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# Barriers and Facilitators to Implementing WHO mhGAP Suicide Protocols in Rural Primary Care Settings of Nepal

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# OUTLINE

- Background and Objective
- Methodology
- Findings
- Conclusion and Key Takeaways
- Acknowledgment

# Background

- Southeast Asia has the highest global suicide rate (17.7 per 100,000)
- Suicide drivers and experiences remain underexplored in non-Western contexts (Hagaman et al., 2017)
- In Nepal, studies show high rates of suicidal ideation (up to 14.8%) and attempts (up to 7.4%) in health facilities, but low disclosure and help-seeking (Jordans et al., 2017)
- Prior research suggests suicide prevention can be integrated into primary care if carefully implemented (Hagaman et al., 2025)
- Despite widespread use of WHO mhGAP, there is limited evidence on how well providers implement suicide-related care in practice (Robles & Lopez-Garcia et al., 2019)

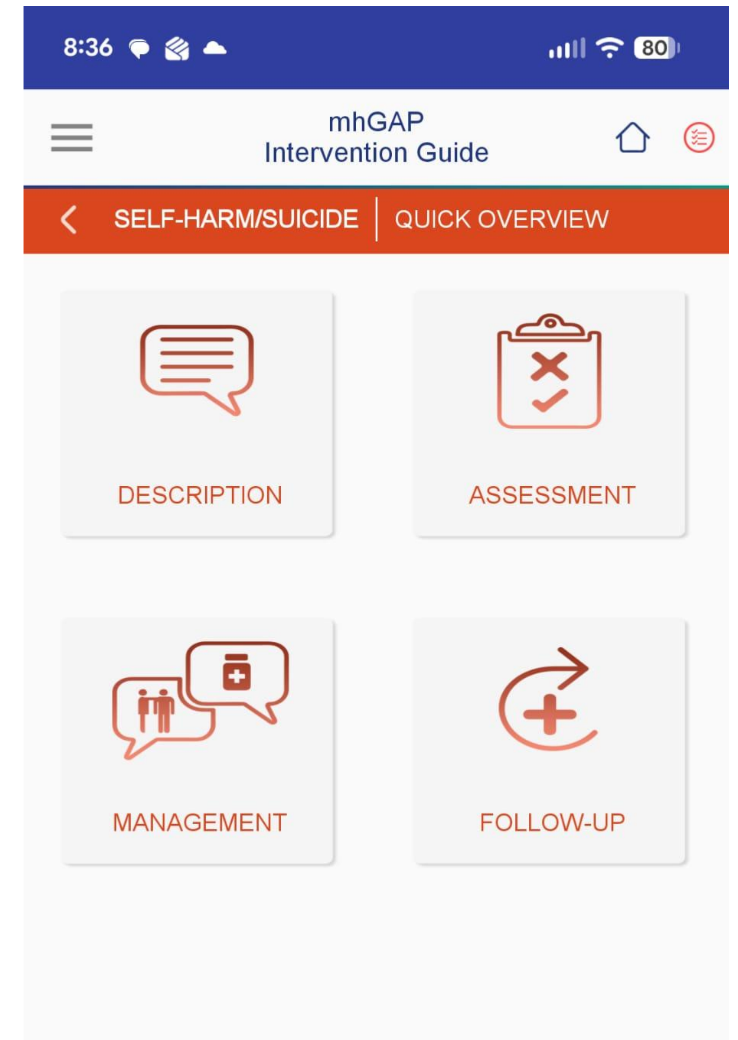

[1]*Hagaman, A. K., Maharjan, U., Kohrt, B. A., et al. (2017). Suicide in Nepal: A modified psychological autopsy investigation from randomly selected police cases between 2013 and 2015. Social Psychiatry and Psychiatric Epidemiology.*

[2]*Hagaman, A. K., et al. (2025). Integrating suicide prevention into primary healthcare in low-resource settings: Implementation research findings. [Details to be updated based on final publication].*

[3]*Jordans, M. J. D., Rathod, S. D., Fekadu, A., et al. (2017). Suicidal ideation and behaviour among primary care patients in Nepal: Findings from a nationally representative study. BMC Psychiatry, 17, 124.*

[4]*Robles, R., López-García, P., et al. (2019). Implementation of WHO mhGAP in low- and middle-income countries: A systematic review of barriers and facilitators. Global Mental Health.*

WHO's mhGAP2.0 is implemented in over 90 countries



# Objective

To explore provider-level barriers and facilitators to implementing mhGAP suicide modules in primary care setting to inform new implementation strategies.

# METHODOLOGY

- **Framework:** RAPICE (Rapid Assessment Procedures Informed Clinical Ethnography) was used to capture real-world clinical practices.
- **Data Collection:**
  - In-depth interviews with mhGAP trained primary care providers (n=14).
  - 2 Focus group discussions with 15 community health workers.
  - Three-day ethnographic observations at four health posts.
- **Analysis:** Data (observation templates, fieldnotes, and interview recordings) were triangulated and analyzed using rapid assessment procedures, with codes focused on CFIR2.0 barriers and facilitators to uptake of mhGAP suicide protocols.
- **Setting:** Bhimeshwor Municipality, Tamakoshi, Baiteshwor, and Kalinchowk Rural Municipalities in Dolakha District, Nepal
- **Study Timeline:** February, 2024 to February, 2027
- **Participants:** 14 primary care providers (Health Assistants, Auxiliary Health Workers) and community health workers.

# FINDINGS

Implementation Gap

Provider Beliefs and Stigma

Systemic and Operational Challenges

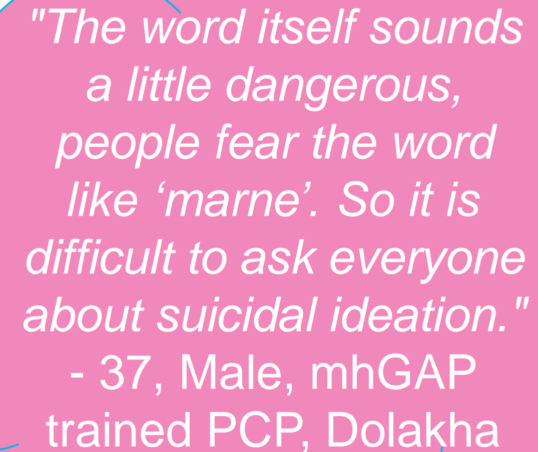
# Implementation Gap

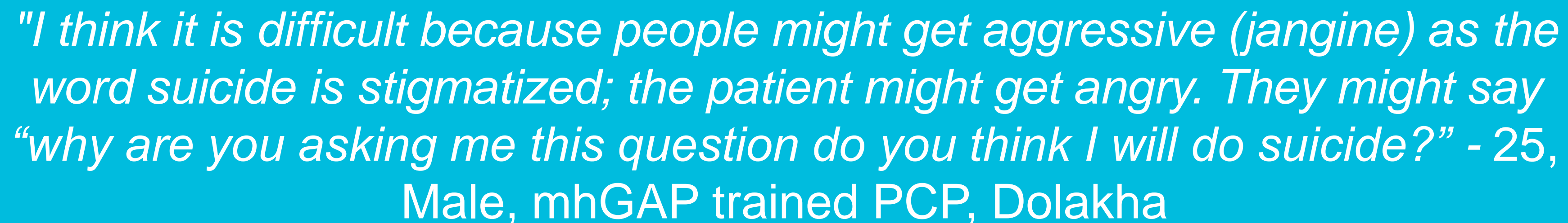
- **Routine Omission:** Suicide risk is rarely assessed, even when patients show clear signs of psychological distress.
- **The Disclosure Tension:** A fundamental mismatch exists where providers wait for patients to "self-disclose," while patients stay silent due to mistrust or lack of awareness.
- **Evidence Gap:** While implementation is feasible, there is a lack of systematic examination regarding how well trained providers actually apply these modules.

*It didn't seem like there was any external motivation for the staff to do a "good job." No one was observing the patient/provider interactions and there is no incentive or reward for doing a better job with the patients. The female doctor was popular, so more patients ask to see her, but she does not get paid any more or receive any special recognition.*
- Researcher, Observation, Day 2

# Provider Beliefs and Stigma (1)

- **Avoidance of "The Word":** Providers find the word "suicide" (or *"aatmahatya"*) dangerous and fear that asking directly will offend or anger patients.
- **Misconceptions of Disclosure:** Many believe that if a patient is truly suicidal, they will bring it up themselves, meaning providers don't need to ask.



# PROVIDER BELIEFS AND STIGMA (2)

- **Rapport Concerns:** There is a perception that suicide cannot be discussed during a first visit because a relationship hasn't been established yet.

*“When people come with mental stress, it’s difficult to ask, 'Do you feel like dying? Do you feel like committing suicide?' It's challenging to ask these questions"*
- 32, Female, mhGAP trained PCP, Dolakha

# PROVIDER BELIEFS AND STIGMA (3)

- Providers perceived that most people in the communities do not know that health posts offer treatment for mental health issues, and are therefore unlikely to come to the health post with mental health issues
  - This perception was corroborated by CHW's:
    - *"I am also a member of that community. I live in the same community. I visit the health post regularly like 3 time a week. If even I didn't know about it (the mental health services), then how could others possibly know? I have a good relationship with the staff there, yet I wasn't aware that such services or cases existed. That made me reflect a little-it really struck me."* (CHW, in FGD 1)

# Systemic and Operational Challenges

- **Skill Decay:** Because providers perceive a "lack of cases," they rarely practice the protocols and forget their training over time.
- **Infrastructure Gaps:** Many health posts lack private rooms, meaning consultations often happen within earshot of other waiting patients.
- **Lack of Technical Support:** Following initial training, there is a distinct lack of ongoing supervision, refresher courses, or implementation support.
- **Monitoring:** Mental health delivery is not formally monitored or incentivized compared to other administrative duties.

*"I didn't try to implement it because there were no cases so with time when there is no practice we tend to forget about it"* - 25, Male, mhGAP trained PCP, Dolakha

# Facilitators for Success

**Cultural Adaptation:** Successful providers use indirect questioning, narrative storytelling, and gradual probing to ease into the topic.

**Available Time:** While larger hospitals are busy, many rural health posts see only 4-10 patients a day, providing ample time for psychosocial counseling.

**Provider Empathy:** Motivated providers who believe supportive conversations can encourage disclosure are effective at engaging families.

# Conclusion and Key Takeaways

- **From Passive to Proactive:** Care must move away from "patient-initiated disclosure" toward proactive, routine assessment.
- **System-Level Support:** Training alone is insufficient; providers require ongoing supervision and practical assessment tools to maintain competency.
- **Public Awareness:** Increasing community knowledge about available services is essential to bridge the gap between providers and those in need.

# Acknowledgements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- *Mental health professional with 9 years of experience in community-based settings*
- *Master's in Clinical Psychology from the University of Delhi*
- *Expertise in implementation research using mixed methods and participatory approaches, with a strong focus on transdiagnostic treatments*
- *Experienced in task-sharing approaches and capacity building of non-specialist health workers*

# THANK YOU!