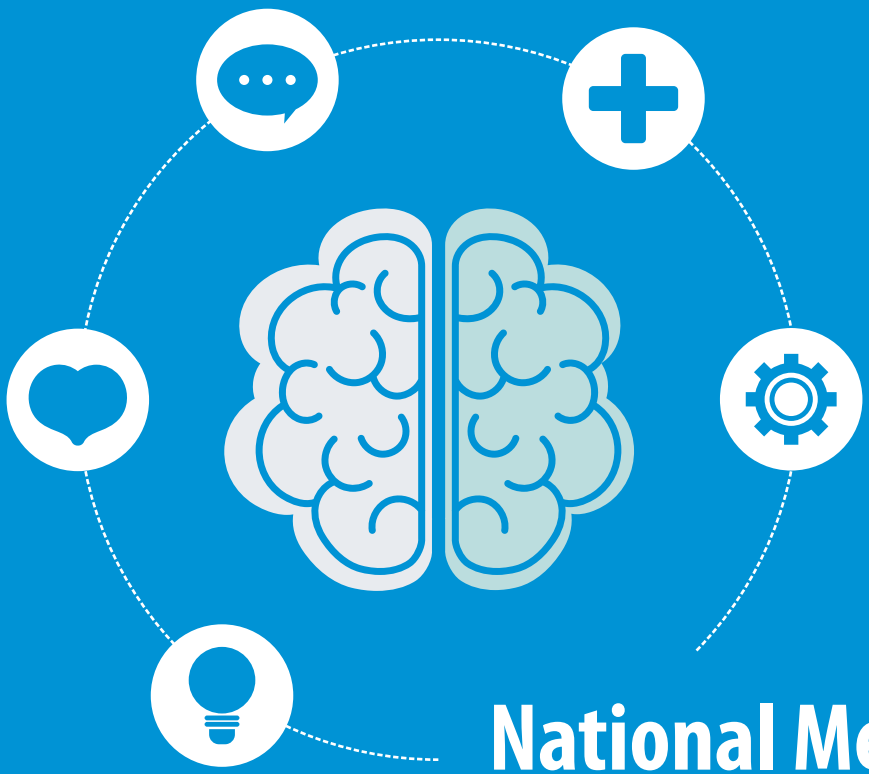


National Mental Health Care Programme Nepal 2022

Strengthening primary care mental health services in Nepal

World Health Organization
Nepal

Guide to cancer early diagnosis

ISBN 978-92-4-151194-0

Suggested citation. Guide to cancer early diagnosis. Geneva: World Health Organization; 2017. Licence: CCBY-NC-SA3.0IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris. Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Printed by the WHO Document Production Services, Geneva, Switzerland

Design and layout: Inís Communication – www.iniscommunication.com

Abbreviations

ANM	Auxiliary Nurse Midwife
CAMH	Child and Adolescent Mental Health
CMA	Community Medical Assistant
EDCD	Epidemiology and Disease Control Division
HA	Health Assistant
HP	Health Posts
MBBS	Bachelor of Medicine and Bachelor of Surgery
GP	General Physician
MH	Mental Health
MNS	Mental, Neurological, and Substance Use Disorders
MoHP	Ministry of Health and Population
NHTC	National Health Training Centre
OPD	Outpatient Department
PHC	Primary Health Care
UHC	Universal Health Coverage

Intended audience and scope of the document

The National Mental Health Care Programme 2022 is intended to guide health policy-makers, managers of mental health programmes and of health facilities, and service providers on the delivery of mental health services at the primary health care (PHC) level. The document is intended to guide health coordinators in the municipalities, district public health officers and provincial health directors in the development of the annual work plan and budget for mental health services. It puts forward clear steps for the organization of people-centred mental health services, quality management and monitoring of the performance of mental health services. The key beneficiaries of the document are the managers of health facilities, as well as health-care teams at basic health service centres (BHSCs), basic hospitals and general hospitals. The beneficiaries are thus those who are expected to deliver essential health services to improve universal health coverage. The document does not cover the delivery of care or the organization of mental health services at tertiary-level facilities. However, institutes at the tertiary level can also benefit from people-centred approaches to the delivery of care, which is the main focus of the document.

Executive Summary

Background

The National Mental Health Care Programme 2022 provides a framework for the delivery of primary health care (PHC)-oriented mental health services. It is intended to guide programme managers from all levels of the government on the implementation of the provisions of the Public Health Service Act 2018, Public Health Service Regulation 2020 and National Mental Health Strategy and Action Plan 2020. The programme aims to promote mental health care that is practical, equitable and need-based. It takes into consideration the current capacity of the health system, the existing infrastructure and the community's mental health-care needs. Emphasis is laid on people-centred care and community participation, as well as on improving access to care.

Objectives

The overall objective of the National Mental Health Care Programme 2022 is to deliver the basic package of mental health services at the PHC level and focused mental health care at secondary health facilities. This would be achieved in collaboration with academic institutions, NGOs and communities through a PHC-oriented model of service delivery.

Overview

The programme has defined a minimum set of mental health services to be delivered by health facilities at every level – basic health service centres, basic hospitals and general hospitals (25–50 beds) – in keeping with the objectives of the Public Health Service Act 2018, Public Health Service Regulations 2020 and National Mental Health Strategy and Action Plan 2020. The basic health service centres will assess basic mental, neurological and substance use conditions, initiate treatment, manage referral and ensure follow-up care, including the refill of prescriptions. The basic hospitals, in addition to carrying out these responsibilities, will provide care to patients who have mental health needs and require further evaluation. This includes people suffering from epilepsy, psychoses and other severe mental disorders, addiction, alcohol withdrawal, and child and adolescent mental health conditions. The general hospitals will provide focused mental health care through a new dedicated cadre of mental health nurses and a visiting psychiatrist, who will run a monthly specialist outpatient department service.

The programme provides a logic model of the operational levers and systems inputs for the effective operation of mental health services. It spells out the measures needed to ensure that health facilities provide the specified package of care. These touch upon reform of the administration and programme governance, supply chain management, bolstering the health information system and adjusting the care culture to the requirements of chronic care.

" Innovative measures have been proposed, combining onsite visits, phone/zoom calls and the use of social media platforms, to make mentoring less resource-intensive.

The programme provides guidance on the types of human resources and capacity-building that will be required. It details the specific competencies for each cadre of service providers in order to ensure quality care. In addition, it sets out a plan with different options for ensuring that the cadres acquire the requisite competencies. The options include the

revision of the pre-service curricula for medical/health workers and needs/plans related to in-service training and ongoing clinical mentoring and supervision. Recognizing that clinical mentorship and supervision are relatively weak in the current programme, a section has been devoted to ongoing support and supervision and transferring what is learnt in training to the clinical setting. Innovative measures have been proposed, combining onsite visits, phone/zoom calls and the use of social media platforms, to make mentoring less resource-intensive. In addition, guidance has been provided to the programme manager on periodic programmatic monitoring to review progress, identify bottlenecks and troubleshoot management issues.

The programme follows a model of care aimed at promoting comprehensive and coordinated people-centred services. It provides guidance on the coordination and continuity of care, team-based care, refill of prescriptions, counselling sessions and setting recall and reminders. In addition, information is presented on the coordination of referrals to ensure that health facilities at all levels and of all types work together in an efficient manner.

The programme stresses activities to engage the community, considering the critical role of communities in promoting mental health, reducing stigma, and preventing mental conditions and suicide. There is a special emphasis on the empowerment of people living with mental health conditions, as well as on organizing community outreach and home-based care to support vulnerable individuals. This is expected to build trust between the community and frontline health-care teams. Female community health volunteers will play a central role in the activities aimed at engaging the community. Linkages and communication with the school nurse programme, social care programmes, disability support programmes and one-stop crisis management centres are of critical importance, including in the rescue and rehabilitation of persons living in extreme poverty.

Due importance has been given to the quality of management and clinical governance to improve performance, manage the increasing expectations of the public and gain the confidence of the service users. The plan-do-study-act (PDSA) cycle has been presented as a tool to identify the gaps (problems or issues) in quality, undertake root cause analysis, and identify and implement solutions to address the delivery of mental health care at health facilities. There is a provision for rating health facilities on the quality of mental health services they provide. If a health facility fulfils certain given criteria upon assessment by an independent team, it will be deemed a mental health-friendly facility and designated as a "Khulla Man health facility".

It is envisaged that academic institutions will be engaged in supporting the provinces and municipalities and health facilities to deliver people-centred mental health services. This will be done through a tripartite partnership between the Ministry of Health, medical/health institutions and provincial /local health authorities. Nongovernmental organizations and CBOs will be engaged to partner provincial governments and academic institutions in filling the gaps left by government services. It is visualized that by incorporating new skillsets for the management of mental health in in-service curricula, academic institutions will serve as capacity-building hubs. Further, they will educate the future health workforce at the formative stage and integrate mental health into the existing 'teaching district' concept and provide training in the new competencies of mental health services to serve the needs of district programmes. Faculty members will also undertake implementation research to generate evidence to improve mental health care.

A set of specific, quantifiable and measurable indicators of performance have been identified to assess the performance of the programme. These will be used to inform policy-makers, health managers and health-care teams about the performance of the programme. They will also provide a means of evaluating the access to and quality and coverage of services. The district mental health services will be implemented guided by the following measures at the facility, district/provincial levels.

In summary, the programme defines service delivery functions and prescribes service organization reforms with an emphasis on improving care culture, effective coordination, team-based management and use of standardized treatment protocols.

Context

The Constitution of Nepal mandates free basic health services and equal access to health services for every citizen. Mental health care has been included in the list of basic health services in Subsection 4 (e) of Section 3 of the Public Health Services Act, 2075 (2018). Mental health services have also been included in the "basic and emergency health services" in Schedules 1 and 2 of the Public Health Regulations 2077 (2020), and service arrangements to be made for mental health at the federal, provincial and local levels. Chapter 7 of the Act Relating to Rights of Persons with Disabilities, 2074 (2017) confers all citizens with the rights to health, rehabilitation, social security and recreation. Sections 35 and 36 of the Act also ensure additional service facilities for people with mental or psychosocial disabilities.

The National Mental Health Strategy and Action Plan 2020 was developed with the vision of "enabling all Nepalese to lead a productive and quality life by improving their mental health and psychosocial well-being". The strategy aims to achieve the vision by strengthening the promotion of mental health and including essential mental health services at the primary care level and referral care services at the secondary care level and above.

The Ministry of Health and Population (MoHP) started implementing the Community Mental Health Care Package in 2017 to integrate mental health services into the primary health care system. The package was partially implemented in 44 districts by government and NGOs and critical lessons may be learnt from that experience. However, the system of government has since changed from a unitary to a federal one, consisting of three tiers. Each tier has independent authority to plan and organize health services. Consequently, the Community Mental Health Care Package 2017 has been revised and replaced by the National Mental Health Care Programme 2022. The latter incorporates the global best practices, the country's experiences with the implementation of the Community Mental Health Care Package 2017, and the experience of community-based organizations (CBOs) and nongovernment organizations (NGOs) at the grassroots level.

" The approach adopted by the programme emphasizes people-centred care, community participation and mental health equity.

The National Mental Health Care Programme 2022 focuses on the primary health care level and aims to deliver mental health services in a practical, equitable and need-based manner. It takes into consideration the current capacity of the health system, the existing infrastructure and the community's needs with respect to care. The approach adopted by the programme emphasizes people-centred care, community participation and mental health equity. One of the objectives of the programme is to improve access to care. This programme replaces the Community Mental Health Care Package 2017.

Objectives

In alignment with objective 1 of the National Mental Health Strategy and Action Plan (2020), the National Mental Health Care Prorgamme 2022 will deliver the basic package of mental health services at the primary care level and focused mental health care at secondary health facilities, in collaboration with the tertiary care level and communities. A PHC-oriented model of service delivery will be used to achieve this.

More specifically, the National Mental Health Care Programme 2022 will:

- strengthen health care system to allow for the integration of mental health services, on a priority basis, into BHSCs, basic hospitals and general hospitals;
- follow an integrated people-centred model of care characterized by team-based practices, strive for result-oriented care, and ensure coordination of care and continuity of services across all levels of care;
- improve staffing, including the creation of a dedicated cadre to deliver the specified mental health services in district-level general hospitals;
- develop strategic linkages with communities for the promotion of mental health, reduction of stigma and improvement in help-seeking behaviour; and
- strengthen data system to measure and monitor the progress of mental health services.

Guiding Principal

The guiding principles of the National Mental Health Care Programme 2022 are to:

- strengthen people-centred, culturally sensitive, gender-appropriate mental health services;
- enhance the capacity of the primary health system to enable it to deliver mental health care services;
- build connected services along the continuum of care, with a focus on the capacity of the PHC system to improve access to care;
- respect the rights of people living with mental health conditions and provide rights-based care;
- focus on equity so that the poor and deprived are covered while pursuing mental health care for all;
- recognize the roles of persons with mental health conditions, their caregivers and the wider community in promoting mental health and well-being; and
- ensure collaboration and partnership between the government, NGOs and the private sector.

Minimum service package for health facilities in districts

A set of mental health services has been specified for health facilities at every level, i.e. BHSCs, basic hospitals and general hospitals. This has been done in accordance with the provisions of the Public Health Service Act 2018, Public Health Service Regulations 2020 and National Mental Health Strategy and Action Plan 2020. As mentioned already, health facilities will be strengthened at all levels to deliver the set of mental health services decided upon, with a special focus on the PHC system.

The minimum mental health services to be offered by BHSCs are listed in Box 1.

Box 1: Minimum mental health services to be offered by BHSCs

- Assessment and management of basic mental, neurological, and substance use (MNS) disorders, in accordance with the training package of the National Health Training Centre (NHTC) under supervision:
  - common mental disorders (anxiety, depression, suicidality, conversion);
  - psychoses (including bipolar disorder) – initiate treatment and refer for validation;
  - epilepsy – initiate treatment and refer for validation;
  - alcohol use disorder – initiate brief intervention, primary treatment and referral to Basic Hospitals for management of withdrawal;
  - monitoring and follow-up of patients;
  - refill of medicines and continuation of care for all the conditions listed;
- Case identification, provision of basic support, and referral for child and adolescent mental health (CAMH) conditions and dementia.

Patients who need help for conditions such as epilepsy, psychoses and other severe mental disorders, addiction, alcohol withdrawal and CAMH conditions, and who require further evaluation, will be referred to the basic hospitals after the initiation of treatment.

The basic hospitals shall provide the services listed in Box 2.

Box 2: Minimum mental health services to be offered by basic hospitals

- Identification of mental health cases among patients seeking general health care;
- Assessment and management of common MNS disorders, in accordance with the NHTC training package:
  - anxiety, depression, suicidality, conversion
  - psychoses, including bipolar disorder
  - alcohol and substance use disorders
  - epilepsy
  - dementia
  - CAMH conditions;
- Acute inpatient care for psychiatric emergencies;
- Basic psychological support;
- Prescription and refill of medication, and follow-up.

The level of services at general hospitals (25–50 beds) will be upgraded to provide focused mental health care. A new cadre of mental health nurses will be sanctioned. They will function as care coordinators for patients and support general physicians in the management of mental health cases. A visiting psychiatrist will be engaged to run a monthly specialist clinic for complicated and referred cases, thus improving the level of care. In instances when a psychiatrist is not available, a trained general practitioner should be mobilized to run the mental health clinic. A general hospital is also encouraged to collaborate with a medical college so that the latter may deploy a resident psychiatrist to manage the mental health clinic. General hospitals with more than 100 beds will have a regular psychiatrist, who will provide daily outpatient department (OPD) services and manage the acute inpatient care ward.

Box 3: Minimum mental health services to be offered by general hospitals (25–50 beds)

- A regular mental health outpatient service to provide follow-up care and focused psychological support by a mental health nurse;
- Referrals and linkages to social care programmes;
- Assessment, diagnosis and treatment for patients with complex mental disorders;
- Acute inpatient care for psychiatric emergencies;
- Specialist mental health services at least once a month, and regular mental health services in partnership with a medical institution;
- Telemental health services;
- Outreach support, and mentoring and supervision of primary care;
- Collaboration with the one-stop crisis management centre (OCMC);
- Initiatives to improve quality to facilitate clinical processes.

The logic model of the National Mental Health Care Programme

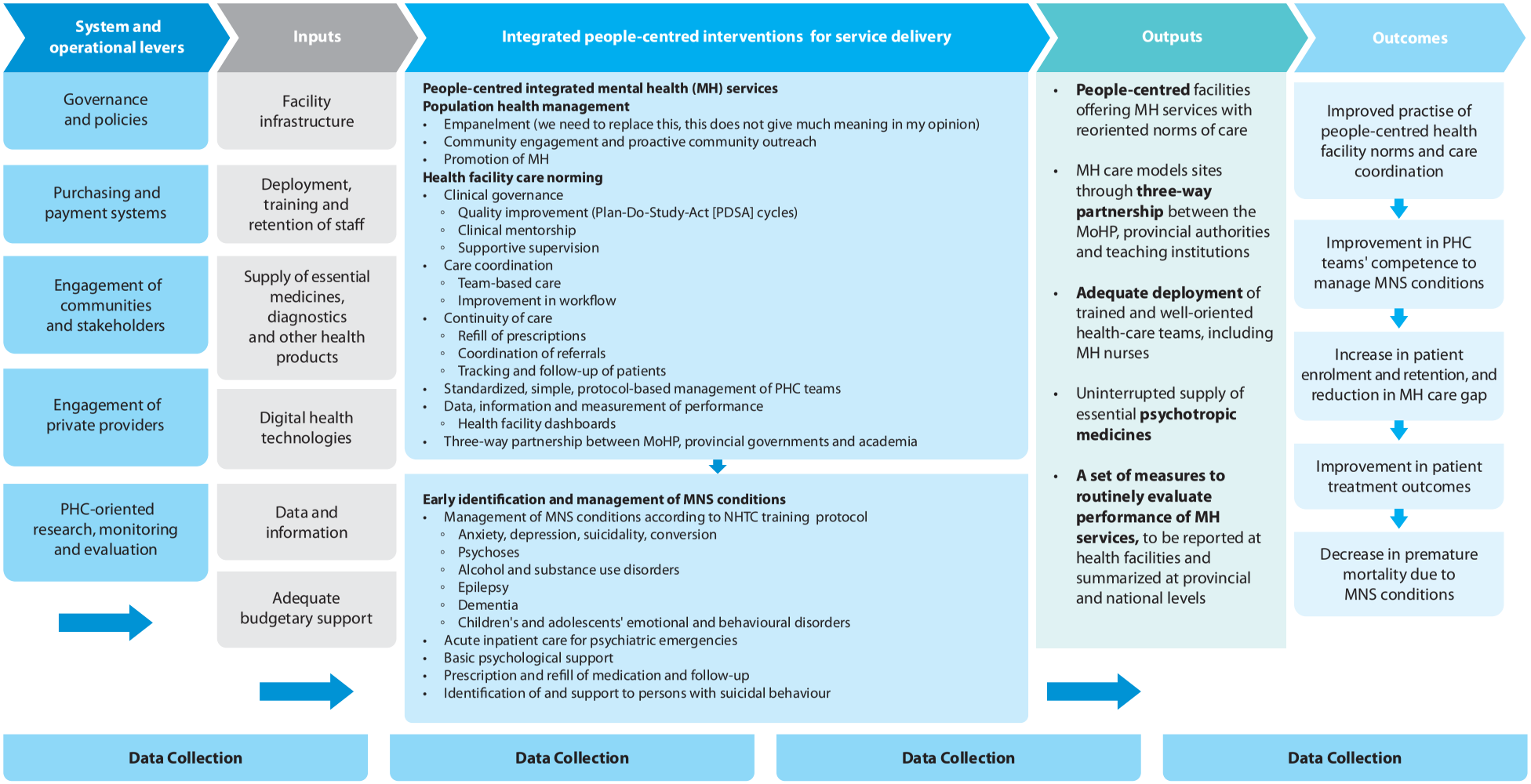
The structure of the PHC system and its responsiveness to the needs of patients and populations should be improved for the effective integration of mental health services into PHC.

The logic model for the programme is reflective of the fundamental levers for systems change; it recognizes the unique and distinguishing features of PHC and the actions required to improve the mental health outcome. The model will guide the monitoring of the progress of the programme, its evaluation, the documentation of evidence required for policy-making, administrative and practice communities to plan, and improve mental health services. The logic model is intended to serve as an overarching guide to the implementation of the programme without being overly rigid and prescriptive. The model may be revised to ensure that the needs/goals of the programme continue to be met.

The operational levers and systems inputs required for the PHC system to deliver effective mental health services have been identified. The service delivery functions and reform of the organization of services are the main areas where reorientation is required for the effective operation of the programme. Some important components of the programme are its emphasis on improving the care culture, effective coordination, team-based management and the use of standardized treatment to improve the organization of care.

Fig. 1. Framework for integrated care model for mental health services in Nepal

Goal: Improve access to essential mental health services through PHC system as part of the Basic Health Service Package of Nepal to improve



Operational levers for mental health services

The operational levers of the PHC system need to be streamlined so that they can prepare the system to deliver chronic care. For this purpose, several dedicated actions must be prioritized. These include taking steps to improve the structure of public health governance, increasing staffing at health facilities, using the people-centred care model and maintaining strong linkages with communities, ensuring the availability of supplies and diagnostics, and improving data collection and the information system. These actions can produce a system-wide impact on PHC and improve the delivery of not only mental health care, but also overall health services.

Reinforcing administrative and programme governance

Setting up people-centred mental health services requires transformational leadership and appropriate systems at all levels of the health system, so as to manage change processes, facilitate collaboration and undertake course corrections, if necessary. The extent to which responsibilities are shared between the different levels of government will largely determine the success of the effort to deliver the package of mental health services. Table 1 outlines the main roles of the government at all three levels in scaling up mental health services.

Table 1. The roles of the three levels of government in scaling up mental health services

Federal MoHP
• Develop policy guidance and standards. • Develop national in-service training curricula. • Conduct national-level master training of trainers. • Manage essential medicines and diagnostics. • Engage academic institutions in improving pre-service training and competency-based training. • Allocate adequate resource • Coordinate with other ministries and sectors
Provincial MoH/ Ministry of Social Development
• Start capacity-building programme for in-service health workforce. • Procure essential medicines and supplies. • Introduce enhanced mental health services at all levels of health system.
Municipality
• Start capacity-building programme for in-service health workforce. • Take responsibility for supplementary procurement of essential medicines and supplies. • Support community-based services with the help of a network of CBOs and NGOs including for psychosocial disability. • Engage the community and reduce stigma. • Collaborate with traditional healing system.

The municipality health office is responsible for the organization and delivery of basic mental health services by the BHSCs and basic hospitals. In addition, the municipality will mobilize the community to assist with the promotion of mental health and help-seeking behaviour. It will also facilitate the incorporation of traditional healing practices. The authorities at the provincial and federal levels shall set

norms and standards, develop plans, organize and implement services, arrange for the training of service providers and undertake periodic monitoring and evaluation.

The three tiers of the government will act together to regularize the supply of drugs, strengthen the health information system for mental health, and establish linkages with line ministries, academic institutions, development partners and civil society organizations. Meaningful consultations will be held with Individuals with lived experience of mental illness, as well as their families and organizations, before decisions on systems and service reform are taken.

An organizational restructuring will be required for the implementation of this programme. Strong programme management and administrative functionaries will be needed, as will adequate staffing within the organogram of the federal, provincial and municipal governments, for a national scale-up of mental health services. To effectively manage and implement the programme, it will be necessary to have a Division of Mental Health at the federal MoHP, a mental health unit in each province and a mental health focal person in the municipal health offices.

Management of supplies and logistics

The regular availability of essential psychotropic medicines is imperative for the effective delivery of mental health services. Teams from the health facilities will undertake facility-based forecasting, monitor stocks and make requisitions, while programme managers at the federal and provincial levels will ensure timely procurement and supply. The health-care teams will be given an orientation on the essentials of stock management and maintenance. The main actions which will be taken to ensure a supply of essential medicines for mental disorders are listed in Table 2.

Table 2: Actions to be taken at different levels to ensure drug supply

Provincial and municipal managers	Health facility teams
• Forecast a district/province annual need and procure the supply of medicines and logistics through local mechanisms. • Assess the stock of short-expiry medicines and use them to replenish the stock of centres experiencing shortages. • Undertake periodic random surveys on the storage, availability and quality of health products. • Implement the technical guidelines, norms and standards for quality assurance and the safety of health products.	• Monitor the stocks of essential medicines and diagnostics every month. Maintain up-to-date records of inventory and take corrective actions. • Forecast the quarterly need and make a requisition to the provincial and district units for timely restocking. • Conduct an annual forecast exercise and submit the requirement to the federal/ provincial procurement unit for the planning of supply chain management.

Annual budgetary support

The mental health care programme will be funded by the dedicated annual work plan and budget of all levels of the government. The budget will cover all major areas: the training and supervision of the health-care providers, procurement of essential mental health medicines, salary of the mental health nurses, specialist mental health clinics, and annual meetings, reviews, training sessions and workshops at the provincial and district levels.

Financial protection of patients

Teams from the health facilities will assist MH patients in enrolling in social health insurance programmes to reduce out-of-pocket payment by patients and their families. This support will include identifying potential patients who are not covered by social health insurance among the health facility's catchment communities, and encouraging them to enroll, in collaboration with social health insurance agents.

Staffing arrangements

Programme management and administration

The administrative structures at all levels of the government shall have staff with adequate skills to manage the mental health progarmme. Programme managers will establish management processes and accountability to optimize the motivation, satisfaction, retention and performance of the staff. They will prioritize the provision of support to ensure the deployment of trained staff or to train untrained teams, if requested by a health facility manager.

Service provision

The delivery of MH services requires coordination between multidisciplinary teams which function well, and have the right skill mix. Owing to the severe shortage of specialist human resources, the capacity of the existing health-care providers will be enhanced using the principle of task sharing.

The services will be delivered by physician-led teams in the hospitals and PHC teams in the BHSCs. General hospitals with a capacity of 25–50 beds will be strengthened by the introduction of a cadre of mental health nurses who, along with general physicians, will coordinate care. They may be linked to medical colleges for a resident psychiatrist to be posted on duty on rotation. In addition, a visiting psychiatrist will run a monthly specialist clinic and supervise health facility staffs for complicated cases and referred patients. When the psychiatrist is unable to visit, a trained general physician could run the mental health OPD. General hospitals with a capacity of 100–300 beds will have a psychiatrist to run a daily OPD clinic and provide inpatient care services. Whenever there is an expected shortage of staff due to transfers or the departure of staff, the managers of health facilities will ensure that trained personnel are available at their facility by sending a written communication to the municipal/provincial/federal health office.

Box 4: Staff at different health facilities

Health facility	Team
Basic health service centre	Health assistant (HA), community medical assistant (CMA), auxiliary nurse midwife (ANM)
Basic hospital	Medical doctor (MBBS/MD), HA, CMA, ANM
General hospital (25–50 beds)	Mental health nurse, doctor (MD/MBBS), HA, CMA, ANM
General hospital (100–300 beds)	Psychiatrist in addition to general health–care team

Although not formal health workers, female community health volunteers (FCHVs) will be engaged in the promotion of help–seeking and reduction of stigma and for the follow–up of patients in the community.

Competencies of health–care providers

The health–care teams must possess the core competencies required for the management of mental health problems, as set out in Table 3.

Table 3: The core competencies of the health-care team

Mental health nurses

Provision of clinical services

- Establish and operate regular mental health outpatient services in district hospital.
- Provide basic and focused psychological/ psychosocial support to patients attending OPD or inpatient services, either through one-on-one sessions or group sessions, as appropriate.
- Refill prescriptions to ensure continuity of care for patients with MH conditions in coordination with clinical team of the hospital.
- Provide crisis management interventions to patients with suicidal behaviour, as also to their family members.

Coordination and management

- Coordinate the maintenance of the patient register and facilitate forward reporting from the hospitals and primary health centres in the district, in close collaboration with the district and municipal health offices.
- Collaborate with the OCMC to manage cases with special needs, such as victims of gender-based violence and survivors of torture.
- Assist in introducing an initiative for the improvement of quality in the hospital by arranging care coordination meetings, monitoring the stock of medicines, etc.
- Arrange for the referral and follow–up of those with complex needs for care at monthly specialist clinics.

Support to primary care

- Help primary care providers to deal with their daily clinical and programmatic needs.
- Promote community engagement in collaboration with PHC centres and the municipal health office.

Has and CMAs

Common mental disorders (anxiety, depression, suicidality, conversion)

- Identify and manage according to protocol.

Psychosis (including bipolar disorder)

- Identify and manage in the beginning.
- Refer to medical doctor to validate the clinical care plan.

Alcohol use disorder

- Administer brief intervention, primary treatment.
- Refer for detoxification (management of withdrawal).

Epilepsy

- Initiate treatment according to the Mental Health Gap Action Programme (mhGAP) protocol and refer for further evaluation.
- Refill antiepileptic drugs for continuation of care.

Identify cases of CAMH conditions and dementia and initiate referral.

MBBS doctors

Manage MNS conditions according to the NHTC training package:

- anxiety, depression, suicidality, conversion
- psychosis
- alcohol and substance use disorders
- epilepsy
- dementia
- emotional and behavioural disorders of children and adolescents.

Provide acute inpatient care for psychiatric emergencies.
Train and supervise HAs/CMAs as co-trainers.

MD general practice physicians

Manage priority MNS conditions according to mhGAP V 2.0.

- anxiety, depression, suicidality, conversion
- psychosis
- alcohol and substance use disorder
- epilepsy
- dementia
- CAMH conditions

Provide acute inpatient care for psychiatric emergencies.
Train and supervise HAs/CMAs as trainers.

Nurses/ANMs

Promptly identify and refer

- mothers with depression, during their ANC and PNC visits
- women with postpartum psychoses.

Provide basic psychosocial support.

Programme managers

Develop the annual work plan and draw up the budget.
Take responsibility for supervising the programme.
Take charge of the management of information.

Adequate training, clinical mentoring and supportive supervision will ensure that the staff acquires the requisite competencies.

Capacity-building and training

Training and ongoing mentoring are important for the staff to provide patient care. To build the capacity of the staff, there is a need for support from and strong leadership at the central as well as provincial levels.

The NHTC, in collaboration with the Epidemiology and Disease Control Division (EDCD), will revise and update the training packages and develop new training materials as and when required. The cascade training model will be used to train all service providers. Table 4 shows the current plan for the training of health-care providers.

Table 4: Training plan for health-care providers

Service provider	Training	Trainer	Remarks
FCHV	One-day Community Informant Detection Tool workshop	Trainer: MBBS doctor/mental health nurse Co-trainer: HA/staff nurse/CMA	The current NHTC module needs to be revised to focus on priority mental conditions.
HA/CMA	4-day training on priority mental health conditions	Trainer: Psychiatrist/ GP (MD) Co-trainer: MBBS doctor	The NHTC module 2 will be used to develop a 4-day training package for the specified disorders.
Nurse/ANM	Training on maternal mental health	Trainer: Psychiatrist/clinical psychologist/mental health nurse	No training package on maternal mental health has been developed yet.
MBBS doctor	5 days' training as per the NHTC module 2/mhGAP IG V2.0	Trainer: Psychiatrist Co-trainer: GP (MD)	
GP (MD)	5 days' training as per NHTC module 2/mhGAP IG V2.0 with	Trainer: Psychiatrist	
Programme manager	additional module on CAMH conditions		
	Two-and-a-half days' training on public mental health	Trainer: Psychiatrist, clinical psychologist Co-trainer: GP (MD), or specialist (MD community medicine/ MPH)	

Clinical mentorship

Health-care providers need ongoing support and supervision to apply what they have learnt in training to the clinical setting. To increase the competence and boost the confidence of the PHC teams, the programme envisages regular clinical mentorship of service providers. The mentorship programme will be designed innovatively and utilize a blend of onsite visits, phone/zoom calls or social media platforms, such as WhatsApp, Viber, Google and WeChat.

The mentoring team of each district will consist of a psychiatrist, clinical psychologist and psychiatric nurse. When the specialist team is not immediately available, a GP (MD) can be designated as the clinical lead of the mentoring team. The mentoring team will obtain mentorship skills during workshops for the training of trainers and supervisors.

Table 5: General procedure for clinical mentorship and coaching

Preparation by mentoring team:

- Agree on a particular date of the month and time both for face-to-face and remote supervision.
- Circulate his/her contract information to all mentees.
- Create a social media group.
- Draw up a weekly schedule for the health facility team to call the experts for discussion.
- State the expectations, including the following, in advance.
  - Every mentee should present at least 2 cases during the entire mentorship cycle.
  - All health-care providers should attend at least 4 sessions of clinical mentoring and supervision under expert guidance.

During a mentoring session:

- The mentee will consult the mentoring team on the management of complex cases, on a need basis.
- The team will Introduce the purpose of mentoring.
- The team will assess and facilitate the clinical decision-making, as follows.
  - Ask 2–3 participants to present a difficult case that they have encountered in their practice.
  - Facilitate a group discussion and encourage other participants to offer suggestions or give examples based on their own experience.
  - Discuss any problems or concerns related to the assessment, management and treatment.
  - Review the trainees' understanding of and ability to use the mhGAP-IG/national protocol, offering them feedback, encouragement and suggestions for improvement.
  - Address record-keeping, referrals and follow-ups.
  - Assist the mentees, facility director and other staff members in setting goals for the implementation of the programme and team-based care.
  - Discuss the ethical treatment of persons using services and respect for their human rights.

Onsite mentoring

- During the visit, the team will provide consultation to patients under the care of the health facility team. The visiting team and PHC team will hold discussions on the cases and face-to-face mentoring will take place through case presentation and discussion.
- The PHC team will maintain a brief record of the visit, the number of cases seen during the visit, that discussed with the mentoring team and that of PHC team members who participated in the discussion. The record of the visit will be countersigned by the visiting team before it leaves the health facility.

Virtual mentoring

- During online mentoring, the mentoring team will supervise teams from different health facilities in groups. The cases will be preselected by the mentors, in consultation with the mentees.
- The mentor team will prepare a brief discussion note and circulate with it among the mentee team through email and the social media.
- The mentee team will keep a record of the mentoring session in the health facility book and the mentoring team will do the same in its records.

Programmatic supervision

Supportive supervision is built on mutual agreement between the supervisory and supervisee teams on finding a solution to a problem. This approach promotes joint action and ownership in the exercise to address the gaps that have been identified in mental health services. Remote supportive supervision offers a transformative supportive system and will be integrated into the Khulla Man model through the following measures.

- Each district will establish a coordination committee on mental health that will consist of managers of health facilities, public health officers from the district health office and municipal health office, service providers and persons with psychosocial disabilities.
- Every month, the committee will review the progress, identify bottlenecks and report to the authorities at the provincial and federal levels for troubleshooting of management issues.

Table 6: Modalities of supervision

- Due to the expansion of online digital technologies, supervision will be carried out both through the online and onsite modalities to optimize supportive supervision.
- Health supervisors from the provinces will visit select health facilities in the districts on a monthly basis. (Note: The supervisors may not be able to cover all facilities in a month. It is important to provide quality supervision in a select few facilities each month.)
- The teams of supervisors and supervisees will agree upon the schedule in advance.
- The supervisory team will use a standard checklist for supportive supervision. (Refer to the checklist.)
- During the discussion, the supervisory team will review the caseloads, balance of stocks of medicines and supplies, availability of staff, issues related to treatment and case management, coordination of referrals, and community outreach.
- The observations and recommendations will be documented in the supervisory visit forms.
- The recommendations made during the visit will be mutually agreed upon by the teams of supervisors and supervisees and the form will be countersigned by both teams.
- The supervisors will follow up on the recommended actions with the health-care team a month later.

Online supervision

- The health supervisors will organize monthly online supervisory discussions (telephone, zoom meetings) with health facility teams and public health officers. The district will report its progress to the province, which will share the findings of the previous month and provide feedback.
- The supervisory team will fill the supervision form and circulate it to the team of supervisees at the health facility by email.

Onsite visits

- Health supervisors from the provinces will visit select health facilities in the districts, according to a fixed a monthly schedule, and will also hold online supervisory meetings.

Model of care

The provincial and municipal health systems will develop a model of care aimed at promoting comprehensive and coordinated people-centred services, with a focus on PHC. A team of mental health experts, i.e. psychiatrists, clinical psychologists and psychiatric nurses, will assist with the provision of services. These personnel, in turn, will proactively guide other providers, such as paramedic health workers, nurses and general doctors.

Teams from public health facilities will be involved in the design and organization of service delivery throughout. Persons with lived experience in mental health and community members will be asked to share their perspectives and needs so as to ensure rights-based and evidence-based mental health services.

To shape the model of care, steps will be taken to streamline the areas of governance, accountability and financing. In addition, evidence-based tools and clinical guidelines will be developed. Digital technology for health will be harnessed to improve the quality and efficiency of care.

To mainstream mental health care, provincial and district health managers will do the following.

- Prioritize the model of care in BHSCs, basic hospitals and general hospitals, by ensuring proper planning and resource allocation, improving the supply chain and ensuring better management of information to monitor the model.
- Set up a system of MH-friendly health facility designation and ensure incremental adoption of the care model.
- Partner with academic institutions and stakeholders, including CBOs, NGOs and OPDs, to support interprofessional continuing education and training of PHC teams and the implementation of the model of care.

Coordinating care and setting a shared vision

It is vital to adopt a proactive approach in terms of bringing together health-care professionals and providers to meet the needs of service users and ensure that they receive integrated, person-focused care across various settings. It will be driven by a shared vision, owned by and communicated to all health facility teams at all levels of health care.

Health facility teams will take the team-based approach to mental health care further by taking the following measures.

- Set goals for health facilities to promote people-centred services, and communicate these to all staff members.
- Schedule monthly review meetings of the team and share the lessons that have been learnt.
- Maintain a logbook to note down the proceedings of the meetings and follow up on the meetings.
- Conduct intermittent internal reviews to assess the workflow and team practices, and make corrective changes to the processes.
- Make the review of the performance of teams and individuals an integral part of the performance appraisal system.
- Support and provide simple group incentives to improve teamwork.

Fostering continuing team-based learning at health facilities

- The health workers will provide a detailed briefing to the team in their health facilities on completion of their mental health training and will send a report to the district authorities.
- Health facilities will organize a monthly meeting for continuing medical education as topic presentation. In addition, a conference, to be attended by members of the clinical team, will be held to discuss a range of mental health issues, such as the management of complex cases and cross-referral.

Ensuring continuity of care

People living with mental health conditions require long-term follow-up care. Due to numerous factors, patients are likely to interrupt care. A system for the follow-up of patients is essential for ensuring the continuity of mental health services. The continuity of the provider–patient relationship and ensuring that patients consistently receive information related to their health-care needs are important aspects of mental health care.

Health facilities will implement the following measures to improve the continuity of care:

- prescription refill, psychosocial counselling and follow-up care;
- proactive recall and reminder system; and
- coordination of referral.

Prescription refills, psychosocial counselling and follow-up care

Mental health patients require long-term care and counselling. The dosage of medicines may need adjustment and the treatment plan may need to be changed over time. Prescription refills will make it possible for patients to continue with their treatment in the case of common mental health problems.

Health facilities will take the following actions to simplify prescription refills and follow-up care.

- Issue medicines for a longer duration of time, in keeping with the need for medical review (up to three months for stable cases).
- Consider patients' requests for refills for longer duration due to travel/other reasons.
- Arrange for telephonic conversations with the physician/specialist, if and when required.
- Maintain a list of cases who are provided a monthly refill of medicines.
- Maintain a buffer stock of medicines.
- Ensure that medicines are delivered from the warehouse to BHSC, basic hospitals once a month.

Mental health patients also require psychosocial support and counselling. Counseling will be provided by a team member, such as the ANM, staff nurse or health assistant, who has additional training on psychosocial counselling. Psychological support and counselling will be offered in coordination with the OCMCs in the general hospitals, and mental health nurses and counsellors, where available.

Recalling patients and sending reminders

Health providers are likely to come across a subgroup of patients who miss visits or interrupt care. In such cases, the health provider has to adopt a proactive approach to care by reaching out effectively. The kind of support that should be offered to a patient with a mental health condition should be similar to that provided to tuberculosis patients or mothers attending antenatal and postnatal services: these patients are closely followed up by health workers if they miss the expected date of their next visit.

Health facility teams will take the following measures to improve the tracking and recall of patients to ensure continuity of care.

- Assign a team member (e.g. nurse/HA) the task of managing recall and follow-up care within the health facility's community catchment area.
- Maintain an appointment register which mentions the date of each patient's next visit (patients' next visit register).
- Check the tentative number of visits by patients expected for the next day.
- At the end of every day, go over the patients' list/quality report to identify patients who were expected to visit on the day but did not.
- Before closing the clinic, follow up by making a telephone call or texting a message to patients who did not come and find out why they missed the visit. Agree on the next visit and update the patients' next visit register.
- Engage community informants such as FCHVs in the locality to inform patients missing care.
- Gradually develop a computerized alert mechanism at district/provincial hospitals for sending recall and reminders to patients missing care.

Coordination of referrals

Referrals for service are made for patients who request, or are assessed as being in need of, treatment at a higher centre. Effective coordination and communication between health facilities are critical to ensure that referrals and case handovers are as seamless as possible. The patient's experience with services should be smooth and the services should not be lost in referral pathways. To assure patients of coordinated referrals, health facilities will follow the steps listed in Table 7.

Table 7. Measures to coordinate referrals

Referrals from lower to higher centres	Counter-referrals from higher to lower centres
Health-care teams will take the following steps when making referrals to a higher centre. • Provide a referral form/letter with the prescription, indicating the reasons for referral. • Maintain a record of the referred patient in the referral registry. • Ask the patient to contact the health worker in case of any problem with the referral pathway. • Give the patient the contact number/s of the health-care team and advise him/her to contact them in case of any problem with the referral pathway.	When referring a case to BHSCs/basic hospitals, the treating team at the referral hospital will provide the following support for follow-up care. • Provide the prescription, together with the patient's treatment plan and clear instructions on the actions to be taken by the health-care team for further follow-up care. • Discuss the case and make the handover through a telephone call in select complex cases (when required).

Designated referral sites

Bigger health facilities with a psychiatrist or trained GP and counsellors will be selected as designated referral sites. These facilities will have 24-hour services to handle psychiatric emergencies. They will serve as midway referral sites, at which most of the patients referred from the BHSCs and basic hospitals can be treated. These strategic sites will be supported through online clinical supervision and monthly outreach clinics by psychiatrists. Thus, they will be in a good position to manage referred cases that require a higher level of care. Tertiary care facilities with psychiatry departments, such as teaching institutions, are the highest referral sites in the geographical locations.

- Patients should be referred to designated referral centres to minimize costs and travel.
- In the case of patients who require further referral to a tertiary centre, proper coordination with the higher centre is essential.

Referral to social care

Patients with mental health conditions may need referrals for reasons other than health, such as legal support or social protection. The referring team should confirm with the referral centre whether it has the service and expertise for which the patient is being referred. This will spare patients the trouble of travelling unnecessarily to the higher centre. In corollary, co-ordination and referral from existing social care program shall be facilitated such as legal systems (court, juvenile bench, police) and child protection (child care homes or safe houses).

Escorted referrals in special situations

Urgent referrals are required in the case of psychiatric emergencies, such as alcohol use disorder with a complicated withdrawal, severe mental disorders that pose a risk of harm to the self or others, and a recent history of suicidal thoughts, plan or attempt. Such patients must be supported with free ambulance services and escorted to the next referral centre by a health worker assigned by the health facility's management.

Engagement and mobilization of the community

A lifelong relationship between health-care providers, patients and community members is necessary for mental health care. Communities play a critical role in the promotion of mental health, reduction of stigma, and prevention of mental health conditions and suicide. Community resources provide social support to vulnerable individuals and play a part in ensuring that the patient reports for follow-up care. They are also a source of support to those who have been bereaved by suicide. In addition, the engagement of community members is fundamental to building trust between frontline health-care teams and patients.

It is not enough to invite community feedback when designing and delivering people-centred health services. Formal systems should be promoted to encourage patients and community members to express their concerns, suggestions and needs. Community-based ambulatory services consisting of outreach clinics, home visits to patients and the organization of activities to create mental health awareness in the community are fundamental components of mental health care.

Health facilities will take the following steps to engage communities.

Table 8: Measures to engage communities

Community engagement	Empowering people living with mental health conditions	Reaching the needy through community-based outreach and home-based care
• Map the prominent traditional healers and orient them to refer patients to health facilities, in partnership with CBOs and NGOs. • Facilitate the formation of peer support and self-help groups in partnership with CBOs and NGOs. • Form a community advisory board for health services in BHSCs and basic hospitals with the community and its leaders, CBOs and NGOs. • In partnership with CBOs and NGOs, strengthen the capacity of community members to address stigma and promote help-seeking.	• Make education materials (posters/ videos/ pamphlets) available and accessible to patients and encourage self-care. • Establish patient and family support groups, using the community network. • Set up feedback counters/ corners in health facilities or try to get feedback over the telephone or through face-to-face interaction; use the information to make course corrections.	• Maintain a record of patients who require special care in the catchment area. • Schedule community-based/ home visits to patients who have been left behind. • In partnership with CBOs and NGOs, organize outreach clinics for unreached communities living in difficult geographical terrain, and urban and peri-urban communities.

School mental health

The government has endorsed a school nurse programme so that schools may have dedicated nurses to see to the mental health needs of the students. In addition, the government has taken initiatives to involve schoolteachers in fostering mental health in schools. The health facilities and the school mental health nurse or focal teacher will work together to initiate school-based interventions on the promotion of mental health and identification of children with mental health conditions.

Engagement of FCHVs and linkage with communities

FCHVs can play an important role in the effort to improve mental health care. Promising FCHVs should be identified and provided additional training on the promotion of mental health. They should be identified as community champions and empowered to perform the following functions:

- identifying cases in the community and making referrals to health facilities;
- engaging the community and mobilizing traditional healers; and
- functioning as the liaison to facilitate community engagement.

Linkages with other social care programmes

The programme managers and incharges of health facilities will seek every opportunity to establish linkages with other health and social care programmes.

Health facilities will carry out the following functions.

- Collaborate with the OCMCs operating in the general hospital and provide mental health service providers to facilitate cross-referral and align activities.
- Liaise with school health nurses for health promotion, early identification of mental health conditions, and referral.
- Collaborate with programmes that support migrant workers and their families.
- Identify CBOs and NGOs involved in the area of mental health and network with them to co-organize community-based activities aimed at raising awareness of mental health.

Rescue and rehabilitation

Many people in the community who have mental health disorders are living in inhuman conditions, and are homeless or victims of social neglect. Concerted efforts should be made to improve their lives, rescue them and rehabilitate them into society, in keeping with the spirit of "leaving no one behind". Though some efforts have been made to rescue people in need, community rehabilitation is still in its infancy in Nepal. What is required is a strong partnership between health facilities, CBOs and NGOs. The treatment and rehabilitation of homeless persons with mental health conditions shall proceed, in accordance with the approved procedure of the MoHP, as follows.

- Health facility teams will actively collaborate with NGOs and CBOs in rescue and rehabilitation programmes.
- People in need of rescue will be line listed through health facility outreach programmes and linkages with community informants and FCHVs.
- The treatment, referral and follow-up care of rescued patients will be supported in accordance with the programme operating procedure for the treatment and rehabilitation of homeless patients with mental disorders and psychosocial disabilities.

Quality management and rating

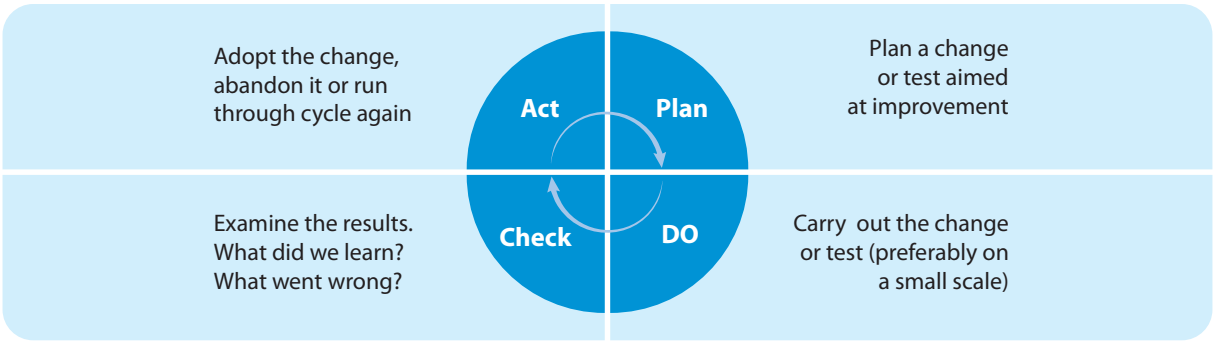
While scaling up the coverage of the programme, it is important to pay attention to the quality of mental health care to improve services, meet the public's rising expectations and gain the confidence of service users. It is vital to bring together management and quality assurance as part of a whole-health-facility approach and to engage the entire staff in improving the quality of care, and share accountability for health outcomes.

Health-care managers and the teams at health facilities will implement the PDSA cycle (Fig. 2) to identify the gaps in quality (problems or issues), undertake root cause analysis, and identify and implement solutions to address shortcomings in the delivery of mental health care.

The district and provincial health directors will take the same steps to improve the quality of care in their respective jurisdictions.

The quality of mental health services will use bench marking through rating of health facilities.

Fig 2: The Plan-Do-Check-Act (PDCA) Cycle



Source: based on Taylor et al., 2014

Rating of health facilities

Health facilities that obtain an adequate rating will be designated as Khulla Man health facilities. Building Khulla Man mental health services will be a gradual process. The health facility teams, health coordinators of the municipality, and directors and managers in the provinces and districts should work consistently to transform health facilities into Khulla Man facilities. A heath facility will be certified as a Khulla Man facility if it scores >80% on the assessment criteria shown in Box 5.

Box 5: Criteria for Khulla Man health facilities

Designated space for Khulla Man

- Patients' confidentiality is maintained.
  - The health facility has a private room with signages for mental health assessment and counselling.
  - Mental health promotion materials are displayed and distributed.
- Leaflets are available with guidance on self-care, stigma, help-seeking and community care.

Trained human resources available (20)

- At least two trained health workers/doctors are available in PHC centres and HPs throughout the year.
- The staff members have completed at least 4 clinical mentoring sessions with a specialist team through the onsite and online modalities.

Use of national training/protocol/guidelines (5)

- A physical copy of the national protocol is available at the prescriber's desk and there is evidence of the use of this protocol in clinical decision-making.

Uninterrupted, free supply of essential mental health medicines (5)

- Fluoxetine and risperidone are available in the health facility, with no stock-outs in the preceding 12 months.

Patients' rights always respected in service delivery (10)

- Materials on the rights of patients are clearly displayed and distributed.
- Service users are consulted and their feedback incorporated.

Initiative to improve quality (5)

- The team holds regular discussions on case management and these are well documented.

Coordination of referrals (5)

- The referral registers are well maintained and show evidence of coordinated referrals.

Regular reporting of provision of mental health service (10)

- An OPD register is maintained to reflect daily MNS cases.
- Monthly reports are submitted in a timely manner.

§Increase in case detection, adequate follow-up visits and improved outcomes (15)

- MH cases form 5% of the total caseload.
- One-third of the new cases come for follow-up.
- The condition of half of the follow-up cases improves.

Determining which is a Khulla Man facility

Determining whether a health facility is a Khulla Man facility is a neutral decision, taken by an independent team. However, provincial health authorities will be responsible for making the request for quality assessment of the health facility and facilitating the process of assessment.

Box 6: Steps in designation of health facilities as Khulla Man facilities

- The EDCD will request the Quality Assurance and Regulation Division (QARD) of the MoHP to commission a team to assess the performance of the health facility.
- QARD will form an assessment team of 5–7 members, consisting of an official from QARD and one from the EDCD, a MH expert, a representative of people with lived experience of mental illness, and CBO/NGO representatives.
- The team will submit a detailed report, containing recommendations.
- Once the health facility has been recognized as a Khulla Man facility, it will be issued a placard bearing its new designation and the signature of the MoHP.
- The duration of the designation will be two years. Thereafter, it will be renewed every two years, subject to the fulfilment of the criteria.
- The Provincial Health Directorate will share the findings and recommendations of the team.
- The Provincial Health Directorate will maintain an inventory of Khulla Man health facilities in the province, while the EDCD will maintain the national inventory.

Strengthening information system

Health facilities should have efficient data and information systems that allow health-care teams to share information about their contribution. Information is crucial for managers and decision-makers since it will give them an idea of the success of their efforts and enable them to make the corrections required. Information also plays a major role in helping community members and community leaders to understand the population's health status. It is important to collect valid data, make the data accessible and actionable, and act on the data.

The use of digital innovations, such as electronic reminders, electronic health records, app-based monitoring of patients and service coverage, will be introduced in an incremental manner to strengthen district mental health-care services.

The main actions that will be taken to strengthen health facility-based and programmatic information for mental health services are listed in Table 9.

Table 9: Steps to improve data collection and data systems

Actions by MoHP and provincial health departments	Actions for data collection at health facilities

• Standardize registries and record and reporting forms, and integrate data collection into the health information management system (HMIS).
  ◦ Collect monthly reports of new and follow-up cases, disaggregated by age and sex, at the health facility.
  ◦ Develop suicide registries and collect information on suicide and suicide attempts.
• Ensure the quality of data in health facility reports to the district and provincial levels at quarterly intervals.
• Analyse the data periodically to develop fact sheets and national status reports.
	• Maintain NCD and MH registers as required by the EDCD/HMIS.
	• Submit a monthly report according to the reporting format.
	• Maintain data on visits for home-based care.

Health facility-based dashboards

Khulla Man services will be reported against a set of key performance indicators (KPIs) by health posts, PHC centres and district hospitals. This information is a self-evaluation of the performance of health facilities and health system managers. A KPI dashboard will be set up at each facility and the information will be accessible to the staff and health-care teams of the facility.

Frequency of reporting and feedback

At the end of each month, the manager and team of the health facility will compile the facility report in accordance with the recording format and submit upstream in the system.

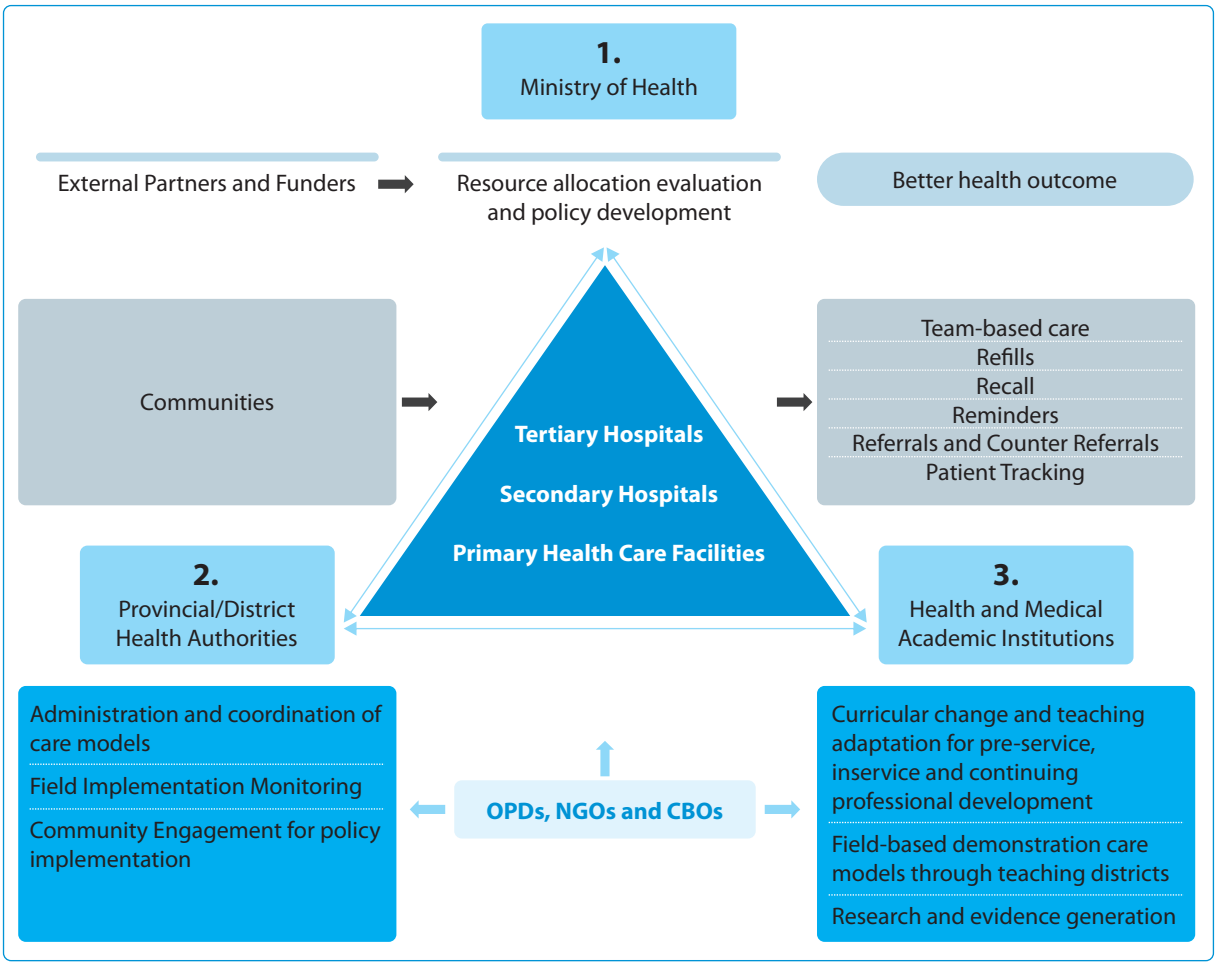
Fostering a "three-way" partnership for mental health care

In accordance with the Public Health Service Regulation 2020 and the National Mental Health Strategy and Action Plan 2020, academic institutions will support health facilities in the provinces and municipalities in the delivery of people-centred MH services through a tripartite partnership between the MoH, medical/health institutions and provincial/local health authorities. Academic institutions can transform themselves into capacity-building hubs by incorporating new skill sets for the management of MH services in the in-service curricula; educating the future health workforce in the formative stage; integrating Khulla Man into the existing "teaching district" concept; and teaching the new competencies of MH services to serve the needs of the programme at the district level. Faculty members themselves will attempt to generate evidence through implementation research to improve MH care.

The MoHP and provincial governments can replicate a series of training and capacity-building programmes on diverse areas of mental health to strengthen services across all levels of the health system.

Nongovernment organizations and CBOs play an important role in service delivery and community-based interventions for mental health. They will be engaged to partner with the provincial governments and academic institutions to complement services and attend to those areas which the government services are unable to address.

Fig. 3: Partnership model for implementation of district mental health care plan



Main steps for establishing three-way partnership

The MoHP, provincial health authorities and medical and health training institutions will collaboratively:

- establish a model for mental health-care services in teaching districts and transform these into national learning sites;
- include mhGAP resources and NHTC training manuals in the pre-service curricula;
- incorporate the mental health care model into the internship training of medical graduates (MBBS), nurses and HAs;
- establish a "community MH unit" in the psychiatry department of medical institutions and make provision for the rotation of trainee psychiatrists/ nurses/ psychologists at the district hospitals and primary care centres; and
- implement policy and practice relevant health systems research on MH care.

The MoHP and provincial governments will:

- support joint funding projects for the improvement of service delivery and for implementation research to generate local evidence.

NGOs and CBOs will:

- partner with the provincial authorities and municipalities and implement MH care, with a focus on community-level interventions; and
- contribute to designing rights-based MH services.
- The MoHP, provincial health directorates and academic institutions will:
- conduct annual joint reviews to take stock of the progress and plan for the next phase; and
- share the lessons learnt from the teaching district activities with policy-makers during annual academic consortia and workshops.

Main steps for establishing three-way partnership

The district mental health services will strive to embrace a performance-based culture, in which progress will measured by a set of specific, quantifiable key performance measures. These measures will give policy-makers, health managers and health-care teams an idea of the performance, and will also provide evidence to support claims related to the access to, quality of and coverage of services. The implementation of mental health services will be guided by the following measures at the facility, district/provincial levels.

Table 10: Key indicators of performance

Domain	KPI (health facility)	KPI (provincial/district level)
Availability of mental health care	• Number of days in last month that the health facility did not have at least one trained mental health-care provider • Number of days in last month that fluoxetine, risperidone or carbamazepine were out of stock	• Number and percentage of paramedics trained in the district • Number and percentage of MBBS doctors/ GP (MD) trained in the district • Number and percentage of health facilities with at least two trained service providers • Number of clinical supervision sessions organized in the district • Number of general hospitals (district level) with a daily MH OPD run by a mental health nurse • Number of general hospitals (district level) with a monthly OPD run by a specialist • Number of health facilities / hospitals that have reported "no-stock-outs" of fluoxetine, carbamazepine and risperidone in the past 12 months

Domain	KPI (health facility)	KPI (provincial/district level)
Access to care		• Percentage of population in the district that can reach a facility with MNS services within 2 hours • Number of MNS facilities / services per 100 000 population in the country
Quality of care	• Number of people who were receiving mental health care now lost to follow-up	• Number and percentage of trained health workers who have undergone at least 4 supervision sessions after training • Number of health facilities providing protocol-based care • Number of district hospitals supported by academic institutions
Coverage of services	• Number of new mental disorder patients enrolled and disaggregated by priority mental health conditions per month • Number of total cases (new and follow-up) enrolled every month and disaggregated by priority mental health conditions	• Number of priority mental health conditions who have received treatment from public or private mental health services in last 12 months/ number of mental and neurological disorders in the community
Community-based care	• Number of homebound patients visited by health-care team per month	• Total patients receiving homebound care visits in a quarter • Number of FCHVs oriented on mental health care
Mental health services through partnerships	• Number of visits to the health facility by staff of partner medical institution • Number of mental health events organized in partnership with CBOs and NGOs in the month	• Number of health facilities supported by academic institutions • Number of health facilities working in partnership with NGOs and CBOs for mental health care

Evaluation of the model of care

Implementation science will be used to test and evaluate the model of care. Implementation science can systematically identify facilitators and barriers, as well as the lessons that can help with the integration of mental health care into the PHC system.

Annexes

Annex 1. List of free essential mental health medicines

SN	
1	Tab chlorpromazine 100 mg
2	Tab amitriptyline 10 mg and 25 mg
3	Tab alprazolam 0.25 mg
4	Tab phenobarbitone 60 mg
5	Tab carbamazepine 200 mg and 400 mg
6	Inj. diazepam 2 ml
7	Tab risperidone 1mg and 2mg
8	Cap fluoxetine 10mg and 20 mg
9	Tab sodium valproate 200mg and 300 mg
10	Tab diazepam 2 mg and 5 mg
11	Tab trihexyphenidyl 2 mg
12	12. Tab thiamine 100 mg

Annex 2. Checklist for integrated supportive supervision and monitoring of NCD and MH services

For health post

Name of the health post: ..... **Date of visit: .....**

District: ..... **Province: .....**

Observations	Actions agreed upon by supervisor and supervisee
A. Administration and management	
A1. Are the teams for improving the quality of patient care formed in the health facility? ☐ Yes ☐ No ☐ Don't know Observation details:	
A2. Are discussions on improving the quality of NCD and MH care conducted monthly? ☐ Yes ☐ No ☐ Don't know Observation details:	
B. Logistics (medicines, supplies and equipment)	
B1. Are enough stocks of the following essential NCD medicines available (in stock) to cover the expected patient load in the health facility for 2 months?	

Name of the drug	Availability
Amlodipine	Yes ☐ No ☐
Hydrochlorothiazide	Yes ☐ No ☐
Enalapril	Yes ☐ No ☐
Furosemide	Yes ☐ No ☐
Aspirin	Yes ☐ No ☐
Metformin	Yes ☐ No ☐
Glimepiride	Yes ☐ No ☐
Statins	Yes ☐ No ☐
Salbutamol (DPI)	Yes ☐ No ☐
Aminophylline	Yes ☐ No ☐
Steroids (oral)	Yes ☐ No ☐
Nebulizer	Yes ☐ No ☐
Others (if available, mention)	

Psychotropic medicines	
Amitriptyline	Yes ☐ No ☐
Sodium valproate	Yes ☐ No ☐
Risperidone	Yes ☐ No ☐
Fluoxetine	Yes ☐ No ☐
Carbamazepine	Yes ☐ No ☐
Chlorpromazine	Yes ☐ No ☐
Diazepam	Yes ☐ No ☐
Thiamine	Yes ☐ No ☐
Trihexyphenidyl hydrochloride	Yes ☐ No ☐
Others (if available, mention)	

B2. Is the blood glucometer functioning and in use?

☐ Yes ☐ No ☐ Don't know

Reason if not in use:

B3. Are urine protein and urine ketone strips in use?

☐ Yes ☐ No ☐ Don't know

If not, why?

B4. Is the following essential equipment available and functional in health facilities?

Equipment	Availability
Sphygmomanometer	Yes ☐ No ☐
Weighing scale	Yes ☐ No ☐
Measuring tape	Yes ☐ No ☐
Stadiometer	Yes ☐ No ☐
Peak expiratory flow meter	Yes ☐ No ☐

If not, why?

B5. Are printed PEN protocols and flip charts available in the health facility in a manner that allows health-care workers to refer to them easily during patient care, e.g. the OPD desk?

☐ Yes ☐ No ☐ Don't know

If not, why?

B6. Is the WHO-ISH CVD risk prediction chart available and in use for patient care in the health facility?

☐ Yes ☐ No ☐ Don't know

If not available /not in use, why?

B7. Is a printed mental health treatment protocol and flip chart available in the health facility and is it kept in a place where health-care workers can easily refer to it during patient care, e.g. the OPD desk?

☐ Yes ☐ No ☐ Don't know

If not, why?

B8. Is the mhGAP Master Chart displayed in the examination room and is it used?

☐ Yes ☐ No ☐ Don't know

If not displayed/ used, why?

C. NCD and mental health service delivery

C1. Total number of health workers trained in NCD, MH and other areas

Designation		Number trained		
	Total staff	PEN	mhGAP	Other NCDs (VIA, STP, etc.)
HA				
Senior AHWs/ AHWs				
Senior ANMs /ANMs				
Others				

Reason:

C2. Are the following NCD services, as mentioned in PEN, provided to clients as per the protocol abs standards?

Services	
Blood pressure measurement of all clients above 40 years of age	Yes ☐ No ☐
Blood sugar measurement of all clients above 40 years of age	Yes ☐ No ☐
Body mass index measurement	Yes ☐ No ☐
Waist- circumference measurement	Yes ☐ No ☐
Cardiovascular disease risk estimation	Yes ☐ No ☐
Urine protein measurement of all clients above 40 years of age	Yes ☐ No ☐
Peak expiratory flow rate of chronic obstructive pulmonary disease and asthmatic clients	Yes ☐ No ☐
VIA services as per PEN protocol IV	Yes ☐ No ☐
Brief intervention using 5A and 5 R for tobacco cessation, unhealthy diet, alcohol intake and physical inactivity	Yes ☐ No ☐
For diabetes	
Urine ketone measurement	Yes ☐ No ☐
Foot examination	Yes ☐ No ☐
Oral examination	Yes ☐ No ☐
Counselling for eye examination	Yes ☐ No ☐
Health education for foot care advice	Yes ☐ No ☐

If not, why?

C3. Are clients offered the following mental health services?

Services	For Yes √, For No **X**
Prescription of psychotropic medicine by trained HWs according to mhGAP module- 2	Yes ☐ No ☐
Psychosocial counselling by health workers with mhGAP training	Yes ☐ No ☐
Refilling of prescriptions of psychotropic medicines by specialists	Yes ☐ No ☐
Number of days per week that mhGAP health-care providers are available for treatment of MNS disorders:	

If not, why?

C4. Is there an examination room that allows for confidentiality?

☐ Yes ☐ No ☐ Don't know

If not, why?

C5. Does the health facility provide any NCD and MH services to homebound patients?

☐ Yes ☐ No ☐ Don't know

If not, why?

C6. Does the health facility provide any community-based NCD and MH care?

☐ Yes ☐ No ☐ Don't know

If not, why?

C7. Does the health facility run any school-based programme for the prevention of NCDs and MH disorders and to promote MH?

☐ Yes ☐ No ☐ Don't know

If not, why?

C8. Does the health facility have a patient tracking mechanism, such as recall and reminder, for NCD and MH clients?

☐ Yes ☐ No ☐ Don't know

If not, why?

D. Health information

D1. Is the OPD register for NCD clients updated regularly?

☐ Yes ☐ No ☐ Don't know

If not, why?

D2. Is the OPD register for MH clients updated regularly?

☐ Yes ☐ No ☐ Don't know

If not, why?

D3. Is the information on NCD and MH dashboard updated?

☐ Yes ☐ No ☐ Don't know

If not, why?

D4. Is the monthly reporting form sent to the authority concerned?

☐ Yes ☐ No ☐ Don't know

If not, why?

D5. What is the number of people who sought NCD services in the preceding month?

D6. What is the number of people who sought MH services in the preceding month?

D7. Is there a dedicated focal person for the NCD and MH programme?

☐ Yes ☐ No ☐ Don't know

If not, why?

E. Integration of NCD services

E1. Are most health workers and units of the health facility aware of the purpose of the PEN programme?

☐ Yes ☐ No ☐ Don't know

If not, why?

E2. Are most health workers and units of the health facility aware of the purpose of the mhGAP programme?

☐ Yes ☐ No ☐ Don't know

If not, why?

E3. Is health education on tobacco, alcohol, unhealthy diet and physical activity provided at the antenatal and postnatal clinics?

☐ Yes ☐ No ☐ Don't know

If not, why?

E4. Are patients screened for raised blood pressure and raised blood sugar at the antenatal clinic?

☐ Yes ☐ No ☐ Don't know

Reason:

F. Overall observations and summary

F1. How would you rate the overall performance in NCD management on a scale of 1–10, 1 being the poorest and 10 excellent?

F2. How would you rate the overall performance in MH management on a scale of 1–10, 1 being the poorest and 10 excellent?

F3. Write a clear summary of recommendations made by a supervisor to a supervisee, to be implemented within an agreed fixed time.

G. Signatures

Supervisor:	Representative of health facility:
Date/month/year	Date/month/year

World Health Organization

Nepal