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The Integration of Mental Health and Psychosocial Support Services in Primary Health Care Facilities in Post-Earthquake Nepal

A Summary of the International Medical Corps Mental Health and Psychosocial Support
Program Evaluation in Nepal, April 2015 - February 2017



BACKGROUND

Context

In April and May 2015, Nepal was struck by two major earthquakes, which killed 8,790 people, injured more than 22,000, and left 2.8 million homeless.^{1,2} Half a million houses were completely destroyed and more than 1,000 health facilities were destroyed or damaged,³ leaving thousands destitute and without access to care.

In collaboration with Transcultural Psychosocial Organization Nepal (TPO) and Integrated Community Development Campaign (ICDC), International Medical Corps established a Mental Health and Psychosocial Support (MHPSS) program in three severely affected districts (Dhading, Gorkha and Sindhuli; Figure 1). The program was designed to respond to immediate MHPSS needs and to support the longer-term integration of MHPSS services in to primary health care.

The specific program objectives were:

Objective 1 To strengthen the capacity of health workers and community members to provide high-quality MHPSS services

Objective 2 To provide community-based mental health and psychosocial support services

Objective 3 To improve access to MHPSS services through awareness-raising initiatives and anti-stigma campaigns

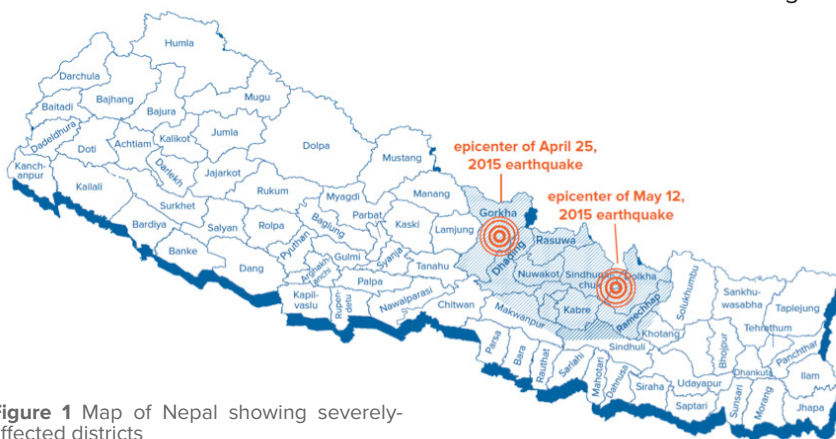


Figure 1 Map of Nepal showing severely-affected districts

Program evaluation

In 2017, International Medical Corps conducted an evaluation to identify program achievements, challenges, and lessons learned, and to generate recommendations for future program design and management. A mixed-methods approach was adopted, combining quantitative data on program activities with qualitative data from stakeholder interviews and focus groups. This document summarizes the key findings. An in-depth evaluation report is also available.

MHPSS CAPACITY-BUILDING

Health worker training: MHPSS training was provided to 1,041 health workers affiliated with 78 health facilities. Trainees included both existing government health workers and new health staff hired by the partner NGOs for the duration of the program.

- *Government-affiliated staff* were engaged with the aim of enabling them to incorporate MHPSS into their regular healthcare duties, both within and beyond the duration of the program. The groups trained were: Prescribers (Doctors, Health Assistants, and Auxiliary Health Workers); Non-Prescribers (Staff Nurses, Auxiliary Nurse Midwives); and Female Community Health Volunteers (FCHVs).
- *Partner staff* were hired to provide community-based care, to facilitate community outreach activities, and to support the development of referral networks between community-based and facility-based services. The groups trained were: Psychosocial Counsellors (PSCs) and Home-Based Care Workers (HBCWs).

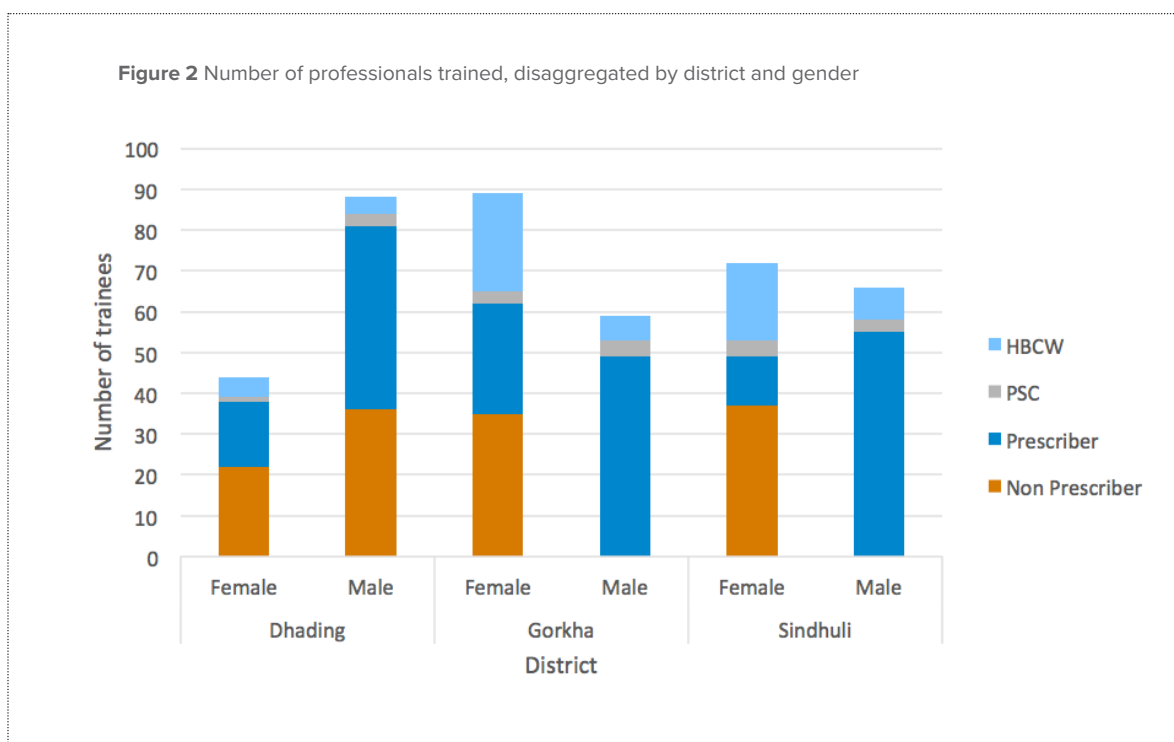
“Previously, I found it difficult to deal with mental health patients, but now this program is helping me a lot in treating and diagnosing mental health disorders. I used to be worried when a patient with psychosis came for treatment, but now I know how to deal with it and treat it.” (Prescriber, Dhading, focus group)

The training focused on six priority mental health conditions: depression, psychoses, epilepsy, suicide, Alcohol Use Disorders (AUDs), and Post-Traumatic Stress Disorder (PTSD). Figure 2 shows the gender and district breakdown of trained health professionals.

Community MHPSS training: Psychological First Aid (PFA) training was provided to 626 community members; PFA is an evidence-based approach to providing compassionate emotional and practical support to people who have recently been exposed to a traumatic event. An introductory mental health orientation was provided to 1,900 community members to enable them to recognize common MHPSS needs, to inform them about the available services, and to explain access and referral mechanisms.

Impact of training: 86% of trainees surveyed demonstrated improvements in knowledge test scores between the first and last day of training. 92% reported improved perceived competency.

“We learned how to communicate properly, about talking styles, about how to treat service users and how to understand their needs.” (HBCW, Gorkha, interview)



SERVICE PROVISION

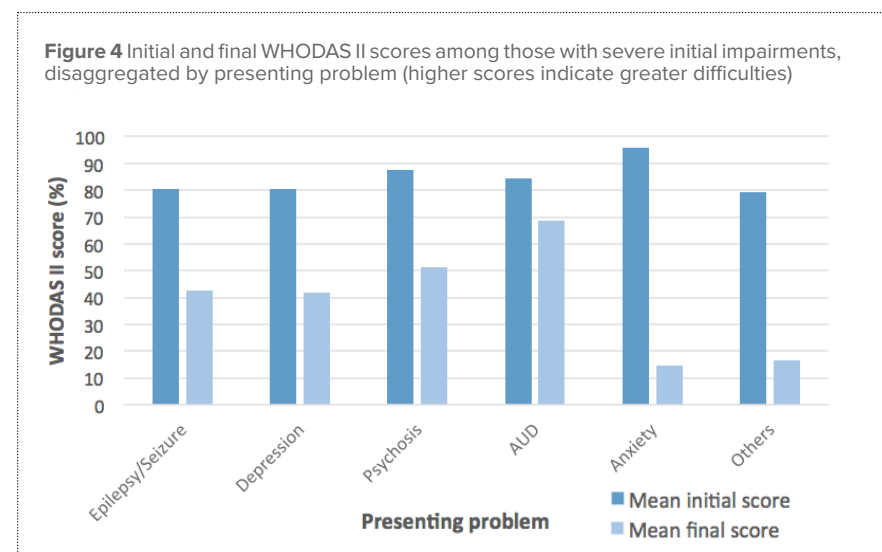
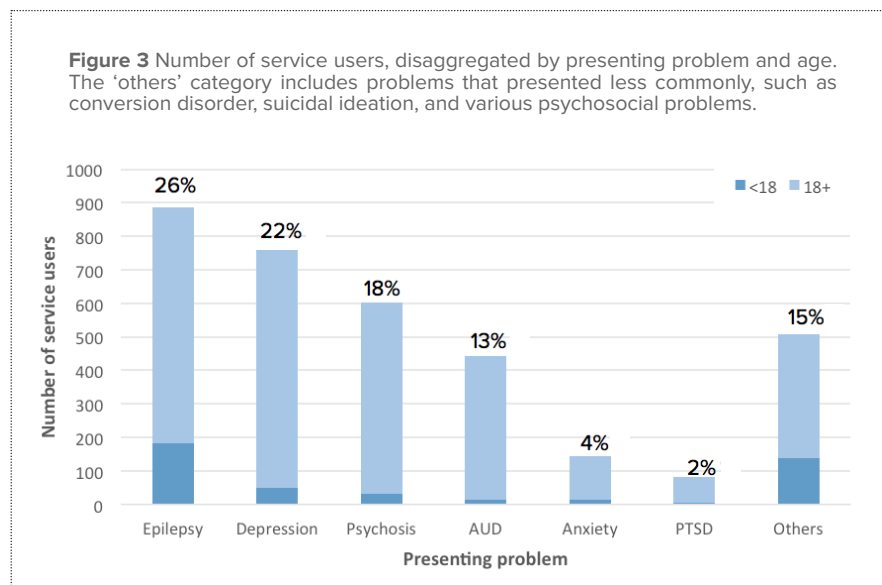
Service users: MHPSS services were integrated into existing government primary health services and provided to 3,422 service users (44% male, 56% female) at community health facilities and through home-visits. The most common presenting problem was epilepsy, followed by depression, psychoses, AUD, anxiety disorders, and PTSD (Figure 3).

Improvements in symptoms and functioning: Service users, carers and health workers shared many examples of cases where the program led to recovery, improved wellbeing, and a new sense of hope that mental illness is treatable.

“I feel that everything has changed. I have been transformed ... It’s all improved because of counseling.” (Service User, Dhading, focus group)

“I used to feel like I didn’t have strength to do things. Things that I wanted to do seemed impossible and I would often get sad. But now if I start something I feel I have the strength to complete it.” (Service User, Sindhuli, focus group)

The World Health Organization Disability Assessment Schedule (WHODAS II) was used to assess service users’ day-to-day functioning over the course of the program. Overall, 54% of service users demonstrated improvements over a six-month period, with the greatest improvements seen among those experiencing anxiety disorders and psychoses.



Among those who had severe impairments at the beginning of the program, 89% demonstrated improvements in daily functioning (Figure 4). The number of days these service users reported being unable to carry out their “usual activities or work” reduced by half (Figure 5).

Service user satisfaction: 67% of service users surveyed reported being “completely satisfied” with the services they had received, 31% reported being “somewhat satisfied”, and 2% reported being “unsatisfied” (Figure 6).

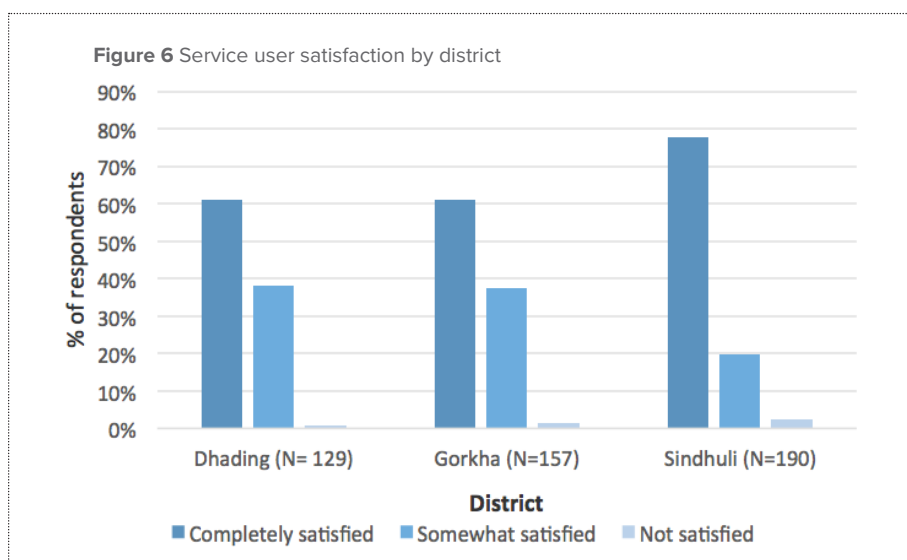
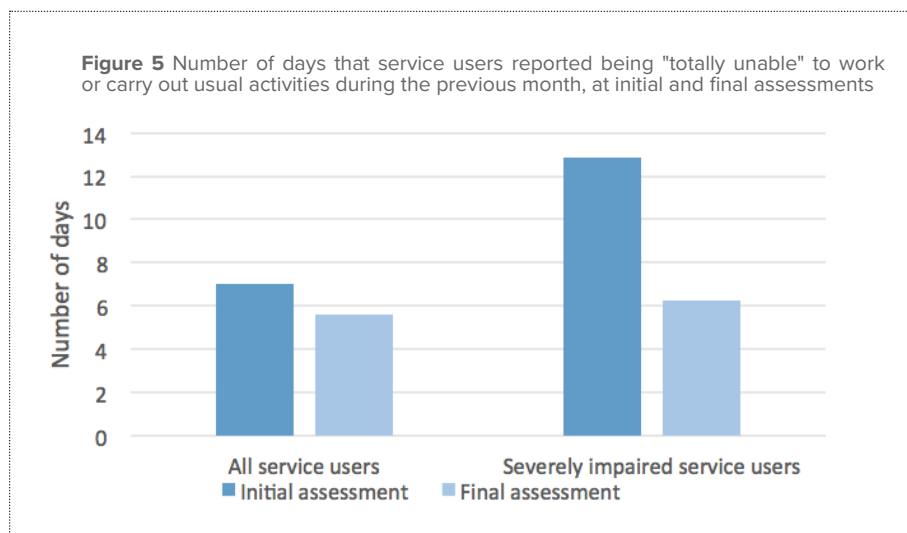
COMMUNITY OUTREACH & AWARENESS ACTIVITIES

Mental health awareness events: Program staff (PSCs and HBCWs) conducted 263 MHPSS education and anti-stigma events with school students, teachers, health workers and community groups. The sessions were attended by 7,933 people, and focused on:

- improving knowledge and challenging misconceptions about mental health and illness
- educating people about effective medical and psychotherapeutic treatment options
- decreasing the use of stigmatizing words
- encouraging reflection on the roles of community members in promoting mental health.

Educational materials: 25,357 educational brochures were distributed; 152 radio programs were broadcast; and 40 educational billboards and flex-boards were displayed (Figure 7).

Community support groups: Four support groups were established to help 36 service users to develop economic independence through vocational training.



Reduction in stigma: Service users and health workers described a reduction in the use of stigmatizing language to refer to mental health service users.

“People used to insult me, saying I’m diseased, but it’s not like that anymore.” (Service User, Dhading, focus group)

“We used to call mental health patients ‘mad’ and ‘insane’, but now we are aware that those words are insensitive and should not be used.” (FCHV, Gorkha, focus group)

Several health workers commented that they were no longer afraid to interact with people experiencing mental health problems, and that they had developed a more supportive style of communication.

“Before this program, I used to feel afraid to talk with mentally ill people ...I wouldn’t listen to them; but, after working in this project, I talk less and listen more.” (HBCW, Gorkha, interview)

Figure 7 Example of a billboard displayed throughout program districts. The square-shaped pictures illustrate six priority mental health conditions. The central section explains the support available at local health facilities.



RELEVANCE, IMPACT AND SUSTAINABILITY

Relevance: The aims of the program were highly relevant in the context of Nepal, given the increased mental health needs following the 2015 earthquakes and the lack of a robust pre-existing national mental health system.^{4,5} Program activities were consistent with the 1996 National Mental Health Policy of Nepal, which promotes the integration of mental health services into the general health system and the training of all government health workers on mental health.⁶

“Other organizations used to distribute things and go, but this program listens to how people feel.” (HBCW, Gorkha, interview)

Alignment with best practice guidance: Program activities were largely consistent with international best practice guidance on MHPSS emergency response and systems strengthening. Where available, training curricula were based on internationally recognized evidence-based manuals and guidelines (e.g. the WHO mhGAP Intervention Guide).⁷⁻⁹

Social impact: Evaluation respondents reported that the program had generated a new interest in mental health and a demand for improved mental health services, both within and beyond program catchment areas. Some health workers reported that, as a result of the improvements in mental health brought about by the program, there had been a reduction in social problems such as domestic conflicts.

“We got to see certain individuals rise up out of different regions that became champions for the agenda ... All of a sudden you saw this demand for accessible medications and services.” (Program Manager, interview)

Political impact: Through advocacy and participation in national strategy meetings with the Government of Nepal’s Primary Health Care Revitalization Division, program staff contributed to three major changes in mental health policy: government authorization for the procurement of psychotropic medication by local authorities; revisions to the Government of Nepal Free Essential Drug List to include modern antipsychotics and SSRIs; and updates to the national Standard Treatment Protocol for primary care mental health services.

Sustainability: The program trained 1,041 government health workers who will continue to provide services

in primary health care facilities and communities after program close. The extent to which they will continue to focus on mental health, without the support of partner-funded community follow-up mechanisms and staff (i.e. PSC and HBCW services), is yet to be seen. However, the large numbers of people trained, the large numbers of people reached through community outreach, and the policy advances achieved provide cause for optimism regarding longer-term benefits.

SUMMARY OF LESSONS LEARNED & RECOMMENDATIONS

Analyses of the quantitative program data, feedback from evaluation respondents, and a review of research and best practice guidance led to a number of lessons learned and recommendations. Many of these may be applicable to other programs offering MHPSS services in similar settings.

Program strengths

The program increased the availability and accessibility of mental health services by developing a layered system of supports, involving health professionals and community members, with different degrees of specialization.

Evaluation respondents considered the ongoing supervision of trainees and home-based care visits to be key strengths of the program.

By engaging national-level health authorities, program staff were able to influence major changes in mental health policy which will strengthen national mental health services in the long term.

Challenges to effectiveness

Limited availability of government health workers: Government staff were often transferred from program areas soon after their training. Limited health worker availability and geographical access issues made it difficult to coordinate regular supervision sessions for trainees.

Limited facilities and resources: Limitations on the medications available through government mechanisms, a lack of private counselling spaces, and problems in distributing medications among health facilities as needed posed challenges to implementation.

Though many participants reported improvements in community attitudes to mental health, some argued that these **changes were largely limited to those affiliated with the program** (e.g. service users, carers and health staff). There were also reports that some community

members were suspicious of the program, fearing that there was a hidden agenda behind the services offered (e.g. that community-based health workers were motivated by financial gain rather than a desire to help).

Summary of recommendations

Capacity-building: The findings suggest that effectiveness and sustainability could be improved by training health facility managers and support staff (e.g. training on information systems and supply-chain-management), as well as training health workers.

Community outreach: The impact of community outreach activities and uptake of services may be enhanced by: employing a more diverse range of activities (e.g. street plays and social media campaigns); developing advocacy partnerships with service users, community groups; community leaders, and traditional healers; and assessing the relative effectiveness of different outreach activities to inform effective resource allocation (e.g. by collecting systematic data on the source of referrals and by conducting pilot projects).

Coordination: The program would benefit from holding regularly scheduled field-level coordination meetings with IMC staff, partner staff, and government representatives in program districts (rather than ad hoc meetings in response to specific issues). This would be valuable in improving the coordination of trainings, minimizing the risk of miscommunication, and collaboratively planning for the handing over of services to the government in advance.

Monitoring and evaluation: Program data could be used more effectively to facilitate ongoing learning and improvement, for example, by training program and partner staff on the routine analysis of data, to investigate trends and to adapt programs accordingly.

Time-frame and sustainability: A longer program time-frame would have allowed for a more comprehensive hand-over to government authorities and greater capacity-building with government staff to develop their self-sufficiency in providing high-quality care and managing MHPSS services.



The report summarizes the findings of an evaluation conducted by Dr Caoimhe Nic a Bháird (MHPSS Monitoring and Evaluation Consultant), with support from Ashley Leichner (Senior Global MHPSS Officer), and Dr Inka Weissbecker (Global MHPSS Advisor). The full evaluation report is available on request. For more information, please contact aleighner@internationalmedicalcorps.org.

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on this project and their support facilitating the evaluation. This evaluation would not have been possible without the voluntary participation of service users, carers, health workers, and government officials, who took the time to provide constructive feedback.

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