Implementation science study of acceptability, appropriateness, adoption, feasibility, fidelity, cost, penetration and sustainability of community based Mental Health and Psychosocial Service (MHPSS) interventions for conflict victims in primary health Care system of Nepal

Final Report

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Centre for Mental Health and Counselling Nepal (CMC-Nepal)

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Acronyms

AHW	Auxiliary Health Worker
CMC-Nepal	Centre for Mental Health and Counselling-Nepal
CMD	Common Mental Disorders
CPSW	Community Psychosocial Worker
DMO	Data Management Officer
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
HSC	Hopkins Symptom Checklist
HW	Health Worker
KII	Key Informant Interview
NHTC	National Health Training Centre
mhGAP	Mental Health Gap Action Program
MHPSS	Mental Health Psychosocial Support Service
MHPSD	Mental Health and Psychosocial Disability
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
NHRC	Nepal Health Research Council
PC	Project Coordinator
PHTC	Provincial Health Training Centre
PSC	Psychosocial Counselor
PTSD	Post Traumatic Stress Disorder
RA	Research Assistant
RS	Research Supervisor
WHO-DAS	World Health Organization, Disability Assessment Scale
WHO-QOL	World Health Organization, Quality of Life
SPSS	Statistical Package for Social Sciences
SWC	Social Welfare Council
URC	University Research Co.

1. Introduction

The Centre for Mental Health and Counselling-Nepal (CMC-Nepal) has been implementing a four-year project named Psychosocial Counselling for Community Integration of Conflict Victims (PCCICV). It is a Mental Health and Psychosocial Support (MHPSS) intervention started in the year 2021 and targets conflict victims (CVs). Activities span the local to the federal levels of the health system. A conflict victim is a person who had lost family member (killed or disappeared) or were tortured and/or injured during the armed conflict period from both sides i.e. state securities and Maoist during the conflicts (spanning 1996-2006) in Nepal. The Project aims to support conflict victims with articulating their needs and benefits from the transitional justice process and has two main outcomes i) conflict victims resume stable psycho-social health, and ii) local and provincial government understands and responds to MHPSS needs of CVs. It was first piloted in five municipalities of two districts from February 2020 to August 2021. The pilot phase included task shifting of MHPSS services through training and clinical supervision of health workers (HWs) in primary health care system and psychosocial counselors (PSCs) and community psychosocial workers (CPSWs) in community. The project also recognizes the need for mental health support of community people other than CVs and are therefore included as target group for service. The pilot phase was lightly assessed through a few focus group discussions with CVs who received services along with interactions with municipality authorities (elected leader and administrative staff). Findings showed mental health and psychosocial support services were helpful for coping with fear and worry of COVID-19 pandemic and helped support people with moderate to severe mental health problems receive timely treatment. This community-based MHPSS

intervention was expanded to another eight municipalities, making 13 including pilot phase municipalities. The intervention also focused on active participation of CVs and municipality authorities, including their participation in policy level discussion. During these meetings, CVs shared their experiences with MHPSS services and provided feedback on making MHPSS services regular and easily accessible. Municipality authorities have developed and endorsed a separate mental health policy and activity so that regular budget and activity be developed and implemented to sustain the intervention. The pilot phase and post pilot phase of intervention implementation was funded by Swiss government through Swiss Embassy office Kathmandu.

Major MHPSS intervention components

- **Training:**
    - Mental health treatment services in selected health facilities of local government (municipalities) consist of a health workers receiving a standard training package (module 2a, 2b, 3) developed by National Health Training Centre (NHTC), Ministry of Health following WHO Mental Health Gap Action Program (mhGAP) to reduce treatment service gap. It has content on common mental disorders (CMD) observed in primary health care settings with information on identification, diagnosis, prescription for the treatment following standard treatment protocol (STP) and referral mecchanism. The STP has been developed by the Ministry of Health and includes twelve psychotropic drugs to facilitate mental health service delivery within the primary health care system.
    - Health workers (HWs) are trained to identify and provide basic treatment after five days training from psychiatrist and clinical psychologist. Training

incorporates vignette case discussion and practice in real cases in the health facility where training will take place. Training package and STP recommends regular clinical supervision of trained health workers to strengthen their competency and knowledge in treatment of CMDs. The CMDs observed in the primary health care system of Nepal were anxiety disorder, depression, psychosis, alcohol and substance abuse and epilepsy.

Psychosocial counselling service in health facility: Through Project support, psychosocial counselling services were developed by the municipality health service system. Two positions of psychosocial counselors were created by the municipality with the support of Project, recruited and sent for training on NHTC for a six-month modular training on psychosocial counselling. This training has three submodules each lasting 10 days. Module content comprised basic information on mental health problems to help trainees identify and refer patients for treatment, improve patient communication skills, and to use psychological first aid and stress reducing activities. Trainees then practice for six weeks within their health facility and through outreach services in the community. The psychosocial counselors in training are assigned a supervisor who is a psychologist who will continuously mentor on skills contained in the first submodule. Trainees have online reading materials provided by NHTC and have an online test. Trainees should score at least 85% on the test to be eligible for two other advanced skill on psychosocial counselling.

- The second submodule, also called the advanced skill module in psychosocial counseling, includes 10 days of theoretical content. This includes being taught mental health disorder specific intervention skills along with opportunities for

practice exercise and feedback from NHTC accredited trainers (clinical psychologist, psychologist, senior psychosocial counsellors). This module comprises trauma healing techniques to work on loss and grief components of conflict victims. Specifically, this includes grounding activities such as breathing techniques, body scanning, quick and progressive muscular relaxation techniques, emotional focused therapy (tapping), reattribution therapy for loss that facilitate the acceptance of loss and support to process the grief, and practices of grief rituals in group linking with cultural healing activity. After this module training candidates have to practice for another six weeks in their health facility. Trainees get regular supervision support during this time.

- The last submodule is implemented over 10 days with a focus on strengthening skills on psychosocial intervention for common mental health problems, trauma and loss issues, group counselling in a community setting, counselling skills for child and adolescent cases, skills of psychoeducation, self-care and stress management, and documentation of psychosocial counselling services as prescribed in the training manual. There will be a knowledge and skill test at the end of 10th day where again candidate should secure 85% to be certified as trained and skilled psychosocial counselor. They need to practice for another six weeks under close supervision of the assigned supervisor before being certified. All 26 PSCs were trained through the NHTC training package.

- **Awareness:**
  - There is an effort to orient and make aware the Project goals and activities among elected representatives and staff of the municipality. This includes information about project activities, why there is specific target groups and

specific interventions for CVs. There is education on common mental health problems and where to refer individuals for treatment, and an emphasis on the role of the municipality in creating awareness and supporting CV integration into the community. There is also promotional intervention information delivered through radio programs (local FM), and social media related materials to make the target population aware of MHPSS services in their community.

- **Advocacy and linkages**
    - Another component is an advocacy activity implemented at policy level to mainstream MHPSS services into local and provincial health service systems. The Project developed an activity to work closely with both governments, lobby for an MHPSS strategy and plan of action and to build the services into the health system and community. A staff member with policy dialogue experience is assigned to implement this activity and is supported by the technical director. Further community level interventions such as group counselling and family counselling develop linkages among CV beneficiaries and opportunities related to social security, livelihood / income generation options and other relevant activities.

Intervention Implementation

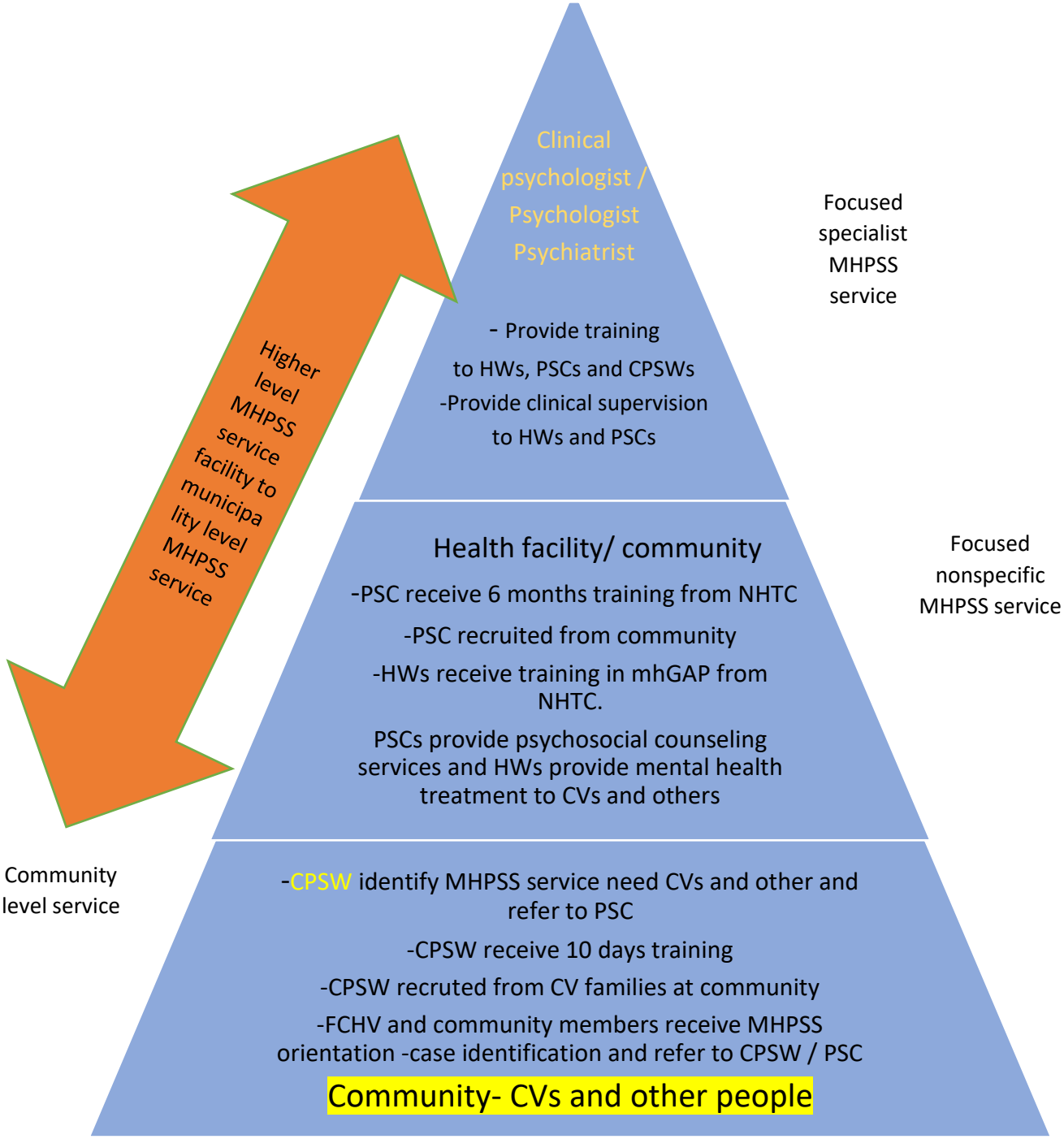
CMC-Nepal has been implementing the MHPSS intervention project in partnership with 13 municipalities. The implementation team consists of various cadres working at all levels from grassroots in municipalities to authorities at the provincial and federal level. The details of MHPSS intervention providers, their professional qualification and their tasks are shown in the pyramid below and described accordingly.

Figure: Details of MHPSS service providers is shown in pyramid

Community based mental health and psychosocial support (MHPSS) interventions have following layers of providers involved in the provision of services.

1. **Community level service providers:**

- A CV volunteer has been appointed by municipality to serve as community psychosocial workers (CPSW) after passing grade ten, completing basic training in mental health, psychosocial wellbeing, communication skills and developing skills on client provider communication, psychoeducation and psychological first aid. CPWs move around community, identify CV in need of MHPSS service and refer to health facility for mental health and psychosocial counselling services. They also do follow up with patients in the community to assess progress with psychosocial conditions.



- Female Community Health Volunteer (FCHV): They are the health campaigner cadre in the community, mobilized by the municipality for health awareness and prevention activities such as immunization, vitamin A distribution etc. FCHVs have completed primary school and some secondary (8th-10th grade). They receive mental health awareness training from PSC and HWs and refer

identified cases to CPSWs or to health facility where MHPSS service is available in the community.

- Local community members, community group members, elected representatives receive MHPSS orientation from PSCs and CPSWs with support of psychologists. Community members refer cases to CPSWs for needful support and further coordination for MHPSS services. Community members also play role in reducing stigma against mental illness and support to increase social participation of CV and other who receive MHPSS services from municipality health facility.

2. Health facility and community level service provider (focused non-specific intervention)

a. Psychosocial Counselor (PSC): Two PSCs are employed by each municipality having academic qualifications of at least high school completion (through grade 12), and as defined by training package, received six months training in psychosocial counselling from NHTC. PSCs provide services from primary health care center and community level through home visit of clients.

b. Health workers (HWs): At least two health workers (auxiliary health worker (AHW) and health assistant (HA) are providing general health services from primary health care centre and health post, have academic qualifications 12-13 years schooling (completion of high school or proficiency certificate level (PCL) in technical education area such as health, which is equivalent to completion of secondary school). AHW and HA are the prescribers and involved in providing services from the outpatient department of health facilities. They receive mental health

(mhGAP) training developed by NHTC and receive clinical supervision from psychiatrists and clinical psychologists. HWs are involved in providing mental health treatment services for CVs and other people referred by PSCs and CPSWs.

3. **MHPSS expert involvement (focused specialist service)**
    a. Psychiatrists, clinical psychologists and psychologists have professional academic degrees with professional council registration except psychologist. They are involved in providing training for PSCs, CPSWs and HWs in MHPSS interventions and supervision support. They also serve as referral points during clinical supervision visits in health facility of municipality where project is implemented.

4. **Municipality Administration**

Municipal administration provides approval to implement MHPSS project activities, involved in the regular monitoring of the MHPSS intervention, provide feedback to mainstream service in the health system, provide space for psychosocial counselling service. Allocate budget to purchase and supply of psychotropic medicine for mental health treatment in health facility, support to improve economic status of CVs through skill training and start up support, health insurance scheme for CVs and their family member and community healing activities such as building monuments and memorial on the name of killed or disappeared CV.

A. MHPSS Intervention Theory of Change

Nepalese people are at increased risk of developing mental ill health conditions due to the extremely stressful environment brought about by the impact of ten years of

armed conflict, political unrest and high vulnerability to natural disasters. In Nepal, the burden of mental health problems in terms of morbidity, disability and costs to individuals, families and societies are overwhelmingly high and occupy 18% of the non-communicable disease burden1. Among the 10 disability causing problems, four are related to mental health in Nepal2. Recent mental health survey showed that the prevalence of mental health problems in adult is 10% and 5.2% among 13-17 years3, and that 18% of children and adolescents of have behavioral and emotional problems4. There is high risk and incidence of gender-based violence in Nepal which is a common risk factor for suicide among women5, especially those belonging to reproductive age group6.

Mental health services are largely concentrated in the big cities, with one psychiatrist for one hundred fifty thousand population, one clinical psychologist for seven hundred thirty thousand population and psychologist per 100,000 population7, leaving a 70% treatment gap in mental health8 due to lack of trained providers. As the country has seven provinces, Koshi province which is the eastern part of the country having ten psychiatrists, and three psychologists are serving for five million people; five

[1] Multisectoral Action Plan for the Prevention and Control of Non Communicable Diseases (2014-2020) 2014, Government of Nepal: World Health Organization Country Office for Nepal.
[2] National Mental Health Strategy and Action Plan 2077 (2020), Ministry of Health and Population, Government of Nepal.
[3] https://publichealthupdate.com/national-mental-health-survey-nepal-2020-fact-sheet/, National mental health survey report, Nepal Health Research Council, 2020.
[4] Ma et al (2021) Parent Report on Children's Emotional and Behavioral Problems in Low and Middle Income countries (LMIC): An epidemiological study of Nepali Schoolchildren. PLoS ONE 16(8): e0255596. https://doi.org/10.1371/journal.pone.0255596
[5] Mahat et al (2021), Study of suicidal risk factors in survivors of Gender-Based Violence.
[6] Marahatta, K., et al., Suicide burden and prevention in Nepal: the need for a national strategy. WHO South-East Asia journal of public health, 2017. 6(1): p. 45.
[7] Luitel et al (2017), Treatment Gap and Barriers for Mental Health Care: A Cross Sectional Community Survey in Nepal. PloS one
[8]National mental health survey report, Nepal Health Research Council, 2020.

psychiatrists, one clinical psychologist and three psychologists are serving to six million people in Madhesh province. There are more than a hundred psychiatrists, twenty-five clinical psychologists and over 100 psychologists are serving to six million population in Bagmati province with high concentration in Kathmandu capital city. Seven psychiatrists and two psychologists are serving to 2.6 million population in Gandaki province; 12 psychiatrists and 2 psychologists are serving to 5.1 million people in Lumbini province; two psychiatrists and two psychologists are serving to 1.6 million people in Karnali province and three psychiatrists and two psychologists are serving to 2.7 million people in Far western region. Community based MHPSS study project located (see table 1 in page 14) in remote rural municipality of Bagmati province, semi urban area of four municipalities of Lumbini province and two semi-urban and four remote rural municipalities of Karnali province9. Nepal experienced a decade-long conflict where many people have been affected severely because of the significant loss of family members (killed or disappeared) and being severely tortured or physically injured. Many of them need regular psychosocial support and mental health treatment, which however is not yet integrated into the existing health service system. Often when the impact of disaster on mental health is well documented, there is little attention to develop intervention to integrate into the regular service system10. Moreover, there are cultural beliefs, myths, and religious convictions around the causes and consequences of mental disorders that further discourage people from seeking service from the health facilities. Therefore, they tend to seek help from traditional healers. The lack of awareness on mental health prevents the

[9]National population and housing census 2021, National Report, Nepal Statistic office, Thapathali, Kathmandu. https://censusnepal.cbs.gov.np/results/files/result-folder/National%20Report_English.pdf

[10] Diaz J. O. P., Lakshminarayana R., & Bordoloi S. (2004) 'Psychological Support in Events of Mass Destruction: Challenges and Lessons', Economic and Political Weekly, Vol. 39 (21), pg. 2121-2127.

realization of constitutional rights and the achievement of Sustainable Development Goals (SDGs) related to health and education.

The project goal is to have conflict victims articulate their needs and receive benefits from the transitional justice process and aims for two main outcomes i) conflict victims establish a stable psychosocial situation and ii) local and provincial government understand and respond to MHPSS service needs of CVs.

2. Methodology of the study

2.1. Purpose and Research Design

The primary purpose of the study is to use an implementation science approach to investigate the implementation barriers and facilitators of the aforementioned MHPSS intervention and determine potential for scalability. If the intervention is found to be scalable, advocacy will be done to expand the intervention to the other municipalities of Nepal. The results is to be utilized to inform policy makers at local, provincial and federal level. This intervention study is in alignment with the Government of Nepal's National Mental Health Strategy and Action Plan 2020.

Study employed a **mixed methods design involving both quantitative and qualitative data**. Quantitative method includes survey, record review and observations exploring acceptability, cost, feasibility, fidelity and penetration. Qualitative methods include Focus Group Discussion (FGDs), Key Informant Interviews (KIIs) and In-Depth Interviews (IDI) and yield information related to all the study domain. We conducted a survey with MHPSS service users from all 13 municipalities where the intervention has been implemented. For qualitative data we selected five municipalities - one from Bagmati provinces and two each from Lumbini and Karnali provinces - considering the geographical representation, mental health service score (i.e. service users' data), and the type of conflict victims.

Research question(s):

1. What is the acceptability, appropriateness, adoption, fidelity, feasibility, cost, penetration and sustainability of CMC-Nepal's community based MHPSS intervention?
2. What is the experience of conflict victims who access the community based MHPSS services?

3. What are barriers and facilitators to implementation of the community based MHPSS services?

2.2. Geographic Focus of the study

The MHPSS intervention is being implemented in 13 municipalities (local levels) of five districts from three provinces. The municipality (administrative unit of Nepal) and districts were selected for program implementation based on the concentration of conflict victims who experienced loss of family member, were severely tortured and were assaulted from state security or Maoist party. Further selection of municipality was also determined by the demand of MHPSS services from the conflict victims and their interest to participate in it. The table below presents the locations where MHPSS are being implemented.

Table 1. Project location of MHPSS intervention for conflict victim

Province	District	Municipality having MHPSS implementation
Bagmati	Kavre	Dhulikhel municipality, Panchkhal municipality Chaurideurali rural municipality
Lumbini	Bardiya	Rajapur municipality, Thakurbaba municipality Barbardiya municipality Banshgadhi municipality
Karnali	Surkhet	Gurvakot municipality Birendranaganr municipality
	Jajakot	Bheri municipality, Nalgadh municipality
	Rukum West	Chourjahari municipality, Aathbishkot municipality

With regards to conflict victims, the characteristic of suffering varies between provinces and municipalities. Conflict victims of Lumbini province (Bardiya) experienced a high number of family member disappearances and killing while the victims of Karnali province experienced mass abduction, extortion, threat, torture and damage (house, properties, crops etc.). The victims of Bagmati Province (Kavre district) experienced almost similar situation as like that of Karnali province such abduction, rape, killing, damage of properties and torture. Moreover, the availability of mental health service varies across the provinces. Although some mental health services were available in Bagmati and Lumbini, there were no such services in Karnali province at the time of implementation of MHPSS project. Experiences of conflict victims across different provinces make them different in one way and similar in another.

We chose the sites for the current research based on the implementation performances revealed in the review of intervention project reports (annual report of last three years (September 2021-June,2024). Sites where more than 90% of planned activities were implemented, had an increased number of MHPSS users, have availability of MHPSS trained service providers at health facilities, and ensured participation of municipality in MHPSS intervention activities including resource contribution, were considered having "good implementation". Sites where challenges were experienced in implementation of MHPSS intervention activities in municipality, had low or no participation of municipality in decision making in implementation of intervention, resulted in no increase of MHPSS users, and reported transfer or change of trained service providers were considered to have "challenging implementation" (See Table 2). For the qualitative component, we selected two municipalities, one "good implementation" and one "challenging implementation" purposively from each province. Therefore, we selected Rajapur (good)

and Barbaridya (challenging) from Lumbini province and Bheri (good) and Birendranagar (Challenging) from Karnali province and Chaurideurali (good) from Bagmati province. The highlighted municipalities were selected for qualitative data collection.

Table 2. Municipalities differentiated based on implementation performance

Province	District	Municipality having good implementation of MHPSS intervention	Municipality having challenging in implementation of MHPSS intervention
Bagmati	Kavre	Dhulikhel municipality, Chaurideurali municipality	Panchkhal municipality
Lumbini	Bardiya	Rajapur municipality, Thakurbaba municipality	Barbardiya municipality Banshgadhi municipality
Karnali	Surkhet	Gurvakot municipality	Birendranaganr municipality
	Jajakot	Bheri municipality, Nalgadh municipality	
	Rukum West	Chourjahari municipality, Aathbishkot municipality	

2.3. Data Sources

CMC-Nepal has maintained documents like detailed implementation plans, training package on mental health and psychosocial counselling training manual that followed WHO mhGAP guideline, clinical supervision guideline, and awareness material. Additional documents include activity reports such as service utilization data from mental health and psychosocial counseling, awareness activities including orientation and advocacy meetings with municipality and province authorities (through municipality project advisory committee and province steering committee). Moreover, progress report of activities implemented and report of monitoring outcome against project log-frame (outcome and indicator based), which are produced twice a year are also available for review. Based

on these documents, we will select study participants, cross-check the trustworthiness of the data being collected for the study and contribute to and triangulate the data collected related to fidelity of intervention implementation. Data on utilization of mental health service is also accessible through government data reporting platform related to health i.e., Health Management Information System (HMIS).

These data has been used for fidelity information such as whether training and supervision happen as per plan, and whether trained service providers are using training manual for identification and treatment of mental health problems identified at the primary health care facilities. New data sources compared to the primary data collected on implementation outcomes/domains of the intervention. This includes acceptability, appropriateness, adoption, cost, fidelity, feasibility, penetration and sustainability (Proctor et. al, 2011).

2.4. Key Variables focused on study

Demographic information (client): **Annex 1: Survey Questionnaire for Service Users**

Acceptability

Definition: Acceptability is multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention. Acceptability will be assessed through four different indicators at provider, receiver and both levels. The method of data collection, tools to be used and annex is presented in the table below.

Indicator	Level	Method	Tool	Annex

Provider's attitude towards intervention	Provider	KII	KII guideline	Annex 10 A
Clients attitude towards intervention	Client	Survey	TFA scale	Annex 1- Section 2, section 3A, 3B
Dropouts of service users	Client	Record review	Record review format	Annex 2

Adoption

Definition: Adoption is defined as the intention, initial decision, or action for a provider to try or employ an innovation or evidence-based practice. Aaron G.A. (2004) (12) has adopted the tools for the attitude of mental health providers on evidence-based practice. Further it has been used on drug addiction related research as well (Haug N.A., 2008)

Indicator	**Level**	**Method**	**Tool**	**Annex**
Provider's attitude towards innovation and change	Provider	KII	KII guideline	Annex 10 a
Providers' education, training/skills	Provider	Checklist	Check list	Annex 1-Section 1, Annex 6, 7
Organization policy for adoption	Provider	KII	KII guideline	Annex 10 A
Innovativeness, and willingness of change in policy or decision making	Provider	KII	KII guideline	Annex 10 A

Appropriateness (Relevancy)

Definition: Appropriateness is the perceived fit, relevance, or compatibility of the innovation or evidence-based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem related to MHPSS service system.

Indicator	Level	Method	Tool	Annex
Perceived relevance of the intervention and compatibility; whether Government policy mandate talk about existing problems and their solutions	Provider	KII, FGD	KII and FGD guideline	Annex 10a, b, c
People's or community need a priority of local government	Provider	KII	KII guideline	Annex 10a, b, c

Cost

Definition: Cost is defined as the cost of implementing the intervention. In this study cost represents the true cost for the service delivery calculated as unit cost.

Indicator	Level	Method	Tool	Annex
Out of pocket expenditure per client	client	Survey	Survey questionnaire	Annex 1
% of total allocated budget vs total spent in Mental Health	Provider (decision makers)	KII and record review	KII and record review format	Annex 7- section 2, Annex 8-section 1, Annex 9- section 1

Feasibility

Definition: Feasibility is defined as the extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting.

Indicator	Level	Method	Tool	Annex
# of recruitment	Organization (municipality, health facility)	Record review	Record review format	Annex -2,6
Retention rate	Provider	Record review	Record review format	Annex-2, 6
Participation rate	Provider and client	Record review	Record review format	Annex 5,7,8,9, 10 a

Fitness and compatibility of initiative with organization mandate, system and service environment	Provider and service providing organization	Observation (Health facility Assessment) KII, FGD	Observation checklist KII and FGD guideline	Annex 10a

Fidelity

Definition: Fidelity is defined as the degree to which an intervention was implemented as it was prescribed in the original protocol or as it was intended by the program developers.

Indicator	**Level**	**Method**	**Tool**	**Annex**
# of provider trained and employed	Provider organization	Record review	Record review format	Annex 2 and 5,
# of cases reached by the intervention	Provider organization	Record review	Record review format	Annex 5
Adherence of process by providers	Provider	Observation	Observation checklist (competency checklist)	Annex 3, Annex 7
Variation on: testing, screening or counselling of patients of two conditions, availability of services on the same day/visit by the same or different providers	Provider	KII	KII guideline	Annex 10 a,b
Variation on: referral practices, common treatment & counselling spaces, availability or receipt of commodities, equipment and medicines for two or more conditions.	Provider	KII	KII guideline	Annex 10 a, b

Penetration

Definition: Penetration is integration of practice within a system (primary health care for this study) and its subsystem.

Indicator	Level	Method	Tool	Annex
# people receiving MHPS service over the year (conflict and non-conflict)	Health facility	Record review	Record review format	Annex- 5
# of conflict victims who received MHPSS services over the year.	Health facility/ municipality	Record review	Record review format	Annex -2, 5

Sustainability

Definition: Sustainability is defined as the extent to which a newly implemented treatment or intervention is maintained or institutionalized within a service setting's ongoing, stable operations.

Indicator	Level	Method	Tool	Annex
Internal and external environment of the organization (infrastructure, location of facility, supply chain, logistic management, human resources)	Provider organization	KII	KII guideline	Annex 10a,b
Infrastructure: room for MHPSS service with required materials and equipment	Organization	Observation (Health facility Assessment)	Observation Checklist	Annex 5- section 2
Funding stability	Provider organization	KII	KII guideline	Annex 10a

2.5. Data Collection

Data Collection and Sites

Participants from all levels of stakeholders involved in the intervention were participated in the study. Survey data were collected from all 13 municipalities from selected CVs who used MHPSS interventions. Qualitative data were collected from five municipalities such Chourdeurali of Kavre, Rajapur and Barabardiya of Bardiya, Birendranagar of Surkhet and Bheri of Jajarkot. MHPSS providers, policy level

decision makers and member of OPD were selected for the KII, while selected MHPSS service users' for IDI and community members for FGDs.

Survey data collection completed by 31 December 2024 and qualitative data collection by 10th January, 2025.

2.6 Sampling and data collection method

2.6.1 Conflict victims/service users:

For the survey of client sample will be decided using Cochran's sample size formula for finite population, n' = n/ [1+ {z2∗p̂(1-p̂)}/ε2∗N], where, n is the sample size calculated assuming infinite population (384) z is the Z-score (1.96) p̂ is the population proportion (50%) ε is the margin of error (5%) N is the population size or number of conflict victim (442) As the population size of the conflict victim is 442, sample size for the conflict victim is 205. Considering non-compliance rate of 10%, the required sample size is 225. Since there is a defined number of conflict victims using MHPSS intervention in the first year, we selected the service user conflict victims from this pool following simple random sampling process. Service user (client) data were collected through the survey. A total of 233 service user's data were collected from the survey, however upon verification of the data we have removed five participants because they had not used MHPSS services. Thus, a total of 228 service user's participated in the survey. Further, 6 MHPSS service users were selected purposively from each municipality where qualitative component implemented considering age, sex, and type of conflict to ensure a diverse pool of participants. So, there were a total of 30 service users for IDI from five municipalities.

2.6.2 Providers at facility level:

A total of 10 health worker, 10 PSCs and 5 CPSWs trained in MHPSS service were interviewed (KII) from five municipalities and one psychiatrist from Karnali province hospital and one from Bheri Hospital, Lumbini. So, we completed 27 KII with service providers with consideration of gender and other characteristics, such as age and ethnicity, while selecting the participants, wherever possible. Competency checklist were administered to 58 participants (MHPSS providers) to assess the adherence to the skills/process.

2.6.3 Decision makers at Policy level:

We completed KII with policy level decision makers (Mayor or Deputy Mayor, chief administrative officer and health section chief) from five municipality selected for the qualitative data. Thus, we completed KII from 13 executives from four municipalities and 6 authorities from Kanali and Lumbini province and two authorities from EDCD, federal ministry. KII also conducted with two members of Organization of People with Disability (OPD) from Karnali and Lumbini. Thus, a total of 24 KII were conducted.

2.6.4 Community members:

A total of 5 FGDs from community members were conducted, one from each municipality selected for qualitative study. Participants were selected purposively through coordination with the health section of municipality. A total of 30 community members participated in five FGDs with diverse gender, ethnicity and age.

2.6.5 Health facilities assessment: Data were collected through using the checklist and observation of health facility and recording of MHPSS service in primary health care settings, a total of 10 health facilities data were collected selecting two health facilities from each municipality where qualitative data collection focused.

Data Collection Method and participants

Data Collection Method	**Participant type**	**Number**
Survey	Service users (client)	Approached individually through home visit (n=228)
IDI	Service users	6 from each municipality @ municipality= 30
KII	Service providers (specialist care providers, psychosocial counsellors, health workers and community psychosocial workers)	2 specialist care providers + 10 psychosocial counselors + 10 health workers + 5 community psychosocial workers = 27 KIIs
KII	Policy level decision makers (elected representative and administrative staff) + organization of people with disability (OPD)	5 mayor/deputy mayor + 5 chief administrative officer + 5 health section chiefs +5 provincial authorities (3 Karnali and 2 from Lumbini) + 2 federal authorities+ 2 OPD members = total KII -24
FGD	Community members in intervention municipality	5 FGDs, one from each municipality (30 participant in 6 participants in each FGDs) of qualitative study.

Note: Total number of qualitative interviews = 81 (including KII and IDI); Including the FGDs, the total number of transcripts will be 86.

2.7 Ethical approval

NHRC and Social Welfare Council (SWC) are concerned government bodies at federal level to approve any studies. We have obtained approval from SWC for research project implementation and ethical approval from Nepal Health Research Council (NHRC) on September, 2024. Similarly, we have obtained approval to conduct research activity from the municipality. Further, we have thoroughly reviewed the research protocol together with URC and BRAC team, their input has helped to finalize the protocol. There was also a visit from USAID-HEARD team and interacted about the research design and preparation for the study.

3. Data collection

3.1 Pre data collection phase- Data collection tool development and pre-testing

Quantitative:

To collect quantitative data, we used available relevant and validated instruments, as well as questionnaires and checklists we developed ourselves. The available standard validated tools selected include Theory Informed Questionnaire (Sekhon, M., Cartwright, M. & Francis, J.J., 2022), Evidence Based Practice Attitude Scale (Aarons, G. A. 2004), Stigma scale (Adhikari, B., Kaehler, N., Chapman, R.S., Raut, S. and Roche, P., 2014) , Participation scale (Van Brakel, W. H., Anderson, A. M., Mutatkar, R. K., Bakirtzief, Z., Nicholls, P. G., Raju, M. S., & Das-Pattanayak, R. K., 2006) to collect quantitative information on Acceptability among Service users. The tools selected and developed are in annex of this protocol. The questionnaire were translated into Nepali language and pretested followed by local contextualization of the instrument. The theoretical framework of acceptability (TFA) was developed in response to recommendations that acceptability should be assessed in the design, evaluation and implementation phases of healthcare interventions. The TFA consists of seven component constructs (affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy) that can help to identify characteristics of interventions that may be improved.

Qualitative:

We developed FGD, KII and IDI guidelines based on intensive literature review related to intervention and study objectives. The guideline was developed from English and were pre-tested in small samples other than present project area. Field testing findings were incorporated in the tools and made ready for main data collection. All data collection tools have been translated into Nepali.

3.2 Recruitment of field staff team

We have recruited a project coordinator (PC) to overall management of the project, 4 research supervisors (RS), 9 research assistants (RAs). RS were selected having at least bachelor's degree of education in public health or social work or psychology or psychiatric nursing or sociology and have at least 3 years of work experience in research including field data collection or master degree in public health, psychology, psychiatric nursing, social work or sociology with 1 year experience of working as a research supervisor. RA were selected having at least higher secondary (12 grade) level education in health sciences or bachelor's degree in public health, social work or psychology or sociology and have at least 1 years of work experience in research data collection. Priority was given to those who have experience in collecting qualitative data. Gender distribution of RA/RS was 7 females and 6 males, this gender distribution supported to address potential gender factors in the data collection process. A data management officer also recruited to support tools finalization, development of data collection template and over all data management part.

3.3 Training for research team

Field level data collection team includes Research Supervisor (RS) and Research Assistant (RA). Field data collection team (RA and RS) received a five-days training course on both qualitative and quantitative data collections tools, conducting survey or interview or discussion before deploying in the field. Training content include study objective, overview of intervention, data collection procedure including interview technique and interviewing etiquette, recordings, research ethics and obtaining consent,

familiarization on questionnaire and data collection tools, use of COBO Collect, topic guide and probing technique, transcription, data safety, storage and transportation. Training methods followed lecture, discussions, and practical sessions. A mock interview session also conducted to ensure that data collection team has the interview skills along with theoretical understanding.

3.4 Field testing of the tools:

a) **Pretesting of study tools:** It is part of training of field data collection team (RA and RS), they visited in field testing site, conducted survey in small sample of MHPSS service users in other site than this research project area, conduct 2 FGD, 2 KII and one IDI, 10 survey to get information whether data collection tool is understandable for the participants, whether it can generate required data, how much time require in survey, IDI, FGD and KII. Research team (team lead, consultants, PC) conducted reflection of field testing with RS and RA and do needful review of each items of each tool, do needful modification as required for qualitative tools and sentence phrasing in simple and understandable language of survey tool. Field testing helped RA and RS better understand on using COBO collect through android tablet for the survey.

b) Participant selection: PC and DMO prepared the list of selected participants for survey and qualitative data collection. We collected the list of MHPS service users from the health section of the municipality. Survey participants (MHPSS service users) were selected following simple random sampling from the MHPS service users' list of municipalities.

3.5 Data collection phase:

Once selected, the participant were informed through the health facility in-charge (for users, and community members) of the municipality. Interview was conducted at community visiting the family for survey. RA conducted survey, first introduce who s/he is, why visit the family then share about consent to participate in the research before starting the survey. Survey questionnaire were feed into COBO collect software in android version tablet, RA present survey question as structured in the COBO Collect. Once the survey data collection was completed, RA reviewed whether any question was missed or properly recorded the response of the participant, then upload to the central server. Similarly, for qualitative data collection, participants were informed by the health section of municipality. The RS share the study information and consent process including confidentiality of the data and purpose of the study to obtain the consent both verbally and written. FGD was facilitated following discussion guide by research supervisor. The data collection team ensure of obtaining written informed consent from each participant to enroll in this study and collect data. We printed information sheet about this research and why and how it will be conducted, any potential risk to the participant and how it will be addressed (e.g. if any CV participant showed emotional overwhelming reaction while talking about their history), responsibility of participant and their right if they took part in the research. All written, data notes, recorded data and data collection devices were collected from both RS and RA once the field level data collection work is completed. All devices that were used in this research have a separate password to protect access and the data. Paper data information were computerized by DMO and PC and kept in double lock system filing cabinet. We anonymized the identification of the participation using a code system in the computer.

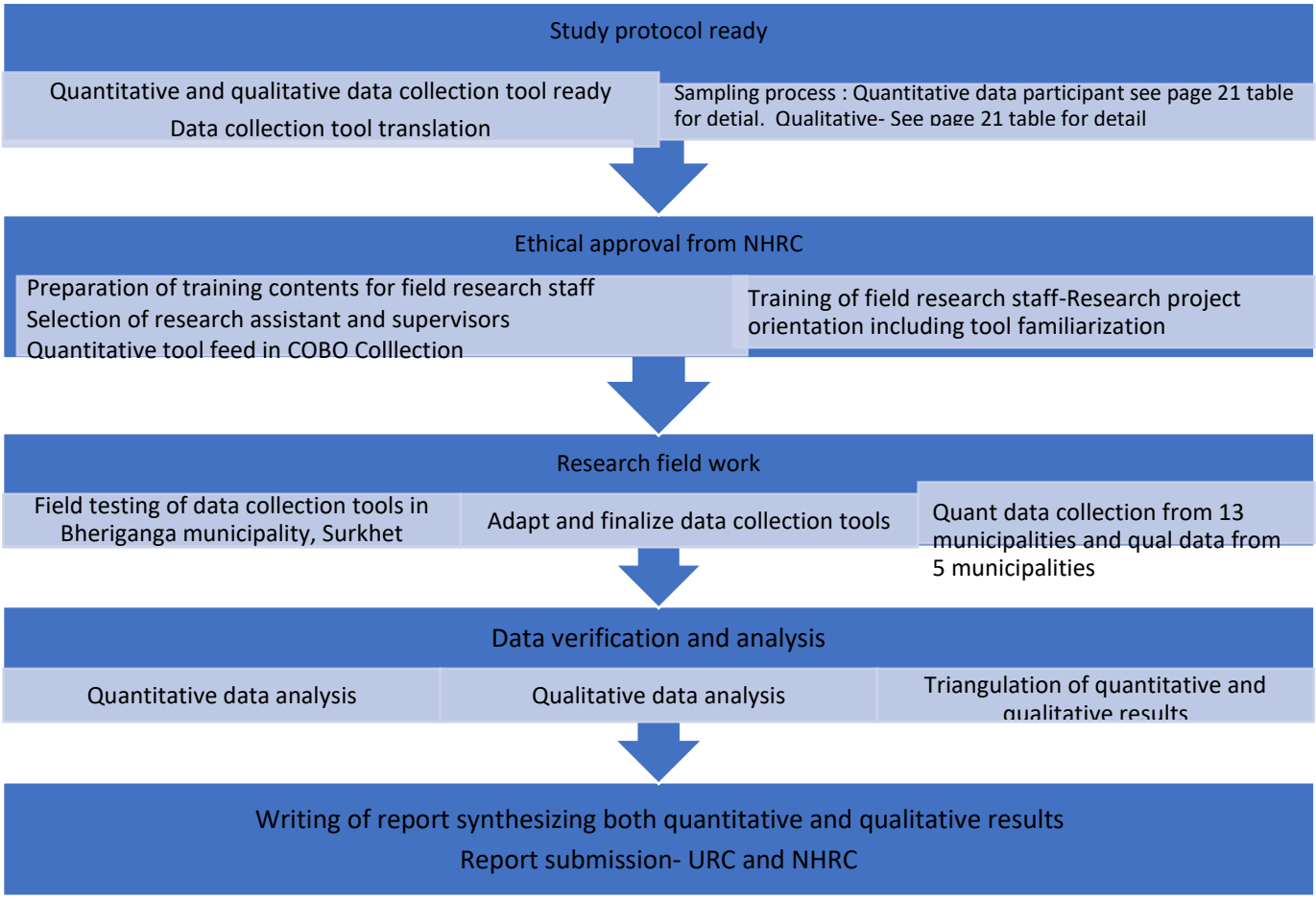
Quantitative

As stated above quantitative data includes Survey information record review and observation checklist. Data uploaded from the RA from field were regularly reviewed daily by DMO and provide necessary feedback to respective RA and PC as well. The approximate duration of one survey interview would be 30-40 minutes.

Qualitative

The RS together with RA collected qualitative data through FGD/IDI/KII from selected participants as shown in previous table. KII, IDI and FGD facilitated by research supervisor and assisted to make notes in a separate note book by RA having experience in qualitative data collection. Data were recorded in Android tab device with consent of participant. Key notes of the interview were shared by the supervisor to research team (team leader, PC, data management officer, research consultants) who reviewed the notes and provide necessary feedback to the field team to support the data collection process. Qualitative data recordings was transcribed by the research supervisor and shared to the PC including original interview records. It was further reviewed by the research team.

Study flow chart



3.6 Monitoring, Supervision and Quality Assurance

The research team leader, research consultants, PC and DMO closely monitored the overall process of data collection, data storage, verification, transcription and translation. In-house monitoring of data was done daily by DMO and PC. The research team (team leader, consultant and PC) visited the field at the initial phase of data collection to provide proper guidance and supervision to the data collection and sort out issues related to data collection.

Quantitative:

The data collection team were provided with the interview tracking form which was sent to the DMO each day. The DMO ensured that the right participant is selected and interviewed through verification of interview tracking form with the list provided to the data collection team. She also ensured that all data was sent to the central server on a daily basis. She further verified the completeness and consistencies of the data sent

from the field and provide feedback accordingly. Any issues raised during data collection were sorted out by DMO after consultation with the research team leader.

Qualitative:

PC conducted online debriefing meetings with data collection team every evening during initial days and every alternate day on later weeks of data collection to discuss the key points of the interview. The research consultant reviewed the key-finding-template sent by the data collection team. Feedback related to content adequacy; probing area were provided to data collection team to encourage collection of rich information to the best possible. Interview transcript and recordings were sent to PC/ DMO every weekend. These transcripts were also reviewed, and feedback provided accordingly.

Post data collection phase

Data processing

Quantitative data were checked for completeness and consistency. Data coding and cleaning was done by DMO and research team (team leader, PC and consultant statistician). All interview audio files were transcribed verbatim in Nepali language. Then it was translated into English. The daily field notes and debrief notes has helped the local and the international team to get idea of core themes and identify potential questions to explore should data collection continue. URC and BRAC team were consulted for data analysis mainly for qualitative data.

4. Data Analysis

Quantitative data: SPSS software used to analyze quantitative data. Descriptive statistics performed to investigate the participants' characteristics and mean scores, chi-square to study the relationship. Percentage of a particular response category derived from the data obtained in Likert scale.

Qualitative: The data analysis process starts with systematically searching and arranging the interview transcripts, observation notes, or other non-textual materials that the researcher accumulates to increase the understanding of the phenomena. We used the Framework Analysis Method which incorporates thematic analysis and display of data in a matrix for theme and pattern identification. As a first step, the transcripts were read a few times for familiarity. Second, a list of priori codes developed and added to codebook. These a priori codes are based on tools and research questions. This is the deductive analysis method where those codes were applied to the text. New codes that emerge from the transcripts were applied and added to the codebook, and necessary modifications to existing codes made, whenever necessary. This is the inductive analysis method. Once all the transcripts are coded, the data are extracted and put into a data display matrix. The matrix enables us to find similarities and differences across cases, locations, type of conflict victims etc. and therefore enable us to determine themes and patterns in the data. Data entered into the matrix are in English, and therefore the international colleagues can also crosscheck the data, analysis and work together as a team to identify answers to the research questions.

Qualitative data are triangulated with quantitative data, and within methods, wherever possible. For example, data collected through survey with clients are triangulated with interview with clients. Instances where acceptability is high or poor it is correlated with qualitative data on their experiences. Similarly, the checklist used to determine the number of trainings providers are supposed to receive versus the number of trainings happening in practice are matched for similarities or differences.

5. Results

5.1 Quantitative result

A total of 228 conflict victims participated in the study with average age 49.69 years and ranged from 16-88 years old (Table 1.1). Similarly average approximate monthly income of conflict victims is 19,864. Thy spent in average Rs. 694 per month for the treatment. There is slightly higher number of conflict victims in the study which is because of availability factor of the victims during the data collection period.

Distribution of participants according to municipality (Table 1.3) showed higher number in Chourideurali rural municipality followed by Banshgadhi municipalilty, Bheri municipality and Dhulikhel municipality. Gurbakot municipality of Surkhet and Athbishkot municipality of Rukum west has least number of participants in the study. As we have selected conflict victims who received MHPSS service at first year of project implementation and selected proportionately based on having number of conflict victims in the intervention. Sociodemographic result (Table 1.4) showed higher representation of female (64%), married (64%), Brahmin/Chhetri, Janjati and Dalit in case, Hinduism by religion and nuclear family. About 28% participants are widowed and is significant factor for mental health. Regarding education qualification of the participants half of the participants only can read and write, among them 23% attained basic level education and only 15.8% attained secondary level education. Result showed majority conflict victim participants' have agricultural farming occupation (Table 1.4) followed by domestic work (house wife). Nature of conflict victim experienced (Table 1.5) showed 45.6% victim had lost their family member (killed during conflict) and 25% experienced disappearance of family member and have yet not received whereabout information. Large number of victims experienced self-tortured and family member tortured during conflict.

Conflict victims have been using both individual counselling (63.6%) and group counselling (77.2%) service while mental health treatment service has been used only by 19.7% conflict victims (Table 1.6). This is because mental health service had been mainly developed in the first year, so seems it is taking more time to accept while recent government report (HMIS and DHIS-2) report showed very high number of people including conflict victims are using mental health services.

Psychosocial counsellor (PSC) and CPSW were the major source of case referral followed by friends, relatives and FCHVs (Table 1.7), indicating the potential strengths of referral

source as PSC and CPSWs have better knowledge on mental health and psychosocial problems and service availability while other's need more frequent awareness regarding MHPSS service availability. More conflict victims have information about health insurance followed by agriculture related support, medical treatment and exposure visit related services of municipality (Table 1.8) while 57.9% have utilized it (Table 1.9). CV have utilized mainly skills training, honoring activity, exposure visit, health insurance and agricultural services (Table 1.10).

MHPSS service acceptance (Table 2.1) is high among conflict victims (AC8-96%) and all other items have high percentage of acceptance which is good sign of liking and utilizing MHPSS service by the conflict victims. Conflict victims faced difficulty in the trust from family and society so they experienced challenges in social participation (Table 2.2), increased problem in getting equal opportunity to work and social participation. Even CV rates in other scale good while they still feel challenges in equal respect and participation in various domain of social life though there is growing trend of supporting from family and community. Municipality has also started recognizing MHPSS service need as they are increasing investment in metal health. Participants rated reduced stigma while being in family, peers and community and increased awareness that mental health problems will not transmit while contacting to others, people are visiting MHPSS service user's house easily (Table 2.3). It is good sign that people with mental health problems growingly recognized as curable health problems and support is available in the community.

5.2 Qualitative result

Acceptability

Service users and providers appear to be highly positive and receptive toward the intervention. Service users reported feeling relieved and happy after receiving treatment/counselling service. A positive shift has been seen in the community's awareness and acceptance of mental health care. There has been a noticeable change attitudes toward mental health, with more people seeking care at health facilities instead of relying on shamans and faith healers. Health workers mentioned that people are now more likely to seek out mental health services, and they often refer others to the service.

> *"Now, the first thing is that this organization has brought programs targeting conflict victims, I think these programs are very good, all the programs (activities) are good…….Now, I think the services we have received …. it 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… let's say a little transformation, something for ourselves, now something huh…. The different feeling is that…. 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)*

> *"The service recipient who takes regular medicine and has been cured is very happy. They say - if we had known about such medicine from the beginning, we would not have ended up in this situation in the first place, the medicine is available in our health institution nearby, I went to so many places to faith healer, so much was spent, it would have been better if I had known about this earlier." (KII with health care provider 02 at Karnali)*

> *Now, it's like this: wherever there is a spiritual healer, the talk of ghosts, witches, or shamans arises, right? You hear about spirits, Goddess Durga, etc. But where there are doctors, the focus is on*

diseases, right? Before, there was no counseling, and people didn't understand what mental illness was or what symptoms it had. But as things started moving forward, people began to realize, "Oh, this is what it is." Once the symptoms were identified, people started coming forward. So, wherever treatment starts, that's where the illness is detected and cure begins. Similarly, once mental health treatment began here, people started to understand and came for help. People with those symptoms started coming, and the treatment continued. (KII with Municipality Authority 54 Lumbini)

Service providers feel motivated when they see improvements in their patients' conditions. Before training, they had limited knowledge and couldn't provide formal treatment, but afterward, they began diagnosing and treating many mental health conditions.

"Earlier, she used to play water every time and would sit alone. But now, she can have conversations and talk normally. Now, she comes by herself to ask for the medicine. …. Yes, we are happy when our work positively impacts their lifestyle." (KII with health care provider 01 at Karnali)

"Well, before we received training from CMC Nepal, we had a limited understanding of mental health issues, but we were not formally providing medication or treatment. After receiving training from CMC Nepal, we started offering mental health treatment from this health facility and referring patients with complex cases to higher-level institutions. We provide services for issues like psychosis, epilepsy, and other problems like depression and anxiety, as much as we can….. We've been able to manage about 90% of the service users we encounter in the community without needing to refer them." (KII with health care provider 01 at Karnali)

Now, when I see someone in my neighborhood who is going through such a difficult mental state, it gives me a lot of encouragement. If we could have provided service to them, it would have been even better. For any case that I am treating now, when I see significant improvement, it makes me feel happy. (KII with health care provider 34 at Lumbini)

While many service users benefit from mental health services, dropout rates remain high. Some people stop visiting service provider and taking medication due to a lack of

understanding, traditional beliefs, or logistical challenges like difficult terrain, travel costs, time constraint and so forth. To address this, service providers actively follow up through phone calls and community outreach to encourage continued treatment. However, they report feeling burdened by heavy workloads, juggling multiple responsibilities, limited resources—especially shortages in medication supply and dosage variations—and challenging geographical terrain to reach the service users.

> *"The dropout rate is much higher. Once they come, this mental health counseling has become one thing, another is the mental health treatment service. Once they come and take medicine, if something goes wrong, then they don't come for follow-up for the one requires continuous follow-up, and if there is no continuous follow-up, the mental health problem that they have, the diagnosis that they have, will not be cured by treatment. For those who are not able to come for follow-up, we are doing a good job there. What we have is that those who do not come for follow-up, our counselors go and bring them for follow-up immediately. Their contact numbers are kept, they {service provider} call them in advance and inform them that they should come on a certain date, but if no one comes, they call again, if not on the same day, then they keep bringing them in anyway." (KII with health care provider 56 at Karnali)*

> *"I feel that it is a little more difficult for them to arrange their time than us, they don't have time. Some are farmers or some have family problems, so it is a little more difficult for them to arrange their time than ours, sir." (KII with PSC 03 at Karnali)*

> *"With determination, nothing is impossible. However, it's challenging for two health workers to manage everything, including family planning, psychosocial issues, dental issues(laughing), dressings, etc. Now, if we look at the mental problems of CMC, they have a matter of counseling, they have a matter of confidentiality, they have a matter of management of their speaking style. Each mental health consultation takes about 30-45 minutes, including medication management and patient counseling. We feel sad because we can't always give enough time due to the heavy workload and patient flow.*

Having more staff would help manage the patient load better." (KII with health care provider 01 at Karnali)

"Now we have a small problem, sometimes there is no medicine as required, sir, sometimes the dosage of those 12 medicines is different. We usually give a medicine called sodium valproate 500 (mg??) to patients, but in the municipality, we get 200 and 300. The patient was supervised by the doctor yesterday and was told to take it from 7 am to 7 pm. He was to be given 1400 (mg??). When he mixed it up, it was a little difficult to explain it to the patient. Even if the patient takes the medicine for a month at once, he had to take a lot, it was a bit difficult. Otherwise, most of the patients who come there are fine. Sir, it is not that difficult." (KII with health care provider 02 at Karnali)

Appropriateness

Stakeholders acknowledge the increasing burden of mental health issues within the community, driven by modernization, societal changes, and the lasting effects of past conflicts. Over the past decade, they have observed a shift in health concerns from primarily communicable diseases to a growing prevalence of non-communicable and mental health conditions. They emphasize that this service remains particularly relevant for conflict victims, who continue to experience long-term psychological distress, necessitating sustained mental health support. However, mental health concerns extend beyond conflict-affected individuals to a broader population, including those impacted by domestic violence, economic hardships, and social pressures. The intervention is reported to be effectively aligning with local needs, addressing both conflict-affected populations and others as well. People have been able to effectively continue their daily activities and are slowly being integrated into the community.

"They (conflict victim) have problems with their previous work {life experience}, apart from that and now we are also doing it to others. Huh…. it would be better to focus on people other than only

conflict victims….. By others, you mean all [pause for 3 sec] affected people…… No, it's not only just because of the conflict, sir, there is one problem because of the conflict , families have lost their family members, some have been tortured, which might comes to mind, how many have lost their family members, they were displaced at a young age, that was the time when the investment that should have been made, those things cause pain to them and to other people as well, as I said before, according to the new changing environment, even when modernization is taking place, it shows problems, even if you can't become like others, there is a problem. Even if you can't keep up with the times, there is a problem. That being said, this is still somewhat relevant in the current situation, sir." (KII with PSC 03 at Karnali)

"The training is good. It would be beneficial to provide it to all health workers and also raise awareness among female community health volunteers. 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 amlodepin for non-communicable and mental health diseases in the past eight to nine years." (KII with health care provider 01 at Karnali)

Training provided to health workers has enhanced their ability to address mental health needs. However, stakeholders recommended expanding this training to include all health workers and female community health volunteers (FCHVs) to strengthen service delivery. The introduction of mental health services through CMC has significantly improved accessibility to care. Additionally, stakeholders emphasize the importance of integrating mental health services with more livelihood and skill development programs to promote long-term well-being especially for conflict victims.

"I think one thing is that, now when we say conflict affected, it is understood that these are people who were affected by the conflict and it seems that this mental impact, that is, the need for psychological counseling, will be needed for a long time until eternity." (KII with service user 11at Karnali)

"Right now, especially the service users here tend to be people with somewhat better financial conditions. They go to places outside, like Lakhnaut (India) or Nepalgunj, but those with weaker financial conditions, the ones from lower-income communities, come to us. The community here is also similar. They are very happy with the service. They say the medicines are for only a short time, but some need to take them long-term, and some may need to take them for life. Given that, hmm ... the financial situation is also an issue. The main members of the family, the ones who earn, are in a tough situation. The financial condition becomes weak. Because of this, they can't afford to buy the medicines and need to go outside for follow-ups. That was very difficult before, but now it's much easier. They respond very positively now." (KII with health care provider at Lumbini)

Municipalities recognize mental health as a critical priority and have incorporated mental health services into their plans and policies. Local government officials, including mayors and administrative staff, actively support these initiatives through referrals, medication provision, and financial assistance for treatment. However, while mental health strategies have been formulated and formally adopted, full implementation remains a challenge due to gaps in service provision and resource availability.

"The municipality has provided support, they, the mayors do the referring [hand folded]. The mayors, the administrative staff,the official chief, provide support over the phone and ask to understand [ahh]. When we ask the municipality that if we need any support, they don't say no. When we say this in our partnership programs, they have a slightly different vision about the work that partner organizations have been doing. Municipalities have done it themselves." (KII with PSC 03 at Karnali)

"रणनीति मा त समावेश हुने एउटा कुरा भयो के अब गरेको भएपनि मलाई मुख्य कुरा रणनीति भन्दा पनि कार्यनीतिमा त्यसलाई चाहिँ लागू गर्नुपर्छ जस्तो लाग्छ, कार्यपालिकाले त्यो गरे पनि तर त्यसलाई जुन रूपमा लागू गर्नु पढ्थ्यो नि अब ,अब यो सम्बन्धीको कार्यक्रम मनोपरामर्श नभएर अन्य सुविधाहरू जस्तै द्वन्द्व पीडितहरुका लागि अन्य सुविधाहरु पनि त दिनुपर्ने होला अथवा दिन सकिन्छ होला नि त ,त्यस्ता अन्य कुराहरुमा पनि अलिकति अन्य समस्याहरुलाई पनि खोदलेर हैन त्यो समस्याहरूलाई पनि बुझेर त्यस्ता किसिमका कार्यक्रमहरु पनि अब लागू गर्न सकियो भने पछि र नगरपालिकाले पनि अझ

प्रभावकारी ढंगले लागू गर्न सके राम्रो हो,तर त्यति राम्रो अझै भनौँ न पूरै एकदम भइसकेको चाहिँ भएको छैन जस्तो लाग्छ" (IDI with service user 11 at Karnali)

Adoption

As the burden of disease is increasingly dominated by non-communicable diseases, knowledge of mental health conditions has equipped service provider to better serve the people. Before receiving training from CMC Nepal, providers had a limited understanding of mental health issues and did not formally provide medication or treatment. After completing the training, they are in better position to offering mental health treatment at their facilities and referring more complex cases to higher-level institutions. There was absence of policies at local level. With support from CMC Nepal, almost all intervention municipalities have developed their mental health strategy and also has included mental health counselling in its yearly plan, recognizing the growing need for mental health service. However, some stakeholders note that while the municipality has provided necessary supplies and included mental health in annual plans, full implementation remains a challenge due to resource constraints. At the local level, the decision to include mental health counselors in municipalities has been integrated into policy. Despite this, there is a growing willingness to change. Though there is a long way to go in ensuring full adoption and implementation, there is a general openness toward mental health initiatives, particularly as communities begin to see the positive impact of the intervention.

"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)

"In the case where the government itself has decided that at least one or two posts should be kept in the hospital, a counselor should also be needed, it has been kept in a policy. The major challenge is how much implementation will be done, who will do the implementation. We have also made a mental health policy at the local level, but we have not been able to allocate the budget in line with it. We are not able to meet it in the plan. Because we have limited resources [hah], that is why we are not able to focus on mental health alone, and the central level and federal government also only get 20 thousand for mental health." (KII with municipality authority 56 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. Health workers have become more capable of independently managing mental health issues, demonstrating greater confidence in diagnosis and treatment. However, logistical challenges such as medication shortages and space constraints and resource constraints remain barriers to fully optimizing the program.

Moving forward, health workers are motivated to continue improving their services, hoping that additional resources and expert support can be integrated to enhance their ability to provide comprehensive mental health care. Furthermore, they are encouraged by the growing trust in the intervention among service users. No significant changes have been observed in the intervention activities, including the standard operating procedures or manuals for managing patients with mental health issues. On site supervision by assigned mentors and consultation from specialist via phone call is being done on regular basis and cases are referred to advanced health centers when necessary. However, the frequency of supervision has reportedly declined in some municipalities over the past year.

"they say that this program is good. Now that we have received this service, it has become easier for us after we received it and there are people like us who did not know about it. They also say that it would be good for them if they received this service. They also recommend the service now, and the service recipients send the people to receive the service ……There have been no such changes (in the implementation of the intervention) …… Now we, rather than changing it a little, it seems that new things have been added a little, Also, the exercises for managing the stress have been added a little, sir, they…… like , first you used to do deep breathing, and then you used to do life guru, now it is the same to the same but Jivan guru is now Jjivan nali……..And then other things have been added recently……QBMR…..Quick Progressive Muscular Relaxation….Now that is a stress management exercise and we also provide counseling or personal counseling to the service recipients …..This counseling makes it easier for them to solve the problems, they do it themselves, we only show them by talking to work on their problems, we only identify them and show how can you do it." (KII with PSC 03 at Karnali)

"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)***

"We have a supervisor. As the supervisor is in (#A001#) municipality and the CMC office is also located here. From upper level , (#S001#) ma'am, (#S002#) sir, and there is also (#S003#) sir who comes and they also supervise us on the things that we don't understand on time to time basis……. we discuss it once a month. we keep discussing it every month. supervision is done sometime in. three months and sometimes in six months……from CMC and from the municipality too." (KII with PSC 20 at Karnali)

"Now... [clearing throat] according to our policy, we will move forward, right? And up until now, our understanding is that, as it is, if we can continue with what is going on, there will be a lot of achievements. But, still, it won't be enough. There needs to be a bit more in terms of the treatment process. For example, if we could make it more regular, that would be better, right? Now, we also need to bring specialists from Kathmandu. How to keep bringing them regularly, what to do–it will be

a bit of a challenge, you see. But we are trying to manage it. Let's see what happens in the coming days." (KII with Municipal Authority 54 at Lumbini)

"बिरामी हेर्दै जाँदाखेरि सुरुमा केही न केही गाह्रो हुन्थ्यो जस्तै डिप्रेसन हो कि साइकोसिस हो छुट्याउने अलिकति गाह्रो हुन्थ्यो अहिले त पहिलाको भन्दा अलिकति सहज भएको छ र औषधिको डोजहरू पनि हामीहरूले [Hhhhh]किताब पनि तालिम किताबबाट पनि मेन्टेन राखिराखेछौँ वेट पनि लिन्छौं बिरामी अहिले सीएमसीको एउटा रजिस्टर पनि छ र पालिकाबाट पनि नसर्ने मानसिक रोगको भनेर छुट्टै रिपोर्ट पनि प्रत्येक महिना हुन्छ अहिले हाम्रो सजिलो के छ भन्दाखेरि PHIRRभन्ने सिस्टम चलेको छ त्यसमा दैनिक रिपोर्ट देखाउँछ आज बिरामी आयो मान्छेको बिरामी आयो औषधि त दिएँ रेकर्ड छुटेको भए पछि पनि अपडेट गर्न मिल्छ कहिलेकाहीँ हतारको बेला छुट्टेको भएपनि हिजो फलाना बिरामीले फलाना औषधि लिएको थियो भनेर रेकर्ड तान्न सकिन्छ त्यसले गर्दाखेरि पहिलाको भन्दा अहिले सहज हुँदै गएको छ" (KII with health care provider 02 at Karnali)

"We haven't referred anyone yet, but service users come from the community, volunteers, schools, or our CMC staff who identify the need for medication management or correct diagnosis. When we manage them with medication, they seem to improve. After receiving this training, we rarely need to refer anyone. If it's necessary, we coordinate with the district and provincial hospitals. The doctors there guide us on management." (KII with health care provider 01 at Karnali)

"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." (KII with health care provider 01 at Karnali)

Feasibility

Mental health services are increasingly accessible at the ward level, with trained health personnel providing care. However, the number of trained staff remains limited, impacting service coverage and availability. Health workers recognize the importance of psychosocial counseling but struggle with high patient loads and time constraints, limiting their ability to provide adequate patient care. Service users' expectations for specialist consultations and external expert opinions has also been highlighted as such to improve

overall satisfaction and trust in the system. Essential psychotropic medications are generally available, though occasional procurement challenges arise. Municipalities have been proactive in responding to shortages when reported. However, some remote areas face delays in medication supply due to logistical constraints. Timely requests and efficient supply chain management can help mitigate these issues and ensure a steady availability of medications. Infrastructure improvements, such as dedicated counseling rooms, have been implemented in most municipalities, enhancing service delivery. However, in some locations, the lack of private spaces for counseling affects the quality and confidentiality of services.

> *"A little bit of access [thinking] to get treatment from a health institution, CMC Nepal has provided MH gap training to health personnel, and they are providing services from their own health institution. Since they are in every ward, it doesn't seem that difficult for them to reach the ward and get services. It's easy, sir. We also go door-to-door to visit the consultants ourselves now ……. I have also felt a little less manpower [inaudible] manpower." (KII with PSC 03 at Karnali)*

The leadership at the municipal level has played a crucial role in prioritizing mental health services. Their commitment has enabled the integration of mental health into primary health care, ensuring greater accessibility for the community. They have also shared different options for integrating the intervention through existing platforms in their system. However, political stability and power dynamics can influence priorities, decision-making processes, and resource distribution, affecting the long-term sustainability of mental health initiatives. Despite these challenges, municipalities have demonstrated responsiveness in addressing emerging issues, such as medication shortages and service gaps. Effective collaboration and shared decision-making are essential to maintaining mental health services as an institutional priority rather than relying on individual

leadership. Strengthening coordination across governance levels can help overcome bureaucratic barriers and promote a more equitable distribution of services across all wards.

"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)

"अब पालिका हाम्रो भेरी नगरपालिकाले मानसिक स्वास्थ्यको लागि प्राथमिकता दिएको नि छ सर नदिएको भए कर्मचारी नै राख्दैनथ्यो साझेदारीमा कर्मचारी राखेको बेलाबेलामा बताएको कुरा औषधिको कुरा छ औषधि को सामान्य औषधि किन्दाखेरि पनि केहीनभएपनि १ लाखभन्दा माथि को रकम त मानसिक स्वास्थ्यकै लागि प्रत्येक वर्ष छुट्टाउनुपर्छ जस्तो लाग्छ त्यही औषधिले पनि नपुग्ला कहिलेकाहीँ प्रेषण गर्नुपर्ला गाडीको अवस्थापनि त्यो काम गरिरहेकोपालिकाले ठिकै गरिरहेको छ त्यस्तो गरिरहेकोछैन।" (KII with health care provider 02 at Karnali)

"Finally, we have organized a program in #A001# Municipality to bring health into a module, a program called Hello Pregnant Mother…..so that we ask pregnant women to come to the hospital every month and then they come to ask what their problem is. Our nursing staff gives consultation over the phone. After this has become our model, this program is in the process of being implemented elsewhere. How can we make a model for mental health programs is the people who are suffering from mental problems" (KII with Municipal Authority 34 at Lumbini)

"This is also a health problem that might take a complex form in the future. Therefore, from today, like we have a column for the treatment of diseases like diarrhea, pneumonia, and anemia, we should also have a section for mental health problems and manage it. If we can manage it like that, it will be easier." (KII with health care provider 01 at Karnali)

[Clearing throat] What happens in this is, look, the need is always greater. Wherever there is a greater need. Right? To address the need, the main thing is financial resources. Financially, it must be strong. For example, even now, a specialist doctor comes once a month. If financially, we were able to do

it, wouldn't it be possible to do it weekly? Right, it could be done weekly, a good OPD could be run, but it's the issue of finances. ….. Now, everything here has to be operated from the municipality, and we must see how much capacity the municipality has. Attention has to be given to all areas, from the room to the physical infrastructure. There is a bit of an issue with that. However, a 15-bed hospital is under construction, and once that is completed, with the two buildings, and all the indicators completed, it will be easier to move forward" (KII with Municipal Authority 54 at Lumbini)

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. Moreover, some individuals, particularly in remote areas, face challenges in affording necessary medications when there are stock shortages or when certain medications are not covered by the government supply. Municipalities have made efforts to provide free health insurance to financially vulnerable individuals.

"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)

Local governments have allocated budgets for mental health services, but funding remains heavily reliant on external partners. While municipalities contribute financially –covering salaries of consultants and some operational costs–which has been increasing gradually each year, sustainability remains uncertain without continued external support. Municipalities acknowledge the importance of expanding financial investments to sustain

and scale up the intervention, yet long-term planning and dedicated resources for mental health remain insufficient.

> *"Now, there are many things to discuss in this partnership regarding the budget aspect as well. They (CMC Nepal) are now talking about what areas they should allocate budget for, salary and allowances, one thing is that our staff -. Apart from that, they are also supporting the office management and training for our health worker. In the ward where there are health workers and doctors, they provide the training of the MH Gap Module 2 of Mental Health in different phases…. On the other hand, now we are doing various programs and activities like World Suicide Prevention Day, World Mental Health Day, etc. To celebrate such days, we have a mental health camp here every month [hum]. We are also providing consultant services. We also have such camps once a month. That is our wish. This project is supporting us." (KII with municipality authority 56 at Lumbini)*

Investments in mental health services extend beyond medication provision, incorporating training for health workers, psychosocial counseling, and awareness programs such as mental health camps. Municipalities recognize the effectiveness of these interventions but highlight the need for an integrated approach that links mental health with broader social and economic support, including income-generating activities.

> *"Some of them (conflict victim's family member) died untimely, there is no one to work in their homes. Now, until the basic needs are fulfilled, our problems are only the problems physically. Only by treating them, nothing will happen. We have to find out the root cause. The root cause may be their poverty or lack of food. Unless that problem is solved, the issue of mental health will not be solved……My suggestion is to think holistically and….. If we are providing every service in an integrated way, then only will overall mental health improve." (KII with municipality authority 56 at Lumbini)*

> *"In that process (serving conflict victim), it is also necessary to connect it with livelihood. They must be able to live a comfortable life, so we have also provided skill-based and income-generating programs for them. Uhh.. in the first year, we gave them goat farming, then livestock, we provided*

improvements for that. After that, we gave them beauty parlors, and this year there's also a work plan." (KII with Municipal Authority 54 at Lumbini)

Penetration

The reach of mental health services has expanded in some regions but remains constrained in others due to persistent gaps in awareness and accessibility as health worker trained in MHPSS are available in limited health facility. Initially, training programs were limited to a few health workers, restricting service delivery. However, gradual expansion has enabled more institutions and neighboring wards to integrate these services effectively. 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. Despite these advancements, there are still gaps in service coverage. A service user noted that while some targeted groups have benefited, the need for continuous psychosocial counseling remains unmet. They emphasized that support should not only focus on conflict victim but should be extended more broadly. The demand for these services continues to grow, indicating that current efforts, though impactful, are still insufficient to meet the overall needs of the community. Furthermore, involvement of mothers group, faith healers could also help identify hidden cases.

"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)

"यहाँको सन्दर्भमा त अब चाहिँ लगभग कताकति पुग्या छ हैन तर यतिले पुग्दैन के मैले भन्न खोज्या यतिले अझै पुगी राखेको छैन, अझै अभाव छ भनौँ न अझै यसको आवश्यकता छ यो चाहिँ अझै ,हामीलाई भनौँ न मलाई नै अझै मनोपरामर्शको खाँचो छ निरन्तर रुपमा त्यसको चाहिँ आवश्यकता देख्छु के मैले त्यही भा हुनाले मलाई नै पुग्या छैन भनेपछि अरुलाई त पुग्या छ जस्तो लाग्दैन ,हैन त्यही भएको हुनाले र यस्तो समस्या त अनि मैले भने अहिले पनि तत्कालै पनि अब समस्याहरु जन्मिदै गर्या पनि हुन सक्छ त्यही भएको हुनाले मैले अब यो चाहिँ अघि पनि भने मैले अब लक्षित वर्ग बाहेक अरुलाई पनि दिनुपर्छ र विशेष गरी लक्षित वर्गलाई पनि दिनुपर्छ र यतिले मात्र हुँदैन अरु पनि दिनुपर्छ निरन्तर रुपमा यसको चाहिँ हुनुपर्छ भन्ने मेरो माग,मेरो भनाई त्यही हो।" (IDI with service user 11 at Karnali)

"Absolutely. In our community, people trust doctors and traditional healers more than leaders or teachers when they get sick. It's part of our culture. If we could provide orientation to traditional healers and involve them in understanding these issues, it would be easier for them to refer patients to us. For example, there was a shaman in my community who attended our training. After that, he started advising people to go to the doctor first. This positive change in mindset can help a lot. If they understand that mental health issues require medical treatment, they can refer patients to us." (KII with health care provider 01 at Karnali)

Sustainability

Municipalities have demonstrated potential to sustain and manage resources for the intervention. Since the second year of implementation, local governments have gradually increased their cost-sharing contributions, indicating a growing commitment to the initiative. While the intervention has proven beneficial at the local level, long-term sustainability and adequate budgeting require more than the support of a single organization. Additionally, the service provider and municipality authority emphasize the need for experts in mental health should be actively involved in policy planning across all levels of government to ensure a well-integrated and effective approach. Municipalities

have taken ownership of the intervention, ensuring continued support for mental health services. Stakeholders stress the need for continuous improvements, expanded mental health services, and more structured integration into local governance.

> *"…our thought is that, in those specific areas, by partnering with various organizations or bodies that have specific knowledge [coughing], we can fulfill the needs and demands that are evident among them, and if such programs come up, we have already set aside a shared budget for that. And another feeling we have is that most of the elected representatives think that they must manage those individuals, and we need to supply their needs and demands through institutional means. There is an inner drive and understanding within them, but the weakness is that without the relevant knowledge and capacity, the willpower alone cannot fulfill that. Because to manage that sector, expert services are needed, right? When I raised this issue in the province last time, I said that there are two or three problems at the local level. The elected representatives have the desire to move forward and do something, but without the related knowledge, processes, and skills for communication, what happens is that, even for them, not everyone among the representatives thinks in the same way or in their own way. Therefore, the Provincial Governance Center also needs to focus on training and orientation for the elected bodies in areas such as development management, plan management, social transformation, and transformation in the lifestyles of the poor. I had said that it's necessary to give such training to them. Here, too, no one will say that they don't want to advance in these areas, but what is needed is the relevant knowledge, alongside training, skills, and the necessary budget for it." (KII with Municipal Authority 07 at Karnali Province)*

> *" 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)*

Experience of Conflict Victims Accessing Community-Based MHPSS Services

Many conflict victims reported feeling supported and valued through counseling and psychosocial services. Positive experiences were often linked to empathetic service providers and strong community support. Counseling sessions allowed participants to share personal experiences, which helped improve their emotional well-being.

However, several barriers affected service utilization. Stigma, lack of awareness, and transportation difficulties prevented many individuals from accessing care. Hidden cases still exist within communities, emphasizing the need to expand services to the ward and community levels. Additionally, some individuals, particularly those with disabilities, found it difficult to seek mental health support, highlighting the importance of home visits by service providers. However, privacy concerns deterred some individuals from receiving home visits from psychosocial counselors. A significant challenge was the financial expectations of service users in need, making access difficult. Family support to individuals in need of mental health services also remained an obstacle.

> *"In (#A001#) Municipality's policy, in terms of health policies, it should provide relief to the victims of conflict, and support should be provided, but perhaps now after the arrival of CMC's helped us to address our policy. Another thing is that now it is a challenge for us…. more than a challenge. The policy of (#A001#) Municipality is to help most of the people, but most of the people are expecting financially…It is expected from people, but we cannot do it all, it was a bit of a problem." (KII with Municipal authority 24 at Karnali Province)*

The lack of trained human resources prevented every ward from offering mental health counseling services. To address this gap, the government should conduct periodic mental health camps and increase awareness efforts. Additionally, some service users expressed

the need for expanded support, including livelihood assistance and family counseling. Counseling sessions were initially conducted once a month, but following disasters, the number of sessions was reduced. Many participants emphasized the need for more frequent and longer group sessions. If services were provided at the nearest health facilities, it would help reduce the financial burden on service users.

> *"समुदाय हजुर हाम्रो सीएमसी अथवा काउन्सेलरहरूको विभिन्न ग्रुप हजुर आमा समूह ग्रुपमा जाने अहिले फेरि तीनजना राखेको छ नि त पालिकाले हजुर हजुर आमा समूहको मिटिङमा जाने स्वयंसेविकाहरूको मिटिङमा जाने र मानसिक स्वास्थ्य द्वन्द पीडितहरूको छलफल गर्ने प्रोग्राम पनि छ रे। अँ त्यसले गर्दा के भयो त भन्दाखेरि समुदाय समुदायमा प्रत्यक्ष लिंकेज भयो हैन । समुदायमा लुकेर छिपेर रहेका समस्याहरू पनि बाहिर आउने भए। ताकि सामुदायलाई नै मानसिक स्वास्थ्य समस्या र बचाउनलाई सहयोग हुन्छ भन्ने जस्तो लाग्छ मलाई.....त्यो पद ठ्याक्कै मलाई पनि थाहा भएन तर तीनजना पालिकाले तीनजना सामुदायिक सहजकर्ता के पद सिर्जना गरेर टोलटोल समुदायमा गएर मानसिक स्वास्थ्यको जनचेतना जगाउने कार्यक्रमहरू राखेको छ" (KII with Health Care Provider 17 at Karnali Province)*

Barriers and Facilitators to Implementation of Community-Based MHPSS Services

Several barriers hinder the effective implementation of mental health services in the community. Stigma and negative social perceptions about mental health remain significant challenges, preventing individuals from seeking support. Difficult geographical terrain further limits accessibility, making it challenging for service providers to reach remote areas. Logistical and resource constraints, such as inadequate infrastructure, a limited workforce, and medication shortages, create additional obstacles to service delivery. Furthermore, added work burden, time management issues, and increased patient flow have impacted the quality and efficiency of services. Policy and financial gaps, including uncertainty in long-term funding and policy support, pose risks to the program's sustainability. Additionally, gender-related barriers influence the willingness of clients to openly share their mental health concerns, limiting service utilization.

Despite these challenges, several facilitators have contributed to the program's success. Community engagement has played a crucial role, with active participation from local leaders and organizations enhancing program acceptance. The involvement of Psychosocial Counselors (PSCs) and Community Psychosocial Workers (CPSWs), many of whom are themselves conflict victims from the same communities, has fostered trust and strengthened connections with service users. Training and capacity-building efforts have improved provider confidence and competence, leading to better service delivery. Furthermore, maintaining confidentiality and responsiveness has encouraged individuals to utilize mental health services. Government commitment has also been a key factor, as municipalities that integrated Mental Health and Psychosocial Support Services (MHPSS) into their health plans demonstrated better implementation outcomes. Addressing existing barriers while leveraging these facilitators will be essential for the long-term success and sustainability of the intervention.

Discussion

Both quantitative and qualitative result showed that MHPSS intervention for conflict victims is highly acceptable by service users', service providers, and policy level decision maker because it has increased service accessibility at community through primary health care system, service is easily accessible in low or no cost, increased acceptability of the service as both mental health treatment and psychosocial counseling service has lead to improve mental health condition, conflict victims are gaining emotional stability as a result they are able to take part in social and cultural activities, daily household chores and start resuming work. It has increased family support. The intervention seems appropriateness in considering conflict victim needs and there has been good scope of sustainability as all municipality has developed mental health policy and plan and increased investment in the implementation. This has show good opportunity for the integration of MHPSS services at primary health care system in Low-and- middle-income country such as Nepal. The service providers also found to maintain competency to

identify and provide intervention to the service in need. Further MHPSS service has been provided as per intervention protocol, trained providers were found to have fully aware of the protocol and were found in treatment room in the health facilities (observed during health facility record checking). There is increased penetration of MHPSS services beyond conflict victims as a result more general public are using the services which has been shown by increased service user's data in national health recording and reporting system of ministry of health. There are also observed gap that more awareness in mental health is needed, due to uncertainty of retention of trained MHPSS provider and regular funding from government may pose challenge in the sustainability of this services. It needs more advocacy. Qualitative findings also indicates that MHPSS service is regularly needed for longer period particularly for conflict victims because of chronic psychological difficulties since they experience strong traumatic incidents (loss of family member, disappear family member, self-tortured). Present intervention provides an appropriate, acceptable, cost effective and appropriate model for LMICs. It can be upscaled with increased investment in mental health and reduced disease burden.

Conclusion

The intervention seems appropriate, given the increasing mental health burden in the community. The program has been well received, but there is a need for expansion, sustainability planning, and integration with livelihood support. Stakeholders, including municipalities and health workers, recognize mental health as a critical issue and are actively involved, but challenges remain in implementation and resource availability. Mental health service integration into PHC centers appears to be feasible with existing municipal support and infrastructure, but sustainability and scalability remain challenges due to financial, human resource, and logistical constraints which may create challenge if local authorities were left to manage the intervention independently. Strengthening and continuous provision of training, funding, and coordination could be key to ensuring long-term success.

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Annexes:

Annex 1: Quantitative result tables

Table 1.1: Demographic descriptive results

	N	Minimum	Maximum	Mean	Std. Deviation
Age	228	16	88	49.69	14.61
D9-Monthly income	228	0000	100000	19864.03	15841.66
D10 Treatment cost per month	228	0	22000	694.3	1934.5

Table 1.2: Distribution of participants according to province

Province	Frequency	Percent
Bagmati	70	30.7
Lumbini	76	33.3
Karnali	82	36.0
Total	228	100.0

Table 1.3: Distribution of participants according to municipality

Minicipality	Frequency	Percent
Dhulikhel Municipality	23	10.1
Panchakhal Municipality	15	6.6
Chaurideurali Rural Municipality	32	14.0
Barbardiya Municipality	20	8.8
Rajapur Municipality	20	8.8
Thakurbaba Municipality	7	3.1
Bansgadhi Municipality	29	12.7
Birendranagar Municipality	13	5.7
Gurvakot Municipality	6	2.6
Bheri Municipality	24	10.5
Nalgadh Municipality	21	9.2
Athbiskot Municipality	6	2.6
Chaurjahari Municipality	12	5.3
Total	228	100.0

Table 1.4 : Sociodemographic result		
Gender	**Frequency**	**Percent**
Male	82	36.0
Female	146	64.0
Total	228	100.0
Marital status	**Frequency**	**Percent**

Never married	13	5.7
Married	146	64.0
Widowed	65	28.5
Divorced / separated	3	1.3
Others	1	0.4
Total	228	100.0

Caste	**Frequency**	**Percent**
Brahmin/Chettri	101	44.3
Janajati	97	42.5
Dalit	27	11.8
Muslim	1	0.4
Others	2	0.9
Total	228	100.0

Religion	**Frequency**	**Percent**
Hinduism	209	91.7
Buddhism	9	3.9
Islam	2	0.9
Christianity	8	3.5
Total	228	100.0

Family type	Frequency	Percent
Nuclear (mother, father, children)	138	60.5
Joint (mother, father, children along with grandfather, grandmother)	81	35.5
Extended (mother, father, children, grandfather, grandmother along with uncle/aunt)	9	3.9
Total	228	100.0

Are you able to read and write?		
	Frequency	Percent
No	114	50.0
Yes	114	50.0
Total	228	100.0

What is the highest level of education you completed?	**Frequency**	Percent
Basic level education (No formal schooling)	18	7.9
Basic level education/grade 1-8 (formal schooling)	53	23.2
Secondary level education /grade 9-12 level	36	15.8
University level and above	7	3.1
Not able to read and write	114	50.0
	228	100.0

What is your main occupation?	**Frequency**	**Percent**

Labour (Skilled/ unskilled)	20	8.8
Service	15	6.6
Business / Self employed	12	5.3
Foreign employment	1	0.4
Farming	137	60.1
Domestic work (house wife/house husband)	29	12.7
Student	6	2.6
Unemployed (unable to work)	3	1.3
Unemployed (able to work)	4	1.8
Others	1	0.4
Total	228	100.0

Table -1.5 How conflict affected the CV?	Frequency	Percent
D12.Family member killed	104	45.6
D12. Family member disappeared	57	25.0
D12. Self-experienced tortured	133	58.3
D12. Family member experienced tortured	118	51.8
D12. Other family member experienced tortured	5	2.2
D12. Family have experienced conflict -Refused	1	0.4
Total	**228**	**100.0**

Table -1.6 In the past three year which service did you receive?	Frequency	Percent
D13. Individual counselling	145	63.6
D13.Group counselling	176	77.2
D13. Mental health treatment from health worker	45	19.7
D13. Referral services (e.g. to psychologist, psychiatrist, other health facility)	6	2.6

Table-1.7 Who referred you to MHPSS service	Frequency	Percent
D14. Community Psychosocial Worker (CPSW)	118	51.8
D14. Psychosocial Counsellor (PSC)	186	81.6
D14. FCHV	16	7.0
D14. Friends, Relative or Neighbor	25	11.0
D14. Elected ward member	7	3.1
D14. Health Care Provider from health facility	3	1.3
D14. Others	0	0.0

Table -1.8 What other services from municipality were you informed by:	Frequency	Percent
D15. Skill training organized by Municipality	55	24.1
D15.Agricultural or technology or grant support (seed, fertilizer, electrical stove, hand tractor, sewing machine etc.)	93	40.8
D15. Scholarship support to children (or self)	31	13.6
D15. CV honoring activity	7	3.1
D15. Exposure visit (cooperative or user group members including CV group)	56	24.6
D15. Health insurance	105	46.1

D15. Medical treatment support	55	24.1
D15. None	51	22.4
D15. Others	4	1.8
Total	228	100.0

Table 1.9 Did you utilize any of the services?	Frequency	Percent
No	96	42.1
Yes	132	57.9
Total	228	100.0

Table 1.10 Which of these services did you utilize?	Frequency	Percent
D17. Skill training organized by Municipality	62	47.0
D17. Agricultural or technology or grant support (seed, fertilizer, electrical stove, hand tractor, sewing machine etc.)	16	12
D17. Scholarship support to children (or self)	0	0.0
D17. CV honoring activity	43	32.6
D17. Exposure visit (cooperative or user group members including CV group)	51	38.6
D17. Health insurance	27	20.5
D17. Medical treatment support	5	3.8
D17. Others	132	57.9

Table 2.1: Acceptance of MHPSS services by conflict victims

	Strongly disagree		Disagree		No opinion (Neutral)		Agree		Strongly agree	
	f	%	f	%	f	%	f	%	f	%
Ac1. It was easy and comfortable to get the MHPSS services	4	1.8	20	8.8	14	6.1	150	65.8	40	17.5
AC2. It required effort for me to engage in the MHPSS intervention	24	10.5	89	39.0	22	9.6	68	29.8	25	11.0
AC3. The intervention has improved my psychosocial well being	4	1.8	20	8.8	10	4.4	152	66.7	42	18.4
AC4. There are moral or ethical consequences while receiving the services	51	22.4	149	65.4	1	0.4	24	10.5	3	1.3
AC5. These services interfered with my other priorities	35	15.4	129	56.6	15	6.6	38	16.7	11	4.8
AC6. I am confident that I can use the services on my own	4	1.8	19	8.3	5	2.2	140	61.4	60	26.3
AC7. It is clear to me how the services will help me achieve my psychosocial well being	2	0.9	12	5.3	15	6.6	176	77.2	23	10.1
AC8. The MHPSS services are acceptable	1	0.4	4	1.8	3	1.3	123	53.9	97	42.5

Table 2.2: MHPSS service user's participation

Participation (PT)	N	No problem		Small problem		Medium Problem		Large problem	
		f	%	f	%	f	%	f	%
PT1. Do you have equal opportunity as your peers to find work? [If no or sometimes] How big a problem is it to you?	71	5	7.0	9	12.7	14	19.7	43	60.6
PT2. Do you work as hard as your peers do? (same hours, type of work etc.) [If no or sometimes] How big a problem is it to you?	106	10	9.4	25	23.6	25	23.6	46	43.4
PT3.Do you contribute to the household economically in a similar way to your peers? [If no or sometimes] How big a problem is it to you?	75	7	9.3	9	12.0	18	24.0	41	54.7
PT4. Do you make visits outside your village / neighborhood as much as your peers do? (except for treatment) e.g. bazaars, markets [If no or sometimes] How big a problem is it to you?	57	27	47.4	9	15.8	7	12.3	14	24.6
PT5. Do you take part in major festivals and rituals as your peers do? (e.g. weddings, funerals, religious festivals) [If no or sometimes] How big a problem is it to you?	30	12	40.0	4	13.3	5	16.7	9	30.0
PT6.Do you take as much part in casual recreational / social activities as do your peers? (e.g. sports, chat, meetings) [If no or sometimes] How big a problem is it to you?	57	20	35.1	14	24.6	13	22.8	10	17.5
PT7. Are you as socially active as your peers are? (e.g. in religious/ community affairs) [If no or sometimes] How big a problem is it to you?	54	20	37.0	10	18.5	11	20.4	13	24.1
PT8.Do you have the same respect in the community as your peers? [If no or sometimes] How big a problem is it to you?	23	3	13.0	2	8.7	6	26.1	12	52.2
PT9.Do you have opportunity to take care of yourself (appearance, nutrition, health, etc.) as your peers? [If no or sometimes] How big a problem is it to you?	29	5	17.2	4	13.8	7	24.1	13	44.8
PT10.Do you have the same opportunities as your peers to start or maintain a long-term relationship with a life partner? [If no or sometimes] How big a problem is it to you?	35	6	17.1			2	5.7	27	77.1
PT11.Do you visit other people in the community as often as other people do? [If no or sometimes] How big a problem is it to you?	60	24	40.0	13	21.7	14	23.3	9	15.0
PT12.Do you move around inside and outside the house and around the village/neighbourhood just as other people? [If no or sometimes] How big a problem is it to you?	32	14	43.8	5	15.6	6	18.8	7	21.9
PT13.In your village / neighbourhood, do you visit public places as often as other people do? (e.g. schools, shops, offices, market and tea / coffee shops) [If no or sometimes] How big a problem is it to you?	50	26	52.0	9	18.0	6	12.0	9	18.0
PT14.In your home, do you do household work? [If no or sometimes] How big a problem is it to you?	36	14	38.9	5	13.9	8	22.2	9	25.0
PT15. In family discussions, does your opinion count? [If no or sometimes] How big a problem is it to you?	29	1	3.4	2	6.9	6	20.7	20	69.0
PT16. Do you help other people (e.g. neighbors, friends or relatives)? [If no or sometimes] How big a problem is it to you?	48	12	25.0	20	41.7	6	12.5	10	20.8
PT17. Are you comfortable meeting new people? [If no or sometimes] How big a problem is it to you?	48	13	27.1	13	27.1	12	25.0	10	20.8
PT18. Do you feel confident to try to learn new things? [If no or sometimes] How big a problem is it to you?	35	3	8.6	12	34.3	4	11.4	16	45.7

Table 2.3: Stigma experienced by service users'	No		Uncertain		Possibly		Yes	
	f	%	F	%	f	%	f	%
ST1. If possible, would you prefer to keep people from knowing about your mental health issues?	145	63.6	9	3.9	16	7.0	58	25.4
ST2. Have you discussed this problem with the person you consider closest to you, the one whom you usually feel you can talk to most easily?	15	6.6	1	0.4	10	4.4	202	88.6
ST3. Do you think less of yourself because of this problem? Has it reduced your pride or self-respect?	120	52.6	2	0.9	33	14.5	73	32.0
ST4. Have you ever been made to feel ashamed or embarrassed because of this problem?	190	83.3	3	1.3	8	3.5	27	11.8
ST5. Do your neighbors, colleagues or others in your community have less respect for you because of this problem?	183	80.3	7	3.1	11	4.8	27	11.8
ST6. Do you think that contact with you might have any bad effects on others around you even after you have been treated?	209	91.7	9	3.9	6	2.6	4	1.8
ST7. Do you feel others have avoided you because of this problem?	180	78.9	3	1.3	20	8.8	25	11.0
ST8. Would some people refuse to visit your home because of this condition even after you have been treated?	217	95.2	3	1.3	3	1.3	5	2.2
ST9. If they knew about it would your neighbors, colleagues or others in your community think less of your family because of this problem?	191	83.8	3	1.3	14	6.1	20	8.8
ST10. Do you feel that your problem might cause social problems for your children in the community?	177	77.6	8	3.5	23	10.1	20	8.8
ST11a. Do you feel that this condition has caused problems in getting married? (Unmarried only)	11	78.6					2	14.3
ST11b. Do you feel that this condition has caused problems in your married life? (Married only)	129	88.4	2	1.4	5	3.4	10	6.8
ST12. Do you feel that this condition makes it difficult for someone else in your family to marry?	212	93.0	4	1.8	4	1.8	8	3.5
ST13. Have you been asked to stay away from work or social groups?	217	95.2	2	0.9	2	0.9	7	3.1
ST14. Have you decided on your own to stay away from work or social group?	205	89.9	3	1.3	13	5.7	7	3.1
ST15. Because of mental health issues people think you also have other health problems	173	75.9	14	6.1	14	6.1	27	11.8

MHPSS competency of providers

Competency	Satisfactory		Good		Excellent	
Items	Frequency	Percent	Frequency	Percent	Frequency	Percent
C1	10	17.2	33	56.9	15	25.9
C2	12	20.7	32	55.2	14	24.1
C3	8	13.8	39	67.2	11	19.0
C4	9	15.5	37	63.8	12	20.7
C5	12	20.7	36	62.1	10	17.2
C6	6	10.3	38	65.5	14	24.1
C7	18	31.0	37	63.8	3	5.2
C8	11	19.0	35	60.3	12	20.7
C9	16	27.6	34	58.6	8	13.8
C10	3	5.2	40	69.0	15	25.9
C11	6	10.3	38	65.5	14	24.1
C12	5	8.6	29	50.0	24	41.4
C13	7	12.1	26	44.8	25	43.1
C14	6	10.3	32	55.2	20	34.5
C15	6	10.3	37	63.8	15	25.9
C16	9	15.5	38	65.5	11	19.0
C17	5	8.6	32	55.2	21	36.2
Average competency score		**15.1**		**60.1**		**24.7**

Provider details

Province	Frequency	Percent
Bagmati	11	19.0
Karnali	26	44.8
Lumbini	21	36.2
Total	58	100.0
District	Frequency	Percent
Bardiya	21	36.2
Jajarkot	10	17.2
Kavrepalanchok	11	19.0
Rukum West	8	13.8
Surkhet	8	13.8
Total	58	100.0

Annex 2: Data Collection Tools

Annex 2.1: Informed consent for survey (Quantitative)

Information sheet
Please read to the participant
Introduction Namaste, my name is _____. I am currently employed at Centre for Mental Health and Counselling –Nepal (CMC-Nepal) and I would like to invite you to take part in the study. Before you decide whether to take part, you need to understand why the study is being done and what it would involve for you. Please take time to read or to listen as I read the following information carefully. Please ask us if there is anything that is not clear to you or if you would like more information. We will also give you a copy to keep for your records. **Purpose of research** Since September 2021, with the support of the Swiss Development Cooperations (SDC), CMC - Nepal has been implementing a psychosocial counseling program for the community integration of conflict victims in your rural/municipality. The main objective of this program is to provide psychosocial counseling services to individuals affected by conflict and their families. To achieve this, the municipality has trained psychosocial counselors who offer services directly in your communities. Additionally, mental health services have been developed and provided through selected health institutions of the municipality. As the mental health and psychosocial counseling services provided through health institutions and municipality have been operational for three years, an assessment of the project's acceptability, appropriateness, and sustainability in integrating these services into primary health care is being conducted with the support of URC, USAID and C.M.C. Nepal. This survey takes around 30 to 40 minutes to complete. The interview will be conducted by trained data collectors. The information provided by you will be kept strictly confidential. The main aim of this research is to study the possibility of integrating mental health and psychosocial counseling services into primary health care, to inform relevant stakeholders, and contribute to further research. We will conduct interviews with beneficiaries, service provider and decision/policy makers of these services. In this process, we aim to collect data from about 225 beneficiaries across 13 rural/municipalities. The collected information will be analyzed in scientific way to draw conclusions. You have been selected randomly for this study. So, I am approaching you for the interview and request to participate in this study. **Your Participation in the Research** During this study, we will ask you some questions regarding sociodemographic details, as well as your understanding, experiences, perceptions, and use of mental health services related to this project. You will need to reflect on and consider your situation after participating in this program when answering the questions. You will be involved only once for 30 to 40 minutes as stated earlier. **Possible Benefits:** There is no direct immediate benefit to you from participating this study. But, the findings from this study will be used to develop policy and planning to improve the mental health and psychosocial services for conflict victims and others, which will eventually benefit you and other people living in your community, in future.

Possible Risks:
Your participation in the survey is voluntary – this means that you do not have to answer all these questions. Whether you take part or not will not affect any future care that you receive. Additionally, you may decline to answer any question or withdraw from the interview without giving a reason. You also have the right to withdraw from the study at any point during the study.

It is also possible to feel uneasy while discussing your experiences with us. In that case, you can choose to withdraw from the interview. Moreover, if you wish, we can coordinate with the psychosocial counsellor or health worker in this municipality who provides services in this area to assist you in accessing the necessary mental health and psychosocial counseling services, based on any difficulties you are facing. For more information, you can also contact the principal researcher of this study, Dr. Pashupati Mahat, at the phone number 9851094831.

Confidentiality
We assure you that no one other than research team will get access to (get to know) your individual identity (names) with regards to your participation in the survey. The data collection process is digitalized and tablets that store your information are password protected. Once the data collection process is complete, your name recorded on the questionnaire will be replaced by a code number. Similarly, your name or personal identifier will not appear in any reports, and all information shared will be an aggregation of all study participants and will not be identifiable to you. All study files that list your name will be kept separately in a locked file and password protected computers. The reports and products coming out of this study will only report collective findings from all the study participants and not any individual results will be reported.

Your Rights:
You do not give up any of your legal rights by signing this form. If you have any questions about your rights as a volunteer or have any issues or any question about the research, please call to Nepal Health Research Council at +977 1 4227460 or to Dr. Pashupati Mahat at 9851094831.

Thank you for your time.

Participant consent form

Participant ID:

I have carefully read (or been read) and kept a copy of the information sheet concerning this study, and I understand what is required of me if I take part. I understand the purpose of the study, benefits and risks involved and what is expected from participant. My (or participant under my guardianship) questions concerning this study have been answered by the study team. I understand that at any time the participant may withdraw from this study or decline to answer a question without giving any reason and without affecting participant's access to health care. I understand that the personal identifiable information will be kept confidential and the information shared will be accessed only by the study team.

I agree to take part in this interview or I agree to permit my …… to take part in the interview (to be filled by participant's legal guardian, if the participant is below 18 years of age)

Name of participant: _____

Signature/thumb print of participant: (to be filled by participant's legal guardian, if the participant is below 18 years of age**)** _____

Date:

Date (dd/mm/yyyy)

Name of participant's legal guardian: _____

Signature/thumb print of participant's legal guardian (applicable if participant is under 18 years of age): _____

Date:

Date (dd/mm/yyyy)

I, the interviewer, have explained the procedures to be followed in this survey, and the risks and benefits involved to the respondent in a language the participant understands.

Name of interviewer: _____

Signature of interviewer: _____

Date:

Date (dd/mm/yyyy)

Information sheet

Please read to the participant

Introduction

Namaste, my name is _____. I am currently employed at Centre for Mental Health and Counselling Nepal (CMC-Nepal) and I would like to invite you to take part in the study. Before you decide whether to take part, you need to understand why the study is being done and what it would involve for you. Please take time to read or to listen as I read the following information carefully. Please ask us if there is anything that is not clear to you or if you would like more information. We will also give you a copy to keep for your records.

Purpose of research

Since September 2021, with the support of the Swiss Development Cooperations (SDC), CMC - Nepal has been implementing a psychosocial counselling program for the community integration of conflict victims in your rural/municipality. The main objective of this program is to provide psychosocial counselling services to individuals affected by conflict and their families. To achieve this, the municipality has trained psychosocial counsellors who offer services directly in your communities. Additionally, mental health services have been developed and provided through selected health institutions in the municipality. As the mental health and psychosocial counselling services provided through health institutions and municipality have been operational for three years, an assessment of the project's acceptability, appropriateness, and sustainability in integrating these services into primary health care is being conducted with the support of URC, USAID and C.M.C. Nepal.

This survey takes around 40 to 50 minutes to complete. The interview will be conducted by trained data collectors. The information provided by you will be kept strictly confidential. The main aim of this research is to study the possibility of integrating mental health and psychosocial counseling services into primary health care, to inform relevant stakeholders, and contribute to further research. We will conduct interviews with beneficiaries, service provider and decision/policy makers of these services. The collected information will be analyzed in scientific way to draw conclusions.

Your Participation in the Research

During this study, we will ask you some questions regarding sociodemographic details, as well as your understanding, experiences, perceptions of mental health services related to this project. The interviews will be tape recorded only for the purpose of the study.

Possible Benefits:

There is no direct immediate benefit to you from participating this study. But, the findings from this study will be used to develop policy and planning to improve the mental health and psychosocial services for conflict victims and others, which will eventually benefit you and other people living in your community, in future.

Possible Risks:

Your participation in the survey is voluntary – this means that you do not have to answer all these questions. Whether you take part or not will not affect any future service that you receive. Additionally, you may decline to answer any question or withdraw from the interview without giving a reason. You also have the right to withdraw from the study at any point during the study.

[It is also possible to feel uneasy while discussing your experiences with us. In that case, you can choose to withdraw from the interview. Moreover, if you wish, we can coordinate with the psychosocial counsellor or health worker in this municipality who provides services in this area to assist you in accessing the necessary mental health and psychosocial counselling services, based on any difficulties you are facing. For more

information, you can also contact the principal researcher of this study, Dr. Pashupati Mahat, at the phone number 9851094831. (*only for beneficiaries*)]

Confidentiality

We assure you that no one other than research team will get access to (get to know) your individual identity (names) with regards to your participation in the survey. Your name or personal identifier will not appear in any reports, and all information shared will be an aggregation of all study participants and will not be identifiable to you. All study files that list your name will be kept separately in a locked file and password protected computers. The reports and products coming out of this study will only report collective findings from all the study participants and not any individual results will be reported.

Your Rights:

You do not give up any of your legal rights by signing this form. If you have any questions about your rights as a volunteer or have any issues or any question about the research, please call to Nepal Health Research Council at +977 1 4227460 or to Dr. Pashupati Mahat at 9851094831.

Thank you for your time.

Participant consent form

Participant ID:

I have carefully read (or been read) and kept a copy of the information sheet concerning this study, and I understand what is required of me if I take part. I understand the purpose of the study, benefits and risks involved and what is expected from participant. My questions concerning this study have been answered by the study team. I understand that at any time the participant may withdraw from this study or decline to answer a question without giving any reason and without affecting participant's access to health care. I understand that the personal identifiable information will be kept confidential and the information shared will be accessed only by the study team. I agree to audio record my interview

I agree to take part in this interview

Name of participant: _____

Signature/thumb print of participant: _____

Date:

Date (dd/mm/yyyy)

I, the interviewer, have explained the procedures to be followed in this survey, and the risks and benefits involved to the respondent in a language the participant understands.

Name of interviewer: _____

Signature of interviewer: _____

Date: | | | | | | | | |
Date (dd/mm/yyyy)

Annex 2.3: Survey Questionnaire for Service Users

Instruction for the interviewer:

- Tick in the appropriate answer or write the answer of participants in the given space
- Read out all the options clearly and ensure that participants understand it clearly

Survey Information and Informed Consent

Survey information			
I1	Interviewer number		
I2	Date of interview	…. / …. / …… **dd/mm/yyyy**	
I3	Province ID		
I4	Municipality ID		
I5	Participant code		
I6	Form number		
17	Participant ID		
Informed consent			
C1	Does participant consent to taking part in the survey ? Remind participants that the risks of participation are minor, but their	Yes 1	If No, END the interview

	participation is voluntary and they can stop their participation at any time.	No 0	

Section 1 - Participant characteristics

Now, I would like to ask few questions related to your personal details such as your caste, religion and income

S. N	Questions	Responses and code		Remarks
D1	How old are now? (completed years of age)			
		Years		
D2	Gender			
		Male	1	
		Female	2	
		Others	3	
D3	What is your current marital Status?			
		Never married	1	
		Married	2	
		Widowed	3	
		Divorced	4	
		Living together	5	
		Others	99	
		if others specify ……..		
		Refused	88	
	What is your caste and ethnicity?			
		Dalit	1	
		Disadvantaged janajati	2	
		Disadvantaged non-Dalit Terai caste group	3	
		Religious minorities	4	
D4		Relatively advantaged janajatis	5	

		Upper caste group	6	
		Refused	88	
	What is your religious belief?			
		Hinduism	1	
		Buddhism	2	
		Islam	3	
		Christianity	4	
		Kirat	5	
		Other (specify) _____	99	
D5		Refused	88	
D6	Are you able to read and write?			If No, GO TO D8
		Yes	1	
		No	0	
	a. What is the highest level of education you completed?			
		Basic level education (No formal schooling)	1	
		Basic level education/grade 1-8 (formal schooling)	2	
		Secondary level education /grade 9-12 level	3	
D7		University level and above	4	
	b. What is your main occupation?			
		Labour (Skilled/unskilled)	1	
		Service	2	
		Self employed	3	
		Foreign employment	4	
		Business	5	
		Farming	6	
		Domestic work (housewife/house husband)	7	
D8		Student	8	

		Unemployed (unable to work)	9	
		Unemployed (able to work	10	
		Others	99	
		If others specify ……		
		Refused	88	
	Do you know your income per year, per month or per week?	☐ Year ☐ Month ☐ Week ☐ Refused ☐ Don't know		
D9	What is the approximate estimated income of your family per year?		NPR per year	SKIP if D9 = month or week or refused or don't know
D10	What is the approximate estimated income of your family per month?		NPR Per month	SKIP if D9= year or week refused or don't know
D11	What is the approximate estimated income of your family per week?		NPR Per week	SKIP if D9 = year or month
D12	How much do you (or family) expense per month for MHPSS treatment?		NPR Per month	
D13	Which type of family do you belong to?	Nuclear (mother, father, children)	1	
D14		Joint (mother, father, children along with grandfather, grandmother)	2	

		Extended (mother, father, children, grandfather, grandmother along with uncle/aunt)	3
	a. Please share us the nature of the conflict you or your family have experienced	Family member killed	1
		Family member disappeared	2
		Tortured (to self)	3
		Tortured (to family member)	4
		Others	99
		Please specify ……	
		Refused	88

D15

In past three year, which service did you take from MHPSS?

(multiple response)

Received individual counselling	1
Received group counselling	2
Received mental health treatment from health worker	3
Received referral services (e.g. to psychologist, psychiatrist, other health facility)	6
Others, Specify …….	99

D16

Who referred you to MHPS service or from where did you know about these services?

(multiple response)

Community Psychosocial Worker (CPSW)	1
Psychosocial Counsellor (PSC)	2
FCHV	3
Friends, Relative or Neighbour/	4
Elected ward member	5

D17

Health Care Provider from health facility	6
Others, Specify …….	99

What other services from municipality were you informed by CPSW or PSC?

(multiple response)

Skill training organized by Municipality	1
Agricultural or technology or grant support (seed, fertilizer, electrical stove, hand tractor, sewing machine etc.)	2
Scholarship support to children (or self)	3
CV honoring activity	4
Exposure visit (cooperative or user group members including CV group)	5
Health insurance	6
Medical treatment support	7
Others, Specify …….	99

D18 Did you utilize any of the services?

If No, GO TO Next section

Yes	1
No	0

D19 Which of these services did you utilize

D20 (multiple response)

Skill training organized by Municipality	1

Agricultural or technology or grant support (seed, fertilizer, electrical stove, hand tractor, sewing machine etc.)	2
Scholarship support to children (or self)	3
CV honoring activity	4
Exposure visit (cooperative or user group members including CV group)	5
Health insurance	6
Medical treatment support	7
Others, Specify …….	99

Section 2: Acceptability of the MHPSS intervention

Now, I would like to ask few questions about how you felt the MHPSS service

Please let us know the appropriate response indicating the extent to which you agree/disagree with following statement:

SN.	Questionnaire Item	Strongly disagree	Disagree	No opinion (Neutral)	Agree	Strongly agree
Ac1	It was easy and comfortable to get the MHPSS services	1	2	3	4	5
Ac2	It required effort for me to engage in the MHPSS intervention	1	2	3	4	5
Ac3	The intervention has improved my psychosocial well being	1	2	3	4	5
Ac4	There are moral or ethical consequences while receiving the services (such as fear of being stigmatized as having mental health issues, biased treatment from health care provider and so forth)	1	2	3	4	5
Ac5	These services interfered with my other priorities	1	2	3	4	5
Ac6	I am confident that I can use the services on my own	1	2	3	4	5
Ac7	It is clear to me how the services will help me achieve my psychosocial well being	1	2	3	4	5
Ac8	The MHPSS services are acceptable	1	2	3	4	5

Section 3A: Stigma Scale

SN	Items	Yes	Possibly	Uncertain	No
ST1	If possible, would you prefer to keep people from knowing about your mental health issues?	3	2	1	0
ST2	Have you discussed this problem with the person you consider closest to you, the one whom you usually feel you can talk to most easily?	3	2	1	0
ST3	Do you think less of yourself because of this problem? Has it reduced your pride or self-respect?	3	2	1	0
ST4	Have you ever been made to feel ashamed or embarrassed because of this problem?	3	2	1	0
ST5	Do your neighbours, colleagues or others in your community have less respect for you because of this problem?	3	2	1	0
ST6	Do you think that contact with you might have any bad effects on others around you even after you have been treated?	3	2	1	0
ST7	Do you feel others have avoided you because of this problem?	3	2	1	0
ST8	Would some people refuse to visit your home because of this condition even after you have been treated?	3	2	1	0
ST9	If they knew about it would your neighbours, colleagues or others in your community think less of your family because of this problem?	3	2	1	0
ST10	Do you feel that your problem might cause social problems for your children in the community?	3	2	1	0
ST11a	Do you feel that this condition has caused problems in getting married? (Unmarried only)	3	2	1	0
ST11b	Do you feel that this condition has caused problems in your married life? (Married only)	3	2	1	0
ST12	Do you feel that this condition makes it difficult for someone else in your family to marry?	3	2	1	0
ST13	Have you been asked to stay away from work or social groups?	3	2	1	0
ST14	Have you decided on your own to stay away from work or social group?	3	2	1	0
ST15	Because of mental health issues people think you also have other health problems	3	2	1	0

Section 3B: Participation Scale

SN	Items	Yes	Sometimes	No	Irrelevant, I don't want to, I don't have to	Not specified, not answered	No problem	Small problem	Medium Problem	Large problem
PT1	Do you have equal opportunity as your peers to find work?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT2	Do you work as hard as your peers do? (same hours, type of work etc.)	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT3	Do you contribute to the household economically in a similar way to your peers?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT4	Do you make visits outside your village / neighbourhood as much as your peers do? (except for treatment) e.g. bazaars, markets	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT5	Do you take part in major festivals and rituals as your peers do? (e.g. weddings, funerals, religious festivals)	0	1	2	3	4				

	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT6	Do you take as much part in casual recreational / social activities as do your peers? (e.g. sports, chat, meetings)	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT7	Are you as socially active as your peers are? (e.g. in religious/ community affairs)	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT8	Do you have the same respect in the community as your peers?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT9	Do you have the opportunity to take care of yourself (appearance, nutrition, health, etc.) as well as your peers?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT10	Do you have the same opportunities as your peers to start or maintain a long-term relationship with a life partner?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT11	Do you visit other people in the community as often as other people do?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT12	Do you move around inside and outside the house and around the village/neighbourhood just as other people?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5

PT13	In your village / neighbourhood, do you visit public places as often as other people do? (e.g. schools, shops, offices, market and tea / coffee shops)	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT14	In your home, do you do household work?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT15	In family discussions, does your opinion count?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT16	Do you help other people (e.g. neighbors, friends or relatives)?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT17	Are you comfortable meeting new people?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5
PT18	Do you feel confident to try to learn new things?	0	1	2	3	4				
	[if sometimes or no) How big a problem is it to you?						1	2	3	5

Annex 3: Fidelity Checklist

Instruction: The assessment will be conducted by an independent researcher from the core research team. It will primarily involve a desk review of the project documents related to the MHPSS intervention and may also include meeting minutes from the municipality and province. The scores for competency in practice, as mentioned in Section 2, will be derived from real-time assessments of the PSC and healthcare providers using the tool attached in Annex section of this document; other scores will be recorded from the project documents.

Section 1

SN	Program Components (planned /recommended activities)	Fully followed	Partially followed	Not followed at all	**Remarks** (if No, please explore and state the reason for the changes that has occurred)
1	**Recruitment of HR**				
1.1	CPSW are selected based on set qualification				to be collected from municipality checklist
1.2	CPSWs are appointed by Palika				
1.3	PSC are selected based on set qualification				
1.4	PSCs are appointed by Palika				
2	**Training**				
	Training to health worker has been provided				
2.1	*for all CPSW*				
2.2	*for all PSC*				
2.3	*For all Health care Provider*				
	If yes for CPSW				
2.4	*Duration of training was 10 days*				
	If yes for PSC				

SN	Program Components (planned /recommended activities)	Fully followed	Partially followed	Not followed at all	**Remarks** (if No, please explore and state the reason for the changes that has occurred)
2.5	*Duration of training was 6 months*				
2.6	*Training received was as per NHTC designed training package (module 6)*				
2.7	*Practicum in between training*				
2.8	*Supervision provided during practicum*				
2.9	*Senior Psychologist/Clinical Psychologist supervised the PSC during practicum*				
	If yes for health worker				
2.10	*Training received was as per NHTC designed training package (mhGAP module 2)*				
2.11	*Duration of training was 5 days*				
3	**Refresher training**				
	There has been refresher training				
3.1	*for CPSW*				
3.2	*for PSC*				
3.3	*for Health care Provider*				
	The frequency of refresher training is once a year				
3.4	*for CPSW*				
3.5	*for PSC*				
3.6	*for Health care Provider*				

SN	Program Components (planned /recommended activities)	Fully followed	Partially followed	Not followed at all	**Remarks** (if No, please explore and state the reason for the changes that has occurred)
4	**Supervision**				
	There has been supervision for service provider				
4.1	*for CPSW*				
4.2	*for PSC*				
4.3	*for Health care Provider*				
	If yes for CPSW				
4.4	*frequency of supervision is 3 times a year*				
4.5	*Senior Psychologist/Clinical Psychologist supervises the CPSW*				
	If yes for PSC				
4.6	*frequency of supervision is 3 times a year*				
4.7	*Senior Psychologist/Clinical Psychologist supervises the PSCs?*				
	If yes for Health Worker				
4.8	*frequency of supervision is 3 times a year?*				
4.9	*Mental health expert/Psychiatrist supervises the PSCs?*				
5	**Joint monitoring**				
5.1	Project organize joint monitoring and supervision				
5.2	Frequency of joint monitoring and supervision is once a year				
5.3	Monitors of the joint monitoring and supervision includes				
	federal representative				
	province representative				

SN	Program Components (planned /recommended activities)	Fully followed	Partially followed	Not followed at all	**Remarks** (if No, please explore and state the reason for the changes that has occurred)
	local government authorities				
	CV local				
	national stakeholders and medias				

Section 2

	Competency (knowledge and attitude)	Pre test	Post test	Real time
6.1	Competency score of PSCs			
6.2	Competency score of Health Workers			
	Competency (practice)			
6.3	Competency score of PSCs			
6.4	Competency score of Health Workers			

Reviewer name:

Initials:

Date of review:

Remarks:

Annex 4: Competency Checklist (service providers)

Instruction: This observation checklist is designed to assess the competency of Health Care Providers, including Psychosocial Counselors, in managing patients with mental health problems. Please score each item based on your observations.

Name of Municipality:
Participant ID:

SN	Performances	Poor	Satisfactory	Good	Excellent
1	Introduces self and services to the person	1	2	3	4
2	Collects history properly	1	2	3	4
3	Properly identifies the mental health problem	1	2	3	4
4	Explains about the mental health condition to the patient	1	2	3	4
5	Gives hope that mental illness is treatable	1	2	3	4
6	Assigns person the sick role	1	2	3	4
7	Agrees person on mental health treatment plan	1	2	3	4
8	Discusses number of sessions/follow up	1	2	3	4
9	Demonstrates good understanding of person's problem and its context	1	2	3	4
10	Maintains adequate record and reporting	1	2	3	4
11	Ensure maintenance of proper dosages of medicine	1	2	3	4
12	Manages case properly and make appropriate referrals	1	2	3	4
13	Provided psychoeducation for patient & family members	1	2	3	4
14	Cooperates with counselor /health worker	1	2	3	4

Remarks (if any)
Name of Supervisor:
Date:
Signature:

Annex 5: Record review and Checklist (Health facility)

Name of municipality:

Name of health facility:

Date:

Name of Reviewer:

Section 1: Record Review

Instruction: The record review is conducted by the research supervisor during field data collection. It will primarily involve review of the records from the municipality and inquiry with the health facility in-charge. Write down any additional notes or clarification that may be relevant to the checklist items in the "Remarks" column.

Indicators		Year 3 2081 Ashad	Remarks
1.Recruitment and retention rate (provider)			
1.1	Total number of Health Woker positioned (according to 'darbandi')		
1.2	Total number of Health Woker available		
1.3	Total number of Health Worker trained in MHPSS		
Mental Health indicators collated by health facility			
2.1	Total # of mental health case		
2.2	Total # of mental health case on regular follow up		
2.3	Total # cases reporting improvement		
2.4	# of cases dropped mental health service?		
2.5	# of cases referred out		
2.6	# of cases referred out by types of health facility		
2.7	# of cases referred		
2.8	# of cases referred in by types of service provider		

Indicators		Year 3 2081 Ashad	Remarks
2.9	# Psychosocial counseling sessions received by service user's		
2.10	# of mental cases received medicines		
2.11	# of cases categorized as cases with Mental Health Problem in 'muldarta' or main OPD register		
2.12	Others		

Section 2: Checklist (feasibility checklist)

Instruction: The health facility assessment checklist will be administered by the research supervisor during field data collection. It will primarily involve observation and may also include inquiry with the health facility in-charge (please refer to the statement with [**] to inquire the health facility in-charge). Write down any additional notes or clarification that may be relevant to the checklist items in the "Remarks" column.

SN	Activities	Options	Remarks
1.	There is list of contact numbers of referral health facility	□Yes □ No	
2.	IEC materials (posters, leaflets etc.) related to mental health is available in the IEC corner / OPD waiting area	□Yes □ No	
3.	At least one of the staff is able (trained) in identification, assessment and treatment of the common mental health problem or refer when needed**	□Yes □ No	
4.	Psychosocial Counselling service is available**	□Yes □ No	
5.	Trained psychosocial counsellor is available **	□Yes □ No	

SN	Activities	Options	Remarks
6.	Presence of trained community volunteer in health facility catchment area to refer people with mental health problems to health facility**	□Yes □ No	
7.	Room for patient checkup is well ventilated and has adequate light	□Yes □ No	
8.	Separate room or space is allocated for psychosocial counselling for synesis for mental health assessment and counseling.	□Yes □ No	
9.	Privacy is maintained in patient checkup room (curtain placed)	□Yes □ No	
10.	Privacy is maintained in patient counselling room (curtain placed)	□Yes □ No	
11.	Standard treatment protocol (STP) is available in OPD	□Yes □ No	
12.	Standard treatment protocol (STP) is used in OPD**	□Yes □ No	
13.	Counselling reading manual is available in psychosocial service unit	□Yes □ No	
14.	Counselling reading manual is used in psychosocial service unit**	□Yes □ No	
15.	Health facility implements daily checkup of patient with mental health problem**	□Yes □ No	
16.	Common Mental Disorder (CMD) is identified, treated and referred as needed for **		
	Depression (follow up and refill medicines	□Yes □ No	
	Anxiety (follow up and refill medicines	□Yes □ No	
	Psychosis (follow up and refill medicines	□Yes □ No	
	substance abuse, alcohol dependency	□Yes □ No	
	epilepsy (follow up and refill medicines)	□Yes □ No	
17.	Identification, treatment and referral of patient with complex mental problem is also done **	□Yes □ No	
18.	Plan is developed for the patient with mental health problem	□Yes □ No	
19.	Complete plan that includes plan for treatment, counselling and follow up exists	□Yes □ No	
20.	The patient's personalized outcomes are measured periodically	□Yes □ No	

SN	Activities	Options	Remarks
21.	Tele mental health services is available for patient/ for consultation from expert	□Yes □ No	
22.	Mentoring and supervision for psychosocial counselors is available from a psychologist	□Yes □ No	
23.	Mentoring and Supervision for health worker is available from a psychiatrist	□Yes □ No	
24.	Specialist mental health services are available at least every four months	□Yes □ No	
25.	Outreach services/mobile services (mobile camp) related to mental health are available for people in remote areas	□Yes □ No	
26.	There is collaboration with the one stop crisis management center (OCMC) to deal gender-based violence / domestic violence having mental health problem	□Yes □ No	
27.	Regular follow up is done**	□Yes □ No	
28.	Screening, counselling and treatment of different health conditions including mental health are being done by same health care provider**	□Yes □ No	
29.	Are following activities for mental health being managed separately or in integration with general health services? **	□ separately □ integrated	
	OPD day	□Yes □ No	
	registration of patient	□Yes □ No	
	drugs supply	□Yes □ No	
	referral services	□Yes □ No	
	treatment and counselling spaces	□Yes □ No	
	recording and reporting	□Yes □ No	
30.	Mental health service users are registered in the main (OPD) register of the HF	□Yes □ No	
31.	OPD register maintained with mental health cases	□Yes □ No	
32.	Confidentiality of personal information is maintained (information kept in locked cabinet)	□Yes □ No	
33.	Records and reports related to mental health from FCHVs / CPSWs are collected and verified monthly**	□Yes □ No	

SN	Activities	Options	Remarks
34.	Referral records are kept using the standard form (HMIS) and register	□Yes □ No	
35.	Follow up register is available	□Yes □ No	
36.	Follow up register is maintained	□Yes □ No	

Annex 6: Record review and Checklist (Municipality)

Instruction: The record review and checklist are administered by the research supervisor during field data collection. It will primarily involve review of the records from municipality and inquiry with health focal person from municipality. Write down any additional notes or clarification that may be relevant to the checklist items in the "Remarks" column.

Name of municipality:

Date:

Name of Reviewer:

Section1: Record review

Indicators		Year 3 2081 Ashad	Remarks
1. Recruitment and retention rate (provider)			
1.1	Number of Municipal Executives directly involving MHPSS		
1.2	Number of Municipality health staff		
1.3	Number of Municipality health staff directly involved in MH service		
1.4	Number of PSC		
1.5	Number of CPSW		
1.6	Number of Community Volunteers (FCHV) of municipality		
1.7	Number of Community Volunteers (FCHV) of municipality involved in MHPSS		
1.8	Total number of conflict victim		
2. Mental Health Indicators in HMIS/DHIS 2			
2.1	Total # of mental health case		
2.2	Total # of mental health case on regular follow up		
2.3	Total # cases reporting improvement		
2.4	# of cases dropped mental health service		

Indicators		Year 3 2081 Ashad	Remarks
2.5	# of cases referred out		
2.6	# of cases referred out by types of health facility		
2.7	# of cases referred in		
2.8	# of cases referred in by types of service provider		
2.9	# Psychosocial counseling sessions received by service user's		
2.10	# of mental cases received medicines		
2.11	Others		

Section 2: Budget

SN	Budget Item	Source of funding	Year 1		Year 2		Year 3		Total	Remarks
			Allocated	Expended	Allocated	Expended	Allocated	Expended		
1	Total Budget in Health									
2	Total Budget in Mental Health									
3	Details on Budget in Mental Health									
3.1	**Human resource**									
a	Human resource municipality 1 CPSW									
b	Human resource municipality 2 PSC									
c	Project focal person and finance officer communication allowance									
d	Health care provider									
3.2	**Capacity building**									
a	Capacity building (training, supervision									

SN	Budget Item	Source of funding	Year 1		Year 2		Year 3		Total	Remarks
			Allocated	Expended	Allocated	Expended	Allocated	Expended		
b	Refresher training and supervision for health worker									
3.3	**MHPSS service delivery**									
a	Group counselling for conflict victim									
b	Community healing activities									
c	Joint monitoring									
d	MPAC meeting									
e	Technical support from province and federal office									
3.4	**Infrastructures and commodities**									
a	Establishment of psychological service centre									
b	Procurement of psychotropic drug									
3.5	**Policy, strategy and plan**									
a	Development and endorsement of MHPSS strategy and implementation plan									
3.6	**Other mental health services**									
a	Community awareness activities									
b	Expanding mental health services									
c	Suicide prevention activities									

Section3: Checklist (Please tick the appropriate response)

SN	Program Components (planned /recommended activities)	Fully followed	Partially followed	Not followed at all	Remarks (if No, please explore and state the reason for the changes that has occurred)
3.7	CPSW are selected based on set qualification				
3.8	CPSWs are appointed by Palika				
3.9	PSC are selected based on set qualification				
3.10	PSCs are appointed by Palika				
3.11	Municipality project advisory committee-MPAC is formed in local level				
3.12	MPAC reviews and provides necessary directions for effective implementation of the project activities				
3.13	Local government develop MHPS policy				

Annex 7: Record review and Checklist (Province)

Instruction: The record review and checklist are administered by the research supervisor during field data collection. It will primarily involve review of the records from province and inquiry with health focal person from Province. Write down any additional notes or clarification that may be relevant to the checklist items in the "Remarks" column.

Section1: Record review

SN	Budget Item	Source of funding	Year 1		Year 2		Year 3		Total	Remarks
			Allocated	Expended	Allocated	Expended	Allocated	Expended		
1	Total Budget in Health									
2	Total Budget in Mental Health									
3	Details on Budget in Mental Health									
3.1	**Capacity building**									
a	Capacity building (training, supervision									
3.2	**Infrastructures and commodities**									
a	Procurement of psychotropic drug									
3.3	**Policy, strategy and plan**									
a	Development and endorsement of MHPSS strategy and implementation plan									
3.4	**Monitoring and Supervision**									
3.5	**Other mental health services**									
a										
b										
c										

Section2: Checklist (Please tick the appropriate response)

SN	Program Components (planned activities)	Recommended	Fully followed	Partially followed	Not followed at all	Remarks (if No, please explore and state the reason for the changes that has occurred)
	Project MHPSS steering committee is formed at province					
	Project MHPSS steering committee at province develops MHPSS strategy at province					
	Project MHPSS steering committee at province implement MHPSS strategy at province					

Name of Province:

Name of Reviewer:

Date:

Annex 8: Record review (Federal level)

Instruction: The record review and checklist are administered by the research supervisor during field data collection. It will primarily involve review of the records from province and inquiry with health focal person from Province. Write down any additional notes or clarification that may be relevant to the checklist items in the "Remarks" column.

Name of Institution:

Name of Reviewer:

Date:

Section1: Record review

SN	Budget Item	Source of funding	Year 1		Year 2		Year 3	
			Allocated	Expended	Allocated	Expended	Allocated	
1	Total Budget in Health							
2	Total Budget in Mental Health							

SN	Budget Item	Source of funding	Year 1		Year 2		Year 3	
			Allocated	Expended	Allocated	Expended	Allocated	
3	Details on Budget in Mental Health							
3.1	**Capacity building**							
a	Capacity building (training, supervision							
b	Development of training package							
3.2	**Infrastructures and commodities**							
a	Development of service sites							
3.3	**Policy, strategy and plan**							
a	Development and endorsement of MHPSS strategy and implementation plan							
3.4	**Monitoring and supervision**							
3.5	**Tele mental Health**							
3.6	**Other mental health services**							
a								
b								
c								

Annexes: Qualitative Data Collection Tools

Annex 10a: Topic Guide

Participants: Political leaders, CEO, Health Department & Social Development Section Chief, HF In-charge, Healthcare provider, FCHV, Community people and Service user

SN/QN	Questions (Variables/Items)	Response/Code
A	**DEMOGRAPHIC INFORMATION**	
1.	Participant ID Number	……
2.	Province	……
3.	District	……
4.	Municipality/Palika	……
5.	Type of Respondents	1. Elected representative 2. CEO, Administrator 3. HF board member 4. Health or Social development section staff 5. Healthcare provider 6. Community/NGO leader 7. Service user
8.	Gender	1. Male 2. Female 3. Others
9.	Age in years (completed years)	……
10.	Caste/Ethnicity	1. Brahmin/Chhetri 2. Jana Jaati 3. Dalit 4. Madhesi 5. Muslim
11.	Education	1. Basic school education 2. Secondary 3. College 4. University (master's & above)
12.	Years of service in this organization	……

Acceptability (providers)

Q1: How far the MHPSS intervention is acceptable by the service providers? Why do you think so?

Q2: How much you feel difficulty to provide MHPSS services from health facility? What about workload? How much it interfered with your other priority work / duty? How are you managing it?

Q3: What is you experiences about usefulness of MHPSS service? Did you see any positive or negative changes in the client or not? If yes what changes you have observed. If not, why?

Q4: Did you feel any moral or ethical consequences while providing MHPSS intervention to your client? If Yes, please explain your experience on it. If not, do think it is important for MHPSS providers or not? Why?

Q5: What is your understanding about the effect of MHPSS service in the community? Do they change their attitude to MHPSS intervention ? If yes, please provide few case example. If not, why do you think so?

Adoption of intervention

Q1: How much you feel comfortable, confident to use MHPSS intervention with your client?

Q2: What is your experience regarding clinical experienced based treatment than manualized form of treatment? Which one do you prefer and why? Do you think you have enough training to practice MHPSS intervention service to client?

Q3: How do you feel about the training you received in MHPSS intervention? Was it demand from client or from your supervisor? Why do you think so?

Organization culture

Q1: How do you feel about the working culture of your organization / health facility/municipality ?

Q2: How much organizational culture supports to practice new intervention (MHPSS)? If not, why?

Q3: How much you think other service providers are feeling satisfactory about the working culture of your institution? Why do they feel like this?

Q4: How much wo you and other providers feel stress while providing MHPSS intervention to the client? How do organization support to provide MHPSS service from your health facility / municipality?

Q5: How much you and your organization give value to your involvement in providing MHPSS service to the client?

Q6: How much you see possibility of growth of your professional skills ? Do you wish to be in the same institution in future ? Why do you think so? What might make you to work in the same institution in future as well?

FIDELITY

Q1: What services are you providing related to MHPSS? What is your role in the mental health intervention program and what service/s do you provide? An

Q2: Are you trained in MHPSS or not? What made you decide to participate in the training? How many trainings have you received so far? How is your work being supervised? Are the people interested in taking the (mental health) services from you or from this organization (HFs)? What is their response to the services provided by you or from this HF?

Q3: Do you apply what you have learned from the training? Have you used the learnings – both knowledge and skills while providing the services?

If yes, how did you find – what supported/motivated you to apply? - Facilitators

If not, why not – could you please explain?

Q4: What are the challenges you experienced while providing MHPSS service? Have there been changes in implementation along the way? If yes, what changes occur? Why did those changes occur? Who took the decisions?

- Challenges regarding implementing training knowledge & skills
- Organizational challenge – policy, system, logistics, settings such as space, support….
- Social, cultural……

Feasibility

Q5: Are the services accessible (adequate, available, affordable, timely….) to the people who need the mental health services? If not, why is it not accessible?

Q6: What can be done to make this MHPSS more inclusive or effective? How can it be more beneficial for conflict or other affected peoples?

Q7: Can you share your thoughts about how community-based inclusive mental health program can be scaled up (throughout the country?

APPROPRIATENESS/RELEVANCY

Q 1: How did you find the PCCICV activities run in this Palika? Were the project and its activities appropriate and effective?

Q 2: Do you think the project identified the appropriate target groups for services? Are the project activities or services such as counselling and mental health treatment provided by the project through the HFs are still relevant to continue?

Q 3: In your opinion, what is the magnitude of the mental health problem and service need in this Municipality? Since the insurgency and conflict situation is over, are the counseling, support and treatment services for people with mental health problem are needed or relevant? If yes, are the services delivered by the HFs adequate addressing the existing problem or need?

Q 4: Are the mental health problem and services to address this problem ranked as a priority by the community people, government (including Municipalities) and included it in their strategy and plan?

SUSTAINABILITY

Q 1: How and to what extent the target groups / stakeholders including local Palika have been involved in the planning and implementation of this project activities?

Q 2: What is the local (government, communities and beneficiaries) ownership at different levels and or stages of the project?

Q 3: What measures have been taken to sustain or continuate the services provided by the project?

Q 4: How this service could be funded? Is there any budget allocation from the local Palika, any other external resources in addition to the provincial and central government funding?

Q 5: In your opinion, is the local Government, or Board/Management committee capable enough to access resources (human and financial), for continuation of the existing services without external support?

Thank you

Annex 10b: KII Topic Guide – Political leaders, CEO. Section Chief, Province & Federal Officers

SN/QN	Questions (Variables/Items)	Response/Code
A	**DEMOGRAPHIC INFORMATION**	
1.	Participant ID Number	……
2.	Province	……
3.	District	……
4.	Municipality/Palika	……
5.	Type of Respondents	8. Elected representative 9. CEO, Administrator 10. HF board member 11. Health or Social development section staff 12. Healthcare provider 13. Community/NGO leader 14. Service user
8.	Gender	4. Male 5. Female 6. Others
9.	Age group	1. 18 -25 years 2. 26 – 35 years 3. 36 – 45 years 4. 46 – 55 years 5. Above 55 years
10.	Caste/Ethnicity	6. Brahmin/Chhetri 7. Jana Jaati 8. Dalit 9. Madhesi 10. Muslim
11.	Education	5. Basic school education 6. Secondary 7. College 8. University (Masters & above)
12.	Years of service in this organization	……

Q1: Do you know about MHPSS project supported by CMC? How did you find the PCCICV activities run in the project districts/Palikas?

Probe: Were the project and its activities appropriate and effective? – the target groups, counselling services, mental health service, training…..

Q2: Are the project activities or services such as counselling and mental health treatment with particular focus to victims provided by the project through the HFs are still relevant to continue?

Q3: In your opinion, were the intervention activities in-line with government policy, strategy or plan? What are the challenges have you seen while providing MHPSS services through the regular health system in the primary care services?

Probe: Policy challenges, Organizational challenges, system challenges, social & cultural challenges

Q4: In your opinion, what is the magnitude of the mental health problem and service need? Does the government rank Mental Health problems and service needs as a priority?

Q5: Since the insurgency and conflict situation is over, are the counseling, support and treatment services for people with mental health problems needed or relevant? If yes, are the services delivered by the HFs adequate for addressing the existing problem or need?

Q6: Are the services accessible (adequate, available, affordable, timely….) to the people who need the mental health services? If not, why is it not accessible?

Q7: What can be done to make this MHPSS more inclusive or effective? How can it be more beneficial for the conflict affected or other victims?

Q8: How could the MHPSS intervention activities or model be sustained?

Probe: Do the government at local, provincial, and federal level have ownership and or commitment for maintenance of the MHPSS activities?

- Resource allocation, system integration etc.

Q9: Can you share your thoughts about how community-based inclusive mental health and psychosocial support programs can be scaled up (throughout the country)?

Thank you

Annex 10c: KII/FGD Topic Guide – FCHV, Community or Stakeholders

SN/QN	Questions (Variables/Items)	Response/Code
A	**DEMOGRAPHIC INFORMATION**	
1.	Participant ID Number	……
2.	Province	……
3.	District	……
4.	Municipality/Palika	……
5.	Type of Respondents	15. Elected representative 16. CEO, Administrator 17. HF board member 18. Health or Social development section staff 19. Healthcare provider 20. Community/NGO leader 21. Service user
8.	Gender	7. Male 8. Female 9. Others
9.	Age group	6. 18 -25 years 7. 26 – 35 years 8. 36 – 45 years 9. 46 – 55 years 10. Above 55 years
10.	Caste/Ethnicity	11. Brahmin/Chhetri 12. Jana Jaati 13. Dalit 14. Madhesi 15. Muslim
11.	Education	9. Basic school education 10. Secondary 11. College 12. University (Masters & above)
12.	Years of service in this organization	……

Q1: How did you find the MHPSS activities run in this municipality? Were the project and its activities appropriate and effective?

Q2: **(Q2 – Q4 for FCHVs only)** What is your role in the mental health intervention program and what service/s do you provide?

Probe: Are you trained in MHPSS or not? What made you decide to participate in the training? How many trainings have you received so far? How is your work being supervised? Are the people interested in taking the (mental health and counselling) services from you or from this organization (HFs)? What is their response to the services provided by you or from this HF?

Q3: What are the challenges (barriers) you experienced while providing MHPSS service? Have there been changes in implementation along the way? If yes, what changes occur?

Probe: Challenges regarding implementing training knowledge & skills

- Social, cultural……

Q4: What supported (facilitated) implementing MHPSS activities? For example, referral services

Q5: Do you think the project identified the appropriate target groups for services? Are the project activities or services such as counselling and mental health treatment provided by the project through the HFs are still relevant to continue?

Q6: In your opinion, what is the magnitude of the mental health problem and service need in this Municipality? Since the insurgency and conflict situation is over, are the counseling, support and treatment services for people with mental health problems needed or relevant? If yes, are the services delivered by the HFs adequate for addressing the existing problem or need?

Q7: Are the mental health problem and services to address this problem ranked as a priority by the community people, government (including Municipalities) and included it in their strategy and plan?

Q8: Are the services accessible (adequate, available, affordable, timely….) to the people who need the mental health services? If not, why is it not accessible?

Q9: What can be done to make this MHPSS more inclusive or effective? How can it be more beneficial for conflict or other affected peoples?

Q10: Can you share your thoughts about how community-based inclusive mental health program can be scaled up (throughout the country?

Q11: How and to what extent the target groups/stakeholders including municipality have been involved in the planning and implementation of this project activities?

Q12: What is the local (government, communities and beneficiaries) ownership at different levels and or stages of the project?

Q13: What measures have been taken to sustain or continuate the services provided by the project?

Q14: How could this service be funded? Is there any budget allocation from the local Palika, any other external resources in addition to the provincial and central government funding?

Q15: In your opinion, is the local Government, or Board/Management committee capable enough to access resources (human and financial), for continuation of the existing services without external support?