

Introduction

727,000
Global Suicide Deaths/Yr

73%
Occur in LMICs

25 / 100k
Estimated Rate in Nepal

Nepal Youth Context

Suicide is the 3rd leading cause of death among 15–29-year-olds globally. In Nepal, over 7% report suicidal ideation. Underreporting persists due to legal and social stigma.

Zero Suicide Paradigm

Pioneered at Henry Ford Health in 2001. Pragmatic elements (screening, safety planning, caring contacts) can be adapted for lower-resource community settings.

~80%

HFH Suicide Reduction

Aim 1: Feasibility Assessment

Conduct a feasibility study with key stakeholders to identify knowledge, perceptions, and experiences regarding suicide behaviors among adolescents and young adults, availability of behavioral health resources, and barriers and facilitators to integration of the ZS model within existing health policies and programs; and

Aim 2: Implementation Strategies

Utilize the feasibility data to develop implementation strategies based on the ZS model to address suicide behaviors in youth.

Methodology

Study Sites

All Seven Provinces in Nepal (Quantitative and feasibility study)

Targeted three provinces, Bagmati Province, Madhesh Province, and Gandaki Province, for assessing the Implementation strategies

Stratified Stakeholder Sample

MOHP Officials, WHO/UNICEF Focal, Psychiatrists, Psychologists, School Nurses, Teachers, Female Community Health Volunteers (FCHVs), Police, and NGO Leaders.

24
Phase 1 Interviews

12
Strategy Reviews

109
Nationwide Surveys



Figure 1. Map of Nepal showing Provinces

SAB Governance

National Stakeholder Advisory Board (SAB) for study oversight.

- Led by the director of the Epidemiology and Disease Control Division, Ministry of Health and Food Safety

Data Collection, Management, and Analysis

- Conducted complementary interviews for the feasibility study.
- Presented four draft implementation approaches for assessment: school-based, community-based, outpatient clinic, and hospital-based.
- Coded data were analyzed thematically.

Study Results

Table 1. Data Overview (n = 109)

Age	
Mean (SD)	38.7 (8.50)
Median [Q1 – Q3]	39.0 [33.0 – 45.0]
Gender	
Female	52 (47.7%)
Male	57 (52.3%)
Province	
Bagmati	24 (22.0%)
Gandaki	14 (12.8%)
Karnali	14 (12.8%)
Koshi	14 (12.8%)
Lumbini	14 (12.8%)
Madhesh	15 (13.8%)
Sudurpashchim	14 (12.8%)

Table 2. Distribution of Implementation Strategy Interview Participants by Location and Occupation (n=12)

	Bagmati	Madhesh	Gandaki	Totals
Provincial/District Governments	1		1	2
Local Police			1	1
Public Health Officer		1		1
Psychiatrist	1	1		2
Psychologist	1			1
FCHV	1	1		2
School Nurse			2	2
Youth Organization Leader	1			1
Totals	5 (41.7%)	3 (25%)	4 (33.3%)	12

System Gaps & Vulnerabilities

▲ Identified At-Risk Youth Groups

Socio-Economic Stress: Poverty and youth unemployment.

Adolescent Dynamics: Peer pressure and family discord.

Gender Trauma: Physical, emotional, and sexual abuse.

Marginalized Groups: Women and LGBTQI individuals.

“...in the last two months, I have seen three suicides around me. Two were my own students. After observing these incidents, I believe 100% that this program needs to be implemented.”

Teacher

☹ Health System Gaps

Resource Imbalance: Severe deficit in rural provinces.

Workload Constraints: Overburdened nurses and FCHVs.

Care Disruption: Lack of standardized referral pathways.

Pervasive Stigma: Fear of isolation prevents care seeking.

“... a patient might receive treatment for a day, but then there's lack of supervision from their family. There's also societal stigma. They don't receive proper counseling. As a result, relapse rates are high among our patients.”

Health Worker

Four Tailored Implementation Settings

1. School-Based Strategy

Implementers: Teachers & School Nurses

Universal screening, means reduction, and training.

2. Community-Based Strategy

Implementers: FCHVs, Health Posts, Local NGOs

Door-to-door screening, community ambassador anti-stigma campaigns.

3. Outpatient Clinic Strategy

Implementers: Psychiatrists & Psychologists

Routine screening, clinical template decision support, telemedicine follow-up.

4. Hospital-Based Strategy

Implementers: Inpatient Clinical Staff

Inpatient psychotherapy, structured discharge protocols, 48h caring contacts.

Table 3. Multivariate Models for Six Components

	Acceptability	Risk Assessment	Safety Plan	Caring Contacts	Care Coordination	Psychotherapy
Age	-0.36 [-1.27, 0.56]	0.01 [-0.94, 0.96]	-0.82 [-1.73, 0.10]	-0.52 [-1.47, 0.43]	-0.55 [-1.50, 0.40]	-0.40 [-1.27, 0.46]
Male vs. Female	0.00 [-1.50, 1.50]	0.30 [-1.26, 1.85]	1.24 [-0.25, 2.74]	0.41 [-1.15, 1.97]	-0.61 [-2.17, 0.94]	0.08 [-1.34, 1.50]
Hospital (vs. Community)	-1.94 [-4.08, 0.20]	-0.45 [-2.67, 1.77]	0.07 [-2.07, 2.20]	0.02 [-2.20, 2.24]	-0.13 [-2.35, 2.09]	-0.51 [-2.53, 1.52]
Government (vs. Community)	-2.53 * [-4.78, -0.28]	-1.63 [-3.96, 0.70]	-0.69 [-2.93, 1.55]	-1.67 [-4.01, 0.66]	-1.32 [-3.65, 1.00]	-1.78 [-3.90, 0.34]
Others (vs. Community)	-7.45 *** [-11.61, -3.30]	0.15 [-4.16, 4.45]	0.66 [-3.48, 4.81]	-1.01 [-5.33, 3.30]	-3.43 [-7.73, 0.88]	-1.44 [-5.36, 2.49]
MH Clinic (vs. Community)	-2.38 [-7.21, 2.45]	-4.08 [-9.08, 0.92]	-1.66 [-6.48, 3.16]	-2.40 [-7.41, 2.62]	-0.44 [-5.44, 4.56]	-2.79 [-7.35, 1.77]
Primary Care (vs. Community)	-1.49 [-3.90, 0.92]	-1.94 [-4.43, 0.56]	-1.42 [-3.82, 0.99]	-0.65 [-3.15, 1.86]	-0.97 [-3.47, 1.52]	-2.71 * [-4.99, -0.44]
School (vs. Community)	-1.48 [-3.50, 0.53]	-1.11 [-3.19, 0.98]	-0.47 [-2.48, 1.54]	-1.30 [-3.40, 0.79]	-1.83 [-3.92, 0.26]	-1.44 [-3.35, 0.46]
N	109	109	109	109	109	109
R2	0.14	0.06	0.08	0.08	0.13	0.13

All continuous predictors are mean-centered and scaled by 1 standard deviation. The outcome variable is in its original units. *** p < 0.001; ** p < 0.01; * p < 0.05.

Organization Overview

Behavioral Health Services at Henry Ford Health, USA delivers comprehensive psychiatric care, mental health services, and evidence-based suicide prevention frameworks. The **Global Health Initiative (GHI)** at Henry Ford Health, USA drives international research collaborations, educational programs, and public health equity initiatives globally.

G.T.A. Foundation, Nepal (Website: www.gtafoundation.org.np, Email: info@gtafoundation.org.np), advances global health equity across Nepal and South Asia through pioneering research in immunization, disease surveillance, Zero Suicide, antimicrobial stewardship, and digital health interventions.

It serves as the Secretariat for the Zero Suicide International Asia Alliance.

Table 4. Feasibility of the Zero Suicide Model

Area	Key Feasibility Considerations
Need & Practicality	Strong need for suicide prevention in Nepal, particularly among youth and disaster-affected populations; ZS provides an integrated prevention and care framework.
Adaptation & Integration	Adapt the model to Nepal's cultural, social, economic and geographic contexts, while integrating with existing government and health systems.
Community & Multisectoral Engagement	Engage local government, health facilities, communities and other sectors through awareness, training, advocacy and stakeholder participation.
Acceptability & Digital Innovation	Growing awareness creates an opportunity for implementation; mobile technology and telehealth can improve access, referral and follow-up.
Evidence & Sustainability	Continuous monitoring, evaluation, workforce training and government ownership will generate local evidence and support long-term sustainability and scale-up.

Conclusion

There is compelling evidence that Zero Suicide model components are highly feasible and strongly supported in Nepal. Pilot integration across schools, communities, and health facilities will serve as a global blueprint for adapting evidence-based suicide prevention in low-resource settings.

Policy Recommendations & Sustainability

Government & Structural Actions

Dedicated Desk: Create a dedicated Suicide Prevention Desk within EDCD/MOHFS for unified case surveillance.

Youth Roadmap: Embed explicit adolescent-focused guidelines into the National Mental Health Roadmap.

Municipal Funding: Engage local municipal budgets to maintain long-term CBO and FCHV staffing.

Implementation Pillars

Continuous Evaluation: Rigorous outcome monitoring to establish context-specific evidence for LMICs.

Telehealth Expansion: Deploy digital follow-up and supervision tools for remote provincial clinics.

Anti-Stigma Media: Utilize local street drama and youth peer champions to normalize care-seeking.

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Ethical Clearances

Approved by the IRBs of Henry Ford Health (USA) and the Nepal Health Research Council (NHRC).

References

- WHO. Suicide. March 2025. [Suicide](#)
- Gyanwali P. *National Mental Health Survey Nepal-2020*. Kathmandu, Nepal2021.
- Hagaman AK, Maharjan U, Kohrt BA. Suicide surveillance and health systems in Nepal: a qualitative and social network analysis. *Int J Ment Health Syst*. 2016 Jun 6;10:46. doi: 10.1186/s13033-016-0073-7. PMID: 27274355; PMCID: PMC4895957.
- WHO. Mental Health and Adolescents. September 2025. [Mental health of adolescents](#)
- Bhusal T, Breen MG. A study of the first five-year tenure (2017–2022) of provincial governments in Nepal. *Asian Polit Policy*. 2024;16(4):524–547. doi:10.1111/aspp.12767
- Ahmedani BK, Penfold RB, Frank C, Richards JE, Stewart C, Boggs JM, Coleman KJ, Sterling S, Yarborough BJH, Clarke G, Schoenbaum M, Aguirre-Miyamoto EM, Barton LJ, Yeh HH, Westphal J, McDonald S, Beck A, Beidas RS, Richardson L, Ryan JM, Buckingham ET 4th, Buttlaire S, Bruscke C, Flores J, Simon GE. Zero Suicide Model Implementation and Suicide Attempt Rates in Outpatient Mental Health Care. *JAMA Netw Open*. 2025 Apr 1;8(4):e253721. doi: 10.1001/jamanetworkopen.2025.3721.