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From Nepal's Gen Z Uprising to Democratic Renewal: A Public Health Agenda for Recovery, Accountability and Resilience

Arjun Aryal

INTRODUCTION

On 8 September 2025, a youth-led protest against a sweeping social-media ban and against deeper frustrations over corruption, exclusion and limited opportunity resulted in a lethal police response near Nepal's Parliament. By the following day, the crisis had widened: public buildings and private property were burned, people on several sides were killed, and the government fell. Later investigations distinguished the largely peaceful mobilisation and disproportionate use of force on 8 September from much of the arson and mob violence that followed on 9 September. That distinction matters. Accuracy is the beginning of accountability, and responsibility for one form of violence must never be used to excuse another (1,2).

As this issue goes to press in August 2026, the scale of harm is clearer than it was in the first days. Seventy-six people were reported killed, and the Government ultimately verified 2,660 injured people from records across 99 hospitals (2,3). These are not merely historical totals. Behind them are people living with disability, disfigurement, chronic pain, bereavement, interrupted education, lost income and fear. The full public-health burden will not be captured by a casualty list, however carefully compiled.

The political transition was rapid. Prime Minister K.P. Sharma Oli resigned, an interim administration led by Sushila Karki oversaw a national election on 5 March 2026, and an elected government headed by Balendra Shah took office on 27 March (4). The election restored an essential democratic pathway for resolving political conflict. It did not, by itself, heal the injured, answer bereaved families or rebuild trust in public institutions. Those tasks now define the harder phase of recovery.

Public health has a legitimate voice in that phase. The Constitution of Nepal recognises free basic health services, protection from denial of emergency care and equal access to health services under Article 35 (5). These guarantees do not disappear during civil unrest. On the contrary, they become most meaningful when institutions are under pressure and when people are frightened, injured or politically unpopular. Emergency care must be based on clinical need alone; no wounded person should have to weigh the risk of seeking treatment against the risk of arrest, intimidation or stigma.

The first obligation is sustained care. Nepal needs a single, secure and regularly updated registry that links the verified injured list to clinical follow-up, rehabilitation, disability assessment, mental-health support, social protection and compensation. People with spinal, neurological, orthopaedic, burn or sensory injuries may need years of treatment. Families may face catastrophic expenditure long after initial hospital bills are paid. A transparent entitlement pathway, with referral standards, grievance mechanisms and public reporting, would turn promises of assistance into an auditable programme rather than a sequence of discretionary decisions.

Correspondence to:
Arjun Aryal
Central Department of Public Health, Institute of Medicine, Tribhuvan University, Kathmandu, Nepal
Email: drarjunaryal@gmail.com

The second obligation is to learn from the health-system response. Every mass-casualty event should trigger an independent after-action review of command, triage, ambulance dispatch, blood supply, trauma referral, hospital security, risk communication, data management and continuity of essential services. The purpose is not to assign blame to frontline staff who worked under extreme conditions, but to identify preventable delays and strengthen readiness. The World Health Organization's 2026 framework for national public-health agencies emphasises legal authority, evidence, flexible financing, coordination, emergency management, workforce capacity, risk communication and clinical-care guidance as core preparedness capabilities (6). Nepal should translate those capabilities into tested plans for civic emergencies at federal, provincial and local levels.

Mental health requires the same seriousness, but also restraint in language. Exposure to violence, bereavement and uncertainty can produce profound distress; it does not follow that every affected young person has post-traumatic stress disorder. The appropriate response is stepped and evidence-informed: clear information and basic support for all; psychological first aid and community-based services for those in distress; and timely specialist care for people with severe, persistent or high-risk conditions. Nepal has a timely policy opportunity. Work on the National Mental Health Strategy 2026–2030 is under way, and a partnership announced on 14 August 2026 will establish psychosocial-support mental-health corners in ten district hospitals while strengthening implementation of the national school mental-health framework (7,8). Protest-affected young people and families should be included without creating a parallel system that disappears when public attention moves on.

Prevention must extend beyond hospitals. The way assemblies are policed is itself a public-health concern because operational decisions determine who is injured, how severely and whether medical assistance can reach them. International human-rights standards require de-escalation, legality, necessity, proportionality, precaution and accountability; firearms are not an appropriate means of dispersing an assembly, and medical provision should be planned when violence is foreseeable (9). Nepal therefore needs publicly available crowd-management protocols, clear command responsibility, identifiable officers, independent review of every discharge of a firearm, fit-for-purpose less-lethal options, trained medical teams and protected ambulance access. Dialogue and preparation are not signs of weak policing; they are evidence of professional policing.

Health facilities must remain places of care. Reports that security personnel entered hospital premises while searching for injured protesters damaged confidence at precisely the moment when trust was indispensable (2). Nepal already has legislation protecting health workers and health institutions; the challenge is enforcement, operational clarity and training, not simply the creation of another offence (10). A national protocol should specify how law-enforcement agencies may lawfully interact with patients, clinical staff and medical records, while preserving urgent care, confidentiality, due process and the safety of everyone inside a facility.

Accountability must be credible rather than theatrical. A government-appointed inquiry recommended criminal investigation of senior former officials, and the National Human Rights Commission subsequently sent its own recommendations to the Government (11,12). Neither an inquiry report nor a public accusation is a conviction. Criminal responsibility must be determined through independent investigation, admissible evidence and a fair judicial process. At the same time, due process cannot become a pretext for indefinite delay. The principal reports should be published, evidence preserved, families kept informed, legal aid made available and implementation reported against clear timelines. Accountability must cover alleged unlawful force, command failures, arson, attacks on public institutions and violence against civilians, police and other workers alike.

The roots of the uprising also demand a broader public-health response. Corruption, unfair access to opportunity, precarious work, outward migration and distrust in government are not clinical diagnoses, but they shape mental wellbeing, household security and confidence in the future. The World Bank has identified stronger job creation and better returns from migration among Nepal's central development priorities (13). Meeting those challenges will require far more than the health ministry. It will require transparent public spending, credible anti-corruption institutions, fair recruitment, responsive local government, rights-respecting digital regulation and economic policies that allow young people to imagine a viable life at home.

Youth participation, finally, must be institutional rather than ceremonial. Young people should have defined roles in municipal planning, health and education committees, digital-policy consultation, emergency-preparedness exercises and monitoring of commitments made after the uprising. Participation should include young women, Dalit, Madhesi, Indigenous, disabled, rural, migrant and gender-diverse voices; not only the most visible activists in Kathmandu. The measure of participation is not how many consultations are held, but whether young people can see how their evidence changed a decision.

A practical recovery compact would therefore do six things: guarantee long-term clinical care and rehabilitation for every verified injured person; integrate trauma-informed mental-health support into ordinary services; conduct and publish an independent health-system after-action review; reform the policing of assemblies around de-escalation and accountable use of force; implement inquiry and human-rights recommendations through lawful, time-bound processes; and give young people durable influence over the policies that shape their lives. Each commitment should have a responsible institution, a budget, a deadline and a public progress indicator.

Public health should not become an instrument of party politics. Its responsibility is more fundamental: to protect life, reduce avoidable harm, defend equitable access to care and insist that institutions learn from preventable deaths. Nepal's democratic renewal will be judged not only by the transfer of power, but by whether the state protects life when citizens dissent, heals those who were harmed and converts a generation's anger into fairer institutions and healthier futures.

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