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Article

Provision of mental health and psychosocial support services at the community level in Nepal: Insights from a midterm evaluation

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Abstract: Background: Foreign employment is a key livelihood strategy in Nepal, contributing to economic stability through remittances. However, it also imposes social costs, affecting the mental health and psychosocial well-being of migrant workers and their families. This study evaluates a mental health and psychosocial support project, assessing its progress and impact on interventions aimed at improving overall well-being. **Methods:** A midterm evaluation was conducted using a cross-sectional study design with a mixed-methods approach. The quantitative survey included 91 participants, utilizing validated tools such as the General Health Questionnaire-12 (GHQ-12), Hopkins Symptom Checklist-25 (HSCL-25), Life Satisfaction Tool, and Happiness Tool. Additionally, 13 Focus Group Discussions (FGDs) and 26 Key Informant Interviews (KIIs) explored community perspectives on mental health and psychosocial issues. Data were analyzed using SPSS version 21.0 for quantitative findings and thematic analysis for qualitative insights. Ethical approval was obtained from the Nepal Health Research Council (Ref. No: 660), and written informed consent was secured from all participants. **Results:** The evaluation demonstrated a positive impact on mental well-being, with anxiety decreasing from 37.25% at baseline to 20.95% at midterm and depression declining from 26.2% to 13.2%. Happiness and life satisfaction levels improved, and mental health services expanded from 4 to 19 health facilities. Challenges remain, including stigma, resource constraints, and policy implementation delays. **Conclusion:** While the project has significantly improved mental health outcomes, addressing systemic barriers is essential for sustaining progress. Strengthening policies and increasing resources can enhance long-term mental health support for migrant workers and vulnerable populations.

Keywords: mental health; psychosocial support; migrant workers; foreign employment; Nepal

1. Introduction

International labor migration is a critical driver of global workforce dynamics, with an estimated 164 million individuals engaged in migrant labor as of 2020. In South Asia, the Gulf Cooperation Council (GCC) countries and Malaysia remain the primary destinations for migrant workers. Nepal, as a major labor-sending country in the region, supplies a substantial workforce to these nations (Devkota et al., 2021).Remittances from migrant workers constitute a crucial component of Nepal's economy, contributing significantly to national development. In 2023, remittances were estimated at US$11 billion, accounting for 26.6% of the country's Gross Domestic Product (GDP). These financial inflows have demonstrated resilience during crises such as the 2015 earthquake and the COVID-19 pandemic (Taban et al., 2024).

However, while migration offers economic opportunities, it also presents substantial risks to the health and well-being of Nepali migrant workers.

Despite the economic benefits of migration, the process often exposes Nepali migrant workers to serious health and psychosocial risks. Migrants are frequently employed in hazardous labor sectors characterized by poor occupational safety, leading to elevated rates of injuries and fatalities (WHO, 2022). Furthermore, the migration experience is shaped by complex psychological, social, and cultural challenges—including language barriers, unfamiliar environments, and legal precarity—which can severely impact mental health (Wojujutari et al., 2024) Factors such as low socioeconomic status, limited education, and pre-existing health conditions further heighten migrants' vulnerability to psychological distress. Reports of exploitation, abuse, cultural dissonance, prolonged family separation, and social isolation are common, exacerbating emotional and mental strain (WHO, 2022).

In response to these pressing issues, the Enhancing Mental Health and Psychosocial Wellbeing for Migrant Workers and their Families (PARBARDHAN) Project was launched in March 2022 by CMC-Nepal in partnership with MFA/Felm Nepal. The project is designed to promote the mental health and psychosocial well-being of migrant workers and their families while mainstreaming disability inclusion in local governance systems. By fostering awareness, reducing stigma, and improving access to mental health and psychosocial support services (MHPSS), the initiative works to integrate sustainable MHPSS practices within public health structures. Implemented across seven municipalities in the Salyan and Kailali districts, the project primarily targets returning migrants, persons with disabilities, and other vulnerable community members (WHO, 2022).

At its mid-term milestone in 2023, a comprehensive evaluation was undertaken to assess the project's effectiveness, identify key challenges, and document lessons learned. This study presents the evaluation findings, providing evidence-based recommendations to strengthen ongoing interventions and support the project's long-term sustainability. The aim of the study is to assess the prevalence of mental health conditions and levels of life satisfaction and happiness among family members of migrant workers. As well as this paper explores community and stakeholders' perspectives on the provision of mental health and psychosocial services for migrant workers' families.

2. Materials and methods

This section outlines the methodology employed for the mid-term evaluation of the Enhancing Mental Health and Psychosocial Wellbeing for Migrant Workers and their Families (PARBARDHAN) Project. The evaluation adopted a mixed-methods approach, combining quantitative and qualitative methods to comprehensively assess the project's impact on mental health and well-being among migrant workers, their families, and individuals with mental health conditions or disabilities.

2.1. Study design

The evaluation utilized a cross-sectional survey design to capture a snapshot of the project's outcomes at its mid-term stage. This design was chosen to provide a

holistic understanding of the project's effectiveness, integrating both numerical data and in-depth qualitative insights.

2.2. Sampling and participants

The sample for the evaluation was drawn from the baseline study conducted in 2022. A total of 25% of the baseline sample from each project-implemented palika (local government) was selected for the quantitative assessment. This included 91 participants from seven municipalities across Salyan and Kailali districts. Participants were selected based on their participation in the baseline survey and their direct engagement with the project interventions. The sample represented diverse groups, including: Families of migrant workers, persons with mental health conditions or disabilities, their family members, and adolescents. Purposive sampling was used to recruit the participants.

For the qualitative component, Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) were conducted. A total of 13 FGDs and 26 KIIs were carried out, involving community health volunteers, school students, self-help group members, health professionals, local government officials, and civil society actors.

2.3. Data collection tools

2.3.1. Quantitative data collection

The quantitative survey utilized the following validated tools:

- General Health Questionnaire (GHQ-12): A 12-item tool to assess psychological distress. A score of 2 or above indicated psychological distress (Wojujutari et al., 2024).
- Hopkins Symptom Checklist (HSCL-25): A 25-item tool to measure anxiety and depression symptoms. A cutoff score of 1.75 or more indicated significant distress (Thapa and Hauff, 2005).
- Life Satisfaction Tool: A 6-item tool to assess satisfaction with various life domains using a 6-point Likert scale.
- Happiness Tool: A 25-item tool to measure subjective well-being using a 5-point Likert scale.

2.3.2. Qualitative Data collection

The qualitative component included:

- Key Informant Interviews (KIIs): Conducted with local government officials, health professionals, and civil society actors to explore their knowledge, attitudes, and practices (KAP) regarding mental health and psychosocial issues. An interview guide was used for KII.
- Focus Group Discussions (FGDs): Conducted with community health volunteers, school students, and self-help group members to understand community perceptions, barriers, and coping strategies related to mental health. The FGD guideline was used for data collection.

2.4. Data collection process

The data collection process was meticulously planned and executed to ensure accuracy and inclusivity. Psychosocial workers (PSWs) were trained as Research

Assistants to administer the survey and facilitate Focus Group Discussions (FGDs), ensuring standardized data collection. Local peer support group volunteers played a crucial role in mobilizing participants and organizing data collection sessions, helping to reach diverse groups within the community. Written consent was obtained from all participants, with caregivers providing consent for individuals unable to do so, such as persons with mental health conditions or adolescents. To enhance accessibility and participant convenience, data collection was conducted at various community-friendly locations, including health facilities, municipal offices, and schools.

2.5. Data analysis

2.5.1. Quantitative data

The quantitative data were analyzed using Statistical Package for the Social Sciences (SPSS) version 21.0. Descriptive and inferential statistical analyses were conducted to summarize the data and identify trends and patterns.

2.5.2. Qualitative data

The qualitative data were analyzed using thematic analysis. For the thematic analysis, an inductive approach was employed. Themes emerged directly from the data without imposing pre-existing categories. All Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) were audio-recorded (with participant consent) and then transcribed verbatim in Nepali. Transcripts were subsequently translated into English for analysis. Coding was carried out by two independent researchers. Both coders initially reviewed and coded the data separately. They then compared and discussed their coding to ensure consistency, resolve discrepancies, and refine the coding framework. This process helped enhance the trustworthiness and credibility of the analysis. Any disagreements were discussed and resolved through consensus.

2.6. Ethical considerations

The evaluation adhered to strict ethical guidelines to ensure the rights and well-being of participants were protected. Ethical approval was obtained from the National Health Research Council (NHRC), ensuring compliance with national research standards. All participants were thoroughly informed about the study objectives, and written consent was obtained before their participation. Confidentiality and data security were prioritized throughout the study, with all collected data securely stored within the CMC-Nepal data management system to prevent unauthorized access and ensure participant anonymity.

3. Results

The survey achieved a response rate of 100%, based on the number of participants initially approached. Participants were primarily spouses or close family members of migrant workers, and efforts were made to ensure that the sample included individuals from different municipalities and ethnic groups. The demographic profile of the respondents was broadly representative of the migrant worker families residing in the project implementation areas, according to available local government and project records.

3.1. Socio demographic characteristics of participants

Table 1 presents the demographic characteristics of the survey participants (n = 91) who completed the structured questionnaire. The majority of participants were women (91.2%), primarily from Salyan district (76.9%), and belonged to diverse ethnic groups, predominantly Dalit (36.3%) and Chhetri/Thakuri (35.2%). Most participants were engaged in agriculture (70.3%) and had low educational attainment, with 37.4% having no formal education. The participants largely belonged to nuclear families (52.7%) and had either arranged or love marriages in almost equal proportions. These demographics align with the broader rural migrant worker family population in Salyan and Kailali districts, reflecting the target communities' characteristics.

Table 1. Socio demographic characteristics of participants.

Characteristics		**Frequency (*n* = 91)**	**Percentage**
Age	0–14 years	1	1.1
	15–24 years	10	11.0
	25 and above	80	87.9
	Mean 38.57, Median 38		
Sex	Female	83	91.2
	Male	8	8.8
District	Kailali	21	23.1
	salyan	70	76.9
Municipality	Baghchaur	12	13.2
	Bangad kupinde	11	12.1
	Chhatreswori	13	14.3
	Ghodaghodi	14	15.4
	Janaki	12	13.2
	Sarada	14	15.4
	Tikapur	15	16.5
Ethnicity	Brahmin	1	1.1
	Chhetri/Thakuri	32	35.2
	Janajati	25	27.5
	Dalit	33	36.3
Religion	Hindu	86	94.5
	Christian	5	5.5
Educational Level	No formal education	34	37.4
	Primary level	26	28.6
	Secondary level	20	22.0
	Higher secondary level	9	9.9
	Bachelors	2	2.2
Type of marriage	By guardians	48	52.7
	Love marriage	43	47.3

Table 1. (*Continued*).

Characteristics		Frequency (*n* = 91)	Percentage
Type of Family	Nuclear	48	52.7
	Joint	43	47.3
Occupation	Agricultures	64	70.3
	Business	7	7.7
	Job	6	6.6
	Daily wages labour	5	5.5
	Homemaker	5	5.5
	Unemployed	4	4.4
Relationship with family members	Very bad	1	1.1
	Not that much good	2	2.2
	Normal	7	7.7
	Good	62	68.1
	Very Good	19	20.9
Relationship with neighbour	Very bad	1	1.1
	Not that much good	2	2.2
	Normal	7	7.7
	Good	62	68.1
	Very Good	19	20.9
Family member gone for foreign employment (n = 79)	Husband	59	72.0
	Son/Daughter	9	11.0
	Wife	1	1.2
	Other	1	1.2
Do they send money regularly (n = 84)	Yes, they send regularly	73	80.2
	Send sometime	9	9.9
	Do not send	2	2.2
Received mental health and psychosocial counselling service by family members	Not received	35	34.9
	Yes, mental health service	5	5.8
	Yes, Psychosocial counselling	51	59.3

3.2. Prevalence of Anxiety, depression and distress

Table 2 outlines the prevalence of mental health conditions among survey participants. Approximately 20.9% reported experiencing symptoms of anxiety, 13.2% reported depression, and 20.9% reported psychological distress.

Table 2. Prevalence of anxiety, depression and distress.

	Frequency (n = 91)	Percentage
Anxiety	19	20.9
Depression	12	13.2
Distress	19	20.9

3.3. Life satisfaction and happiness levels among participants

Table 3 shows participants' levels of life satisfaction and happiness (n = 68). Most respondents indicated a positive outlook: 35.3% were satisfied and 33.8% were slightly satisfied with their life. Regarding happiness, 26.4% reported being very happy and 16.5% extremely happy, while a large proportion (52.7%) remained neutral.

Table 3. Distribution of life satisfaction and happiness levels among participants (n = 68).

Variable	Category	Frequency (n = 68)	Percent
Life satisfaction level	Extremely satisfied	6	8.8
	Satisfied	24	35.3
	Slightly satisfied	23	33.8
	Neutral	4	5.9
	Slightly dissatisfied	6	8.8
	Dissatisfied	3	4.4
	Extremely dissatisfied	2	2.9
Happiness level among participants	Slightly unhappy	3	3.3
	Neutral	48	52.7
	Somewhat happy	1	1.1
	Very happy	24	26.4
	Extremely happy	15	16.5

3.4. Qualitative results

3.4.1. Thematic presentation of findings

From the thematic analysis, we have identified nine major themes, which include perception towards mental and psychosocial health problems, foreign employment and mental and psychosocial problems, mental health services at the community level, management of mental health problems at the community level, effectiveness of mental health programs, policy and regulatory provision regarding mental health at the local level, challenges to address mental health problems, recommendations and suggestions and suicide and its prevention.

3.4.2. Perception towards mental and psychosocial health problems

Most participants noted that understanding of mental health is evolving. They were able to explain mental and psychosocial issues, their causes, and community contexts. Participants shared that, in the past, mental health problems were seen as diseases treated only through medical interventions.

> "The tasks that one usually do daily cannot be performed correctly, confusion arises in thoughts, reasoning, and behavior, one cannot provide emotional support to oneself and one's children, cannot be present when someone dies, and feeling lonely is called mental illness. FGD participant."
>
> "The negative impact generated from various internal and societal interactions within the scope of psychological problems can be termed as negative effects, which persist within an individual. One can observe individuals facing problems

such as worrying, sadness, isolation, and behaving erratically due to such negative influences." KII participant.

According to most FGD participants, mental health problems are increasing among adolescents due to factors such as failing in class, financial issues, romantic breakups, and social and family problems. KII participants also agreed, noting that cases are rising in this age group, with many receiving treatment.

"In recent times, the risk of depression and suicide has increased among adolescents. Even though various factors, such as family and social issues, contribute to this problem during adolescence, it is observed that such issues can also arise with increased involvement in social networks. Consequently, it seems that with the changing dynamics within families, there has been a decrease in the tendency to listen to the concerns of adolescents, further exacerbating such problems." KII participant.

Some participants highlighted that family and school have a significant role in the management of the cases because these entities closely observe all the activities of the person who has mental and psychosocial problems.

"People who have mental health problems, their family members have to understand them. I, too, have gone through mental issues; at first, when someone tried to console me, I felt embarrassed and thought it was normal to feel low; that's why, after being displaced from home and seeking treatment outside, I now feel better." FGD participant.

Participants also noted that supporting one another, following medication regimens, and engaging in mental health programs can lead to positive outcomes. They have observed changes in behaviors, perspectives, and understanding after the implementation of such programs. However, similar issues persist in rural areas and among those with lower education, leading participants to advocate for the expansion of these programs.

"The difference is evident now compared to before. Earlier, there used to be a lot of stigma in society, but now, this isn't the case. Previously, people with mental health cannot participate in social, economic, cultural activities. However, mental illness and other disorders are now considered common. Initially, when someone had mental health issues, they would live alone, isolate themselves, or be ostracized. Seeing someone in such a state used to be considered shameful. People were hesitant to seek help, and families were reluctant to acknowledge the problem. But now, things have changed. People are seeking treatment, and after treatment, they're improving." FGD participant.

3.4.3. Foreign employment and mental and psychosocial problems

Participants noted that family members of foreign workers face issues such as neglect at home, lack of community support, and negative perceptions, particularly towards the wife. These family members often worry about the worker's return, their future livelihood, and the uncertainty of whether the worker will return at all. Such concerns lead to sadness, anxiety, and the potential for mental health problems.

"Family members of those who have gone abroad for employment often face social stigma, with some attributing it to the husband earning money overseas while their family members spend here. Some also criticizing them for walking

with their elder siblings, viewing it negatively. Problems like economic disparities in some places and the resulting mental stress on family members." FDG participant

Currently, the perspective is changing; according to the participants, everyone in the community behaved well and supported the family members of those abroad.

"In the past, community members used to question why they should support those who earned money abroad. However, nowadays, everyone contributes to cooperation in various aspects of life, whether it's providing financial assistance or supporting each other individually." FGD participant

Moreover, according to the participants, the support provided by the organization has also been effective in educating people about mental and psychosocial problems and making them normal in the community. Generally, they provided support through Self-help group awareness activities, regular group meetings, home visits, medication, and counselling.

"In the past, people hated, wouldn't go near, wouldn't give, borrow or lend anything to the sufferers. Now, they approach us while walking, engage in conversation, offer assistance, and even provide medication that aids in healing." FGD participant

The local government has involved such individuals in community-based activities, with three to four women from each ward participating to promote cooperation. The community now supports the families of those working abroad. After the implementation of development projects, it has become easier for others, including partner support groups, to receive assistance, fostering unity and collaboration.

3.4.4. Mental health services at the community level

Most participants were aware of the mental health services accessible at the community level. Counselling and treatment services are now provided at the primary health care center and the health post in urban/rural municipalities, making it convenient for people to access services anytime. Participants also mentioned that they previously encountered difficulties in accessing treatment, as they had to travel to Dang, Salyan, and Nepalgunj for treatment.

"In the past, we had to travel to Dang or Nepalgunj for treatment, but now services are accessible here. Regular meetings, coordination, and consistent participation in programs have made it convenient to receive services." FDG participant

Furthermore, participants emphasized that CMC Nepal initially provided mental health services before any other organization in their area. CMC Nepal also frequently invites doctors to provide treatment and counseling services at the community level. The recipients of these services are identified and referred by self-help groups established by CMC Nepal.

"… CMC Nepal occasionally invites doctors from whom people also receive services. Some patients are cured after treatment, while others are still undergoing medication." KII participant

3.4.5. Management of mental health problems at community level

Most participants reported that at least two treatment and counseling centers had been established in each municipality within the project areas, primarily at primary health care centers and health posts. However, one participant suggested creating a referral center in specific wards, along with training for nursing staff, healthcare professionals, and teachers. Participants also highlighted the key role of CMC Nepal, which deployed volunteers at the ward level, provided counselors, organized community awareness programs, and coordinated with local stakeholders.

> "To reduce mental health problems, we have established two treatment centers from the budget, separated by local level and CMC Nepal. These centers consistently deliver services. Medicine management is handled at both the local and district levels. If medications are insufficient at these levels, we utilize funds allocated by CMC Nepal to procure the necessary medicines." KII participant

The management of services in Nepal involves coordination among the local, district, and CMC Nepal levels. Certain local levels are actively engaged through their own initiatives. Concerning medicinal management, participants noted that local authorities handle medicines in conjunction with district and provincial levels. In instances of medicine shortages, they utilize funds provided by CMC Nepal to acquire the required medications.

> "First, we demand in the district, then province, and if more needed, we purchase from our budget through quotation. Sometimes, we also demand with CMC Nepal to provide timely service to the beneficiaries." KII participant

Some participants noted that individuals with mental and psychological health issues receive a disability card, which provides incentives and support. They also shared various stress management methods, including talking with friends, drinking water, meditation, dancing, singing, using breathing techniques, listening to favorite songs, living alone, writing, crying, and participating in programs.

> "Participants mentioned that individuals with mental health challenges have been issued disability identity cards, and two individuals have started receiving incentives. Moreover, after receiving these incentives, family members have begun treating them better." KII participant

3.4.6. Effectiveness of mental health program

Participants observed a shift in community attitudes towards mental health, moving from beliefs in supernatural causes to an understanding that issues can stem from factors like family conflicts, financial problems, and personal behavior. The use of mental health services has increased, and reluctance to seek help has decreased since CMC Nepal's program, in collaboration with local authorities. Additionally, CMC Nepal provides varying levels of support to the families of individuals employed abroad.

> "In the community, this has had a significant positive impact. Previously, people were unaware of what mental health issues were, hesitant to admit they had mental health problems, faced discrimination, were labeled as crazy, or were in such situations. But now, after initiating the CMC Nepal project, service recipients understand that it will improve when medication and counselling are provided. One hundred fifty-six individuals have received treatment and have

shown improvement, and thirty have received psychosocial counselling. Once improved, they are able to support their families by engaging in livelihood activities. This program's effectiveness is attributed to coordinated cooperation, home visits, training, orientation, and regular meetings, leading to effective implementation." KII participant

According to the participants, after the continuous awareness programs through peer groups, volunteers, and health facilities, the community people's understanding of mental health patients was positive, and they treated mental health patients positively and respectfully.

"Everyone is equally respected in our society, and information is provided through mothers' group meetings." FDG participants

"In the beginning, people used to attribute mental illnesses to demonic possession, ghosts, witchcraft, or curses. When someone exhibited unusual behaviors, they were often perceived to be in danger, even risking their lives. Since the implementation of such programs, individuals have become more aware of mental health and have started seeking medical treatment and counseling from health institutions. They are also becoming more adept at recognizing mental health issues based on symptoms." KII participants

"Various awareness programs have been conducted following the implementation of the Sharada Municipality's cooperation with the CMC Nepal promotion project. As a result, significant changes have occurred, and the community must accept their behavior. Their mindset needs to be addressed, and measures should be taken accordingly to address their emotional state and provide necessary treatment until they can resume their normal activities." KII participant

Similarly, CMC Nepal has also provided training to health workers. According to the participants, 156 patients have received treatment, and 30 have received psychosocial counseling. Patients were able to receive services from their nearby health facilities and were satisfied. Previously they had to visit Nepalgunj, Dang, Lucknow, and Kathmandu for medical treatment.

3.4.7. Policy and regulatory provision regarding mental health at local level

At the local level, efforts on mental health are in the early stages. While some localities have drafted mental health policies, others have passed them but not yet implemented them. These efforts are being carried out in collaboration with organizations like CMC Nepal.

"We have developed a mental health policy; we have encountered challenges in getting it approved due to the municipal assembly not convening for several months. Once the policy is ratified, our work will likely become more manageable. Despite our efforts, we have been unable to meet the expected outcomes." KII participant.

A municipality has already passed the psychosocial strategy 2079 and started allocating budgets based on it. Similarly, a health focal point shared that they and their municipality's elected representatives believe it's imperative to allocate funds and develop a program aligned with this strategy, and they are committed to sustaining these services in the future.

> "The Mental Health and Psychosocial Strategy 2079 has been prepared, and accordingly, it is necessary to implement it by formulating budgets and plans. It is necessary to reduce mental problems. Suicide prevention programs need to be implemented in the community. Awareness-based programs are being planned and implemented." KII participant.

3.4.8. Challenges to address mental health problems

Most participants reported fewer challenges compared to previous times. While minor illnesses were not a concern, chronic mental health issues remained a challenge, as cases were referred to higher-level hospitals for support. The main challenges identified were limited reach to communities, lack of human resources, low budgets, and the dropout of trained staff and volunteers.

> "If we could expand the referral center further, it would be even better. If we could add more counselling sites, and if there could be further development in the community, there are still 168 development sites within Tikapur Municipality. If we raise awareness there, it would be even better. Still, whatever we do, more effort is required. There's still a long way to go. Whatever we do, if CMC could contribute a bit more budget and increase our activities, we could progress." KII participant.

Moreover, participants mentioned that they sometimes didn't get medicine and had to buy it from clinics.

> "At times, certain essential medications are unavailable for patients, causing inconvenience. Obtaining other medicines or purchasing medication for mental illnesses can also be quite challenging. It would have been better if the consultation rooms had been managed better. It was good that no one ignored what two people had done; however, it could not be implemented." KII participant.

3.4.9. Recommendation and suggestions

Most participants recommended ongoing collaboration with CMC Nepal at the local level to ensure continuous mental and psychosocial health services. They also suggested implementing awareness activities through various groups and providing educational materials that include success stories. Additionally, the majority emphasized the need for a continuous supply of medicines at treatment centers.

> "Awareness programs should be extended in each village, interaction programs, expressing feelings during times of distress to someone close, like sisters and medication treatment if there are psychosocial problems." KII participant

Most participants expressed that awareness of mental health can be enhanced through radio programs and organizing skill-based training sessions. Moreover, to diminish superstition, awareness programs should be structured in a manner that enables individuals to comprehend that medication can effectively treat mental health issues. A participant also suggested that,

> "The Nepali government needed to create employment opportunities for all Nepalis in their own country. They noted that as long as unemployment persists in Nepal, such problems will continue to worsen. They suggested that instead of focusing solely on economic advancement, efforts should be made to arrange

employment for individuals, which could also reduce dependency on foreign employment for income." KII participant

Additionally, most participants recommended and suggested that the local level prioritize the mental and psychosocial problem-related programs, build partnerships with the organizations working in the sector and collaborate with the other levels of government.

3.4.10. Suicide and its prevention

The majority of the participants shared that the rate of suicide is a decreasing trend. It was mostly prevalent in the age group of 20 to 40 years. The major causes of suicide reported by participants were betrayal in love stories, unemployment, poverty, family conflict, living alone and depression. According to the participants, after the implementation of CMC Nepal's promotion project, there have been decreasing incidents of suicide.

"In comparison to before, there has been a decrease in the number of individuals committing suicide. Service recipients have received information about receiving medicinal treatment and counselling. Patients with mental illnesses can openly discuss their problems. Patients with mental illnesses have been able to speak up for their rights. Employees facing mental health issues have successfully obtained disability identification cards." KII participant

Participants noted that they can call 1166 anytime for counseling services. They emphasized the importance of timely prevention, early case identification, and prompt provision of medical treatment, counseling, psychological support, and awareness programs. Additionally, they mentioned that various stakeholders, including elected representatives, are now more aware and involved in raising awareness and supporting the reduction of mental health issues.

"Awareness programs, counselling, referrals for medication and treatment, psychosocial counselling, listening to their thoughts and problems, giving them membership in different groups, and participating in the meetings would be effective for prevention." FGD participant

4. Discussion

The findings from the midterm evaluation of the Enhancing Mental Health and Psychosocial Wellbeing for Migrant Workers and their Families (PARBARDHAN) Project highlight significant progress in addressing mental health and psychosocial challenges among migrant workers and their families in Nepal. The reduction in anxiety and depression rates, along with improvements in life satisfaction and happiness levels, underscores the effectiveness of the project's interventions. The evaluation demonstrated a positive impact on mental well-being, with anxiety decreasing from 37.25% at baseline to 20.95% at midterm and depression declining from 26.2% to 13.2%. These results align with previous studies that have emphasized the importance of community-based mental health programs in low-resource settings (Giebel et al., 2022; Taban et al., 2024).

A key achievement of the project has been the expansion of mental health services from four to 19 health facilities, significantly improving access to care. This

is especially important in Nepal, where mental health services are largely concentrated in urban areas, leaving rural populations underserved. As of 2021, the WHO reported that only one in four health facilities in Nepal provided mental health services, mostly in major cities (WHO, 2022). Limited access to care in rural areas is a persistent challenge in low- and middle-income countries (LMICs), where mental health services remain disproportionately distributed, often due to shortages of trained personnel, infrastructure constraints, and weak policy implementation (Kakuma et al., 2011; Patel et al., 2018). A 2021 study emphasizes the need to ensure comprehensive mental health services are available to all, particularly by integrating mental health into existing health systems to improve equity and accessibility (Luitel et al., 2015).

Integrating mental health services into primary healthcare, as seen in this project, has helped reduce stigma and increase service utilization, aligning with best practices for mental health care. A 2018 study supports this, showing that integrating mental health into primary care improves disorder identification and treatment uptake, as these facilities are more accessible and less stigmatizing for those seeking help (Patel et al., 2017). Similar findings have been reported in global mental health research, where task-shifting approaches—training non-specialist health workers to provide mental health care—have proven effective in improving service coverage and patient outcomes in resource-limited settings (Patel et al., 2017; Rahman et al., 2008). Additionally, studies from Ethiopia and India highlight that community-based mental health interventions embedded within primary healthcare not only improve access to care but also enhance early diagnosis and long-term treatment adherence (Hanlon et al., 2008; Lund et al., 2012; Shidhaye and Patel, 2010).

As mental health services continue to expand, ensuring adequate training for primary care providers and developing sustainable financing mechanisms will be crucial for maintaining service quality and accessibility. Strengthening health system capacity through workforce development and policy-level commitment can further support equitable mental health care delivery in Nepal and other LMICs (Lund et al., 2012; Rameez and Nasir, 2023; World Health Organization, 2021).

The qualitative findings reveal a shift in community perceptions towards mental health, with increased awareness and reduced stigma. This is a critical step forward, as stigma has long been a barrier to mental health care in Nepal (Brenman et al., 2014). A study in rural India also found that a significant proportion of adults perceive high levels of stigma surrounding mental illness, which continues to hinder help-seeking behaviors and limit community support (Guttikonda et al., 2019). Similar observations have been noted in other community-based mental health programs across Nepal, where the inclusion of participatory approaches and culturally sensitive messaging significantly contributed to the destigmatization of mental health issues (Jordans et al., 2019). The role of self-help groups, community health volunteers, and local government in fostering this change cannot be overstated. These groups have not only provided psychosocial support to individuals experiencing mental health challenges but have also acted as catalysts in reshaping public attitudes through peer education, counseling outreach, and community engagement (Luitel et al., 2017). For instance, in the PRIME project, the integration of psychosocial workers within primary care settings led to increased mental health literacy and normalization of mental illness, particularly in rural populations (Jordans et al., 2019). Moreover, mobilizing female

community health volunteers (FCHVs) has proven effective in bridging the gap between formal services and underserved groups, while promoting help-seeking behavior among vulnerable populations such as returnee migrants and their families (Singla et al., 2017; Tol et al., 2012). These findings underscore the importance of leveraging local actors and social networks to sustain mental health promotion efforts at the grassroots level.

However, the evaluation also identified several challenges that need to be addressed to sustain and build upon the project's achievements. Resource constraints, particularly the shortage of trained mental health professionals and the inconsistent availability of psychotropic medications, remain significant barriers. These challenges are not unique to Nepal and have been extensively documented in other LMICs undergoing mental health system strengthening (Patel et al., 2018). In Nepal, studies have consistently shown that a critical gap exists in human resources for mental health, with services often concentrated in urban centers and delivered primarily by non-specialist providers with limited training (Luitel et al., 2015). Additionally, supply chain issues, such as irregular procurement and stockouts of essential psychiatric medications, undermine the continuity of care, particularly in rural or hard-to-reach areas (Jordans et al., 2013). These structural bottlenecks are further compounded by low government prioritization and underfunding of mental health in national health budgets—an issue common across many LMICs where mental health often receives less than 1% of total health expenditure (Rajkumar, 2022; World Health Organization, 2022). Addressing these systemic constraints will require a multisectoral approach that combines workforce development, decentralized supply chain management, and sustained political commitment to mental health financing.

Another critical issue is the delay in policy implementation at the local level. While some municipalities have drafted mental health policies, the lack of full implementation limits their potential impact. This is a common challenge in LMICs, where mental health policies are often well-articulated on paper but remain unimplemented due to insufficient political will, inadequate funding, and limited technical capacity (Votruba and Thornicroft, 2016; World Health Organization, 2021). In Nepal, despite the inclusion of mental health in national health strategies, decentralized governance structures often struggle to operationalize these policies effectively at the municipal level (Luitel et al., 2015)Studies from other LMICs highlight similar challenges, where policy inertia is exacerbated by competing health priorities, weak intersectoral coordination, and the absence of accountability mechanisms (Patel et al., 2018; Saraceno et al., 2007). Strengthening multi-sectoral collaboration between government agencies, civil society organizations, and international partners is crucial for overcoming these policy-level barriers and ensuring the effective translation of mental health policies into action (Jordans et al., 2019).

The project also highlights the need for more targeted interventions for specific groups, such as adolescents, who are increasingly vulnerable to mental health issues. The rise in depression and suicide rates among adolescents, as reported by participants, is a concerning trend that warrants further attention. This is consistent with previous studies showing a global increase in adolescent mental health disorders, driven by social stressors, academic pressure, and digital exposure (Kieling et al., 2011; Santos

et al., 2023; Thapar et al., 2012). In Nepal, adolescent mental health remains underprioritized, with limited access to youth-friendly services and culturally appropriate interventions (Kohrt et al., 2009). Evidence suggests that school-based mental health programs and peer support initiatives can be effective in addressing these challenges by promoting mental health literacy, early intervention, and reducing stigma (Barry et al., 2013; Fazel et al., 2014)Future interventions should integrate these approaches while ensuring the meaningful participation of adolescents in program design and implementation.

5. Conclusions

The midterm evaluation of the PARBARDHAN Project highlights substantial progress in enhancing mental health outcomes through targeted interventions. However, overcoming persistent challenges such as stigma, resource limitations, and policy gaps remains essential for ensuring the sustainability and scalability of these efforts. Future research should explore the long-term impact and cost-effectiveness of these interventions to inform evidence-based policy decisions and strengthen mental health support systems for migrant workers.

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