



April 2017

PROGRAM EVALUATION

The Integration of Mental Health & Psychosocial Support Services in Primary Health Care Facilities in Post-Earthquake Nepal

*An evaluation of the International Medical Corps Mental Health and Psychosocial
Support Program in Nepal, April 2015 - February 2017*

Table of Contents

INDEX OF TABLES.....	4
INDEX OF FIGURES.....	5
LIST OF ABBREVIATIONS	6
EXECUTIVE SUMMARY	7
1. Background.....	12
1.1 Program context.....	12
1.2 Mental health in humanitarian emergencies.....	12
1.3 Principles of MHPSS emergency response and systems strengthening	13
1.4 Mental health services in Nepal.....	18
1.5 Program Overview	19
1.6 Participating facilities.....	28
2. Evaluation framework and methods.....	29
2.1 Data collection team	31
2.2 Quantitative methods.....	31
2.3 Qualitative methods.....	35
2.4 Methodological constraints and limitations	39
3. Results	40
3.1 Effectiveness.....	41
3.2 Structural impact.....	70
3.3 Relevance	71
3.4 Sustainability	73
4. Discussion and recommendations.....	79
4.1 Program achievements and limitations.....	79
4.2 Collaborating with local and national health authorities.....	85
4.3 Planning for sustainability.....	89
Appendix 1. Details of quantitative outcome tools.....	92
Appendix 2. Sample interview topic guide	94
Appendix 3. Sample focus group topic guide.....	99
Appendix 4. Qualitative thematic framework	104

Appendix 5. WHO-recommended psychotropic medications	108
References.....	110
Acknowledgements.....	112

Index of Tables

Table 1 Training packages	24
Table 2 Distribution of participating health facilities across the three program districts	28
Table 3 Summary of quantitative outcome measures	33
Table 4 Number of PHC Integration Checklists completed by facility type and district.....	34
Table 5 Summary of qualitative methods.....	36
Table 6 Number of interview participant disaggregated by role and district.....	38
Table 7 Number of focus group participants disaggregated by role and district.....	38
Table 8 Number of trainees disaggregated by gender and provider type	41
Table 9 Distribution of government trainees (prescribers and non-prescribers) across health facilities and districts	43
Table 10 Mean number of supervision contacts per trainee	43
Table 11 Initial and final scores on quantitative evaluation tools	45
Table 12 Number of service users per district.....	50
Table 13 Number of service users consulting each type of service provider.....	50
Table 14 Medication procured by the program.....	58
Table 15 Percentage of facilities reporting that psychotropic medication was "usually" available in the past week	59
Table 16 Number of participants attending community outreach events	62
Table 17 Distribution of educational materials in the three districts.....	65
Table 18 Composition of Support Groups in Gorkha and Sindhuli	66
Table 19 Number of mental health service users referred to health facilities by district.....	69

Index of Figures

Figure 1 IASC Intervention Pyramid for MHPSS in emergencies.....	14
Figure 2 WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health	17
Figure 3 Map of Nepal showing the districts most heavily affected by the earthquakes	20
Figure 4 Program activities corresponding to each of the three program objectives	21
Figure 5 Illustration of categories of health workers trained	23
Figure 6 Evaluation methods.....	30
Figure 7 Number of professionals trained disaggregated by sex and district	42
Figure 8 Mean knowledge test scores pre- and post-training	45
Figure 9 Mean ACE scores on pre- and post-tests.....	46
Figure 10 Mean ENACT-18 scores on pre- and post-tests	46
Figure 11 Mean perceived general competency scores at beginning and end of program	47
Figure 12 Mean Perceived Clinical Competency scores among prescribers	47
Figure 13 Number of service users, disaggregated by presenting problem and age	50
Figure 14 Users accessing program services disaggregated by presenting problem, region, sex..	51
Figure 15 Service users as a percentage of region totals disaggregated by presenting problem...	51
Figure 16 Levels of client/caregiver satisfaction by district	52
Figure 17 Mean WHO Disability Assessment Schedule II daily functioning scores	54
Figure 18 Initial and final WHODAS II scores disaggregated by presenting problem	54
Figure 19 Initial Mean WHODAS II scores among those with severe impairment.....	55
Figure 20 Initial, final WHODAS II scores among those with severe initial impairment disaggregated by presenting problem	55
Figure 21 Number of days service users reported being "totally unable" to work or carry out usual activities in the past month.....	56
Figure 22 Improvements in social functioning among those with severe impairments	56
Figure 23 Improvements in self-care and mobility among those with severe impairments.....	57
Figure 24 Example of a billboard displayed in prominent locations throughout the districts.....	63
Figure 25 Example of a brochure explaining the symptoms of PTSD and how to seek help.....	64
Figure 26 Example of program bulletin to raise awareness of program activities in Dhading.....	65
Figure 27 Percentage health facilities reporting that most staff have received mental health communication skills training.....	69
Figure 28 Services that will be sustained after program close	74

List of Abbreviations

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
AUD	Alcohol Use Disorders
CIDT	Community Informant Detection Tool
CTEVT	Council for Technical Education and Vocational Training
DHO/DPHO	District Health Officer/District Public Health Officer
DSA	Daily Subsistence Allowance
FCHV	Female Community Health Volunteer
HA	Health Assistant
HBCW	Home-based Care Worker
ICDC	Integrated Community Development Campaign
M&E	Monitoring and Evaluation
mhGAP	Mental Health Gap Action Program
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organization
OPD	Outpatient Department
PFA	Psychological First Aid
PHC	Primary Health Care
PHCC	Primary Health Care Center
PRIME	PRogramme for Improving Mental Health carE
PSC	Psychosocial Counselors
SSRI	Selective Serotonin Reuptake Inhibitors
TPO	Transcultural Psychosocial Organization
VDC	Village Development Committee
WHO	World Health Organization

Executive Summary

Overview of context and program

In April and May of 2015, Nepal was struck by two major earthquakes, which killed 8,790 people, injured more than 22,000, and left 2.8 million homeless. In collaboration with Transcultural Psychosocial Organization Nepal (TPO) and Integrated Community Development Campaign (ICDC), International Medical Corps established a Mental Health and Psychosocial Support (MHPSS) program in three severely affected districts, with the aim of responding to immediate MHPSS needs and supporting the longer-term development of MHPSS services.

The objectives of the program were: to strengthen the capacity of health workers and community members to provide high-quality MHPSS services; to provide community-based mental health and psychosocial support services; and to improve access to MHPSS services through awareness-raising initiatives and anti-stigma campaigns.

Purpose of the evaluation

The purpose of this evaluation was to conduct an evidence-based assessment of program strengths and weaknesses, to identify lessons learned, and to generate recommendations for the design and management of future MHPSS programs.

Methods

A mixed-methods approach was adopted, combining quantitative data on program activities with qualitative data from stakeholder interviews and focus groups, to gain a comprehensive understanding of program achievements and challenges.

Key achievements

Objective 1: Capacity Building

- **Number of trainees:** MHPSS training was provided to 1,041 health workers at 78 health facilities. Mental health orientation was provided to 1,900 community members, and Psychological First Aid training was provided to 626 community members.
- **Improved skills, knowledge and competency:** The majority of trainees surveyed demonstrated improved knowledge and skill scores on pre- and post-training tests, with 92% reporting improved perceived competency. Trainees reported that the program gave them a newfound confidence in their ability to detect, diagnose and treat mental health problems, and it became a source of professional pride and satisfaction.
- **Training challenges:** The limited availability of health workers and geographical challenges made it difficult to coordinate regular supervision sessions. In the months following their initial training, trainees were often moved out of program areas, due to the frequent transfer of government health staff between facilities.

Objective 2: Service provision

- **Service users:** Community-based MHPSS services were provided to 3,422 service users (44% male, 56% female).
- **Diagnostic profile:** The most common presenting problem was epilepsy, followed by depression, psychoses, alcohol use disorders, anxiety disorders, and post-traumatic stress disorder.
- **Service user satisfaction:** 67% of service users surveyed reported being “completely satisfied” with the services they had received, 31% reported being “somewhat satisfied”, and 2% reported being “unsatisfied”.
- **Improvements in symptoms and functioning:** Service users, carers and health workers shared many examples of cases where the program led to recovery, improved wellbeing, and a new sense of hope that mental illness is treatable. Overall, 54% demonstrated improvements in daily functioning over a six-month period (assessed using the WHO Disability Assessment Schedule), with those experiencing anxiety disorders and psychoses demonstrating the greatest improvements.
- **Among those with severe impairments** at the beginning of the program, 89% demonstrated improvements in daily functioning. Difficulties in social functioning (i.e. maintaining friendships and participating in community activities) improved by 23-25%, and difficulties in mobility and self-care improved by 21-23%. The number of days service users reported being unable to carry out their “usual activities or work” reduced by half.
- **Service strengths:** Stakeholders considered that the following aspects of the program were particularly effective: the continuous supervision of health workers by mental health specialists; home-based follow-up care for service users; and the use of an integrated approach involving lay people, community-based practitioners, and health facility staff, to develop a comprehensive support network.
- **Challenges to effective service provision** included limitations on the range of medications available through government mechanisms, a lack of private counselling spaces, and problems distributing medications among health facilities as needed.

Objective 3: Awareness-raising initiatives and anti-stigma campaigns

- **Outreach events, educational materials, and support groups:** Mental health awareness and educational events were attended by 7,933 people; 25,357 educational brochures were distributed; 152 radio programs were broadcast; and 40 educational billboards and flex-boards were displayed. Four community-based support groups were established to help service users develop economic independence through vocational training.
- **Reduction in stigma:** Service users and health workers described a reduction in the use of stigmatizing language to refer to mental health service users. Several health workers commented that they were no longer afraid to interact with people experiencing mental health problems.
- **Community outreach limitations:** Though many participants reported improvements in community attitudes to mental health, some argued that these changes were largely restricted to those affiliated with the program (e.g. service users, carers and health staff). They argued that more frequent events in a larger range of geographical areas would be required to change attitudes in the broader community.

Relevance, impact and sustainability

- **Relevance:** The aims of the program were highly relevant in the context of Nepal, given the increased mental health needs following the 2015 earthquakes and the lack of a robust pre-existing national mental health system. Program activities were consistent with the 1996 National Mental Health Policy of Nepal, which promotes the integration of mental health services into the general health system and the training of all government health workers in mental health.
- **Alignment with best practice guidance:** Program activities were largely consistent

with international best practice guidance on MHPSS emergency response and systems strengthening. Where available, training curricula were based on internationally recognized evidence-based manuals and guidelines (e.g. the WHO mhGAP Intervention Guide).

- **Social impact:** Evaluation respondents reported that the program had generated a new interest in mental health and a demand for improved mental health services both within and beyond program catchment areas. Some health workers reported that the improvements in mental health brought about by the program had led to a reduction in broader social problems such as domestic conflict.
- **Political impact:** Through advocacy and participation in national strategy meetings, program staff contributed to three major changes in mental health policy: authorization for local authorities to procure psychotropic medication; revisions to the Government of Nepal Free Essential Drug List to include modern antipsychotics and SSRIs; and updates to the national Standard Treatment Protocol for primary care mental health services.
- **Sustainability:** The 1,041 government health workers trained will continue to provide care in primary health facilities and communities. The extent to which they will continue to focus on mental health, without the support of partner-funded community follow-up mechanisms, is yet to be seen. However, the large numbers of people trained, the large numbers of people reached through community outreach, the policy advances achieved, and the continuing work of local NGOs focused on MHPSS training, service provision and advocacy, provide cause for optimism regarding longer-term benefits.

Summary of lessons learned and recommendations

Analyses of the quantitative evaluation data, feedback from evaluation respondents, and a review of research and best practice guidance resulted in a number of lessons learned and recommendations for program design, many of which may be applicable to other programs offering MHPSS services in similar settings.

Program design

- **Service strengths:** The development of a [layered system of supports](#) with different degrees of specialization was effective in increasing access to mental health services. Evaluation respondents considered the [ongoing supervision](#) of trainees and [home-based care visits](#) to be key strengths of the program.
- **Improving training curricula:** Those designing similar MHPSS programs in the future should include a [wide range of mental health disorders](#) where possible, and should consider including anxiety disorders as a priority. They should also [clearly define how each health worker role contributes to the system](#) of care being developed, and design training curricula accordingly to make the most of the available skills.
- **Training managers and support staff:** The effectiveness and sustainability of the program could be enhanced by [training managers and support staff](#), as well as health workers (e.g. training facility managers and medication store-keepers in supply-chain-management to ensure that that medication shortages are identified, reported, and addressed in a timely manner).
- **Improving community outreach and acceptance:** The impact of community outreach activities may be enhanced by: [employing a diverse range of strategies](#) (e.g. street plays and social media campaigns); [developing advocacy partnerships](#) with service users and community groups; and [assessing the relative effectiveness of different outreach activities](#) by collecting systematic data on the source of referrals and conducting pilot demonstration projects. [Traditional healers and community leaders should be engaged wherever possible](#) to increase community acceptance and uptake of services.

Program management

- **Monitoring and evaluation:** Program data could be used more effectively to facilitate ongoing learning and improvement, for example, by [establishing a manageable set of focused indicators](#) with clearly defined targets early in the program; [conducting baseline assessments before interventions whenever possible](#); and [training program and partner staff on the routine analysis of program data](#) to investigate trends and adapt programs accordingly.
- **Coordination:** [Regularly scheduled field-level coordination meetings with IMC staff, partner staff, and government representatives in program districts](#) (rather than ad hoc meetings in response to specific issues) would be valuable in improving the coordination of trainings, minimizing the risk of miscommunication, managing expectations regarding program timeframe, and planning the exit strategy and hand-over of services to the government from the outset, to minimize the impact on beneficiaries and maximize the potential for sustainability.
- **Time-frame and sustainability:** A [longer program time-frame](#) would have allowed for a more comprehensive hand-over to government authorities and greater capacity-building with government staff to develop their self-sufficiency in providing high-quality care, including managing mental health information systems and medication supply-chains.

SECTION 1
BACKGROUND



1. Background

1.1 Program context

In April and May 2015, Nepal was struck by two major earthquakes, which killed 8,790 people and left more than 22,000 injured.¹ Half a million homes were completely destroyed and more than 1,000 health facilities were destroyed or damaged,² leaving thousands of people homeless, devastated and without access to care. International Medical Corps (IMC) was among the first humanitarian agencies to provide emergency response services following the earthquake, initiating activities on April 26th 2015, the day after the first earthquake occurred. A range of programs was established in response to the urgent medical needs of the affected population. Following the initial emergency response, longer-term programs were established in the areas of: Water, Sanitation and Hygiene; Nutrition; Sexual and Reproductive Health; Gender-Based Violence; Disaster Risk Reduction; and Mental Health and Psychosocial Support (MHPSS). The purpose of this report is to present an evidence-based assessment of the achievements and challenges of the MHPSS program, focusing on effectiveness, relevance, impact and sustainability.

1.2 Mental health in humanitarian emergencies

Mental illnesses are among the most prevalent and burdensome of health conditions worldwide, accounting for up to 32% of Years Lived with Disability.^{3,4} However, mental health services receive a disproportionately low portion of public spending.^{5,6} The World Health Organization (WHO) estimates that 80% of those affected in low- and middle-income countries do not have access to mental health care, despite the availability of a range of cost-effective pharmacological and psychological treatments.⁷ The problem is exacerbated in emergency situations, where large portions of a population are subjected to extreme stress.

In the aftermath of an earthquake, large numbers of people must cope with the sudden deaths of loved ones, missing family members, homelessness, joblessness, loss of property and disruption to their normal support structures. In addition to transient reactions such as distress and grief, humanitarian disasters can trigger the onset and relapse of common mental disorders such as depression, post-traumatic stress disorder (PTSD), and substance abuse.^{8,9} Those with pre-existing mental health conditions are rendered more vulnerable, with interruptions to their usual care and an increased risk of neglect, abuse and abandonment.⁸ In addition to the human suffering endured, mental health problems can have serious economic and social consequences, undermining the potential for affected individuals to return to their daily functioning and work, and increasing the risk of physical health problems.

While prevalence rates vary with the diagnostic criteria used, method of assessment, and context, the WHO estimates that rates of mild or moderate mental disorder increase from a baseline of 10% in the general population to 15-20% following emergencies.¹⁰ A study

conducted four months after the second Nepal earthquake found that 34.2% of people in earthquake-affected districts met validated criteria for depression, 20.4% reported hazardous alcohol use and 10.9% reported suicidal ideation.¹¹ ‘Psychological distress’ was reported to be a common problem by 42% of those surveyed.

Several causal risk factors for mental health problems are prevalent in Nepal, such as poverty, and gender and caste inequality.¹² Previous exposure to violence is also known to increase the risk of mental illness following natural disasters,¹³ a finding relevant to the context of Nepal, a country still recovering from a decade-long civil war in which more than 16,000 people were killed and many more endured torture, abduction and human trafficking.¹⁴

The Government of Nepal has identified the need to address the psychosocial and mental health needs of the earthquake-affected population as one of 18 key priorities in its post-disaster Recovery Framework.¹⁵ⁱ In collaboration with two local partner organizations, *Transcultural Psychosocial Organization Nepal* (TPO) and *Integrated Community Development Campaign* (ICDC), International Medical Corps established a program of evidence-based activities to respond to the immediate needs of earthquake survivors and to strengthen Nepal’s health system by integrating MHPSS into primary health services.

1.3 Principles of MHPSS emergency response and systems strengthening

1.3.1 Responding to MHPSS needs in emergency contexts

The Inter-Agency Standing Committee (IASC)¹⁶ and The Sphere Project¹⁷ have produced guidance on the provision of MHPSS support during emergencies, based on research evidence and expert consensus. Both sets of guidance emphasize the importance of strengthening community-based support and self-help in humanitarian contexts, recommending that volunteers and primary health care staff be trained in providing Psychological First Aid (PFA)¹⁸ to people experiencing acute distress.ⁱⁱ

The guidance also recommends developing a coordinated network of support services offering different levels of specialization to meet different levels of need. The IASC depict this layered model of support in the form of a pyramid of interventions (Figure 1), with basic services and community supports towards the base of the pyramid and more focused, specialized services towards the top.

ⁱ The other priorities relate to infrastructure, shelter, restoration, reconstruction, settlement and livelihood support, skills development, healthcare, education, gender equity, environmental protection, tourism, sanitation, social cohesion, and assisting those with special needs.

ⁱⁱ PFA is an approach to providing humane, compassionate and practical help to people who have recently been exposed to a traumatic event. Because PFA it is designed to be delivered by trained community (as opposed to specialist mental health professionals), it is feasible even in emergency contexts where specialists are scarce.

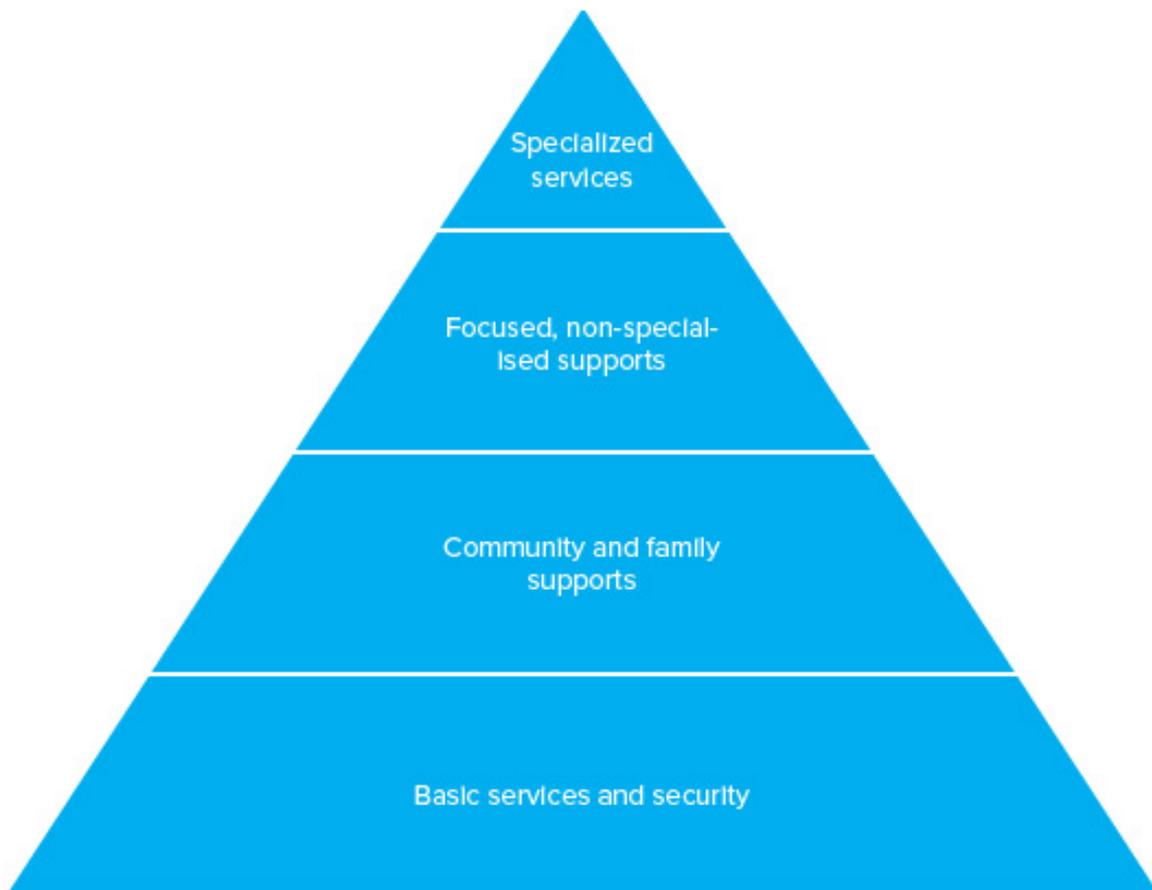


Figure 1 IASC Intervention Pyramid for MHPSS in emergencies (reproduced from IASC, 2007)

Core principles of the IASC approach are that humanitarian actors should promote human rights, maximize local participation, build local capacity, and integrate activities into existing community supports and systems. Developing emergency response activities in accordance with these principles provides a strong foundation for the development and strengthening of sustainable longer-term mental health services.¹⁹

1.3.2 Building back better: transitioning from emergency relief to systems strengthening

Emergency response programs can also serve as catalysts for longer-term mental health service improvement. In the aftermath of disasters, an influx of funding, combined with focused public attention on the suffering of the affected population, can create opportunities for humanitarian actors to collaborate with local governments to create or reform mental health services and to formalize mental health strategy.^{19,20}

International guidance recommends that long-term programming be planned alongside emergency response because:

- Unlike many of the biomedical interventions for health problems that arise in

emergency settings, the intervention and recovery period for mental health disorders is usually six months to two years

- Many of the sociocultural changes required to increase service use, for example, transforming attitudes to mental illness, reducing stigma, challenging associated myths, cannot be achieved in short periods of time
- Trained local staff require ongoing supervision to ensure service quality.²¹

The WHO *Building Back Better* report identifies ten key practices for successful mental health reform following emergencies (Box 1).

1. Mental health reform is supported through planning for long-term sustainability from the outset
2. The broad mental health needs of the emergency-affected population are addressed
3. The government's central role is respected
4. National professionals play a key role
5. Coordination across agencies is crucial
6. Mental health reform involves review and revision of national policies and plans
7. The mental health system is considered and strengthened as a whole
8. Health workers are reorganized and trained
9. Demonstration projects offer proof of concept and attract further support and funds for mental health reform
10. Advocacy helps to maintain momentum for change

Box 1 Key practices for building and strengthening sustainable mental health systems during and following emergencies (WHO, 2013)

Other consensus-based recommendations emphasize the importance of building on existing national policy, designing individual programs with respect to an overall strategy, combining service delivery with research, and planning longer-term financing (Box 2).

Theme I: Government and Policy

1. Determine what relevant strategies, frameworks, or policies already exist
2. Consider the extent to which the government should be involved
3. Consider how government involvement can be sustained long-term

Theme II: Human resources and training

1. Leverage existing human resources and management structures
2. Facilitate long-term mentoring and apprenticeship
3. Develop leadership and ensure professional support
4. Develop accredited certificate and diploma courses where possible
5. Train both services providers and managers, and develop sustainable supervision structures

Theme III: Programming and services

1. Design individual programs with respect to a comprehensive and holistic overall strategy
2. Allow for different entry points into a holistic service package with multiple layers of intervention
3. Consult with varied community stakeholders
4. Plan for long-term sustainability from the outset and incorporate a phase-out plan into program design
5. Identify and provide for neglected and vulnerable groups

Theme IV: Research, Monitoring and Evaluation

1. Combine service delivery and research
2. Factor the funding of continuous monitoring and evaluation (M&E) into program costs from the outset
3. Aim to measure the restoration of functioning at individual and/or community levels
4. Track information on access, acceptability, sustainability and impact

Theme V: Finance

1. “Emergency funding” should be for a minimum of 1-2 years
2. Be aware of the potential for large amounts of short-term funding to undermine local structures
3. Innovate mechanisms for reserving or investing money for long-term use

Box 2 Recommendations on transitioning from relief to development (adapted from Patel et al 2012)

1.3.3 Designing effective and sustainable mental health systems

In common with the IASC and Sphere guidance for emergency settings, the WHO emphasizes the importance of building mental health services that are accessible at the community level, stressing that no single service setting can meet all the mental health and psychosocial needs of the population (Box 3).

The WHO recommends that the design of mental health systems should:

- promote self-care
- build informal community care services
- integrate mental health services into primary health care
- build community mental health services
- develop mental health services in general hospitals
- limit psychiatric hospitals.

Box 3 WHO recommendations for the design of effective mental health services (reproduced from WHO, 2009)

The *WHO Service Organization Pyramid for an Optimal Mix of Services*^{22,23} (Figure 2) provides a model for developing a stratified system of comprehensive services.

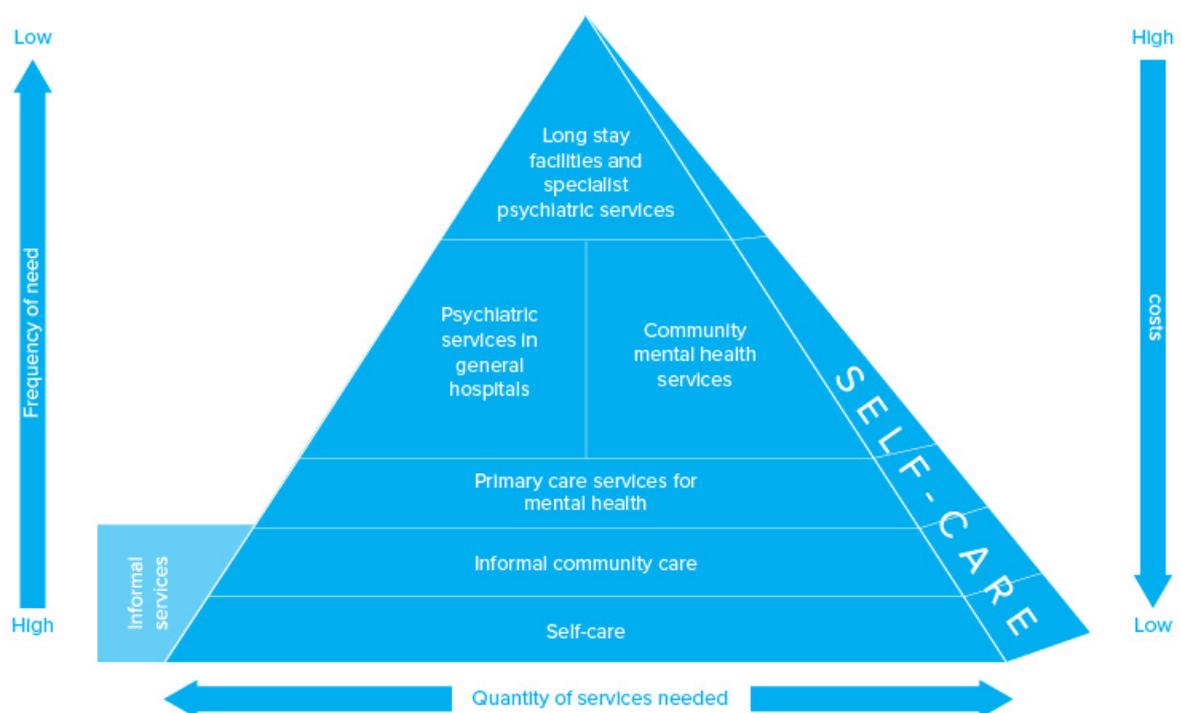


Figure 2 The WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (reproduced from WHO, 2013)

The model is broadly consistent with the IASC Intervention Pyramid in that it emphasizes the importance of self-care, informal community care, and the integration of mental health care into existing primary health services.

Arguments for integrating mental health care into existing community health services include improving access, reducing stigma, facilitating early intervention, reducing the need for specialists, and promoting holistic care that improves both physical and mental health outcomes.²³⁻²⁵ The move toward community-based care is supported by growing evidence for the efficacy of task-shifting models and the feasibility of delivering pharmacological and psychosocial mental health interventions in general health settings.^{7,26,27}

1.3.4 The WHO Mental Health Gap Action Program (mhGAP)

The WHO mhGAP program provides a framework for scaling-up mental health services in non-specialized health care settings.⁷ The program has produced a widely-used manual for the identification and evidence-based treatment of priority mental health disorders in non-specialized settings, known as the mhGAP Intervention Guide.^{7,28} The guide covers the following disorders, selected based on their high morbidity and mortality burden, economic costs or association with human rights violations: Depression; Psychoses; Epilepsy; Child and Adolescent Mental and Behavioral Disorders; Dementia; Disorders due to Substance Use; and Self-harm and Suicide. An adapted version, the mhGAP Humanitarian Intervention Guide, has been developed for use in humanitarian emergencies and provides guidance on additional mental health problems such as Grief, Acute Stress, and PTSD.²⁸

1.4 Mental health services in Nepal

In common with other low-income countries, the formal mental health system in Nepal has been hampered by low budget-allocation, limited human resources, and a lack of comprehensive mental health policy and legislation.

1.4.1 Policy and budget

A national mental health policy was developed in 1996 which committed to providing nationwide access to mental health services by the year 2000 “by integrating mental health services into the general health service system” (p.2).²⁹ The policy proposed the establishment of a dedicated Mental Health Division within the Ministry of Health to oversee this task. However, the portion of health budget allocated to mental health remained minimal at less than 1% of the health budget,³⁰ the Division of Mental Health was not established, and the policy remains largely unimplemented.³¹

1.4.2 Facilities and human resources

For a population of 27.8 million, Nepal has one dedicated psychiatric hospital with a capacity of 50 beds, which is based in Kathmandu.³² Four additional government hospitals (based in the Banke, Chitwan, Kaski, and Morang districts) offer psychiatric services, bringing the total number of public mental health in-patient beds to 112.³¹ There are no dedicated pediatric or

forensic units.^{32,33} There is a severe shortage of trained mental health professionals, with only 60 psychiatrists (0.22 per 100,000 population), 25 psychiatric nurses (0.09 per 100,000 population), and 16 clinical psychologists (0.06 per 100,000 population) serving the entire country. As the majority of these professionals are based in urban centers, the ratio is even less favorable in the rural areas in which 85% of Nepal's population live.³² General primary health workers receive minimal training in mental health, leaving them without the skills to provide community-based care.^{32,33} Those seeking support for mental health problems commonly approach traditional healers rather than the formal medical system.^{32,34}

1.4.3 Psychotropic medication

Psychotropic medications are procured centrally and are not routinely available at the district level.³⁵ Medications are provided free-of-charge to inpatients, but are otherwise considered unaffordable for much of the population, particularly for those living far from Kathmandu who would need to travel long distances to purchase them.³² Atypical antipsychotics and Selective Serotonin Reuptake Inhibitors (SSRIs) are not available through the government system. The lack of a robust information system and infrastructure to support mental health services has been identified as key challenges in establishing an adequate drug supply.³²

1.4.4 The role of NGOs

Prior to the earthquakes, approximately 20 local and international Non-Governmental Organizations (NGOs) offered community-based MHPSS services in Nepal,³⁶ representing 52% of MHPSS service providers in the country as of 2010 (the remaining being private and government agencies).³⁷ Most of these services were established to meet the needs of specific target groups such as refugees, former child soldiers, victims of human trafficking, and survivors of gender-based violence.³¹

In recent years, some NGOs have started to provide MHPSS training to community members, with the aim of developing a cadre of community-based para-professionals to meet the treatment gap.³⁶ These training courses range from one-day MHPSS 'orientations' for community leaders to six-month counselling training programs. For example, in 2015 TPO provided mhGAP training to 64 government health workers in Chitwan and Phyuthan districts as part of the *PRogramme for Improving Mental Health carE (PRIME)*³⁸ and *Mental Health Beyond Facilities*³⁹ initiatives, which aim to improve access to MHPSS services in low- and middle-income countries.⁴⁰ The current program built on the model of care developed for these programs and expanded it to three new districts.

1.5 Program Overview

- The program was implemented in Dhading, Gorkha, and Sindhuli districts, in

collaboration with the Government of Nepal and two local NGOs: TPO (<http://tponepal.org/>) and ICDC (<http://icdc.org.np/>).ⁱⁱⁱ

- Gorkha, Sindhuli and Dhading were selected as IMC program locations at the request of the government, on the basis of need and to avoid duplication of services with others INGOs working on MHPSS (Figure 3).



Figure 3 Map of Nepal showing the districts most severely affected by the earthquakes

1.5.1 Aim and objectives

The program had two phases:

- an initial emergency response phase, which involved conducting a **situation analysis** and providing **PFA training** to health workers and community leaders in the immediate aftermath of the earthquakes; and
- a longer-term recovery phase focused on the **integration of mental health care** into existing primary health services.

This report focuses mainly on the recovery phase of the program, during which the bulk of program activities were conducted. The aim and objectives of this phase are presented in Box 4.

ⁱⁱⁱ The Social Welfare Council, a government body responsible for coordinating and monitoring NGO activities in Nepal, requires that International NGOs collaborate with local NGOs to implement program activities through sub-awards, rather than directly engaging with beneficiaries.

The overarching aim of the recovery phase was to promote the “integration of mental health and psychosocial support services into primary health care facilities in post-earthquake Nepal.” This was operationalized as three specific objectives:

- Objective 1:** To strengthen the capacity of health workers and community members to provide high-quality MHPSS services
- Objective 2:** To provide community-based mental health and psychosocial support services
- Objective 3:** To improve access to MHPSS services through awareness-raising initiatives and anti-stigma campaigns

Box 4 Aim and objectives of the MHPSS Integration program

1.5.2 Program design

The program was designed collaboratively by IMC and TPO, drawing on IMC’s experience in multiple emergency settings and TPO’s experience implementing mental health programs in Nepal. The program focused on **six priority mental health conditions: depression, psychoses, epilepsy, suicide, Alcohol Use Disorders (AUD), and PTSD**. These conditions were prioritized based on consultation with local experts regarding local prevalence, disease burden and the feasibility of culturally acceptable treatments. Figure 4 illustrates the program activities implemented in accordance with the three program objectives.



Figure 4 Program activities corresponding to each of the three program objectives

1.5.3 Capacity building and service provision

MHPSS training and supervision for health workers

Government Primary Health Care (PHC) staff

- The program aimed to train a minimum of two *prescribers* and two *non-prescribers* from each participating facility.
 - *Prescribers* - Medical Officers (doctors), Health Assistants, and Auxiliary Health Workers.
 - *Non-Prescribers* - Staff Nurses and Auxiliary Nurse Midwives.

Government-affiliated Female Community Health Volunteers (FCHVs)

- Local women engaged by the government to promote health education, provide referrals, and distribute health products (e.g. contraceptives, oral rehydration treatments).
- The program aimed to train all FCHVs working within the catchment areas participating facilities.

Psychosocial counselors (PSCs)

- Individuals hired as counselors by the partner NGOs having graduated from a standardized six-month counseling training course endorsed by the National Council for Technical Education and Vocational Training (CTEVT).^{iv}

Home-Based Care Workers (HBCWs)^v

- Community members hired by the partner NGOs to provide an intermediate level of care between community supports and health facilities. A CTEVT-endorsed six-month training program was provided to a subset of these HBCWS to upgrade and certify them as PSCs.

Figure 5 illustrates the staff trained, showing whether they were government-affiliated or partner staff, and whether they were roving community-workers or based in facilities.

- **Government-affiliated staff** were trained with the aim of enabling them to incorporate MHPSS into their regular healthcare duties so that they could continue to provide MHPSS care beyond the duration of the program.
- **Partner staff (PSCs and HBCWs)** were hired only for the duration of the program, to support the initial development of the referral network between community and health facility levels.

^{iv} The CTEVT is a national body responsible for ensuring the quality and relevance of vocational training programs in Nepal.

^v Also known as Community Psychosocial Workers (CPSWs).

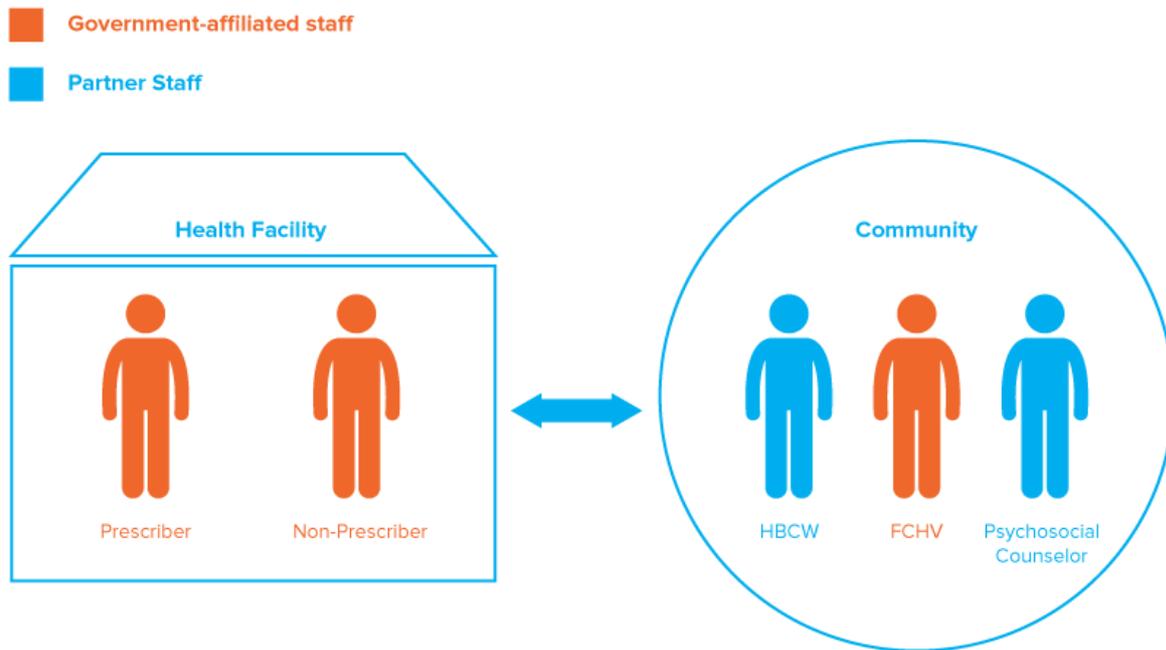


Figure 5 Illustration of the different types of health workers trained as part of the program

Training for community leaders

- **Psychological First Aid** training was provided to community leaders such as health workers, teachers, women’s group members, FCHVs, and youth leaders in Gorkha, Dhading and Kathmandu in the weeks following the earthquakes.
- **MHPSS Orientation Sessions** were held for community leaders such as teachers, youth leaders, political leaders, traditional healers and members of women’s groups, and Village Child Protection Committees.

Table 1 provides details of each of the training packages.

Table 1 Training packages

Trainee group	Aim	Curriculum summary	Duration of initial training (days)	Supervision arrangements	Refresher training
WHO mhGAP Training Package for Prescribers*	Equip trainees to identify mental health and psychosocial disorders and provide appropriate treatment.	mhGAP training focused on clinical management (including pharmacological management) of depression, psychosis, epilepsy, Alcohol Use Disorders (AUD), Suicide, PTSD.	9	Group supervision by partner NGO psychiatrist (monthly in Dhading, bimonthly in Gorkha & Sindhuli)	3 days, 5-6 months after initial training
WHO mhGAP Training Package for Non-Prescribers	Equip trainees to identify mental health and psychosocial problems and provide psychosocial support.	mhGAP training focused on non-pharmacological management of depression, psychosis, epilepsy, Alcohol Use Disorders, Suicide, PTSD.	5	Monthly group supervision by partner NGO Clinical Psychologists, Senior Counsellors, or Health Assistants	3 days, 5-6 months after initial training
Advanced Training for Psychosocial Counselors (PSCs)	Enhance the skills of practicing PSCs in mental health service provision	The curriculum was designed by TPO and endorsed by the National Health Training Center. Topics included counselling for alcohol problems, family counselling, healthy activities, problem solving, self-help group formation, and providing support to HBCWs.	6 in Dhading, 12 in Gorkha & Sindhuli**	Monthly group supervision by clinical psychologists or senior counsellors	5 days in Dhading, 12 days in Gorkha & Sindhuli, 6 months after initial training
Basic Psychosocial Support Training Package for Home-Based Care Workers	Develop community members' skills in basic psychosocial care and appropriate referral.	The curriculum was designed by TPO. Topics included: an introduction to mental health; communication skills; psycho-education; challenging stigma and discrimination; home-based care; and recognition and referral of depression, suicide, AUD, epilepsy, PTSD, psychosis.	5 in Dhading, 20 in Gorkha & Sindhuli	Monthly group supervision by psychologist/ counsellor	5 days, 5-6 months after initial training in Dhading only
Training to upgrade CPSWs and HBCWs to Psychosocial Counselors	Train HBCWs as government-certified PSCs.	The curriculum was developed by TPO and endorsed by the CTEVT. Topics included anxiety, psychosis, bipolar disorder, developmental delay,	45 days of classroom-based training and 78 days of supervised field placements	Monthly group and individual supervision sessions for three months	NA

suicide, depression, harmful drinking, psychosomatic complaints, trauma, resilience and coping strategies, communication skills, counselling, case management, stress management, stigma and discrimination, clinic management and documentation.

FCHV Training Package	Equip FCHVs with the skills to identify psychosocial problems and mental disorders, and to refer appropriately.	The curriculum was designed by TPO and endorsed by the National Health Training Center. The training focused on the use of the Community Informant Detection Tool (CIDT), a step-by-step guide to identifying priority mental health conditions, and referring to health facilities as appropriate.	2	Monthly supervision by PSCs	1 day, 5-6 months after initial training
Mental Health Orientation for Community Leaders	Increase community leaders' knowledge about available MHPSS services and equip them to recognize MHPSS needs and refer as appropriate.	The curriculum was designed by TPO. Topics included basic introduction to MHPSS, recognizing mental health symptoms, introduction to counselling, and referral mechanisms.	1	NA	NA
Psychological First Aid Training	Equip community leaders to provide emotional and practical help to people who have recently been exposed to a traumatic event.	The curriculum was based on the Psychological First Aid Guide for Field Workers developed by the WHO, the War Trauma Foundation and World Vision. Topics included helping responsibly, principles of PFA, and self-care. [†]	1	NA	NA

* Training material on PTSD was sourced from the mhGAP Humanitarian Intervention Guide. Material on all other disorders was sourced from the standard mhGAP Intervention guide.

** The duration of some training courses varied in the different districts due to differences in the budgets of each of the implementing partners.

† A 3-day PFA 'Training of Trainers' course was also conducted with participants from a range of governmental bodies and NGOs from 10 different districts.

Provision of psychotropic medication

IMC procured medication in three batches over the course of the program (November 2015, February 2016, and August 2016). The quantity procured in the first batch was calculated based on a similar program implemented by TPO in a neighboring district, adjusting for the number and size of participating health facilities. Subsequent procurement quantities were based on monthly stock reports collected from participating facilities by HBCWs. The medication was delivered to local health authorities (DHOs or DPHOs) in each of the three districts for distribution among the participating health facilities.

1.5.4 Community outreach and awareness activities

A range of community outreach activities were undertaken to raise awareness about MHPSS, to decrease stigma, and to encourage the participation of people with mental health problems in community life (Box 5).

Mental health awareness events

Partner staff (PSCs and HBCWs) conducted awareness-raising events with school students, teachers, health workers and community groups to raise awareness about mental health. These focused on:

- improving knowledge and challenging misconceptions about mental health and illness
- educating people about effective medical and psychotherapeutic treatment options
- decreasing the use of stigmatizing words
- encouraging reflection on community roles in promoting mental health.

Technical staff from IMC and TPO also attended national advocacy and strategy events to support the development of mental health policy.

Radio Programs

Partner staff and IMC program staff collaborated to develop radio programs on the following topics:

- introducing the mental health program
- symptoms and treatment of depression, epilepsy, PTSD, psychosis, suicide, AUD
- the role of family and community in supporting people with mental health problems
- World Mental Health day
- interviews with stakeholders (e.g. government officials, mental health experts, and health workers).

Educational Materials

Partner staff and IMC program staff collaborated to develop educational materials such as billboards and brochures explaining the symptoms of common mental health problems and advertising support services. Billboards were placed outside health facilities and in other prominent locations in the three program districts. Brochures were distributed by partner staff during training events and community outreach programs.

Support groups

TPO program staff established support groups in Gorkha and Sindhuli to engage service users in income-generating activities and to support family members in caring for people with mental illness. A three-day business planning training workshop was conducted focusing on basic business management skills, analyzing the local economy, managing business risks, and managing savings. Each group was provided with a 'seed fund' of approximately \$400 (US Dollars) with which to buy materials to start a business cooperative.

Box 5 Community outreach and awareness events

1.6 Participating facilities

The program was implemented through 78 health facilities in the three program districts. Participating facilities were selected by the local district health authority^{vi} and represented 47% of all facilities in the districts (Table 2).

Table 2 Distribution of participating health facilities in the three program districts

Facility type	Dhading	Gorkha	Sindhuli	Total
Participating District Hospitals	1	1	1	3
Participating PHCCs	2	3	4	9
Participating Health Posts	25	20	21	66
Total no. participating facilities	28	24	26	78
Total no. facilities in district	49	65	52	166
% of facilities participating	57	37	50	47

^{vi} The District Health Officer (DHO) in Dhading, and the District Public Health Officer (DPHO) in Gorkha and Sindhuli.

SECTION 2

EVALUATION FRAMEWORK AND METHODS



2. Evaluation framework and methods

The purpose of the evaluation was to conduct an evidence-based assessment of program strengths and weaknesses, to identify lessons learned, and to generate recommendations for the design and management of future MHPSS programs.

The evaluation was guided by four quality criteria for evaluating developmental assistance established by the Organization for Economic Co-operation and Development (OECD):⁴¹

1. **Effectiveness:** the extent to which program objectives have been achieved.
2. **Relevance:** the extent to which the activities implemented within a program address the needs and priorities of the intended beneficiaries, recipients and donor.
3. **Impact:** the positive and negative changes produced by a program, directly or indirectly, intended or unintended.
4. **Sustainability:** the extent to which the benefits of a program are likely to continue after the funding has been withdrawn.

A mixed-methods approach was adopted, integrating qualitative and quantitative methods to gain a comprehensive understanding of program achievements and challenges (Figure 6).



Figure 6 Evaluation methods

Most of the quantitative data discussed in this report was collected by partner NGO staff on an ongoing basis for monitoring and evaluation purposes (e.g. data on the number of program activities and participants). Qualitative data and end-line health facility integration data were collected specifically for the evaluation over a 10-day period in February 2017.

2.1 Data collection team

The evaluation data collection team consisted of:

- 1 IMC Program Manager
- 2 IMC consultants (MHPSS Consultant, M&E Consultant)
- 4 partner NGO staff members.

The partner staff members were seconded to the evaluation team for two weeks to support data collection. These individuals were employed as psychosocial counsellors and clinical supervisors, and were familiar with the program, minimizing the time required for orientation. To reduce the risk of social desirability effects, data-collectors did not disclose their clinical backgrounds to participants and they did not collect any qualitative data in the districts in which they worked (i.e. TPO staff collected data in ICDC's districts and vice versa). Interviews were arranged so that the facilitators were not known to the participants wherever possible.^{vii}

The M&E Consultant conducted a training workshop in January 2017 to prepare the data collection team. Topics covered included: the purpose of the evaluation; quality criteria in evaluation; understanding different types of data (e.g. qualitative, quantitative, output, outcome); evaluation methods; confidentiality and ethical practice; establishing rapport; qualitative data transcription; and administering the PHC Integration Checklist. The training also included interview and focus group exercises, which gave participants practical experience of facilitation, and an opportunity to discuss challenges and effective facilitation techniques. This also served as a pilot for the topic guides, and some minor revisions were made to reduce the number of questions.

2.2 Quantitative methods

2.2.1 Data sources

Routine program data

Routine program data on program outputs was collected on an ongoing basis. This included:

- number of training participants and associated demographic details
- number of mental health service users, and associated demographic and service-use details

^{vii} The only exception to this was an interview with one Partner District Coordinator, which was conducted by the IMC Program Manager due to time constraints.

- number of outreach activities and participants.

Quantitative evaluation data

Quantitative data on program outcomes was collected using a range of tools designed to assess:

- trainee competency
- service user satisfaction and functioning
- degree of mental health integration at health facilities.

Outcome data collection tools are summarized in Table 3. Further details on the target group and times of administration for each tool are provided in Appendix 1 (p.92).

Table 3 Summary of quantitative outcome measures

Outcome	Outcome tool	Developer	Respondents	Baseline N	Endline N
Improved trainee knowledge and skills	• Pre- and post-training knowledge tests	TPO	Prescribers Non-prescribers PSCs HBCWs	435	435
	• IMC Perceived Competency Checklist: General Subscale	IMC	Prescribers Non-prescribers PSCs	435	435
	• IMC Perceived Competency Checklist: Clinical Subscale	IMC	Prescribers	221	221
	• Mini-Assessed Clinical Encounter (ACE) Checklist	IMC*	Prescribers Non-prescribers PSCs	369	369
	• ENhancing Assessment of Common Therapeutic factors (ENACT-18)	Kohrt et al. 2015**	Prescribers Non-prescribers PSCs HBCWs	435	435
Service user functioning & satisfaction	• WHO Disability Assessment Schedule II	WHO†	Service users§	476	476
	• Service-User Satisfaction	TPO	Service users§	NA	428
Facility-level MHPSS integration	• IMC Primary Health Care Integration Checklist	IMC‡	Key informants at health facilities (see table below)	76	17¶

* Adapted from The Royal College of Psychiatrists ([www.rcpsych.ac.uk/docs/ST1 mini-ACE rating form.doc](http://www.rcpsych.ac.uk/docs/ST1_mini-ACE_rating_form.doc)); also known as the mini-Clinical Evaluation Exercise (mini-CEX).

**Kohrt et al. Therapist competence in Global Mental Health: Development of the ENhancing Assessment of Common Therapeutic factors rating scale. Behaviour Research and Therapy, 2015; 69, 11-21.

† The most recent version of this tool is available here: http://www.who.int/classifications/icf/more_whodas/en/

‡ Adapted from WHO/UNHCR. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: World Health Organization; 2012.

§ Only administered to service users under the care of prescribers.

¶ Includes participants who did not participate in the initial training course but joined supervision sessions/refresher trainings.

¶¶ 20% of facilities were purposively sampled with the aim of representing a mix of urban and rural locations, and recruiting at least one Health Post, one PHCC and one District Hospital per district.

Table 4 shows the number of PHC integration checklists completed at baseline and end-line.

Table 4 Number of PHC Integration Checklists disaggregated by facility type and district

Facility Type	Dhading (N=28)*		Gorkha (N=24)		Sindhuli (N=26)		Total (N= 78)	
	Baseline	End-line	Baseline	End-line	Baseline	End-line	Baseline	End-line
District Hospitals	1	1	1	1	1	1	3	3
PHCCs	2	1	3	1	5	1	10	3
Health Posts	23	4	20	4	20	3	63	11
Total	26	6	24	6	26	5	76	17

* N denotes the total number of participating facilities; all facilities were sampled at baseline except for two Dhading Health Posts which joined the program after some months.

2.2.2 Procedures

Trainee data

- Training data was recorded on **attendance** sheets at training events and supervisions, and entered into a database by partner M&E staff.
- Quantitative data from **trainee assessment tools** was recorded on printed versions of the tools (Table 3) and subsequently entered into a database by partner staff.
- Databases were checked against the paper versions of the raw data by IMC program staff and M&E staff occasionally throughout the program for **quality assurance**.

Service user data

- FCHVs completed a **Community Informant Detection Tool (CIDT) form** for each service user detected in the community.
- The government health workers (prescribers and non-prescribers) at each participating facility registered all service users in dedicated Mental Health **Outpatient Department (OPD) registers**.
- HBCWs and PSCs recorded all new service users in **Case Management Files**.
- Partner M&E staff collated demographic and service use information on all service users from the CIDT forms, OPD registers and Case Management Files on a monthly basis. They entered this data into an Excel database. Databases from all districts were **compiled into a master database** by IMC Program staff each month.
- Prior to analysis, the IMC program team and M&E Consultant collated, cleaned the data.

Facility-level integration data

- Baseline PHC Integration Checklist data was collected from each facility by IMC program staff and TPO M&E staff prior to program implementation. Data collectors were trained on the use of the tool by an M&E Advisor from IMC headquarters and an IMC Consultant Psychiatrist.

2.3 Qualitative methods

2.3.1 Data sources

Qualitative data was collected through focus groups, in-depth semi-structured key informant interviews, and a 'Lessons Learned' exercise conducted with the two implementing partner organizations.

Interview and focus group topic guides were developed with the aim of eliciting stakeholder views on the effectiveness, relevance, impact and sustainability of the program. The topic guides were developed collaboratively by an M&E consultant, an IMC MHPSS Technical Advisor, and the IMC Program Manager.

Table 5 provides an overview of the qualitative evaluation data. Sample topic guides are provided in Appendix 2 and Appendix 3.

Table 5 Summary of qualitative methods

Method	Participants	Topics covered
Focus groups (N=91; 13 focus groups)	<ul style="list-style-type: none"> • FCHVs • Prescribers & non-prescribers 	<p>Training & supervision: aspects that worked/did not work well, suggestions for improvement, topic relevance, putting training into practice</p> <p>Service provision: changes in care for people with mental health/psychosocial problems, impact on service users, coordination between different service sectors</p> <p>Community outreach: impact on attitudes to metal health, suggestions for improvement</p> <p>Relevance, impact and sustainability: care quality, meeting community needs, positive and negative impact, likelihood of continued benefits</p>
	<ul style="list-style-type: none"> • Service users & carers 	<p>Service provision: positive and negative experiences of services, suggestions for improvement</p> <p>Impact: impact of program on life, impact of program on relationships, any negative impacts</p> <p>Access: access challenges, groups who do not have access</p> <p>Relevance & quality: positive and negative experiences of care, frequency of contact</p> <p>Attitudes to mental health: program impact on community and health worker attitudes, suggestions for improving attitudes</p>
Interviews (N=20)	<ul style="list-style-type: none"> • PSCs • HBCWs 	<p>Training & supervision: aspects that worked/did not work well, suggestions for improvement, topic relevance, putting training into practice</p> <p>Service provision: changes in care provision for people with mental health/psychosocial problems, impact on service users, coordination between different service sectors</p> <p>Community outreach: impact on attitudes to mental health, suggestions for improvement</p> <p>Relevance, impact and sustainability: quality of care, meeting community needs, positive and negative impact, likelihood of continued benefits</p>
	<ul style="list-style-type: none"> • IMC Managers 	<p>General: aspects of the program that worked/did not work well</p> <p>Program objectives: extent achieved, suggestions for improvement</p> <p>Relevance, quality & impact: program flexibility, changes as a result of feedback, coordination between IMC and partners, impact on communities, impact on policy, unexpected and negative consequences, suggestions for improving impact</p> <p>Sustainability: likelihood of continued benefits, strategies for sustainability</p> <p>Coordination: coordination between different parts of IMC Country Office, coordination between IMC Country Office and</p>

		IMC Headquarters, suggestions for improvement
	<ul style="list-style-type: none"> • Partner managers • Government representatives 	<p>General: aspects of the program that worked/did not work well</p> <p>Training & supervision: aspects that worked/did not work well, suggestions for improvement</p> <p>Service provision: aspects that worked/did not work well, suggestions for improvement, service coordination</p> <p>Community outreach: impact on health worker and community attitudes to mental health; aspects that worked/did not work well</p> <p>Relevance & quality: quality of care, meeting community needs, program changes in response to feedback, coordination between IMC and partners</p> <p>Impact & sustainability: changes as a result of program, unexpected and negative consequences, suggestions for improved impact, likelihood of continued benefits, strategies for sustainability</p>
Lessons Learned Exercise	<ul style="list-style-type: none"> • ICDC • TPO 	Partner organizations were asked to provide a report on challenges and lessons learned over the course of the program.

2.3.2 Procedures

Participants were purposively selected with the aim of representing each participant type and each facility type (Health Post, PHCC, and District Hospital) in each district.

Focus groups and interviews began with the facilitator explaining the purpose of the evaluation, how the data would be used, and measures that would be taken to preserve anonymity.^{viii} Verbal consent was obtained. Discussions were recorded, translated into English, transcribed, and thematically analyzed using MAXQDA software.^{ix} The resulting thematic framework is provided in Appendix 4.

Table 6 and Table 7 present the number of interview and focus group participants disaggregated by role and district.

Table 6 Number of interview participants disaggregated by role and district

Participant role	Dhading	Gorkha	Sindhuli	Central	Total
Government Staff*	0	0	2	0	2
HBCW	2	2	2	0	6
IMC Program Manager	0	0	0	3	3
Partner Manager	1	1	1	1	4
Psychosocial Counselor	1	2	2	0	5
Total	4	5	7	4	20 [†]

*District Health Officer/Mental Health Focal Person

[†] 12 females, 8 males

Table 7 Number of focus group participants disaggregated by role and district

Participant role	Dhading		Gorkha		Sindhuli		Total
	Male	Female	Male	Female	Male	Female	
Service Users/ Carers	8	10	0	6	3	5	32
FCHVs	0	9	0	8	NA	8	25
Prescribers & Non-prescribers	10	5	4	4	7	4	34
Total	18	24	4	18	10	17	91

^{viii} Throughout this report, most participants are identified by their role and district rather than by name. Managers are identified by their role only, because including their districts would compromise their anonymity. Within sections, quotes are numbered to distinguish different individuals who have the same role.

^{ix} MAXQDA Version 12, VERBI Software, Berlin, Germany.

2.4 Methodological constraints and limitations

2.4.1 Purposive sampling

- Data collection was shaped by a number of pragmatic considerations such as limited time available for data collection and limited access to some facilities (e.g. some participating facilities can only be accessed by making a two-day journey on foot).
- Sampling of interviewees and facilities was therefore purposive rather than random, based on location and availability of key staff at the time of the data collection visits.

2.4.2 Limited baseline data

- Baseline data was not always collected before programs were initiated for a number of reasons (e.g. travel restrictions due to a fuel crisis, programs implemented before data collection tools finalized). Baseline client functioning data was collected three months after initial medication prescription. Differences between baseline and end-line measurements may therefore underestimate program impact.
- Six subscales of the PHC Integration Checklist relating to pharmacological and clinical management were excluded in 23 of the 76 facilities surveyed at baseline. This was because the original plan in some facilities was to provide only basic counselling training to a limited number of staff. This plan changed due to budget revisions which meant that the full range of program trainings could be conducted in all facilities.

SECTION 3

RESULTS



3. Results

3.1 Effectiveness

Effectiveness refers to the extent to which program objectives have been achieved. This section considers the effectiveness of the program in achieving each of the three objectives in turn.

Objective 1: To strengthen the capacity of health workers and community members to provide mental health and psychosocial support

Program effectiveness in achieving Objective 1 was assessed by:

- measuring the **number of training participants** (as recorded on training attendance sheets)
- measuring **changes in knowledge and skills** between baseline and end-line assessments
- analyzing **qualitative focus group and interview data** on the perceived impact of training and supervision, good practices, and challenges to implementation.

Training participants

Table 8 shows the number of participants trained in each of the nine provider categories.^x In total, 3,575 training courses were completed, with some participants attending more than one type of training.^{xi}

Table 8 Number of trainees disaggregated by gender and provider type

Training type	No. males	No. Females	Total
Prescribers at health facilities	145	55	200*
Non-prescribers at health facilities	36	94	130
Advanced Training for Psychosocial Counselors (PSCs)	9	8	17

^x An individual was considered to have participated in training if they had attended at least 80% of the training course, rounded to the nearest day. This was determined by examining daily attendance sheets.

^yFor example, some of the community members who participated in a basic psychosocial training course to become HBCWs later participated in a more advanced PSC accreditation course.

^{xi} An individual was considered to have participated in training if they had attended at least 80% of the training course, rounded to the nearest day. This was determined by examining daily attendance sheets.

Home-Based Care Workers (HBCWs) Basic Psychosocial Training	16	27	43
Training to upgrade HBCWs to Psychosocial Counselors (CTEVT Accredited)	8	12	20
Female Community Health Volunteer (FCHV)	0	639	639
Frontline Workers and Village Child Protection Committee Members Mental Health Orientation	1150	750	1900
Psychological First Aid (PFA)	289	324	613
PFA Training of Trainers**	4	9	13
Total	1657	1918	3575

*This includes 14 participants who were originally trained by WHO, but for whom IMC provided supervision and refresher training.

** These participants reported training a further 286 individuals (109 male, 177 female) in their districts by July 2015.

Figure 7 shows the number of professional trainees (prescribers, non-prescribers, psychosocial counselors, and HBCWs) disaggregated by sex and district.

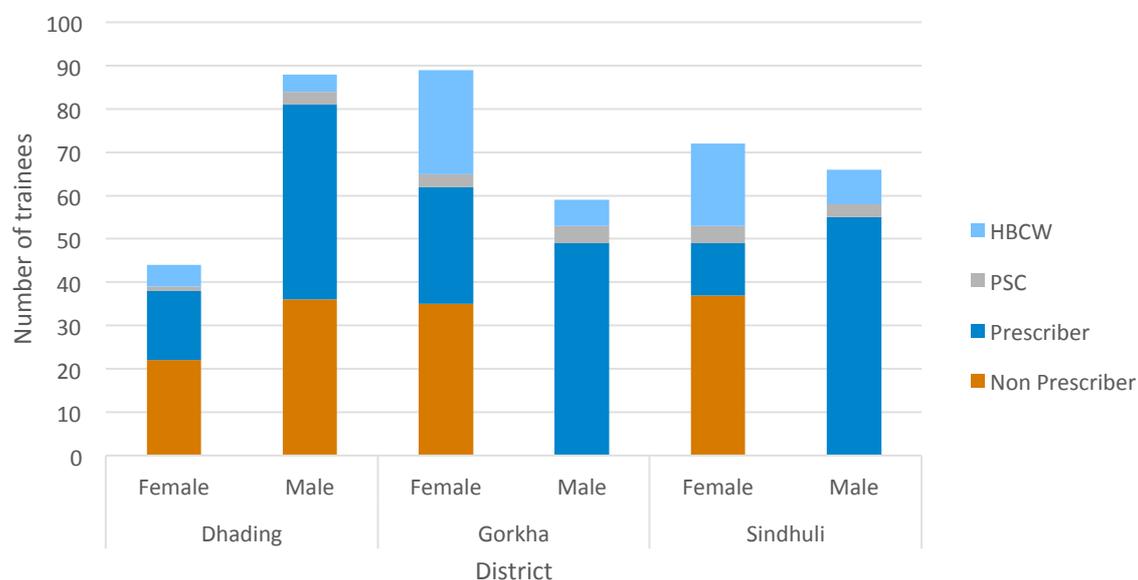


Figure 7 Number of professionals trained disaggregated by sex and district

Table 9 shows the distribution of trained government staff (prescribers and non-prescribers) across health facilities and districts.

Table 9 Distribution of government trainees (prescribers and non-prescribers) across health facilities and districts

	Dhading	Gorkha	Sindhuli	Total
District Hospitals	21	29	25	75
PHCCs	23	22	28	73
Health Posts	83	69	57	209
Total no. trainees	127	120	110	357
Total no. health staff at participating facilities at baseline	126*	140	113	379

* Staff numbers fluctuated over the course of the program due to the frequent transfer of staff between government facilities. The number of trainees is higher than the number of staff at baseline in Dhading due to the hiring of new staff.

Table 10 shows the frequency of post-training supervision contacts provided to each supervised trainee group.

Table 10 Mean number of supervision contacts per trainee

Mean number of contacts per trainee	Prescribers (n=200)	Non-prescribers (n=130)	PSCs (n=17)	HBCWs (n=43)	FCHVs (n=639)	PSC Upgrade for HBCWs (n=20)
Face-to-face supervision	4	5	12	6	9	Data unavailable
Phone supervision	1	2	7	NA	NA	NA
Total	5	7	19	6	9	NA

Trainee knowledge and skills

Trainees reported that the training greatly improved their knowledge and skills, and gave them a new confidence in the detection, diagnosis, and treatment of mental health disorders. Doctors and nurses commented that there had been very little coverage of MHPSS in their formal education, leaving them ill equipped to provide community-based treatment prior to the program.

“Previously, I found it difficult to deal with the mental health patients, but now this mental health program is helping a lot in treating and diagnosing mental health disorders. I used to be worried when a patient with psychosis came for treatment, but now I know how to deal with it and treat it.” (Prescriber, Dhading, focus group)

Trainees were assessed on their skills and knowledge using quantitative outcome tools (see Table 3). Table 11 provides details of each training group and the test scores achieved (see Appendix 1 for details of the outcome tools).

Table 11 Initial and final scores on quantitative evaluation tools

	Prescribers	Non-prescribers	PSCs	HBCWs*	PSC Upgrade for HBCWs
Knowledge tests					
Mean initial score**	67	61	59	71	70
Mean final score	79	74	73	89	90
Skills tests					
Mean initial ACE score	53	43	46	-	-
Mean final ACE score	62	50	57	-	-
Mean initial ENACT-18 score	71	62	67	-	-
Mean final ENACT-18 score	76	77	92	-	-

* A hyphen denotes that the test was not administered to the group.

** All scores are reported as percentages.

Knowledge tests

86% of trainees surveyed demonstrated an improvement in knowledge scores between the first and last day of training. On average, scores improved by 13% (Figure 8).

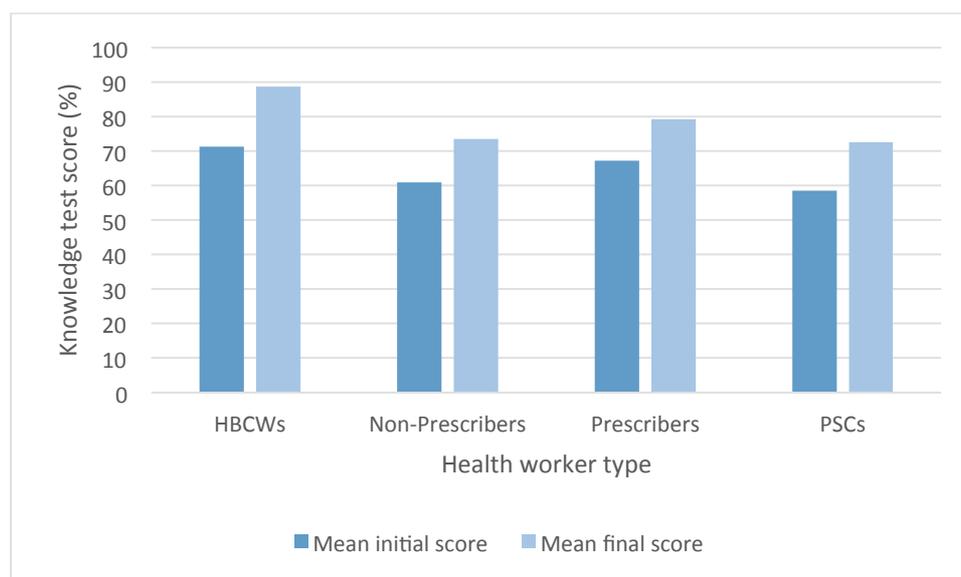


Figure 8 Mean knowledge test scores pre- and post-training

Skills tests

100% of participants demonstrated an improvement in skills scores as measured by the ACE Supervision Checklist tool, with a mean improvement of 9% over the course of the program. An ACE score of 67% or above indicates that the trainee meets or exceeds the “standard expected at the end of six months of supervision”. Mean scores in all three groups fell below this cut-off point at both initial and final assessments (Figure 9).

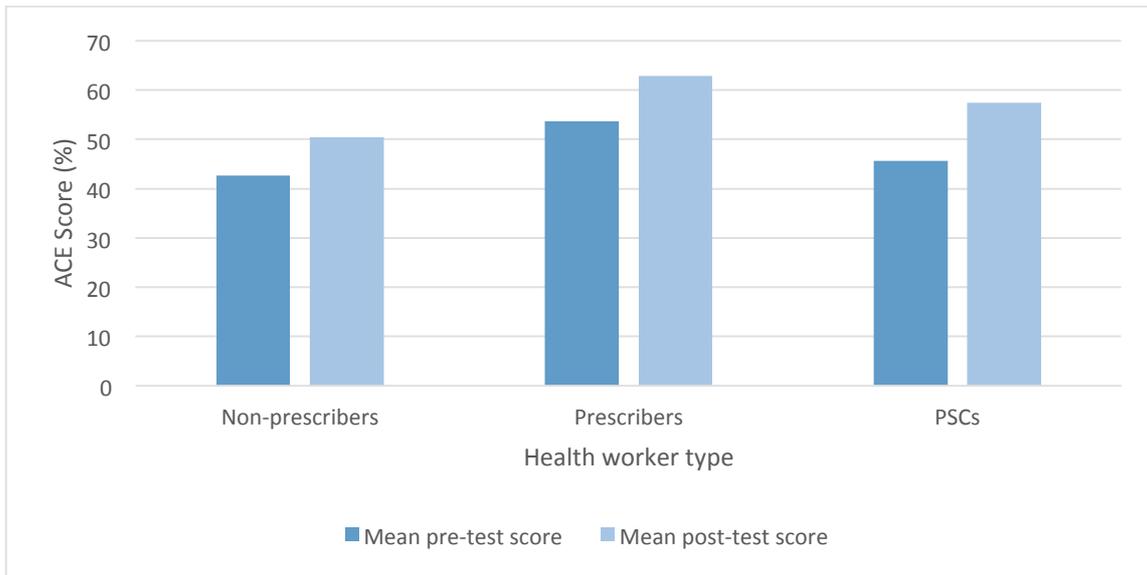


Figure 9 Mean ACE scores on pre- and post-tests

75% of participants demonstrated an improvement in skills scores as measured by the ENACT-18 tool, with a mean improvement of 9% over the course of the program (

Figure 10). A score of 66% or above indicates that the observers rated the consultation as “done well” overall. Prescribers and PSCs met this criteria at both initial and final assessments, while non-prescribers met this criteria at the final assessment only.

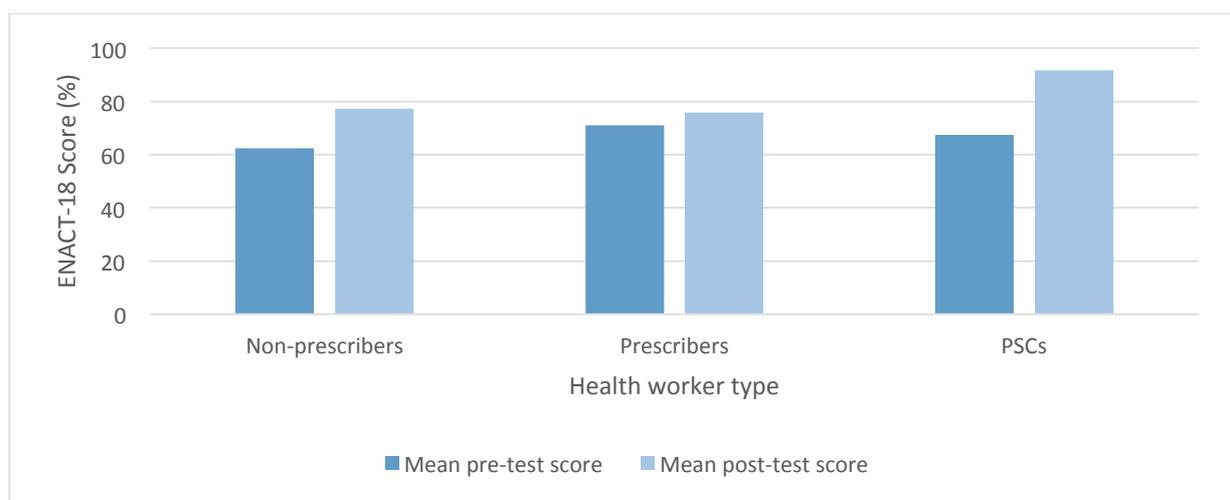


Figure 10 Mean ENACT-18 scores on pre- and post-tests

Perceived competency

Prescribers, Non-prescribers and Psychosocial Counselors completed the IMC Perceived Competency Checklist before and after their training. 92% of those surveyed showed improvements in perceived general competency over the course of the program. Clinical competency scores were reported for prescribers only, with 97% reporting improvements in perceived clinical competency.

Figure 11 and Figure 12 illustrate levels of perceived competency at the beginning and end of training, disaggregated by provider type.^{xii}

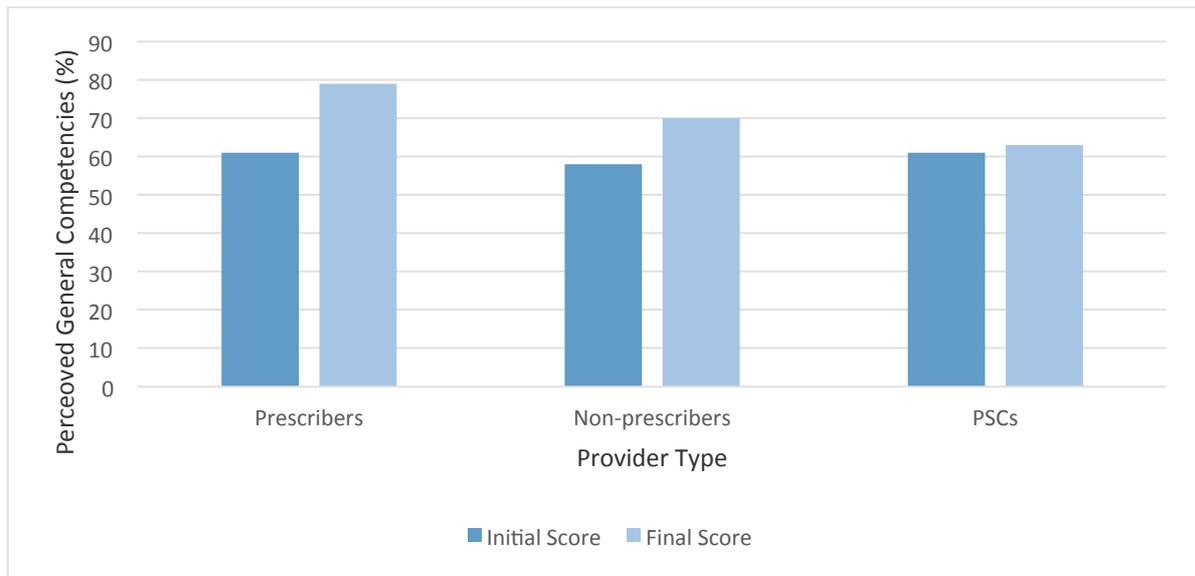


Figure 11 Mean perceived general competency scores at the beginning and end of the program (N=435)

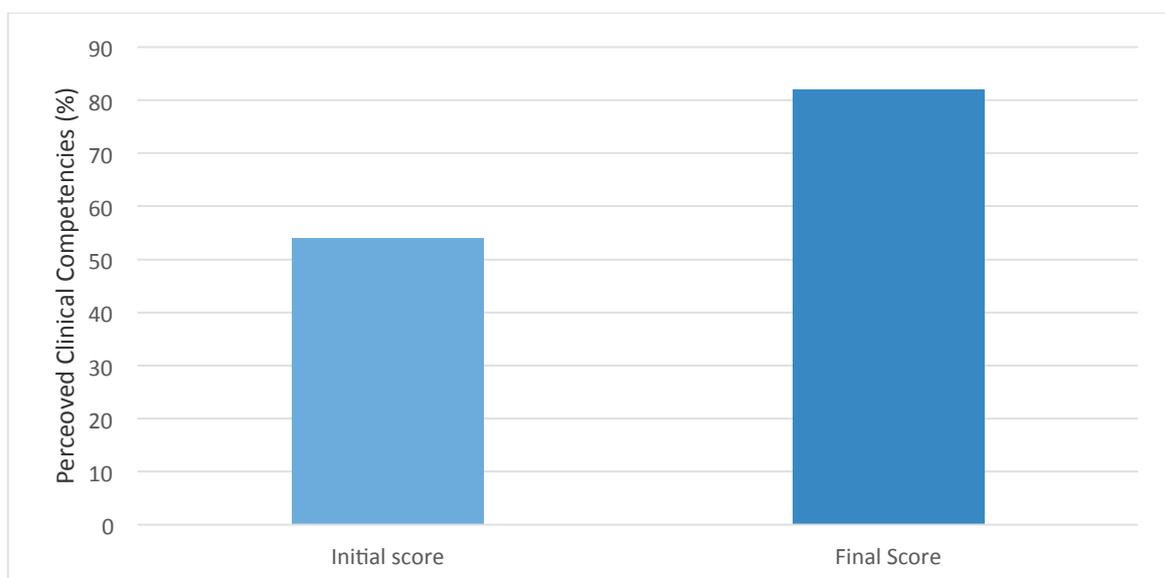


Figure 12 Mean Perceived Clinical Competency scores among prescribers at the beginning and end of the program (N=210)

^{xii} Note: the non-prescriber data does not include Sindhuli, as the tool was introduced after the non-prescriber training in this district.

These findings were consistent with the qualitative data, with health workers expressing a newfound confidence in identifying, diagnosing and treating mental health disorders.

“Our confidence level has increased. Before, even for depression, if we had to prescribe a dose, we would have to think twice. But now it’s really easy to prescribe medication because we understand the side effects. The patients have improved and our confidence has increased.” (Prescriber, Dhading, focus group)

Improved communication with service users

Health workers commented that the training had given them a new understanding of how best to communicate with people suffering from mental health problems, in terms using sensitive language and allowing more time in consultations: “We have become more conscious while handling those mental health patient cases. These days, we normally gives them lots of time compared with other patients.” (Prescriber, Dhading, focus group).

“We learned how to communicate properly, about talking styles, about how to treat service users and how to understand their needs” (HBCW, Gorkha, interview Good practices)

Good Practices

Training techniques

- Feedback from trainees on the **content and format** of training was overwhelmingly positive.
- They emphasized that the **interactive aspects of the training**, such as role plays and group discussions, were particularly effective.
- They also appreciated the **avoidance of overly-complicated language** and the use of **evidence-based guidelines**.

Supervision as a key strength of the program

- Health workers, government officials, and program staff alike commented on how supervisions provided an invaluable opportunity to revise what they had learned in training: “In supervision, we got a **chance to correct our mistakes** and clear up any confusion. Every supervision was important: I did not want to miss a single session because I learnt a lot.” (HBCW, Dhading, interview).
- Interviewees discussed how supervision also allowed them to access **peer support and expert guidance** as they put their training in to practice and encountered complex real-world cases.
- Several participants commented that, while they had received training on different topics from other organizations, this was the first training they had received which involved on-going supervision, which **set it apart from other programs**. “The system of monitoring and supervision, which we were not familiar with before, has been a

very effective and important aspect” (Government Mental Health Focal Person, Sindhuli, interview).

Challenges and suggestions for improvement

- When asked for suggestions on how to improve the training, the most common responses were:
 - **to extend the program**
 - **to hold more regular supervision sessions**
 - **to cover a broader range of topics** (e.g. additional disorders and more time on counseling skills).
- Several participants suggested that training would be **more effective if those with different professional designations were trained separately**, for example, separating Medical Officers, Auxiliary Health Workers, and Health Assistants, and adjusting the focus of the training content accordingly (for example, spending more time on medication with the Medical Officer group).
- Managers noted that they had **difficulty scheduling supervision sessions** due to health workers having other ongoing engagements. Some health workers complained that they were not given sufficient advance notice of supervision sessions, and suggested **changing the location of supervision sessions on a rotating basis** to allow for broader participation.

Objective 2: To provide community-based mental health and psychosocial support services

Program effectiveness in achieving Objective 2 was assessed by:

- measuring the **number of service users** (as recorded on OPD registers, CIDT referral forms, and Case Management Files)
- measuring **service user satisfaction** and changes in **service user functioning** between baseline and end-line assessments
- analyzing **qualitative focus group and interview data** on the perceived impact of the program on service users and health workers.

Service provision

Program MHPSS services reached 3,422 service users in total. Table 12 shows the number of service users accessing services in each district.

Table 12 Number of service users per district

	Dhading		Gorkha		Sindhuli		Total
	Male	Female	Male	Female	Male	Female	
No. service users	657	784	423	571	417	570	3422

Table 13 shows the number of service users consulting each type of service provider.

Table 13 Number of service users consulting each type of service provider

	Prescribers	Non-Prescribers	PSCs	HBCWs	FCHVs
No. of service users*	1875	908	1286	829	852

*Note: Many service users saw multiple categories of provider during the course of their treatment.

Figure 13 shows the number of service users, disaggregated by presenting problem and age. Numbers above the data series show the percentage of service users in each category. The ‘others’ category includes problems that presented less commonly, such as conversion disorder, suicidal ideation, and psychosocial problems.

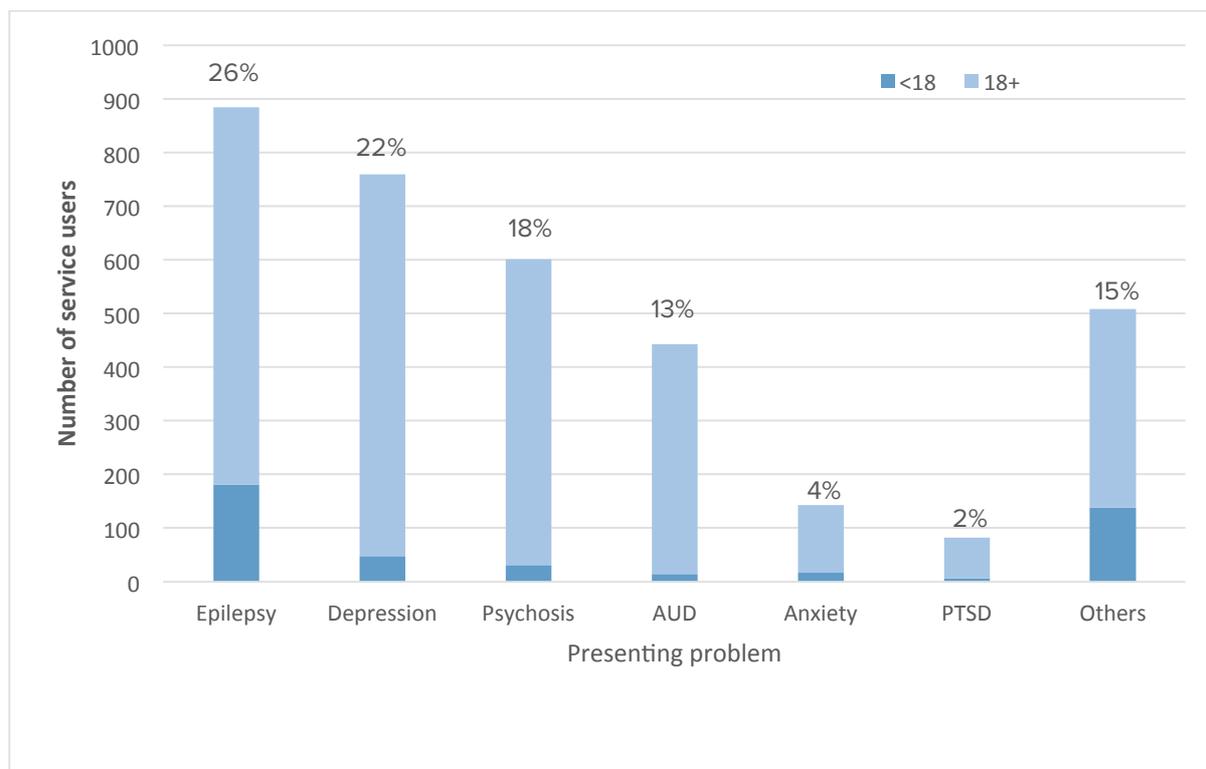


Figure 13 Number of service users, disaggregated by presenting problem and age (AUD: Alcohol Use Disorders)

Figure 14 illustrates the number of service users, disaggregated by presenting problem, region and sex.

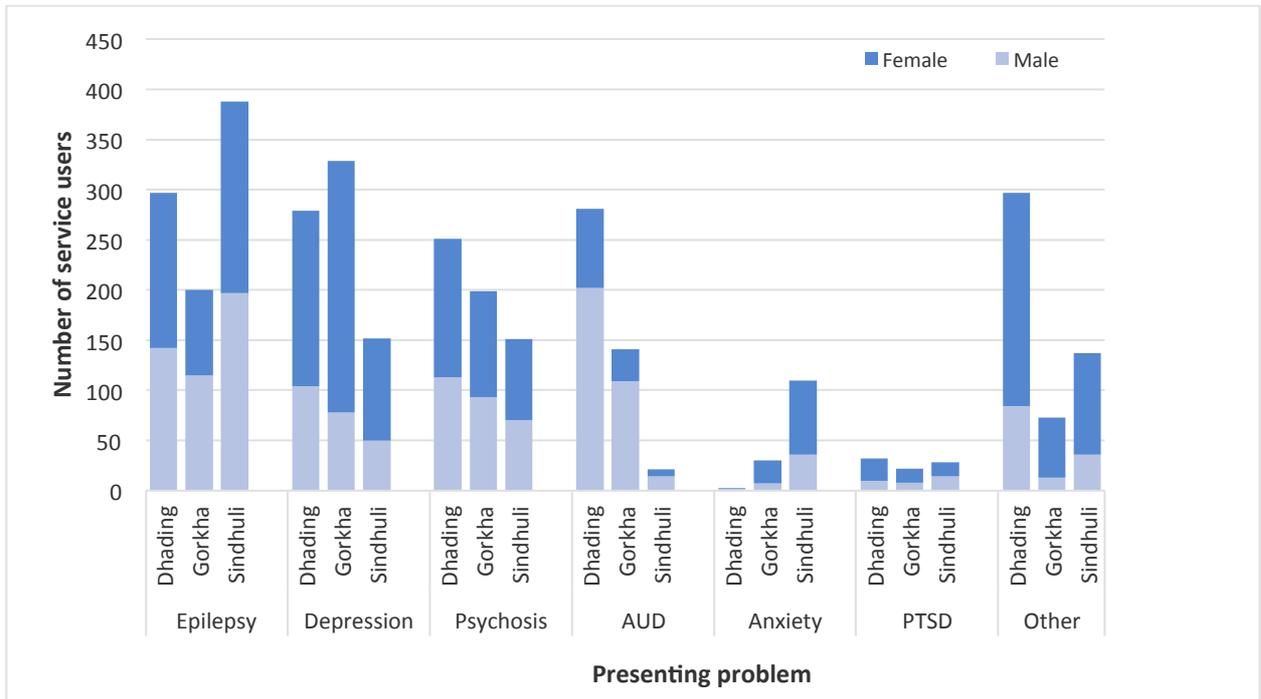


Figure 14 Number of service users accessing program services disaggregated by presenting problem, region and sex

Figure 15 illustrates the number of service users presenting with each problem, as a percentage of the total number of service users within each region.

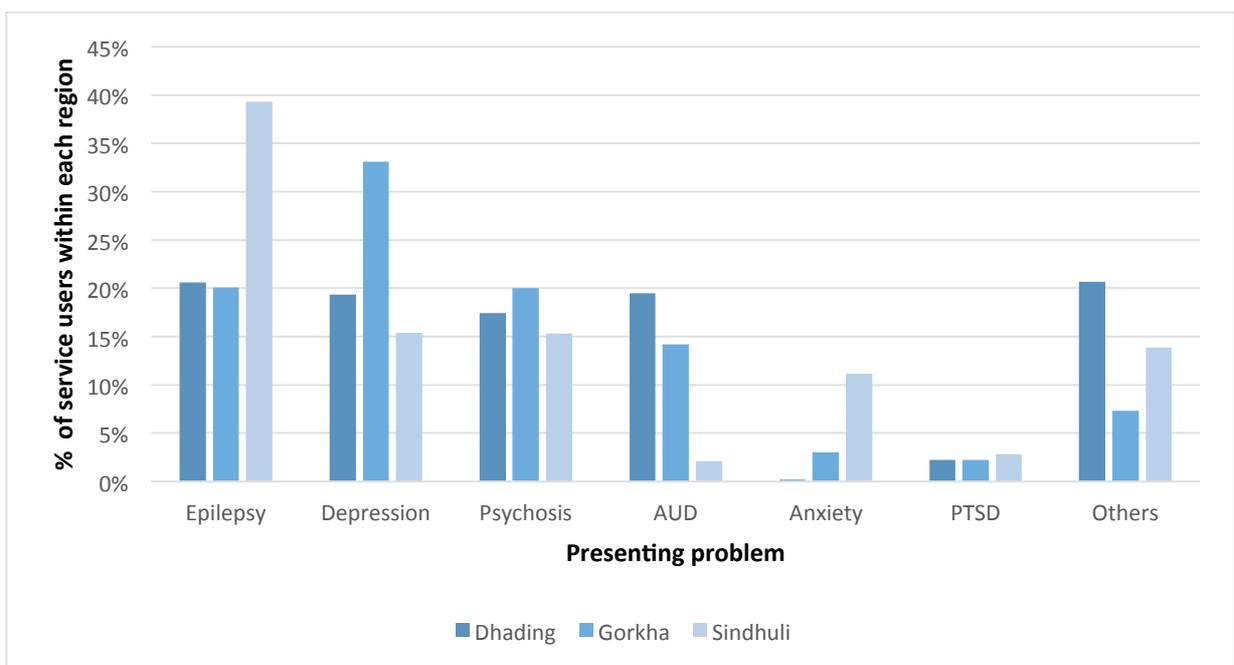


Figure 15 Number of service users as a percentage of region totals disaggregated by presenting problem

Service user satisfaction

98% of clients reported being “completely satisfied” or “somewhat satisfied” with the services they had received as part of the program (see Table 3 for details of the outcome tools used).

Figure 16 illustrates the levels of satisfaction reported in the three districts.

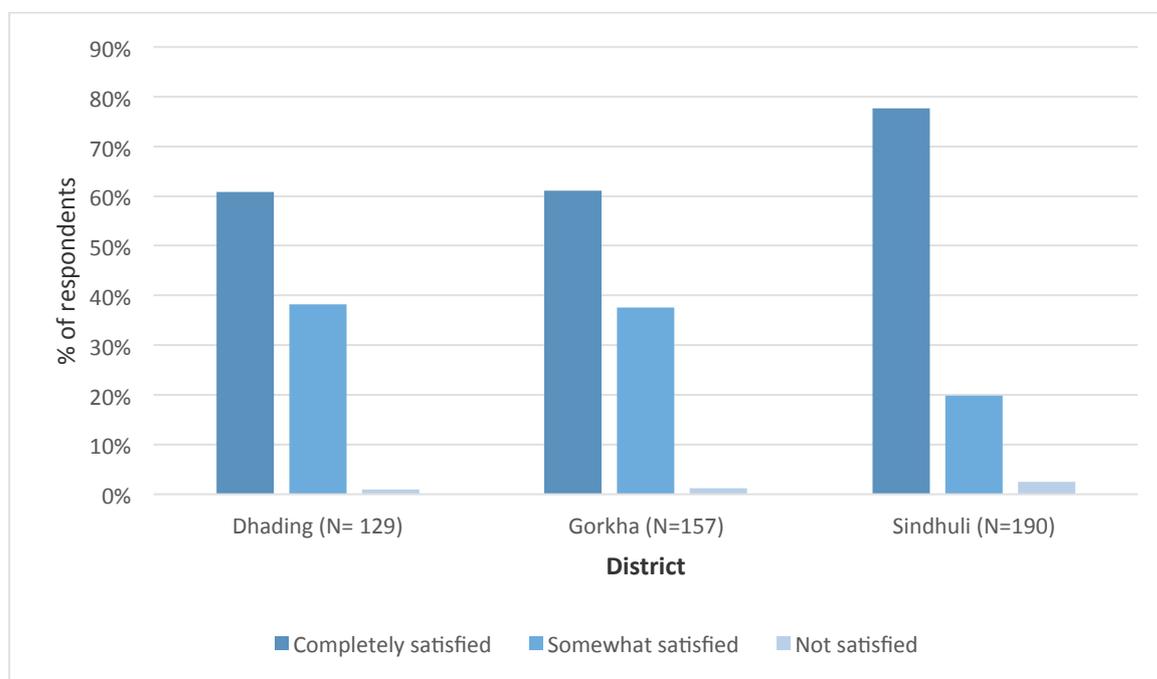


Figure 16 Levels of client/caregiver satisfaction by district (N=428)

The qualitative data reflected these high levels of satisfaction. When asked about their experience of the program, service users described how it met their needs on both emotional and practical levels. They appreciated how health workers made them feel “understood” and remarked on how the availability of free treatment had changed their lives.

“Now that there are free medicines and services available, life has become easy.”
(Service User, Sindhuli, focus group)

“It’s really nice because there are things that we can’t usually share, but here we have a platform where we can put forward our thoughts, feelings and emotions to the counselors ... They understand what is going on with us.” (Service User, Dhading, focus group)

Recovery and symptom reduction

When asked about the impact of the program on service users, staff and service users alike described how the program had been life-changing for some service users, highlighting how their involvement had changed not only their symptoms, but also their perceptions of themselves.

“The impact has been big ... People started using medication for the first time in their whole lives and were symptom-free for the first time in their whole lives. People were sensitized towards mental health problems, realizing that what they were suffering from is not strange, and they are not crazy, and feeling that there are people in their communities, whether they are HBCWs, or FCHVs or health workers, that are actually sensitive to those issues.” (IMC Manager, interview)

Service users reported improvements in their symptoms, their emotional wellbeing, and their daily functioning, which they attributed to their involvement in the program.

“I feel that everything has changed. I have been transformed. Before, my grandmother and others used to think my illness was due to witchcraft and other supernatural powers, but now I confidently tell them it’s all improved because of counseling” (Service User, Dhading, focus group)

“My life has changed in many ways after the service. Before I used to think too much, but now, I’m at peace.” (Service User, Dhading, focus group)

Several participants described a reduction in suicidal thoughts, including one woman who had planned to take her own life, along with those of her two children: “Before the counseling service, I had tried committing suicide twice. But now these thoughts have decreased a lot.” (Service user, Dhading, focus group)

Improvement in daily functioning and social interaction

Both service users and health workers gave examples of people improving enough to return to participating in daily activities such as cooking, cleaning and going to school or work.

“I used to feel like I didn’t have strength to do things. Things that I wanted to do seemed impossible, and I would often get sad. But now if I start something I feel I have the strength to complete it.” (Service User, Sindhuli, focus group)

They also described improvements in social functioning, communication and community participation.

“Some say the treatment has given them a new life ... People who could not talk have now have started to have two-way conversations, started to care for themselves, and to support their families in household activities. Some of the patients have started small businesses like candle-making.” (HBCW, Gorkha, interview)

Overall functioning scores (WHODAS II)

Impairment in daily functioning was assessed quantitatively using the World Health Organization Disability Assessment Schedule (WHODAS II, 12-item version). Overall, 54% of participants demonstrated an improvement in functioning scores over a six-month time period. Figure 17 illustrates mean scores at initial and final administration, disaggregated by district.^{xiii}

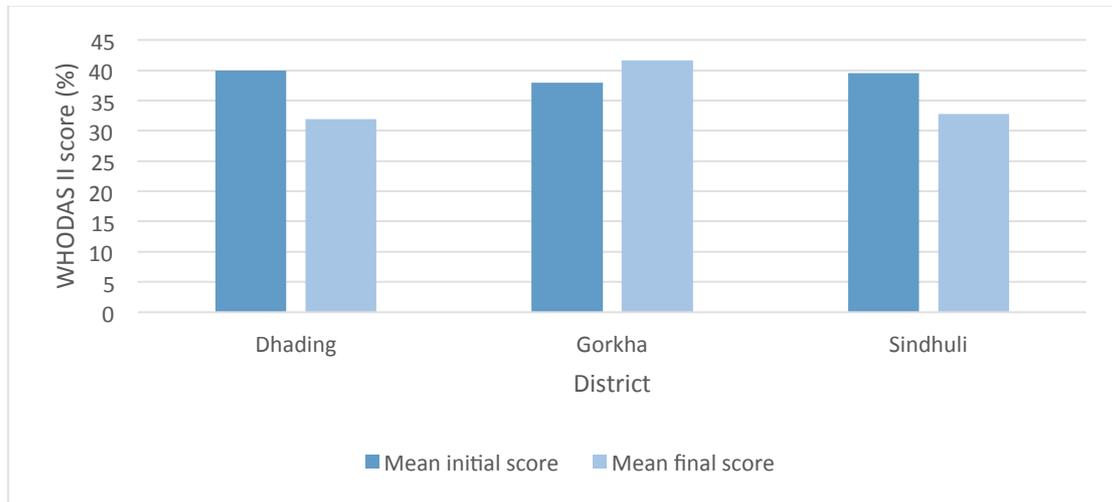


Figure 17 Mean WHO Disability Assessment Schedule (WHODAS) II daily functioning scores (higher scores indicate greater impairment)

Figure 18 shows changes in initial and final WHODAS II scores, disaggregated by presenting problem.

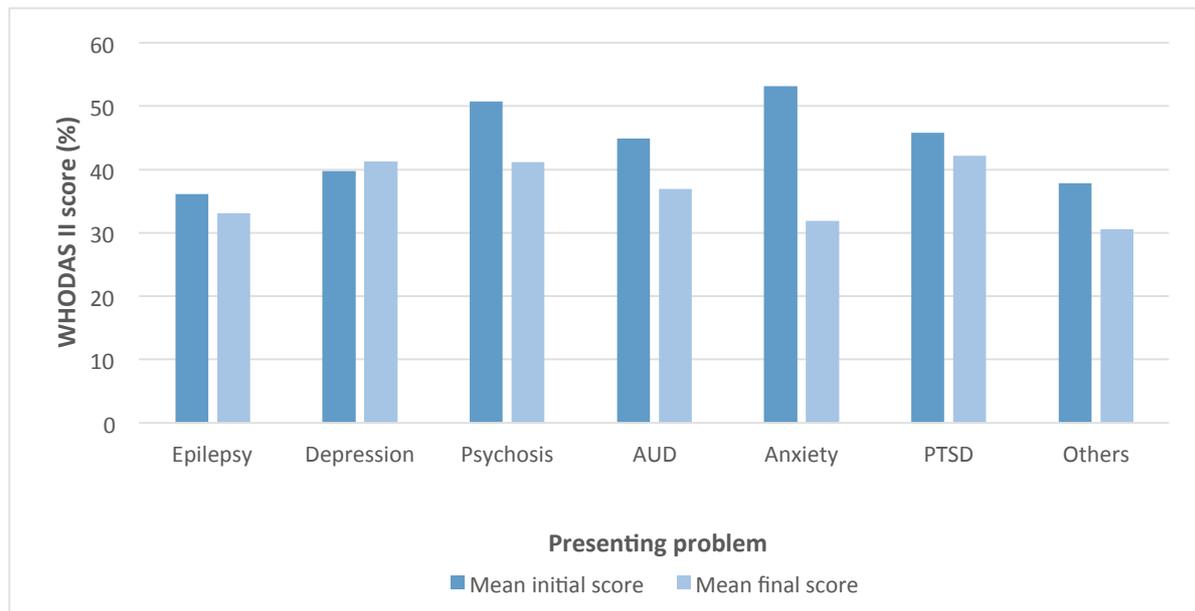


Figure 18 Initial and final WHODAS II scores disaggregated by presenting problem

^{xiii} WHODAS II scores of 0-25 represent *no impairment or mild impairment*, scores of 25-50 represent *mild to moderate impairment*, scores of 50-75 represent *moderate to severe impairment*, and scores of 75-100 represent *severe to extreme impairment*.

Some domains of the WHODAS II Scale (e.g. mobility and self-care) are generally only affected in more severe mental health disorders. Among those with severe or extreme functional impairments at the beginning of their treatment (an overall WHODAS II score of 75 or more), 89% demonstrated improvements, with a mean initial score of 83 and a mean final score of 41 (Figure 19).

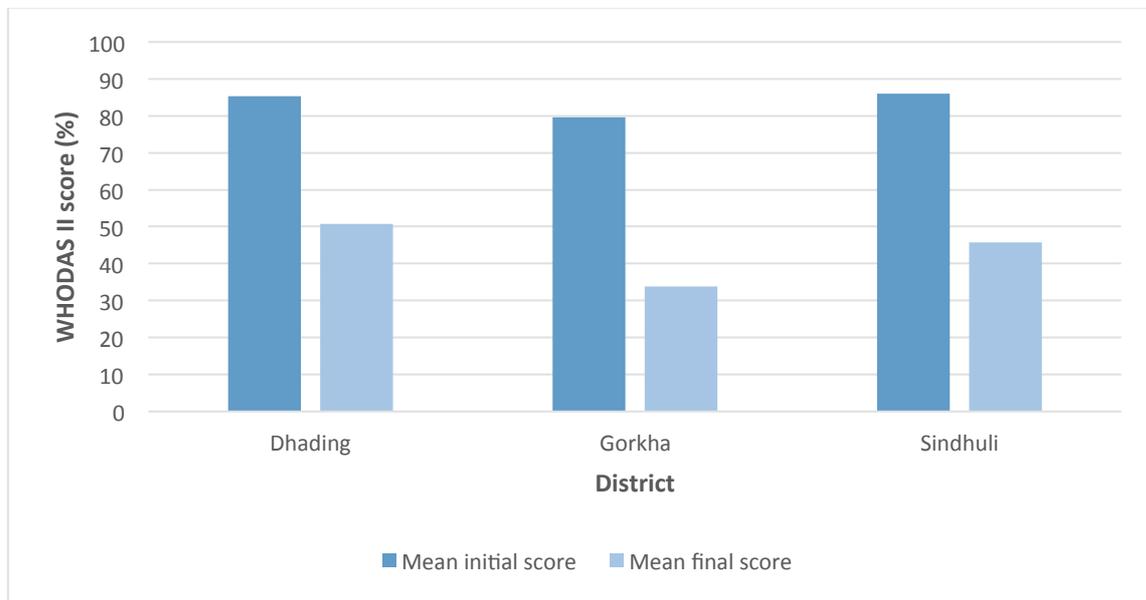


Figure 19 Mean WHODAS II daily functioning scores among those with severe impairment at the beginning of their treatment (higher scores indicate greater difficulties)

Figure 20 illustrates the improvements in scores among those with severe initial impairments, disaggregated by presenting problem.

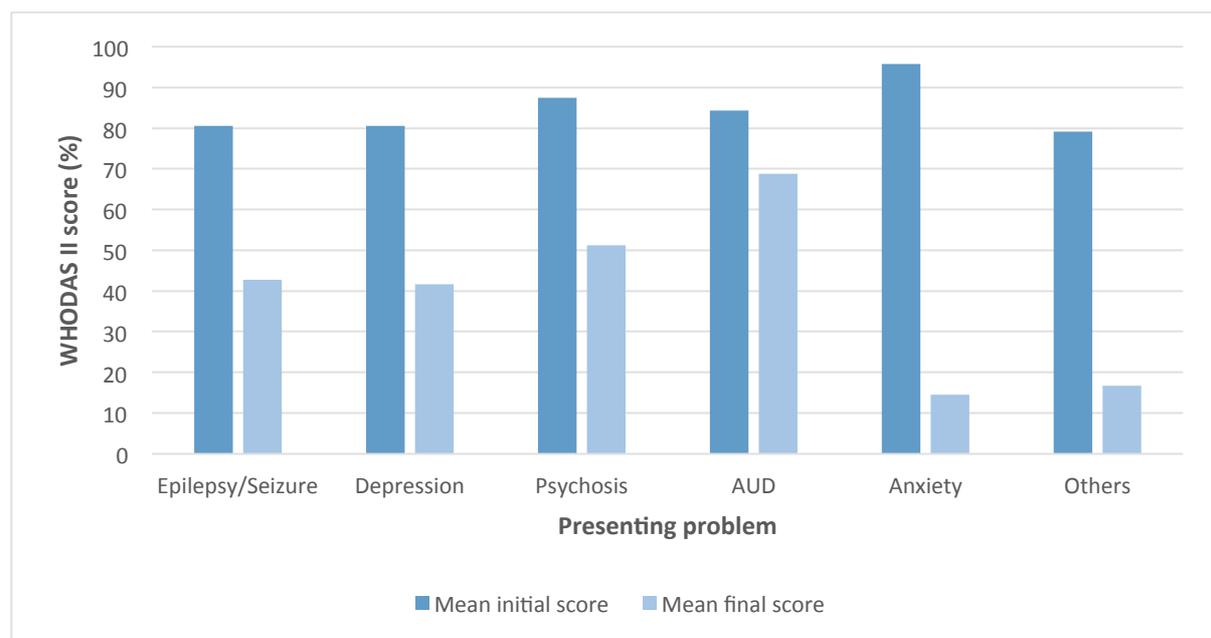


Figure 20 Initial and final WHODAS II scores among those with severe initial impairments disaggregated by presenting problem

Work and daily activities

At the beginning and end of the program, participants were asked how many days in the past month they had been totally unable to carry out their “usual activities or work” because of any health condition. On average the number of days reduced from 7.03 at the start of the program to 5.60 at the end of the program. Among those with severe initial impairments, the number of days reduced by more than half, from 12.85 to 6.26 (Figure 21).

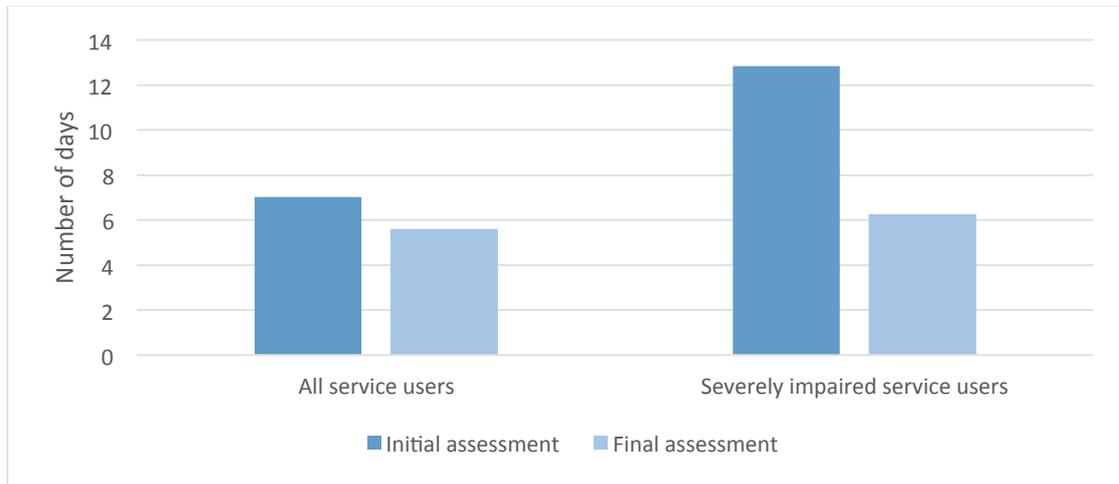


Figure 21 Number of days service users reported being "totally unable" to work or carry out usual activities in the past month

Social functioning

Those with severe impairments at the beginning of the program also experienced improvements social functioning. For example, difficulties in “maintaining a friendship” reduced by 25% and difficulties in “joining in community activities” (e.g. festivals and religious activities) reduced by 23% (Figure 22).^{xiv}

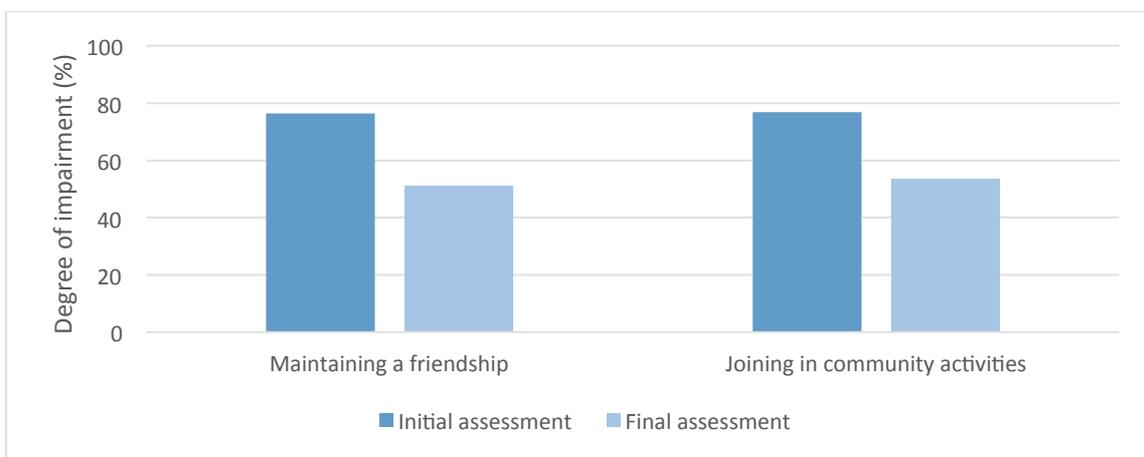


Figure 22 Improvements in social functioning among those with severe impairments

^{xiv} Large improvements in social functioning, mobility, and self-care were not evident among those with mild-to-moderate initial impairments.

Mobility and self-care

Mobility and self-care also improved substantially among those with severe impairments at the beginning of the program. Difficulties in maintaining personal hygiene and dressing oneself reduced by 23% and 22% respectively. Difficulties in walking long distances and standing for long periods reduced by 22% and 21% respectively (Figure 23).

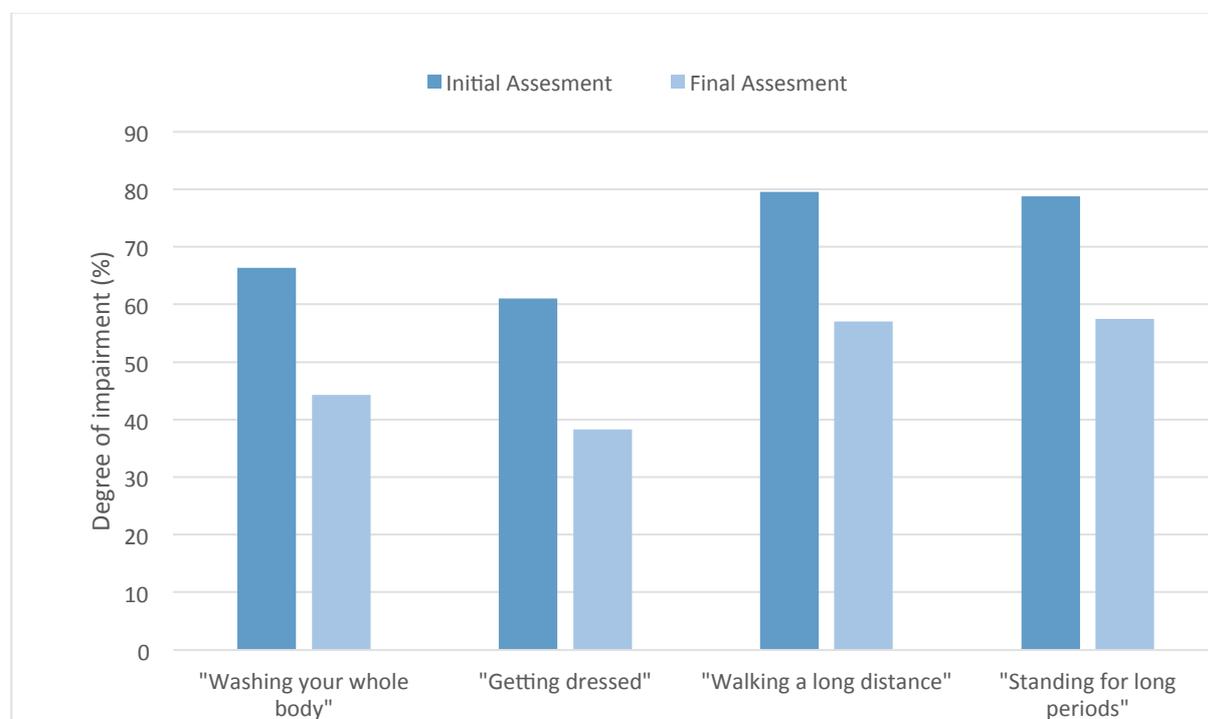


Figure 23 Improvements in self-care and mobility among those with severe impairments

A new sense of hope

Service users spoke of a newfound understanding that mental health problems were treatable, which gave them a sense of hope. Many commented that their families had become more supportive as a result of the family counseling provided: [“Counseling has helped a lot to make our family understand.”](#) (Sindhuli, Service User, focus group).

Several participants shared that, prior to the program, they had been seeking help for many years without success. Few people understood that mental illnesses could be treated medically and with support services, and many of those suffering visited traditional healers instead.

[“There was nothing we didn’t do to try and treat my daughter-in-law. We took her to everywhere possible, even to India. I faced lots of problems personally due to that. But now, after your service, we are really happy.”](#) (Carer, Sindhuli, focus group)

[“There are people who have not been able to get a diagnosis for 12 or 13 years. They had visited different places for treatment but no treatment cured it. But the medication](#)

from our program has cured those patients. They want this program to last longer.”
(HBCW, Gorkha, interview)

Professional satisfaction among health workers

Many of the health workers and program managers interviewed spoke of the satisfaction, pride and sense of achievement they gained from being part of the program and seeing dramatic improvements in the lives of their clients.

“I feel so joyful. I never had expected that I would work in this sector. I feel so happy when someone recovers from their illness ... Now I feel there is no other sector where I could work.” (Counselor, Sindhuli, interview)

“There is a special kind of satisfaction in providing the service to clients and seeing changes and improvements in them. The tiredness from a whole day of walking [to visit them] is quenched after seeing the transformations in them.” (HBCW, Dhading, interview)

Psychotropic medication supply

Medication procurement

Table 14 lists the medication procured over the course of the program.

Table 14 Medication procured by the program

Medication	Type	Sindhuli	Gorkha	Dhading	Total
Alprazolam (0.25mg tablets)	Antianxiety	17,000	9,000	15,200	41,200
Amitriptyline (10mg tablets)	Antidepressant	42,600	23,400	41,600	107,600
Amitriptyline (25mg tablets)	Antidepressant	121,000	128,200	149,200	398,400
Carbamazepine (200 mg tablets)	Antiepileptic	52,650	50,100	61,200	163,950
Carbamazepine (400 mg tablets)	Antiepileptic	32,600	26,200	21,500	80,300
Chlorpromazine (100mg tablets)	Antipsychotic	42,600	31,800	41,100	115,500
Phenobarbitone (60mg tablets)	Antiepileptic	21,600	16,400	20,600	58,600
Diazepam (5mg/ml in 2ml ampules)	Substance withdrawal*	410	320	390	1120

*Also used to treat anxiety and seizures.

Only medications that were listed on the Government of Nepal’s Free Essential Drug List were procured. Appendix 5 compares the psychotropic medications recommended as essential by the WHO with those procured by the program. This decision was made by IMC and TPO

program managers on the basis that service users should be able to continue accessing their prescribed medications after the end of the program. However, this list did not include modern psychotherapeutic drugs such as atypical antipsychotics and SSRIs. Health workers reported that this was problematic for patients who had previously obtained more modern medications through private clinics or other NGOs.

Together with the partner NGOs, IMC attempted to address this issue by advocating that the government update the Free Essential Drug List and make modern medications available in local hospitals through the public system (see section on Policy Impact, p.62).

Medication availability at facilities

Table 15 presents data from the PHC Integration Checklist showing the percentage of facilities reporting that medication was “usually” available in the past week when surveyed at baseline and end-line.

Table 15 Percentage of facilities reporting that psychotropic medication was "usually" available in the past week

Medication type	% of facilities at baseline (N=53)	% of facilities at end-line (N=17)
Antidepressant	15	100
Antipsychotic	4	100
Antiepileptic	8	88
Antianxiety	15	67
Antiparkinsonian*	0	24
Substance withdrawal	0	20

* For the management of extrapyramidal side effects from antipsychotic medication (not part of the Government of Nepal Free Essential Drugs List).

When asked about implementation challenges, the issue of inadequate medication supplies was the most common concern among health workers: “Despite our continuous demand for medications, this was not managed well. This was a negative aspect of the project.” (Prescriber, Dhading, focus group).

Inconsistent medication availability sometimes caused tension between community members and health workers: “We ask for them to go to the health post for the medicine, but then there is no medicine for them and it feels like we are lying to them.” (FCHV, Gorkha, focus group).

Despite efforts to track medication supply and use at the facility-level, distribution was not commensurate with patient flow and need, with some facilities over-supplied, and others undersupplied. These problems were attributed in part to delays in IMC procurement procedures, and in part to problems distributing medications among health facilities once IMC had delivered them to each District Health Office. IMC and partners attempted to address this by providing training to government pharmacy store keepers and by mobilizing partner staff

to visit facilities in person and redistribute stock.

Improvement in documentation

Several managers highlighted the development of more systematic health information systems as a key service-level improvement.

“One of the most important things we have done in our program is that we developed data collection systems like the OPD [Outpatient Department] register ... They have started to report this mental health data regularly to the DPHO [District Public Health Officer]. Now the DPHO has mental health data, so he can advocate for continuation of the mental health program to different donors.” (IMC Manager, interview)

Good practices

- When asked what they perceived to be the most effective aspects of the program, many health workers highlighted how a “joint effort” between different professional groups led to an **integrated and holistic program**, with community members (FCHVs and HBCWs) providing home-based support and referrals, and medical staff providing more intensive care at health facilities.
- Several participants mentioned that the **involvement of multiple groups at different levels helped to reduce the stigma** associated with mental illness.
- Service users and health workers alike considered **home visits to be highly effective** in maintaining contact and monitoring medication use.

Challenges and suggestions for improvement

Underutilization of certain roles

- Some health workers and managers argued that **particular professional groups were underutilized**, due to existing professional hierarchies and a lack of adequate supervision. One manager argued that prescribers were reluctant to refer patients to non-prescribers, who they saw as relatively inexperienced.

“The concept is very good, we have home-based care workers, non-prescribers, and prescribers... But in health posts, prescribers feel it undermines their qualifications to refer to non-prescribers ... They feel like non-prescribers are junior.” (Partner Manager, interview)

- Several participants argued that it would have been more effective to provide in-depth training on counseling and home-based care to FCHVs, who would remain active in communities after the close of the program, rather than recruiting short-term HBCWs.

Staff turn-over

- The problem of staff turn-over was a common theme in interviews. Government health **staff are frequently transferred between different facilities**, and consequently, many of those trained as part of the program were moved to other areas in the following months: “Initially, there were three trained prescribers in our health facility. Two months after the training, I was the only one left.” (Prescriber, Sindhuli, interview).

Lack of private counseling spaces

- Participants from all three districts complained of a lack of private spaces available for counseling. Service users from Dhading described how **some of their counseling sessions had taken place outdoors in public places**, which compromised their privacy and comfort: “If we had proper room, we could speak up openly, but in an open space we feel insecure. People might make comments if they hear what we are saying.” (Service User, Dhading, focus group).

Skepticism among community members

- Health workers reported that some community members were skeptical of the program, fearing that there was a **hidden agenda**. Some were suspicious that the medication being provided free-of-charge was fake, or that it was being distributed by organizations from developed nations as a means of experimenting on those in developing countries.
- Some **questioned the intentions of community-based health workers** (PSCs, HBCWs and FCHVs) accusing them of simply trying to make money: “There is a belief in the community people that we are here to guzzle foreign currency, and that the more patients we get, the more money we receive.” (Counselor, Gorkha, interview).
- Several interviewees argued that **greater involvement of community leaders and traditional healers** would have increased acceptance and uptake of services within communities.

Objective 3: To improve access to services by increasing community awareness about mental health issues and decreasing stigma

Program effectiveness in achieving Objective 3 was assessed by:

- measuring the **number of participants** attending community outreach events (monitored using sign-in sheets)
- measuring the **number of radio programs and educational materials** produced and disseminated
- measuring the **number of self-help group participants** (monitored using sign-in sheets)
- analyzing **qualitative focus group and interview data** on the perceived impact of the program on community and health worker attitudes to mental health
- **measuring access and referrals** using OPD registers, CIDT forms and Case Management Files.

Community outreach activities

263 community outreach events were conducted, which were attended by 7,933 participants (Table 16).

Table 16 Number of participants attending community outreach events

District	Males	Females	Total
Dhading	334	387	721
Gorkha	1312	2056	3368
Sindhuli	1703	2141	3844
Total	3349	4584	7933

Radio programs

Eleven 30-minute radio programs were developed and adapted in each district to reflect the services available locally. Each program was broadcast repeatedly, amounting to 152 broadcasts in total. Three short radio messages were also developed which focused on minimizing stigma and promoting the rights of mental health service users and their families.

Educational materials

14 billboards were erected in prominent locations in 13 different Village Development Committees (VDCs)^{xv} across the three districts (Figure 24).

^{xv} Nepalese districts are divided into administrative sectors called Village Development Committees (VDCs) which encompass between 700-2000 households.



Figure 24 Example of a billboard displayed in prominent locations throughout the districts. The square-shaped pictures illustrate six priority mental health conditions. The central section explains the support available at local health facilities.

26 flex-boards were displayed outside of Dhading health facilities listing the mental health and psychosocial services available at the facility.

Six brochures describing common mental health problems and sources of support were developed. 25,357 copies were distributed across the three districts during training events and community outreach programs (Figure 25).

ख) सामाजिक सहयोग र पारिवारिक जाया :

- व्यक्तिलाई पहिले उसले गर्ने गरेका क्रियाकलापहरू, सामूहिक कार्यहरू वा खुसी हुने विजहहरूमा संलग्न हुन हौसला दिने ।
- समस्यालाई सामान्यीकरण गर्ने ।
- व्यक्तिलाई अनुभूति प्रदान गर्ने ।
- घटनाकोबारे फूटा नगरिकन अहिले मनमा उत्तिरहेको भावनामा कुराफानी वा छलफल गर्ने ।
- मदिना, लागुपदार्थ वा अन्य पुर्यसनीबाट टाढा रहनको लागि मदत गर्ने ।
- स्प-स्याहार गर्न सहयोग गर्ने (नियमित शारीरिक व्यायाम, नियमित सन्तुलित आहार, आरामदायी अन्यास आदि) ।
- आवश्यकता अनुसार सम्बन्धित मानसिक चिकित्सक, मनोवैज्ञानिक वा मनोविर्मशकर्ताकोमा सिफारिस गर्ने ।
- यदि व्यक्तिले आत्महत्या गर्ने प्रयास गरेको छ वा आत्महत्या गर्ने धम्की दिएको छ भने त्यस्ता व्यक्तिलाई निरन्तर निगरानी गर्ने र उनीहरूको मनको कुराहरू भनेर र सुन्ने वातावरण निर्माण गर्ने ।

ग) औषधीको प्रयोग:

- विरामीको अवस्था राम्रो हुँदै गए पनि स्वास्थ्यकर्मी तथा चिकित्सकको सल्लाह बमोजिम नियमित रूपमा औषधीको सेवन गर्ने वा गराउने ।

गोरखा जिल्लाको एक नगरपालिका र १६ वटा गाविसहरूका स्वास्थ्य संस्थाहरूमा बहुसंस्कृतिक मनोसामाजिक संस्था (टि.पि.ओ) नेपाल र इन्टरनेशनल मेडिकल कोर (आई.एम.सी) र जिल्ला जनस्वास्थ्य कार्यालयको संतकार्यमा मानसिक स्वास्थ्यको कार्यक्रमहरू संचालन भएको छ । मनोसामाजिक तथा मानसिक समस्याको पहिचान भएमा तुरुन्तै नजिकको स्वास्थ्य संस्था तथा जिल्ला अस्पतालमा सम्पर्क राख्नुभई नि:शुल्क उपचार सेवा लिनुहोस् ।

मनोसामाजिक तथा मानसिक स्वास्थ्यसँग सम्बन्धित कुनै पनि जानकारी लिनुभएमा १६६००१०२००५ मा सम्पर्क राख्नुहोला । यसमा फोन गर्दा पैसा लाग्दैन ।

विस्तृत जानकारीका लागि सम्पर्क
बहुसंस्कृतिक मनोसामाजिक संस्था
 (टि.पि.ओ) नेपाल
 बालुवाटार, काठमाडौं, नेपाल
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आघातजन्य घटना पश्चात् देखिने तनावपूर्ण अवस्था

आघात भन्नाले यस्तो घटना हो, जसले व्यक्तिलाई अत्याधिक डर, तनाव, तीव्र चिन्ता, असहायपन, नैराश्यता र आफूलाई अति योग्यहीनको अनुभूति दिलाउँछ र उसको तनावसँग सामना गर्ने व्यवहारलाई तहसनहस गर्दछ ।



फुनै आघातजन्य घटना पश्चात् व्यक्तिका तनावको कारणले मनोवैज्ञानिक वा मनोसामाजिक समस्या देखिनु सामान्य मानिन्छ । प्रायजसो व्यक्तिहरूमा यी समस्याहरू केही समयका लागि मात्र देखिन्छन् तर जब यी समस्याहरू लामो समयसम्म वा घटना घटेको १ महिना भित्तिसम्म पनि देखा परिरहन्छ भने त्यस्ता व्यक्तिहरूमा आघातजन्य घटना पश्चात् देखिने तनावपूर्ण अवस्थाको सिर्जना भएको मानिन्छ ।



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Figure 25 Example of a brochure explaining the symptoms of Post-Traumatic Stress Disorder and how to seek help.

ICDC developed two program bulletins giving an overview of the mental health program, explaining the MHPSS services available in Dhading, and describing successful case studies (Figure 26).^{xvi} At the time of writing, 4,387 had been distributed to community stakeholders through health facilities and HBCWs.

^{xvi} The production of program bulletins was proposed by ICDC during budget development as the organization had produced similar bulletins for other programs and found them to be useful in raising awareness about the program. TPO programs in Gorkha and Sindhuli were already established at this time and their budgets did not provide for this.

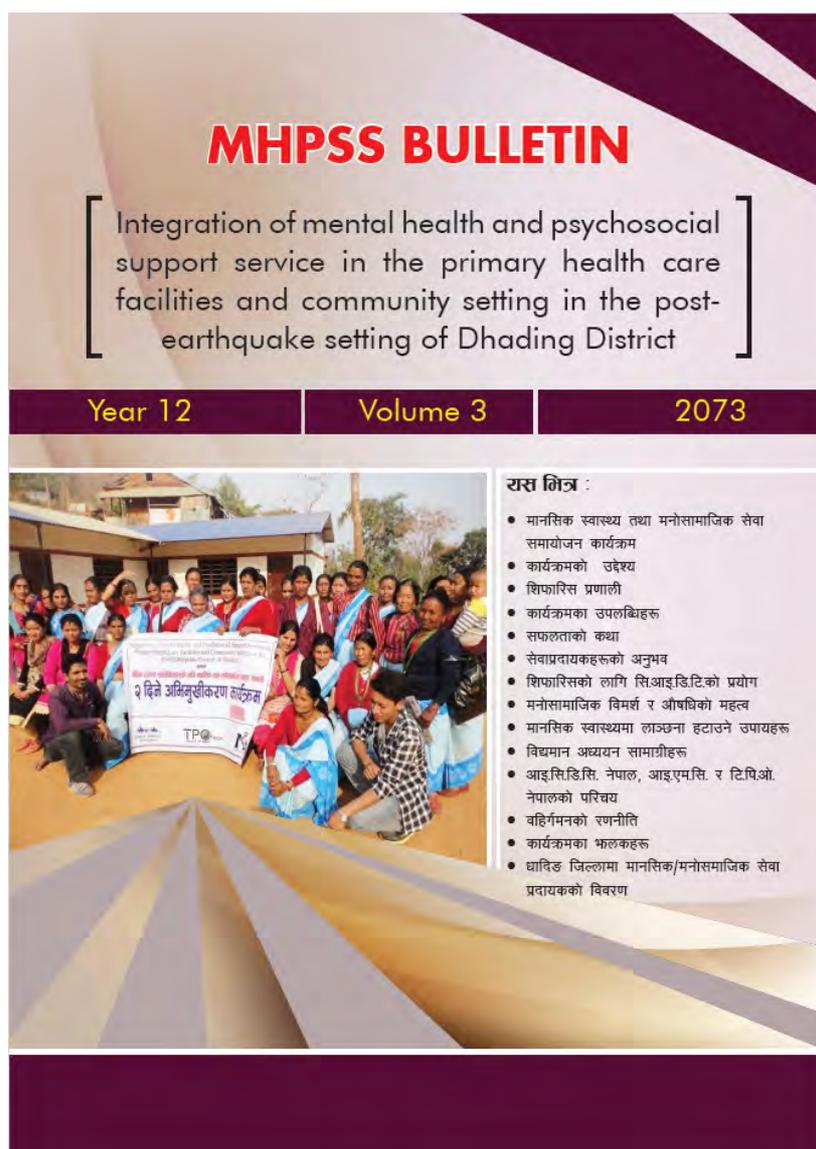


Figure 26 Example of the front page of a program bulletin developed by ICDC to raise awareness of program activities in Dhading

Table 17 shows the distribution of educational materials across the three districts.

Table 17 Distribution of educational materials in the three districts

Material	Dhading	Gorkha	Sindhuli	Total
Brochures	14592	8260	2505	25357
Flex boards	26	0	0	26
Billboards	3	6	5	14
Program Bulletin	4387	0	0	4387
Total	19008	8266	2510	29784

Support groups

Four support groups were established, two in Gorkha and two in Sindhuli. They met twice a month to participate in business skills training and to discuss any challenges encountered, their use of psychotropic medication, and vocational opportunities. Table 18 shows the composition of these groups.

Table 18 Composition of Support Groups in Gorkha and Sindhuli

	Service Users		Carers		Total
	Male	Female	Male	Female	
Gorkha Group 1	2	2	2	2	8
Gorkha Group 2	0	3	0	3	6
Sindhuli Group 1	1	3	2	2	8
Sindhuli Group 2	5	2	1	6	14
Total	8	10	5	13	36

At the time of writing, Gorkha Group 1 had initiated a candle-making cooperative, Gorkha Group 2 had initiated a goat farming cooperative, and both Sindhuli groups had initiated a furniture-making cooperative, using the seed-funding provided. TPO has secured external funding to mobilize one staff member to support these groups for an additional three months after the IMC program ends and is pursuing funding to provide longer-term support.

Impact on community attitudes

Reduction in stigma

Both health workers and service users described witnessing changes in community attitudes to mental health. Many of those interviewed commented on a reduction in the use of stigmatizing language and behavior: “People used to insult me, saying I’m diseased, but it’s not like that anymore” (Dhading, service user, focus group).

New understanding of the nature of mental illness

Both health workers and service users argued that people had gained a new understanding about the nature of mental illness, moving away from superstitious beliefs about mental illness being caused by bad omens or behavior in past lives. They reported that people who had previously believed that mental illnesses could only be treated by traditional healers, now believed that medication and counseling can lead to recovery: “They sacrificed many animals, birds with the practice of traditional healers but at last it was all improved by medicines” (FCHV, Sindhuli, focus group).

Impact on health worker attitudes

Reduction in stigma

There was evidence that the use of stigmatizing language had decreased among service providers as well as among community members, with health workers remarking that they had changed how they spoke about mental health service users: “We used to call mental health patients ‘mad’ and ‘insane’, but now we are aware that those words are insensitive and should not be used” (FCHV, Gorkha, focus group).

Several health workers described how they used to fear interacting with people with mental illness, stating that the program had changed their attitudes completely.

“Before this program, I used to feel afraid to talk with mentally ill people. But now I search for ways to help them in the community. Previously, I wouldn’t listen to these people, but after working in this project, I talk less and listen more.” (HBCW, Gorkha, interview)

“I used to think that people with mental illness were violent, and that they might hit you at any time. But I didn’t get hit by any patients” (Prescriber, Sindhuli, focus group)

Improved quality of consultations

A common theme among health workers was that, as a result of the program, they now spend substantially more time in consultations with people they suspect of having mental health problems, and that they are more thorough in their assessments.

“Our way of seeing things has changed. The field of Mental Health used to be biased due to a lack of understanding and knowledge. Before if a patient with headache came, we would just give them a paracetamol and send them away, but now we try to see if there are other reasons behind the headache.” (Prescriber, Dhading, focus group)

There was also evidence that health workers had developed a more supportive and empathetic style of communication.

“Now they have a different way of talking to patients ... When the patients used to come for medicine, they would just throw the medicines at them: they didn’t even ask how they were doing. This training made them aware of how to communicate with and deal with patients. They have started talking in a softer manner. Their way of asking questions has changed.” (Counselor, Gorkha, interview)

PHC Integration Checklist data showed a large increase in the proportion of facilities reporting that most of their health workers had received mental health communication skills training, from 3% of facilities at baseline to 88% at end-line (Figure 27).

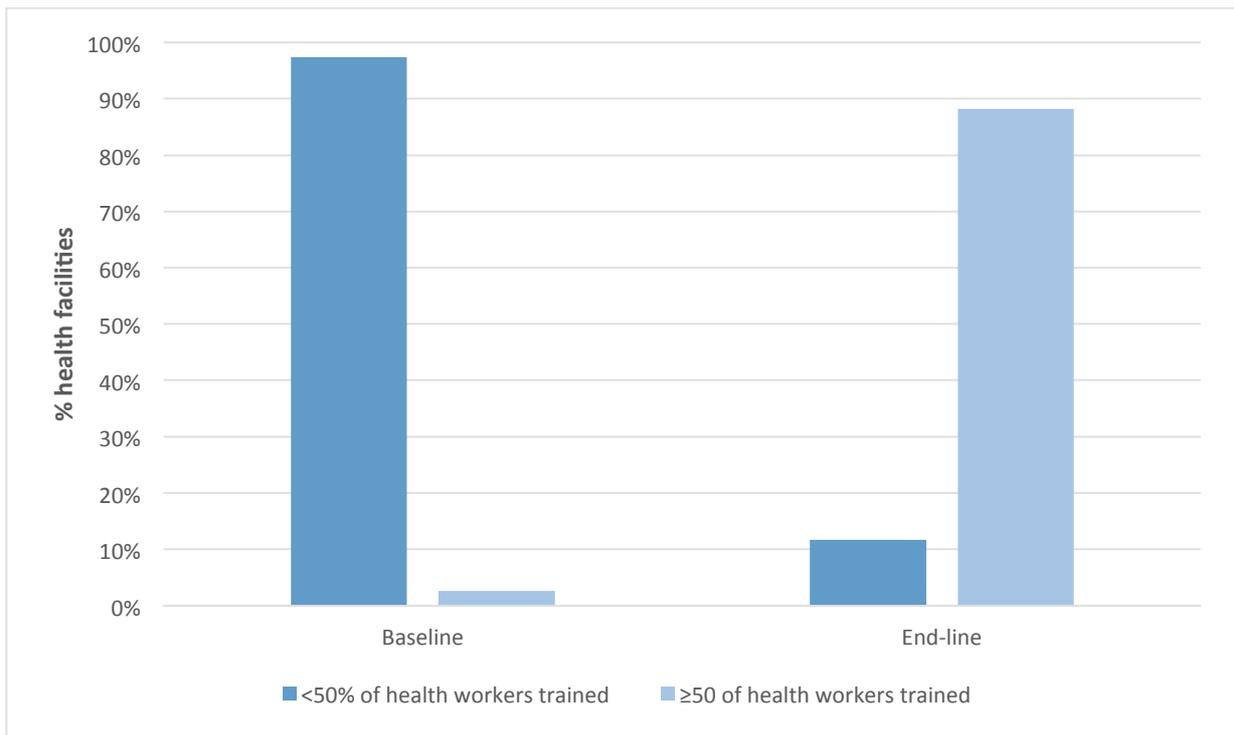


Figure 27 percentage health facilities reporting that most staff have received mental health communications skills training

New professional interest in mental health

Some participants described how the field of mental health had become a special interest for prescribers as a result of the program. Some prescribers reported that they were now considering a profession in Psychiatry: “Psychiatry used to be a neglected subject, even for us doctors, but now it is considered interesting.” (Prescriber, Sindhuli, focus group).

Access and referrals

Participating primary health facilities received 2,499 mental health referrals during the course of the program, and eight service users were referred to the specialist psychiatric hospital in Kathmandu (Table 19)

“There is a huge difference compared with before. Back then, the case detection was low, but now it is very high... Patients’ confidence has increased. They can now openly say ‘I have come to get medicine for my mental illness’ ... People don’t hesitate anymore.” (Prescriber, Dhading, focus group)

Table 19 Number of mental health service users referred to health facilities by district.

Referral type	Dhading	Gorkha	Sindhuli	Total
No. clients who accessed mental health services at primary health facilities	812	864	823	2499
No. clients referred to the specialist mental health facility	0	4	4	8

Several interviewees commented on how the availability of free medication at local facilities has provided relief for those in difficult economic circumstances, many of whom could not afford medication or to travel to purchase it in Kathmandu: [“We’ve spent a lot of money in past. This service is fully free of cost, so we’re satisfied”](#) (Service User, Sindhuli, focus group).

Challenges and suggestions for improvement

Need for continued awareness programs

- Some health workers argued that while attitudes had changed among those connected with the program (service users and family members), there remained a great **need for further educational events** in the wider community.

[“We couldn’t organize awareness-raising activities in each and every place ... I feel we need more awareness activities in our program ... In our community, there are deep superstitious beliefs. So it’s not easy for us to change their beliefs regarding mental health in this short time period.”](#) (Counselor, Sindhuli, interview)

Need for greater geographical coverage

- Many of those interviewed argued that there was a need for more extensive community awareness activities with **greater geographical coverage**: [“Stigma won’t be decreased by organizing one event in a community. For this, we need to organize a regular program related to stigma in each and every ward, not only at the VDC level”](#) (Partner Manager, Gorkha, interview).

Need for a wider range of awareness activities and participants

Other suggestions for improvement included: greater involvement of **traditional healers, mother’s groups, youth groups and school teachers**; more widespread distribution of **information leaflets**; the use of **social media** to deliver key messages; and the staging of MHPSS-themed **street plays**.

3.2 Structural impact

The following sections consider the wider impact of the program, beyond its influence on direct beneficiaries (trainees and service users), considering its impact on social issues and policy.

3.2.1 Social Impact

Several health workers described broad social consequences of the program, such as a reduction in social problems and the generation of a widespread demand for improved mental health services.

Reduction in social problems

When asked about the wider impact of the program, health workers in all three districts reported that they had observed a reduction in domestic conflict and violence and as a result of the program. For example, they described improvements in how service users were treated by their families, and improvements in how service users with substance abuse problems treated their partners.

Generation of demand for service improvement

A common theme in health worker interviews was that the program had generated a demand for quality mental health services in locations in which there had previously been a very limited understanding of mental health. They described how community members would come to participating health posts from outside of the catchment area and request that the services be initiated within their villages. They also described what they saw as a broader movement for change spurred by the success of the program.

“I think we got to see certain individuals rise up out of different regions that became champions for the agenda ... All of a sudden you saw this demand for accessible medications and services. You saw this groundswell of ‘well if it’s there, and the mandate is there, and the policy is there, but it’s never been implemented, what are you doing about that?’... You started to see it at the provider level, at the DHO [District Health Officer] level, at the coordinator level, and all these people that were not previously specialized or even involved in MHPSS services.” (IMC Manager, interview)

3.2.2 Policy Impact

Managers discussed how the earthquake drew attention to the need for major improvements in the pre-existing health system. They argued that that the obvious need for mental health services after the disaster, along with a surge in mental advocacy from both international and national NGOs, served as an impetus for the government to begin developing a more comprehensive mental health strategy.

“Many people experienced feelings like restlessness, anxiety, episodes of disturbed sleep, fear that the earthquake might occur again, as well as some depressive symptoms ... Most of the NGOs and INGOs that work in MHPSS field advocated with the government about the importance of MHPSS. Now the government has started paying significant attention ... the earthquake gave us an opportunity to make people aware that these sorts of problems are mental health problems.” (Partner Manager, interview)

Three **major changes to mental health policy** have been initiated since the earthquake, which managers attributed to a surge of interest in mental health since the disaster, and the collective advocacy of NGOs that have been working on the response:

- (i) procurement of psychotropic medications by local district authorities for the first time - previously patients had to visit specialist hospitals in Kathmandu or private facilities to acquire these medications, as they were not routinely available nationwide
- (ii) revisions to the Nepalese Free Essential Drug List to include more modern psychotropic medications (e.g. modern SSRIs and atypical antipsychotics)
- (iii) revisions to the current Standard Treatment Protocol for mental health services in primary health care to align them with international best practice.

Participants attributed these changes directly to advocacy activities undertaken as part of the program, along with the efforts of other NGOs.

“The major achievements of this project are the revision of the Standard Treatment Protocols ... [and] the addition of new generation psychotropic drugs to the essential drug list ... Because of this project, new generation psychotropic medications, which are believed to have less side effects and better patient compliance, have been added. These are some significant achievements.” (Partner Psychiatrist, interview)

3.3 Relevance

Relevance refers to the extent to which the program activities are consistent with the needs of the relevant stakeholders. This section considers the appropriateness of the program in responding to community needs, remaining unmet needs, and suggestions for improvement.

3.3.1 Increased mental health needs after earthquake

Several participants emphasized that there was a great need for MHPSS in supporting people to return to their normal daily activities after the earthquake. They argued that insomnia and depressive symptoms were common after the emergency, and that social functioning was hindered by large-scale bereavement, fear, and the disruption of regular activities such as school and work.

“There was a huge demand after the earthquakes in Nepal ... People were very afraid ... They had terrible pain in their lives. They had difficulty coping ... the aftershocks were continuously happening. They were not able to sleep...Their daily activities were discontinued. Even for children, school was stopped ... This mental health program tried to minimize the effect of the earthquake and to help those with existing mental health problems.” (IMC Manager, interview)

“Due to the earthquake, many people were in distress ... We were tense and worried. The staff from TPO came up and calmed us down, and we did the same in the village. We brought people here [to the health facility] when we couldn't help them” (FCHV, Sindhuli, Focus Group)

The high levels of service user satisfaction reported in Chapter 3 also suggest that the program responded effectively to local needs.

3.3.2 Favorable comparison to other programs

A common theme raised by health worker and government interviewees was that the MHPSS program compared favorably to other programs initiated in their districts after the earthquake.

“Other organizations used to distribute things and go. But this program listens to how people feel.” (HBCW, Gorkha, interview)

“Many emergency projects came to this district after the earthquake. MHPSS is the best project so far ... Problem identification, categorization of problem, diagnosis, proper treatment; everything was done stepwise. Speaking as a focal person of this district, I can say this program was very helpful and productive ... Our health workers are very excited about the mental health program.” (Government Mental Health Focal Person, Sindhuli, interview)

The training aspect of the program was considered particularly effective compared with other programs. Trainees described how having a comprehensive training package, in which classroom-based training was supplemented with ongoing supervision and case-conferences, set the program apart and ensured that health workers were supported in applying their learning to real-world scenarios.

“As a chief, I am getting positive feedback from people. Of all the programs, this program is very much needed ... It was best training among the trainings that were held.” (District Public Health Officer, Sindhuli, interview)

“Before this project started, two trainers from a different NGO working with mental

health had come and given us training, but it just ended there. Whereas here, the good thing is that this organization is giving close supervision every month and ongoing training to the service providers.” (Prescriber, Dhading, focus group)

3.3.3 Remaining unmet needs and suggestions for improvement

- When asked about unmet needs, health workers from all three districts argued that there was a **need for greater coverage** in terms of the number of health facilities engaged within each district, and the proportion of health workers trained within each health facility.
- While acknowledging the issue of limited financial resources, one partner manager argued that providing even very basic training to health workers in other facilities could be worthwhile in order to increase the number of referrals to those facilities running the full program.
- Another suggestion was to **run trainings on a repeated cycle**, so that new staff that had missed the original training could also engage.
- An overarching message from all interviews was that the training and service provision were relevant and appropriate, but that wider coverage would greatly increase the impact. In the words of one IMC Manager, “It was relevant, but it was not enough.”

3.4 Sustainability

Sustainability refers to the extent to which the benefits of a program are likely to continue after the funding has been withdrawn. This section outlines the aspects of service provision that were expected to continue beyond the scope of the program and stakeholder views regarding the likelihood of long-term benefits.

3.4.1 Continuation of services

Figure 28 illustrates the activities introduced by the program that were expected to continue after the program closed.

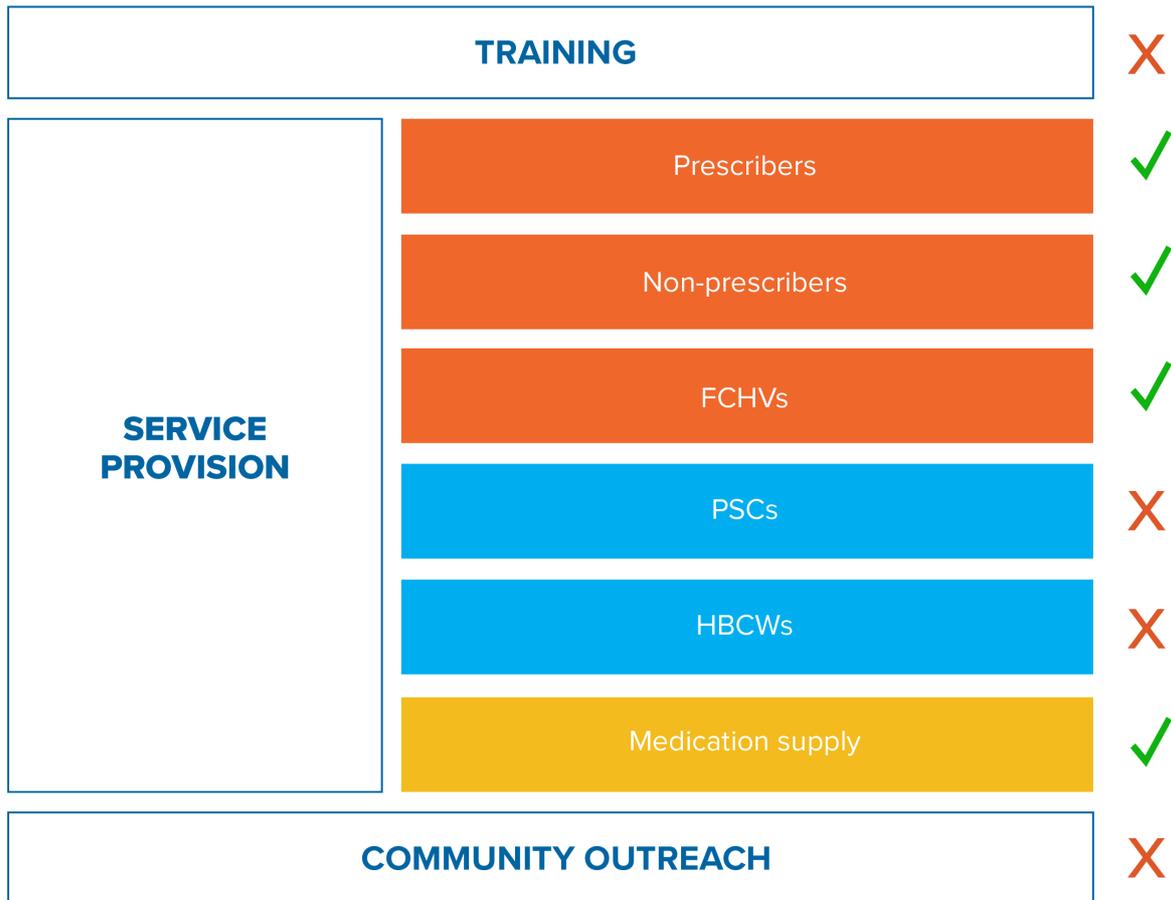


Figure 28 Services that will be sustained after program close

Government-affiliated health workers

Government-affiliated staff trained as part of the program (prescribers, non-prescribers, and FCHVs) were expected to continue in their roles after the close-out of the program, and to continue to apply what they had learned in their mental health training. However, there were mixed views among participants as to the extent to which this was likely to happen.

Many health workers expressed their intention to continue provided MHPSS services: “The knowledge will be there forever” (Prescriber, Dhading, focus group); “We will provide our service forever” (FCHV, Dhading, focus group). Others, however, were not convinced that they would be able to continue providing high-quality services without longer-term technical supervision and support: “We are trained on mental health issues, but still sometimes it is difficult to manage by ourselves” (Non-prescriber, Sindhuli, focus group).

Two managers stated that they did not think government staff would be sufficiently motivated to continue providing mental health services without ongoing supervision and support: “I don’t think it will sustain ... If we don’t provide supervision, prescribers will lose their interest in mental health.” (Partner Manager, interview).

“I’m pessimistic about it ... if it’s not going to be in their job description, and they are

not going to be followed-up with supervision, I doubt that they will do it ... I think once the medicine runs out, they will not take it upon themselves to say, 'Hey, Mr. DHO can you please get me my blah blah blah' ... I'm afraid and worried that they will not take it upon themselves." (IMC Manager, interview)

Program-supported health workers

Program-supported roles, such as PSC and HBCW, will no longer be receiving financial compensation, and most interviewees expected that their services will cease. Several HBCWs, however, stated that they would continue to provide their services informally.

"[Service Users] want this program to last longer. I reassure them, saying 'even though the program will phase out, and counselors will go, I will remain here since my home is here. You can come and talk with me, share with me, your difficulties, your problems'." (HBCW, Gorkha, interview)

Again, others were more skeptical, arguing that, without ongoing supervision and monitoring, and without the formal home-based-care, follow-up, and referral mechanisms supported by the program, many of the improvements would not sustain.

"In my view, if counselors remained in the VDC it would go smoothly, otherwise I don't think it will sustain. We are providing continuous follow-up to patients about regular medication intake and doing continuous family counseling. In my view, only the distribution of medication will continue after this program ends." (Counselor, Sindhuli, interview)

Medication supply

The need for a continuous supply of psychotropic medication was a major concern expressed by both health workers and managers, who feared that clients would relapse once program medications run out. Though the government has committed to procuring psychotropic medication in the next procurement cycle (see Section 3.2.2), the policy does not come into effect immediately. At the time of writing, IMC was in the process of procuring an eight-month supply of medication to mitigate this risk. The WHO has provisionally agreed to support the Ministry of Health in managing and distributing this medication.

Communicating program close

Program staff from IMC and partners developed key close-out messages for each service provider group, local authorities, and community members. The messages covered:

- Dates of program close in each district
- Encouraging trained government health workers to continue providing MHPSS services and to continue advocating for systems-level service improvement

- Explaining that medication supplies would continue for eight months
- Explaining that services provided PSCs and HBCWs would cease
- Explaining that supervision for prescribers would continue for a period of three months (using funding secured by TPO from other sources).
- Communicating that TPO is pursuing further funding to continue program activities.
- Highlighting other MHPSS resources available within each district (e.g. other NGOs and government services) and specialized mental health service nation-wide.

The messages were delivered during the final two months of the program at health worker supervision sessions, community outreach sessions, meetings with district authorities, national-level psychosocial and mental health sub-cluster meetings, and through radio programs and ICDC's Program Bulletin.

3.4.2 Program timeframe and planning for sustainability

Health workers and managers argued that the program was too short to be fully sustainable for a number of reasons.

Improvements in mental health take time

A related point was that, given the nature of mental health problems, it takes time to see the results of the work. Two managers highlighted that, unlike some physical ailments that can be cured with a short course of medication, it takes time for those with mental health problems to recover and longer-term support is required.

“For this kind of project, we don't need a huge budget, but we need to have time ... The program is phasing out before there's been time to see the results ... We are leaving the patients while they are still recovering ... While designing these kinds of projects we should be more sensitive to the nature of these types of health issues.”
(Partner Manager, interview)

Establishing government buy-in takes time

There was a pervasive view that more time was required to generate political will and develop the capacity of government staff to take over the program and make it fully sustainable (e.g. collaborating to develop government-operated systems for ongoing MHPSS training and reliable medication supply chains): “It is not possible to integrate a mental health program into the government system within one year.” (IMC Manager, interview)

Partner and IMC managers argued that, had the program lasted for three to five years, rather than 18 months, its impact would have been exponentially greater.

“What we did, that was fantastic, it was excellent ... [but] to integrate this component

with the government's primary healthcare facilities, it would take at least four years ... If we could have more time to work with the government then we could fully integrate with the government and it could be fully sustainable." (Partner manager, interview)

Despite the common view that more time would be required to fully integrate the program at the district level, managers acknowledged that important progress had been made at a central level, and expressed cautious optimism about the future of Nepalese mental health services, given the forthcoming changes in policy and the data generated by the program.

"I think on a policy level, things are moving. We are dependent on the energy and the fighting spirit of the national NGOs. That is going to determine whether or not things will be followed-through." (IMC Manager, interview)

"Now we have data about the number of people seeking services and the number of people sensitized ... This will help us in the sustainability of the project. Even though the IMC-funded MHPSS project is phasing out, we have a background from which we can advocate." (Partner Manager, interview)

Perception that program is "ending in the middle"

Many health workers expressed the feeling that the program was "ending in the middle" (Prescriber, Gorkha, focus group). They argued that service users taking medication were being forced to stop in the middle of their course, and counseling relationships were stopping abruptly. Several health workers mentioned that the program ending had damaged the trust between the community members and the partner organization, and put them in a difficult position in terms of their relationship with their clients.

"Clients are complaining that the conversation is stopping in middle. They feel like this should be continued." (Counselor, Dhading, interview)

"The program shouldn't have ended. It is like leaving a wound half healed." (HBCW, Sindhuli, interview)

SECTION 4

DISCUSSION AND RECCOMENDATIONS



4. Discussion and recommendations

This evaluation has used quantitative and qualitative methods to assess the effectiveness, relevance, impact and sustainability of the MHPSS program in three earthquake-affected districts of Nepal. This final chapter reviews the key findings in light of research and best-practice guidelines, and provides recommendations to inform future program design. The chapter first reviews program achievements and limitations with reference to the three program objectives of capacity building, service provision and awareness-raising. Second, it discusses how the program engaged local and national health authorities and aligned with national and international policies. Finally, it considers the legacy of the program and factors shaping the likelihood of sustained benefits.

4.1 Program achievements and limitations

4.1.1 Building MHPSS capacity

The program trained health workers and community members to provide services through a network of MHPSS support. The majority of trainees demonstrated improvements in skills and knowledge, with evaluation participants describing a newfound confidence in their ability to detect, diagnose and treat mental health problems. The findings identified several aspects of the training curricula and monitoring tools that could be improved on in future programs.

Improving training curricula

Trainees suggested that the training curricula could be improved by covering a broader range of mental health disorders beyond the six conditions prioritized by the program (which were based on MHPSS programs in Nepal prior to the earthquakes). This is consistent with best practice guidance which advocates addressing a wide range of mental health problems in emergency-affected populations.¹⁹ Anxiety disorders were among the most common presenting problems (more common than PTSD and suicidal ideation combined); yet, they were not among the six conditions prioritized in the training curricula. A representative cluster sample survey conducted four months after the second earthquake found that 34% of the population in three earthquake-affected districts (Kathmandu, Gorkha, and Sindhupalchowk) met validated cut-off scores for anxiety disorder, indicating that this is an important area of need.¹¹ The WHO estimates that the prevalence of common mental disorders, including mild-to-moderate anxiety disorders, increases by 50-100% in humanitarian emergencies.¹⁹ [Those designing future MHPSS training programs in similar contexts should therefore include a wide range a of mental health disorders where possible, and should consider including anxiety disorders as a priority.](#)

Managers and trainees argued that some professional groups were underutilized due to a lack of role clarity, professional status hierarchies, and a lack of distinct training courses for each professional group (e.g. doctors, health assistants, and nurses). Research on multidisciplinary teamwork in mental health care highlights the importance of role clarity in maximizing the effectiveness of service provision.^{42,43} Those designing future MHPSS training programs in similar contexts should therefore clearly define how each role contributes to the system of care and tailor training curricula accordingly, making the most of the skills available (e.g. medication prescription, counselling, local knowledge) to develop a coherent system of care.

Improving the use of trainee knowledge and skill measures

While the majority of the trainees assessed showed improvements in their **knowledge scores** over the course of the training, the size of these improvements was relatively small, at 13% on average. This finding is inconsistent with the qualitative data, in which trainees unanimously reported greatly enhanced knowledge and skills. This inconsistency may reflect weaknesses in the quantitative tools used; for example, if they did not correspond closely enough with the content of the training, or if they were pitched at an inappropriate level of difficulty. The fact that pre-test knowledge scores were relatively high may indicate that some questions were too easy, making it unlikely that improvements would be detected.

The majority of trainees showed improvements in **skills scores** over time.^{xvii} PSCs showed the largest improvements, which may reflect the fact that they received supervision approximately three times more frequently than prescribers and non-prescribers.^{xviii} As with the knowledge tests, the improvements detected were small, at 9% on average, and most participants were in the same performance category at initial and final assessments.^{xix} Again, the small effect-sizes may reflect weaknesses in the measures used. The ACE and ENACT-18 are subjective observational tools administered by a non-independent rater (the trainee's supervisor), which may undermine their reliability. Supervisors' expectations about their trainees' performance may change as they become familiar with the normative abilities of the cohort and as these abilities change. Differences in scores between initial and final assessments are therefore likely to reflect changes in the supervisor's expectations as well as changes in the trainee's skill. For example, having provided six months of intensive supervision involving in-depth discussion of clinical skills, a supervisor may inadvertently be more critical in their later assessments. If supervisors hold their trainees to a higher standard in their later assessments than they did in their initial assessments, this would manifest as small improvements in skills scores.

^{xvii} 100% for ACE tests, and 75% for ENACT-18 tests.

^{xviii} At 19 contacts per trainee for PSCs, versus seven for prescribers and five for non-prescribers.

^{xix} The mean ENACT-18 score was in the highest category of 'done well' at both initial and final assessments, while the mean ACE score was in the lowest category of 'below the expected standard' at both initial and final assessments.

Published evaluations of several versions of the ACE tool have highlighted problems with reliability and ‘acquaintance effects,’ where ratings vary with how well-known the trainee is to the rater.⁴⁴⁻⁴⁷ Wilkinson and colleagues demonstrated that, for ACE scores to be statistically reliable, the trainee “should be observed by at least eight different assessors observing at least two encounters each” (p.368), something that is unlikely to be practical in resource-limited emergency settings. [These findings highlight the need for a comprehensive review of the available measures of mental health practitioner competency, to establish which are likely to yield the most valid and reliable data in emergency and post-emergency contexts.](#)

It is likely that larger improvements in skill would have been detected had baseline skills assessments been administered prior to training rather than at initial supervision. This would capture improvements that occur as a result of knowledge gained during training, as well as those gained over the course of supervision. [In future programs, baseline skills assessment tools should be administered prior to training where possible, rather than at the initial supervision session.](#)

Where there is little difference between pre- and post-training scores, it suggests that either the tool or the training curriculum should be amended. [On the basis of the methodological issues highlighted above, it is recommended that knowledge tests are piloted prior to their use, and that results are monitored on an ongoing basis to facilitate improvements.](#)

4.1.2 Providing MHPSS services

The program developed a layered system of support services, involving both laypeople and health professionals, to create a coordinated care system and referral network. Service users, carers, and health workers shared many stories about how the program had led to recovery, improved wellbeing, and a new sense of hope that mental illnesses are treatable. This was supported by the quantitative data, which showed large improvements in daily functioning and social interaction among those with severe impairments. A comparison of service use across the three program districts revealed variations in diagnostic patterns and service user satisfaction, which warrant closer monitoring and investigation.

Integrated and comprehensive network of support as a key strength

The development of an integrated network of supports, involving both health workers and laypeople, was a key strength of the program, and was consistent with international best practice guidance on developing effective mental health services. For example, in accordance with the WHO Service Organization Pyramid (Figure 2), program activities:

- focused predominantly on community-based care, informal community care and self-care (the base layers of the pyramid) through awareness-raising events and educational activities such as family counseling
- strengthened primary care services and general hospital services (mid-sections of the pyramid) by providing MHPSS training to health staff at health posts, PHCCs, and district hospitals, and by supplying psychotropic medications
- developed community mental health services (a mid-section of the pyramid) by training FCHVs, HBCWs and PSCs.

Health workers considered the provision of home-based follow-up care as part of this network of services to be an effective way of maintaining contact with service users and monitoring medication use. This is consistent with a substantial body of evidence suggesting that home-based treatment can reduce the need for crisis hospital admissions, reduce costs, and improve service user satisfaction.⁴⁸ [It is recommended that future programs build on this model of care, engaging diverse actors offering different levels of specialization to develop a layered system of services, including home-based follow-up care.](#)

Geographical variation in diagnostic patterns

The proportion of depression diagnoses was particularly high in Gorkha, at 33% of all diagnoses in the district (compared with 19% in Dhading and 15% in Sindhuli). A possible explanation for this is that Gorkha was the “hardest-hit” of the three regions in terms of damages and losses to infrastructure after the earthquakes,^{xx} and the second most severely affected district in the country after Sindhupalchowk.⁴⁹ A similar pattern was reported by Kane and colleagues in a survey conducted in Sindhupalchowk, Gorkha, and Kathmandu in September 2015, which found higher rates of depression in more severely affected districts.¹¹

The proportion of epilepsy and anxiety disorder diagnoses was higher in Sindhuli than in the other districts, while rates of AUD diagnoses were lower.^{xxi} The reasons for these differences are not clear. They may reflect differences in the cultural and sociodemographic profile of service users in the different districts. Kane and colleagues¹¹ found substantially higher rates of alcohol disorder among those identifying as belonging to the more marginalized Janajati and Dalit ethnic groups (known as ‘lower’ castes) compared with those identifying as Brahmin or Chhetri (groups in which alcohol consumption has traditionally been considered forbidden).³² [Collecting systematic socioeconomic data on service users would aid in the interpretation of these variations.](#)

^{xx} Gorkha accounts for an estimated 6.7% of earthquake-related financial losses, while Dhading and Sindhuli account for 5.7% and 3% respectively.

^{xxi} Epilepsy accounted for 39% of diagnoses in Sindhuli, compared with 21% in Dhading and 20% in Gorkha. Anxiety disorders accounted for 11% in Sindhuli, compared with 0.21% in Dhading and 3% in Gorkha. AUD accounted for 2% of diagnoses in Sindhuli, compared with 20% in Dhading and 14% in Gorkha.

There appeared to be an inverse relationship between AUD and anxiety disorders (Figure 15). Dhading had the highest rates of AUD (20%) and the lowest rates of anxiety (<1%), while Sindhuli had the highest rates of anxiety (11%) and the lowest rates of AUD (2%). One possible explanation for this pattern, suggested by a partner program manager, is that Dhading residents use alcohol as a form of self-medication for anxiety, resulting in high rates of AUD which mask underlying anxiety disorders. The self-medication theory has gained substantial support in the scientific literature.⁵⁰ As discussed above, it is not clear why this might occur in some geographic regions and not others, but it may reflect underlying demographic differences.

The geographical trends observed could also indicate over-diagnosis of certain disorders by trainees in particular locations, which would indicate an important need for further training. The risk of inaccurate diagnoses has been highlighted as a potential threat to quality in evaluations of similar programs in Nepal.³⁸ [It would be valuable to monitor geographical variations in diagnostic patterns on an ongoing basis so that, where discrepancies arise, supervisors can engage with health staff to assess whether these patterns truly reflect different service user needs or whether they are a result of inaccurate diagnoses, indicating a need for further training on the correct identification of different disorders.](#)

Geographical variation in service user satisfaction

Overall, 67% of service users reported being “completely satisfied” with the services they had received, 31% reported being “somewhat satisfied”, and 2% reported being “unsatisfied”. The highest levels of satisfaction were in Sindhuli, with 78% reporting that they were “completely satisfied,” compared with 61% in Gorkha and Dhading. One possible explanation for these differences, suggested by a program manager, was that medication supply from the district pharmacy store to health facilities was more consistent in Sindhuli than in Dhading and Gorkha. Closer collaboration with local health authorities to improve supply chain management and the consistency of services in the other districts may therefore have resulted in higher levels of satisfaction (discussed further below).

4.1.3 Awareness-raising initiatives and anti-stigma campaigns

A range of community outreach activities was conducted to raise awareness about mental health and the services available (e.g. awareness events, educational brochures, radio programs and billboards). Evaluation respondents reported that the program had led to a reduction in stigma among both health workers and community members, and that many people had gained a new understanding that mental illness is treatable. Some health workers, however, argued that these changes had mainly occurred among people affiliated with the

program (health workers, service users and carers) rather than in the general population, and provided suggestions for raising greater awareness in the wider community.

Improving community outreach activities

Evaluation participants argued that repeated educational events in a greater number of geographical areas would be required to influence the wider community beyond direct program stakeholders. They suggested that greater awareness could have been raised by employing a more diverse range of outreach strategies such as using social media and staging themed street plays. This recommendation is consistent with WHO guidance on mental health advocacy, which highlights how “education through entertainment” can be a successful means of improving attitudes about mental health and illness.⁵¹ WHO guidance also recommends developing partnerships with service users, advocates and other stakeholder groups (e.g. community groups, religious groups) who may be able to assist with awareness campaigns.^{51,52}

The impact of community outreach activities could potentially be improved by employing a diverse range of outreach strategies (e.g. street plays and social media campaigns), and developing advocacy partnerships with service users, community groups, and special interest groups.

WHO guidance recommends implementing local pilot projects (e.g. in schools, workplaces, or neighborhoods) with clear measurable indicators to build an evidence-base on the effectiveness of various awareness-raising efforts in a given context.^{51,53} It was not possible to tell which of the different outreach activities implemented by this program (e.g. radio programs, awareness sessions, brochures) were the most effective in generating referrals, because data on the source of referrals was not consistently documented.

Future programs would benefit from collecting systematic data on how each service user heard about the program, to assess the relative effectiveness of each of the community outreach activities and ensure that resources are dedicated accordingly.

Improving community acceptance

Some community members were skeptical of the program, worrying that there were hidden financial agendas behind the services offered (e.g. that local program staff were exploiting community members for financial gain, or that international organizations were exploiting community members for pharmaceutical experiments). Some interviewees suggested that greater involvement of community leaders and traditional healers in all program VDCs would have increased community acceptance and uptake of services. This is consistent with IASC guidance on MHPSS in emergency contexts which advocates that programs engage existing social structures and human resources to mobilize and educate community members.¹⁶ This is particularly relevant in the context of Nepal, where traditional healers are typically the first

service sought by those seeking help with mental health problems.³² **Traditional healers and community leaders should be engaged wherever possible to increase community acceptance and uptake of services.**

4.2 Collaborating with local and national health authorities

The program was instrumental in supporting key improvements to mental health policy at a national level, with program staff actively contributing to strategy development and advocating for improved treatment protocols and medication access. The findings suggest that, at the district-level, program effectiveness could potentially have been improved by closer collaboration with health service managers and local authorities.

4.2.1 Engaging health service managers and support staff

There was evidence that greater involvement of the government health service managers and support staff based in the participating facilities could have increased program effectiveness in a number of ways, for example, by improving medication supply management and information systems. International best practice guidance emphasizes the importance of building the capacity of health facility managers and support staff, as well as health practitioners, to develop organizational leadership and strengthen the health system as a whole.^{19,21}

Improving medication supply management

Prior to the program, supplies of psychotropic medication at participating health facilities were very limited. Of the facilities surveyed at baseline, only 15% reported that antidepressant and antianxiety medications were usually available, 8% reported that antiepileptic medication was usually available, and 4% reported that antipsychotic medication was usually available. The program supplied six psychotropic medications to the local health authorities of the three participating districts (one antipsychotic, one antidepressant, two antiepileptic medications, and two benzodiazepines), on the agreement that these local authorities would distribute the medications to the participating facilities as needed.

In line with best practice guidance on planning for sustainability, the range of medications procured was restricted to those listed on the Government of Nepal Free Essential Drug List⁵⁴ on the basis that service users would be able to continue to access their prescribed medications after the program ended.¹⁹ The medications included five of the 23 medications recommended on the WHO Model List of Essential Medicines for psychotic disorders, depressive disorders and epilepsy⁵⁵ (see Appendix). IMC, TPO, ICDC and others were successful in lobbying the government to add a wider range of the modern medications recommended by the WHO to the Government of Nepal Free Essential Drug List for the 2016

edition (e.g. risperidone, fluoxetine, and sodium valproate).

By the end of the program, medication availability had improved substantially, with 100% of facilities surveyed at end-line reporting that antidepressant and antipsychotic medications were usually available. However, many facilities still experienced shortages of antiepileptic, antianxiety, and antiparkinsonian medications. Evaluation respondents reported that inconsistent medication availability was a major source of frustration during the program. This was attributed partly to delays in IMC procurement procedures (e.g. difficulty sourcing medications), and partly to a failure of local authorities to distribute the medications from the district pharmacy store to the health facilities as needed. [Future programs would benefit from collaborating closely with district health authorities in the early stages of the project to train pharmacy staff in supply-chain management and to develop a robust system to monitor medication use.](#)

Improving documentation

According to the baseline survey, none of the participating facilities documented mental disorders in clinical charts prior to the program. Two main documentation procedures were introduced by the program: a mental health outpatient register in each participating health facility (in which service users' demographic details and presenting problems, and treatment plans were documented); and an outpatient docket retained by patients (on which details of each clinical encounter were documented). Some evaluation respondents considered the systematic documentation of mental health information to be a key achievement of the program. However, the extent to which this information was incorporated into government health information systems is unclear. The degree to which the documentation methods will be sustained after program close, and how the information will be used by district health authorities, remain to be seen. [Closer engagement with service managers to develop sustainable integrated mental health information systems and placing a greater emphasis on clinical documentation during training may therefore improve program effectiveness and the long-term impact of the program.](#)

4.2.2 Balancing hiring new staff and engaging government staff

The program engaged both existing government health workers (prescribers, non-prescribers, and FCHVs) and new health staff (PSCs and HBCWs) hired by the partner NGOs. Some health workers argued that certain government roles were under-utilized, suggesting, for example, that providing more in-depth training to government-affiliated FCHVs and non-prescribers would have been more effective than hiring short-term HBCWs to work alongside the government system. This suggestion is consistent with international best practice guidance which promotes the engagement of existing health service staff rather than the

hiring of additional staff, for the purposes of integration and sustainability.²¹ However, these arguments must be balanced against a number of practical considerations.

First, unlike HBCWs, FCHVs and non-prescribers have a wide variety of duties and commitments other than MHPSS programs and cannot focus on mental health full-time. **When engaging government staff, program planners must consider the burden imposed by additional training and duties.**²¹ Second, FCHVs generally did not have the levels of literacy required to undertake the training and reporting completed by HBCWs.

Although the services provided by HBCWs and PSCs were not sustainable after program close, most evaluation respondents nonetheless considered their work a valuable supplement to government capacity-building during the early stages of systems strengthening, while referral mechanisms and community awareness were still being developed. This model of engaging existing health workers, while also training an additional cadre of psychosocial workers to provide community-based care, was based on the work of TPO in other districts of Nepal as part of the PRIME project (see Section 1.4.4).⁵⁶ A recent assessment of that project found that such workers can “safeguard and bolster” (p.27) psychosocial care within the overall system.³⁸ However this approach requires significant resources and its cost effectiveness, in terms of adding value to the overall system of care, has yet to be empirically investigated.

4.2.3 Engaging local government

While the program was successful in engaging policy makers in systems-strengthening at a national level (e.g. revising national treatment protocols), several program managers argued that, in retrospect, program planning and implementation would have benefited from more regular coordination meetings between IMC, TPO/ICDC field staff and local health authorities at the district level.

Throughout the program, IMC and partner staff based in Kathmandu had regular central-level meetings, while district level-meetings between IMC staff, partner field staff and local health authorities were organized in response to particular issues on an ad hoc basis. Managers argued that having regularly scheduled (e.g. monthly) district-level meetings would have given them greater insight into the challenges arising in the field and allowed them to better manage program implementation (e.g. helping them to better coordinate supervision sessions for government staff to minimize disruption to their regular duties, to minimize the risk of miscommunication between the different organizations, to collaboratively improve medication supply systems, and to collaboratively plan the exit strategy and government take-over of services from the outset, rather than in the final few months of the program. Evidence suggests that close collaboration with local government can increase the likelihood that emergency programs will have a long-term impact and reduce the risk that external

interventions will undermine existing services (e.g. by overburdening health workers).¹⁹

The findings suggest that programs would benefit from regular (rather than ad hoc) field-level meetings between IMC staff, field staff, and government representatives in program districts to optimize coordination between the relevant organizations.

4.2.4 Engaging national government and supporting national and global priorities

The program was highly relevant to the Government of Nepal's Post-Disaster Recovery Framework, which lists addressing the psychosocial and mental health needs of the earthquake-affected population as a key priority.¹ The framework emphasizes how the psychological distress caused by the earthquake is likely to have a widespread negative effect on economic productivity and educational attainment, and highlights the increased demand for psychological services in the immediate aftermath of disaster. In strengthening human resources for mental health and improving referral mechanisms, the program supported these government priorities.

The program was also consistent with the 1996 National Mental Health Policy of Nepal, which promotes the integration of mental health services into the general health system and the training of all government health workers in mental health.²⁹

Through advocacy and participation in national strategy meetings with the Government of Nepal Primary Health Care Revitalization Division, program staff from IMC, TPO and ICDC contributed to three major changes in mental health policy: updates to the national Standard Treatment Protocol for primary care mental health services, revisions to the Nepal Free Essential Drug List to align them more closely with WHO guidance, and government authorization for district authorities to directly procure psychotropic medications in the coming year (so that service users no longer have to travel to Kathmandu for their medication). An IASC desk review of MHPSS activities in Nepal following the earthquakes highlighted the importance of NGOs in contributing to policy development in Nepal.³²

By engaging with policy development in this way, the program implemented several of the WHO's recommended practices for 'building back better' following emergencies (see Section 1.3.2:

- using advocacy to generate momentum for change
- revising national policies and plans
- respecting the government's central role in mental health system development.

The program was also consistent with the priorities of multilateral development agencies such as the WHO and the World Bank which, recognizing the growing burden of mental illness,

increasingly promote MHPSS as an integral part of emergency response and human development.^{25,57} The training curricula for government health workers and PFA practitioners were based on internationally-recognized evidence-based guidance manuals developed by the WHO and adapted for the local context based on the experiences of TPO while implementing similar programs in other districts of Nepal.^{7,18}

The findings demonstrate the value of actively engaging with central government authorities to strengthen mental health systems on a national scale, drawing on both local experience and international best practice guidance to improve mental health policy and support systems.

4.3 Planning for sustainability

The extent to which government-affiliated health staff will continue to offer mental health support without the aid of partner-funded supervision and community follow-up mechanisms is unclear. A recent review of the overall MHPSS response to the Nepal earthquakes raised similar concerns, questioning the sustainability of MHPSS programs initiated by international NGOs, given the lack of government funding and the low capacity of district authorities to maintain interventions.⁵⁸ Some evaluation respondents expressed concerns that government staff may not focus on MHPSS without ongoing technical supervision and support. Others argued that more time was needed to adequately train government health staff to be self-sufficient in providing high quality care, establishing supervision and quality assurance mechanisms, managing mental health information systems, and managing medication supply-chains.

Future programs may benefit from dedicating more time during training and supervision sessions early in the program to establishing clear expectations among government health practitioners about the continuation of MHPSS services after program close and collaboratively developing strategies to enhance sustainability.

Planning for sustainability in initial program design is a common theme in international best practice guidance on transitioning from emergency response to systems development.^{16,19,21} Expert consensus indicates that emergency interventions generally require between one and two years of funding to serve beneficiaries through their recovery time, to train staff on the cycle of mental illness, and to tailor programs to community needs.²¹ However, evidence suggests that longer-term support is crucial to developing sustainable integrated mental health services.²¹ The amount of time required will depend on a range of contextual factors, including the functioning of pre-existing primary care services, geographical accessibility, human resources and financial support.^{21,23} WHO guidance emphasizes that integration is a process - not an event - highlighting a best practice example from Australia which took five years to become functional.^{23,58} The mental health integration programs implemented by TPO

in other districts of Nepal (the PRIME and Mental Health Beyond Facilities projects), on which this program was based, were funded for four and six years respectively (evaluations of their sustainability have not yet been published).^{40,59}

Expert guidance recommends that program managers innovate mechanisms to invest funds for long-term use, for example, by collaborating with the government to seek out opportunities for public-private partnerships.^{6,21} This may be particularly relevant in a context such as Nepal, where public spending on mental health has traditionally been very low (less than 3% of the national budget is spent on health, and less than 1% of this is allocated to mental health).³²

Several factors offer cause for optimism regarding sustained program benefits. Large numbers of people were reached through community outreach activities which provided accurate information on mental health and challenged stigma and misconceptions. There was evidence that the program increased the demand for quality mental health services among both community members and government staff, and developed a momentum for change. With input from IMC, TPO, ICDC, and other NGOs, substantial progress has been made in revising national policies on standard treatment protocols for mental health care and the supply of modern psychotropic medications. These changes may signify an increase in political will and public interest in mental health which, with continued advocacy from local NGOs, can be channeled for longer-term mental health systems strengthening.

APPENDICIES



Appendix 1. Details of quantitative outcome tools

	Measuring Tools <i>(Developer)</i>	Description	Respondents	First assessment (T1)	Last assessment (T2)
Trainee outcome tools	Pre- and post-training knowledge tests (<i>TPO</i>)	Multiple choice knowledge tests corresponding to each training package.	- Prescribers - Non-prescribers - PSCs - HBCWs	First day of training	Last day of training
	Perceived Competency Checklist (<i>IMC</i>)	Questionnaire measuring self-reported perceived competency on two subscales: general skills (e.g. knowledge of the effects of stress on mental health, ability to communicate appropriately with service users) and clinical skills (e.g. e.g. ability to conduct appropriate assessments, diagnoses, interventions and referrals).	- Prescribers - Non-prescribers - PSCs	First day of training	Last day of refresher training
	Assessed Clinical Encounter Checklist (<i>ACE; IMC</i>)	Checklist completed by supervisor while observing trainee role-playing a clinical consultation. Evaluates clinical assessment, care planning and record-keeping.	- Prescribers - Non-prescribers - PSCs	Within first 3 months post-training	During refresher training/ final supervision
	ENhancing Assessment of Common Therapeutic Factors (<i>ENACT-18; Kohrt et al., 2015</i>)*	Form completed by supervisor while observing trainee role-playing a consultation. Evaluates verbal and non-verbal communication, client-centered discussion, and promotion of realistic hope.	- Prescribers - Non-prescribers - PSCs - HBCWs	Last day of training	Last day of refresher training

Trainee outcome tools	WHO Disability Assessment Schedule II (WHODAS II; WHO) **	Standardized tool developed to measure level of disability. It covers six domains of daily functioning: cognition, mobility, self-care, "getting along", life activities and participation.	- Service users receiving care from prescribers	Three months after initial medication prescription	Nine months after initial medication prescription
	Service-User Satisfaction Measure (TPO)	Satisfaction was assessed by asking service users under the care of prescribers whether they were "completely satisfied", "somewhat satisfied" or "not satisfied" with the services they had received.	- Service users receiving care from prescribers	Nine months after initial medication prescription	NA
Facility-level MHPSS	IMC MH PHC Integration checklist IMC [†]	Measures the extent to which mental health services have been integrated into a health facility on 15 subscales assessing factors such as psychotropic medication availability, staff MHPSS training, and MHPSS service provision.	Key informants at health facilities	Prior to program implementation at each facility.	During final two months of program (sample of 20% of facilities)

* See the following publication for the latest version of this tool: Kohrt et al. Therapist competence in Global Mental Health: Development of the ENhancing Assessment of Common Therapeutic factors rating scale. Behaviour Research and Therapy, 2015; 69, 11-21.

** The most recent version of this tool is available here: http://www.who.int/classifications/icf/more_whodas/en/

† Adapted from WHO/UNHCR. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: World Health Organization; 2012.

Appendix 2. Sample interview topic guide



Nepal MHPSS Final Evaluation

Mental Health Integration into Primary Health Care

Interview Topic Guide for Health Workers

Name of interviewer			
Participant role			
Gender of participant	Male	Female	Other
Region	Gorkha	Sindhuli	Dhading
Location			
Date			

Welcome & Introduction

- Thank you very much for agreeing to meet today.
- My name is _____ and I work with IMC in partnership with TPO and ICDC. We have been working in Nepal to support the integration of mental health care into primary health care in this district.
- Currently, we are talking to people who have been involved in our programs. Our aim is to learn about 1) both positive and negative experiences you have had in the project, and suggestions to improve our programming in the future.

- We would like your help in understanding what worked well and what did not work well in this program. We cannot promise to give you anything in exchange for participating, but by taking part you are helping us to improve services for the future.
- The questions we will ask do not have 'correct or 'incorrect' answers. Because you have first-hand experience of the program, you are the expert and we would greatly value your ideas.
- You are free to take part or not. If you choose to take part, we want you to feel comfortable speaking openly. We will not use your name or the name of your health-facility/area when we write the findings. Recordings will not be shared with anyone outside the evaluation team.
- The interview will take between 30 minutes and 1 hour.
- Do you have any questions?

Interview Topics

Warm-up

1. This interview is about your experience of the Mental Health Program. In general, how have you found being involved in this program?
2. What do you think has worked well about the program?
3. Can you tell me about some things that did not work so well?
 - a. How could this have been done differently?
 - b. Is there anything you would change about the program?
 - c. How could the program be improved?

Training

The first objective of this program was to increase health worker's ability to provide services for people experiencing mental health problems. Thinking specifically about the training aspect of the program...

4. What worked well in the training part of the program?
5. To what extent was the training relevant to your work?
6. How could the training have been improved?
 - a. How appropriate were the training topics?
 - b. How did you find the standard of the training (e.g. too difficult? too easy? Just right?)
7. Are there any topics you feel should have received more attention during training?

- a. E.g. certain mental health problems, case management, referral methods, communication skills, confidentiality

8. What kind of challenges did you face when putting your training into practice?

I'd like to know what you all think about the supervision aspect of the training.

9. What do you think worked well about the supervision?

- a. What did your supervisor do that you found helpful?

10. What did not work well about the supervision?

- a. Were there parts of the supervision that you did not like?
- b. How appropriate was the frequency of supervision?

Service Provision

The second objective of the program was to support the provision of community-based mental health services. Thinking specifically about the mental health services provided under the program...

11. How has the care provided to people with mental health problems changed as a result of the program?

- a. What do you think has worked well about the program?
- b. What did not work so well?
- c. How could the services be improved?

12. What impact has this had on patients/service users?

I'd like to know what you think about how the different parts of the service worked together, for example, prescribers and non-prescribers, facility-based health workers and community based health workers (FCHVs, CPSWs/HBCWs, Psychosocial counsellors).

13. What do you think about how the different parts of the service worked together?

- a. Were there any challenges?
- b. Can you think of some suggestions for how coordination could have been improved?

Mental Health Awareness Campaigns

The third objective of the program was to improve access to MHPSS services through the creation of awareness-raising initiatives and anti-stigma campaigns. Thinking specifically about this aspect of the program...

14. How has the program affected attitudes to mental health among community members, if at all?

- a. Can you give some examples?
15. How has the program affected health workers' attitudes towards mental health, if at all?
- a. Can you give some examples?

Relevance & Quality

16. In your opinion, what are the most important factors in providing high-quality mental health services?
- a. e.g. staff training, availability of medications, community attitudes, free services, physical facilities
17. To what extent do you think the program meets the needs of people with mental health problems?
18. Are there people whose needs are not met by this program?
- a. If so, what are the barriers?
 - b. E.g. are there certain groups who do not know about/ cannot access the service?
 - c. Are there certain groups of people who could not reach the service?
19. How has the way you provide mental health care changed over the course of the program?
- a. Did you learn things as the program continued that meant you needed to change your approach?
 - b. Can you tell me about any unexpected issues or challenges that you needed to adapt to?

Impact

20. What changes have you noticed as a result of the program?
- a. What difference has the program made to people with mental health problems?
 - b. Has the program had any impact on their daily lives?
 - c. Can they do any things now that they could not do before? E.g. daily functioning, social life, economic activities)
 - d. What difference has the program made to health workers?
21. Can you tell me about any **negative consequences** (results) of the program?
- a. How could these have been avoided?

Sustainability

22. In your opinion, how likely is it that the benefits of the program will continue after the program is finished?

- a. e.g. Are there some benefits that will continue and some that will not?

Close

23. Finally, is there anything else you would like to add?

- a. Is there anything else about the program that you think is important to discuss?

Thank you very much for your time. It has been very helpful to hear your thoughts and ideas.

[End of interview]

Appendix 3. Sample focus group topic guide



Nepal MHPSS Final Evaluation

Mental Health Integration into Primary Health Care

Topic Guide for Service User/Carer Focus Groups

FACILITATOR GUIDE

Name of facilitator			
Name of transcriber			
Health Facility Name			
Region (circle)	Gorkha	Sindhuli	Dhading
Date			

Welcome

- Thank you very much for coming to participate in this focus group today
- **Introduce both facilitator and transcriber e.g.**
 - Facilitator: My name is _____ and I work with _____. I will be leading today's discussion.
 - Transcriber: My name is _____ and I work with _____. I will be helping with the discussion today and taking notes.
- International Medical Corps and ICDC/TPO Nepal have been working together to support the development of mental health and psychosocial support services in this district.
- We have organized these discussion groups because we would like to hear about your experiences of the care you have received as part of this program. We are

particularly interested in hearing your thoughts about what has worked well and your ideas about what could be done to improve the service. The questions we will ask do not have 'correct' or 'incorrect' answers.

- We cannot promise to give you anything in exchange for participating, but by taking part you are helping us to improve services for the future.
- You are free to take part or not. If you choose to take part, we want you to feel comfortable speaking openly. We will not use your names or the names of your health workers when we write the findings, and your responses will not be shared with your health worker.
- Recordings will not be shared with anyone outside the evaluation team.
- We would like to reassure you that you do not have to answer any question that makes you uncomfortable, or share any information that you would prefer to keep private. We do not need detailed information on your personal or private problems, rather we would like to hear about your experience of services.
- We also ask you to respect each other's confidentiality and privacy.
- The discussion will take around 1 hour.
- Do you have any questions?

Introductions

- Let's do some introductions to start. [Introduce yourself again and invite each participant to state their name and role]

Interview Topics

Warm-up

This discussion is about your experience of Mental Health and Psychosocial counselling services.

1. First of all, how did you hear about these services?
2. Why did you think this service might be able to help?

Service Provision

3. Can you tell me a little about the services provided to you by your health worker?
 - a. Are there any ways in which the service has helped you?

4. What did you like most about your experience with the services here?
5. What did you not like about the services?
 - a. How could this have been done differently?
 - b. How could the program be improved?

Impact

6. Has your life changed in any way because of the services you have received to help with your mental health/psychosocial problem?
 - a. What changes have you noticed?
 - b. Have you been able to return to any activities that you could not do before? (e.g. work, school, social life?)
7. Can you tell me about any advice or coping skills that you learned from your health worker that has helped you in your daily life?
 - a. Can you give some examples?
8. Has your involvement with these services had any effect on your relationships with friends or family?
 - a. E.g. has it changed how they see your problems?
 - b. Any positive effects?
 - c. Any negative effects?
9. Has your involvement with services had any negative impacts on your life?
 - a. Can you give some examples?

Access

10. Have you faced any challenges in getting help for your condition?
 - a. E.g. accessibility/ transport, cultural acceptability, financial constraints
11. Are there people whose needs are not met by this program?
 - a. If so, what are the barriers?
 - b. E.g. are there certain groups who do not know about the service?
 - c. Are there certain groups of people who could not reach the service?

Relevance & Quality

We would like to learn what you think about the quality of the care you have received.

12. To what extent do you think your health workers understood your concerns?
13. Can you tell us some things you liked about the way the health provider interacted with you?
14. Can you tell us some things you did not like about the way your health worker interacted with you?
15. What do you think about how often you saw your health workers?
 - a. Would you have preferred to see them more often, less often, or was it about right?
16. What could be done to improve the services you receive?
 - a. Are there additional services that you would find helpful?
 - b. Do you have care needs that are not being met?

Mental Health Awareness

In this final section, we would like to talk about community attitudes towards mental health and mental health problems.

17. How do you think the program has affected attitudes to mental health among community members, if at all?
 - a. Can you give some examples?
18. How do you think the program has affected health workers' attitudes towards mental health, if at all?
 - a. Can you give some examples?
19. What do you think are the most effective ways to change negative attitudes towards mental illness in this community?

Close

We have covered all of the topics we had planned to discuss. Thank you all very much for your time.

20. Is there anything else anyone would like to add?
 - a. Is there anything else about the program that you think is important to discuss?

Thank you again. It has been very helpful to hear your thoughts and ideas.

[End of Focus Group]

Focus Group Topic Guide for Health Workers

TRANSCRIBER GUIDE

Name of transcriber						
Name of facilitator						
Health Facility Name						
Region (circle)	Gorkha		Sindhuli		Dhading	
Participants	No. of Males		No. of Females		Total	
Date						

No.	Unique Initials Please add A or B if participants have common initials	Role e.g. Service user/ Carer	Sex M/F/Other
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Appendix 4. Qualitative thematic framework

Global theme	Organizing theme	Sub-themes (where applicable)
Effectiveness: Objective 1. Training	Impact of training	<ul style="list-style-type: none"> Enhanced knowledge and skills New confidence in detection, diagnosis and treatment Limited or no prior understanding
	Impact of supervision and refresher trainings	<ul style="list-style-type: none"> Supervision as a key strength of the program Revision and reminders Putting training into practice Continued learning Seeking expert guidance and sharing ideas
	Training feedback and suggestions for improvement	<ul style="list-style-type: none"> Simplifying concepts Use of evidence-based guidelines Need for better coordination of supervision sessions Need for more regular supervision and refresher training Need to cover more disorders and topics Need to dedicate more time to counselling Need to separate professional groups
Effectiveness: Objective 2. Service Provision	Impact on service users	<ul style="list-style-type: none"> Hope & understanding that mental illness is treatable Recovery and symptom reduction Daily functioning and social interaction Family support Livelihood Finances

	<p>Impact on Health Workers</p> <p>Good practices</p> <p>Remaining challenges</p> <p>Suggestions for improvement</p>	<ul style="list-style-type: none"> • Job satisfaction, sense of achievement, feeling appreciated & proud • Professional development • Self-care and wellbeing/personal impact • Value of home-visits and follow-up • Effective integration and coordination between health workers • Underutilization of certain roles • No private counselling space • Community suspicion or skepticism • Medication supply issues and mismatch • Problem with staff turn-over • Review medication (see also med supply & mismatch) • Greater involvement of community leaders and traditional healer • Wider geographical remit
<p>Effectiveness: Objective 3. Awareness and Access</p>	<p>Impact on health worker attitudes</p> <p>Impact on community attitudes</p> <p>Impact on service user access</p>	<ul style="list-style-type: none"> • New interest in psychiatry • New sense of ownership and responsibility for mental health • Reduction in use of stigmatizing language • Reduction in fear of mental health service users • Increase in time spent with service users • Improved communication style • Reduction in stigma • Change in language used to describe people with mental health problems • New understanding of causes and treatments for mental health problems • Limited impact – more time and awareness required • New confidence in revealing mental health problems • Increased access

	Recommendations: Awareness and Access	<ul style="list-style-type: none"> • Awareness activities in all VDCs • Street plays, dramas and art exhibitions • Greater involvement of community leaders
Structural impact	Impact on policy	<ul style="list-style-type: none"> • District-level procurement of psychotropic medications • Revisions to the Essential Drug List of Nepal • Revisions to National Standard Treatment Protocols
	Social impact	<ul style="list-style-type: none"> • Generating Demand • Reduction in social problems (e.g. gender-based violence)
	Improved data and documentation	
Relevance	Pertinent after earthquake	<ul style="list-style-type: none"> • Emergency as impetus for change
	Appropriateness of services	<ul style="list-style-type: none"> • Needs of SUs well met
	Appropriateness of training	<ul style="list-style-type: none"> • Effective compared with other programs
	Remaining unmet needs	<ul style="list-style-type: none"> • Need to train a greater number of staff • Need to cover more geographical areas
Sustainability	Continuation of services	<ul style="list-style-type: none"> • Mixed views about whether government-affiliated staff will continue to provide MHPSS services • Mixed views about whether partner-affiliated community-based staff will continue to provide services

Perception that program too short for sustainability

Organizational and managerial capacity building

- Medication supply
- Changing attitudes takes time
- Government buy-in takes time
- Improvements in mental health take time
- Sense that program “ending in the middle”

Appendix 5. WHO-recommended psychotropic medications

Relevant disorder	Drug	Preparation	Recommended by the WHO**	Procured by the program?
Psychotic disorders	Chlorpromazine	Injection: 25 mg (hydrochloride)/ mL in 2 ml ampoule.	✓	✗
		Oral liquid: 25 mg (hydrochloride)/5 ml.	✓	✗
		Tablet: 100 mg (hydrochloride).	✓	✓
	Fluphenazine	Injection: 25 mg (decanoate or enantate) in 1- ml ampoule.	✓	✗
	Haloperidol	Injection: 5 mg in 1- ml ampoule. Tablet: 2 mg; 5 mg.	✓ ✓	✗ ✗
	Risperidone*	Solid oral dosage form: 0.25 mg to 6.0 mg.	✓	✗
Depressive disorders	Amitriptyline	Tablet: 25 mg; 75mg (hydrochloride).	✓	✓
	Fluoxetine*	Solid oral dosage form: 20 mg (as hydrochloride).	✓	✗
Epilepsy	Carbamazepine	Oral liquid: 100 mg/5 ml.	✓	✗
		Tablet (chewable): 100 mg; 200 mg.	✓	✗
		Tablet (scored): 100 mg; 200 mg.	✓	✓
	Diazepam	Gel or rectal solution: 5 mg/ ml in 0.5 mL; 2- ml; 4- ml tubes.	✓	✗
	Phenobarbital	Injection: 200 mg/ ml (sodium).	✓	✗
		Oral liquid: 15 mg/5 ml.	✓	✗
	Phenytoin	Tablet: 15 mg to 100 mg.	✓	✓
		Injection: 50 mg/ ml in 5- ml vial (sodium salt).	✓	✗
		Oral liquid: 25 mg to 30 mg/5 ml.	✓	✗
		Solid oral dosage form: 25 mg; 50 mg; 100 mg (sodium salt).	✓	✗
Sodium valproate*	Tablet (chewable): 50 mg.	✓	✗	
	Oral liquid: 200 mg/5 ml.	✓	✗	
	Tablet (crushable): 100 mg. Tablet (enteric-coated): 200 mg; 500 mg (sodium valproate).	✓ ✓	✗ ✗	
AUD †	Diazepam*	Injection: 5mg/ml in 2ml ampules	✓	✓

Anxiety	Alprazolam	Tablet: 0.25mg tablets	x	✓
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* As of 2017, Nepal Free Essential Drug List has been revised with input from IMC and TPO, to include these additional medications at all facilities with mental health programs.

** As published in the WHO Model List of Essential Medicines (2015) or the mhGAP Intervention Guide.

† Diazepam was predominantly used for the sedation and detoxification of service users with AUD, and occasionally for sedating violent service users experiencing acute psychosis and for acute control of seizures in service users with epilepsy.

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