**Formative Research towards the Development of a Mental Health Care Plan in Nepal**

**Date: 2013**

**Background**

This report was written in response to PRIME’s key research questions on the implementation phase of its mental health programme; a strategy to integrate services into the context of primary and maternal health care. Together with the Ministry of Health, (MoH), PRIME is in the process of developing a package of care that deals with the priority disorders of alcohol use, depression and schizophrenia. The research component of this phase seeks to determine the feasibility, and acceptability of the proposed model of care and gather detailed information on the contextual factors involved in delivering the package. Specifically, information on the barriers that influence access to services for people living in poverty, people with severe mental disorders, and women, particularly during the perinatal period.

**Methods**

The participants comprised of community members, health workers and policy makers. The data collection and analysis for this piece of formative research took place between April 2011 and September 2012. Explorative qualitative interviews were conducted, using 38 Focus Group Discussions (FGD) and 32 semi-structured Key Informant Interviews (KII). Ethical clearance for the study was gained from the Nepal Health Research Council. The qualitative data was analyzed following a Framework Analyses approach (Lacey and Luff, 2001). Coding frameworks were developed by the research team under the themes of ‘Demand and Access’ and ‘Delivery and Recovery’ a priori (to ensure key research questions were addressed) and elaborated as emergent concepts arose during the coding process. Final coding frameworks were applied and used to analyze the data thematically. Analyses were done in NVIVO 9.0.

**Results**

The study revealed poor awareness about mental illness and services on all section and caste and even health workers. Attitude of community members was negative. Mentally ill people in all places were stigmatized and groups with underprivileged groups and women were most vulnerable to discrimination. Poor and disadvantaged groups were more likely to seek help from traditional healers. It was found that there was low demand of mental services due to low self-esteem, humiliation, lack of family support, unawareness of services, poor quality or absence of services**,** anticipated cost, culture, and religion. Barriers to access: Family or community, logistics, service availability, and poverty. People with low access: Women, poor, and uneducated. Human resources: Insufficient staff, posting policy leading to frequent staff turnover, multiple projects, and lack of qualified staff at SHP.

**Conclusions**

Clear protocol that outlines roles and responsibilities, training, supervision, district mental health coordination, and a mechanism of monitoring and evaluation is needed.

**Keywords:** development; formative research; mental health care plan.