From Design to Delivery: Exploring the Implementation of MHPSS Interventions through Stakeholder Perspectives

Photo with consent

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Introduction

- Nepal's decade-long armed conflict (1996–2006) caused lasting psychosocial and mental health challenges, worsened by limited access to formal services, especially in rural and post-conflict areas with 18% of the non-communicable disease burden.
- 10% adults, 5.2% and 13-17 years adolescents of have mental health problems.
- Even urban-centered, mental health services lacks; one psychiatrist per 150,000, one psychologist per 730,000 making it a 70% treatment gap
- Low community awareness and widespread stigma
- Providing comprehensive, integrated, and responsive mental health and social care services within communities was recommended by WHO.

MHPSS

- Stands for community-based **'Mental Health and Psycho-Social Support'**
- A four-year MHPSS intervention project implemented since 2021 targeting conflict victims (CVs)
- Aimed to promote mental health and well-being among conflict victims (CVs)at local level engaging and empowering to address psychosocial issues exited
- CVs defined as individuals who lost family members (through killing or disappearance), or were severely tortured and/or injured during armed conflict.

Intervention description

- National Health Training Centre (NHTC) (mhGAP) for prescriber -5 days.
- Psychosocial counseling training package of NHTC- module 6, a 6 month practicum based training for health-workers.
- Training of Psycho-Social Counselors (PSC)
- Community awareness through multi-media platforms and, psychoeducation sessions

……………..……………and,

R E F E R R A L.

Study Objectives

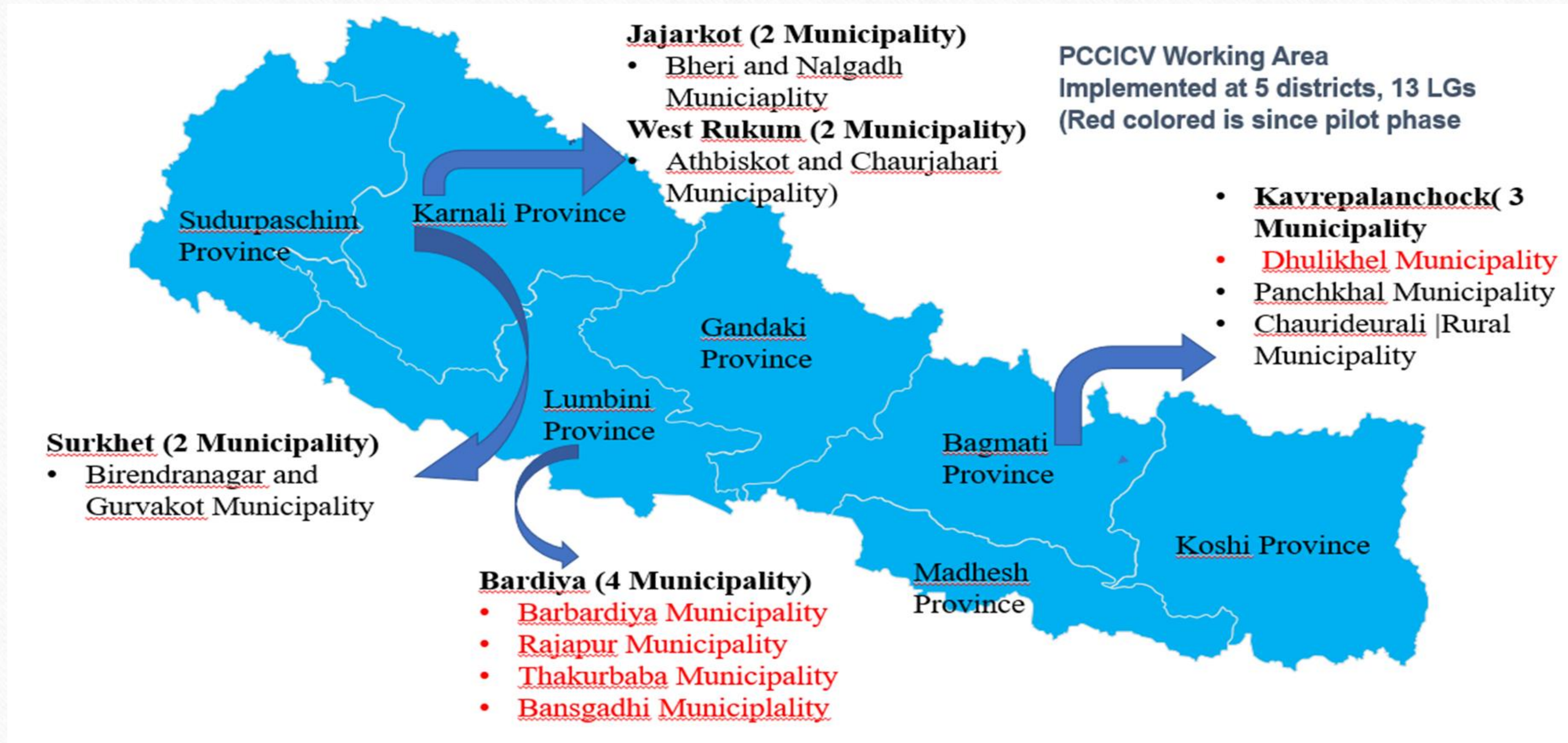
General Objectives

- Assess the impact of MHPSS intervention in the community.

Specific Objectives

- To assess the acceptability, appropriateness, adoption, fidelity, feasibility, cost, penetration and sustainability of the MHPSS intervention.
- To assess the experience of using the MHPSS service among the conflict victims.
- To assess the barriers and facilitators of implementation of the MHPSS service.

Map of the project implemented area



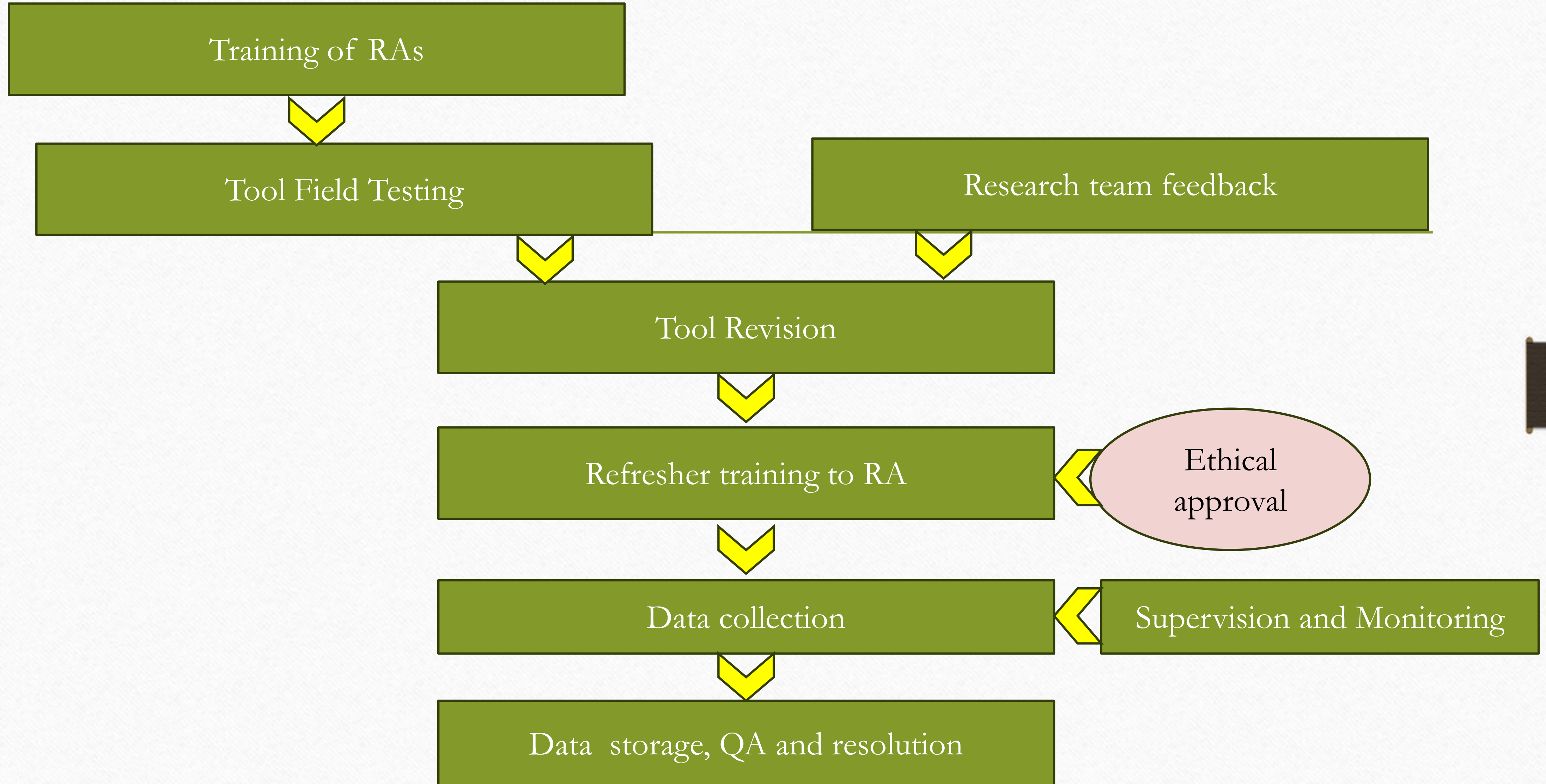
Methodology

- A mixed-methods design was used, integrating quantitative and qualitative approaches under an implementation science framework
- Quantitative data: 228 semi structured structured surveys, record reviews, and observation checklists
- Qualitative interview acceptability, 86 qualitative transcripts were generated from 30 IDIs, 51 KIIs, and 5 FGDs
- Ethical approval was obtained from the Nepal Health Research Council (NHRC), and consent from participants.

Study variables (Implementation Science framework):

Acceptability, appropriateness, adoption, fidelity, feasibility, cost, penetration and sustainability

Data collection



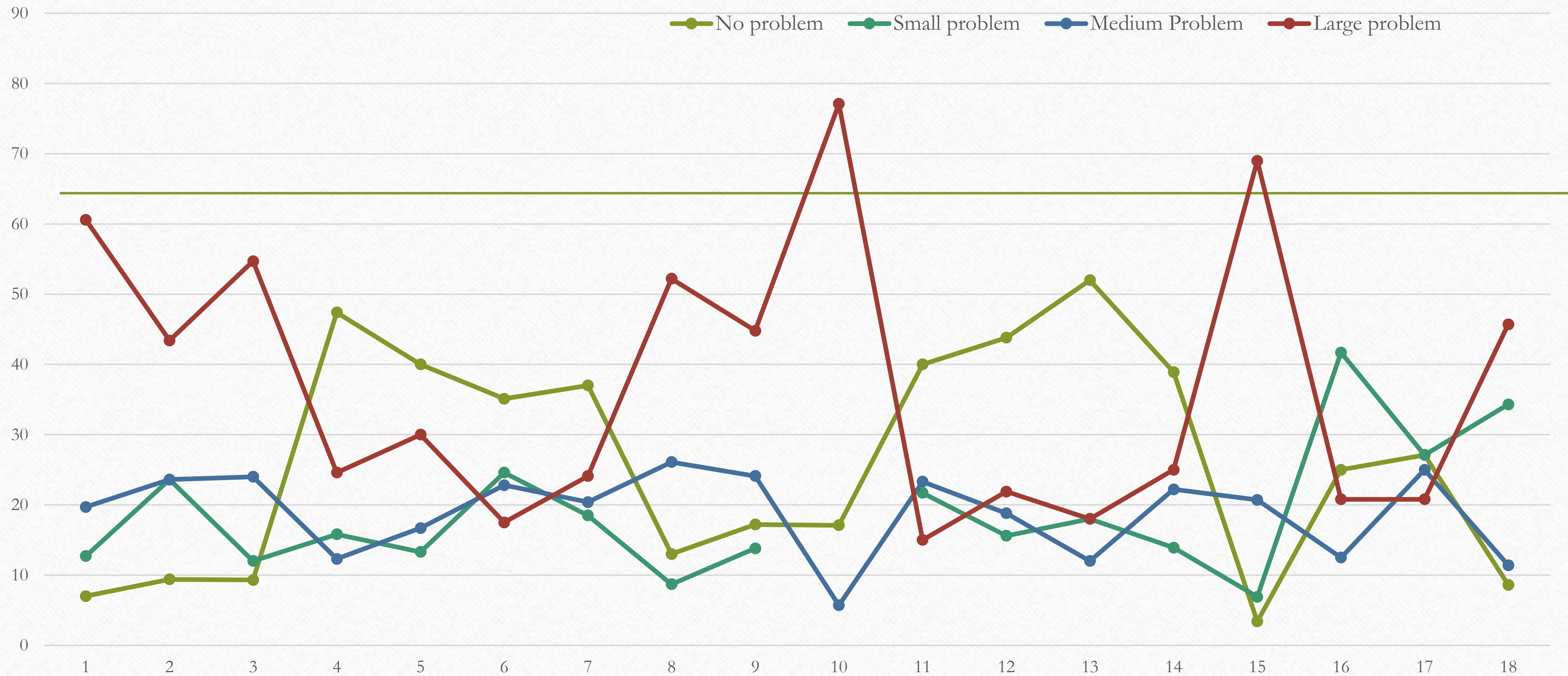
Results

Quantitative Results

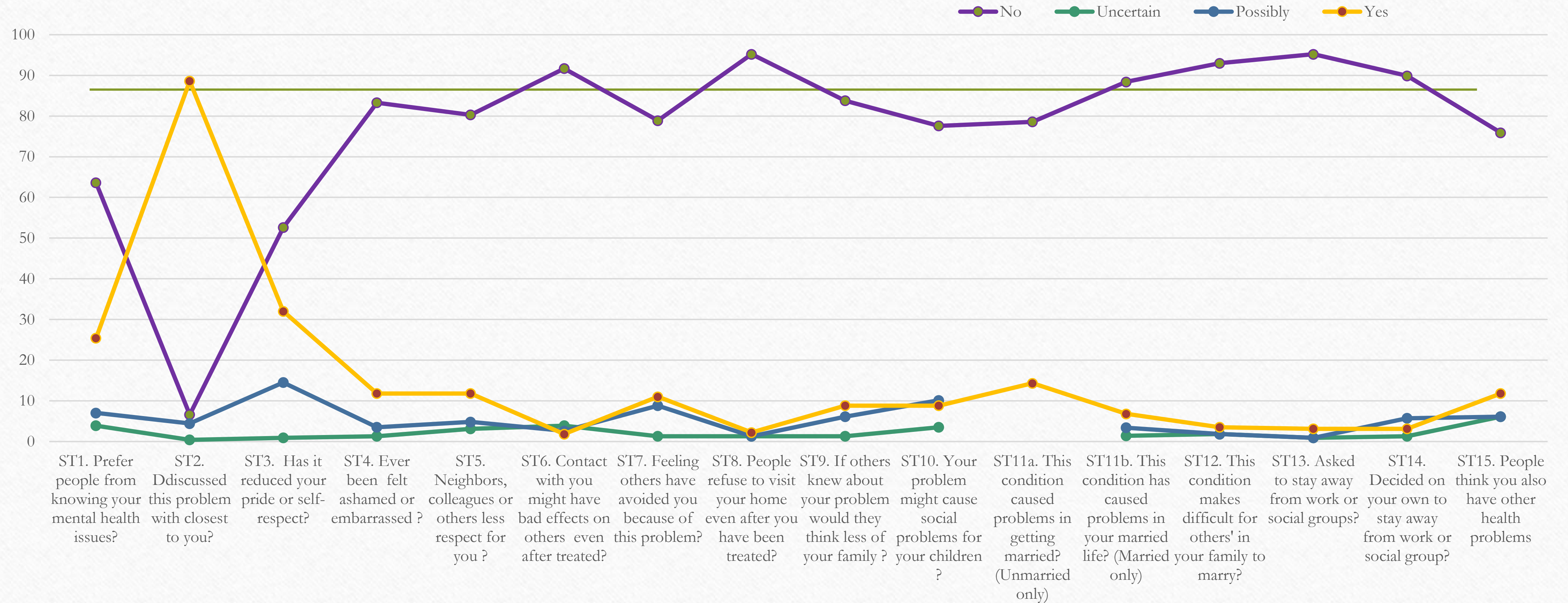
Quantitative result summary

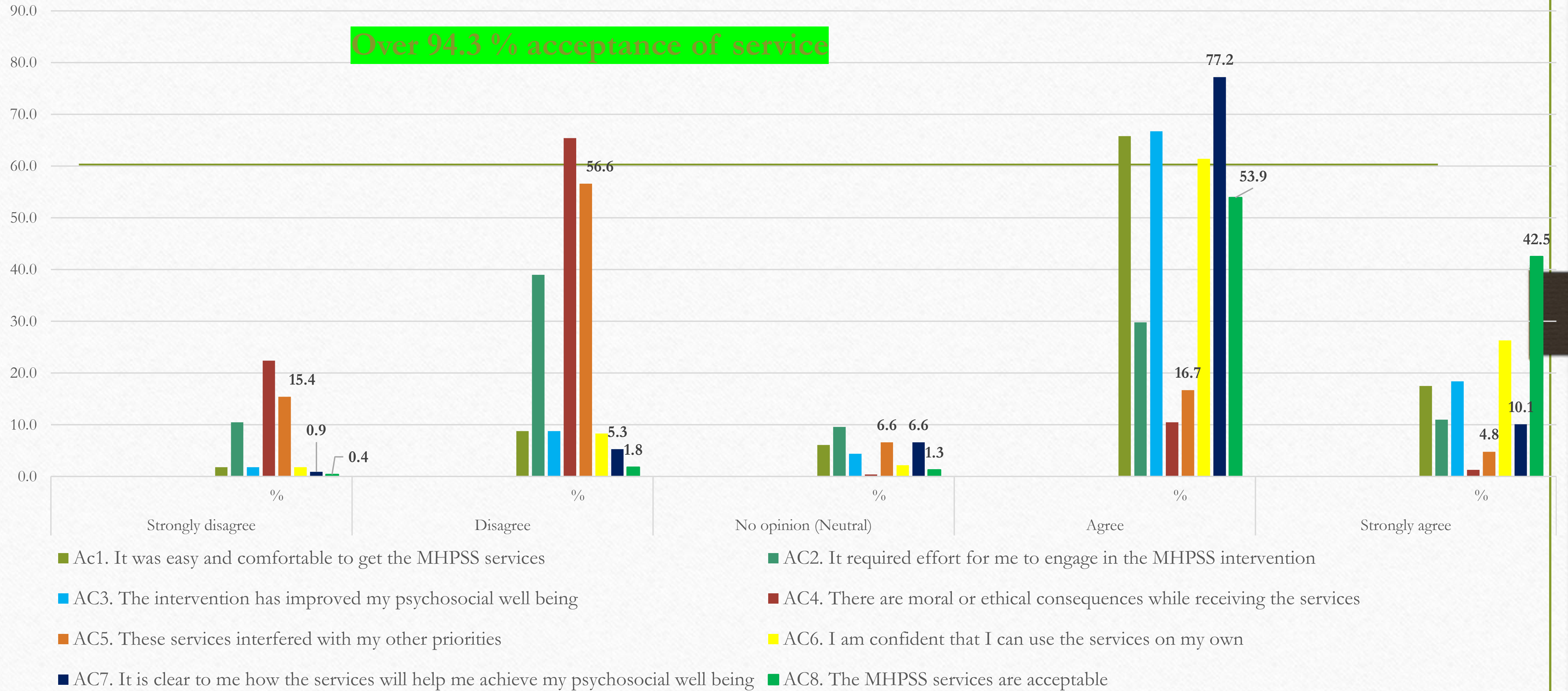
- Participant **mean age 49.69 years** with 16-88 years range,
- **Female 64%,** Literate-50%
- Married 64%, widowed 28.5%
- Family- **Nuclear- 60.5%** and joint 35.5%
- Ethnicity- Brahmin Chhetri 44.3%, Janjaati 42.5%, Dalit 11.8%
- Average **monthly income 19864** and average **treatment cost 494**
- **Farmer** as major occupation (60.1%) and domestic work 12.7%

Participation



Stigma experienced by CV because of mental health problems





MHPSS service acceptance
Over 94.3 % acceptance of service
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
15.4
0.9
0.4
56.6
5.3
1.8
6.6
6.6
1.3
77.2
53.9
16.7
42.5
10.1
4.8
%
Strongly disagree
Disagree
No opinion (Neutral)
Agree
Strongly agree
Ac1. It was easy and comfortable to get the MHPSS services
AC2. It required effort for me to engage in the MHPSS intervention
AC3. The intervention has improved my psychosocial well being
AC4. There are moral or ethical consequences while receiving the services
AC5. These services interfered with my other priorities
AC6. I am confident that I can use the services on my own
AC7. It is clear to me how the services will help me achieve my psychosocial well being
AC8. The MHPSS services are acceptable

Qualitative findings

Acceptability, Appropriateness, Adoption, Fidelity, Feasibility, Cost, Penetration, and Sustainability of CMC-Nepal's Community-Based MHPSS Intervention

Acceptability

- Service users and providers appear to be highly positive and receptive toward the intervention.

- After training from CMC, service provider are self confident in diagnosing and treating many mental health conditions.

"Now, I think the services we have received .... has helped a lot, for people like us, it seems like a good thing to bring people like us on track……. after we have received it (counselling), I think there has been some change, something, we, I mean a little huh… there has been some ease……… There are such people, even such a person, even if they are a little bit tired, they need to show a little bit of energy, a little bit of a basis for living, or they need to give energy huh…, now they give that energy, because of that, now they have some basis. I understand this as if I found it."

(IDI with service user 11 at Karnali)

Appropriateness

- Stakeholders emphasize on service being relevant for conflict victims, experiencing long-term psychological distress.

- The intervention is reported to be effectively aligning with local needs, addressing both conflict-affected populations and others as well.

"As the population in the village grows, so do the mental health issues. Initially, we only knew about treating diarrheal diseases, and we only distribute ORS, but now we see a growing demand for medications like amlodipine for non-communicable and mental health diseases in the past eight to nine years."

(KII with health care provider 01 at Karnali)

Adoption

- Almost all intervention municipalities have developed their mental health strategy and also has included mental health counselling in its yearly plan

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- At the local level, the decision to include mental health counselors in municipalities has been integrated into policy.

"Now our municipality has passed this mental health strategy……. Like [Background noise] free health care is not being managed… They should be provided with medicines from local health institutions, sir ….. Yes, it has been included in the annual plan."

(KII with PSC 03 at Karnali)

Cost

- While 12 essential mental health medications are available for free, patients sometimes need to purchase additional medicines.

- Health insurance plays a crucial role in covering some costs, yet not all service users are insured, leaving gaps in access to medication.

- Local governments have allocated budgets for mental health services, but funding remains heavily reliant on external partners.

"If they have to buy (apart from the 12 types of free medicines), there are people who will buy it. We encourage them to get health insurance. They will be able to get their medicines through that…. health insurance covers some of it. Sometimes, when there's a shortage of medicines, they may need to buy them separately. In those cases, they would purchase it."

(KII with health care provider 34 at Lumbini)

Fidelity

- Trained healthcare providers have applied their skills in practice.
- Training, refresher training, and supervision provided by CMC have been pivotal in increasing the fidelity of the intervention.

"Yes, before the training, we were doing counseling and referrals, but now we are able to manage cases ourselves. It's [thinking] been about four years now."

(KII with health care provider 34 at Lumbini)

Feasibility

- Mental health services are increasingly accessible at the ward level, with trained health personnel providing care, with occasional procurement challenges arise.

- The leadership played a crucial role in prioritizing mental health services, and demonstrated responsiveness in addressing emerging issues, such as medication shortages and service gaps.

"As I mentioned earlier, they ask us to list any shortages of essential medications. This is positive. Sometimes there are procurement challenges, but overall, they have been supportive. I'm not clear on whether it is exactly included in the policy, but according to the needs and demands of the patients, the municipality has provided the supplies, and we are happy about that."

(KII with health care provider 01 at Karnali)

Penetration

- The reach of mental health services has expanded in some regions but remains constrained in others

- Service provider claim that the intervention has improved the identification and management of mental health conditions, with nearly 90% of cases being handled locally, reducing the need for referrals.

"Initially, the training was limited to a few health workers, but now it is gradually being extended to all institutions. This makes me happy because health workers in neighboring wards are also receiving this training and are able to manage and implement it. Previously, it was difficult to start due to a lack of training, but now, with training, they can register and request medication. Gradually, we are building the capacity to identify and manage these problems in the community. We have managed nearly 90% of the patients here, (05:00) with only a few needing referral. This shows effective results based on my experience."

(KII with health care provider 01 at Karnali)

Sustainability

- Municipalities have taken ownership of the intervention and demonstrated potential to sustain and manage resources for the intervention.

- Municipalities acknowledge the importance of scale up the intervention, however, acknowledged long-term planning and dedicated resources for mental health remain insufficient.

" I think our municipality is capable, sir. As of now, especially with our mayor's tenure, he has never cut funding for health matters. When it comes to mental health issues, he never says no to the necessary actions. This has allowed us to have 12 health institutions across several wards, some even with hospitals. To continue these services, the key requirement is training. Once everyone has received training, funding can be allocated for refresher training. Also, if the medications are continuously supplied, the service can keep going. There is no difficulty in that. We can manage the cases we hold, operate them regularly…."

(KII with Health Care Provider 02 at Karnali Province)

Barriers of Community-Based MHPSS Services

- Stigma and negative social perceptions about mental health
- Difficult geographical terrain
- Logistical and resource constraints, such as inadequate infrastructure, limited workforce, medication shortages, budgetary dependency.
- Added work burden, time management issues, and increased patient flow
- Policy and implementation gaps

Facilitators of Community-Based MHPSS Services

- Community engagement, active participation from local leaders and organizations enhancing program acceptance.
- Empathetic approach of intervention providers (PSCs and CPSWs)
- Training and capacity-building efforts, responsiveness and quality service from service provider

Conclusion

- The intervention was appropriate and well received given the surging mental health burden.
- Sustainability and scalability are limited by financial, human resource, and logistical constraints.
- Integration into PHC centers is feasible with current support and infrastructure.
- Ongoing training, funding, coordination, and task-shifting are key for long-term success

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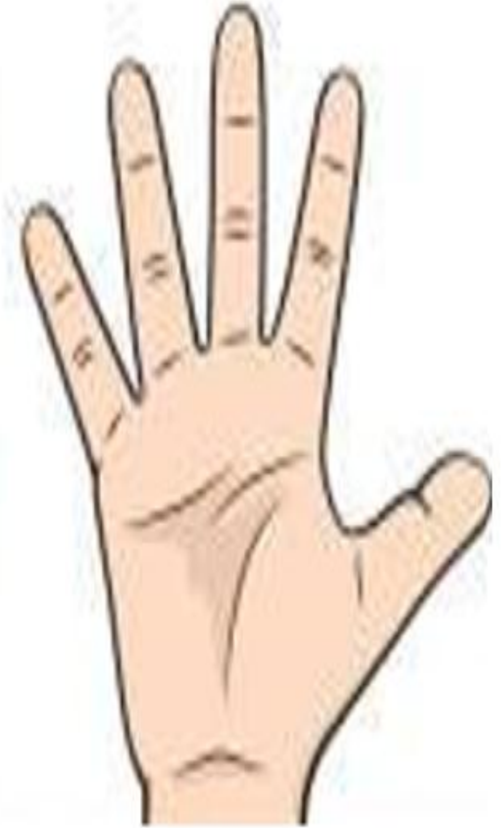

Presenter's Biography

Pashupati Mahat, Ph.D. (Child & Adolescent Mental Health), specialist clinical psychologist and Technical Director at CMC-Nepal, has extensive experience in the integration of MHPSS service into primary healthcare system, expert in development of MHPSS capacity development materials such as mhGAP module- 1, 2 and module 6 (6-month psychosocial counselling training package), contributed to evidence-based Mental health policy and strategy development @ national and provincial levels

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THANK YOU