The role of mental health and psychosocial support nongovernmental organisations: reflections from post conflict Nepal

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Armed conflicts and other humanitarian crises impact mental health and psychosocial wellbeing. In contexts of overwhelming need and overstretched government health systems, nongovernmental organisations may play important roles. In this paper, we reflect on the role of Nepali nongovernmental organisations in providing mental health and psychosocial support services. In Nepal, nongovernmental organisations have provided a range of trainings, implemented interventions, organised awareness raising campaigns and conducted research on mental health and psychosocial issues in the context of political violence and natural disasters. Some have been able to capitalise on the emerging interest of humanitarian donors in mental health to strengthen the platform for sustainable mental health reforms. Nongovernmental organisations taking on such tasks have demonstrated strengths as well as presented challenges. Strengths included easy access to local communities, better understanding of local contexts, quick and flexible response mechanism and access to marginalised populations and under served areas. Challenges have included a lack of programme sustainability, weak collaboration and high staff turnover. Similarly, due to a lack of accreditation of training courses and rigorous monitoring of services, it has been difficult to independently verify the quality of services provided by nongovernmental organisations. Based on observations, the authors highlight the importance of: the integration of mental health into the broader humanitarian, health and social systems; strong partnerships with governments; strong alliances between nongovernmental organisations for more effective advocacy with policy makers; a focus on monitoring, evaluation and research; standardisation of training curriculums and clinical services; and a focus on anti-stigma interventions.

Keywords: mental health, Nepal, nongovernmental organisations, role

Introduction

Nongovernmental organisations (NGOs) globally support government initiatives and social development by assuming the role of advocates, service providers, activists and researchers on a variety of issues affecting the lives of people (Thara & Patel, 2010). In addition, NGOs play an important role in delivering and developing models for more innovative services than those delivered by governments (Harwin & Barron, 2007). Alongside the more familiar roles of service delivery and campaigning, NGOs are also active in a complex range of broader development activities that include: promotion of democracy, peacebuilding, conflict resolution, human rights protection and policy analysis (Lewis & Mensah, 2006).

NGOs play a crucial role within all settings, but during conflict and disasters they commonly take on a greater role, as humanitarian crises typically overwhelm already overstretched government health systems (de Jong, 2007; Ejaz, Shaikh, & Rizvi, 2011). The increased mortality and morbidity

associated with mental health and psychosocial problems, during and after natural or human made disaster, receives greater media attention and public interest, which may convince policy makers to more seriously consider suffering associated with mental health and psychosocial problems (de Jong, 2007). As described by the World Health Organization (WHO), these crises thereby provide opportunities in terms of increased funding and political will to support mental health and psychosocial well-being beyond the humanitarian crisis (WHO, 2013). Opportunities include creating new leadership, new ways of thinking and redefining existing service delivery models (Perez-Sales et al., 2011). For example, Sri Lanka and Indonesia after the 2004 tsunami made rapid progress in the development of basic mental health services, extending beyond tsunami affected zones, to most parts of the country. Similarly, Burundi, Kosovo, Iraq and Afghanistan have used the opportunity of greater support for mental health during conflict (WHO, 2013).

Given that NGOs may contribute to creating healthcare systems with increased efficiency, more equity, and good governance (Ejaz et al., 2011), it is worthwhile reflecting on the role of NGOs in specific humanitarian settings, discussing the pros and cons of their involvement and setting future strategies. This paper, based on authors' work experiences and grey literature, documents the contributions made by mental health and psychosocial support NGOs in conflict/post conflict contexts, analyses their strengths and limitations, and discusses their future role for strengthening the mental health system in Nepal.

Background

Nepal, home to 26.5 million people (CBS, 2012), is a small, mountainous, multi-ethnic country located in South Asia. It has poor development indicators, including the Human Development Index [157 out of 186] (UNDP, 2013), low literacy rate [65.9%] (CBS, 2012) and relatively low GDP per capita at purchasing power parity [US$ 1102] (UNDP, 2013), among others. Nepal has also suffered a violent conflict that has claimed the lives of more than 13,000 people, while many more were subjected to torture, intimidation, extortion, and abduction (Russell, 2012). The fragile health care system of Nepal became even weaker, during a period of Maoist insurgency, as health staffs were often intimidated and tortured by both the government and the insurgents, and delivery of essential commodities disrupted (Singh, 2004).

Although formal registration of NGOs in Nepal began in 1977, the emergence of mental health NGOs started only after the 1990 s with the numbers increasing during the 10 years of Maoist conflict (1996–2006). Currently, an estimated 20, out of over 37,000 nationally registered NGOs, work specifically in the field of mental health and psychosocial support. Previously, Nepali NGOs commonly supported government initiatives of delivering quality health services. However, during and after the Maoist conflict, they played increasingly important roles in providing health services to conflict prone areas and marginalised populations. In our observations, increased funding during the conflict periods helped NGOs to develop and strengthen their work in the mental health field in Nepal. Learning from the programmes implemented during conflict period, NGOs have become successful advocates for, and partners in, policy revision and integration of mental health into primary health care (PHC).

Key strengths

We compiled data from a 4Ws (who is where, when, doing what) mapping tool developed in MS Excel format (O'Connell et al., 2012), which documents mental health training, services and research activities of several

stakeholders in the aftermath of emergencies. The tool was completed by interviewing NGO staffs. We also collected information available in the websites of Nepali mental health and psychosocial support (MHPSS) NGOs. Data are summarised in Table 1, which highlights the contribution of NGOs in developing human resources, raising awareness, conducting rigorous research, and delivering services in the field of MHPSS care. These key strengths of NGOs are described below.

Capacity building

Training paraprofessional counsellors Very few mental health practitioners are trained by government institutions. Those who are commonly prefer a more biomedical orientation and are frequently based in the major city centres (WHO, 2006). As a result, mobilisation and retention of mental health workers in rural areas has been a challenge (Acland, 2002). Recognising this gap, NGOs started developing para-professionals by training community members in psychosocial and mental health issues (Jordans et al., 2007; Jordans et al., 2003; Kohrt et al., 2007; Sapkota Gurung & Sharma, 2007). These trainings range from a few days '*orientation*' to 6-month psychosocial counselling training programmes. In addition to a classroom based teaching, they also focus heavily on field practicum, introducing trainees to the challenges of real life settings and reflecting how psychosocial support and counselling services can address the needs of the population (Jordans et al., 2003). Based on the training materials available, paraprofessionals have been trained to play roles in promotion, prevention, detection, referral and follow-up in psychosocial and mental health care.

Other training programmes At the community level, a 2–4 week training is provided to develop community psychosocial workers (CPSW) whose main function is raising awareness about mental health, and includes identifying and referring people with mental health problems (Kohrt et al., 2008b). Additionally, female community health volunteers (FCHVs) have been trained in a community informant detection tool that assists in identifying people with mental health problems and promotes referral to health service providers at PHC. In addition, a 1–2 week training is conducted for PHC workers to help them deal with psychosocial and mental health aspects of PHC attendees (Upadhayaya, 2013; WHO, 2006). More recently, training through district level government mechanisms on the mental health gap action programme (mhGAP), which promotes integration of mental health into primary health care (WHO, 2008), has been introduced. The counsellors are developed to provide individual, group and family counselling (Jordans et al., 2003) and support the CPSW, FCHVs and PHC workers (TPO Nepal, 2013) at the community level.

Several tailor made training packages have also been developed and delivered by different organisations. Some NGOs have integrated psychosocial concepts in training packages for teachers, health workers, children affected by conflict (Kohrt et al., 2008a), HIV/AIDS (NCASC, 2012; Sapkota et al., 2007). front line workers during emergencies (Jordans et al., 2012), staff of the Nepal Police force, staff working in the nutrition sector, protection workers at Bhutanese Refugee camps (Reiffers et al., 2013), staff working in gender based violence and trafficking (TPO Nepal, 2012), and outreach workers in the entertainment sector. Trainings on psychosocial aspects of conflict mediation, peacebuilding, legal protection and human rights are also being provided.

Post training follow-up and clinical supervision One of the strengths of NGOs' training is that they have had mechanisms for onsite clinical supervision, group case conferences and follow-up during refresher trainings. These mechanisms encourage

Table 1. NGO activities in mental health and psychosocial support in Nepal

Training	Service delivery	Awareness raising and advocacy	Research
Two weeks basic psychosocial care training for community psychosocial workers	Psycho-education	Radio programme	Need assessments
Six months para-professional counselling training	Psychological first aid	Street drama	Process evaluation
Training on psychological first aid (PFA)	Counselling (individual, group and family)	Information dissemination through pamphlets, cultural programs, dance and sports	Effectiveness evaluation of interventions
mhGAP training to PHC workers	Psychotherapies (cognitive behaviour therapy, child parent relationship therapy, creative movement therapy, art therapy, Gestalt therapy, play therapy, sand play therapy, Eye Movement Desensitization Reprocessing (EMDR), Emotional Freedom Technique (EFT) and hypnotherapy)	Community orientation programmes	Cross-sectional studies and longitudinal studies
Non violent communication training	Psychiatric consultation and medication	Press meetings	Qualitative studies
Training on *Inter-Agency Standing Committee (IASC) guidelines for mental health and psychosocial support in emergencies*	Legal support/legal counselling	Newspaper articles	Cohort studies

Table 1. (Continued)

Training	Service delivery	Awareness raising and advocacy	Research
Care for care givers' training	Case management, documentation, referral, networking and follow-up	Workshop and seminars	Delphi studies
Training on stigma reduction	Emotional support, problem management, relaxation and meditation	Street rallies and silent march	Validation studies of western psychological instruments
Peacebuilding training	Rehabilitation services		Development of ethical guidelines
Vocational training	Residential and day care services		
Life skills training	Sport and recreational activities		
Effective parenting training	Livelihood assistance		
Classroom based intervention training			
Healthy Activity Program			
Training for depression, based on behavioural activation			
Counselling for alcohol problems training based on motivational interviewing			
Family intervention training for psychosis, bipolar disorder and epilepsy			

trainees to practice the skills learnt and provide opportunities to express difficulties and discuss suggestions for improvement.

Service delivery

Our observations suggest NGOs have commonly taken on mental health and psychosocial care that does not focus on strict diagnostic categories, but rather on more broadly defined distress.

Community based service delivery model In line with the global focus towards community mental health services, Nepali NGOs appear to have adopted a community based model of mental health care. Psychiatric consultation during mobile health camps, integration of mental health into primary health care (TPO Nepal, 2013) and rehabilitation and family support through home visits (Raja et al., 2012) are examples of community based service delivery models. Other examples include: school based mental health services (Jordans et al., 2010a), conflict resolution and community mediation programmes. In our observations, the residential rehabilitation centres contribute to this model by working as a bridge between medical and social models by conducting recreational activities, providing day care services and include strong family engagement alongside medication.

Culturally relevant intervention designs NGOs are making efforts to design culturally relevant interventions. Examples of culturally relevant interventions implemented by research based mental health NGOs include: Classroom Based Psychosocial intervention (Jordans et al., 2010a), Child Led Indicator programme (Karki et al., 2009), Alternative to Violence, Effective Parenting, Community Mental Health Promotion programmes (Sapkota et al., 2011), Women Empowerment Group intervention (Reiffers et al., 2013) and Tree of Life intervention (Ncube, 2006). Formation of self-help groups, for peer support between people experiencing mental health problems, is another commonly used intervention, with group members connected to community resources and provided livelihood support through vocational training and grants for setting up small businesses (Raja et al., 2012). Although there remains strong debates within the literature on the relevance and sustainability of activities by *'external'* actors in humanitarian crises, many NGOs have taken a participatory approach, combining service delivery with efforts to better understand local priorities and resources (Kohrt & Hruschka, 2010), adapting *'western'* interventions to make them culturally sensitive to local contexts (Jordans et al., 2003; Tol et al., 2005).

Multidisciplinary team of service providers Mental health service provision is a multisectoral affair (Upadhayaya, 2013). NGOs have tried to combine medical and social models of mental health care (Raja et al., 2012) and often promote a multidisciplinary team approach of service delivery (Thara & Patel, 2010). In our observations, mental health Nepali NGOs are gradually involving service providers from different backgrounds (medical, social and legal) and are more aware of client's privacy and confidentiality. The direct interaction between PHC workers and psychiatrists (TPO Nepal, 2013; Upadhayaya, 2013), the inclusion of psychosocial counsellors in mobile mental health camps and the involvement of nurses, counsellors and social workers in community rehabilitation programmes are some examples of a multidisciplinary team approach.

Awareness and advocacy

Another key strength of NGOs is that they are good at mental health promotion (e.g. through popular interventions aimed at strengthening psychosocial wellbeing, such as child friendly spaces, recreational activities, etc.), mental health advocacy, and awareness raising programmes (Jordans et al., 2003; WHO, 2006). Because of their knowledge of local contexts and quick access to, and acceptance by, the local community, NGOs have been able to sensitise the population through direct community orientation

sessions or street plays, radio programmes, cultural programmes, newsletters and short films (Thara & Patel, 2010). In our experience, continued NGO lobbying and advocacy has made stakeholders more sensitive and responsive, resulting in increased coverage of mental health in government policies and programmes, and in the national media.

Strong focus on stigma reduction In Nepali society, mental illness is highly stigmatised as a '*mark of shame, disgrace and disapproval*' (Regmi et al., 2004). An important aspect of NGOs awareness programmes is the focus on stigma reduction in society (Jordans et al., 2003; Sapkota et al., 2007) and the education of both people with mental health problems, and their family members (TPO Nepal, 2013). In our opinion, these efforts have produced some positive results including greater acceptance of service user involvement in programme planning and policy development.

Policy advocacy NGOs can play a vital role in mental health advocacy (Funk et al., 2005). Since 2009, NGOs have joined hands for policy advocacy by establishing a loose network named '*National Mental Health Network*'. Advocacy efforts of NGOs have yielded positive outcomes, such as endorsement of national minimum standards for shelter homes [Ministry of Women, Children and Social Welfare (MWCSW) 2011], promulgation of psychosocial guidelines for HIV/AIDs affected children [National Center for AIDS and STD Control (NCASC), 2012] and integration of psychosocial issues in other sectors, such as education, sexual and gender based violence, trafficking (MWCSW, 2011), child protection, reproductive health, nutrition, disaster preparedness and response (IASC Nepali version, 2009), conflict and peacebuilding. Other examples of positive results of NGO advocacy are: provision of social benefits under a disability allowance provided by the Ministry of Women, Children and Social Welfare and establishment of a One Step Crisis Center under the Ministry of Health and Population [Nepal Health Sector Strategic Plan (NHSSP), 2014]. In the authors' observations, NGOs are increasingly involved in national level policy discussion forums. For example, they have contributed to the multi stakeholder action plan for mental health (2013–2020) and a chapter on mental health to be included in the proposed integrated Nepal Health Act.

Research

Due to the lack of national level prevalence studies and larger scale research (Regmi et al., 2004; Tol et al., 2009), little is known about the mental health burden in the general population. Though NGOs have not been able to address this gap at the national level, they have provided rich information about mental health and psychosocial situations in specific geographic locations and for subpopulations (Upadhyaya & Pol, 2003), including torture survivors (Tol et al., 2007), Internally Displaced Persons (Thapa & Hauff, 2005), refugees (Reiffers et al., 2013), people affected by natural disasters (Jordans et al., 2010b), girls/women working in entertainment sectors, and children associated with armed forces and armed groups (Kohrt et al., 2008a). To ensure that research is conducted in an ethical manner, guidelines such as the C4P model: Four Principles for ethical research with Child Soldiers (Kohrt & Hruschka, 2010) have been developed. Similarly, western instruments, such as Beck Depression Inventory (Kohrt et al., 2002), posttraumatic stress disorder (PTSD) Checklist Civilian Version (Thapa & Hauff, 2005) and child mental health and psychosocial research instruments (Kohrt et al., 2011) have all been validated for use in Nepal.

Research collaboration and publications A few NGOs have focused their efforts on conducting psychosocial and mental health research, which has been

published in academic journals. Publication of research findings on community mental health care (Upadhyaya et al., 2013), impact of torture on refugees (van Ommeren et al., 2001), psychosocial care for conflict affected children (Kohrt et al., 2010) and prevalence of mental disorders (Upadhyaya & Pol, 2003) are some of the examples of NGO's contributions to research and publication. NGOs have also collaborated with foreign academic institutions such as McGill University, Canada, King's College London, University of Cape Town, South Africa and Makerere University Uganda to conduct psychosocial and mental health research in Nepal. In our opinion, these collaborations have contributed in developing local research capacity and dissemination of research findings to larger international audiences. This includes research publication and dissemination via collaborative article writing, incorporating the strengths of experts from high income countries with both senior and junior Nepali researchers, have been developed (Kohrt et al., 2014).

Translation of research knowledge Findings from mental health research conducted by NGOs have been used by government and UN agencies to design rehabilitation packages for Children Associated with Armed Forces and Armed Groups (CAAFAG) and other programmes for specific subpopulations. Research results have also been used to develop new interventions or modify the existing ones. The revision of Classroom Based Intervention (CBI) by TPO Nepal, after the results of a randomised control trial (RCT), is one such example (Jordans et al., 2010a). Information collected by NGOs has also been used by others in various forms. For example, the process documentation of disaster during the Koshi river floods was used for the adaptation and contextualisation of the *Inter-Agency Standing Committee (IASC) Guidelines* in Nepal (IASC Nepali version, 2009). Research findings have also been able to provide strong advocacy tools to lobby the government for policy changes, such as the inclusion of mental health in *Nepal Health Sector Support Program* (NHSP-II) a noncommunicable disease, multi stakeholder action plan (2014–2020).

Key challenges

Despite the identified strengths, NGOs have also equally displayed several challenges in terms of coordination, sustainability, accreditation and licensing, as described below.

Coordination and collaboration

Between mental health and psychosocial support NGOs In our opinion, coordination and collaboration among mental health NGOs in Nepal has been a challenge. Since 2000, several networking efforts among mental health and psychosocial organisations have been pursued. Groups were formed, often with strong participation in the beginning, but after running successfully for some time these groups often collapse, perhaps due to the lack of a shared vision. Differences of opinions between stakeholder groups, regarding mental health treatment and mechanisms for service provision also play a part. As a result, several policy level consultation workshops have not been able to produce consensus policy documents. Additionally, due to a lack of clarity and shared vision for mental health and programmatic directions, duplication of NGOs activities has been observed. This has also been a theme in other countries (Lewis & Kanji, 2009). Overall, there appears to be a hesitance towards sharing and learning from each other's best practices and challenges.

Among the government and mental health and psychosocial support NGOs In our observations, a similar lack of collaboration has plagued relations between the government and NGOs. NGOs are free to run their projects in isolation if they so wish, with little government oversight and/or internal coordination. NGOs

that work closely with government institutions also face red-tape and unnecessary delays. Additionally, in the case of Nepal, during the armed conflict the government was party to the conflict, so NGOs distanced themselves from the government institutions in order to retain a neutral position. Although this approach facilitated service delivery during peak conflict periods, it appears to have also prevented strong alliances with the government and subsequently lost opportunities for public/private partnerships.

Between government institutions In our observation, coordination among government intuitions for mental health has also been scant. Currently, the mental hospital, Primary Health Care Revitalization Department, Management Division and National Health Training Center are involved in mental health, but due to lack of clear policies guiding their relationships, activities of these government institutions do not appear to be well coordinated. Similarly, there does not seem to be any clarity about which institution is the official focal point for mental health, with the Ministry of Health and Population unable clearly instruct NGOs to coordinate with a particular division within the ministry to date.

Low priority of mental health in Nepal

Neither the government, nor civil society organisations, have prioritised mental health as one of their core areas of focus.

Lack of government attention to mental health The mental health policy formulated in 1996 is not yet implemented (Regmi et al., 2004) and three rounds of efforts to endorse mental health legislation have been in vain (Upadhayaya, 2013). The policy proposes establishing a separate mental health division within the Ministry of Health and Population, but still there is no one to oversee mental health within the ministry. There is one central mental hospital and a few regional hospitals with limited psychiatric services. Thus, mental health care is largely institutionalised, with limited community mental health activities in the government health system. The lack of law, regulation, government systems and procedures for mental health, and non implementation of mental health policy clearly demonstrate the governments' lack of attention to mental health.

This lack of government priority in mental health (Upadhayaya, 2013) is a challenge for NGOs because low priority means inadequate funding, weak government mechanisms and a lack of systems, procedures and infrastructure. In the absence of these factors, the grassroots successes of NGOs may not be sustainable and opportunities to translate experiences gained by NGOs into lasting policy changes are missed. Furthermore, continuation of pharmacological treatments through institutional based psychiatric care is a challenge for NGOs that often advocate for a socio-medical model of mental health service provision. In fact, the lack of government initiatives towards the integration of mental health into primary health care, despite commitments in a 1996 policy, is an obstacle to improving mental health care.

Due to lack of government priority in mental health (Regmi et al., 2004), many bilateral and multilateral donors supporting health sector development in Nepal are not providing sufficient funding to mental health NGOs. The government allocates less than 1% of the total health budget (Regmi et al., 2004) to mental health, and among that a large portion is allocated for the operation of psychiatric facilities. There is almost no budget for community mental health activities, an area where NGOs have mastery.

Lack of civil society organisations' attention to mental health Although psychosocial and mental health is a cross-cutting issue and should be addressed by NGOs in other sectors, (e.g. education, protection, livelihood, shelter, site planning), many NGOs have not prioritised integration of mental health and psychosocial issues into their existing programmes.

Sustainability

Almost all the mental health NGOs in Nepal depends on external funding, normally of short duration. Due to these short term projects, NGOs cannot commit to long term treatment services. Likewise, NGOs do not have influence over the structures and mechanisms to enable a continuity of services. Apart from these external limitations, NGOs are also weakened by the competition for scarce resources and move quickly from one location or theme to another for reasons related to funding, without properly addressing the ethical issues of phasing out programmes and projects. The discontinuation of services, after phase out of a project, can make people even more vulnerable, and as a result, frustrated about the way NGOs work. While there are exceptions, most NGOs are running activities in isolation, without formal collaboration with government entities meaning services end when the project is phased out. Consequently, there are issues both of the sustainability of the NGOs themselves, and the sustainability of services initiated by them.

Discussion

This paper touches on the strengths and limitations of the role of NGOs in mental health and psychosocial support in Nepal. Below, we discuss these key issues in relation to: a) the important role NGOs play in strengthening mental health systems; b) the need for partnerships with the government; c) the standardisation of training programmes and services; and d) the need for a central coordinating body for mental health within the Nepal government.

NGOs can play an important role in mental health system strengthening. The efforts of mental health NGOs in Nepal appear to have mainly focused on three of WHO health systems building blocks, namely human workforce development, information and service delivery (WHO, 2007). Service delivery by NGOs, especially following conflict and natural disasters (Harwin & Barron, 2007) is a contribution to health system strengthening, as NGOs' work helps in achieving increased health coverage. NGOs' potential contribution to mental health system strengthening has been well demonstrated in other settings. For example, in Afghanistan, due to NGOs' contributions, the capacity of service providers improved, service utilisation increased and donors finally agreed to fund mental health care (Ventevogel et al., 2012). Pakistan has benefited substantially through '*health education, health promotion, social marketing and advocacy by the not-for-profit private sector*' (Ejaz et al., 2011). Similarly, the mental health sectors in Uganda and Burundi were largely supported by NGO initiatives (Baingana & Onyango, 2011; Ventevogel et al., 2011). Likewise, Basic Needs (NGO), has introduced a mental health and development model in Nepal that focuses on concepts like user empowerment, community development and health system strengthening, offering a feasible method of integrating mental health into existing community based interventions (Raja et al., 2012).

Also, as previously stated, while NGOs have several strengths (easy access to the local community, better understanding of the local context, quick and flexible response mechanisms (Lillehammer, 2003) and access to the marginalised and under served areas), they also have a number of challenges (including limited sustainability of donor driven programmes, weak collaboration and high staff turnover). It is also important to note that NGOs' direct action in humanitarian settings may result in laudable gains in the short term, but without sustained networking and advocacy strategies, NGOs are unlikely to have any significant long term national impact (Edwards et al., 1999).

Experiences of conflict and emergency affected countries illustrate that mental health reform efforts may begin in the midst of an emergency and, if capitalised on, can have positive impacts on the long term

development of mental health care systems (WHO, 2013). However, NGOs alone cannot achieve system strengthening goals, highlighting the need for strong partnerships with government. The government, except when party to the conflict, bears primary responsibility for providing key mental health services to its population, as access to health services is a basic human right. NGOs can support the government through a clearly defined public/private partnership approach, which has been demonstrated to be effective in many low and middle income countries. For example, over an eight year period in Burundi, NGO activities shifted from the delivery of services to strengthening the capacity of government staff and embedding mental health and psychosocial support within existing health services and social systems (Ventevogel et al., 2011). Similarly, Raja and colleagues (2012) argue that strategic engagement and involvement of government is critically important to influencing mental health practice and policy. Lessons learnt from Uganda also stress the importance of coordination and joint planning between government and NGOs (Baingana & Onyango, 2011).

Another major challenge is that the quality of training courses and clinical services of NGOs cannot be independently verified. This is due to a lack of accreditation for NGO training courses and a regulatory body that monitors the quality of clinical practices. This is a serious threat to the quality of services and, therefore, the longer term sustainability of psychosocial human resources developed by NGOs, and the counselling services provided by them.

In line with the humanitarian principle '*First Do No Harm*', NGOs should work towards development of minimum standards' for training and clinical practices, with facilitation from the government in accreditation and licensing processes. Even fully trained staff requires regular refresher training and onsite clinical supervision mechanisms to ensure service quality is maintained (Baingana & Onyango, 2011; Jordans et al., 2003).

Finally, in the absence of a central coordinating body for mental health within the government, coordination and collaboration have been challenging. The competing interests of several governmental and nongovernmental stakeholders appear to have given rise to confusion, tension and frustration. This sharp division can only be minimised by a legitimate government body responsible for coordination of mental health activities. NGOs can advocate and help in establishing a coordinating body as has been demonstrated elsewhere. In Afghanistan, for example, NGOs assisted the government in establishing a mental health department within the Ministry of Public Health, which greatly facilitated policy development and service coordination (Ventevogel et al., 2012).

Way forward

We propose the following concrete roles that NGOs could potentially play in post conflict Nepal, where the impact of the conflict is still prevalent in many communities. First, NGOs could contribute to government efforts to integrate mental health into primary health care as suggested by WHO's mhGAP. To do this, NGO's could utilise their knowledge and skills of training, research and service delivery, and support the government to develop training curriculum, treatment protocols and supervision guidelines. This would address, to some extent, the challenges related to the availability and sustainability of primary mental health services.

Second, micro level programmes, conducted by NGOs in certain geographic areas, no matter how good and effective, have not been scaled up to a national level. So, to address the challenges related to policy formulation and revision, NGOs should use their grassroots knowledge and experiences by linking field priorities to national policies

and programmes. Government also needs to be proactive in collaborating with NGOs and the private sector (Thornicroft et al., 2010). This can be done best through a jointly developed public/private partnership strategy (Baingana & Onyango, 2011; Nakimuli-Mpungu et al., 2013) which acknowledges the central stewardship role of government and importance of NGOs for assisting the government, providing critical but positive comments and advocating for the importance of quality and equitable government delivered services based on a health systems strengthening approaches (Ventevogel et al., 2011).

Third, there is no national quality control mechanism for mental health and psychosocial support services. Therefore, the government, together with the NGOs, needs to establish a mechanism like the national mental health council to assess the quality of services provided. There has to be a reciprocal accountability that NGOs hold government accountable, while the government also has a role in ensuring NGOs are accountable to local populations.

Fourth, there is also an urgent need to standardise the training curriculum, manage the accreditation of training courses and develop the licensing mechanisms for psychosocial counsellors.

Conclusion

Nepali NGOs working on mental health and psychosocial support, despite facing several challenges, have also been able to contribute to the promotion, prevention and treatment of mental health and psychosocial problems. Human workforce development, service delivery and awareness raising have been the core areas of focus for most NGOs, while some have also been involved in mental health research and scientific publication. As these NGOs already work on several health system building blocks, they can play an important role in post conflict mental health system strengthening. While there is little doubt of the important role that NGOs can play in post conflict Nepal, more attention must now also be given to stewardship from the government to facilitate sustainability of services, acceptance by other stakeholders and ensuring continued funding. Further, the credibility of NGOs and their services is negatively impacted by the lack of accreditation for training courses and lack of provisions for monitoring and licensing of counselling services. It is now time for the government to take leadership and assume a central coordinating role. NGOs could then complement the work of the government through a public/private partnership approach.

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