Field Implementation of the 2021 mhGAP-HIG Capacity Building Project: A Case Study

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List of Acronyms

AHA	Africa Humanitarian Action
AICHM	Africa Inland Church Health Ministries
ARRA	Administration for Refugee and Returnee Affairs
COOPI	Cooperazione Internazionale
COP	Community of practice
HI	Humanity and Inclusion
HRI	HealthRight International
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International non-governmental organization
IOM	International Organization for Migration
IRC	International Rescue Committee
KII	Key informant interview
LNGO	Local non-governmental organization
M&E	Monitoring and evaluation
mhGAP-HIG	mhGAP Humanitarian Intervention Guide
mhGAP-IG	mhGAP Intervention Guide
MHPSS	Mental health and psychosocial support
MHPSS TWG	Mental health and psychosocial support technical working group
MHPSS WG	Mental health and psychosocial support working group
MNS	Mental, neurological and substance use
MOH	Ministry of Health
MOU	Memorandum of understanding
MSF	Medecins Sans Frontieres
NFI	Non-food items
OFDA	Office of US Foreign Disaster Assistance
PFA	Psychological first aid
PHC	Primary healthcare
PM+	Problem Management Plus
SH+	Self-help Plus
SPANS	Society for Pre and Post Natal Services
SSSD	Syrian Society for Social Development
TNA	Training needs assessment
TOT	Training of trainers
TOTS	Training of trainers and supervisors
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WHO	World Health Organization

Acknowledgements

1. Executive Summary

1.2 Introduction

In October 2020, International Medical Corps launched a two-year project to strengthen organizational capacity for delivering mental health and psychosocial support (MHPSS) services in humanitarian settings through training and mentoring in the implementation of Mental Health Gap Action Program Humanitarian Intervention Guide (mhGAP-HIG). The virtual mhGAP-HIG training workshop and subsequent technical support aimed to develop capacity in two ways: a) train humanitarian workers in using the mhGAP-HIG, and b) improve the utilization of mhGAP-HIG and associated tools within humanitarian health programming for effective operationalization (including monitoring, supervision, organization of services and integration into existing systems of care). The overall objective of this case study is to review and document the field implementation of the mhGAP-HIG Capacity Building project.

1.3 Methodology

Following a rigorous selection process, a total of 24 participants (8 female, 16 male) enrolled in the mhGAP-HIG Capacity Building program, representing 17 countries across Africa, the Middle East, Southeast Asia and Latin America. They represented 11 LNGOs and 10 INGOs. Before implementation of the workshop, we conducted a training needs assessment (TNA) to learn more about the organizational and individual needs for mental health integration knowledge and experience, and ensure that the training would meet the needs of the participants. The capacity building project first required that participants complete a six-module pre-workshop preparatory e course designed to introduce the basics of mhGAP-HIG for participants who had not yet attended training, so that all participants were prepared and confident to undertake the Training of Trainers and Supervisors (TOTS) workshop. Thereafter, participants engaged in an eight-week virtual workshop followed by six months of technical support, supervision and mentoring provided by the International Medical Corps Capacity Building Specialist to support mhGAP-HIG rollout within the participants' organizations or their partner organization(s).

We collected data on mhGAP-HIG rollout within organizations through various means, including workshop participants' training reports detailing the implementation of mhGAP-HIG training to healthcare providers within their or their partner organization(s); completion of supervision checklists that enabled a structured and systematic approach to assessing how trainees were applying the knowledge and skills taught during the mhGAP-HIG rollout training; recording the number of beneficiaries assessed and managed by the trained mhGAP-HIG health service providers on a monthly basis using a morbidity data collection form; and a supervision log maintained by the International Medical Corps Capacity Building Specialist that documented not only the date and time of each supervision encounter with workshop participants, but—more importantly—the content discussed and guidance provided.

The case study was based on data derived from key informant interviews (KIIs) and a survey. KIIs were implemented at the conclusion of the six-month technical support and mentoring phase of the implementation, with workshop participants and one healthcare staff member who they trained. In addition, at the completion of the project implementation period, workshop participants were also invited to complete a survey, administered through

SurveyMonkey, to provide information on the status of key activities related to mhGAP-HIG field implementation.

1.4 Results

The results section of the report provides information on workshop participants' and their organizations' mhGAP-HIG implementation activities, including conducting a situation analysis or comprehensive MHPSS assessment, developing an implementation plan, coordinating MHPSS activity and advocating for it with key stakeholders, fundraising to support continued mhGAP-HIG implementation, building the capacity of health workers, strengthening health system activities, raising awareness about MHPSS, monitoring and evaluating, and planning for sustainable mhGAP-HIG implementation. In addition, this report provides a detailed analysis of the mhGAP-HIG field implementation experiences of five diverse organizations: Africa Humanitarian Action (AHA; South Sudan), BRAC (Bangladesh), HealthRight International (HRI; Uganda), Malteser International (Myanmar) and Syrian Society for Social Development (SSSD; Syria). These organizations were specifically selected to ensure inclusion of both INGOs and LNGOs, gender balance in terms of trainees and geographic representation, and a representation of relevant experiences and information related to the spectrum of activities involved in mhGAP-HIG implementation. Lastly, the report presents aggregated morbidity data, which provides mhGAP-HIG mental, neurological, and substance use (MNS) conditions by sex and age groupings (e.g., younger than 18 years old, 18 years and older) and the scope of the impact of mhGAP-HIG capacity building by identifying the number of clients served by MNS conditions.

1.5 Project Successes

A review of the collected data indicated that project was successful in a number of key areas related to mhGAP-HIG capacity building and rollout:

1. The preparatory mhGAP-HIG e-course was effective in creating a foundation for the eight-week capacity building workshop.
2. Virtual capacity building in mhGAP-HIG is not only feasible but successfully builds both knowledge and skills in mhGAP-HIG and its implementation within organizations.
3. The six-month tailored mentoring and technical supervision provided important support and guidance for successful mhGAP-HIG field implementation.
4. The M&E tools (e.g., supervision checklist, morbidity data form) were identified as being easy to use. The supervision checklist was helpful in the ongoing assessment of trainee capacity development, in identifying areas for additional technical support and in informing the development competency-based capacity building plans. The morbidity data form enabled organizations not only to collect data on the number of beneficiaries presenting with mhGAP-HIG MNS conditions separated by gender and age (e.g., younger than 18 years, 18 years and older) and thereby tailor their services, but to also assess trainee skills development in the identification of MNS conditions.

1.6 Challenges and Lessons Learned in mhGAP-HIG Field Implementation

The data collected identified challenges as well as a number of important lessons related to mhGAP-HIG field implementation:

1. Workshop participants' mhGAP-HIG implementation plan goals were too ambitious for the implementation period and included large target numbers for primary healthcare

(PHC) providers trained, for service users and for the completion of the supervision of trained PHC providers in a short period of time.

2. For some organizations, the M&E plan included inappropriate means of verification. There also was a lack of alignment with the implementation plan in that not all proposed activities had corresponding indicators and targets.

3. A lack of financial, logistical and/or human resources hindered organizations' mhGAP-HIG capacity building training implementation.

4. The selection of training participants resulted in specific capacity building challenges. For example, training professionals with varied backgrounds resulted in difficulties with adapting the training to meet the training needs of all participants, and including trainees from various organizations created challenges in terms of providing follow-up and supervision, including the need to travel to multiple supervisee sites and the travel time involved.

5. Workshop participants requested specific guidance related to the implementation of remote supervision and the use of M&E tools.

6. Stakeholder priorities and lack of support affected the implementation of mhGAP-HIG capacity building trainings.

7. Challenges in the availability of psychotropic medication had implications for the implementation of mhGAP-HIG pharmacological interventions within health facilities.

8. Socio-political factors (e.g., COVID-19, political instability) and cultural factors (e.g., stigma associated with mental illness) affected the implementation of mhGAP-HIG within health facilities and created challenges in access to services.

9. Inadequate infrastructure, including inferior roads and poor internet connectivity, resulted in challenges in the delivery of in-person and remote supervision.

10. Some workshop participants did not engage in the technical support requirements for the capacity building project. Seven workshop participants failed to meet the supervision and mentoring requirements of the project and either did not attend the supervision and/or community of practice (COP) webinars, or only attended a limited number, all of which were important components of the capacity building and field implementation aspects of the project.

1.7 Recommendations

1. mhGAP-HIG capacity building training recommendations
   - Consider the advantages and disadvantages of future in-person and remote mhGAP-HIG capacity building training, as some participants reported a preference for in-person training.
   - Continue implementation of the six-module preparatory mhGAP-HIG course.
   - Provide additional teaching and training on the supervision tools, and specific training on providing remote supervision.
   - For workshop participants who do not have a medical background, identify an appropriate co-facilitator who can train on mhGAP-HIG pharmacological interventions as early as possible in the capacity building workshop (e.g., during implementation of the TOTS) so as to prevent potential delay in mhGAP-HIG rollout.
   - Consider implementing refresher training for workshop participants that includes not only the relevant topics and skills that should be reviewed to further capacity development, but also examines challenges in mhGAP-HIG field implementation that can be addressed through additional technical support.

- Consider a regional approach for future mhGAP-HIG capacity building workshops, as this may facilitate adapting the training to a particular culture and context, and allow for the training to take place in participants' native language, thereby making it more accessible.

2. Supervision and the community of practice recommendations
- Consider making supervision and COP webinar participation an explicit and compulsory component of the mhGAP-HIG capacity building project, to improve participation.
- Continue use of the supervision checklist, as it provides a structured and systematic approach in assessing trainee capacity development and in informing the development of competency-based supervision plans.

3. mhGAP-HIG field implementation recommendations
- Continue use of the implementation plan to support mhGAP-HIG field implementation, as it guided workshop participants in developing an implementation framework that included specific activities and an anticipated timeline for the clinical and operationalization components of mhGAP-HIG implementation.
- Continue disseminating the mhGAP-HIG training slides to workshop participants, who reported these were helpful for their own training sessions, while International Medical Corps noted that the majority of participants had adapted and translated the slides.
- Continue implementation of the training needs assessment, role plays, case simulations and case examples from the field.
- Ensure that workshop participants are developing a realistic mhGAP-HIG training agenda, through supervision and technical support.
- Develop a competency-based supervision plan in collaboration with trainees that details frequency and duration of supervision, mode of communication (e.g., in-person, online, phone) and modality (e.g., group, individual) in addition to capacity development goals. The plan should be shared with the International Medical Corps Capacity Building Specialist for review and feedback.
- Train on mhGAP-HIG conditions that are addressed through psychosocial interventions (e.g., acute stress, grief and other significant mental health complaints) in contexts where psychotropic medication is limited or inaccessible.
- Continue use of the morbidity data collection form, as it provides data on presenting mhGAP-HIG MNS conditions that organizations can use to tailor their interventions. Furthermore, the data represent the scope of the impact of mhGAP-HIG capacity building, in that it identifies number clients served by MNS conditions.
- Consider implementing a formal memorandum of understanding and regular briefings with workshop participants' organizations, to promote continued support for and investment in the mhGAP-HIG Capacity Building project.

2. Background to the Project

Mental health conditions affect one in four people during their lifetime, and populations in humanitarian contexts are especially at risk, due to increased exposure to violence and adversity; loss of homes, livelihoods and social support systems; and stressors related to displacement. The availability of mental health professionals qualified to offer vital MHPSS services remains a critical gap in humanitarian settings. A key strategy for addressing this treatment gap involves integrating mental health care in general healthcare, and training non-mental health specialists to offer psychosocial and basic psychological support, and to manage priority mental health conditions.

The "Strengthening Organizational Capacity for Delivery of Mental Health and Psychosocial Support Services in Humanitarian Settings through Training and Mentoring" project was funded by USAID's Bureau for Humanitarian Assistance (BHA), building on previous efforts led by the World Health Organization (WHO), with International Medical Corps as a partner and the United Nations High Commissioner for Refugees (UNHCR) supporting the implementation of the capacity building workshop. Its goal is to boost leadership and the capacity to implement integrated mental health programs in emergencies within humanitarian organizations.

In 2015, WHO and UNHCR released the mhGAP Humanitarian Intervention Guide (mhGAP-HIG) and in 2018 an mhGAP Operations Manual to support its rollout. Also in 2018, International Medical Corps, in collaboration with WHO and other agencies, released an accepted framework for mental health integration, and an online toolkit for integrating mental health programs in general healthcare in humanitarian settings, to strengthen operationalization beyond the clinical capacity component. The framework was intentionally designed to reinforce and complement the guidance provided in the mhGAP Operations Manual.

In October 2020, International Medical Corps launched a two-year project to strengthen organizational capacity for delivering MHPSS services in humanitarian settings through training and mentoring. The project built on International Medical Corps' previous work with mental health integration efforts utilizing the WHO mhGAP program approach, and including mhGAP-HIG and complementary resources. The training workshop and technical support aimed to develop capacity in two ways: 1) train humanitarian workers in using the mhGAP-HIG, and 2) improve the utilization of mhGAP-HIG and associated tools within humanitarian health programming for effective operationalization (including monitoring, supervision, organization of services and integration into existing systems of care).

The eight-week virtual workshop covered: a) mhGAP-HIG project design and service implementation; and b) mhGAP-HIG TOTS in clinical assessment and management of MNS conditions. The workshop was followed by a six-month capacity building phase in which trainees implemented mhGAP-HIG within their organizations or partner organizations, with tailored mentoring and technical supervision from International Medical Corps to support successful mhGAP-HIG rollout. In addition, to facilitate peer exchange and learning, COP webinars were held throughout this phase for the trainees to share lessons learned among each other, and to learn best practices on various aspects of MHPSS programming and mhGAP implementation from experts in the field.[1]

3. Methodology

3.1 mhGAP-HIG Training of Trainers and Supervisors Methodology

3.1.1 Participant selection

In January 2021, the project team released a global announcement introducing the 2021 mhGAP-HIG Capacity Building Workshop, detailing the criteria and qualifications for participation, and soliciting applications through an online form. Outreach resulted in nearly 240 applications from various organizations around the world.

The project team conducted participant selection through a two-step process. In the first round, a brief application form gauged organizational capacity, experience, commitment and dedicated funding for integrating mhGAP-HIG into organizations' programs and services. Through this step, the project team identified 23 promising organizations. The shortlisted organizations were then contacted to propose one to two participants who met the minimum selection criteria and addressed the following points in the second-round application form.

- All nominated candidates were required to be mental health professionals, possessing an advanced degree in one of the following: psychology, counselling, social work, psychiatric nursing or another related mental health field. Medical doctors were required to possess training in psychiatry. This requirement was based on the lessons learned from the previous workshops, to ensure that all participants would have a baseline understanding of mental health care, and be able to successfully undertake training of trainers on clinical modules.

- All nominated candidates were required to have a general level of English proficiency (both verbal and reading), as the workshop would be conducted in English only, with no synchronous translation available, due to the virtual format and other constraints.

- A draft mhGAP-HIG rollout plan was requested, which would include building capacity of general healthcare workers in nonspecialized health settings in humanitarian contexts to close the mental health treatment gap.

- Applicants were asked to submit documentation to ensure the proposed rollout went beyond just training staff or partners, and indicated a clear plan to integrate mhGAP-HIG into their own or into partners' ongoing health or health-focused programs in the July to December 2021 timeframe, as this was an integral component of the post-workshop capacity building phase.

- Applicants were asked to demonstrate organizational leadership commitment and support for their participation, and the post-workshop rollout and integration of mhGAP. They needed to confirm that either existing or anticipated funds and other resources were in place to implement the integration of mhGAP-HIG.

- Unlike previous similar initiatives that tended to focus on international non-governmental organizations (INGO), which typically have substantial financial and technical resources, this project prioritized engaging participants from local non-governmental organizations (LNGOs), to ensure local ownership, sustainability and organizational strengthening, and to enable learning related to mhGAP-HIG implementation by LNGOs. These organizations were identified through outreach to local partners of UN agencies and INGOs.

Twenty-four participants (8 female, 16 male) enrolled in the program, representing 17 countries across Africa, the Middle East, Southeast Asia and Latin America. They represented 11 LNGOs and 10 INGOs. The following table represents the list of participating organizations.

Table 1: List of Participating Organizations

Organization Local NGOs	Number of participants	Organization International NGOs	Number of participants
1. Africa Humanitarian Action* (Rwanda & South Sudan)	2	1. Action Against Hunger (Bangladesh)	1
2. AIC Health Ministries (Kenya)	1	2. COOPI (Niger)	1
3. Al-Birr (Syria)	1	3. HealthRight International (Uganda)	1
4. ARRA (Ethiopia)	1	4. Humanity & Inclusion (Yemen)	2
5. Belize West Regional Hospital	1	5. IOM (Bangladesh)	1
6. BRAC (Bangladesh)	1	6. IRC (Libya & Somalia)	2
7. Red Cross Kenya	1	7. Malteser International (Myanmar)	1
8. Society for Pre and Post Natal Services (Zimbabwe)	1	8. Medecins du Monde France (Nigeria)	1
9. Syrian Society for Social Development	1	9. MSF Paris (Libya)	1
10. Tanzania Red Cross Society	1	10. World Vision (DRC)	1
11. Viyan Organization* (Iraq & Syria)	1	—	—
Total LNGO participants	**12**	**Total INGO participants**	**12**

AHA began as a local NGO in Rwanda and Viyan as a local NGO in Iraq.

3.1.2 Workshop implementation

Before implementation of the workshop, we conducted a training needs assessment (TNA) to learn more about the organizational and individual needs for mental health integration knowledge and experience, and to ensure that the training would meet the needs of the participants.

Due to the COVID-19 pandemic, the mhGAP-HIG Capacity Building workshop was adapted to a virtual format and conducted online over an eight-week period between April 19 and June 9, 2021. Each week, two live Zoom sessions of about 1.5–2 hours were held. The rest of the content was shared with participants asynchronously through the Instructure Canvas e-learning platform, requiring participants to devote another 1.5–3 hours on self-guided asynchronous learning, discussion boards, and group and individual assignments.

The workshop integrated the following practices and activities to support learning.

- Training methods and skills:
  - An overview of training methods and guidelines was provided, including on basic training preparation and delivery skills, selecting participants and common challenges faced by trainers.
  - To ensure that all participants had equal opportunity to practice skills in designing and delivering training, participants were contacted one week before the start of the workshop, assigned a clinical module and asked to prepare a 10-minute training activity in how they would teach their assigned module to others.

- Given the time limitation during the live sessions, case simulations were conducted asynchronously as individual or group homework assignments. In live sessions, 30-minute introductions by the trainers were given, to provide an overview of the case simulation topics and explain the instructions. Participants were assigned at the beginning to groups in which they remained for the duration of the six weeks.

- Role playing was incorporated by trainers, to increase engagement.

- Based on a mid-term pulse-check survey, optional "office hours" were introduced during which participants could virtually "drop in" and ask questions.

- Clear instructions and ample lead time were provided to participants to prepare for TOTS, case simulations and other activities.

- Clinical and implementation modules were linked, to round out the learning experience.

- Participants were assigned to groups based on diverse backgrounds (professional background, experience with mhGAP, prior training experience, etc.), to facilitate peer-to-peer learning.

In previous mhGAP-HIG Capacity Building workshops, many selected participants had no prior training or experience with mhGAP-HIG. As a result, International Medical Corps decided to implement an innovative pre-workshop preparatory phase designed to introduce the basics of mhGAP-HIG for participants who had not yet attended relevant training, so that all participants were prepared and confident to undertake the TOTS workshop. The preparatory phase was conducted online and took place between March 29 and April 18, 2021. This six-module preparatory e-course, accessed through the Instructure Canvas e-learning platform, was self-guided and self-paced. Participants completed the course on their own time, within three weeks of the start of the main workshop. The e-course modules included weekly lectures in the form of brief pre-recorded videos, flash cards, quizzes and discussion boards. In addition, participants were given the option of joining weekly live sessions via Zoom to participate in discussions in lieu of responding to the discussion boards on the e-learning platform.

3.1.3 Test of participant knowledge

Participants were asked to complete pre-test (after completion of the preparatory phase and before Session 1 of the workshop) and post-test (following the final session) questionnaires measuring knowledge of clinical, theoretical and implementation components of mhGAP-HIG. The tests were conducted online via SurveyMonkey, and designed with both multiple choice and fill-in-the-blank or open-format response items. The test, which included four items on mental health integration, tested knowledge of implementation (described in the International Medical Corps Toolkit and mhGAP Operations manual), and contained 13 multiple choice items on clinical components of mhGAP-HIG, two case examples where

participants needed to correctly identify the mhGAP-HIG condition and five items measuring perceived confidence and skills in mhGAP-HIG. Participants displayed significant increases (+13%) in knowledge from pre-test (M =74%) to post-test (M = 84 %), with particular gains noted for questions addressing the planning and implementation of mhGAP-HIG and identification and management of mhGAP-HIG conditions.

3.1.4 Workshop evaluation

Participants completed a workshop evaluation in which they were asked to rate each training component on a Likert-scale out of 10 points, and were also invited to provide, through an open-response format, suggestions for improvements to content and delivery of course material. The questionnaire was administered online via SurveyMonkey, and the responses were collected anonymously. Nearly 80% of the participants (19 out of 24) responded to the workshop evaluation survey and, overall, participants rated the course on average as 9 out of 10.

3.2 mhGAP-HIG Implementation Methodology

The mhGAP-HIG Capacity Building workshop was followed by a six-month capacity building phase in which organizations implemented mhGAP-HIG with tailored mentoring and technical supervision from International Medical Corps to support successful mhGAP-HIG rollout and broader mental health integration efforts. Mentoring and technical supervision were provided by the International Medical Corps Capacity Building Specialist—a psychiatrist with extensive and long-term experience in mhGAP rollout.

3.2.1 Implementation plans

As a first step to facilitate mhGAP-HIG implementation, each trainee developed an action plan for mhGAP-HIG training and supervision rollout to general healthcare providers, as well as a plan for the operationalization of mhGAP-HIG in their organization or their partner organization(s). Both plans were key in helping trainees develop an implementation framework that included specific activities and an anticipated timeline for the clinical and operationalization components of mhGAP-HIG implementation.

The action plan addressed key aspects of training and supervision implementation. These included determining the need for mhGAP-HIG training, a description of the trainer's professional background, the number and professional background of trainees and the time period for training and supervision. The operationalization plan addressed the following aspects related to the successful integration of mhGAP-HIG into the trainee's organization or their partner organization(s): conducting a situation analysis, adaptation of materials, establishment of an operations team, advocacy, coordination with other stakeholders and fundraising to support sustainable mhGAP-HIG implementation. The International Medical Corps Capacity Building Specialist reviewed and provided feedback and guidance on both the action plan for mhGAP-HIG training and supervision, and the plan for the operationalization of mhGAP-HIG in organizations.

3.2.2 Supervision, community of practice and ongoing technical support

Shortly after the conclusion of the mhGAP-HIG Capacity Building workshop, the International Medical Corps Capacity Building Specialist facilitated a supervision launch meeting to orient the trainees to the mhGAP-HIG implementation phase. The orientation session supplemented the workshop module on supervision, and reviewed existing guidance tools on supervision for mhGAP-HIG and mental health integration efforts (e.g., WHO mhGAP-

HIG, WHO mhGAP Operations Manual, International Medical Corps' Mental Health Integration Toolkit and IFRC's Clinical Supervision: The Missing Link) and the goals of mhGAP-HIG supervision. It also provided an overview of models of supervision, and discussed in-person and virtual supervision and best practices in supervision, including addressing supervision challenges. Lastly, the meeting also provided trainees with an overview of the technical assistance available to them during the six-month capacity building phase, and expectations related to their attending supervision and COP webinars. Trainees were incentivized to complete these capacity building requirements with the opportunity to receive a certificate confirming their participation in the supervision phase.

All trainees received one-on-one-supervision on an as-needed basis from the International Medical Corps Capacity Building Specialist from July 1 until December 31, 2021. Most trainees received an average of four supervision sessions. The goal of supervision was to help participants practice skills learned during the workshop on training general healthcare providers, and with operationalizing mhGAP-HIG in their selected settings. Questions addressed were related to seeking guidance on implementing mhGAP-HIG training and supervision (particularly related to providing remote supervision), the completion of M&E tools, and the supervision checklist and context-specific challenges (e.g., how to manage a large volume of cases, lack of organizational support for the implementation of mhGAP-HIG training, lack of funding to support training implementation).

In addition, to facilitate peer exchange and learning, COP webinars were held throughout this phase for trainees, enabling them to share lessons learned and learn best practices on various aspects of MHPSS programming and mhGAP implementation from experts in the field. Six COP webinars were implemented on the following topics:

1. Addressing critiques and divergent perspectives about mhGAP;
2. Improving access to psychosocial and psychological interventions;
3. Remote consideration in training and supervision;
4. Strengthening community-based MHPSS referrals and follow-up for more effective MHPSS services;
5. Strengthening mental health services at the community level; and
6. Supervision challenges and best practices.

Trainees were expected to attend a minimum of three COP webinars and complete a minimum of four supervision sessions to meet the requirements of the project and receive a certificate of completion.

3.2.3 Implementation data collection
Data on the implementation of mhGAP-HIG within organizations was collected through various means:

1. Workshop participants submitted training reports detailing their implementation of mhGAP-HIG training to healthcare providers within their or partner organization(s).
2. Workshop participants completed a Supervision Checklist document following each supervision meeting with their trainee(s). The checklist, a newly implemented tool that was not used in previous mhGAP-HIG capacity building workshops, is a competency-based assessment tool that allows for a structured and systematic way to assess how trainees are applying the knowledge and skills taught during the mhGAP-HIG training. It evaluates clinical competency (e.g., communication, assessment, management and referral skills) and assesses various aspects of MHPSS integration (e.g., community

sensitization activities, integration of psychotropic medications in pharmacy, MHPSS documentation tools integrated into recordkeeping, promotion of human rights). The checklist identified gaps and areas for additional learning and skills-building, and enabled users to monitor for overall capacity development over the course of the implementation phase. Participants shared this supervision data with the International Medical Corps Capacity Building Specialist.

3. Workshop participants recorded the number of beneficiaries assessed and managed by the trained mhGAP-HIG health service providers on a monthly basis, using a morbidity data collection form. The form detailed the number of beneficiaries presenting with mhGAP-HIG mental health conditions, separated by gender and age (e.g., younger than 18 years old, and 18 years and older).

4. The International Medical Corps Capacity Building Specialist maintained a supervision log that documented not only the date and time of each supervision encounter with workshop participants, but—more importantly—the content discussed and guidance provided. The log therefore served as one record of challenges, barriers, successes, trainee questions and guidance provided related to implementation.

3.3 Case Study Methodology

3.3.1 Case study objective and questions

The overall objective of the case study is to review and document the field implementation of the mhGAP-HIG capacity building program. The case study reviews data collected for all activities relevant to mhGAP-HIG implementation, including MHPSS system strengthening, advocacy, mhGAP-HIG rollout training, mhGAP-HIG supervision, community-based activities such as awareness raising, and MHPSS service delivery.

The case study seeks to specifically address the following two questions while generating recommendations for future mhGAP-HIG capacity building and implementation initiatives.

1. To what extent did mhGAP-HIG capacity building activities lead to improved coverage and quality of mhGAP-HIG services implemented in new or ongoing responses?

2. What unique needs and challenges face both INGO and LNGOs in implementing mhGAP-HIG?

3.3.2 Case study data collection

The case study reviews all data collected from participating organizations to document challenges and lessons learned related to mhGAP-HIG field implementation and to generate recommendations. However, five diverse organizations in particular were selected to inform the case study: Africa Humanitarian Action (AHA, South Sudan), BRAC (Bangladesh), HealthRight International (HRI, Uganda), Malteser International (Myanmar) and Syrian Society for Social Development (SSSD, Syria). Selection criteria focused on including INGOs and LNGOs, on gender balance in terms of trainees, on geographic representation and on best capturing relevant experiences and information related to the spectrum of activities involved in mhGAP-HIG implementation.

The case study utilized data derived from key informant interviews (KIIs) and a survey.

1. KIIs were designed to be implemented with workshop participants and one healthcare staff that they trained, and were administered at the completion of the six-month technical support and mentoring phase of the implementation. Interviews were carried out remotely using Microsoft Teams or WhatsApp. Of the 21 organizations that

participated in the capacity building workshop, KIIs were collected from eight organizations: AHA, AIC Health Ministries (AICHM, Kenya), BRAC, Humanity & Inclusion (HI, Yemen), HRI, Malteser International, Society for Pre and Post Natal Services (SPANS, Zimbabwe) and SSSD. These organizations were selected in an effort to have broad geographic representation and to capture a range of mhGAP-HIG field implementation experiences.

2. At the completion of the project implementation period, workshop participants were invited to complete a survey, administered through SurveyMonkey, to provide information on the status of key activities related to the implementation of mhGAP-HIG within organizations. Activities assessed included conducting a situation analysis or comprehensive MHPSS assessment, developing an implementation plan, coordinating MHPSS activity and advocating for it with key stakeholders, fundraising to support continued mhGAP-HIG implementation, capacity building of health workers, strengthening health system activities, raising awareness about MHPSS, monitoring and evaluation, and planning for sustainable mhGAP-HIG implementation. The survey included a rating for each activity: 1. The activity is taking place or complete; 2. The activity is partially taking place or incomplete; and 3. The activity is not taking place [yet]. Open-response questions allowed respondents to provide narrative information on activity implementation, including any challenges or barriers to implementation. Of the 24 trainees that participated in the project, eight (33%) completed the survey. Although a response rate of 33% is not representative of the trainee group, the survey data can be used to identify trends as well as context-specific information related to the implementation of mhGAP-HIG that can be applied to future implementation of mhGAP-HIG capacity building trainings.

3.4 Implementation Results

3.4.1 Survey Results

As indicated above, workshop participants were invited to complete a survey, administered through SurveyMonkey, to provide information on the status of key activities related to the implementation of mhGAP-HIG within organizations.

Detailed survey results are included in Annex 1. Aggregated survey data showed that half the organizations (50%) were either carrying out or had completed a situation analysis, and a majority (62.5%) reported that they were either in the process of or had completed developing an implementation plan that included specifying the financial, human and physical resources needed to implement mhGAP-HIG. In addition, 75% of respondents reported that they had either completed or were in the process of completing mhGAP-HIG manual adaptation (e.g., translation and contextualization).

Regarding coordination with MHPSS working groups (MHPSS WG), ministries of health (MOHs) and other relevant groups, only 30% of respondents indicated that the activity was taking place or had been completed. Another 30% indicated that this activity was partially taking place or incomplete. Data indicated that a majority of organizations had difficulty meeting with key stakeholders, with 75% reporting that this activity was partially taking place, incomplete or not taking place as yet. Similarly, data seemed to suggest that fundraising activities to ensure sustainable implementation of mhGAP-HIG was a challenge, with 62.5% of organizations indicating that this activity was not yet taking place. With regards to establishing a functional referral system, half of the organizations (50%) reported that this activity was partially taking place or incomplete, while 37.5% of the organizations had either established a referral system or were actively engaged in establishing one. A majority of

respondents (62.5%) were engaging in awareness raising regarding mental health and available services.

Half of the respondents (50%) indicated that mhGAP-HIG adoption by trained health workers was partially taking place or incomplete, and only 37.5% reported that the activity was either taking place or complete. A majority of organizations (62.5%) reported that ensuring access to psychotropic medication (defined as ensuring that at least one medication in each psychotropic medication category is available in supported health facilities) was either taking place or complete, and the remainder indicated that they had not engaged in this activity at the time of completing the survey.

With regards to monitoring and evaluation (M&E) activities, 37.5% of respondents reported that they were collecting key M&E indicators for mhGAP-HIG implementation, while 37.5% reported that this activity was partially taking place or incomplete. However, a majority (62.5%) reported that the data that was collected was used to inform program adjustment and improvements. Data that most organizations were collecting included trainee knowledge (87.5% of organizations), trainee competency (62.5% of organizations) and MNS consultations by diagnosis (62.5% of organizations). Fewer organizations were collecting data on reduced symptoms or improved functioning of service users (25%) and service user satisfaction with mental health care (25%).

A majority of organizations (62.5%) reported that the mhGAP-HIG program did not link to national level mental health programs, policies and priorities, and only 50% of the organizations indicated that the larger healthcare system, organization or staff had adopted mhGAP-HIG. Lastly, a majority of respondents (75%) reported that sustainability of mhGAP-HIG capacity in the organization or setting where the training took place was either partially ensured or incomplete.

3.5 Morbidity Data

As reported above, workshop participants recorded the number of beneficiaries assessed and managed by the trained mhGAP-HIG health service providers on a monthly basis, using a morbidity data collection form. Of the 21 participating organizations, 10 organizations (47.6%) working in 10 distinct geographic areas submitted morbidity data for one, two or three months of service delivery between September 2021 and January 2022.

The capacity building project resulted in trained healthcare providers implementing mhGAP-HIG in Niamey, Niger; Cox's Bazar, Bangladesh; Kigoma, Tanzania; Tripoli, Libya; Upper Nile, South Sudan; Asosa, Ethiopia; Maiduguri, Nigeria; Raqqa, Syria; Kayin, Myanmar; and Pakwach, Uganda.

Table 2 below provides aggregated morbidity data for males and females for mhGAP-HIG MNS conditions across all 10 organizations and geographic areas, and Table 3 provides aggregated morbidity data by age group (e.g., younger than 18 years of age, 18 years and older) for mhGAP-HIG MNS conditions. As the data indicate, the more common diagnoses for men were other significant mental health complaints (157), epilepsy/seizure (130), acute stress (119) and psychosis (81). For women, the more common presenting problems were other significant mental health complaints (205), acute stress (176), epilepsy/seizure (144), moderate-severe depressive disorder (142) and post-traumatic stress disorder (88). In the 18-years-and-older group, acute stress (261), other significant mental health complaints (252), moderate-severe depressive disorder (175), epilepsy/seizure (162) psychosis (140) and post-traumatic stress disorder (116) were more commonly diagnosed. Lastly, in the

younger-than-18 age group, the most common diagnoses were other significant mental health complaints (116) and epilepsy/seizure (112).

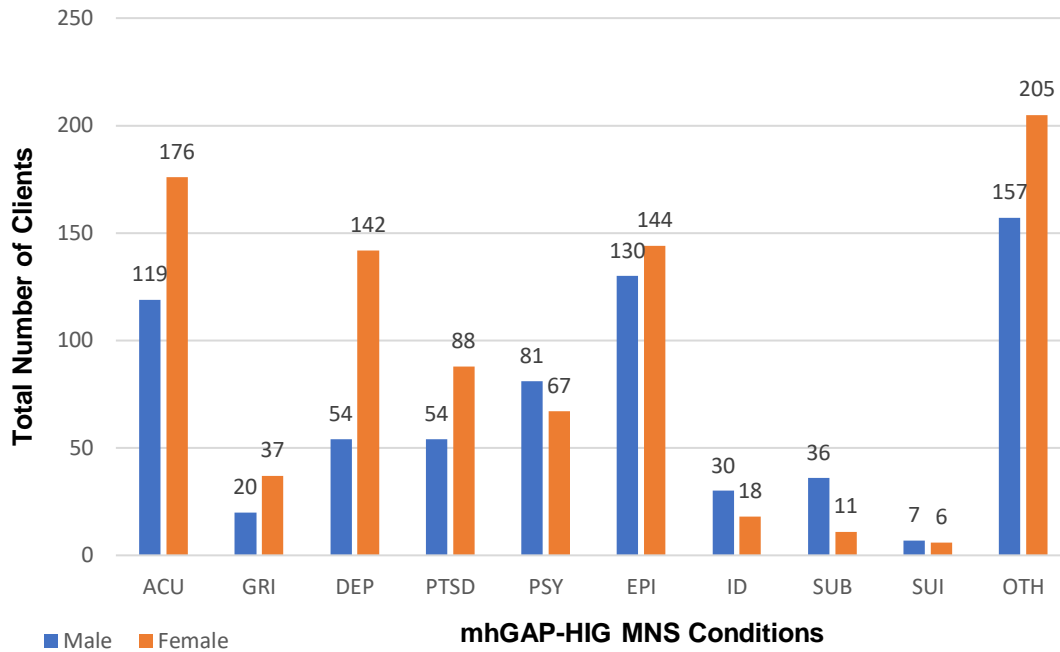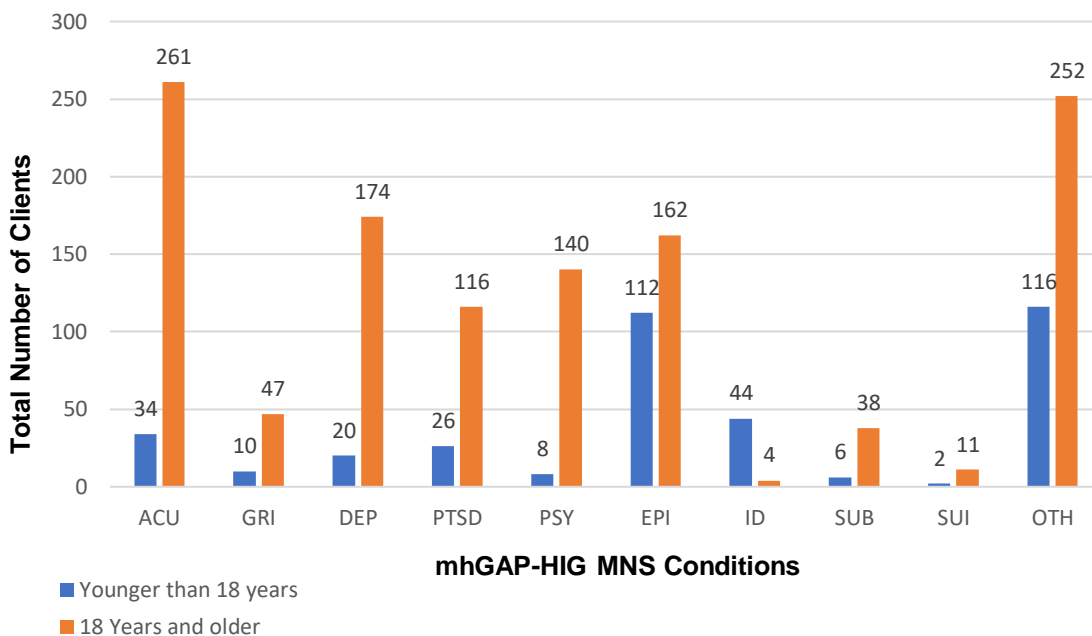**Table 2: Aggregated Morbidity Data by Sex**

Table 3: Aggregated Morbidity Data by Age Group

3.6 Implementation Results by Focus Organization

The following is an overview of each of the five focus organizations, their MHPSS programming and the status of their mhGAP-HIG implementation activities at the conclusion of the mhGAP-HIG Capacity Building project.

3.6.1 Africa Humanitarian Action (AHA), South Sudan

AHA has been operational in South Sudan since 2013, in Abiemnhom and Pariang counties in Unity state, providing services to refugees from Sudan, South Sudanese internally displaced persons (IDPs) and host communities around the Ajuong Thok refugee camp. AHA's core intervention areas include health, nutrition and livelihoods. Through funding from the US State Department's Bureau of Population, Refugees and Migration (BPRM), AHA expanded its health programming to integrate MHPSS in Ajuong Thok refugee camp. AHA's MHPSS activities include awareness-raising and sensitization to increase mental health literacy and address stigma related to mental illness; integration of mental health care into health facilities through capacity building of primary healthcare providers using mhGAP-IG and mhGAP-HIG; and home visits for patient follow-up care.

Before implementing the mhGAP-HIG capacity building training, AHA successfully carried out a situation analysis and a needs assessment to identify service gaps and availability of resources (e.g., human resources, psychotropic medication), and adapted the mhGAP-HIG training materials to the South Sudan context.

AHA succeeded in securing funding from UNHCR for the rollout training and supervision, and received support related to logistics and the selection of training participants. The organization completed an in-person mhGAP-HIG training for nine healthcare providers, including staff from the outpatient and inpatient departments, reproductive health, HIV/TB and nutrition. A psychiatric nurse trainee who received the training and completed a KII reported that participants now have the necessary knowledge and skills to identify cases and provide non-pharmacological, psychosocial interventions (e.g., problem solving, psychoeducation). She also reported that she can now facilitate training sessions for religious leaders and traditional healers as part of awareness-raising, is able to link clients to other services as needed and will consult with specialists on more difficult cases.

Following the training, AHA initiated service delivery at Hakima Yakob primary healthcare (PHC) Center in Ajuong Thok refugee camp. AHA reported that the mhGAP-HIG capacity building training resulted in providers having a "different attitude," in that clients are no longer immediately referred to mental health specialists, but are instead being assessed and managed by their PHC provider. In addition, before the training, PHC providers would treat all somatic symptoms with medication, but are now able to recognize psychosomatic symptoms and manage these through psychosocial interventions. Lastly, client satisfaction surveys indicated that the quality of mental health services had improved.

All trained PHC providers received supervision starting in August 2021, which was implemented as a combination of in-person and remote supervision through WhatsApp. The competency-based group and individual supervision took place once per month and as needed (on-call supervision).

M&E activities for rollout training and supervision was being conducted with data collection, including trainee knowledge (e.g., pre-/post-tests), trainee competency, MNS consultations by diagnosis and morbidity data. The collected morbidity data provided information on which conditions were being identified and managed, and helped determine that additional training was needed in identifying suicide. Client satisfaction surveys were also administered during home visits by psychosocial workers who collected feedback, including improvement after treatment.

AHA developed a sustainability plan to ensure the integration of mhGAP-HIG into the health system, which included building local capacity in case identification and management, the referral system and the supply of psychotropic medication. In addition, the plan included

training for teams on raising mental health awareness at the community level, and linking cases with available services through the referral pathway. AHA reported engaging in fundraising activities and coordination with key stakeholders (e.g., UNHCR, MOH, MHPSS WG, NGOs and INGOs) to ensure sustainable implementation of, and continued capacity building in, mhGAP-HIG. AHA carried out awareness-raising about mental health conditions and available services through mass sensitization and continuous health education, and held meetings with religious leaders to sensitize them. AHA was also advocating to establish an MHPSS technical working group (MHPSS TWG) at the state level (an MHPSS TWG currently exists only at the national level) for improved availability of psychotropic medications and increased training of PHC staff. Lastly, AHA achieved strengthening of the mental health system by establishing a referral system and improving the availability of psychotropic medication. AHA indicated that referral systems were working well at both the community and interagency levels.

3.6.2 BRAC, Bangladesh

BRAC, which was founded in 1972 in Bangladesh, works in disaster management and humanitarian response, particularly for people who are affected by disasters or living in poverty in rural areas and urban slums. In its work, BRAC takes a community-led, holistic approach that brings together social development, social enterprises and humanitarian response for lasting, systemic change.

BRAC has also been providing humanitarian assistance to almost 1.3 million people from the Rohingya and host communities in Cox's Bazar through a multi-sectoral integrated approach combining WASH, shelter, non-food items, health, nutrition, site management support, education, protection, child protection, food security and MHPSS. Its MHPSS programming focuses on integrating MHPSS into primary healthcare services, with the goal of providing beneficiaries with community-based, culturally relevant mental health services. MHPSS services also use lay counsellors who provide home-based care and psychosocial support, and are able to identify and refer beneficiaries in need of more specialized services to psychologists and psychiatrists.

With financial support from WHO, BRAC completed in-person mhGAP-HIG training with 20 staff from BRAC and other NGOs. A physician trainee who participated in the training and completed a KII reported that he felt better able to communicate with clients in a culturally and context-appropriate manner, and to assess and provide pharmacological interventions for mental health conditions. For psychosocial interventions, however, they continue to refer clients to psychologists. The trainee also reported that, as a result of the training, there was increased identification of clients with mental health concerns that previously would have gone unrecognized. Another impact of the training was to decrease stigma related to mental illness.

BRAC initiated service delivery following the training and, as of November 2021, BRAC trainees received in-person supervision that was supplemented with WhatsApp messaging to discuss cases. One challenge noted by a trainee who completed a KII was that access to the trainer supervisor was limited due to geography. M&E activities for the implemented rollout training and supervision included collecting data on trainee knowledge (e.g., pre-/post-tests), trainee competency and MNS consultations by diagnosis.

Lastly, BRAC reported initiating coordination with other stakeholders (e.g., WHO), engaging in advocacy efforts internally and supporting health system strengthening through establishing a referral system and improving the psychotropic supply chain, as certain

psychotropic medications (e.g., mood stabilizers and antiepileptics) were not always available.

3.6.3 HealthRight International (HRI), Uganda

HRI has been operational in Uganda since 2018, providing MHPSS services to conflict-affected populations in northern parts of the country, including both refugee and host communities. HRI works to reduce the symptoms of mental health disorders through pharmacological, psychological and social interventions. The organization employs a multi-disciplinary team of psychiatrists, clinical psychologists, psychiatric clinical officers, psychiatric nurses, social workers, counsellors and community health workers. HRI's service model cultivates community-based solutions and empowers lay health practitioners to deliver the majority of the psychosocial care.

HRI provides MHPSS services through two main programs: maternal mental health and integrated mental health. The maternal mental health program integrates mental health into routine maternal and child health care for women affected by violence. Together with Help a Child Face Tomorrow, a local NGO, HRI provides integrated physical, surgical and psychosocial rehabilitation to people injured during the Lord's Resistance Army (LRA) insurgency. HRI's MHPSS programming, which is implemented in coordination and collaboration with the Ugandan MOH, utilizes various scalable psychological interventions including Self-Help Plus (SH+), Problem Management Plus (PM+) and group interpersonal therapy.

HRI first completed a training needs assessment that was followed, with support from the district health office, by an in-person mhGAP-HIG capacity building training for nine primary healthcare providers of the Pakwach Health Center IV. The training lasted two days; feedback from participants indicated that this was too short. A trainee who completed a KII reported that the training resulted in improved identification and management of mental health concerns, communication with clients, referral skills and understanding of client rights and consent to services. The trainee reported that an added benefit of the training was addressing myths related to mental illness (e.g., some staff associated mental illness with witchcraft). A noted challenge in HRI's ability to implement the mhGAP-HIG training was the lack of a psychiatrist or medical provider to deliver training on the pharmacological interventions in mhGAP-HIG. However, HRI's coordination with other stakeholders (e.g., the district health office, MOH) resulted in a collaboration with the district health office, which provided a psychiatrist to co-train with the HRI trainer on the pharmacological interventions in mhGAP-HIG.

In December 2021, following the initiation of services, HRI implemented remote supervision using WhatsApp, Zoom and phone. Trainees created a WhatsApp account for peer consultation and support, which was also used to provide supervision. Supervision was implemented remotely because the trainer supervisor was located 500km away from the trainees and transportation was lacking. Workshop participants reported that the monitoring tools (e.g., the monthly morbidity data form and supervision checklist) and COP webinars were instrumental in supporting supervision activities and skill-building.

Regarding service delivery, HRI's lack of staff with a medical background meant that its services were limited to the implementation of mhGAP-HIG psychosocial interventions. HRI also noted that there were challenges related to the availability of psychotropic medications. Lastly, mental health system strengthening had been initiated through establishing a referral system.

HRI developed a sustainability plan that involved cascading the mhGAP-HIG training and providing supervision. HRI reported that the MOH was carrying out a "case study" to learn how to roll out the training, which suggests an interest in assessing how to integrate MHPSS services into PHC settings. As a result of the initial needs assessment HRI carried out, it was able to identify stakeholders with whom to engage in advocacy efforts and capacity building related to mhGAP-HIG. Through the MHPSS WG, HRI initiated a discussion about conducting a situation analysis among NGOs and INGOs implementing MHPSS services. As a result of HRI's advocacy with the MHPSS WG, the working group was considering carrying out a mhGAP-HIG TOT through which those trained would train and supervise healthcare providers.

3.6.4 Malteser International, Myanmar

Malteser International has been operational in Myanmar since 1996, implementing small-scale relief projects with local partners. It has been active with its own staff in the country since 2001. Malteser International currently implements programs in Rakhine, Shan and Kayin states, focusing on primary healthcare services; water, sanitation and hygiene; disaster risk reduction and climate change adaptation solutions; and disaster relief.

The organization initiated its MHPSS services in 2019, supported by a consultancy firm based in Yangon that developed training and support materials derived from the Myanmar MHPSS WG. Malteser International now has the foundation for basic MHPSS programs in all three of its locations, overseen by MHPSS focal points. In two locations (Rakhine and Shan states), the focal point is a general project manager who is tasked with implementing the initial phase of MHPSS programming, consisting of developing awareness among Malteser International staff of MHPSS and self-care. The third location (Kayin state) has a dedicated MHPSS focal point. Training on psychological first aid (PFA) was delivered in all three locations as a TOT to location-responsible and other project staff, followed by cascading training to community mobilizers. In Rakhine state, Malteser International was able to integrate self-care and stress management into two health clinics; in Kayin state, village community mobilisers implement MHPSS awareness sessions.

Malteser International had secured dedicated funding for mhGAP-HIG capacity building training, which significantly aided in its ability not only to implement the training but to engage in activities to ensure continued and sustainable implementation of mhGAP-HIG within health settings. Before implementing the mhGAP-HIG training, Malteser International first completed a situation analysis and adapted and administered the training needs assessment tool. In addition, it adapted mhGAP-HIG materials to the Burmese and Kayin languages and to the local context. Thereafter, a two-day mhGAP-HIG training was carried out for nine health staff working in four different primary healthcare centers. The first day of training was implemented in-person and the second day was implemented remotely.

Following the training, services were initiated by the trained healthcare workers and implemented in mobile clinics and tuberculosis and malaria clinics, and both group and individual supervision was provided as of November 2021. In addition, community workers trained in psychosocial support engaged in mental health awareness-raising activities within the community, and linked community members to mental health services as needed. It also implemented M&E activities for the rollout training and supervision, including collecting data on trainee knowledge, trainee competency, reduced symptoms or improved functioning of service users, and MNS consultations by diagnosis. Malteser International reported that the data was key to redefining strategies, adjusting activities and meeting targets.

Malteser International reported that challenges with mhGAP-HIG field implementation included establishing a functional referral system due to the political instability in Myanmar,

and accessibility to psychotropic medication, which only was available through general and specialized hospitals. However, the organization developed an agreement with the MOH that allows it to have some control over the dispensing of psychotropic medication, and it was making referrals to Médecins Sans Frontières (MSF) for psychiatric services.

Lastly, it developed a plan to ensure sustainability of the implemented activities, consisting of increased capacity of primary healthcare workers in providing MHPSS service; implementation of community-based MHPSS case-management services; maximizing the use of existing local and regional healthcare infrastructures and of existing resources, including those of partner organizations; ensuring consistency with local capacities and national strategies; establishing partnerships to create longer timelines for investments of funds and human capital; and working in partnership with other like-minded organizations and the MHPSS WG. To this end, Malteser International had started to coordinate with other key stakeholders and the MHPSS WG on mhGAP-HIG implementation.

3.6.5 Syrian Society for Social Development (SSSD), Syria

SSSD, a Syrian NGO, became operational in 2009 and is present in all 14 governorates. It works in the protection, education, shelter, WASH, non-food-item, health, MHPSS and livelihood sectors providing assistance to marginalized and vulnerable Syrians, including internally displaced and returnee individuals.

SSSD's MHPSS services comprise home-based rehabilitation for children with disabilities, which includes parenting skills; group counselling, case management and group mental health awareness sessions. Services are provided by case managers with a background in psychology, social workers and volunteers.

Before implementation of the mhGAP-HIG capacity building training, SSSD's Psychosocial Support department assessed training needs related to mhGAP-HIG and the mental health disorders commonly seen by providers. It also adapted the mhGAP-HIG training materials to the local context. A remote mhGAP-HIG training for eight healthcare providers in three different sites (Deirezor, Latakia, Damascus) was completed. A trainee who completed a KII reported improved communication skills and the ability to assess and manage mental health conditions.

With support from WHO and UNHCR, SSSD plans to implement a second mhGAP-HIG training for other organizations, after completing the supervision phase for the first training cohort. SSSD reported that one challenge related to the implementation of mhGAP-HIG was difficulty obtaining approval from health authorities to access and administer psychotropic medication. M&E activities for the implementation rollout training and supervision had started, and included collecting data on trainee knowledge, trainee competency and MNS consultations by diagnosis.

SSSD reported that it had developed a plan to ensure sustainability of the implemented activities, and that the organization was engaging in fundraising activities and internal advocacy efforts to support continued capacity building in mhGAP-HIG integration. SSSD indicated that it planned to coordinate with other stakeholders (e.g., WHO, Red Cross, MHPSS WG) and activities related to strengthening of the health system, including the development of a more robust referral system and coordination between organizations.

4. Project Successes

A review of the data collected noted the following project successes.

The preparatory mhGAP-HIG course was effective in creating a foundation for the capacity building workshop. This capacity building workshop integrated a six-module preparatory mhGAP-HIG e-course designed to introduce the basics of mhGAP-HIG, so that all participants were ready and able to undertake the TOTS workshop. Workshop participants reported that the preparatory mhGAP-HIG course was effective in creating an important foundation for the TOTS workshop.

Virtual capacity building in mhGAP-HIG is not only feasible but successfully builds both knowledge and skills in mhGAP-HIG and its implementation within organizations. As the survey and KII data indicate, workshop participants were able not only to acquire knowledge about mhGAP-HIG but also able to develop the necessary training skills to successfully train and supervise health providers and to ensure mhGAP-HIG rollout.

The six-month tailored mentoring and technical supervision provided important support and guidance for successful mhGAP-HIG field implementation. The mhGAP-HIG capacity building workshop was followed by a six-month capacity building phase in which workshop participants implemented mhGAP-HIG rollout with technical support from International Medical Corps. The technical support consisted of supervision with the International Medical Corps Capacity Building Specialist and COP webinars. Participants reported that the combination and structure of supervision and COP webinars was effective and that it supported their continued learning and skills development, providing necessary and important guidance during the mhGAP-HIG field implementation phase. One participant specifically mentioned that the COP webinar on supervision skills was particularly helpful.

The M&E tools were identified as being easy to use and provided data on trainee capacity development. Some workshop participants noted that the supervision checklist and morbidity data form were easy-to-use monitoring tools. The supervision checklist provided workshop participants with a structured tool to systematically assess trainee capacity development and identify areas for additional technical support. In addition, the information derived from the supervision checklist could be used to develop individualized, competency-based supervision plans. The morbidity data form enabled organizations not only to collect data on the number of beneficiaries presenting with mhGAP-HIG MNS conditions separated by gender and age (e.g., younger than 18 years of age, and 18 years and older) and thereby tailor their services, but also to assess trainee skills development. Thus, one organization reported that it was able to use this data to identify additional training needs by noting that certain conditions were being under-identified.

5. Challenges and Lessons Learned in mhGAP-HIG Field Implementation

The collected data identified not only challenges, but also a number of important lessons related mhGAP-HIG field implementation.

Workshop participants' mhGAP-HIG implementation plan goals were too ambitious for the implementation period. In terms of goals and targets, International Medical Corps noted the following concerns related to the implementation plans developed by workshop participants:

- large, unrealistic, target numbers for PHC providers trained and service users;
- overly ambitious goals, such as changing the national policy in a short period of time;
- completing the supervision of trained PHC providers in a short period of time (e.g., one month);
- conducting both the mhGAP-HIG pharmacological and nonpharmacological interventions training by psychologists; and
- in some cases, including the training of specialized mental health professionals in the implementation plan.

M&E plans lacked alignment with the implementation plan and appropriate means of verification. For some organizations, there was a lack of congruency between the implementation plan and the M&E plan, in that not all proposed activities had corresponding indicators and targets in the M&E plan. In addition, some workshop participants suggested unrealistic means of verification and indicators that were not specific, measurable, attainable, relevant and time-bound.

The lack of financial, logistical and/or human resources hindered the implementation of mhGAP-HIG capacity building training. At least three organizations reported that a lack of financial and/or logistical resources impacted their ability to engage in mhGAP-HIG implementation. For example, one organization's implementation of the mhGAP-HIG training of healthcare providers was halted due to a lack of budget to support the activity. A second organization's lack of financial resources resulted in the training being postponed. However, as a result of guidance provided by the International Medical Corps Capacity Building Specialist, the organization coordinated with available MHPSS service providers and local health actors, and assessed what type of support they might be able to provide for the training. This resulted in a relationship with the district health directorate, which provided a psychiatrist to co-train on mhGAP-HIG pharmacological interventions and thereby decreased the cost of the training. A second organization overcame the funding challenge by holding the training remotely. Lastly, the International Medical Corps Capacity Building Specialist's guidance to train a smaller number of individuals and to train them on fewer mhGAP-HIG MNS conditions as a means of decreasing costs facilitated training rollout for organizations with limited funding.

For some organizations, a lack of human resources impacted the implementation of activities. For example, one organization reported that it was able to only partially complete the situation analysis due to lack of human resources. A second example relates to trainers who did not have a medical background and who therefore first had to secure a co-trainer

with the necessary expertise to train on the mhGAP-HIG pharmacological interventions before implementing the training.

The selection of training participants resulted in specific capacity building challenges. An organization reported that its training cohort had varied professional backgrounds, which resulted in difficulties adapting the training to meet the training needs of all participants. A second organization commented that including trainees from various organizations created challenges in terms of providing follow up and supervision, including the need to travel to multiple supervisee sites and the travel time involved. Other organizations directed questions to the International Medical Corps Capacity Building Specialist about including social workers and community health workers in the mhGAP-HIG training, suggesting that there may have been a lack of clarity on who should receive mhGAP-HIG training and how to select participants.

Workshop participants requested specific guidance related to the implementation of remote supervision and the use of M&E tools. Several workshop participants had questions about how to implement remote supervision effectively, and reported experiencing this type of supervision as challenging. Questions related to what modalities to use for remote supervision (e.g., Zoom, WhatsApp) and whether remote supervision can be an effective approach for skill-building. Additional questions included how to utilize the supervision checklist and the morbidity data form. For example, three workshop participants did not know how to complete the supervision checklist and requested guidance from the International Medical Corps Capacity Building Specialist in its implementation.

Stakeholder priorities and lack of support affected the implementation of mhGAP-HIG capacity building training. Two organizations operating in the same geographic area reported that they had to adjust their training based on a key stakeholder's priorities for MHPSS capacity building in that region. Thus, in addition to providing training on mhGAP-HIG, the organizations were required to also train on the mhGAP Intervention Guide (mhGAP-IG). A second organization reported that there was a lack of support from the MOH related to mhGAP-HIG training of PHC providers, which had implications for sustainability and for the widespread integration of MHPSS into healthcare centers. Lastly, one organization reported that healthcare staff were either not cooperative or available to complete the full mhGAP-HIG training.

Challenges in the availability of psychotropic medication had implications for the implementation of mhGAP-HIG pharmacological interventions within health facilities. Challenges related to psychotropic medications included a lack of availability; poor supply chain, resulting in delayed psychotropic medication delivery; a limited supply of psychotropic medications; medications only being accessible through government hospitals; lack of funding to procure medications; and lack of staff with the appropriate background to be able to prescribe (e.g., physician, nurse, psychiatric nurse). In these situations, the International Medical Corps Capacity Building Specialist advised organizations to train on conditions that are addressed through psychosocial intervention, including acute stress, grief and other significant mental health complaints.

Certain socio-political and cultural factors affected the implementation of mhGAP-HIG within health facilities and created challenges in access to services. Two organizations reported that COVID-19 and the resulting restrictions in movement and primary healthcare facility lockdowns created barriers to carrying out their mhGAP-HIG implementation plans. A third organization reported that political instability negatively affected efforts to strengthen mental health systems. An organization reported that though the mhGAP-HIG training increased access to MHPSS services within the refugee camp setting, the host community—

where there was an absence of MHPSS services—was unable to access the camp-based services due to distance, which potentially created a disparity in access to healthcare between the refugee and host community. Lastly, one organization noted that some mhGAP-HIG trainees preferred not to be identified as "mental health service providers" due to the stigma attached to mental illness.

Poor infrastructure resulted in challenges in the delivery of in-person and remote supervision. Poor roads affected one organization's ability to access trained healthcare providers in more remote areas to deliver in-person supervision, while several organizations reported internet challenges that affected their ability to provide remote supervision.

Some workshop participants did not engage in the technical support requirements for the capacity building project. Seven workshop participants failed to meet the supervision and mentoring requirements of the project and either did not attend the supervision and/or COP webinars or only attended a limited number, all of which were important components of the capacity building and field implementation aspects of the project. For example, one participant attended one supervision meeting and no COP webinars; a second attended all supervision meetings, but no COP webinars; and a third did not attend either supervision or COP webinars. It may be relevant to note that these seven workshop participants did not implement mhGAP-HIG training following the capacity building workshop, which may explain their lack of engagement in the post-training technical support.

6. Recommendations

6.1 mhGAP-HIG capacity building training

Future mhGAP-HIG capacity building training should consider the advantages and disadvantages of in-person and remote training. As indicated above, virtual capacity building in mhGAP-HIG implementation is feasible and successfully builds both knowledge and skills in mhGAP-HIG and its implementation. However, some participants reported a preference for in-person training. For future mhGAP-HIG capacity building training, consideration should be given to the advantages and disadvantages of in-person and remote training. For example, training costs, access to participants, ease of knowledge and skills acquisition, participant access to technology and stability of the internet, global public health considerations, the preferences of the organizations' management and participant learning preferences might be considered when deciding on in-person or virtual training.

Continue implementation of the six-module preparatory mhGAP-HIG course. As reported above, workshop participants reported that the preparatory mhGAP-HIG course was effective in creating an important foundation for the workshop for participants who had not previously participated in mhGAP training or desired a refresher, and should therefore be retained in future capacity building initiatives.

Provide additional teaching and training on the supervision tools and specific training on providing remote supervision. The supervision checklist and morbidity data form were reported by some workshop participants to be easy-to-use monitoring tools and should therefore continue to be utilized. However, several workshop participants asked questions related to the use of the supervision and monitoring tools and how to provide remote supervision. This may indicate a need to provide additional teaching and training on the supervision tools and specific training on providing remote supervision, including use of

technology, methods and addressing possible challenges. Similarly, as part of the TOTS training, participants would benefit from training on how to implement mhGAP-HIG training virtually. International Medical Corps' *Guidelines for Remote MHPSS Programming in Humanitarian Settings* and associated training might serve as an important resource to support skills-building in the implementation of virtual training and supervision.

Identification of an appropriate co-facilitator who can train on mhGAP-HIG pharmacological interventions should take place as early as possible. To help workshop participants who do not have a medical background, it would be useful to identify an appropriate co-facilitator as early as possible in the capacity building workshop (e.g., during implementation of the TOTS) to prevent potential delay in mhGAP-HIG rollout.

It is recommended that the capacity building training content be revised as follows.

- Include training on service mapping, as this is relevant to both the situation analysis and developing a referral system.

- Based on the data collected, provide specific training addressing advocacy and strategies for stakeholder relationship building. This may benefit participants, given the importance of stakeholder relationships for sustainability and access to resources to support field implementation.

- Include practical exercises related to strengthening the mental health care system, and include procedures and activities in the "sustainability" component of the workshop.

- Consider including a module on attitudes toward and stigma related to mental health. At least one organization reported that PHC providers were reluctant to be identified as providing mental health services due to the stigma attached to mental illness. Integrating content on identifying and addressing stigma and problematic attitudes toward mental illness may prepare workshop participants to address these topics in the training they provide to others.

Consider implementing refresher training for workshop participants. A training needs assessment should be administered to identify the relevant topics and skills that could benefit from review and further capacity development. In addition, the assessment might identify challenges in the field implementation of mhGAP-HIG that can be addressed through additional technical support.

Consider a regional approach for future mhGAP-HIG capacity building workshops. The capacity building project might benefit from a regional approach in which workshop participants are recruited from specific regions (e.g., the Middle East). This may facilitate adapting the training to a particular culture and context, and also enable the training to take place in participants' native language, thereby making it more accessible.

6.2 International Medical Corps technical support: Supervision and the community of practice

Consider making supervision and COP webinar participation an explicit and compulsory component of the mhGAP-HIG capacity building project, to improve participation. Although participants reported that both supervision and the COP webinars were effective in supporting their continued learning and skills development, some participants failed to attend some or all of the supervision and/or COP webinars. It is unclear what affected participation, and follow-up with participants to better understand factors that contributed to the lack of participation is recommended. Making supervision and COP participation a compulsory component of the capacity building project may improve

participation. Other steps that could ensure participation include making participation requirements for the program (e.g., capacity building workshop, participation in supervision and COPs) explicit when introducing the project; assessing applicants' motivation and ability to attend and participate in all aspects of the program, as well as any barriers at the time of application reviews (through, for example, an interview); and a formal memorandum of understanding between International Medical Corps and the participating organization that details expectations related to participation.

Continue use of the supervision checklist. As indicated above, the supervision checklist was important in providing a structured and systematic approach to assessing trainee capacity development and to informing the development of competency-based supervision plans.

6.3   mhGAP-HIG field implementation

Continue use of the implementation plan to support mhGAP-HIG field implementation. The implementation plan comprised an action plan for mhGAP-HIG training and supervision rollout to general healthcare providers, as well as a plan for the operationalization of mhGAP-HIG in workshop participants' organizations or their partner organization(s). Both plans were key in helping workshop participants develop an implementation framework that included specific activities and an anticipated timeline for the clinical and operationalization components of mhGAP-HIG implementation.

Continue disseminating the mhGAP-HIG training slides to workshop participants. It is recommended to continue sharing the mhGAP-HIG training slides, as workshop participants reported that this was helpful for the training sessions they were conducting, and International Medical Corps noted that the majority of participants had adapted and translated the slides. WHO has released an mhGAP-HIG training manual (mhGAP Humanitarian Guide training of healthcare providers), which includes slides that might serve as an additional resource in future mhGAP-HIG capacity building training.

Continue implementation of the training needs assessment, role plays, case simulations and case examples from the field. Continued implementation of a training needs assessment is recommended, as it not only provides information that informs the content of training, but was also found by workshop participants to increase trainee buy-in as a result of seeing their feedback represented and integrated into the training. In addition, feedback indicated that role plays, case simulations and using real cases from the field were effective training strategies.

Through supervision and technical support, ensure that workshop participants are developing a realistic mhGAP-HIG training agenda. Two trainees who received two days of mhGAP-HIG training reported that this was not sufficient. Additionally, workshop participants recommended training on one or two modules at a time. It is therefore recommended that workshop participants consult with International Medical Corps Capacity Building Specialist when designing their mhGAP-HIG rollout training and tailor the duration and content of the training to participants' training needs.

Develop a competency-based supervision plan in collaboration with trainees. It is recommended that workshop participants develop a competency-based supervision plan for both in-person and remote supervision (if applicable), in collaboration with their trainee(s). The plan should detail frequency and duration of supervision, mode of communication (e.g., in-person, Zoom, phone) and modality (group, individual) and capacity development goals.

The plan should be shared with the International Medical Corps Capacity Building Specialist for review and feedback.

In contexts where psychotropic medication is limited or inaccessible, train on mhGAP-HIG MNS conditions that are addressed through psychosocial interventions. In situations where there are challenges related to accessing psychotropic medication (e.g., delayed supply, lack of availability), it is suggested that workshop participants train on conditions that are addressed through psychosocial interventions, including acute stress, grief and other significant mental health complaints.

Continue use of the morbidity data form. The morbidity data form, developed by International Medical Corps for this initiative, provides important data related to presenting mhGAP-HIG MNS conditions that organizations can use to tailor their interventions. In addition, the data represent the scope of the impact of mhGAP-HIG capacity building in that it identifies the number of clients served by MNS condition.

Consider implementing a formal memorandum of understanding and regular briefings with workshop participants' organizations, to promote continued support for and investment in the mhGAP-HIG Capacity Building project. A significant barrier to mhGAP-HIG implementation was lack of funding, and it was noted that those organizations with dedicated funding were more readily able to implement mhGAP field training. Although International Medical Corps confirmed during the participant selection process that participating organizations had the necessary funding to support implementation, this was not always the case. In addition, some organizations experienced challenges in implementation due to managers' or supervisors' lack of support for the project. Implementing a formal memorandum of understanding (MOU) that details the participating organizations' engagement and confirms the availability of funds may help address this issue. It is recommended that the MOU be signed by someone with decisionmaking authority. Keeping the participant organizations' program or management focal person updated on the progress of the capacity building initiative may promote support for and investment in the project. Implementers of the mhGAP-HIG capacity building initiatives may consider providing organizations with a subgrant to specifically support the implementation phase of the mhGAP-HIG. However, it is important to note that providing organizations with funding for mhGAP-HIG rollout may disincentivize them from engaging in fundraising activities, which has implications for their mhGAP-HIG program's sustainability. In addition, providing subgrants would require that International Medical Corps revise the structure of its mhGAP-HIG Capacity Building program to accommodate grants management, which may require additional human, financial and administrative resources.

7. Annex

7.1 Survey Results

Q1: Situational analysis or comprehensive MHPSS assessment conducted

Answer Choices	Responses	
The activity is taking place or complete	50%	4
The activity is partially taking place or incomplete	37.5%	3
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q2: Implementation plan developed (that specifies the financial, human and physical resources required to implement mhGAP-HIG)

Answer Choices	Responses	
The activity is taking place or complete	62.5%	5
The activity is partially taking place or incomplete	25%	2
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q3: mhGAP-HIG program is coordinated with MHPSS WG, MoH and other relevant groups

Answer Choices	Responses	
The activity is taking place or complete	37.5%	3
The activity is partially taking place or incomplete	37.5%	3
The activity is no taking place (yet)	25%	2
TOTAL		**8**

Q4: Meetings held with key stakeholders to advocate for mental health and establish partnerships

Answer Choices	Responses	
The activity is taking place or complete	25%	2
The activity is partially taking place or incomplete	37.5%	3
The activity is no taking place (yet)	37.5%	3
TOTAL		**8**

Q5: Fundraising activities have been conducted

Answer Choices	Responses	
The activity is taking place or complete	25%	2
The activity is partially taking place or incomplete	12.5%	1
The activity is no taking place (yet)	62.5%	3
TOTAL		**8**

Q6: mhGAP-HIG materials adapted (e.g., translation and contextualization)

Answer Choices	Responses	
The activity is taking place or complete	75%	6
The activity is partially taking place or incomplete	12.5%	1
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q7: mhGAP-HIG adopted by trained health workers

Answer Choices	Responses	
The activity is taking place or complete	37.5%	3
The activity is partially taking place or incomplete	50%	4
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q8: Functional referral system established

Answer Choices	Responses	
The activity is taking place or complete	37.5%	3
The activity is partially taking place or incomplete	50%	4
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q9: Access to psychotropic medicine ensured (at least one medication in each psychotropic medication category is available in supported health facilities)

Answer Choices	Responses	
The activity is taking place or complete	62.5%	5
The activity is partially taking place or incomplete	0%	0
The activity is no taking place (yet)	37.5%	3
TOTAL		**8**

Q10: Is the mhGAP-HIG program linked to national level mental health programs, policies and priorities?

Answer Choices	Responses	
Yes	37.5%	3
No	62.5%	5
TOTAL		**8**

Q11: Has the larger healthcare system/organization/staff adopted mhGAP-HIG?

Answer Choices	Responses	
Yes	50%	4
No	50%	4
TOTAL		**8**

Q12: Awareness is raised about mental health conditions and available services

Answer Choices	Responses	
The activity is taking place or complete	62.5%	5
The activity is partially taking place or incomplete	25%	2
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**

Q13: Key M&E indicators for mhGAP-HIG implementation are collected

Answer Choices	Responses	
The activity is taking place or complete	37.5%	3
The activity is partially taking place or incomplete	37.5%	3
The activity is no taking place (yet)	25%	2
TOTAL		**8**

Q14: M&E data being collected

Answer Choices	Responses	
Trainee knowledge (e.g., pre-post tests)	87.5%	7
Trainee competency (e.g., checklists)	62.5%	5
MNS consultations by diagnosis (e.g., HMIS form)	62.5%	5
Reduced symptoms or improved functioning of service users	25%	2
Service user satisfaction with mental health care	25%	2
Other (please specify)	25%	2
TOTAL		**8***

Those surveyed could choose more than one answer.

Q15: M&E data has been used to inform program adjustments and improvements

Answer Choices	Responses	
Yes	62.5%	5
No	37.5%	3
TOTAL		**8**

Q16: Sustainability of mhGAP-HIG capacity in the organization and the setting where the training took place is ensured

Answer Choices	Responses	
The activity is taking place or complete	12.5%	1
The activity is partially taking place or incomplete	75%	6
The activity is no taking place (yet)	12.5%	1
TOTAL		**8**