

Evaluation of Community-based Mental Health Programme in Selected Districts of Nepal

2015



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Evaluation of Community-based Mental Health Programme in Selected Districts of Nepal 2015

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ACRONYMS

DHO	District Health Office
DoHS	Department of Health Service
ERB	Ethical Review Board
FCHVs	Female Community Health Volunteers
HF _s	Health Facilities
HMIS	Health Management Information System
HW _s	Health Workers
INGOs	International Non-Governmental Organizations
KII	Key Informant Interview
MG _s	Mother Groups
MH	Mental Health
MoHP	Ministry of Health and Population
NGOs	Non-Governmental Organizations
NHRC	Nepal Health Research Council
OPD	Outpatient Department
PHC	Primary Health Care
PHI	Public Health Inspector
SPSS	Statistical Package for Social Sciences
TH _s	Traditional Healers
VDC _s	Village Development Committees
WHO	World Health Organization

SCOPE AND STRUCTURE OF THE REPORT

This report comes as a depiction of the evaluation of community-based mental health programme implemented by Mental Hospital, Patan with the support of the World Health Organization for the year 2010-2011 in Dhading and Nuwakot district of Central Nepal. Current report stands on the ground of five sections and various subsections underneath including executive summary at the beginning.

- ❖ **Chapter 1** basically covers what led to this evaluation, rationale behind evaluation, major evaluation questions to be answered, and evaluation criteria.
- ❖ **Chapter 2** explains the methodology aspect of this evaluation project.
- ❖ **Chapter 3** portrays the findings of the evaluation focused on five major evaluation components: relevance, efficiency, effectiveness, sustainability, and impact of the community-based mental health programme.
- ❖ **Chapter 4** deals with the interpretation of the findings; principally mental health project's evaluation taking into account the evaluation criteria's. This section also provides an insight into lessons learnt with potential for wider application.
- ❖ **Chapter 5** is all about recommendation to different level of programme stakeholders based on answers of evaluation questions.

The scope of the current report lies within the modification and scaling up of the programme. Annexes displayed at the end of report comprised of the tools used during the evaluation process. Various materials supplement to current evaluation research are also attached in the annex.

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EXECUTIVE SUMMARY

Context of the evaluation: With the aid of the World Health Organization (WHO), Country Office for Nepal, a community-based mental health programme incorporating two components; mental health outreach camp and training of community health workers was commenced by the Mental Hospital in December, 2010 for a year. However, the programme with the goal of increasing accessibility of mental health services is still underway in Dhading and Nuwakot with own resources of the Mental Hospital. As the programme crosses its four years; necessity of evaluation does exist in order to have an insight into current status, achievement of objectives, and justify the significance of its presence to the relevant stakeholders. Therefore, evaluation was carried out independently by the Nepal Health Research Council (NHRC) to help to make a decision on the amendment and expansion of the programme; giving the figure of relevance, efficiency, effectiveness, sustainability, and impact.

Methodology: Both qualitative and quantitative methods were employed. Study participants were Public Health Inspectors, trained health workers, including female community health volunteers (FCHVs), community leaders actively involved in the outreach camp, and clients of outreach camp. Qualitative information was assembled through key informant interview (KII) guideline and exit client interview guideline. Checklist was used for quantitative data. Quantitative information were cleaned, entered, and analyzed in the Statistical Package for Social Science full version 16.0. Thematic analysis was the process used for accumulated qualitative data. The study stood by ethical guidelines, with an ethical approval from an independent Ethical Review Board of NHRC and a written informed consent from the participants.

Relevance of the programme: Demonstrating the scenarios of mental health problem burden, justified programme objectives in relation to beneficiaries need, competency building of community health workers, overwhelming response of clients, adequate in addition to acceptable services, sufficient and competent mental health teams to manage most of cases excluding severe cases; programme was considerably relevant in the duo districts. Nonetheless, what left unconcerned in both the sites was prioritization of mental health by district health authorities. Dearth of equitable services somehow questioned the programme's significance.

Efficiency of the programme: Provided the unavailability of the cost of every single unit of the programme, efficiency could not be appraised well. Nevertheless, with raw information of NRs. 1.5 million as an input, and a number of local health workers trained along with number of mentally ill treated under the same input, could be considered a sort of efficiency; though this component needs further investigation.

Effectiveness of the programme: In some measures, the programme remained effective. It was particularly due to limited institutionalization of mental health in district health system,

satisfactory numbers of clients mostly from camp adjacent areas, partly accessible mental health services, content of clients with services, reported increment in counseling and referral of clients by community health workers, and concentrated awareness among mental ill and their family. At both the locations, hindrances in the course of programmes effectiveness were: confined monitoring and supervision of the camp, no follow ups of trained community health worker's, restricted dissemination of camp's information up to the grass root level, infrequent involvement of district health authorities in the camp, and limited mental health capacity building endeavors by the District Health Office and other organizations.

Fair to say, effectiveness was higher in Dhading district than its counterpart Nuwakot by certain degree. Unveiled supporting evidences were: active involvement of local non-governmental organization, *Koshish* providing fund of NRs. 15,000 per month to buy mental drugs for the camp, generation of community organization promoting mental health in the community, and active involvement of trained health workers in mental health promoting programmes.

Sustainability of the programme: For both the districts, measuring in terms of continuation of outreach camp without external assistance, the programme looked sustainable in some way. Prospects of further continuation may be viewed in the context of number of organizations operating in Nuwakot and Dhading after the Gorkha Earthquake of 25 April 2015. A plenty of opportunities for collaborating with these organizations are therefore visible.

Some piece of information showing the evidence of durability of results attributed to programme was noticed in Dhading. Explored events were: energetic involvement of local organization named *Mental Swabalamban Group* and community health workers, over the time in promoting community mental health.

Impact of the programme: In light of the programme's running status, questions of the major impact of programme, sustainable change in the health of the population and marked results after the completion of programme could not be answered. Though, unintended short-term effect, discontinuation of drug use by some of the regular clients was noted due to shifting of *Rajmarga* Hospital's outreach camp to District Hospital in Dhading after the Gorkha Earthquake 2015. As the price of drugs surged after this event, most of the deprived people could not make it to afford increasing the pattern of drug use discontinuation.

Lessons learned: Just an implementation of programme in isolation may not always work. Importance of supervision, monitoring, and evaluation also counts. All above that, factors influencing implementation, failure, and success of programme need to be considered equally; this was hardly found in this programme. Inadequate awareness of mental health in the community, still persisting negative perception of the community towards mental health problems, difficulty in counseling client and their family to refer to camp somehow hindered the success of the programme. Some of the beneficiary's vital needs crucially lacking were

camp's wide coverage and frequency, thus affecting patient flow more or less. A great lack of coordination and collaboration with district health authorities and other private organizations greatly got into the way of promoting activities of outreach camp. It was also inadequate dissemination of message of outreach camp up to the grass root level that negatively impacted the programme's success. Paying attention to all these influences together with the socio-cultural environment, a refined programme incorporating these aspects may assist in reaching the goal of the programme.

Recommendation: Owing to programme's relevance, mild effectiveness, and possible sustainability, community-based mental health programme deserves continuation, with the amendment in programme modality. Learning from strengths, weaknesses, opportunity and challenges of this programme, possible constructive approaches could be: focused monitoring and supervision of camp activities, training of all FCHVs, health worker's(HWs) of problem severe areas, orientation to mother groups(MGs) and key community persons of problem loaded areas, coordination and collaboration with private organizations with a lead of district health authorities, and active dissemination of message of outreach camp mobilizing community people. The current programme may be scaled up in other districts too; programme modality being harmonized with local circumstances and loads of mental cases.

CHAPTER ONE

INTRODUCTION

1.1 Study background

To ensure the availability and equitable access to mental health (MH) services for the population of Nepal, and in particular the most vulnerable and under-privileged groups, MH services have to be integrated into the primary health care (PHC) services system of the country. MH services should also have an active and dynamic interaction with the communities they serve.

In Nepal, both physician and non-physician based PHC facilities only provide negligible MH services to the general population. This is mostly attributable to a lack of training in MH of the workforce. As, for instance, only two percent of the training for medical doctors is devoted to MH and the same percentage goes to nurses. A number of non-governmental organizations (NGOs) providing MH services are operating; however, their reach and distribution is not based on expected case load or equity considerations. In addition, most of the NGO based MH services do not report to the district health system.

Comprehensive data on utilization of MH services are therefore limited in Nepal. The Department of Health Service (DoHS) receives MH services data from the hospitals and PHC facilities through the Health Management Information System (HMIS), and is published in its annual report. These data, recorded as per six different MH categories indicate a huge treatment gap for MH disorders.

Since December 2010, with financial support from the World Health Organization (WHO), Country Office for Nepal, the Mental Hospital implemented a community-based MH services in Dhading and Nuwakot districts with the goal to make MH services more accessible through monthly outreach activities for a year and then programme was continued by a team of Mental Hospital in its own resources. The Mental Hospital also provided two training sessions for providing community-based MH services at the primary care level to local health workers (HWs): nursing and paramedical staffs. Same was given to 15 FCHVs for one day in each district.

1.2 Scope of the evaluation

In order to find out the status of the programme and inform the decision makers about its effectiveness with the aim of helping them to decide the further course of this programme from the perspective of scale up and expansion, evaluation was deemed necessary. This project evaluation was thus conducted in close coordination with Mental Hospital by the NHRC with the support of WHO Country Office for Nepal to provide information to both the Ministry of Health and Population (MoHP) and the development partners about the status of project implementation, to ensure accountability for the expenditures to date, and the delivery of outcomes/outputs so that corrective actions as appropriate can be taken by managers. The scope of the current evaluation lies within the modification and scaling up of the programme.

1.3 Evaluation questions

PROGRAMME RELEVANCE RELATED QUESTIONS

- Is the problem prioritized in the district area by the district health authorities?
- Is there a high burden of the problem in the districts?
- Are the programme objectives well-matched with the need of beneficiaries?
- Are MH outreach camp services adequate, affordable, acceptable, and equitable?
- Is MH team of the Mental Hospital sufficient and competent to address the need of clients?
- Is the training curriculum of the Mental Hospital well-matched with the need of local HWs and FCHVs?
- Has the training on community-based MH services built the capacity of local HWs and FCHVs?
- What is the response of clients and community people towards MH outreach camps?

PROGRAMME EFFICIENCY RELATED QUESTIONS

- Have the objectives been achieved at the lowest cost?
- Could better result be obtained at the same cost?

PROGRAMME EFFECTIVENESS RELATED QUESTIONS

- Have MH services been successfully institutionalized in the district health systems (Inclusion of MH component in district health plan and service roster of district hospital, availability and use of the MH service treatment guidelines, training to HWs and volunteers in the MH service guideline, availability of free MH drugs, recording and reporting of MH services in HMIS, and discussion of MH issue in monthly review meeting)?
- Has MH outreach camp been properly managed including documentation, monitoring, supervision, and evaluation of the activities?
- Is there active involvement of the District Health Office (DHO), organizations, and community people in MH outreach camps?
- What is the pattern of client flow in the camp (gender and ethnic wise)?
- Is MH outreach camp accessible to public of Nuwakot and Dhading?
- Are clients satisfied with the services offered by MH outreach camp?
- Are there any MH capacity building efforts by the DHO and other private organizations in the district?
- Has there been an increase in referral of MH clients to health facilities (HFs) by local HWs?
- Has there been an increase in counseling and referral to camp and nearby HFs by the

FCHVs?

- Has information about the camp been properly disseminated up to the periphery level?
- Is there any involvement of trained HWs and FCHVs in MH promoting programmes after the training?
- Has there been rise in MH awareness among the community after the programme?
- Has there been a reduction in stigma among people with mental illness after the programme?
- What are the successes and difficulties/challenges faced during implementation of the programme?
- Are there any strength/worthiness of MH outreach camp and local HWs training?

PROGRAMME SUSTAINABILITY RELATED QUESTIONS

- Are the beneficiaries still benefitting from MH outreach camp, even, after the completion of major assistance?
- Is there any probability of continued long-term benefits?
- Is there any durability of the results, including institutional changes over the time?

PROGRAMME IMPACT RELATED QUESTIONS

- What are the positive and negative, primary and secondary long-term effects produced by a community-based MH programme?

1.4 Evaluation criteria

- Relevance
- Efficiency
- Effectiveness
- Sustainability
- Impact

Relevance of the programme was assessed based on the following measures.

- ❖ Prioritized problem in districts,
- ❖ Burden of problem in districts,
- ❖ Programme matched with need of beneficiaries,
- ❖ MH outreach camp (adequacy, affordability, acceptability, and equitability of the services),
- ❖ Sufficiency and competency of MH team of the Mental Hospital,
- ❖ Training curriculum of the Mental Hospital matched with the need of local HWs and FCHVs,
- ❖ Capacity building of the local HWs (HWs and FCHVs training), and
- ❖ Response of clients and community people towards outreach camp

Efficiency of the programme was investigated based on

- ❖ Achievement of objectives at lowest cost
- ❖ Better effects obtained at the same cost

Effectiveness of the programme was judged based on

- ❖ Institutionalization of MH programme in district health system,
- ❖ Management of the MH outreach camp,
- ❖ Active involvement of the DHO, organizations, and community people in outreach camp,
- ❖ Client flow in camp,
- ❖ Accessibility of MH services,
- ❖ Satisfaction of clients with the services offered by the MH outreach camp,
- ❖ MH capacity building efforts by the DHO and other private organizations in the district,
- ❖ Referral of MH clients to HF's by local HWs,
- ❖ Counseling by FCHVs and referral to camp and nearby HF's,
- ❖ Dissemination of information about the camp,
- ❖ Involvement of trained HWs and FCHVs in MH promoting programmes after the training,
- ❖ MH awareness,
- ❖ Stigma of mental ill client after the community-based MH programme,
- ❖ Successes and difficulties/challenges faced during the programme, and
- ❖ Strength/worthiness of MH outreach camp and local HWs training

Sustainability of the programme was appraised based on

- ❖ Continuation of benefit from MH outreach camp after the completion of major assistance,
- ❖ The probability of continued long-term benefits, and
- ❖ Durability of the results, including institutional changes over the time

Impact of the programme was evaluated based on

- ❖ Presence of positive and negative, primary and secondary long-term effects produced by a community-based MH programme

1.5 Conceptual framework of evaluation

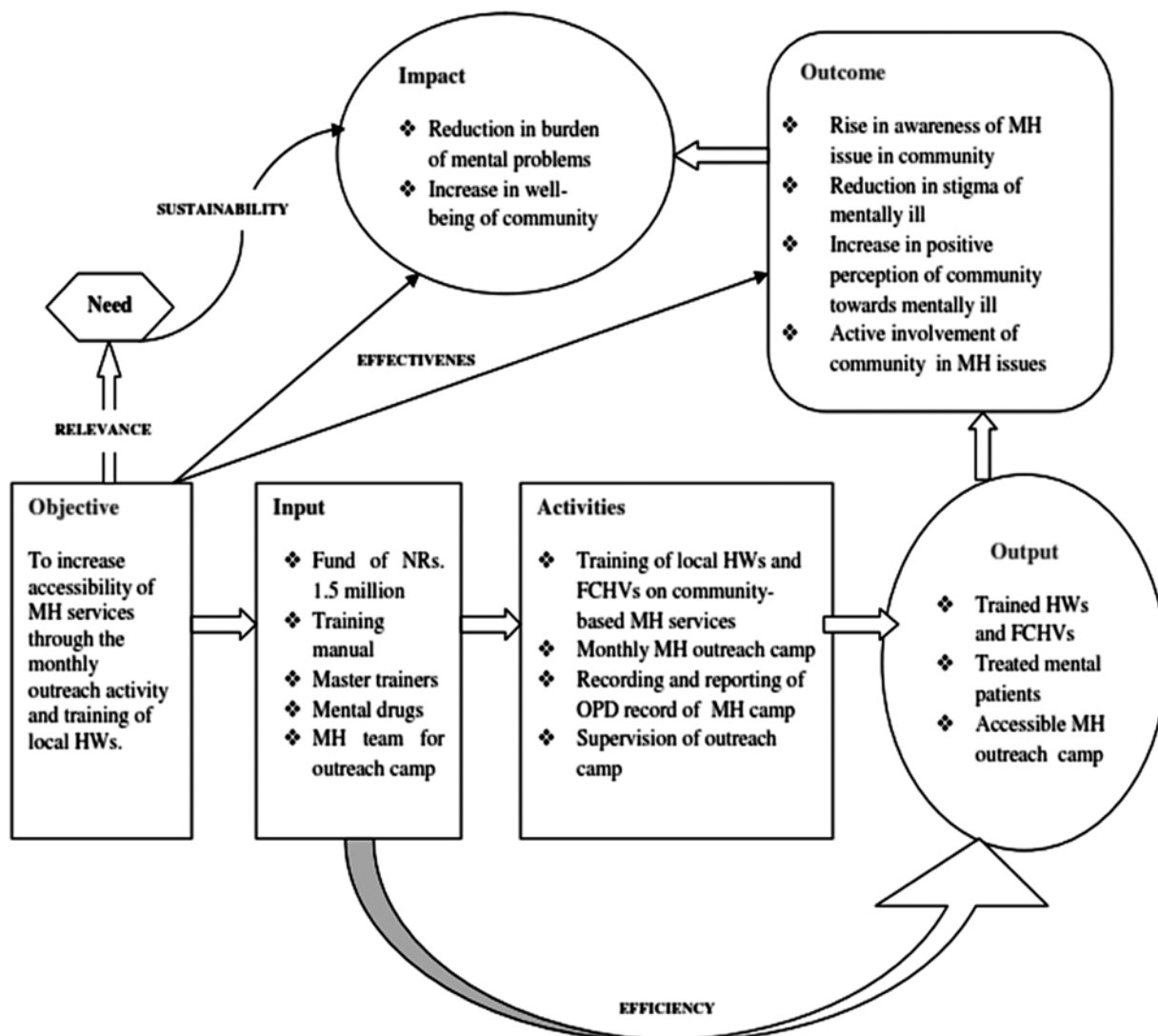


Figure 1: Conceptual framework of evaluation process of community-based MH programme

CHAPTER TWO

METHODOLOGY

Based on key evaluation questions and criteria, methodological approach was adopted. This was predominantly qualitative study, with a slight mix of quantitative approach. A series of stakeholder consultation meeting was also organized for understanding the process of programme implementation. For this purpose, consultation with Mental Hospital Director and Psychiatrist was done.

2.1 Study population and site

Study populations of concern were respectively: Public Health Inspector (PHI) of Nuwakot and DHO of Dhading district, HWs and FCHVs who got training from the Mental Hospital, community leaders actively involved in the MH outreach camp, and clients of outreach camp. This evaluation study was carried out in Nuwakot and Dhading districts, where the MH outreach camp is currently running.

2.2 Sampling method and sample size

Applying theory of saturation, purposive sampling of study participants were done. Only those HWs and FCHVs who were part of the training of the Mental Hospital were included. For the community leaders, those who got actively involved in MH outreach camp were invited for the study.

Study was accomplished with nine exit client interviews (five in Dhading and four in Nuwakot), and six key informant interviews (KII) in Dhading (one PHI, one hospital staff directly engaged in outreach camp, one community leader, two HWs, and one FCHV). For Nuwakot district also it was six KII (one PHI, one doctor of MH service provider team, two HWs, and two FCHVs).

2.3 Data collection tool and technique

Desk review and field visits were accomplished to collect the required information. The study assembled the required subjective information through KII guideline and exit client interview guideline. While for objective information, it was checklist to review documents.

To get qualitative information, KII was undertaken with PHI, community leaders, MH service providers of camp, trained HWs, and FCHVs. For the same purpose, exit client interview was done with the clients seeking services from the MH outreach camp. When it came to quantitative data, record review of Outpatient Department (OPD) record of monthly MH outreach camp was done. Document review was also done accordingly. Reviewed documents were: draft report of activities of community-based MH programme, training manual for the trainers of PHC

workers in MH, and training manual for PHC workers on MH.

During the course of the evaluation, involvement of stakeholders was substantial from the process of study design to data collection.

2.4 Data processing and analysis

Prior to entry, quantitative data extracted from OPD record were checked for inconsistencies, repetitions, missing data (if any). Manually checked quantitative data was entered and analyzed in the Statistical Package for Social Sciences (SPSS) full version 16.0.

Qualitative information was thematically analyzed giving the equal emphasis to say of all the participants, not only the common views. Firstly, information gathered through KII in field was kept in written form in field notes. This was supplemented to the audio record used during the interview process. Use of field notes was followed by the transcription process. The processes carried out during transcription were respectively: transcription of discussions in Nepali language from the audio record, notes and then translated to English for facilitation of data processing. Just after the transcription, coding of data was done. Post coding, wide range of data was reduced into five themes: relevance, efficiency, effectiveness, sustainability, and impact. The given themes were further categorized into various sub-themes. Development of theme was based on putting together the codes with similar meaning under the common theme.

2.5 Data validity and possible biases

The evaluation team encountered a number of systematic errors like missing and inconsistent data in the OPD report of MH camp, thus challenging the internal validity of the study. It was also found that the answers to questions differed by the level of educational status among the MH clients. This may have resulted in information bias. There were also no any means to verify the subjective information, especially on topics: burden of mental problem in district, response of community people towards outreach camp, referral of clients to HFs and outreach camp by local HWs, counseling and referral to camp and nearby HFs by FCHVs, MH awareness in community, and reduction in stigma of mentally ill after the programme.

Nevertheless, to minimize researcher bias, KII was conducted not just by asking the questions, but by raising the issues and probing to further facilitate the data collection process. Moreover, reliability of data was maintained by using a number of techniques (field note, audio record) for the data collection. Further, triangulation was done to validate data regarding client flow in the camp and accessibility of the camp.

2.6 Ethical considerations of the study

The study was fully abided by ethical guidelines, with an ethical approval from an independent Ethical Review Board (ERB) of NHRC. Right to voluntary participation was fully assured by taking a written informed consent from the study participants.

2.7 Boundaries (limitations) of the evaluation and problems encountered

The field team confronted the problem of inadequate information showing expenses of the costs of every single unit of the programme. On account of limited information on programme funding, appropriate judgment of programme's efficiency could not be carried well. Despite that, assessment of efficiency was undertaken a bit.

The major impact assessment question, 'Are the result still evident after the intervention is completed?' could not be answered in the light of the ongoing status of the programme. Basically, it was too early to assess the impacts, chiefly long-term effects produced by the programme, directly or indirectly. Yet, short-term effects due to the programme were explored.

Existence of a number of organizations working for MH in study sites leading to a contamination effect and maturation effect because of time factor created a massive challenge to review the independent effect of this programme.

CHAPTER THREE

FINDINGS

With reference to the outputs of qualitative and quantitative analysis, answers of evaluation questions have been unveiled in this chapter. The findings revolve around the five criteria's of evaluation: relevance, efficiency, effectiveness, sustainability, and impact of the programme.

3.1 Relevance of the programme

The thematic relevance of the programme was evaluated based on number of corresponding factors (sub-themes) as explained below.

Prioritized problem in Dhading and Nuwakot

Though, almost all the participants perceived the severity of problems in their respective districts, though it was not given a weight by the district health authorities. A number of other P1 programmes and non-allocation of separate budget and programme for MH in districts might be the reason. Equally, limited services and very few MH trained HWs in both the settings further gives the justification of the problem being underestimated. In addition, it might not be reasonable to expect the outcome with limited input of around 1.5 Million NRs. For the community-based MH programme, reflecting limited priority.

Burden of the mental problem in Dhading and Nuwakot

"Yes, mental health problems is one of the highly prevalent public health problems in this district." This remained a common voice of all the participants. As per the self-report of one of the influential key informants, HMIS Report analysis of 75 districts gave the figure of the comparatively higher number of mental cases from Nuwakot and Dhading, reflecting the substantial presence of mental problems in the programme sites. However, validation of the views of the participants was not carried out to quantitatively assess the extent of problem in the study sites.

Programme matched with need of beneficiaries

The ultimate beneficiaries of this community-based MH programme were local HWs, FCHVs, and the MH clients. All the trained HWs and FCHVs from both the districts highly acknowledged the training as their need.

"That training helped me a lot. I utilized that skill mostly on counseling postpartum psychosis clients." Female HW, Trishuli Hospital, Nuwakot

"Undoubtedly, training helped us a lot to improve management skill of MH clients. Before this training, I even did not have an idea to manage simple cases also." **Male HW, Salyantar Primary Health Care Center, Dhading**

As well, it was all MH clients who appreciated the launch of MH camps in their accessible areas, thus suggesting the programme's objective linked with need of beneficiaries.

"The Local community has greatly benefitted from the outreach camp, as it's accessible to them. Mostly poor have benefitted." **Social Worker, Dhading**

The significance of MH training as the need of beneficiaries was thus noticed; despite that, some rational concerns were raised by few HWs regarding the limited content and duration of training to match their needs, particularly when it comes to the management of severe cases.

MH outreach camp (adequacy, affordability, acceptability, and equitability of the services)

For most of the clients, services were adequate. Only matter of interest to them was inadequate frequency of camp to address their real need.

In contrary, some of the HWs emphasized on the inadequacy of the drug to address the mental health problems, especially chronic one. This huge margin of difference in opinion could be due to variation in level of knowledge regarding the services.

"Easily treated clients are given services in the camp. Services provided and doctor was sufficient to cover on an average of 80 clients per camp. But, if the load exceeds this flow, it will not be enough." **Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading**

Analyzing affordability of the drug, the common voice of all the clients was expensive medicine at the camp. All the study clients of Dhading complained about increase in drug price, after the Earthquake of April 25, 2015. (Note: MH outreach camp of the Mental Hospital in Rajmarga Community Hospital got shifted to Trishuli District Hospital after the Earthquake of April 25, 2015).

"Since Koshish (NGO working on mental health) left coordinating this MH outreach camp, cost of drug has increased. Previously, Koshish used to provide Rs. 15,000 every month to buy mental drugs." **Social worker, Dhading**

"Previously, they used to give some subsidy on the drug price. But, now we have to pay all. We don't have money to buy medicines (Weeping voice)." **Female Client, Rajmarga Community Hospital Outreach Camp, Dhading**

Relying on reports of all MH clients of *Trishuli* Hospital MH outreach camp, Nuwakot, cost of drugs was beyond their purchasing power.

"Drugs are expensive. I did not complete the entire prescribed dose, due to the lack of money." **Male client, Trishuli Hospital Outreach Camp, Nuwakot**

On the other hand, with reference to HW's voice, drugs are not as expensive as outside. As per them, considering the opportunity costs, price of drug is not as high as exaggerated by the clients.

Acceptability of MH services at the camp, while considering with their socio-cultural environment was considered good enough by all the participants. The study also did not identify any information about programme hitting the social norms of society at both the districts.

As far as equitable service is concerned, no any evidences were detected. Clients of both the outreach camp were charged with a certain amount of an OPD charge, irrespective of economic status and disease severity status.

A unique mark was traced out in a *Rajmarga* Community Hospital, Dhading questioning the equitable services, as greater financial support was restricted to clients of nearby three Village Development Committees (VDCs) only.

"Clients from Benighat, Mahadevsthan, and Gajuri VDCs were given 75% subsidy, and rest was given only 10% subsidy on the drug's price. As, our focus was to provide MH services to clients of these three VDCs only." **Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading**

Sufficiency and competency of MH team of the Mental Hospital

"MH team is sufficient and competent to manage us." It remained undoubtedly widespread say of clients of Nuwakot and Dhading district. Alternatively, HWs came with different opinions. Parallel to their views, answer of PHIs from Nuwakot and Dhading went like this: *"MH team is not equipped to look after severe cases, and what particularly the team lack is counseling skill, most probably because of the limited time of the camp."*

"This team of Mental Hospitals not able to manage all categories of mental clients. They themselves also refer severe cases to Kathmandu. Drugs brought by them are also not sufficient." PHI, Nuwakot

A subject concerning to almost all participants was limited/no counseling to clients by MH team. *"Just questioning signs, symptoms, and distributing drugs may not always work well; what counts most is counseling in the case of mental patients. Therefore, a MH team must counsel the patients as well."* All the HWs suggested.

Training curriculum of the Mental Hospital matched with the need of local HWs and FCHVs

While evaluating MH training curriculum, a number of strengths were identified. To point out, they were accordingly:

- ❖ Well covered topics
- ❖ Finely organized topics from simple to complex
- ❖ Adequate content
- ❖ Written in simple language making it easily understandable by the community HWs
- ❖ Pre and post test assessment covering all the contents of the curriculum

Despite its positive points, training curriculum needs improvement in some areas.

- ❖ The chapter childhood mental disorders need to cover a little bit more in some of the topics commonly seen in the community nowadays. As, for instance: school phobia, how to take care of child at home by parents/caretakers, and how to manage an enuresis problem at home.
- ❖ Under the psychiatric emergencies, the topic suicide needs to focus on how to prevent suicide in the community as this is an emerging problem faced by the community.
- ❖ Under the chapter psychotropic drugs, it would be better if some tips are added on how to overcome the side effects of drugs, so that patient's / caretakers can help the patient at home setting.
- ❖ In the chapter community-based MH service approach, different levels of prevention of mental problems could be added.

Capacity building of local HWs (HWs and FCHVs training)

All the HWs and FCHVs who were part of this evaluation stood with the view that training was substantial and need-based to address the MH problems at the community level. They commented that this training developed the skill of detecting, counseling, treating, and managing the mental clients at their working facilities. Of all the HWs, two were of the view that duration and content of the training was not enough to meet their needs.

*"While I was at Kaule Health Post, I used to see many people with simple mental health disease. Due to the lack of knowledge on handling cases, I used to refer them. We were not provided with any MH related training by government also. This training helped me to correctly counsel, treat, and manage clients. I treated many mental clients with diazepam, amitridine, and with injection in psychosis cases. This training not only increased my knowledge, but also developed my positive attitude towards mental client and disease. That training was our huge need." **PHI Nuwakot(Previous HW, Kaule Health Post)***

It was largely appreciated by the HWs, when it came to training of FCHVs on MH issue.

*"FCHV knows more about their catchment VDC than us. She is the first to deliver services in community. HWs play the secondary role. Therefore, FCHVs must be trained and oriented on MH issues, so that they can raise awareness in the community." **Male HW, Salyantar Primary Health Care Center, Dhading***

All the participating HWs and FCHVs recommended follow up of training, as no any steps to follow up were initiated by the Mental Hospital after training, signifying drawback of the programme.

Response of the clients, HWs, and community people about the MH outreach camp

It was a mixed response by clients. Clients were pleased as it was accessible to them. At the same time, they were worried about the cost of drug. For HWs, reaction was positive, leaving some concerns like duration and content of training. While from the community people, response was average. Only group that showed concern with the active involvement in promoting outreach camp was some handful of families of mentally ill that too remained active only in Dhading district, around the sites of *Rajmarga* Community Hospital for some time.

3.2 Efficiency of the programme

As the field team did not find any supporting documents (cost of every single input of the programme) required for checking the programme's efficiency, it was not fully possible to assess this component. However, based on raw information of overall input of NRs. 1.5 million and output of number of local HWs, FCHVs trained and many patients treated, programme could be apparently viewed as somehow efficient, though inconclusive. On top of that, the study design itself was not ideal to assess the efficiency.

3.3 Effectiveness of the programme

The study judged the effectiveness of the programme on the basis of following sub-themes.

Institutionalization of MH programme in District health system

Inclusion of MH component in the District health plan and service roaster of the District Hospital

was observed in both the Districts, though not implemented. MH treatment guidelines of the Mental Hospital and Center for Mental Health and Counseling Nepal were followed to treat the clients in both the district hospitals. However, there were no separate mental wards in both the hospitals. Frequency of visit by MH doctor was scheduled only twice per month in both the sites. None of the nurses and paramedics was available for treatment of mental patients in both the District hospital. It was three paramedics who received special training on MH services in Dhading, while this figure remained zero for Nuwakot. A total of 30 HWs (three doctors, two nurses, and 25 paramedics) received training in MH service guideline in Nuwakot. This statistics was non-existent in Dhading District Hospital. Four MH drugs, namely Diazepam, Amitriptyline, Alprazolam, and Phenobarbitone were available free of cost. Recording and reporting of all the MH services delivered were done in the HMIS form in both the districts. Discussion of MH issues in monthly meeting was rare event in both the districts. Similar was the case for discussion of MH community programmes in review meetings.

*"In case clients are excess according to the mental cell of HMIS format, we discuss what might be cause, (whether it's true problem or wrong diagnosis, or writing mistake). But, generally we do not discuss in normal case." **PHI, Nuwakot***

An urgent need of institutionalization of MH programmes in the district health system was underscored by all the participants. A female HW from *Trishuli* Hospital, Nuwakot strongly stressed that given the overflow of chronic mental clients in *Trishuli* District Hospital, a competent MH team in district hospital is required. Another key informant from Nuwakot also gave similar opinion.

*"There must be trained team of MH with a group of two doctors, two paramedics, and three nurses at district hospital. One MH focal person in every HFs is also needed. If this can be done, we can manage all clients daily. There will be no client load and also no need of camp." **PHI, Nuwakot***

*"MH related programmes from government at the district level is completely lacking." **Male HW, Salyantar Primary Health Care Center, Dhading***

*"We are seeing many such cases after the quake. Therefore, MH services must be institutionalized." **Male HW, Trishuli District Hospital, Nuwakot***

Mental Hospital's programme pushed MH activities through the outreach camp and local HWs training, though was evidently one-way. No any piece of data was uncovered to detect the contribution of this programme in the institutionalization of MH programme in the district.

On the whole, despite visibility of partial institutionalization of the MH programmes in both the District health system; a huge gap in implementation, particularly on service delivery

mechanism, with no HWs for mental treatment, very few trained HWs, limited OPD services and drugs were spotted.

Management of the MH outreach camp (recording, reporting, monitoring, and supervision of the activities)

Monthly reporting of outreach camp was done in a form of OPD report in both the districts. One copy of OPD report was submitted to DHO and the Mental Hospital by both the camps. Whereas in Dhading, reporting was also done to *Koshish*, an NGO actively involved in providing drugs to camp for two years dated 2069 Ashoj to 2071 Ashoj.

The study came across several shortcomings when going through recording of OPD report of the MH clients. Missing of data was a frequent problem in the OPD report of Nuwakot outreach camp; this was also a problem of Dhading outreach camp's OPD report, though lesser. Another flaw that study identified was initiation of recording of the data only after few months of an initiation of both the camps.

Despite monthly reporting, monitoring and supervision of camp activities were hardly done from the central and district level.

"Till now, supervisory visit is only twice from the center and twice from the district. However, no feedback was given. " Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading

"We monitored the camp only twice. We observed the client flow, treatment process, and recording and reporting process. " PHI, Nuwakot

Active involvement of DHO, other organizations, and community people in outreach camp

A good example of active participation of private organization and community people, especially mentally ill people in outreach camp was observed in Dhading district. *Koshish*, an NGO was actively involved in implementing outreach camp in Dhading by funding NRs. 15,000 monthly to buy drugs. Likewise, a committee named *Aatmanirbhar Swabalamban Samiti* had its origin in *Malekhu*, Dhading to support activities of MH outreach camp in Dhading.

The scenario was, however, different with none of the organizations and community people collaborating with the camp in Nuwakot district. Involvement of the DHO was insignificant in both the settings, except for limited supervision of the camp.

"Only Koshish has been involved in this camp, together with Rajmarga Hospital and the Mental Hospital. Koshish provided NRs. 15,000 per month to buy drugs from 2069 Ashoj to 2071

Ashoj." Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading
"I don't see any community participation in MH issues. Though, some of the families with mentally ill members have developed a committee made in coordination with Koshish, an NGO. This group helped mentally challenged people by providing training on mushroom farming, candle making, and also providing equipment. However, soon after Koshish left partnership in outreach camp of Rajmarga Community Hospital, this committee got deactivated." Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading

Client flow in camp

Yearly trend of patient flow in camp (gender wise)

Statistics of Nuwakot: On a whole, though in following year of camp, number of clients decreased considerably, figure depicted slight increment of cases since then (Figure 2). An immediate drop of cases in the subsequent year, 2069 is due to the fact that most of the cases were old coming for follow up. This study analyzed new and old cases for the year 2068 only. Taking a look at gender-stratified yearly trend of patient flow in Nuwakot (Figure 2), line diagram portrayed the figure of comparatively higher number of male clients seeking the services than their female counterparts in the year 2068 B.S, immediately after an initiation of the camp. This trend went alike in the year 2069 and 2070 B.S. Surprisingly, the year 2071 B.S saw more female clients as beneficiaries.

Relatively, more male than the female during the beginning year might be due to social desirability bias. Regardless of this, later year showed more female clients indicating the output of community awareness, exposure to mass media, women empowerment, family support, and many other factors, which the current study did not assess.

Not only clients of Nuwakot, but also that of other adjoining districts: Rasuwa, Dhading, and Sindhupalchowk were the beneficiaries of the Nuwakot MH outreach camp. This calls for necessity of continuation of outreach camp beyond the working areas.

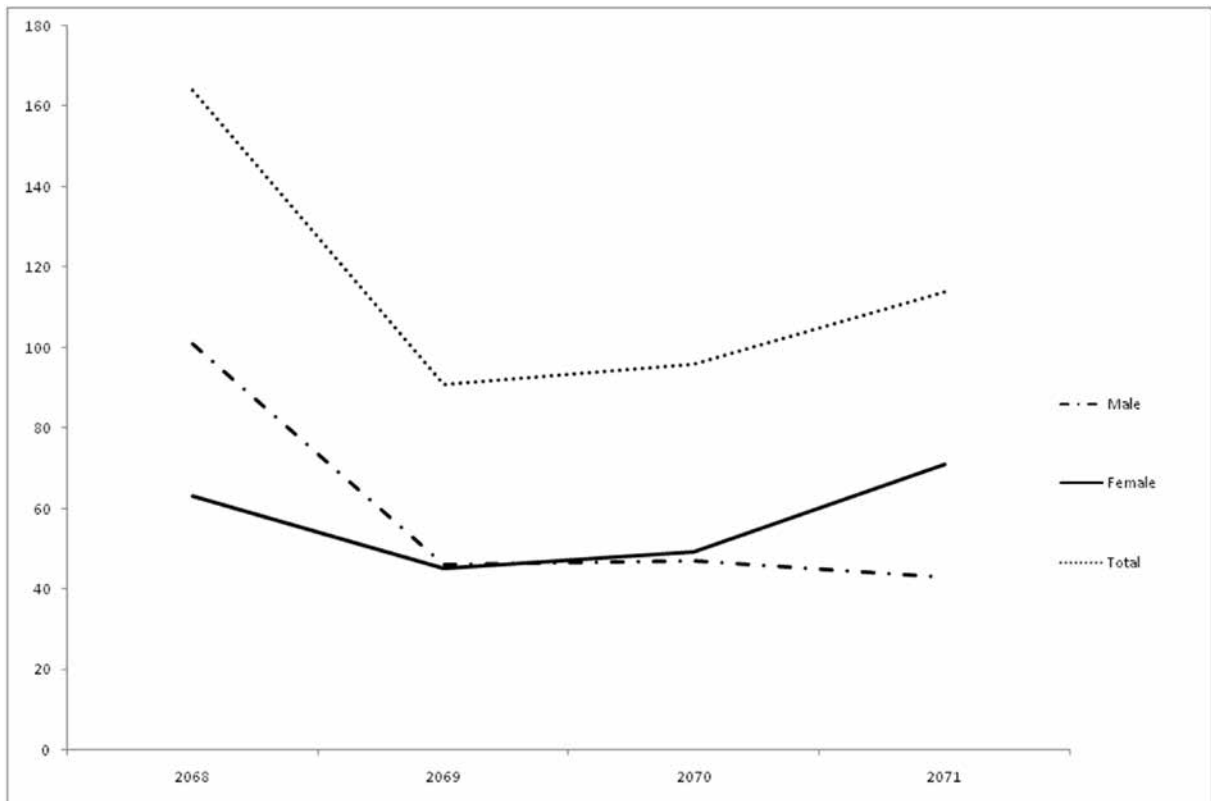


Figure 2. Yearly trend of patient flow (gender wise) in MH outreach camp of Nuwakot

Statistics of Dhading: As suggested by Figure 3, number of cases (overall, male, female) was overwhelming in the beginning year. Number of cases however, plunged in the year after a foundation of the camp, phenomenon common to that of Dhading camp. The reasons are similar to that of Nuwakot's.

Majority of the clients paying visits at camp were female. This trend went parallel from the early year and is still going, demanding MH interventions mostly focusing the female.

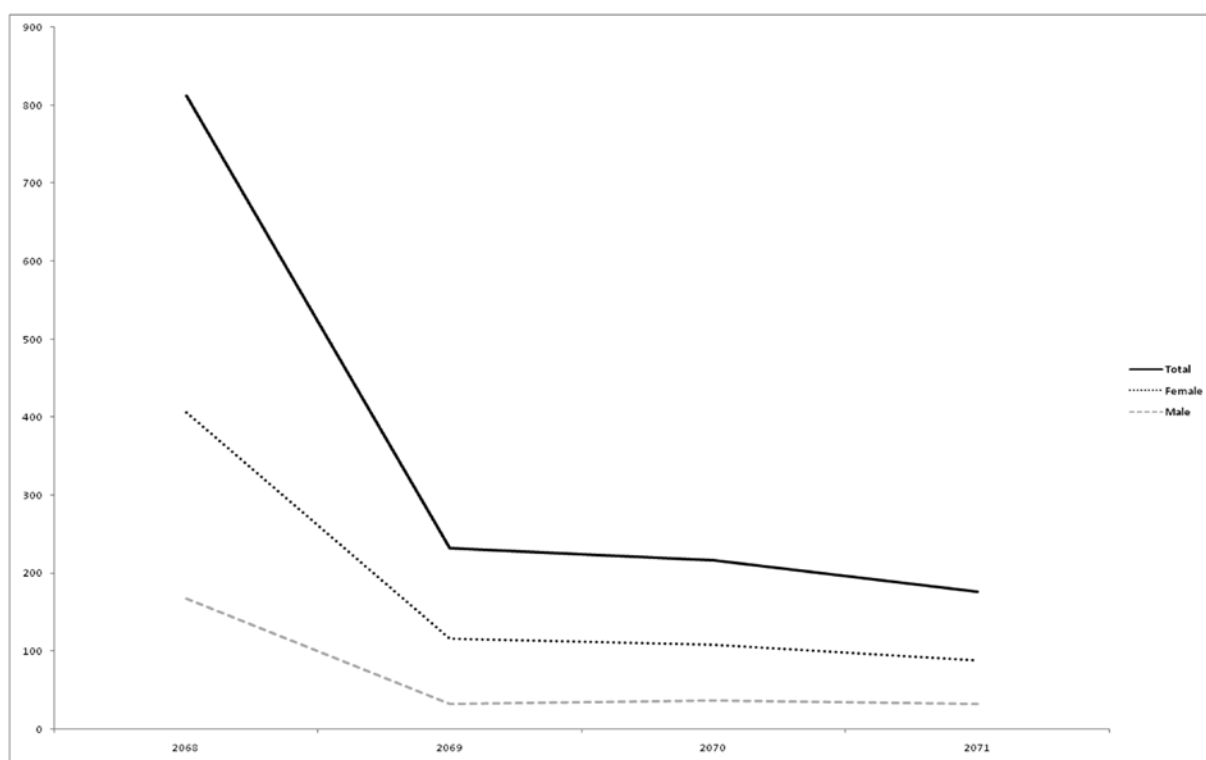


Figure 3. Yearly trend of patient flow (gender wise) in MH outreach camp of Dhading

Figure of Nuwakot: When assessed for the ethnicity of the clients, majority belonged to the Upper caste, whereas a mere of five percent was shared by *Dalits*. This trend went parallel throughout all the years (Table 1).

Most of the clients came from surrounding VDCs and *Trishuli Bazar*, as the camp was close to them. Having looked at the ethnic distribution of these sites, they were mostly occupied by Upper caste groups and disadvantaged *Janajatis* like *Tamang*. Therefore, the possibility of these ethnic groups utilizing the services might have been increased mostly due to accessible services and exposure to information about the camp. Number of other reasons might have also led to this output.

Table 1: Yearly trend of patient flow (ethnicity) in MH outreach camp of Nuwakot

Ethnicity	Date				Total n=370, *95
	2068	2069	2070	2071	
Dalit	10	5	1	3	19 (5.1%)
Disadvantaged Janajati	31	8	18	22	79 (21.4%)

Relatively advantage Janajati	12	6	7	10	35 (9.5%)
Upper caste group	81	54	49	53	237(64.1%)
Total	134	73	75	88	

*missing

Figure of Dhading: Pattern alike to Nuwakot was observed, with four out of ten clients were from Upper caste. Over the span of four years, upper caste clients were found to benefit most. However, with reference to Nuwakot camp, comparatively higher numerals of clients from *Dalits* were found (Table 2).

Greater part of the clients were inhabitants of surrounding VDCs and *Malekhu* Highway. The camp was located at *Malekhu* Highway, the southern belt of Dhading. Counting on Wikipedia report, south belt of Dhading is the home to *Brahmin* and *Chhetris*. Considering this fact, the chances of these groups utilizing services mostly than other groups are high. Possibility of other factors influencing this outcome does subsist as well.

Table 2: Yearly trend of patient flow (ethnicity wise) in MH outreach camp of Dhading

Ethnicity	Date				
	2068	2069	2070	2071	Total n=538
Dalit	23	50	43	33	149 (27.69%)*
Disadvantaged Janajati	37	30	18	18	103 (19.14%)*
Religious minorities	0	1	0	0	01 (0.18%)
Relatively advantage janjatis	22	19	10	9	60 (11.15%)*
Upper caste	80	65	42	38	225 (41.82%)
Total	162	165	113	98	

Accessibility of MH camp

Accessibility was examined based on the number of clients from electoral constituency with and without the camp.

Accessibility of Nuwakot's MH outreach camp: Illustrating an evidence of role of distance to camp on utilization of health services, nearly half of the client's were from electoral constituency number 3 in which the camp is being conducted (Table 3). The reasons for less patient flow from other constituencies may be accessibility issues and other factors which need further detail investigation.

Table 3: Yearly trend of patient flow (electoral constituency wise) in MH outreach camp of Nuwakot

Electoral constituency	Date				Total (n=460*5)
	2068	2069	2070	2071	
1	25	21	13	17	76 (16.5)
2	27	09	19	16	71 (15.4)
3**	83	44	43	54	224 (48.7)
4	29	16	19	25	89 (19.3)
Total	164	90	94	112	

*Missing

Accessibility of Dhading's MH outreach camp: Similar finding of Nuwakot was replicated in Dhading outreach camp as well, with one out of two clients from the electoral constituency in which the camp is running (Table 4). This further strengthens the evidence of relationship between accessibility of MH camp and flow of patients.

Table 4: Yearly trend of patient flow (electoral constituency wise) in MH outreach camp of Dhading

Electoral constituency	Date				Total (n=531*7)	
	2068	2069	2070	2071		
1	7	6	4	6	23	4.33
2 **	84	69	58	44	255	48.02
3	60	67	39	44	210	39.55
4	11	18	11	3	43	8.10
Total	162	160	112	97	531	

*Missing

In addition to an OPD report analysis, subjective information was also gathered from the participants with emphasis to the camp's accessibility.

When it came to accessibility of the camp, the term given by most of the clients and HWs was partially accessible, in the sense that it reduced long distance of Kathmandu. However, almost all revealed that camps being located at district headquarter in Nuwakot and Malekhu Highway at Dhading still remained out of reach to inhabitants of remote VDCs. Particularly, in Dhading, most of the clients came from nearby VDCs of Malekhu highway, indicating the role of accessibility on utilization of the services.

"This camp is located in southern belt. from its highway, this is accessible than Kathmandu, but for overall Dhading, it's not accessible, especially for two remote VDCs of northern belt."
Social worker, Dhading

"The 70% clients come from VDCs of this Malekhu highway. Only 10% clients come from north belt." **Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading**

Not surprisingly, one of the key informants from Dhading revealed the influence of other enabling factors like lack of transportation and presence of traditional healers (THs), thus suggesting the importance of increasing the number of camps at various locations, not only specified to the highway.

"No matter how educated a person is, his first doctor will be THs, as they are accessible and relatively economical, especially for northern belt of Dhading district, where there is a lack of transportation." **PHI, Dhading**

Satisfaction of the clients with the services offered by MH team

The common answer of all the clients to this question was "Yes, we are satisfied with the services offered by the MH outreach camp." Their only dissatisfaction was with limited counseling of MH team.

A social worker from Dhading differently shared her view, *"Actually, not satisfied, mostly the poor, as there is no special subsidy on drug price."*

MH capacity building effort by DHO and other private organizations in the district

In spite of need of MH training to the HWs from district level to grass-root level, training given by the DHO and private organizations was limited to countable HWs only. It also happened depending on the working areas of different private organizations.

In Dhading, few private organizations like *Centre for Mental Health and Counseling–Nepal, Koshish*, and *Jagatjyoti Rural Development Society* were focusing on some MH components targeting major key persons of the community, though in limited areas. Citing the information of the PHI of Nuwakot, none of the NGOs were involved in MH capacity building of HWs so far. A must say, quantity of training was not sufficient to cover the need of both the HWs and clients.

"Six days training in mental treatment guideline was provided by the Mental Hospital in past. The 30 paramedics and nurses got training in four different batches from 2067 to 2070 (three doctors, two nurses, and 25 paramedics). Also, Management Division gave training to 20

HWs (at the end of 2070). I also recently got seven days MH training provided by the Mental Hospital. None of the NGOs/INGOs have given training. But they have started after the 2015 Gorkha Earthquake." PHI, Nuwakot

"Center for Mental Health and Counseling-Nepal provided basic MH training to social mobilizers, teachers, THs, and local HWs in four VDCs (Nilkantha, Salyantar, Gajuri, and Jogimara). Also, Jagatjyoti Rural Development Society has been working on sensitization of MH issues among HWs, school teachers, and FCHVs in three VDCs (Muralibhanjyang, Maidi, and Tripureshwor). Management Division also trained 25 HWs on MH." PHI, Dhading

"Training on MH is inadequate for local HWs like us. Even DHO has not trained on MH issues to us." Female HW, Kewalpur HP, Dhading

Referral of MH clients to HFs by local HWs

Relying on the self-report of local HWs, trend of referral of MH clients from community level to HF level and camp notably increased in the last three to four years.

"In district hospital, MH cases referral has increased, especially after they got training by the Mental Hospital." PHI, Dhading

Although, the formal referral mechanism was still lacking. There were no any records of referred number of MH clients at all the levels of health care (FCHVs, local HFs, District Hospital, and MH outreach camp).

Counseling by FCHVs and referral to camp and nearby HFs

Citing to report of selected clients and HWs, counseling on MH issues and referral to camp and nearby HFs by FCHV was zero. Social worker of Dhading too went in line with this report with a say of FCHVs minimal role in counseling and refer of cases.

"Teachers and local leaders counsel mentally ill clients to seek services from the camp. Counseling by FCHVs is unnoticed." Male client, Rajmarga Hospital Outreach Camp, Dhading

"Owing to increased case load, we think that they must have been counseled. I am sure; mostly HWs have referred the cases. Well, about FCHV, I am not sure." PHI, Nuwakot

Opposed to the view of key informants and clients, all the selected FCHVs strongly reported their active involvement in counseling of MH clients and refer to nearby HFs and camp.

Dissemination of information about the camp

All but none told active dissemination of information about camp to community people. Channels reported was mostly District Hospital notice board, monthly review meeting of HFs, and mother groups (MGs) meeting. In contrast to the view of key informants and FCHVs, all of the clients responded, "I came to know about this camp through my neighbor."

*"In every monthly meeting, we inform HF in-charges. They disseminate that to FCHVs. We have also noticed in hospital notice board." **PHI, Nuwakot***

*"I have disseminated information about MH camp to MGs meeting every month." **FCHV, Dhading***

Active involvement of trained HWs and FCHVs in various MH promoting programmes after the training

A higher involvement of trained HWs and FCHVs in MH promoting programmes was found in Dhading district, as the current study did not unveil any such activities in Nuwakot district. Few formal organizations that came into origin because of community-based MH programme incepted by the Mental Hospital were marked in Dhading. These organizations were engaged in promoting MH, though one of them got dissolved, leaving question mark on the sustainability of the programme.

*"Currently, we have registered organization Mental Swabalamban Group with three HWs, me, one FCHV, and mental client members. We conducted survey in VDC to estimate mental client in 2071 (approx. 350 cases, more women). We also conducted meeting with mental clients and orientation of MH on MGs meeting to raise awareness (5-7 activities every year). Nowadays, we are conducting orientation about MH in schools." **Male HW, Salyantar Primary Health Care Center, Dhading***

*"Our Aatma Nirbhar Swabalamban Samiti used to refer clients to Koshish and outreach camp. Our committee conducted school health programme in coordination with Koshish. We also used to conduct door-to-door visit and follow up mental ill clients, but now we don't do. Our committee is now completely disabled formally (but not informally)." **Social worker, Dhading***

MH awareness

MH awareness, according to participant's information, slightly increased. This awareness, however, was limited only to a particular group: mentally ill clients and their family. Community awareness on MH issues remained non-substantial, on a whole. Some HWs also gave their views that awareness is concentrated more among educated people and students. Following

this, an urgent need of awareness was highly emphasized by all the participants.

"MH awareness has only slightly increased. It's limited only to family of mentally ill clients. Community people lack awareness that it's curable. Awareness must be created." **Social worker, Dhading**

"Awareness has risen to some extent, but seen, especially among mentally ill and their family only. Awareness is inadequate among whole community, particularly, Dalit and Chepang. They generally first prefer Dhami, Jhakri, and go to the hospital only after reaching the severe stage." **Resource Person, Rajmarga Community Hospital Outreach Camp, Dhading**

"Awareness has now increased. It is more among students and family with mentally ill members. Even HWs are less aware." **PHI, Nuwakot**

"Because of the increased OPD flow, we believe that there has been rising on MH awareness." **Female HW, Trishuli Hospital, Nuwakot**

Stigma of mentally ill client after the community-based MH programme

The study came up with mixed review regarding this phenomenon in the community. It was, however difficult to trace out independent effect of this community-based MH programme. The reasons behind this could be: other organizations involved in MH in the district, raised MH awareness among the community people because of exposure to media, an increase in accessibility to health services, and many other factors.

"Mentally ill are mostly stigmatized; though, the condition has slightly changed." **Social worker, Dhading**

"My family is supportive towards me. But, this community calls me Bahulai, Pagal, Sankai." **Female client, Rajmarga Community Hospital Outreach Camp, Dhading**

"Nowadays, due to awareness, perceptions of community people towards mental disease and patients have changed to positive somehow." **Male HW, Nuwakot**

Successes and difficulties/challenges faced during implementation of the programme

Undeniably, this programme had a share of some successes. Important to point out are accessible MH services, capacity building of local HWs and FCHVs thus helping to raise awareness of MH and referral of cases to camp and nearby HFs.

While executing this programme, some of the challenges faced by the implementers at district level covered limited time and frequency of outreach camp to properly counsel the client, difficulty in referring clients to camp because of low awareness and still persisting social stigma, management of severely ill patients due to scarcity of professionals, and limited coverage of the camp to welcome clients from different parts of the district.

As this evaluation found the lack of active participation of district health system in promoting and implementing this camp; room of challenges, particularly to disseminate the message up to the periphery level was seen.

Strength/worthiness of MH outreach camp and local HWs training

MH outreach camp carried a number of strengths. Listing of some of the plus points according to key informants are as below: increased accessibility of the services, raised the number of beneficiaries of the camp, improved competency of HWs on managing mental patients, and increased referral of mental cases from community to HF.

3.4 Sustainability of the programme

Continuation of benefits from MH outreach camp after the completion of major assistance

Four years have passed, since the major assistance to programme was discontinued by the WHO. The MH outreach camp is still in its way providing benefit to the mental ill patients, on an independent execution of the Mental Hospital, since then. The prospect of continuation of camp does exist, as in current scenario MH issue has been drawing attention of different stakeholders. In the context of number of organizations operating for the sake of MH in Nuwakot and Dhading after the Gorkha Earthquake severely hit these areas, circumstances of involving these organizations in promoting MH outreach camp was also seen. Still, one of the major challenges remained was inactive involvement of the district health system in the implementing MH promotion activities, despite the presence of MH promotion in their operation plan.

The probability of continued long-term benefits

An answer to this question is partly yes. Long-term benefit like reduction in severity of mental problems is distinguishably possible in these regions, given that the activity of MH outreach camp be properly disseminated up to periphery level as well. An active involvement of FCHVs, local HWs, school teachers, students, local NGOs, political leaders, and social workers is must in the promotion of the MH outreach camp for the sensitization of mental patients to seek the services of camp. All above that DHO must take an active lead in integrating MH issues in district health system. What matters most is the implementation of the MH policy by the central level authorities.

Durability of the results, including institutional changes over the time

Well, there seemed no any proofs of the durability of institutional changes in Nuwakot. Very few results were marked in Dhading.

Institutionalization of MH programmes in the district health system: Institutionalization of MH was hardly visible across the programme sites.

Involvement of DHO, other organizations, and community people in the outreach camp: It can be said that active involvement of DHO in both the areas was nominal, thus making it tough to assess its sustainability over the time.

The study spotted few organizations running on behalf of the MH promotion in Dhading district. Indisputably, these organizations, namely *Mental Swabalamban Group (Salyantar VDC)* and *Aatma Nirbhar Swabalamban Samiti (Malekhu Highway)* had their origin due to community-based MH programme. Pleased to share, *Mental Swabalamban Group* is still functioning

and is working on various dimensions of MH targeting number of sub-groups. Sadly, *Aatma Nirbhar Swabalamban Samiti* got dissolved, demonstrating difficulty in the sustainability of the programme.

"The Aatma Nirbhar Swabalamban Samiti is functionless after Koshish left coordinating this MH outreach camp. We used to refer clients to Koshish also. But, now there is no any responsible organization. We also used to go for door-to-door visit and follow up mentally ill patients, but now we don't do. Our committee is also economically deprived now. This is now completely disabled formally (but not informally)." **Social worker, Dhading**

Active involvement of trained HWs and FCHVs in various MH promoting programmes after the training: Continuous active involvement of few trained HWs and FCHVs in MH promoting programmes was found in Dhading, demonstrating sustainability of the programme reasonably.

Conversely, MH not being one of the prioritized programmes in the health system of Nepal, it's not uncommon to encounter challenges in sustainability of this programme.

3.5 Impact of the programme

Some unwanted negative effects came as a result of shifting of the MH outreach camp of *Rajmarga Community Hospital, Malekhu* to District Hospital, *Dhadingbesi* after the tragic incident of the Gorkha Earthquake. Negative results reported were discontinuation in use of MH drugs by some of the regular clients of *Rajmarga Hospital Outreach camp*. Those discontinuing drugs were mostly from the members of underprivileged groups.

"After the programme stopped here, the price of drugs suddenly surged. So, I left taking drugs. Then, I got the problem of insomnia." **Female client, Rajmarga Community Hospital Outreach Camp, Dhading**

A Query of the long-term impacts of the programme: sustainable change in health of the population and marked results after the completion of programme could not be answered. Likewise, comparison of the effects of the programme, with what would have occurred in absence of programme was impossible to carry out due to the absence of control group. Need to highly address, the current study design was not a gold standard for impact evaluation.

CHAPTER FOUR

DISCUSSION AND CONCLUSION

Relevance of the programme

Current programme went in line with real need of beneficiaries like requirement of skilled local HWs in domain of MH and necessity of accessible MH services and competent MH professionals. With these facts, unquestionably, it can be concluded that the programme was noticeably relevant in both the districts, parting few issues like equitability of the services and insufficiency of MH teams to address range of mental problems.

The programme can work to the fullest, given that it reflects the real requirement of the most demanding places with widespread cases. What even takes into account is community participation while assessing the programme's actual relevance, rather than planning the programme from birds-eye views .

Efficiency of the programme

With the lack of required programme costing information of inputs and outputs, judgment of programme's efficiency remained out of the scope of the current evaluation study. The study with appropriate study design (with control groups) is warranted to inquire the efficiency question of "Could better effects be obtained at the same cost?"

Effectiveness of the programme

By some means, the programme left higher effectiveness in Dhading district than its counterpart Nuwakot. Standing on the evidences of active collaboration of private organization *Koshish* in MH outreach camp, generation of number of MH promoting community organizations, chiefly due to community-based MH programme, and active involvement of some of the trained HWs in executing community organizations for MH; this programme certainly came up with more effectiveness in Dhading.

A programme with certain modality may go well with particular sites only. Many factors might have resulted comparatively minor effectiveness of the programme in Nuwakot. One of the possible reasons could be sample selection bias. Those HWs and FCHVs purposively chosen might have been different than those not chosen. This study may not have been able to trace out other HWs who may have been directly or indirectly involved in any other organizations in Nuwakot.

Furthermore, relying on reports of PHIs of Nuwakot and Dhading, fewer organizations were working for MH in Nuwakot than Dhading that may have resulted into lesser chances of those

organizations joining hands with an outreach camp of Nuwakot. Moreover, the working areas of those organizations in Nuwakot may be different than Trishuli Bazaar, where camp is currently operating.

Sustainability of the programme

Talking about the camp and its benefit in terms of the accessible services, without a doubt, camp kept on pushing benefits to the clients without external support as well. In some way, Dhading stood ahead in the durability of the results brought by the programme. Supporting information were energetic involvement of private organizations and HWs in promoting MH of the community.

The possibility of long-term continuation of the camp can be seen, as in contemporary situation, MH has started to pull the attention of government bodies. With the presence of plenty of organizations devoted in MH in Nepal, further opportunity of collaborating with them to exists. At current scenario, numbers of organizations have begun to serve on MH in Nuwakot and Dhading, especially after the Gorkha Earthquake 2015, thus fairly ascertaining enabling environment.

Impact of the programme

A report of discontinuation of drug uses by some of the regular clients of Dhading, after discontinuation of camp in *Malekhu* Highway gives the lesson of massive role of accessibility of health services in service utilization, thus demanding a need of increasing number of camps across the district. With the figure of most of the members of disadvantaged groups discontinuing the drug use, future programme need to be address these special population.

While for long-term effects of the programme; practically, not irrational to say that, "It's not high time to assess the long-term effects of the programme." Also, long-term changes like improved lifestyle and quality of life of mentally ill were not documented. On balance, most significant is use of highly specialized tool to assess the long-term impacts of the programme, which current study lacked.

Factors influencing the implementation and success of the programme

Predisposing, reinforcing, and enabling factors operating at programme sites influenced the implementation and success of the programme fairly. Inadequate awareness of MH issues among the community people, still persisting negative perception of community people towards mental problems and mental illness, difficulty in counseling client and their family to refer to the camps were some of the factors challenging the execution and success of the programme. Likewise, forces hindering the accomplishment of the programme included limited frequency and duration of camp, limited coverage, and lack of competent MH professionals

to manage severe disease. Also, there was not even a single MH focal person in both the districts to coordinate the activities of outreach camp. Inadequate dissemination of information regarding MH outreach camp up to the grass root level might have also negatively impacted the programme. Allowing for these influences, a refined programme incorporating these aspects may assist in reaching the goal of the programme.

Margins of the evaluation

The current study could not provide the evidences of independent effect of the programme on reaching its predetermined objectives. The thing harder to predict was, whether the exposure of this programme really caused the desired outcome among the study beneficiaries or not.

Way forward

Counting on evaluation findings, it would be somehow fair to arrive at a conclusion that the Community – based MH programmes needs to be continued, provided that the programmes are holistic. Just an implementation of MH outreach camp in a vacuum and a single shot training of HWs and FCHVs are hardly enough to reach the long-term goal of programme. Inclusion of components: standard training approach covering FCHVs and HWs of problem severe areas, MH orientation to MGs and key community persons of problem severe areas, standard referral mechanism, equitable services, coordination and collaboration with private organizations with a lead of DHO, and dissemination of information about MH camp up to the common people could be productive.

Learning from the strengths, weaknesses, and findings of this programme, such community-based activities could be designed and implemented in other districts as well, depending on the burden of mental health problems. The programme should be flexible enough to adjust with social environment.

Concluding remarks

Conclusively, parting some flaws, community-based MH programme left a substantial mark, principally in Dhading district. Mentally challenged population of Nuwakot district also got benefitted ; nevertheless, when compared with community changes, Dhading outstood with a certain degree.

CHAPTER FIVE

RECOMMENDATION

Piece of advices pen downed in this section is solely based on what this study came across while searching, the answers of evaluation queries. Some of them were given by the participants. Recommendations have been put forward to different level of stakeholders.

TO MENTAL HOSPITAL, KATHMANDU

For execution of MH outreach camp

- **Recording of the OPD report of outreach camp should be complete, consistent, and accurate.**

Poor documentation of OPD reports was found in both the districts.

- **Number of MH outreach camps need to be extended to cover the need of clients from remote VDCs as well.**

Single camp was carried out in both districts. Mostly residents of nearby VDCs were utilizing the services.

- **Frequency of MH outreach camp should be increased at a district headquarter level, making it on a weekly basis.**

It was only monthly camp in both the districts. Most of the HWs and clients demanded it. This could help to manage the overflow of patient and doctors will also get enough time to counsel their clients as well.

- **Number of MH professionals should be increased in a team of MH outreach camp with at least one highly proficient doctor in district headquarter level camp to address the need of severely ill clients.**

A MH team was not equipped with specialized MH professionals to examine the severe cases. Instead, severe cases were referred to Kathmandu. This was quoted as an urgent need by most of the HWs and PHIs.

- **MH outreach camp must include counseling as one of the important components.**

Approximately all laid stress on the importance of counseling to treat the clients.

- **Formal mechanism for referral of clients needs to be developed.**

It's an essential component of programme documentation. Making a proper record of referred cases from the periphery and to central level may help to analyze the impact of the programme. No any use of referral slip was seen in both the camps.

- **Number of supervisory visits of MH outreach camps should be increased from both the center and district level.**

Limited number of supervision was unveiled in both the district camps.

- **Ultra-poor clients should be given drugs free of cost, if possible. Another way to address them could be providing them with a benefit of subsidy on the drug price.**

The Study did not find any special mechanism for helping poor people to cope with price of drugs in Nuwakot. In Dhading special subsidy was limited only to patients of nearby three VDCs, questioning the right to equitable services by the deprived people.

- **A disadvantaged group like Dalits need to be targeted the most to increase their utilization by allocating heavy subsidies on the drug price.**

Involvement of Dalits was minimal in both the camps. To address vertical equity, this means a lot.

- **Upcoming programme should come with the special MH package for women.**

The study showed more female clients at both the sites.

- **Possible opportunities of pairing with NGOs/INGOs and local community organizations should be searched to improve effectiveness and increase sustainability of the programme.**

An involvement of private organizations in collaborating with outreach camp was not seen in Nuwakot. *Koshish* was actively engaged in providing monetary fund for drugs in the outreach camp of Dhading for two years. Working in isolation is not always enough to reach the outcomes. Therefore, increasing participation of local organizations, NGOs/INGOs, and community people in outreach camp could be one of the best ways to promote camp, sensitize community people, raise awareness, and increase patient flow. Even, this may lead to the sustainability of the programme.

- **To support the activities of camp, awareness campaigns must be launched targeting beneficiaries, in coordination with district health authorities, local organizations, and influential people of the community.**

Dissemination of camp's information was very limited.

FOR THE IMPLEMENTATION OF OTHER MH PROMOTION ACTIVITIES

- **Management of MH promotion activities is not only about implementation of the programme. Other elements like planning of the programme together with relevant stakeholders, recording and reporting of activities, monitoring, supervision, and internal evaluation need to be in full phase as well.**

Recording with systematic errors, restricted supervision activities, and the absence of internal evaluation was highly noticed in both outreach camps.

- **Follow up of trained HWs and FCHVs along with refresher training is of high need.**

Trained HWs and FCHVs were not followed up in both the districts. Training for once may not be effective. In order to sensitize the trained ones, proper follow up mechanism along with refresher training needs equally, if possible.

- **FCHVs must be the center of concern on MH training.**

This was the most predominant recommendation of the key informants. FCHVs know more about community, far better than any HWs. To increase counseling and referral of submerged cases to nearby HF and camp, this approach could be fruitful. Very limited numbers of FCHVs were trained in this programme.

- **Those HWs working in the areas with huge burden of mental cases should be given high priority on training.**

Considering the fact of the nominal role of treating the mental cases by FCHVs, HWs working on areas with significant statistics of mental cases need to be trained on management of mental cases. Not all deserving HWs got a chance to be part of this training.

- **Orientation on MH issues needs to be provided to diverse groups like THs, school teachers, community leaders, and social workers depending on the burden of mental problems at different electoral constituencies.**

According to key informants, to increase awareness on the importance of MH, sensitization of other influential persons of community also carries logic. FCHVs alone are not sufficient to convey the message of MH and raise awareness.

- **Special MH promotion packages focusing MGs need to be initiated, especially in areas with sizeable mental problems.**

The study unveiled more female cases in Dhading in last four years. This was also observed in the last two years in Nuwakot. Therefore, programme focusing on the cause of disease among women would carry a great significance.

- **Specialized training in managing MH problems must be given to groups of HWs of district hospital to increase the sustainability of the programme.**

In the context of scarcity of specialized MH resources in district hospitals, this could be a long-term beneficial approach to address the need of the local clients.

TO DHO OF DHADING AND NUWAKOT

- **Institutionalization of MH in the district health system needs to be initiated in practical.**

Lack of visibility in implementation; particularly on service delivery mechanism, with no HWs for mental treatment, very few trained HWs, limited OPD services, and drugs were observed. Full prioritization of MH by district health authorities could help other organizations working on MH to reach their objectives by some degree.

- **One MH focal person needs to be recruited to manage MH programme in the district.**

Unfortunately, no any MH focal persons were appointed in both the districts. Recruiting MH focal person could be influential to increase the ownership and attract the partnership of all the relevant organizations by district health authorities.

- **District Hospital needs to be occupied with a team of well-trained MH worker comprising a group of doctor, nurses, and paramedics to provide all round services to local people.**

Both the district hospitals had insufficient MH professionals. It's utmost to increase the accessibility of services to the community people. There may not be always MH outreach camp in the district.

- **At least one HW in each level of HF needs to be trained on managing mental problems.**

Most of the HWs strongly emphasized this need, as it plays a role in increasing the accessibility of services.

- **Essential drugs of mental problems need to be continuously supplied in each level of HFs.**

As per the report of HWs, shortage of medicine and irregular supply of drug is the most common problem in HFs.

- **Depending on the prevalence of mental problems in certain sites, orientation should be given to those areas focusing major key persons like school teachers, community leaders, THs, FCHVs, and social workers.**

Orientation on MH issues to leading community people are deemed necessary for the community awareness and referral of cases to nearby HFs.

- **Community awareness on MH must be done. Direct mobilization of social leaders in such programmes is crucial to increase community participation.**

It was half of the participants who gave the figure of still persisting social stigma among mental ill in the community. For increasing positive attitude of community people towards mental disease and mentally ill and to reduce discrimination of the mentally ill in community, this would add a lot meaning.

- **Promote the MH sensitization activities of private organizations.**

DHO with its active coordination must create an enabling environment for MH sensitization activities of other institutions. As most of resources are concentrated on other P1 programmes in districts, NGOs and INGOs may leave substantial influence on promoting MH. The DHO can act as a bridge to facilitate their activities.

TO MoHP, KATHMANDU

- **Separate MH division needs to be established to take on the ownership of MH programmes.**

In spite of significant proportion of mental problems in recent years, MH has not occupied a central place in public health domain, except for MH policy. To promote MH in national level, separate MH division should be founded with a clear ownership.

- **The MH policy 1996 should be implemented in the context of growing burden of mental problems in Nepal.**

It must to promote institutionalization of MH in district health system.

- **Nationwide survey must be implemented to estimate the prevalence of MH in district and national level .**

Till now, there is no any recorded evidence of country level and district level MH estimate in Nepal. Availability of such data is indeed mandatory to launch the community-based MH programmes in the districts with a heavy toll of mental problems.

ANNEXES

Annex I: Terms of Reference (ToR)

Context of evaluation: Community-based MH programme of the Mental Hospital (supported by the WHO for year 2010-2011) successfully crossed its 4th year. Evaluation is therefore highly warranted for the justification of programmes significance.

Purpose of evaluation: To find out the status of the programme and assist the decision makers for programme's modification and expansion

Scope of evaluation: Modification and expansion of programme

Criteria's of evaluation: Relevance, efficiency, effectiveness, sustainability, and impact

Key evaluation questions:

Is programme relevant? [Problem prioritized; problem burden; programme's objectives matched with beneficiaries need; adequate, affordable, acceptable, and equitable MH services; sufficient and competent MH team; capacity building of local HWs, FCHVs and response of clients and community towards MH outreach camp]

Is programme efficient? [Mental clients treated and local HWs trained at low cost]

Is programme effective? [Institutionalization of MH services in district health system; management of MH outreach camp; active involvement of DHO, organizations, and community in camp; client flow in camp; accessibility of camp; satisfaction of clients with camp's services; MH capacity building efforts by DHO and other organizations; referral of MH clients to HF's by local HWs; counseling and referral to camp and nearby HF's by FCHVs; dissemination of camp's information up to the periphery level; involvement of trained HWs and FCHVs in MH programmes after the training; rise in MH awareness in community; reduction in stigma of mentally ill client; successes and difficulties faced during programme implementation ; worthiness of camp and local HWs training]

Is programme sustainable? [Clients benefitting from camp after the completion of WHO support; probability of continued long-term benefits and durability of the results including institutional changes over the time]

What are the impacts of the programme? [Short and long-term effects of the community-based MH programme]

Adherence: Strictly adhered to gender, equity, and human rights.

Users: WHO Country Office for Nepal; MoHP; Mental Hospital; NHRC; Nuwakot DHO; Dhading DHO; Organizations working for MH in Nuwakot and Dhading and other researchers

Methodology: Mixed method; purposively selected PHIs, HWs and FCHVs trained by the Mental Hospital, community leaders actively involved in the camp, and clients of the camp ;

Qualitative tools: KII guideline and exit client interview guideline; quantitative tool: checklist for document review and data management in SPSS full version 16.0.

Evaluation team:

Dr. Meghnath Dhimal (Team Leader/Principal Investigator)

Dr. Khem Bahadur Karki (Public Health Expert)

Dr. Krishna Kumar Aryal (Public Health Expert)

Dr. Jaya Regmi (Consultant Psychiatrist)

Ms. Chandrakala Sharma (Psychiatric Nursing)

Mr. Purushotam Dhakal (Bio-statistician)

Ms. Pushpa Thapa (Data collection, analysis, and report writing)

Ms. Arpana Pandit (Data collection, analysis, and report writing)

Mr. Madhab Khatiwada (Representative of affected population)

Deliverables:

Final report to WHO Country office for Nepal; Mental Hospital; NHRC and DHO of Dhading and Nuwakot

Structure of the final report: Executive summary; Background; Methodology; Findings; Discussion and Conclusion; Recommendation and Annexes

Inputs to the final Report: Dr. Meghnath Dhimal; Dr. Khem Bahadur Karki; Dr. Krishna Kumar Aryal; Ms. Pushpa Thapa and Ms. Arpana Pandit

Final control over the report's structure and content: NHRC

Distribution strategy of the report: NHRC website; finding dissemination meeting with the Mental Hospital, MoHP, NHRC, Dhading and Nuwakot's DHO

Annex II: Key Informant Interview Guideline for the Evaluation of Community-based Mental Health Programme

Name of the participant		Designation of the participant	
Name of the district		Name of the health facility	
Name of the interviewer		Date of the interview	
Total duration of the interview (in minutes):			

(Please kindly note the response in separate paper)

1. How do you perceive institutionalization of MH programmes in your district?
 - ❖ Matching with local needs
 - ❖ Reflect district and national priorities (national health policy 2071, national MH policy 1996)
 - ❖ Contribution of Mental Hospital's programme (HWs training and outreach camp) in institutionalizing the programme

2. How do you see this community-based MH programme launched by the Mental Hospital?
 - ❖ Need based (real need, observed need vs. felt need)
 - ❖ Prioritized problem in districts,
 - ❖ Burden of problem in districts,
 - ❖ Services sufficient and rational as per need
 - ❖ MH outreach camp accessible (coverage),
 - ❖ Adequate, affordable, and acceptable services (culturally sensitive and specific) at the camp
 - ❖ Equity (reaching the more vulnerable group)
 - ❖ Sufficiency and competency of the MH team of camp
 - ❖ Need-based MH promotional activities (FCHV training, HWs training)
 - ❖ Assisted in building local HWs capacity
 - ❖ Response of clients, community towards outreach camp
 - ❖ Satisfaction of the client with the services offered by MH outreach camp
 - ❖ Coordinating with district health authorities and other partners
 - ❖ Established referral linkage including continuum of care
 - ❖ Active involvement of trained HWs and FCHVs in MH promoting programme
 - ❖ Implementing programme (worth or useless and why)

3. What do you think about the quality of the community MH services provided by specialist of the Mental Hospital to diagnose and treat the patients?
 - ❖ Number (enough or inadequate) as per category of MH worker
 - ❖ Competency in both counseling and clinical (to address various categories of mental problems)
 - ❖ Improvement required

4. What do you think about the capacity of HWs for delivering MH services in the district to see and treat the patients? If MH teams are not available, how many and which type of MH workers will be enough to provide services?
 - ❖ Number (enough or inadequate) as per category of MH worker
 - ❖ Competency both counseling and clinical (to address various categories of mental problems)
 - ❖ Local volunteer/ outsider (clinical, non-clinical) required as per need and demand
 - ❖ Capacity required

5. Has there been a capacity building effort for MH providers in the district in the past?
 - ❖ Type of capacity building (training/orientation/hands on practical)
 - ❖ Targeted population: Hospital/PHCC/HP or community HWs
 - ❖ Organization: DHO, DDC, Mental Hospital, NGOs (name...)
 - ❖ Assisted for increasing competency both counseling and clinical (to address various categories of mental problems)

6. How the costs of services are being financed?
 - ❖ Funding agency (external; internal)
 - ❖ Total cost incurred for the programme yearly (2068 to 2071: including direct and indirect cost/ allocated cost yearly and total expenditure yearly)
 - ❖ Cost allocated for different set of activities yearly ((2068 to 2071: including direct and indirect cost/ allocated cost yearly and total expenditure yearly)
 - ❖ Charge to patients for mental health services, if any (specify)

7. Is the MH programme discussed in district health annual review meeting?
 - ❖ Issues discussed usually
 - ❖ Involvement of district level HWs
 - ❖ action taken (if any for problem encountered)
 - ❖ Mental Hospital community programmes discussed during review

8. What is the status of monitoring, supervision, and reporting of programme activities since an inception date?
 - ❖ Frequency (timely or untimely)
 - ❖ Who does monitoring and supervision?
 - ❖ Suggestion and recommendation (if any given by supervisors)
 - ❖ Action taken to correct errors (as per suggestion of supervisors)
 - ❖ Reporting frequency (timely or untimely); Reported to whom
 - ❖ Feedback of reporting

9. What is the pattern of patients using MH services in the community after an inception of this programme? Please specify overall and strata-wise (ethnic, gender, location).
 - ❖ Before vs. after an inception of the programme
 - ❖ Yearly trend.....
 - ❖ Trend of counseling and referral of mentally ill patients to nearby HFs (public or private) by FCHVs and HWs)
 - ❖ FCHVs and other HWs role in increasing the utilization of MH services

10. Has there been any change in awareness level of mental problems among the community people?
 - ❖ Before vs. after an inception of the programme
 - ❖ Yearly trend.....
 - ❖ level of awareness among group
 - ❖ Stigma to mentally ill people (family, community people, HWs)
 - ❖ Community people's perception towards mental problems and mentally ill
 - ❖ FCHVs and other HWs role in raising awareness of MH services

11. What are the strengths, and weaknesses of this programme?
12. What are the opportunities and challenges of this programme?
13. What do you think about the sustainability of the programme?
14. Please provide your suggestion to make this programme more effective, efficient, and sustainable?

WE THANK YOU FOR YOUR KIND PARTICIPATION

Annex III: Exit Client Interview Guideline for the evaluation of Community-based Mental Health Programme

Name of Client.....
Age.....
Sex.....
Address.....
(Please kindly note the response in separate paper)

- Adequacy of services:** Types of services; adequate as per need and demand of community; frequency of outreach camp
- Accessibility of services:** Distance to outreach camp from house (walking, transportation); difficulty to access services because of topographical barriers; coverage of services
- Affordability of services:** Cost of service; ability to afford; and opportunity cost
- Equitability of the services:** Subsidy on services with respect to economical status
- Acceptability of the services:** Influence on socio-cultural norms
- Awareness of mental problems in community:** Awareness; level of awareness among various sub-groups of community; belief, perception of community towards mental problems
- Stigma of mental problems in community:** Behavior of family members (service seeking, supportive environment) HWs, and community
- Satisfaction with services:** Services; HWs skill; behavior of HWs

WE THANK YOU FOR YOUR KIND PARTICIPATION

Annex IV: Check list for documents review

Questions	Yes	No
1. Is a district health plan available in DHO/DPHO?		
2. Is MH component included in the district health plan?		
3. Is a health service roster maintained in district hospital?		
4. Is MH component included in service roster of the district hospital?		
5. Are MH treatment guidelines available in district hospital? If yes, please specify the guidelines.		
6. Are MH guidelines used to treat mentally ill patient?		
7. No. of doctor's visit per month for treatment of mentally ill patients		
8. No. of nurses available for treatment of mentally ill patients.....		
9. No of paramedics available for treatment of mentally ill patients (who received special training on MH services).....		
10. Has any training on MH guideline been conducted in the district? If yes, from when it was initiated? How many people have got the training till the date?		
11. No. of PHC workers or volunteers received training in MH service guidelines. Doctors		
Nurses		
Public Health Officers.....		
Paramedics (HA/CMA/AHW/ANM)		
FCHV		
12. Are MH drugs available free of cost?		

13. List of the drugs available for treatment of mentally ill patients		
14. Have all the MH services provided been recorded in programme record?		
15. Have all the MH services provided been recorded in HMIS forms?		
16. Have the MH services provided been reported?		

MH service utilization (No. of users)

Months	2068		2069		2070		2071	
	Male	Female	Male	Female	Male	Female	Male	Female
Baisakh								
Jestha								
Asadh								
Shrawan								
Bhadra								
Aswin								
Kartik								
Mangsir								
Poush								
Magh								
Falgun								
Chaitra								

Geographic and Ethnic distribution of service users (for the year 2068)

Ethnic code Address	01		02		03		04		05		06	
	M	F	M	F	M	F	M	F	M	F	M	F

Geographic and Ethnic distribution of service users (for the year 2069)

Ethnic code Address	01		02		03		04		05		06	
	M	F	M	F	M	F	M	F	M	F	M	F

Geographic and Ethnic distribution of service users (for the year 2070)

Ethnic code Address	01		02		03		04		05		06	
	M	F	M	F	M	F	M	F	M	F	M	F

Geographic and Ethnic distribution of service users (for the year 2071)

Ethnic code Address	01		02		03		04		05		06	
	M	F	M	F	M	F	M	F	M	F	M	F

Annex V: Written consent form for Key Informants

लिखित मञ्जुरीनामा फारम

विषय : समुदायमा आधारित मानसिक स्वास्थ्य कार्यक्रमको मुल्याक्तन सम्बन्धी अनुसन्धान

नेपाल स्वास्थ्य अनुसन्धान परिषद् (स्वास्थ्य तथा जनसंख्या मन्त्रालय) बाट नुवाकोट र धादिङ जिल्लामा विश्व स्वास्थ्य संगठनले संचालन गरेको मानसिक स्वास्थ्य कार्यक्रमको मुल्याङ्कन गर्न पाउदा हामी हर्षित भएका छौं । यस अध्ययनको शिर्षक- “नेपालको नुवाकोट र धादिङ जिल्लामा समुदायमा आधारित मानसिक स्वास्थ्य कार्यक्रमको मुल्याङ्कन सम्बन्धी अनुसन्धान” रहेको छ । अध्ययन प्रयोजनका लागि हामीले यी दुई जिल्लाका जनस्वास्थ्य कार्यालय, र मानसीक अस्पतालबाट २०६७ सालमा मानसीक स्वास्थ्य सम्बन्धी १५ दिने तालीम प्राप्त गर्नुहुने स्वास्थ्यकर्मचारीहरुसंग अन्तरवार्ता लिने छौं ।

उद्देश्य: यस अनुसन्धानको उद्देश्य समुदाय स्वास्थ्य स्याहार कार्यक्रम जिल्ला स्वास्थ्य प्रणालीमा कुन तह सम्म एकिकृत भएको छ पत्ता लगाउने, समुदायमा मानसिक स्वास्थ्य सेवाको पहुँच एवम् उपलब्धता कस्तो छ पत्ता लगाउने र समुदायमा मानसिक रोगका बिरामीहरुको अवस्था पत्ता लगाउनु हो। यस अध्ययनले नेपाल स्वास्थ्य अनुसन्धान परिषद, नेपालको आचार संहिता समिति बाट स्वीकृति प्राप्त गरेको छ । यो सर्वेक्षण नेपाल स्वास्थ्य अनुसन्धान परिषद (स्वास्थ्य तथा जनसंख्या मन्त्रालय) बाट तालिम प्राप्त स्वास्थ्यकर्मी/ तथ्याङ्क संकलकहरु द्वारा सञ्चालन गरिनेछ ।

गोपनीयता : तपाईंले दिनुभएको सूचना पूर्णरूपमा गोप्य राखिनेछ । यो सूचना केवल अनुसन्धानको उद्देश्य पूरा गर्न मात्र प्रयोग गरिनेछ । तपाइको नाम, ठेगाना र अन्य व्यक्तिगत जानकारी सूचना बाट हटाइनेछ र केवल एउटा सूचक कोडको माध्यमबाट तपाइको नाम पहिचान गरिनेछ र यहाँहरुले दिनुभएको उत्तरहरुलाई अध्ययन गरिनेछ ।

स्वैच्छिक संलग्नता : यस सर्वेक्षणमा संलग्न हुन चाहने वा नचाहने तपाइको स्वेच्छाको विषय हो । तपाईं यस सर्वेक्षणमा सहभागी हुने सहमति जनाईसकेपछि पनि कारणवश छोड्न चाहनु हुन्छ भने छोड्न सक्नुहुनेछ । तपाइले प्रश्नावलीबाट सो धिएको कुनै पनि प्रश्नको उत्तर नदिन पनि सक्नुहुनेछ । तपाईंलाई यस सर्वेक्षण सम्बन्धी कुनैपनि जिज्ञासा र प्रश्न छ भने तपाईं यस सर्वेक्षणका प्रमुख अनुसन्धानकर्ता डा. मेघनाथ धिमालसँग यो सम्पर्क नम्बर ९८४१४६७५८१ मा कुरा गर्न सक्नु हुनेछ अथवा नेपाल स्वास्थ्य अनुसन्धान परिषद को अनुसन्धान शाखा, रामशाहपथको सम्पर्क नम्बर ०१४२५४२२० मा फोन गरी बुझ्न सक्नुहुनेछ ।

मञ्जुरीनामा : तपाईंको मञ्जुरीनामा पत्रको हस्ताक्षरले तपाईंले यस सर्भेका बारेमा पुरा जानकारी लिई सर्भेमा भाग लिन चाहनु भएको छ भन्ने बुझाउँछ ।

सहभागीले जानकारी पत्र र मञ्जुरीनामा पत्र पढेको		अन्तरवार्ताकर्ताले जानकारी पत्र र मञ्जुरीनामा पत्र पढेर सुनाएको	
मञ्जुर		अस्विकार	

नाम.....हस्ताक्षर

पद:.....मिती.....

Annex VI: Written consent form for exit clients

लिखित मन्जुरीनामा फारम

आदरणीय सहभागी.....,

छनौट तपाईं यस अनुसन्धानमा छनौट हुनुभएको छ । त्यसैले तपाईंलाई यस अर्न्तर्वातामा सहभागी हुनुका लागि अनुरोध छ । यो सर्भे विश्व स्वास्थ्य संगठन र स्वास्थ्य तथा जनसंख्या मन्त्रालयको संयोजित्वकमा ने पाल स्वास्थ्य अनुसन्धान परिषद्ले गरेको हो । नेपाल स्वास्थ्य अनुसन्धानका अनुभववी तथ्याङ्क सङ्कलकले तपाईंको तथ्याङ्कहरू लिनैछन् ।

गोपनियता तपाईंले दिएका तथ्याङ्कहरू गोप्यरूपमा यस अनुसन्धानमा मात्र प्रयोग गरिनेछ । तपाईंको नाम, ठेगाना तथा अन्य व्यक्तिगत विवरणहरू यस प्रश्नावलीबाट हटाई तपाईंको परिचयात्मक कोड मात्र प्रयोग गरिनेछ । तपाईंलाई यस सर्भेक्षणका प्रतिनिधिले आवश्यक परेको खण्डमा सर्भेको समायावधी भर कुनै पनि समयमा भेट्न आउन सक्नेछन् ।

सहभागीता यस सर्भेमा तपाईंको स्वेच्छक सहभागीता हुनेछ । तपाईं यस अध्ययनको कुनै पनि वेला अलगिन सक्नु हुनेछ । तपाईंलाई यस सर्भेको बारेमा कुनै पनि कुराको जिज्ञासा भएमा जुनसुकै वेलामा पनि सर्भे टोलीलाई राख्न सक्नुहुनेछ । अध्ययनको सम्बन्धमा थप जानकारीका लागिनेपाल स्वास्थ्य अनुसन्धान परिषद् रामशाह पथ को टेलिफोन नं. ०१-४२५४२२० मा सम्पर्क राख्न सक्नुहुनेछ ।

मन्जुरीनामा तपाईंको मन्जुरीनामा पत्रको हस्ताक्षरले तपाईंले यस सर्भेका बारेमा पुरा जानकारी लिई सर्भेमा भाग लिन चाहनु भएको छ भन्ने बुझाउँदछ ।

सहभागीले जानकारी पत्र र मन्जुरीनामा पत्र पढेको		अन्तरवार्ताकर्ताले जानकारी पत्र र मन्जुरीनामा पत्र पढेर सुनाएको	
मन्जुर		अस्विकार	

हस्ताक्षर म अर्न्तर्वातामा सहभागी हुनुका लागि मन्जुर छु । (यदि सहभागी १५-१८ वर्ष उमेर भित्रको भएका सहभागीको बुबा आमा वा संरक्षकले पनि हस्ताक्षर गर्नुपर्दछ ।

नाम

हस्ताक्षर

बुबाआमा/संरक्षक

हस्ताक्षर

अन्तरवार्ताकर्ता

हस्ताक्षर

मिति.....

AnnexVII: Information Sheet to the participants

जानकारी पत्र

परिचय: यो फारमले यस सर्भेमा तपाइको सहभागिता कस्तो रहनेछ भन्ने कुरा प्रस्ट्याउँछ ।

अनुसन्धानको शिर्षक : समुदायमा आधारित मानसिक स्वास्थ्य कार्यक्रमको मुल्याङ्कन सम्बन्धी अनुसन्धान

अनुसन्धानको उद्देश्य: यस अनुसन्धानको उद्देश्य समुदाय स्वास्थ्य स्याहार कार्यक्रम जिल्ला स्वास्थ्य प्रणालीमा कुन तह सम्म एकिकृत भएको छ पत्ता लगाउने, समुदायमा मानसिक स्वास्थ्य सेवाको पहुँच एवम् उपलब्धता कस्तो छ पत्ता लगाउने र मानसिक रोगका बिरामीहरूको अवस्था पत्ता लगाउनु हो। यस अध्ययनले नेपाल स्वास्थ्य अनुसन्धान परिषद, नेपालको आचार संहिता समिति बाट स्वीकृति प्राप्त गरेको छ । यो सर्वेक्षण नेपाल स्वास्थ्य अनुसन्धान परिषद (स्वास्थ्य तथा जनसंख्या मन्त्रालय) बाट तालिम प्राप्त स्वास्थ्यकर्मी/तथ्याङ्क संकलकहरू द्वारा सञ्चालन गरिनेछ ।

तथ्याङ्क संकलन विधि: यस अनुसन्धानमा नुवाकोट र धादिङ जिल्लाका जनस्वास्थ्य कार्यालय, र मानसिक अस्पतालबाट २०६७ सालमा मानसिक स्वास्थ्य सम्बन्धी १५ दिने तालिम प्राप्त गर्नुहुने स्वास्थ्यकर्मचारीहरूसंग अर्न्तवार्ता लिइने छ। अर्न्तवार्तामा हामी तपाईंलाई समुदायमा मानसिक रोगका बिरामीहरूको अवस्था कस्तो छ?, मानसिक स्वास्थ्य कार्यक्रमको सान्दर्भिकता, यसको उपलब्धता, पहुँच, र दिगो बनाउन के गर्नुपर्छ भनेर सोध्नेछौं ।

गोपनीयता : तपाईंले दिनुभएको सूचना पूर्णरूपमा गोप्य राखिनेछ । यो सूचना केवल अनुसन्धानको उद्देश्य पूरा गर्न मात्र प्रयोग गरिनेछ । तपाइको नाम, ठेगाना र अन्य व्यक्तिगत जानकारी सूचना बाट हटाइनेछ र केवल एउटा सूचक कोडको माध्यमबाट तपाइको नाम पहिचान गरिनेछ र यहाँहरूले दिनुभएको उत्तरहरूलाई अध्ययन गरिनेछ ।

स्वैच्छिक संलग्नता : यस सर्वेक्षणमा संलग्न हुन चाहने वा नचाहने तपाइको स्वेच्छाको विषय हो । तपाईं यस सर्वेक्षणमा सहभागी हुने सहमति जनाईसकेपछि पनि कारणवश छोड्न चाहनु हुन्छ भने छोड्न सक्नुहुनेछ । तपाइले प्रश्नावलीबाट सो धिएको कुनै पनि प्रश्नको उत्तर नदिन पनि सक्नुहुनेछ । तपाईंलाई यस सर्वेक्षण सम्बन्धी कुनैपनि जिज्ञासा र प्रश्न छ भने तपाईं यस सर्वेक्षणका प्रमुख अनुसन्धानकर्ता डा. मेघनाथ धिमालसँग यो सम्पर्क नम्बर ९८४१४६७५८१ मा कुरा गर्न सक्नु हुनेछ अथवा नेपाल स्वास्थ्य अनुसन्धान परिषद को अनुसन्धान शाखा, रामशाहपथको सम्पर्क नम्बर ०१४२५४२२० मा फोन गरी बुझ्न सक्नुहुनेछ ।

Annex VIII: List of VDCs according to Electoral Constituency(Dhading District)

Electoral Constituency Number 1	Electoral Constituency 2	Electoral Constituency 3	4 (Other Districts)
Salyantar	Jyamruk	Jogimara	Nuwakot
Tripureswor	Chainpur	Dhussa	Sindhu palchowk
Katunje	Khari	Mahadevsthan	Tanahun
Aginchowk	Maidi	Kiranchowk	Makwanpur
Mulpani	Salang	Benighat	Lamjung
Marpak	Kumpur	Gajuri	Gorkha
Gundi	Kalleri	Pida	
Satyadevi	Sunaulabazar	Baireni	
Phulkharka	Khalte	Bhumesthan	
Budhathum	Nilkantha	Thakre	
Baseri	Katunjee	Naubise	
Lapa	Sangkosh	Tasarpu	
Sirtung	Nalang	ChhattreDyaurali	
Tipling	Gaganpani		
Semjong	kewalpur		
	Murali Bhanjyang		
	Dhola		

Annex IX: List of VDCs according to Electoral constituency (Nuwakot District)

Electrol constituency 1	2	3	4
Belkot	Bageswori/ Chokade	Budhasing	Rasuwa district (Dhunche, Haku, laharepauwa, bhorle)
Duipipal	Beteni	Bungtang	Dhading (katunje, Baireni)
Jiling	Chaughada	Charghare	Sindhupalchowk (Haibung, Mahankal)
Kakani	Gerkhu	Dangsing	
Kumari	Ganeshthan	Deurali	
Madanpur	Kalibas	Fikuri	
Ratmate	Kharanitar	Gorsyang	
Sikre	Khanigaun	Kalyanpur	
Ratmate	Panchakanya	Kaule	
Sunkhani	Ralukadevi	Khadagbhanjyang	
Suryamati	Rautbeshi	Kintang	
Thanapati	Shikharbesi	Manakamana	
Thansing	Thaprek	Salme	
		Samari	
		Taruka	
		Tupche	

Annex X: Ethnic group classification

1. Dalit

Hill: Kami, Damai, Sarki, Gaine, Badi

Terai: Chamar, Musahar, Dusah, Paswan, Tatma, Khatway, Bantar, Dom, Chiadimar, Dhobi, Halkhor

2. Disadvantaged Janajatis

Hill: Magar, Tamang, Rai, Limbu, Sherpa, Bhote, Walung, Byansi, Hyolomo, Garri/ Bhujel, Kuumal, Sunar, Baramu, Pahari, Yakkah, Chhantyal, Jirel, Darai, Dura, Majhi, Danuwar, Thami, Lepcha, Chepang, Bote, Raji, Hayu, Raute, Kusunda

Terai: Tharu, Dhanuk, Rajbansi, Tajpuria, Gangai, Dhimal, Meche, Kisan, Munda, Santhal/Satar, Dhangad/Jhangad, Koche, Pattarkatta/kusbadiay

3. Disadvantaged non Dalit Terai caste groups

Yadav, Teli, Kalwar, Sudhi, Sonar, Lohar, Koiri, Kurmi, Kanu, Haluwai, Hajam/Thakur, Badhe, Bahae, Rajba, Kewat, Mallah, Nuniya, Kumhar, Kahar, Lodhar, Bing/Banda, Bhediyar, Mali, Kumar, Dhunia

4. Religious Minorities

Muslims, Churaute

5. Relatively advantaged Janajatis

Newar, Thakali, Gurung

6. Upper Caste Groups

Brahmin(Hill), Chhettri, Thakuri, Sanyasi, Brahmin (Terai), Rajput,
Kayastha, Baniya, Marwadi, Jaine, Nuraang, Bengali



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