USAID FROM THE AMERICAN PEOPLE

International Medical Corps

Operational considerations for remote MHPSS programming in humanitarian settings

A case study of International Medical Corps programs in Central African Republic, Iraq, Libya, South Sudan and Venezuela

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Section 1: List of Acronyms

CAR – Central African Republic

GBV – Gender-based violence

HQ – Headquarters

IDP – Internally displaced person

IOM – International Organization for Migration

KII – Key informant interview

mhGAP – Mental Health Gap Action Programme

MHPSS – Mental health and psychosocial support

MoH – Ministry of Health

NGO – Nongovernmental organization

PFA – Psychological first aid

PHC – Primary health center

PM+ – Problem Management Plus

PSS – Psychosocial support

PWD – Persons with disabilities

USAID – United States Agency for International Development

WHO – World Health Organization

Section 2: Executive Summary

Before the COVID-19 pandemic, few comprehensive guidelines at the global level were available to guide mental health and psychosocial support (MHPSS) programming in geographically remote or inaccessible settings. The COVID-19 pandemic has highlighted the additional challenge of delivering in-person MHPSS services during movement restrictions and infection control measures, and ensuring continuity of care. This case study documents the best practices and recommendations from International Medical Corps' global experience, and lessons we learned when transitioning to remote MHPSS programming during the COVID-19 pandemic in Central African Republic (CAR), Iraq, Libya, South Sudan and Venezuela. The case study findings will guide the revision and expansion of the [International Medical Corps Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients during the COVID-19 Pandemic](#) field-test version, aiming to contribute to increased and improved remote MHPSS programming in humanitarian settings globally.

The case study was developed using primarily qualitative methods combined with a desk review of project records from each country, as well as client case records. Primary data was collected between August and October 2021, through 220 key informant interviews (KIIs) with various stakeholders, including International Medical Corps staff and service providers, community leaders, clients and caregivers. Government restrictions in response to the COVID-19 pandemic and security risks necessitated transitioning to remote programming in each country, though specific adaptations varied by country contexts. Remote service delivery was found to be generally effective and to positively impact client well-being and functioning, but there were contextual challenges in implementing it.

Access to technology and the quality of connectivity determined the level of success of transitioning to remote programming, with different means of communication addressing barriers to communication to varying degrees. For example, areas and sites that utilized creative solutions, such as disseminating information through radio broadcasts or megaphones, were able to mitigate connectivity challenges and other limitations to remote programming. In addition, less complex interventions—such as follow-up psychosocial support and case management, medication management for existing clients, and maintenance sessions—were easier to conduct remotely. This was especially true for mild-to-moderate cases, because severe and emergency cases, as well as vulnerable clients, were found to be more challenging to support remotely and were therefore prioritized for in-person care.

Adaptations to outreach activities contributed to the continuity of care during the pandemic and can be further strengthened to improve the identification of new cases. More robust training and supervision were identified by various stakeholders as ways to alleviate implementation challenges. Providing tools before transitioning to remote care, as well as training, would also aid in improved effectiveness and more systematic adaptions. In addition to bolstering capacity, more intentional staff care and teambuilding during remote periods are needed, as staff well-being was impacted in the context of the pandemic, creating a "double emergency" in humanitarian settings.

Resulting recommendations from the case study findings emphasize the need for flexibility and customization of remote programming to country contexts, identified client needs and programmatic priorities; the importance of robust preparation and contingency planning, including assessment of resource needs and equipping staff with skills, tools and the means to successfully transition to remote delivery; ongoing education of clients and caregivers about remote modalities, and leveraging their feedback to continue improving remote services; and innovation and creativity to overcome structural challenges and resource limitations.

Section 3: Introduction

There has been a longstanding critical gap at the global level regarding comprehensive guidelines and practical recommendations for the delivery of MHPSS services and supervision to geographically remote or inaccessible settings. Often, humanitarian settings present significant security risks, are difficult to travel to or from, and have limited to non-existent mobile, landline or internet connections. The COVID-19 pandemic has highlighted the additional challenge of ensuring in-person MHPSS during movement restrictions and under infection control measures. More comprehensive guidelines, tools and training materials on how to adapt or develop remote MHPSS services in low- and middle-income countries would contribute to improved quality and quantity of remote MHPSS capacity building and service delivery.

"Strengthening Organizational Capacity for Delivery of Mental Health and Psychosocial Support Services in Humanitarian Settings through Training and Mentoring," funded by the US Agency for International Development (USAID), is designed to document how best to develop and adapt remote MHPSS programming in humanitarian settings, through a multi-country case study. The case study findings will inform revision and expansion of the [International Medical Corps Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients during the COVID-19 Pandemic](#), with the aim of contributing to increased and improved remote MHPSS uptake globally in humanitarian settings.

Section 4: Objectives and Case Study Questions

The overall objective of the case study was to synthesize International Medical Corps' global experience and lessons learned from setting up a new program remotely and from transitioning to remote MHPSS programming in Central African Republic, Iraq, Libya, South Sudan and Venezuela during the COVID-19 pandemic.

We developed formative case study questions based on these objectives, and used them to identify sources of information and methods for data collection. The questions examined:

- the specific adaptations made to MHPSS programming to ensure continuity of care, as well as factors that contributed to decisions taken on service adaptations;
- factors that enabled and prevented the transition to remote programming;
- the role of outreach in continuity of care;
- the benefits and challenges of remote service delivery, as perceived by service providers and clients;
- the effectiveness of remote service delivery on client well-being and functioning;
- specific considerations made for vulnerable groups in delivery of services remotely;
- adaptations, methods and overall experience with receiving and providing remote supervision; and
- adaptations made to delivering training and supervision remotely, and perceived effectiveness of remote training and supervision.

Additional questions were included to understand remote program set-up and management (see the Annex for detailed case study questions).

We identified primary sources of information for each case study question, and included International Medical Corps country and program management staff, International Medical

Corps and external MHPSS service providers, clients and family members, government stakeholders, and MHPSS trainers and supervisors.

Section 5: Overview of Focus Countries

International Medical Corps identified five countries for the case study—Central African Republic, Iraq, Libya, South Sudan and Venezuela—based on the country programs' experiences with implementing remote MHPSS, varying capacities and health infrastructures, geographic and regional variation, and ongoing or confirmed anticipated funding for MHPSS programs for populations affected by conflict or crises.

5.1   Central African Republic

Central African Republic (CAR) is a landlocked country with a population of 4.8 million.[1] Despite its abundant natural resources, it is one of the world's most impoverished and fragile states and has faced cycles of violent conflict over the last 40 years.[2] Weak institutions and inadequate infrastructure in CAR have limited citizens' access to basic services. Recent violence and human rights violations have left 2.6 million people in need of humanitarian assistance.[3] Collective experiences of adversity, trauma and conflict have had detrimental effects on community and individual well-being and mental health.

According to International Medical Corps' 2014 MHPSS needs assessment, acute stress, adjustment problems and common mental disorders are prevalent among the population. The national mental health plan created by the Ministry of Health (MoH) and technical partners in 2011 has yet to be enacted into law and integrated into primary care. The inadequate mental health care system is underscored by an acute shortage of trained mental health professionals, with only three psychologists and 12 service providers in the whole country, and currently no practicing national psychiatrist.[4] The COVID-19 pandemic, resulting in 11,708 confirmed cases and 101 deaths as of November 30, 2021, has prompted periodic business and school

Locations
Bria, Bambari and Birao prefectures

Services since 2010
Psychosocial support (PSS) activities, select psychological interventions, case management, psychiatry, MHPSS capacity building of local hospitals and MoH staff (mhGAP, PM+)

2020 Caseload
1,431 (848 males, 583 females)

International Medical Corps MHPSS staff
16 (2 psychiatrists, 4 psychiatric nurses, 2 case managers, 2 youth advisors, 1 PSS officer and 5 PSS agents)

Remote activities
PSS, case management, basic psychological support, medication management for existing clients and mild-to-moderate cases, training, supervision

[1] The World Bank. *Population, total — Central African Republic.* Retrieved November 9, 2021, from https://data.worldbank.org/indicator/SP.POP.TOTL?locations=CF
[2] *Ibid.*
[3] UNHCR. (2021, June 25). *UNHCR Central African Republic Situational Emergency Update — 25 June 2021 — Central African Republic.* Retrieved July 8, 2021, from https://data2.unhcr.org/en/documents/details/87596.
[4] International Medical Corps (2014, March*). IMC CAR Mental Health Assessment-April 2014.* Retrieved July 8,2021 from https://www.mhinnovation.net/sites/default/files/downloads/resource/IMC%202014%20CAR.pdf.

closures and movement restrictions, and exacerbated the livelihoods, health and well-being of many CAR residents.[5] International Medical Corps adapted to these conditions by moving some MHPSS services to remote delivery.

5.2   Iraq

With a population of 40 million people, Iraq has faced decades of conflict, occupation and humanitarian crises. The country has struggled with tensions along social, ethnic, national, religious and tribal fault lines. Armed conflicts and violence perpetrated by various armed factions in the country and region have resulted in mass displacement of people and movement of refugees to other countries, as well as to Iraq from neighboring countries. Roughly 1.2 million internally displaced persons (IDPs) reside in the country; in 2020, the Humanitarian Needs Overview estimated that 1.46 million people across Iraq faced critical problems related to physical and mental well-being.[6] Resources and services for mental health in the country are sparse, and recent heightening of security threats has further impeded access to services for those most in need. At present, people cannot be guaranteed safe access to MHPSS services, where available, due to ongoing insecurity, conflict, and cannot afford the financial costs associated with traveling long distances to health centers. As of November 30, 2021, more than 2 million confirmed cases and 23,820 deaths due to COVID-19 have been reported nationwide in Iraq.[7] The Iraqi government's effort to curb the spread of the virus through lockdowns and restrictions of movement have aggravated access issues for those suffering from mental health conditions and widened the existing care gap. In face of these challenges, International Medical Corps has continued to provide MHPSS services throughout the pandemic, including by transitioning several services to remote delivery.

Locations
Baghdad, Ninewa, Salah Al-Din and Anbar governorates (and Erbil and Dohuk until September 2021)

Services since 2003
PSS activities, select psychological interventions, case management, psychiatry, MHPSS capacity building of local health staff (mhGAP, PM+)

2020 Caseload
9,306 (3,713 males, 5,593 females)

International Medical Corps MHPSS staff
66 (50 service providers and 16 MHPSS program staff)

Remote activities
PSS, case management, basic psychological support, follow-up for mild-to-moderate cases, training, supervision

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[5] Johns Hopkins University Coronavirus Resource Center: Central African Republic. Retrieved November 30, 2021 from https://coronavirus.jhu.edu/region/central-african-republic
[6] United Nations Office for the Coordination of Humanitarian Affairs (2019, November). *Iraq: 2020 Humanitarian Needs Overview*. Retrieved June 25, 2021, from https://reliefweb.int/sites/reliefweb.int/files/resources/iraq_hno_2020.pdf
[7]   Johns Hopkins University Coronavirus Resource Center: Iraq. Retrieved November 30, 2021 from https://coronavirus.jhu.edu/region/iraq

5.3 Libya

Since the outbreak of war in 2011, Libya has been in turmoil, with different factions competing for power, resulting in a vacuum of governance and conflicts with severe humanitarian ramifications. Libya has a population of nearly 7 million people; in 2020, 3.5 million people lacked consistent access to primary and secondary healthcare services, including 1.2 million people in need of critical assistance.[8] Moreover, the ongoing migration crisis is further straining the national health system in already resource-deprived areas across the country, with a detrimental impact on individual and community mental health and well-being.[9] The Libyan MoH and the World Health Organization (WHO) have created plans to strengthen the mental health care system by developing comprehensive services, strengthening the mental health unit within the ministry and updating related legislation to protect the rights of people with mental disorders, but these plans are yet to be fully implemented. Currently, multiple Mental Health Action Gap Programme (mhGAP)-trained specialists in the country supervise psychosocial workers in delivering MHPSS services.[10] As of November 30, 2021, 372,636 confirmed cases and 5,456 COVID-related deaths in Libya have been reported.[11]

Locations
Tripoli, Misrata, Benghazi, Sabha, Ash-Shati

Services since 2019
PSS activities, select psychological interventions, medication management, community outreach activities, and MHPSS capacity strengthening of local staff (mhGAP)

2020 Caseload
1,600 (431 males, 1,135 females, 34 not identified)

International Medical Corps MHPSS staff
11 (9 service providers, 1 mhGAP trainer and 1 MHPSS specialist)

Remote activities
Limited number of PSS and case management; primarily training and supervision

International Medical Corps' MHPSS teams in Libya implemented minimal adaptations to remote delivery of MHPSS services, with much of the care provided in-person throughout the pandemic, because the government imposed only localized, short-lived restrictions after the initial three-month countrywide lockdown (March–June 2020). Primary healthcare centers (PHCs) where International Medical Corps implemented activities remained mostly open, and except for a few brief episodes of outbreaks necessitating remote working, International Medical Corps field staff continued working in clinics with COVID-19 safety measures in place.

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[8] United Nations Office for the Coordination of Humanitarian Affairs (2021, December). *Libya: 2021 Humanitarian Needs Overview.* Retrieved June, 2021, from https://www.humanitarianresponse.info/en/operations/libya/document/2021-libya-humanitarian-needs-overview-hno

[9] Zarocostas, J. (2018). Libya: war and migration strain a broken health system. *The Lancet (London, England)*, *391*(10123), 824–825

[10] World Health Organization. (2017). Mental Health ATLAS 2017 Member State Profile: Libya. Retrieved July 2021, from https://www.who.int/mental_health/evidence/atlas/profiles-2017/LBY.pdf

[11] Johns Hopkins University Coronavirus Resource Center: Libya. Retrieved November 30, 2021, from https://coronavirus.jhu.edu/region/libya

5.4 South Sudan

With a population of more than 11 million people, South Sudan is ranked as one of the worlds' least developed and most fragile states. In 2020, communities throughout the country were hit hard by the triple shock of intensified conflict, major flooding and COVID-19, a combination resulting in 8.3 million people in need of humanitarian assistance.[12] The civil war has exacerbated the psychological distress and mental health issues left behind by decades of conflict. An MHPSS study[13] conducted between 2015 and 2019 indicated persistent experiences of cumulative distress, mourning and grieving of multiple losses, acculturative stress, loneliness, anxiety, loss of self-esteem, strain and fatigue from cognitive overload. There is a substantial treatment gap due to an acute shortage of trained mental health professionals, lack of mental health policy and insufficient funding. The COVID-19 pandemic has worsened the mental health situation and constrained the availability of already limited mental health services. As of November 30, 2021, 12,755 confirmed cases and 133 deaths due to COVID-19 have been reported.[14] In response to the government restrictions and lockdowns, International Medical Corps transitioned some of the MHPSS services to remote modality, including for COVID-positive patients in isolation.

Locations
Maban, Upper Nile State and Central Equatoria State

Services since 2013
PSS activities, select psychological interventions, case management, psychiatry, and capacity building of local facility staff (mhGAP-HIG and psychological first aid, or PFA)

2020 Caseload
365 (186 males, 179 females)

International Medical Corps MHPSS staff
35 (4 mental health officers, 3 PSS officers and 28 community psychosocial workers)

Remote activities
PSS, case management, follow-up for mild-to-moderate cases, psychoeducation, training and supervision

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[12] United Nations Office for the Coordination of Humanitarian Affairs (2021, March). *South Sudan: 2021 Humanitarian Needs Overview.* Retrieved July, 2021, from https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ south_sudan_2021_ humanitarian_response_plan_print.pdf
[13] IOM, Focus Group Discussions in PoC sites by the Mental Health and Psychosocial Support Working Group, July 2019.
[14] Johns Hopkins University Coronavirus Resource Center: South Sudan. Retrieved November 30, 2021, from https://coronavirus.jhu.edu/region/south-sudan

5.5 Venezuela

Though once one of the richest countries in the region, Venezuela has experienced severe political, economic and social crises over the last decade that have resulted in food shortages, lack of access to basic services, diminished livelihoods and increased human rights violations.[15,16] With the population of slightly more than 28 million, 5.6 million of Venezuela's citizens have recently fled the country as a result of the political and social upheaval and dire economic conditions. [17,18] An estimated 7 million people throughout the country need humanitarian assistance.[19] A National Mental Health Policy was formulated in the early 1990s and reviewed in 2011, but only 10–25% of its recommendations have been implemented by the regional and national authorities.[20] Care in the country is mainly curative, focused on services provided by psychiatric hospitals. The shortage of key medicines and a collapse of community-based services have created a major gap in mental health care. The pandemic only deepened the crisis. As of November 30, 2021, Venezuela has reported 431,296 confirmed cases of COVID-19 and 5,144 deaths.[21] International Medical Corps launched its first MHPSS program in Venezuela in September 2020, with some of the program set-up and management implemented remotely. Service delivery began in Spring 2021; by then, previously established restrictions had been lifted, allowing services to be provided in person.

Locations
Caracas

Services since 2021
PSS activities, select psychological interventions

2021 Caseload
583 (131 males, 452 females)

International Medical Corps MHPSS staff
14 (1 coordinator, 1 manager, 2 officers, 10 service providers)

Remote activities
Program set-up and management

[15] Brodie, C. (2017, August 7). *Venezuela was once South America's richest country. Here's what went wrong.* World Economic Forum. Retrieved November 2021, from https://www.hrw.org/world-report/2021/country-chapters/venezuela
[16] Human Rights Watch. (2021, January 13). *World Report 2021: Rights trends in Venezuela*. Retrieved 2021, from https://www.hrw.org/world-report/2021/country-chapters/venezuela#
[17] The World Bank (2021). *Population, total — Venezuela, RB. Data*. Retrieved November, 2021, from https://data.worldbank.org/indicator/SP.POP.TOTL?locations=VE
[18] United Nations High Commissioner for Refugees. (2021, May 15). *UNHCR, IOM aid partners call for urgent support to refugees and migrants from Venezuela and their hosts*. UNHCR. Retrieved July, 2021, from https://www.unhcr.org/uk/news/press/2021/6/60c88e8c4/unhcr-iom-aid-partners-call-urgent-support-refugees-migrants-venezuela.html
[19] United Nations Office for the Coordination of Humanitarian Affairs. (2021). *Appeals and response plans 2021. Appeals and response plans 2021*. Retrieved July 2021, from https://fts.unocha.org/appeals/overview/2021
[20] World Health Organization. (2013). *Report on the system of mental health in the Republic Bolivarian of Venezuela*. Retrieved November 2021 from, https://cdn.who.int/media/docs/default-source/mental-health/who-aims-country-reports/venezuela_who_aims_report.pdf?sfvrsn=87a39c5e_3&download=true
[21] Johns Hopkins University Coronavirus Resource Center: Venezuela. Retrieved November 30, 2021, from https://coronavirus.jhu.edu/region/venezuela

Section 6: Case Study Approach

The following sections outline case study methods, criteria for selecting data sources and the data collection and analysis process, as well as limitations encountered during the development of the case study.

6.1 Methods

Primary data was collected through key informant interviews (KIIs) with International Medical Corps staff, frontline service providers (case managers/psychosocial workers, psychologists, psychiatrists and mhGAP-trained healthcare staff), external stakeholders from community leadership and MoH, and in-depth interviews with clients and caregivers. Purposive sampling was used to identify respondents for the interviews and for clinical record reviews, using pre-determined criteria to ensure representativeness and relevance of the samples.

Clinical records from client case files were selected with the aim of investigating changes in the process of recordkeeping during remote service delivery, considering a variety of cases and their use of remote or in-person services. Key informants were proposed by the MHPSS country teams in consultation with the case study lead (the headquarters Technical Unit MHPSS Technical Advisor) for each country. A purposive sample of clients and caregivers of clients were selected to achieve variation in the following characteristics:

- Males and females proportional to actual caseload
- Age groups
- MHPSS services received
- Types and severity of mental health conditions
- New and follow-up clients
- Experience with different levels and intensity of remote service (e.g., fully remote or hybrid, only remote follow-up vs. remote counseling sessions, etc.)

6.2 Data Collection

Interviews and record reviews took place between August and October 2021. Data collection was conducted primarily by International Medical Corps MHPSS staff through a combination of remote or in-person interviews, according to the preference and location of the respondent. The leads of the case study first trained program staff remotely on the data collection tools and protocols, using Skype or Microsoft Teams. Interviews with clients, caregivers and external stakeholders were conducted in each country either in-person, by phone or by tools such as Skype, WhatsApp, Microsoft Teams and Viber. The leads for each country interviewed International Medical Corps management and program staff remotely, using Skype. Detailed notes were taken for each interview. A total of 220 interviews were completed and 37 records were reviewed for the case study (Table 1).
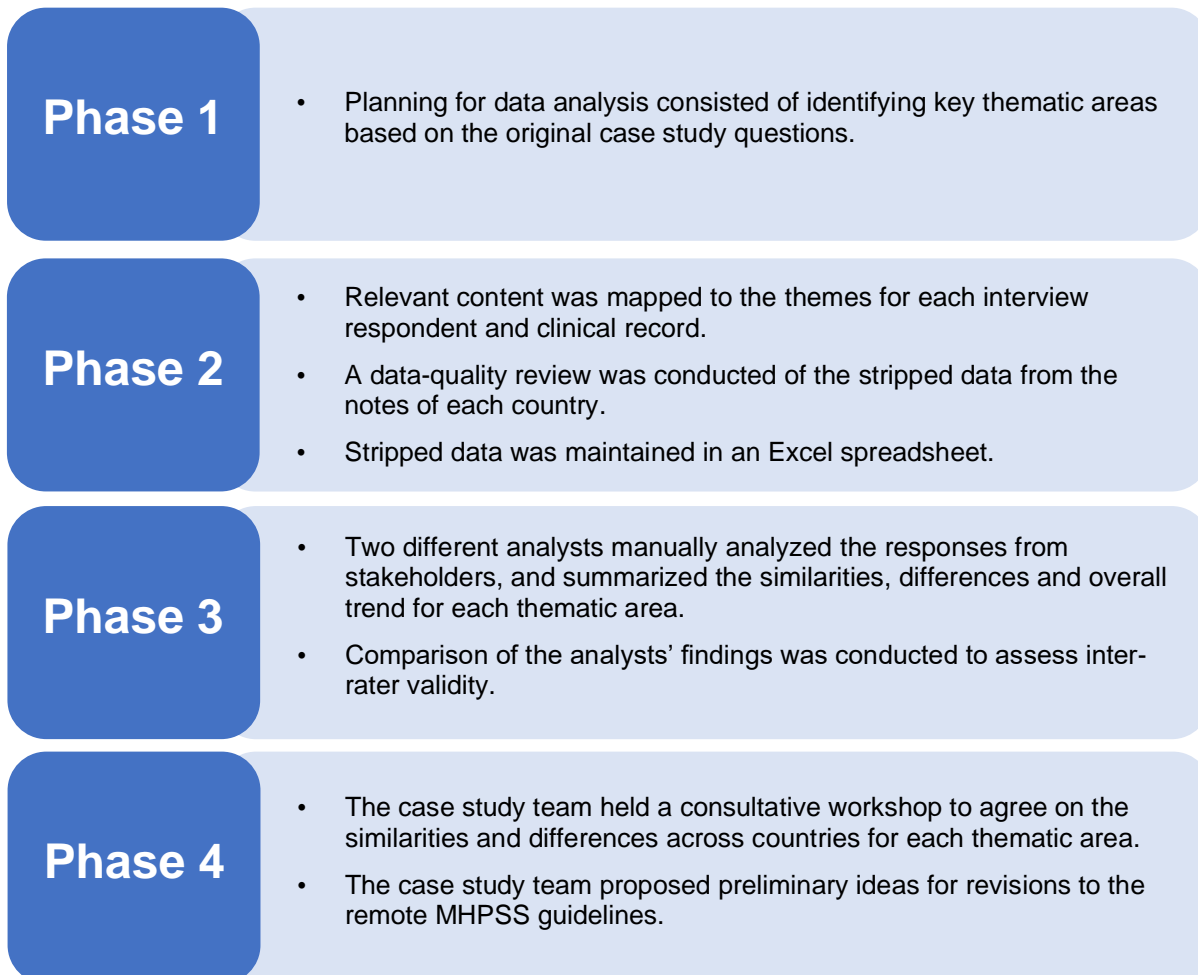
Table 1. Primary Data Collected

Country	Number of KIIs[22]	Clinical Records
Central African Republic	79 KIIs ■ 2 International Medical Corps management ■ 11 staff, providers and outreach workers ■ 60 clients and caregivers ■ 2 supervisors ■ 4 other stakeholders	19 case records
Iraq	66 KIIs ■ 3 International Medical Corps country management ■ 24 staff, providers, and outreach workers ■ 34 clients and caregivers ■ 1 supervisor ■ 4 other stakeholders	8 case records
Libya	9 KIIs ■ 1 International Medical Corps management ■ 4 staff, providers, and outreach workers ■ 4 supervisors	0 case records
South Sudan	60 KIIs ■ 1 International Medical Corps management ■ 9 staff, providers, and outreach workers ■ 44 clients and caregivers ■ 2 supervisors ■ 4 other stakeholders	10 case records
Venezuela	6 KIIs (management and program staff)	N/A

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[22] Reference Section 4.4 Limitations section for an explanation in sample size variance across countries

6.3   Data Analysis

Data analysis was conducted in four phases, using a semi-formal content analysis approach with manual data-stripping in Excel.

Figure 1. Stages of Data Analysis

Phase 1	• Planning for data analysis consisted of identifying key thematic areas based on the original case study questions.
Phase 2	• Relevant content was mapped to the themes for each interview respondent and clinical record. • A data-quality review was conducted of the stripped data from the notes of each country. • Stripped data was maintained in an Excel spreadsheet.
Phase 3	• Two different analysts manually analyzed the responses from stakeholders, and summarized the similarities, differences and overall trend for each thematic area. • Comparison of the analysts' findings was conducted to assess inter-rater validity.
Phase 4	• The case study team held a consultative workshop to agree on the similarities and differences across countries for each thematic area. • The case study team proposed preliminary ideas for revisions to the remote MHPSS guidelines.

Separately, clinical records were reviewed for completion of all required elements of records, level of detail in notetaking, variation in notetaking across remote and in-person, variation in types of documentation retained in each country and types of documentation used in emergency cases receiving remote treatment.

6.4   Limitations

The development of this case study had certain limitations that may influence findings. First, International Medical Corps headquarters (HQ) Technical Unit MHPSS Technical Advisors were not able to travel to the countries to manage data collection as originally planned, due to waves of COVID-19 cases making travel inadvisable. Country-based program staff—and, in the case of CAR, additionally hired enumerators—were trained to collect most data, while the technical advisors conducted interviews with country program and management staff. This approach presents some risk of bias in the responses given by clients.

Second, the methodology used was primarily qualitative, relying on in-depth and key informant interviews with a variety of stakeholders. No data on client outcomes (e.g.,

psychometric scales such as client functioning and perceived well-being) was collected, as the implementation of these scales was not yet standardized across the five countries.

Third, the case study team was not able to assess any potential causal effects of the remote MHPSS service delivery using the chosen methods, and in the absence of quantitative data and statistically valid comparison groups. The majority of remote MHPSS services also had ended by the time data collection was carried out, and the length of time in which remote services varied considerably across the five countries. This could have influenced the recall patterns of respondents.

In addition, the overall sample sizes for interviews and case file reviews was not necessarily representative of the overall size of the programs in each country, as was originally envisioned. Rather, the sample sizes reflected adjustments made to the data collection process because of circumstances not anticipated during the design of the case study. For example, the sample sizes for Libya and Venezuela were smaller, to reflect the limited scope of the case studies in these countries. In Libya, only a small number of cases were managed remotely on occasion (e.g., remote follow-up with COVID-positive patients). This did not provide a big enough sample to draw firm conclusions about remote service delivery, but presented an opportunity to learn about remote program oversight and capacity building activities.

In Venezuela, International Medical Corps launched its first MHPSS program in September 2020. Due to unforeseen challenges beyond International Medical Corps' control, including the necessity to transition from a partnership to a direct implementation model, the launch of program activities was delayed until Spring 2021. By then, previously established restrictions had been lifted and services began to be provided fully in person. In addition, the government of Venezuela limited issuance of visas and work permits to expatriate staff during the pandemic. This prevented International Medical Corps senior management staff from entering the country, and program set-up and management took place partially remotely during this period, enabling the case study team to document lessons and best practices about these aspects of programming that was not originally envisioned.

The revised travel plans by the HQ team also limited the size of the client case files reviewed, as the country teams had to take on this additional task while ensuring timely completion of interviews and managing daily responsibilities.

Section 7: Findings

The following sections present findings on specific adaptations made to MHPSS service delivery to ensure continuity of care and engage clients; factors that enabled or prevented the transition to remote services; benefits and challenges of remote services, as noted by clients and service providers; adaptations, challenges and best practices for remote training and supervision; and considerations for remote program set-up and management.

7.1 Adaptations to MHPSS service delivery, including continuity of care and new client engagement

Government restrictions to curb the transmission of COVID-19 as well as security risks during this period necessitated a transition to remote programming in each country.[23] However, the specific adaptations to MHPSS services throughout the pandemic varied between and within country contexts. The main trends observed relate to the timing, models of remote implementation and criteria for providing services remotely.

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[23] As noted earlier, in Venezuela all services were implemented in person because all restrictions had been lifted by the time MHPSS program activities launched.

Most countries transitioned to a hybrid model, but the changes were limited and temporary.

Hybrid models typically included clients receiving initial consultations, including assessments and potential medication prescriptions, in person, with subsequent follow-up and management over the phone. Though hybrid models were employed and remote services offered in some capacity in most countries, most care was still provided in person in many areas. Even within countries, the extent of remote service delivery varied based on decisions made by country teams and according to geographic and local contextual factors, such security risks and changing COVID-19 restrictions.

At health centers, measures were taken to cope with COVID-19 safety risks for those receiving in-person services by providing handwashing stations, requiring the use of masks and social distancing, and limiting the number of staff and clients in the center at a time.

In many areas, adaptation occurred mainly in the first months of the pandemic. Once government lockdowns and restrictions eased, many services returned to face-to-face modalities. For example, in both Libya and South Sudan the vast majority of services were delivered in person, with very few done remotely. In Iraq, some clients continued to receive remote services even after lockdowns and restrictions were lifted, based on their preference and ease of access. Group sessions and awareness-raising activities were halted in the beginning of the pandemic in many areas, but returned with limited numbers of participants when the local situation improved.

Severe and emergency cases,[24] new client intake, initial medication prescription(s) and vulnerable groups were largely managed in person following COVID-19 safety measures.

Where MHPSS services were typically delivered following a hybrid model, severe cases and first appointments were seen in person and follow-ups were conducted remotely. Case management and prescription-refill appointments were done mostly in person at clinics, with the length between appointments extended to decrease the number of clients in the clinic at one time. However, in Iraq and CAR, medication management was done in hybrid format, with some clients receiving services remotely and others coming in for refill appointments. Factors contributing to such variance included prescribing medication(s) to new clients whom service providers preferred to see in person for accurate diagnosis, an ability to send prescriptions to clients remotely (e.g., electronically, or via community health worker or family member) and severity of symptoms.

Remote services were typically conducted over phone. However, in countries where clients had access to smartphones and the internet, applications such as WhatsApp and the Viber were also used for remote delivery. Familiarity with and availability of a platform was the driving factor for the platform choice.

Priority access to in-person care was also given to certain vulnerable groups, such as women and survivors of gender-based violence (GBV),[25] for whom remote services were not easily accessible. Emergency cases were received exclusively in person in all countries, as remote care for urgent cases was not preferable. Family members or caregivers of vulnerable groups or people with disabilities (PWD) were also engaged in Iraq, CAR and Libya, and sometimes received remote support themselves.

In some areas of South Sudan, caregivers were educated and encouraged by radio to have discussions with their children on topics of mental health and COVID-19. However, systematic considerations for vulnerable populations do not appear to be in place in any of

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[24] Severe and emergent cases include clients with risk of self-harm or harming others, suicidality, and severe mental illnesses.
[25] Due to different cultural or religious reasons, many women cannot freely speak with service providers (more specifically, male providers) by phone or at home. For similar reasons, many women cannot leave the house alone.

the countries included. Additional guidelines can improve access to remote services by vulnerable populations.

Community outreach continued in smaller numbers, supplemented by radio and social media messaging.

Adapted outreach campaigns typically consisted of promotion over radio, megaphone or social media. Referral pathways with local health centers and organizations were also vital in maintaining services. Group community awareness campaigns and larger gatherings were halted in most instances and, where continued, the number of participants was reduced and social distancing guidelines were employed. Community outreach workers and community relays, self-referrals and referrals through previously established pathways were the main routes of case identification.

LESSONS LEARNED

- A hybrid model of care was used in most countries, but implementation of remote services was not standardized across sites. Having a set protocol for remote service delivery would lead to improved quality and sustainability of remote services.

- Systematic adaptations and considerations for vulnerable populations are needed to increase their access and engagement to remote MHPSS services.

- Traditional outreach can be bolstered by radio, social media and megaphone messaging to support continuity of care.

7.2 Enabling and preventing factors for transition to remote service delivery

Access to technology, however varied, enabled transition. So did staff and client willingness and flexibility, as well as coordination among stakeholders.

Availability of technology served as an enabling factor across all contexts, albeit with variance in the level of access and quality of connectivity. To address technological limitations, the program teams adapted the use of technology to the context. For example, in areas with poor cellular networks or internet connectivity, information—including psychoeducation—was disseminated through radio broadcasts and messaging via megaphones by community workers. Similarly, in areas with high technology availability—including smartphones—video capability was utilized to enhance interaction between service providers and clients, supervisors and supervisees, and among the program staff. These adaptations highlighted the importance of flexibility and innovative thinking in the face of resource and infrastructural limitations.

Staff willingness, dedication and motivation were also noted as enabling factors across many contexts. While the humanitarian field draws professionals willing and dedicated to persevere in the face of crises, organizational and leadership support to sustain motivation during times of uncertainty cannot be overlooked. For example, the surveyed program staff and service providers noted the provision of means to be able to do their work remotely (e.g., phone credit and internet subscription), ongoing support from their direct supervisors as well as the HQ Technical Unit, internal and external guidelines, and training as factors that helped them transition to remote or hybrid programming and service delivery. Where such support was perceived to be lacking or insufficient—such as the absence of phone

credits, training and guidelines noted in Libya, and the lack of laptops for some of the field staff in South Sudan—increased impediments and decreased willingness to transition to remote delivery were noted.

Additional enabling factors unique to one or two case-study countries were also noted. In Iraq, International Medical Corps' reputation and the trust built with communities helped mitigate initial apprehension among clients and community members about an unfamiliar modality of service delivery.

"International Medical Corps built trust with local communities, and community members used to inform each other about the type of service and level confidentiality that we respect as service provider."

– Service provider in Iraq

In Iraq and South Sudan, coordination among nongovernment organizations (NGOs)— including through interagency working groups and clusters—helped with transition challenges and generated innovative solutions. For example, an external stakeholder interviewed from International Organization for Migration (IOM) noted the establishment of a helpline to support client outreach and referrals as a successful inter-agency collaboration in South Sudan.

"We started training the volunteers, mobilizing resources, bringing our heads together and coming up [with] how we [were] going to manage the remote helpline services....It is still running up to now… and we have volunteers from International Medical Corps and IOM who are running the helpline."

– IOM service provider in South Sudan

Adapted outreach was vital in continuity of care for existing clients, but played a limited role in identification of new cases.

The role of outreach in continuity of care and transition to remote modality was generally favorable. Awareness-raising activities—both before and during the pandemic—contributed to the continuity of care. As noted earlier, adaptations for outreach varied across contexts, and included the use of radio, social media and megaphones to transmit messages related to COVID-19 and MHPSS services. The clients and community members primarily learned about the transition to remote or hybrid services directly from their service provider or outreach workers. However, particularly in CAR, some clients noted being unaware that remote services were offered or about how to reach service providers remotely, pointing to the need for ongoing awareness-raising about the availability of such services.

Proactive outreach to identify new cases in a remote modality was limited, and new cases continued to be identified based on previous practices, including self-referral and referral by other organizations and community members. Community health workers continued to play a vital role in linking clients to services, as many of them continued to work in person once lockdown restrictions eased, and following requisite safety protocols (e.g., not entering people's home or using megaphones). In CAR, Libya and South Sudan, the use of a helpline or hotline was implemented in some areas, primarily for referrals or appointment-making purposes, but their role in continuity of care or new case identification is not immediately clear. For example, in CAR, the helpline (aka "ligne verte" or "green line") was intended to be used by clients and their families in times of crisis. However, it was underutilized due to the

lack of access to phones and other means to make such calls, or lack of awareness about the helpline.

Poor connectivity and limited access to technology, and lack of means to access remote services, were major impediments for clients.

Although technology enabled access to remote service delivery, difficulty in access and the poor quality of connectivity disrupted—or, in some cases, entirely prevented—transition to remote modality. The challenge was acutely felt in communities with limited mobile-network coverage and access to technology. Frequent power outages, resulting in inability to charge phones, as well as lack of access to even basic phones and phone credits by clients and weak internet connections were observed in South Sudan and CAR. However, poor internet and network coverage were also cited as a hindrance in Iraq, Libya and Venezuela. Many clients and service providers noted during the interviews that providing a means of communication to clients—in the form of phone credits, solar chargers, mobile phones or establishing community call centers for those without phones—would ease these challenges.

Lack of experience, robust training and necessary tools and resources inhibited service providers' ability to provide services remotely.

Lacking experience and training on remote service delivery also contributed to challenges across several contexts, both among International Medical Corps staff and government counterparts, highlighting the need for systematic capacity building to provide remote services. Among other things, such capacity building would focus on appropriate adaptations of assessment and diagnosis, as well as techniques and interventions that were noted to be particularly challenging in remote modality and in the absence of video capabilities (e.g., demonstration of breathing techniques, Problem Management Plus (PM+), management of emergency cases and engaging certain clients, such as children, people with intellectual disabilities, the hearing-impaired, etc.). In the absence of robust capacity building on remote service delivery, service providers across contexts reported lacking confidence in their ability to effectively provide services remotely, or awareness that certain services can be effectively adapted for remote delivery.

While preference for in-person or hybrid modality were noted by many clients and service providers across all contexts, such preference was the decisive factor in limiting remote delivery only in Libya. According to the Libya management team, service provider and client feedback that favored continuation of face-to-face services, coupled with limited restrictions imposed by the government, led to the continuation of service largely in person, with ad-hoc remote follow-up in exceptional cases (e.g., COVID-positive clients in isolation or those in remote locations). However, service providers in Libya pointed out the need for additional training, tools and resources (such as providing phone credits), and the lack thereof, may have affected their perception about the efficacy of remote services and their ability to implement it, resulting in a preference for retaining in-person services to the extent possible.

In South Sudan, other unique factors included linguistic and tribal diversity and the difficulty of facilitating translation over the phone. This was exacerbated by the fact that body language cannot be observed by the service provider and that translation requires more time. In CAR, MHPSS service providers identified a lack of budget to support the adaptation to remote services, and highlighted the need for time, support and budget to carefully plan such a transition, which should include training and preparing the staff. The lack of guidance by MoH on remote service delivery was also noted as an impediment in CAR.

Disruptions in referral pathways posed barriers to access in some places.

Similarly, in Iraq, Libya and South Sudan, disruptions to the previously established referral pathways may have prevented some clients from receiving the services they needed. For example, in South Sudan, the established practice was to accompany clients to the next referral point, to ensure they were received and the service provider understood the client's needs. However, with the transition to a remote referral process, this communication often broke down. In some instances, service providers at the next referral point were not available or did not respond, which was perceived to erode clients' trust in the availability of services and the referring organization.

> *"During the pandemic, the referral was done through email communication or phone, which was a bit difficult, as you may find the [service provider] was not responsive via email because of network issues or the phone was off."*
>
> *– Service provider, South Sudan*

Similarly, pre-pandemic, periodic in-person gatherings of partners facilitated connections between service providers and agencies, and helped build reliable and trusted referral pathways. This practice moved to Skype during the pandemic, with inconsistent attendance or an inability to gauge who was present. In Iraq and Libya, discontinuation of services—including support for transportation to referral points—by some organizations, due to funding shortages or pandemic-related restrictions, contributed to similar referral challenges. The challenges encountered with regard to referral pathways during this period highlight the necessity for robust referral-tracking systems and service mapping to ensure that clients are not inadvertently lost along the continuum of care.

LESSONS LEARNED

- Staff and client flexibility and willingness supported the transition; providing more robust training on remote service delivery would improve providers' capacity and confidence in delivering remote services.
- Outreach was vital to continuity of care, but further adaptation in identification of new cases is needed.
- Access to technology can enable the transition to a remote model, but providers and clients need strong phone and internet connections to provide and access quality remote services.

7.3 Benefits and challenges of remote service delivery

Convenience served as the primary benefit for clients and expanded access.

Benefits of remote modality noted by clients and service providers across contexts included convenience, such as avoiding long-distance travel to get to clinics, saving time and eliminating transportation costs.

Service providers also noted that remote modality facilitated access to clients who were previously excluded or had difficulty seeking in-person services, including mobility-impaired clients, women who have to be accompanied by men in public places and people unable to

afford transportation costs or take time off from work to go to or accompany their families to the clinic. During the pandemic, remote modality also ensured continuity of care for COVID-positive clients in isolation.

"The confined had a feeling of despair that could lead them to suicide. They did not receive visits from parents. This is why we must adapt our services to meet these needs."

– MHPSS staff member from CAR

In CAR and Iraq, service providers felt that during remote service delivery there was greater engagement collaboration from family members and caregivers in the care and support being offered to the person.

Reduced stigma was perceived as an advantage of receiving services remotely.

In addition, respondents also noted reduced concerns about stigma that clients and caregivers usually associate with seeking mental health services in person. Both clients and family members noted the benefits of not being seen going to the clinic to receive services. Some discussed how previously going to the clinic for services caused distress, as they worried about privacy and their standing in the community.

"I do not want anyone to know that I am going to the…center, so receiving treatment online was better for me in terms of privacy."

– MHPSS client from Iraq

"There are people who prefer the remote communication to avoid meeting with counselors and prevent stigma. They feel embarrassed when people see them coming to counselors, so they feel better when they receive psychosocial support sessions remotely."

– Service provider from Libya

Remote services were generally perceived to have positively impacted client well-being, but with different opinions about the level of effectiveness.

In terms of client well-being and functioning, perceptions about remote services generally ranged from "better than nothing or slightly effective" to "very effective or just as effective as in-person services," while a few respondents expressed the remote services were "not effective at all." The latter categorization was significantly higher among respondents in South Sudan (slightly more than half of respondents). These perceptions reflected the overall preference for in-person or at least hybrid services in most cases. Except for a few cases, where client conditions deteriorated or remained unchanged during this period, overall there was a perceived improvement in or maintenance of previously attained levels of well-being. Though it is difficult to attribute improvements or maintenance of well-being to remote services alone given the prevalence of hybrid modalities in most contexts, the transition to hybrid services to ensure continuity of care likely contributed to fewer deteriorations observed across the board.

In South Sudan, clients noted the more frequent follow-up by service providers as an added benefit of remote modality that contributed to their overall sense of well-being and a perception that the service providers cared for them. Interestingly, an opposite effect was noted in CAR, where clients noted less frequent or inconsistent follow-up by service providers during the hybrid modality. This is partly explained by the fact that at the end of

each face-to-face session clients are handed a card with their next appointments, allowing them to keep track of appointments. This cannot be done during phone sessions, possibly leading to confusion about when to expect follow-up. This highlights the need for reminder calls or text messages in advance, where appropriate, to ensure that clients do not miss sessions or feel abandoned.

Lack of privacy and confidential spaces posed a major challenge for clients.

The lack of confidential spaces and privacy was consistently noted by clients and service providers as a challenge to providing remote services. This factor especially affected those clients living in densely populated quarters (e.g., camp settings), women and GBV survivors, and those choosing not to disclose their mental health-seeking behavior to their families. The mitigation measures for such cases often entailed accommodation in person if the circumstances permitted, highlighting the challenge of receiving MHPSS services while at home.

Building trust and rapport and observing clients remotely for accurate assessment and diagnosis proved difficult, as did management of severe and emergency cases.

The inability to observe body language and accurately assess clients in general, the difficulty of building trust and rapport over the phone and the challenge of implementing complex interventions and techniques were noted as impediments to remote service delivery. In the absence of video-enabled technology, some respondents noted having to rely on family members or community workers with the client to facilitate accurate assessment and diagnosis, highlighting the importance of psychoeducation for caregivers and capacity building for community workers to be able to identify and relay basic mental health-related information.

Service providers across all contexts also noted difficulties in addressing severe and emergency cases over the phone or web conferencing. As noted earlier, emergency and severe cases were treated either entirely in person or transitioned to remote/hybrid modality once stabilization and remission were achieved and only required periodic follow-up by the service providers. One service provider in Iraq noted that remote management of at-risk or emergency cases went as far as doing risk assessment and psychoeducation for family members on how to prevent harm until the client reached the nearest referral pathway. The absence of standard operating procedures and prior training for remote management of emergency, complex and severe cases may have, to some degree, inhibited the teams' ability and confidence to manage such cases remotely.

Remote medication prescription and management differed based on the context.

Medication management and prescription-refill practices varied considerably between countries and even between different areas within the same country, and presented some challenges, such as clients experiencing disruptions in their medication routines in rare cases. Though disruptions of medication are largely attributable to overall shortages, especially in places like CAR, the lack of a standardized approach to prescribing and refilling medications remotely may have contributed to the challenge. In Iraq, some providers took pictures of prescriptions and shared them with clients over smartphone applications, which may not be feasible in contexts lacking such technology or where pharmacies do not accept such methods. In CAR, one of the recommendations to address this challenge included establishment of an online system of authorized psychotropic medication prescribers who have access to client records and can validate prescriptions for clients who arrive at the pharmacy to receive or refill their medication.

Service providers experienced work-life imbalance.

Service providers in several countries also noted work-life imbalance as an added challenge to remote modality. Clients would often perceive remote availability as 24/7 access to services, and reach out to service providers outside of traditional work hours. This led many providers to work long hours and feel they needed to be available around the clock. A provider in Iraq mentioned feeling that they could not say no or turn clients away. Many providers noted an increase in stress and an inability to devote time to self-care. In some instances, where providers did not answer calls, it affected the rapport between providers and clients, as clients would get frustrated with the provider not being instantly available.

> *"Sometimes, clients call me while I am on leave…[or] at inappropriate times….I am also a human and I need self-care…this is a big challenge in remote service delivery."*
>
> *– MHPSS service provider in Libya*

LESSONS LEARNED

- Remote services positively impact client well-being, and have convenience and stigma-reduction benefits for clients and caregivers. However, the lack of privacy and difficulty establishing rapport and observing clients pose major challenges in remote delivery.

- Remote modality can increase access to services for those who previously could not access them. However, considerations are needed for vulnerable populations and those for whom remote services are challenging due to lack of access to private space or technology.

7.4 Remote training: adaptations, challenges and best practices

Approaches to training during this period varied considerably, with remote training generally perceived as less engaging, despite convenience and other benefits.

The modality of training and adaptations differed between countries. Even within countries, the extent of remote delivery varied based on geographic area, local restrictions and context. For example, in South Sudan and Libya, training sessions were done in person where possible, and remotely only in areas with movement restrictions. In CAR, training was done in person in some areas and remote in others, though fewer training sessions were organized overall. In South Sudan, training continued where possible, but in Malakal, where there were stricter movement restrictions, training was suspended until restrictions eased. In Iraq, training was suspended during initial lockdowns and resumed in May of 2020, and was conducted remotely or in-person depending on context. These non-standardized adaptations to training activities make drawing firm conclusions about the effectiveness of remote delivery difficult.

Overall, stakeholders in many countries found remote training to be somewhat effective but generally not as effective as in-person training. Also, a very strong preference for in-person training was expressed by stakeholders from various countries.

> *"The remote training was less interactive. I did not see the same leve*
> *of interest from trainees in the remote model....The remote*
> *training was better than nothing…[but] not that useful....I prefer*
> *the in-person training."*
>
> *– Service provider in Iraq*

Connectivity, technology used and trainer capacity affected the remote training experience.

When it was possible to provide training remotely, phone calls, WhatsApp, Zoom and Skype were among the modalities used. Access to technology and bad internet connection were widespread challenges that rendered remote training difficult. In Iraq, Libya and South Sudan, engagement and attendance decreased with remote training, due to connectivity issues and the non-interactive nature of the modality. Providing training to trainers on how to provide engaging sessions using remote modalities could help mitigate some of these challenges. Many stakeholders recommended providing service providers and staff with laptops and/or smartphones so they can better access and interact with training and supervision remotely.

Convenience and cost savings were noted as benefits for remote training.

Benefits of the remote modality included the ability of those living in distant locations to participate in training when they may normally not have had the time or ability to travel to session sites. It was also noted to be less costly, as travel expenses were eliminated. While remote training appears to have had some effectiveness, in-person or hybrid sessions were widely preferred across the five countries.

Training on remote MHPSS service delivery was conducted, but more is needed.

Providers received some training on how to deliver remote services in all countries. However, many service providers and MHPSS program staff called for more in-depth and extensive training on remote service delivery, and felt they were not given all the necessary tools and skills to implement the new modality. For example, in Iraq, providers wanted training on communication skills and the technology used for providing remote services. In Libya and South Sudan, multiple providers called for greater training on manualized interventions, such as mhGAP and PM+. In CAR, a member of the program staff requested more-specific training for service providers on how to identify certain mental health conditions when assessing clients over the phone. Additionally, some service providers found it difficult to implement certain services (such as breathing techniques or specialized counseling skills) remotely, and requested more-specific training on how to adapt these techniques to remote care.

> *"Training should be provided for staff on communication skills for*
> *remote management and service delivery, and risk of misinterpretation*
> *[while] providing service with or without video/in-person."*
>
> *– Management staff in Iraq*

LESSONS LEARNED

- Remote training was effective, but there is greater need for more-interactive elements in remote sessions. Providers also need additional training on providing services remotely.

- Training trainers on how to hold sessions remotely could increase general effectiveness and engagement.

- Addressing issues of connectivity and technology would improve quality and attendance of remote training.

7.5 Remote supervision: adaptations, challenges and best practices

Transition to remote supervision was not systematic, and was compounded by technological problems and lack of previous experience.

Though supervision differed by location and local context, a hybrid model generally was used for both individual and group supervision sessions. Remote sessions were conducted over the phone, WhatsApp, Skype or, in the case of Iraq, Viber. The frequency of meetings increased in many areas to make up for lack of in-person interaction. However, it is fair to note that in CAR, supervision was done fully in person in many instances, and hybrid modalities were used in some areas.

There were many challenges to these supervision adaptations. On-the-job observation was halted, which made it difficult for supervisors to fully assess the impact and effectiveness of remote service delivery. It also meant that providers were not receiving feedback on the quality of care they were providing, and few adaptations were implemented systematically. Supervisors in Libya found this to decrease overall effectiveness, especially as it related to prescribing of medications and managing severe or complex cases. Though remote supervision sessions did allow for case-conferencing—which both supervisors and supervisees found to be quite useful in working through mild-to-moderate cases—a key element to supervision was missing when providers could not be directly observed. In Iraq, this challenge was mitigated by having providers record sessions and share them with supervisors for review. However, this practice was not noted in any of the other included studies, likely due to unavailability or access to video-enabled technology and poor connectivity.

> *"[I] did not receive on-the-job observation, which can help improve the quality of work and turn weaknesses into strengths."*
>
> *– MHPSS service provider in South Sudan*

As with remote service delivery, lack of access to stable technology and poor quality of internet connection kept many from effectively engaging with remote supervision. These sessions took more time and required more effort from participants than in-person activities, while being less interactive. Many found it difficult to fully exchange ideas via the remote modality. Conducting highly interactive sessions was especially difficult due to poor connectivity, which prevented video-conference calls.

Implementation of supervision adaptations was not systematic or consistent. Lack of experience with remote modalities and lack of guidance on how to implement remote supervision meant that the effectiveness of remote delivery was often contingent on the experience and skill of individual supervisors. In general, supervisors and supervisees felt that the quality and effectiveness of supervision decreased when done remotely and that a hybrid model was preferred to solely remote supervision.

Flexibility and ease of access served as benefits of remote and hybrid supervision, but greater adaptations are need to improve effectiveness.

Some benefits to remote supervision were also noted. Ad-hoc communication was employed to compensate for many challenges of remote service delivery, with great success. Supervisees found that this helped them receive additional support when a challenge arose. The flexible and often-practical nature of remote supervision was beneficial. Though the remote modality may not have been useful for many kinds of supervision, it worked well for case conferencing and apprenticeship sessions. More people could also engage in remote group sessions, as they did not have to travel to participate. In Libya, a provider also mentioned that female participants were more willing to engage in supervision over the remote modality.

> *"The staff can contact me at any time as soon as there is a difficulty….The best practices remain free exchange and flexibility…between supervisee and the supervisor, in terms of the frequency and subjects to be discussed."*
>
> *– Supervisor in CAR*

There was wide agreement that hybrid supervision would be preferred to a completely remote model. There were mixed findings regarding the impact of supervision on staff well-being. Some (e.g., in Libya) noted a positive impact, due to increased access to one-on-ones with supervisors, while others (e.g., in Venezuela) noted a negative impact, considering the expectation of around-the-clock availability of many supervisors, and the toll it takes and time this requires of them.

LESSONS LEARNED

- Generally, hybrid supervision has its benefits, but there is greater need for adaptation if it is to be fully effective.

- Addressing the challenges regarding technology would increase the quality of remote supervision sessions.

- Providing training for supervisors on how to implement remote supervision could increase the effectiveness of remote elements and create more systematic approaches for the delivery of remote supervision.

7.6   Considerations for remote new program set-up and management

Setting up a new program remotely presented challenges primarily for staff well-being and teambuilding.

Remote program set-up and management were the primary focus of the case study in Venezuela, as services were provided only in person. As noted previously, an expatriate senior management team member worked remotely outside of Venezuela due to visa restrictions, while local staff worked in country, with some working from home and others in the office. This set-up often blurred the line between work and rest, as management staff made themselves available around the clock to compensate for the lack of physical presence. This impacted not only the well-being of management staff but also local staff, as they sometimes felt they needed to make themselves available all the time as well. Though Venezuela was the country where most of the data related to new program set-up and management practices was collected, respondents in all countries shared concerns about staff well-being due to the lack of human interaction and work-life imbalance when working from home.

> *"I would like the MHPSS team and TU to provide more staff well-being in these situations, as it was difficult for some staff to adapt and manage working from home, and it was more difficult for staff who live alone and expats than for those living with their families."*
>
> *– Management staff in Iraq*

> *"Show staff how to set clear boundaries about managing their time and not working too hard....Find ways to meet face-to-face (video sessions, or how to run icebreakers online, etc.) to improve communication and stop loneliness."*
>
> *– Manager in Venezuela*

Though the technical quality of programming in Venezuela was not affected, team building suffered. Senior staff's absence from the office resulted in their inability to fully observe team dynamics and effectively manage team conflict. The team in country often felt as if they did not have a way to fully explain or reflect what was happening on the ground to the coordinators over the remote modality. This inhibited their ability to resolve issues within the team and fully manage the team dynamic. Conflict between staff members would arise and go unresolved for a period until the remote management team was made aware. This impacted staff motivation at times, with some staff simply not acknowledging conflict or not answering calls.

In contrast, management in Iraq reported that staff were more productive and organized when they transitioned to working from home. There was good communication between staff, and overall team tension decreased when people were working from home. Similarly, in Libya, where the team had remote working and management experience, no such tensions or team dynamic challenges were noted. This points to the unique challenges posed by starting up a new program and building a new team entirely remotely without prior in-person interaction, which tends to more easily facilitate rapport and trust building.

Open communication and use of collaboration tools eased some of the challenges.

Management staff in Venezuela recommended the use of document sharing and other collaboration tools as a best practice to decrease delays associated with team members working in various time zones. Additionally, a great need for open and clear communication styles was consistently discussed. Being explicit when communicating with various members of the team left less room for misinterpretation, and helped inexperienced staff across geographic areas know how to properly implement program set-up.

> *"Always have an agenda....Always have a presentation or something you can share on the screen as a starting and talking point."*
>
> *– Manager in Venezuela*

The need for open communication and seeking input from the team was also highlighted in South Sudan, where one program staff member felt that remote program set-up was done without the input of those outside of management, and this caused some frustration among staff.

A hybrid approach is preferred to solely remote work and management.

Experience with remote or hybrid management seemed to be integral in the success of these models during the COVID-19 pandemic. Management had been partially remote in Libya since 2016, when the expatriate staff left the project site in Sabha (Southern Libya) due to security reasons. From the management team's perspective, it took trial and error, but the team successfully implemented remote management nearly five years ago and had no issues continuing remote management during the pandemic. Some team members who were supervised and managed remotely noted that in-person management was more effective, expressing preference for periodic field visits by the managers. For staff in program set-up and management, key informants in Venezuela recommended the use of a hybrid model of working.

> *"Take a blended approach if remote working has to happen for security reasons, then do remote for a bit, but then have field visits and then go back to do a bit more remote working."*
>
> *– Manager in Venezuela*

LESSONS LEARNED

- Country teams with experience in remote management (as well as prior face-to-face interactions) had an easier transition to remote program set-up and management during the COVID-19 pandemic.
- Staff well-being needs to be prioritized in the transition to remote work. Including measures to help staff create a better work/life balance could improve remote working.

Section 8: Lessons Learned for Remote Programming

Though many challenges were encountered in transitioning to remote programming across all contexts, the country teams and local communities showed a great level of flexibility, ingenuity and resilience in overcoming or mitigating these challenges. Lessons learned have been captured in the following sections, to reflect on best practices as well as areas that require further improvement.

Access to technology and quality of connectivity influence the level of success in transitioning to remote modality.

In areas with better technological infrastructure and access, fewer impediments were noted, while challenges were more acutely felt among the most vulnerable stakeholders with little or no means of accessing services remotely. Providing a means of communication—such as phone credits, phone chargers, or community call centers—was favored by various stakeholders across different contexts to address this challenge.

Flexibility and adaptability are key to mitigating infrastructural and resource limitations.

Creative solutions to address contextual limitations resulted in better outcomes for continuity of care and overall programming. For example, in areas with poor cellular network or internet connectivity, teams disseminated information through radio broadcasts and messaging via megaphones. In areas with high-tech availability, teams utilized video capability to enhance remote interaction, and leveraged social media for outreach and awareness-raising. Medication prescription intervals were increased to reduce the need for in-person contact. Supervisors increased frequency of contact with supervisees, or made use of video-recorded sessions to compensate for the lack of on-the-job training and supervision.

Less-complex interventions are easier to transition to remote modality.

Follow-up and maintenance sessions as well as medication management for existing clients and clients with mild conditions were noted to be easier to conduct remotely, likely due to previously established rapport and familiarity with the client symptomology and functioning. In addition, case management, psychoeducation, referrals and basic techniques were easier to implement than more specialized counseling skills.

Severe and emergency cases, and vulnerable groups, are most challenging to effectively support remotely.

Service providers across all contexts noted the difficulty of addressing complex, severe and emergency cases, as well as cases involving children, those with hearing impairment and intellectual disability, over the phone or via web conferencing. In line with existing guidelines and risk assessment, most of these cases were accommodated in person. Developing standard operating procedures may enhance service providers' capacity and confidence to manage such cases remotely.

Adapted outreach contributed to continuity of care, and can be further strengthened to improve identification of new cases.

Adaptations for outreach, such as the use of radio, social media and megaphones to transmit messages, built on previous in-person efforts and favorably affected continuity of care. However, the need for greater utilization of such tools, as well as broader awareness-

raising among clients about the availability of remote services and how to access them were noted as ways to improve and expand outreach during remote and hybrid implementation.

More robust and extensive capacity building in remote service delivery is needed, as are enhanced delivery methods for remote capacity building.

A need to provide more in-depth and specialized training, as well as tools and guidelines, before transitioning to remote care was consistently noted as a way of alleviating some of the challenges encountered during implementation. Additionally, the lack of engagement and interaction may have impacted the quality of learning during remote training and supervision, pointing to the importance of participatory training methods and use of interactive platforms to enhance capacity building experience.

Established teams with experience in remote program management had an easier transition, but staff well-being was impacted across the board by remote work.

Building trust and rapport and facilitating team cohesion among an entirely new team posed unique challenges in Venezuela, challenges that were not observed in countries with established teams and programs. However, blurred home-work lives contributed to increased stress among staff across all countries. More intentional teambuilding, virtual social activities, open communication channels and self-care resources for staff were noted as mitigation measures.

Section 9: Recommendations

The following recommendations aim to inform transition and improve the quality of remote implementation in future scenarios where programming must be implemented remotely or in a hybrid modality.

9.1 General recommendations

1. Service delivery can be implemented on a continuum, from entirely remote to partially remote (hybrid) to fully in-person. Communicate the need to transition to remote or hybrid modality to all stakeholders consistently, and as soon as possible.

2. Be flexible and tailor the approach to the country context, identified staff and client needs and programmatic priorities.

3. Ensure availability of services in multiple modalities, and train both providers and clients on how to engage with services in all formats.

4. Use creative outreach modalities based on available resources and context, such as radio broadcasts and social media messaging, to raise awareness about existing remote options and ways to utilize them.

5. Consider establishing an MHPSS line (phone and/or social media) as an entry point for clients to connect to services (e.g., for referrals, appointment-making, etc.). Consider rotating responsibility for the line among MHPSS staff.

6. For clients lacking privacy or phones to connect to remote services from their homes, consider establishing safe and confidential areas in community spaces for clients to access phone-based services.

9.2 Recommendations to MHPSS program management teams and country leadership

1. Conduct an in-depth assessment of resource needs and related budget for remote programming, in line with the country context (e.g., technology infrastructure, connectivity issues, staff capacity building, etc.).

2. Ensure that additional responsibilities and level of effort related to the transition to remote service delivery are reflected in the budget, and advocate with donors for budget flexibility to support the transition.

3. Before transitioning to a remote or hybrid modality, ensure that service providers have access to communication technology and platforms that are used by clients, including a business number if possible, to facilitate work/life separation.

4. Develop contingency plans in consultation with MHPSS teams and clients, to include establishment/updating of referral pathways and identification of collaborative actors to be engaged during the transition to remote MHPSS programming.

5. Consider piloting remote service delivery for simpler MHPSS interventions, and gradually introduce more complex interventions as service providers gain experience and clients get acclimated to the new modality.

6. Train trainers on how to adapt their training style to remote delivery, including teaching time management skills, participatory methods and how to balance knowledge-based learning and practice.

7. Train supervisors and supervisees on how to engage with remote supervision, including finding the right remote methods that suit both the program and individual participants. Use a hybrid model where possible.

8. Advocate for the Human Resources department to put in place a staff-care program that accounts for and provides practical tools for staff well-being, self-care and boundary setting. Model these behaviors.

9. To the extent possible, avoid entirely remote working arrangements during the initial set-up of the program. Provide opportunities for managers and staff to meet face-to-face to build team cohesion and rapport.

10. Ensure that staff and service providers adhere to the guidelines on remote documentation and confidentiality of data and information.

9.3 Recommendations to HQ technical support team

1. Conduct advocacy with your organizational leadership and donors on the importance of adapting MHPSS programming during movement restrictions and similar scenarios; exploring options for remote services; addressing budgetary needs; and supporting staff well-being.

2. Facilitate regular information and resource sharing with program staff to improve their confidence in remote models and increase buy-in; provide orientation and training on evidence-based remote modalities, including by sharing global examples of how remote services have been successfully implemented by others.

3. Build staff capacity, including through specialized and technical training, on how to deliver and document remote MHPSS services. Training curriculum could include communicating with clients via online platforms, building rapport remotely and ensuring confidentiality and informed consent over remote modalities.

4. Provide additional guidance required for service providers to effectively support vulnerable groups remotely, including people with disabilities, GBV survivors and children.

5. Develop interactive training modules to be implemented remotely. Provide training for program staff, including training of trainers, on training of service providers in remote delivery. Prioritize participatory models.

6. Develop specific guidance, methods and tools for remote supervision.

7. Complement guidance and training for remote programming with translated and context-appropriate practical tools and materials, such as intervention manuals and standard operating procedures.

8. Develop or support development of communication materials, and share examples of radio messages and use of hotlines across country programs, to support outreach efforts.

9.4   Recommendations to service providers

1. Customize approach to each client's needs, situation (risks, access to private spaces and technology, etc.) and preferences. For example, use a messaging service instead of voice calls for clients concerned about privacy or those with hearing impediments.

2. If possible, conduct an initial session with new clients in person to establish rapport and trust before transitioning to remote services.

3. Call or send text reminders to clients in advance of remote appointments, to prevent missed appointments.

4. Educate clients and families on how to engage with remote services, including using psychoeducation for families and caregivers to help them understand their role in supporting clients in receiving MHPSS services.

5. Provide clear messaging to clients and caregivers on "working hours" and your availability to take calls; have a contingency plan for instances when you cannot be reached, as well as a protocol for emergencies.

6. Obtain client feedback on how the transition and remote modality is working on an ongoing basis (informally and through M&E satisfaction surveys).

7. Attend training sessions and review existing guidelines for practical tips for client interactions, such as setting up locations, minimizing interruptions, lighting, technology, etc.

8. Discuss and troubleshoot with supervisors the challenges encountered with remote service delivery, such as logistical problems and challenging client interactions.

9. Practice with supervisors delivering sessions remotely, and applying existing guidance and good practices.

10. Advocate for self-care and well-being, and bring up concerns to supervisors.

11. In collaboration with MHPSS program management team, establish referral pathways to include available in-person services capable of providing support for suicidality, psychosis and other severe cases.

12. In collaboration with MHPSS program management team, develop a robust referral tracking system and conduct periodic service mapping, to ensure clients are successfully reaching the next referral points.

Annex: Case Study Questions

Case Study Questions	Primary sources of information
1. How were MHPSS services adapted to ensure continuity of care while taking into account public health risks, geographic remoteness, and security and movement restrictions? What factors contributed to decisions taken on service adaptation?	• Country and program management • MHPSS service providers
2. What factors enabled or prevented the transition to remote service delivery, particularly in terms of the a) country context, b) program management, c) mental health conditions treated, d) type of service provided, e) remote modality, and f) referral pathways?	• Country and program management • MHPSS service providers • MHPSS trainers • Outreach workers • Clients • External stakeholders
3. What benefits and challenges did service providers perceive in the process of conducting services remotely? In particular, how did remote service delivery affect a) Identification of new cases, b) Medication management and prescribing practices, and c) provision of psychosocial and psychological interventions?	• MHPSS service providers • Outreach workers
4. What benefits and challenges did clients perceive in the process of receiving remote services?	• Clients and family members/caregivers • PSS group participants
5. To what extent was the remote delivery of MHPSS services perceived to be effective in improving client well-being and functioning?	• MHPSS service providers • Clients and family members
6. What were the specific considerations of the remote service delivery arrangements for groups such as women, men, children, adolescents, PWDs, and older persons, and emergency cases? How could access to care be improved in remote service delivery arrangements?	• Program management • MHPSS service providers • Clients and family members • Catchment area community members

7. What methods were adopted by country teams for supportive supervision during remote service provision?
  a. What challenges did they experience in conducting supportive supervision remotely?
  b. Which remote supervision models were more effective (apprenticeship, case conferencing, remote peer supervision, or combined model)?
  c. How did the remote modality influence the implementation (who, how, and how often) the supervision was carried out?
	• Program management
	• MHPSS service providers
	• MHPSS trainers and supervisors

8. In what ways did outreach contribute to the continuity of MHPSS services?
   a. how could they be more effectively utilized in periods of remote service delivery?
   b. Were there any changes in how the entry points were utilized in identification and referral of new clients for remote service delivery?
   c. Were there any new outreach methods developed for new clients?
	• Program management
	• MHPSS service providers
	• Outreach workers
	• Clients and family members
	• Catchment area community members

9. How were MHPSS trainings adapted to be delivered remotely to different audiences? How effective were these remote trainings from the perspective of trainers and supervisors, non-specialized health service providers, policy makers and planners, and community health / outreach workers?	• Program management • MHPSS service providers • MHPSS trainers • Outreach workers • External stakeholders

Section 10: Acknowledgements

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