

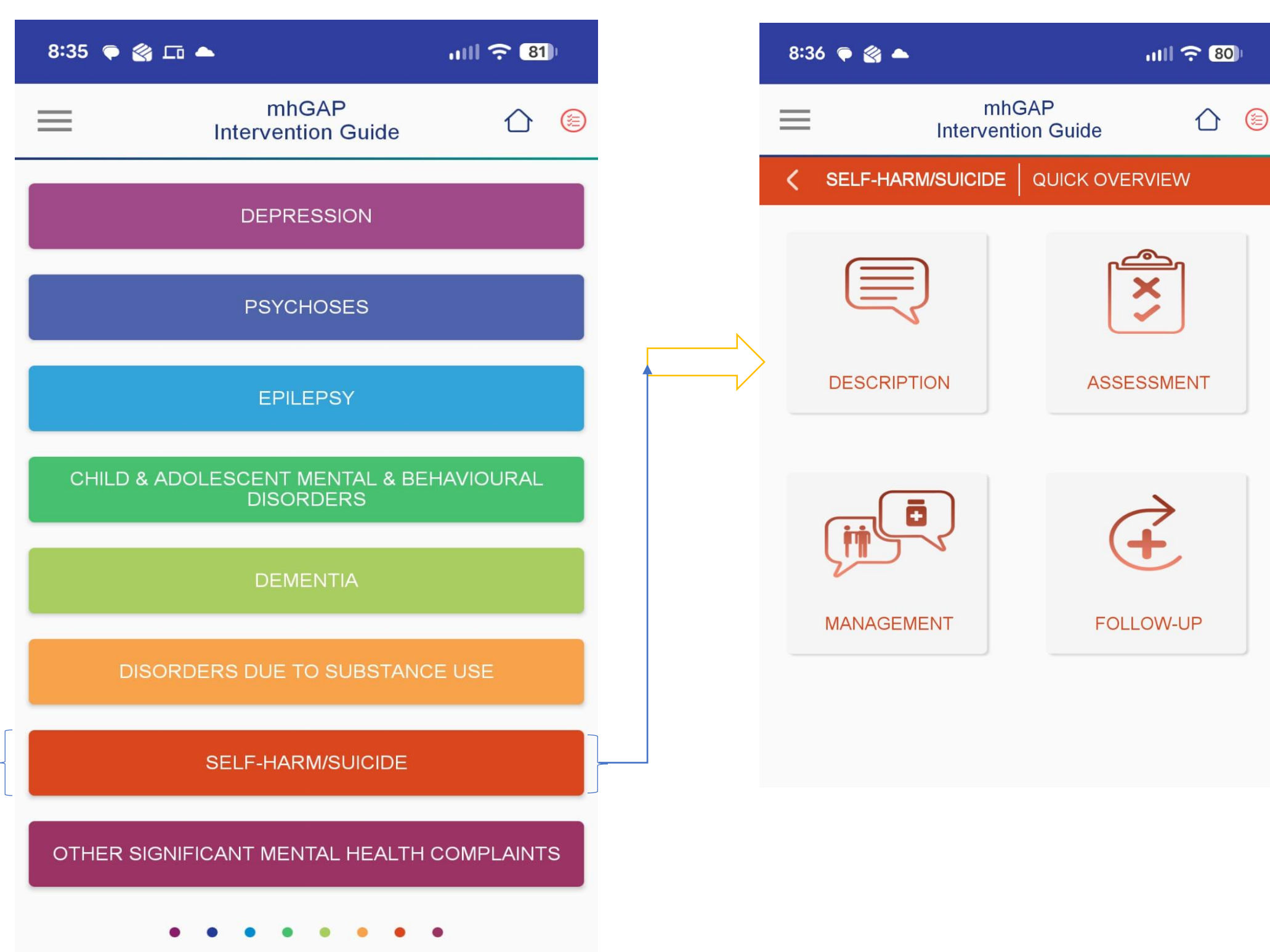
"It's hard to ask those questions": Evaluating Implementation of mhGAP Suicide Protocols in Rural Nepal

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BACKGROUND

- Southeast Asia has the highest global suicide rate (17.7 per 100,000).
- Suicide drivers and experiences remain underexplored in non-Western contexts (Hagaman et al., 2017).
- In Nepal, studies show high rates of suicidal ideation (up to 14.8%) and attempts (up to 7.4%) in health facilities, but low disclosure and help-seeking (Jordans et al., 2017).
- WHO mhGAP is used in 90+ countries, yet provider-level evidence on suicide care is limited (Robles & Lopez-Garcia et al., 2019).



OBJECTIVE

- Explore provider-level barriers and facilitators to implementing mhGAP suicide modules in primary care, to inform new implementation strategies

METHODOLOGY

- RAPICE (Rapid Assessment Procedures Informed Clinical Ethnography)
- CFIR Framework

14 IDIs
mhGAP-trained
Primary Care
Providers

2 FGDs
15 Community
Health Workers
(CHWs)

3 Day Ethnographic
Observation of 4 health
facilities

Setting & Data Collection Timeline: Rural District, Nepal (January, 2025 – May, 2025).



Pic. 1 One of the health facilities participated in the study

FINDINGS

1. OBSERVED IMPLEMENTATION GAP

- Suicide risk is rarely assessed, even when patients show clear signs of psychological distress.
- Consultations focus on physical symptoms, with little or no attention to mental health.
- Providers report “no cases,” but observations show missed potential cases.



Pic. 2 Interior of one of the healthcare facilities

2. BARRIERS

1. Patient Disclosure Mismatch & Limited Awareness of Available Services (Outer-Setting)

"I live in the same community... If even I didn't know about it (the mental health services), then how could others possibly know? That made me reflect a little, it really struck me."
CHW, FGD 1

2. Discomfort Asking Directly (Individual)

"When people come with mental stress, it's difficult to ask, 'Do you feel like dying? Do you feel like committing suicide?' It's challenging to ask these questions."
Female, 32 years, PCP

3. Stigma & Fear of Reaction ("Jangine") (Individual)

"I think it is difficult because people might get aggressive (jangine)... They might say 'why are you asking me this question, do you think I will do suicide?'"
Male, 25 years, PCP

4. Skill Decay (Inner-Setting)

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

5. Systemic and Operational Barriers (Inner-setting)

- **Unavailability of medicine:** Many providers believed that the unavailability of medicines made the implementation of mhGAP impossible.
- **Infrastructure Gaps:** Many health posts lack private rooms, meaning consultations often happen within earshot of other waiting patients.
- **Competing Priorities:** Personal priorities and reporting burdens crowd out assessment time.
- **Lack of Technical Support:** Following initial training, there is a distinct lack of ongoing supervision, refresher courses, or implementation support.

"To start this we don't have anything that is in place like there are no medicines available, no separate rooms screen/curtain (parda), and training to all health care providers."
Female, 25 years, PCP

3. IMPLEMENTATION FACILITATORS

Indirect, Culturally-Adapted Questioning

Framing suicide questions indirectly and in locally resonant language eases discomfort.

Rapport-Building

Grounding suicide conversations in an established provider-patient relationship.

Safety-Plan Protocols

Structured management protocols for identified high-risk patients.

Task-Shifting to CHWs

Engaging Community Health Workers for follow-up and monitoring.



Pic. 3 CHW on one of their field-visits

CONCLUSIONS

Care models should shift from waiting for patient self-disclosure to routine, proactive screening, supported by ongoing supervision and structured tools beyond classroom training. Community-facing awareness campaigns are also essential to increase visibility of services and reduce stigma.