duplication, only more strength." (IDI, Janaki Municipality Executive)

Theme 2: Government Engagement and Ownership

Respondents reported a visible increase in municipal responsiveness and collaboration, with stronger intersectoral partnerships contributing to enhanced ownership of MHPSS activities.

Strengthened Government Responsiveness

Participants described increased municipal engagement in MHPSS, with several municipalities reporting the inclusion of mental health in their annual plans and budgets.

"Nowadays government bodies listen to us. Compared to before, there has been a lot of change." (FGD, Kupinde)

"We raised the issue of limited medicine supplies with the municipality. At least some medicines are being sent now, though not all." (FGD, Janaki SHG)

Partnerships as a Cornerstone

Municipal–NGO–community collaboration was repeatedly highlighted as essential to the project's progress and as a catalyst for building municipal ownership.

"Could we have done this work on our own? It was only possible because the ward, municipality, and stakeholders supported us." (FGD, Kupinde)

Theme 3: Systemic Gaps and Sustainability Challenges

Despite progress, critical system weaknesses — particularly in medicine supply, administrative processes, and disability support — were seen as major barriers to sustaining MHPSS services.

Fragile Medicine Supply Chain

A major barrier to continuity of care was the unreliable supply of psychotropic medicines in primary health care facilities. Participants noted that although some improvements had occurred, availability remained inadequate for sustained service delivery.

"The health post has 12 types of medicines, but more are needed. Some medicines are not available there." (FGD, SHG Janaki Municipality)

"For physical disabilities, the allowance is provided. But for mental health problems, the government process is still complicated." (IDI, Health Facility In-charge)

Policy-Implementation Gap in Disability Inclusion

Despite increased awareness about mental health conditions, administrative delays in issuing disability identity cards for mental disabilities limited access to social protection and government benefits.

"The identity card for mental disability has not come yet, but treatment is available." (FGD, Kupinde)

Theme 4: Community Capacity and System Readiness for Sustainability

Community groups reported increased autonomy and confidence, while stakeholders emphasised the need for strengthened municipal systems to ensure long-term sustainability.

Community Integration as a Sustainable Model

Community-based groups — particularly self-help groups and peer support groups — developed organisational capacity and confidence to function independently. Participants viewed these groups as a sustainable platform for ongoing psychosocial support and community mobilisation.

"Absolutely, we can operate independently... we may not need any external supporting organisation in the future." (FGD, Kupinde)

"The municipality and health posts know about our groups. If there is any problem, we can coordinate with them." (FGD, Janaki SHG)

Future System Requirements

Respondents emphasised the need for long-term governmental commitment, including dedicated municipal budgets, reliable medicine supply chains, and the integration of awareness activities into routine planning.

"Activities like volunteering, forming groups, and ensuring medicine supply should be continued... the responsibility on local government is very high." (IDI, Health Chief)

"The municipality has been taking mental health seriously... I feel the municipality will play a strong role." (IDI, Health Section Chief)

Discussion

This qualitative study explored how local policy commitments, system-level processes, and community structures shape the implementation, accessibility, and sustainability of MHPSS services in two underserved provinces of Nepal. The findings revealed both encouraging progress and persistent systemic bottlenecks that influence the translation of national mental health policy into meaningful local action. Overall, municipalities demonstrated growing political recognition of mental health, strengthened engagement with communities, and increasing reliance on community-based structures. Yet continuity of care remains constrained by fragile medicine supply chains, administrative barriers in disability certification, and insufficient institutionalisation of financing and supervisory systems. Together, these findings underscore the need for a whole-of-system approach: coordinated governance, predictable resourcing, and formal integration of community–government partnerships as core components of Nepal's decentralised MHPSS system.

Comparing these endline findings with the midterm evaluation of the same project reveals important shifts. At midterm, Gaire et al. [19] found that while community-level MHPSS activities were being delivered, municipal ownership remained weak and medicine supply chains were nearly non-functional. The present endline findings suggest progress on both fronts: municipalities have begun integrating mental health into annual plans, and while medicine supply remains fragile, participants reported partial improvements. Similarly, a 2025 study [23] reported that migrant workers' mental health needs remain largely unrecognised in local policy. The present study extends this evidence by showing that community groups and peer support networks are beginning to address these gaps, although formal policy recognition is still incomplete. These comparisons suggest that sustained NGO-supported technical assistance over 24–36 months can catalyse measurable but incomplete system change.

A central finding concerns the increasing political prioritisation of mental health at the municipal level, with several municipalities incorporating MHPSS activities into annual plans and budgets. This shift is significant in Nepal's federal context, where local governments hold primary responsibility for delivering basic health services including mental health care under the Public Health Service Act 2018 and the Public Health Regulations 2020 [24, 25]. Global evidence underscores that local political commitment is a critical enabler of sustainable mental health system strengthening, particularly in resource-constrained settings where national policies alone rarely guarantee implementation [2]. The alignment between municipal priorities and project activities further reflects an important dimension of system integration: by intentionally using existing municipal and community platforms rather than creating parallel structures, efficiency was improved and administrative duplication minimised, strengthening local ownership. This observation is well supported by international literature indicating that harmonised service delivery models, which leverage existing governmental and community systems, enhance scalability and cost-effectiveness of mental health interventions [26, 27]. The strong multisectoral partnerships seen in this study linking municipalities, primary health care facilities, NGOs, and community groups also align with global recommendations for coordinated governance to reduce fragmentation and improve accountability in decentralised mental health systems [16].

Another key contribution of this study is the finding that government responsiveness to community concerns has increased, particularly regarding medicine supplies and administrative support. Community groups described being heard more readily by municipal bodies, indicating a behavioural and relational shift in governance. This is notable because, in many LMIC contexts, community voice and bottom-up accountability mechanisms play a vital role in shaping governmental responsiveness and service prioritisation [28]. The ability of SHGs and peer support groups to escalate concerns and influence municipal decisions demonstrates an emergent form of participatory governance that strengthens local accountability and enhances MHPSS accessibility. While previous studies in Nepal have documented the importance of municipal leadership in health planning [29, 30], this study adds new evidence that community engagement itself can serve as a catalyst for improved governmental responsiveness.

Participant perceptions indicated that integration of MHPSS activities into existing structures was associated with reduced perceived duplication and strengthened local ownership. However, this study did not directly measure referral pathway functionality or objectively assess duplication. Evidence from Nepal shows that embedding psychosocial interventions within primary health care systems increases feasibility and acceptability, particularly when health workers receive adequate training, supervision, and ongoing technical support [16]. Similarly, situational analyses of Nepal's mental health system demonstrate that community-linked primary care models are more effective and sustainable than standalone vertical programmes [17]. The strong functioning of peer support groups and self-help groups in this study aligns with broader evidence showing that community-based structures improve service uptake, reduce stigma, and enhance continuity of care, even after external donor-supported projects end [7, 9]. Importantly, participants emphasised that many of these groups had already developed the organisational capacity and confidence to function independently, a finding suggesting that when community structures receive early investment in governance skills and linkages with local systems, they can serve as durable foundations for decentralised MHPSS delivery. This aligns with global evidence that local psychosocial support structures, when institutionally recognised, often sustain programming beyond the project cycle [18, 31].

Despite these encouraging developments, several structural weaknesses continue to undermine sustainable MHPSS delivery in local health systems. Participants highlighted persistent interruptions in the supply of psychotropic medicines, a challenge echoed in recent evaluations showing that Nepal's primary care facilities frequently lack essential formulations because of weak procurement systems, limited provincial purchasing capacity, and inadequate budget allocations for non-communicable conditions such as mental illness [13, 32]. Weak supply chains are a recognised barrier in LMICs, where inconsistent medicine availability disrupts treatment continuity and increases the risk of relapse and unmet needs [4]. A second major challenge relates to disability certification for mental illness, which remains hindered by cumbersome administrative procedures and limited clinician capacity for mental disability assessment. National reports show that delays in issuing disability identity cards disproportionately affect individuals with psychosocial disabilities, restricting their access to social protection schemes and government allowances intended to reduce vulnerability [14]. Evidence from South Asia similarly indicates that bureaucratic barriers and persistent stigma often prevent people with mental health conditions from obtaining formal disability status, reducing access to entitlements and contributing to greater socioeconomic exclusion [6]. This study further revealed inequities in administrative processes, with mental disability allowances perceived as more difficult to obtain than allowances for physical disabilities a disparity that reflects structural stigma and administrative inconsistency, and which has been noted in regional analyses of disability governance [33].

The findings of this study underscore that sustaining recent gains in MHPSS provision will require deliberate system-level strengthening, a conclusion that is strongly supported by national and global evidence. Municipal leaders and health facility staff consistently highlighted gaps in predictable financing, regular training and supervision, and the integration of community-level awareness activities into routine public health programming needs that mirror broader structural constraints documented

within Nepal's mental health system. National analysis shows that mental health continues to receive less than 1% of the health budget, limiting the availability of trained human resources, constraining procurement of psychotropic medicines, and contributing to fragmentation across levels of care [34]. Process evaluations of district mental health care plans further illustrate how the absence of institutionalised supervision systems and frequent staff turnover undermines the quality and continuity of primary care-based mental health services, even where initial training has been delivered [35]. International evidence from low- and middle-income settings similarly emphasises that financing, governance and workforce structures not stand-alone training or pilot projects – are essential to embed mental health within routine primary care and universal health coverage initiatives [27]. Recent work from Nepal likewise highlights the need for strengthened provincial leadership, coordinated supply-chain management and formalisation of community-based structures such as FCHVs and psychosocial support groups within municipal planning cycles to enhance sustainability and reduce dependence on short-term external funding [1, 18]. Together, these findings point to a clear policy direction: institutionalising MHPSS within provincial and municipal health systems through stable financing, structured supervision, workforce retention strategies and integration of community engagement into routine health programming is critical for ensuring that recent improvements transition from project-based gains to durable, system-wide capacity.

Implications for Policy and Practice

Strengthening MHPSS in decentralised settings requires coordinated action across multiple system levels. Priority strategies include: (1) enhancing municipal and provincial financing mechanisms; (2) improving supply-chain management for psychotropic medicines; (3) institutionalising structured supervision and workforce retention systems; and (4) formally integrating community-based groups within municipal planning and referral pathways. These actions are essential to improving accessibility, continuity, and long-term sustainability of MHPSS services.

Conclusions

This study demonstrates that health system governance, policy commitments, and community structures collectively shape the integration and sustainability of MHPSS within Nepal's decentralised federal health system. Municipal engagement and the maturation of community groups have created a stronger foundation for service uptake and local ownership. Yet persistent system gaps; particularly unreliable medicine supply, barriers in disability certification, and the lack of institutionalised financing and supervision continue to limit equitable, long-term access. Strengthening these structural elements will be essential to ensure that emerging gains translate into a durable and scalable MHPSS system.

This qualitative study reflects the perspectives of selected municipal, facility-level and community stakeholders and may not capture the full heterogeneity of experiences across provinces. The setting within an ongoing NGO-supported programme may have influenced perceptions of government ownership or progress. The study also did not assess municipal budget allocations, supply-chain data or

longitudinal service utilisation, which would deepen understanding of system performance. Future research should examine MHPSS integration using mixed-methods approaches, track changes in service readiness and financing over time, and evaluate how community groups function once external support diminishes. Comparative work across additional provinces would further clarify the conditions under which decentralised MHPSS systems can achieve sustainable scale.

Abbreviations

COREQ

Consolidated Criteria for Reporting Qualitative Research

DALYs

Disability-Adjusted Life Years

FGD

Focus Group Discussion

IDI

In-Depth Interview

LMICs

Low- and Middle-Income Countries

MHPSS

Mental Health and Psychosocial Support

NHRC

Nepal Health Research Council

PHC

Primary Health Care

SHG

Self-Help Group

Declarations

Ethics approval and consent to participate:

Ethical approval was obtained from the Nepal Health Research Council (Ref. 1088, 13 January 2026). All participants provided written or verbal informed consent prior to participation. The study was conducted in accordance with the Declaration of Helsinki.

Consent for publication:

Not applicable. No individual personal data are reported.

Competing interests:

None declared.

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Author Contribution

HG conceptualised and designed the study, supervised data collection, led the analysis and wrote the first draft. GB contributed to data analysis and interpretation. MV, PM, RLS, TBC contributed to data collection and critical revision of the manuscript. KB, BBS, and RM facilitated data collection at provincial level and reviewed the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials:

Qualitative data consist of interview and focus group transcripts containing potentially identifiable information. Due to ethical restrictions approved by the Nepal Health Research Council (Ref. 1088), transcripts cannot be publicly deposited. Anonymised excerpts supporting the findings are presented within the manuscript. Requests for data access may be directed to the corresponding author (himal.gaire@gmail.com) and will be considered by the institutional ethics committee on a case-by-case basis.

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