Factors influencing the quality of mental health and psychosocial support (MHPSS) activities for malnourished children under five years in Medecins Sans Frontieres (MSF-OCA) inpatient therapeutic feeding centers (ITFCs) in Nigeria (Zamfara), Anka and South Sudan, Bentiu - "Healthcare provider perspective"

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Master of Science in International Health

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A thesis submitted for partial fulfillment of the degree of Master of Science in International Health (MIH) at KIT (Royal Tropical Institute) in January 2022

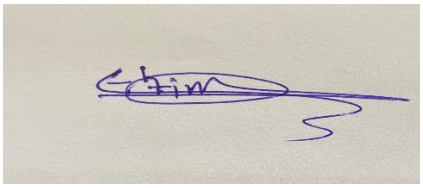
By Ebtesam Zabara

Yemen

Declaration:

Where other people's work has been used (from either a printed or virtual source, or any other source), this has been carefully acknowledged and referenced following academic requirements. The thesis "**Factors influencing the quality of mental health and psychosocial support (MHPSS) activities for malnourished children under five years in Medecins Sans Frontieres (MSF-OCA) inpatient therapeutic feeding centers (ITFCs) in Nigeria (Zamfara), Anka and South Sudan, Bentiu - "Healthcare provider perspective"** is my own work.

Signature



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IV. Abbreviations

ATFC	Ambulatory therapeutic center
HP	Health promotion
HQ	Headquarters
IASC	The Inter-agency standing committee
IDP	Internally displaced people
ITFC	Inpatient Therapeutic Feeding Center
KIT	Royal Tropical Institute
LMICs	Low and Middle-Income Countries
MH-GAP	The Mental Health Gap Action Program (MH-GAP)
MSF-OCA	Medecins Sans Frontieres- Operational Center Amsterdam
MH	Mental Health
MHPSS	Mental Health and Psycho-Social Support
SAM	Severe Acute Malnutrition
SGBV	Sexual and gender-based violence
UNICEF	United Nations Children's Fund
WHO	World Health Organization

V. Glossary

Severe Acute Malnutrition (SAM)	"A very low weight for height (below -3 z scores1 of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional oedema. In children aged 6–59 months, an arm circumference less than 110 mm is also indicative of severe acute malnutrition"(1).
Psychosocial Stimulation	"Refers to the extent that the environment provides physical stimulation through sensory input (e.g., visual, auditory, tactile), as well as emotional stimulation provided through an affectionate caregiver-child bond"(2).
Mental Health	" is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community"(3).

VI. Acknowledgments

This research has been a great learning opportunity in an exceptional time of my life (prepared to be a new mother soon). Although, the journey has been long, and fatiguing over countless sleepless nights, back pain, Covid-related challenges, and away from home, etc.; it has been exciting, and captivating in every sense of the word.

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VII. Abstract

Background

Nutrition projects integrated mental health and psychosocial support (MHPSS) into the treatment of malnutrition

Problem

The quality of the MHPSS in inpatient treatment centers for severe malnutrition (ITFCs) is not clear. Studies that describe and evaluate the MHPSS interventions and identify the best practices are scarce.

Aim

To explore factors influencing the quality of MHPSS for malnourished children from a healthcare provider's perspective to provide recommendations for the existing interventions.

Methodology

A qualitative exploratory study in 2 MSF-OCA projects in Anka project (Nigeria) and Bentiu project (South Sudan) by interviewing fourteen healthcare providers on MHPSS activities in ITFCs.

Results

Projects lack clear objectives and measurable outcomes. Activities vary according to the insights of the MHPSS providers and the demands of colleagues. Guidance is not well known and not adapted. Staff requirements and job descriptions are not detailed. Training and supervision are not well implemented.

Recommendations

Anka and Bentiu's projects should review and assess the needs for MHPSS care in the ITFC to define measurable objectives and develop a delivery strategy for the MHPSS intervention. Projects should have detailed, standardized, and structured protocols, templates, activity plans, job descriptions and, basic, sustainable, and culturally adapted resources. Furthermore, projects should develop detailed guidance and training adapted to the local context and translated into the local language. The research recommends providing regular and adequate training and professional development, self-care sessions, mentoring, and supervision. Developing measurable indicators for success and failure (outcome indicators) is key to understanding the impact and quality of the MHPSS intervention.

Keywords

Mental health and psychosocial support (MHPSS), Severe Acute malnutrition (SAM), Inpatient therapeutic Feeding Centre (ITFC), Nigeria, and South Sudan.

Word count: 11695

1. Background

1.1. Mental Health and Psychosocial Support (MHPSS)

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition has been embraced by the Alma Ata Declaration on primary health care and as a result, WHO and the World Organization of Family Doctors recommended the provision or integration of mental health services within primary healthcare. However, worldwide vision to integrate mental health (MH) into primary care remains debatable(4). The compound expression mental health and psychosocial support(MHPSS) is defined as "Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder"(5). Attention to MHPSS started after World War II and continues to be an area of focus. One of the most crucial turning points that MHPSS has passed through is the Inter-agency standing committee's "IASC" guidelines in 2007 which describe the different levels of MH support needed during emergencies (figure 1)(5,6).

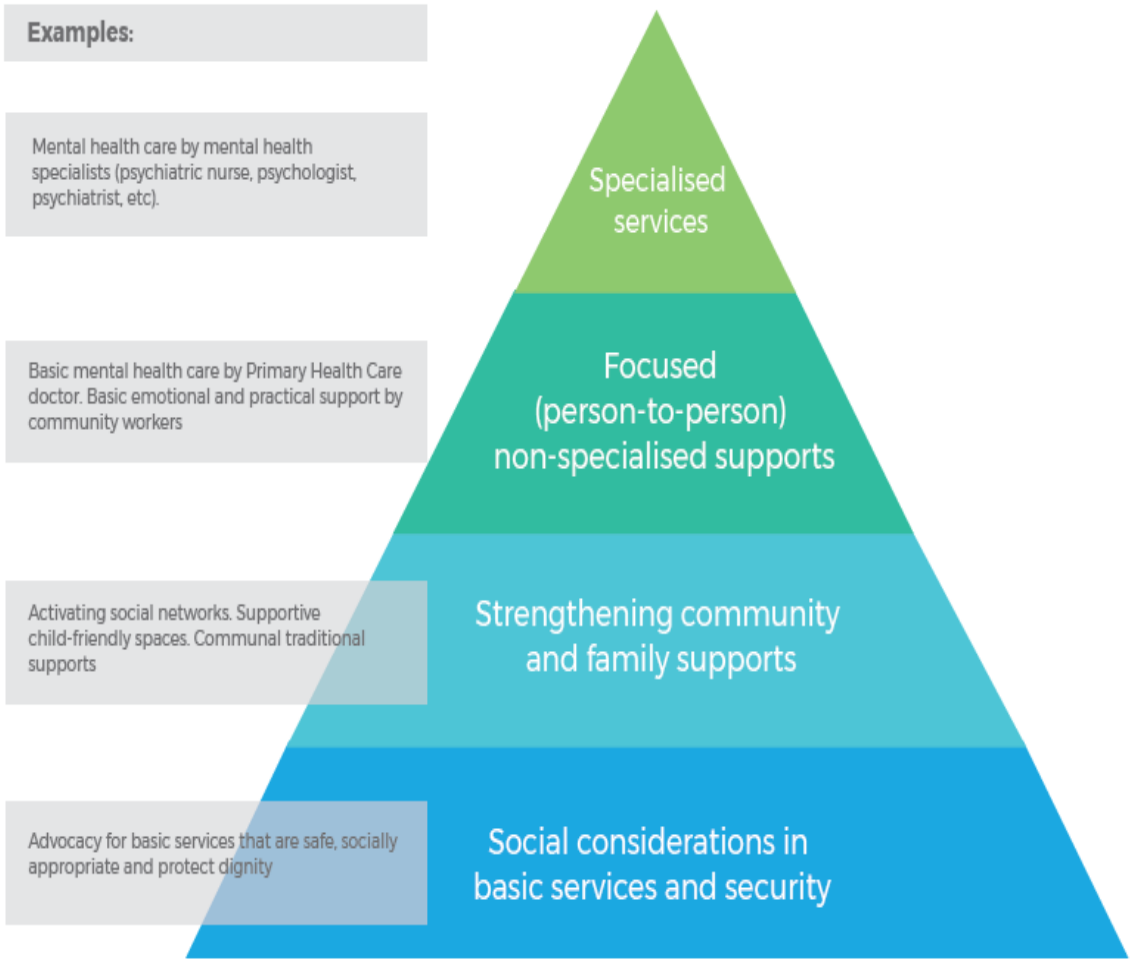

Figure 1: Intervention pyramid for mental health and psychosocial support in emergencies(5)

According to the 2021 global humanitarian overview, humanitarian needs are expanding rapidly, with one in every 33 people around the world needing some form of humanitarian

aid. MH issues are specifically concerning and have been exacerbated by the Covid-19 pandemic(7). Addressing MH issues as a critical public health concern is particularly challenging in low and middle-income countries (LMICs) due to the limited resources, particularly during crises (emergencies). People in humanitarian settings are more vulnerable to distressing experiences which affect their mental health and psychosocial well-being. To improve access and cost-effectiveness in such settings in LMICs, WHO has advocated for integrating MHPSS services into other primary healthcare activities instead of stand-alone programs (4–10). Since, there is a global commitment to MH based on the WHO MH action plan (2013-2020), MH services become an essential component of humanitarian projects(11).

1.2. Malnutrition

The number of people in food insecurity has increased by 75% in the last four years. Malnutrition affects over 224 million children of whom 112 million are living in conflict areas in LMICs. Twenty million children under 5 endure Severe Acute Malnutrition (SAM) and this leads to 1 million child deaths yearly. As well as contributing to mortality in this age group. SAM can have temporary and permanent health consequences including chronic cognitive and physical disabilities(1,2,12–15). In addition to the Zero hunger goal among the sustainable development goals 2030, 11 other goals are linked to nutrition(16,17).

Medecins Sans Frontieres- Operational Center Amsterdam (MSF-OCA) is an international medical organization that works in humanitarian crises mostly in LMICs(18). The multisectoral nutrition strategy (2014-2025) recommends community- based management of acute malnutrition approach as one of the highly effective interventions for the treatment of SAM in children under 5 years. MSF-OCA follows this approach in its nutrition projects in many countries. Children with no appetite and with medical complications are admitted in the in-patient department called the in-patient therapeutic feeding center (ITFC) while children who have an appetite and with no medical complications are admitted to the out-patient department called the ambulatory therapeutic center (ATFC)(19,20). The MSF-OCA's protocol classifies treatment into 3 phases based on the progress of health status: Phase one, to stabilize the child and treat the medical complications which lasts for about 5 days. Phase two, the transition phase, in which the treatment continues and the child is closely observed and monitored. Phase three, the rehabilitation phase, in which the child is moved to ATFC(20).

1.3. MHPSS in nutrition programs

Women and children are more vulnerable during conflicts. Increased mortality among women and children has been connected with conflicts and reported as higher than in those who are on the frontlines (10). In humanitarian settings, children's nutritional and psychological conditions are adversely affected. Similarly, the caregiver's poor psychological conditions might exacerbate the children's malnutrition where they are not able to give full attention to their already malnourished child. A malnourished child is physically less active, which demotivates the parents and affects the parent-child bond. This goes in an endless loop (figure 2) and can harm the child's nutritional status, MH, and delay in development (2,10,13,21).

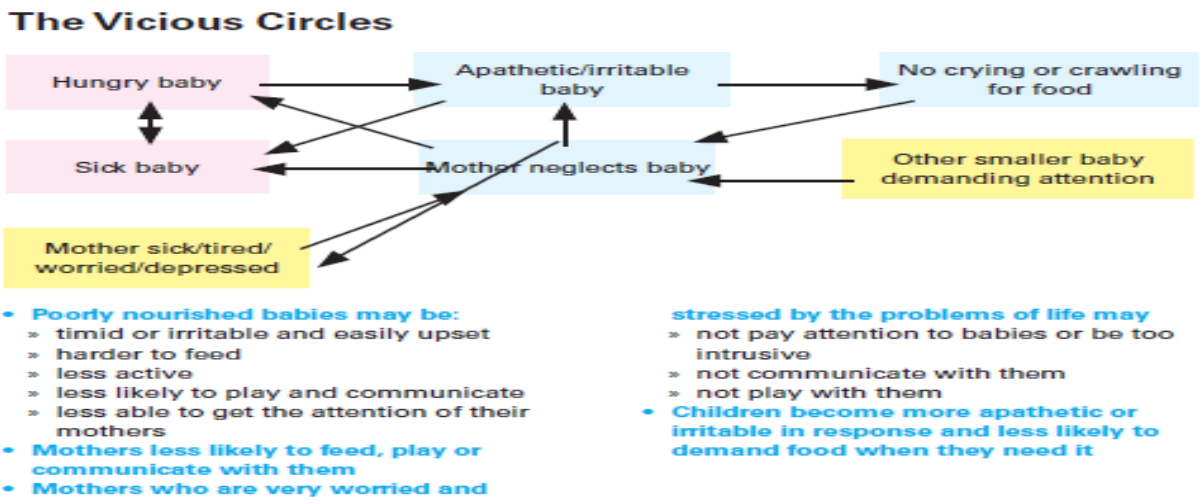

Figure 2: How mother and infant problems in stressful environments may interact(22)

WHO and United Nations Children's Fund (UNICEF) have highlighted children under 5 years as highly vulnerable and recommended integrating MHPSS into nutrition emergency projects as part of the routine care of the malnourished child during the stabilization and the rehabilitation phases(22,23). MHPSS service should be provided by staff who understand the needs of the malnourished child/caregiver and have the skills to deliver appropriate care. Staff continuity has been highlighted by WHO to be key in providing equal support to all children without prejudice about the success or failure of the treatment. Rotation and turnover of staff should be minimized within the same facility to ensure routines are established(24).

Humanitarian organizations have adopted the integrated approach, so has MSF- OCA. The MSF-OCA approach to nutrition projects addresses the 3 intervention points suggested by WHO and UNICEF which are: the provision of food and medical care, supporting the mother, and improving mother-child interaction (figure 3)(22).

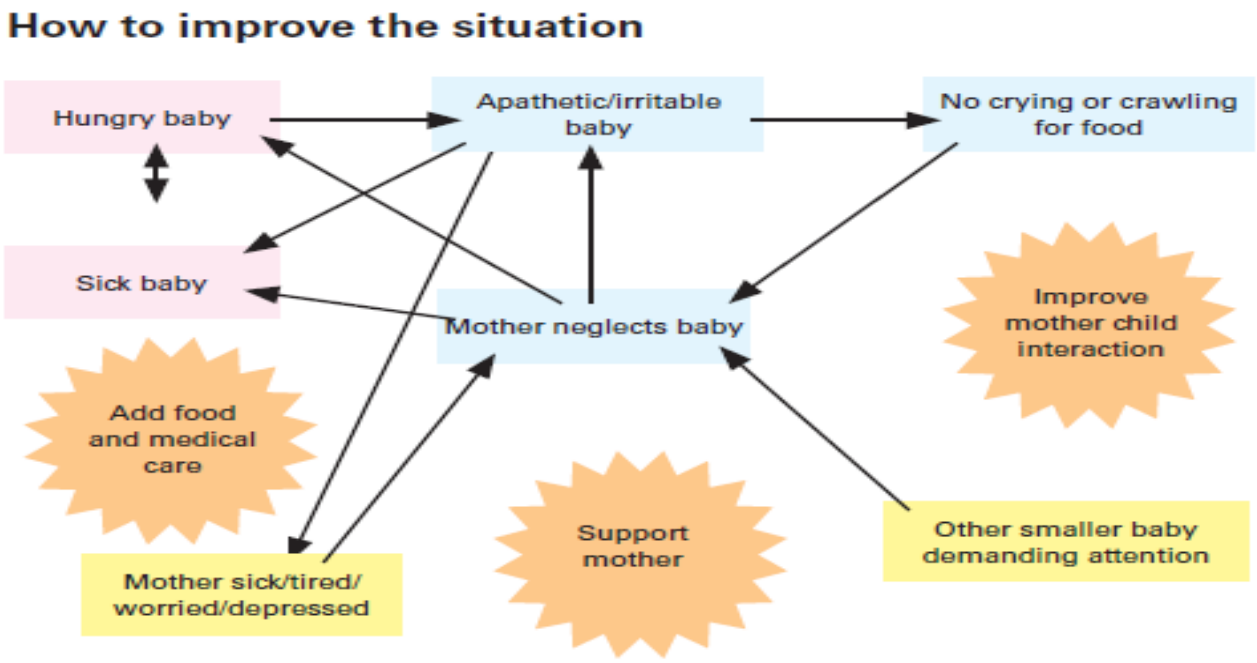

Figure 3: Intervention points(22)

1.4. MSF-OCA MHPSS in nutrition programs

MSF-OCA recognizes the importance of MHPSS in nutrition projects. MSF-OCA has implemented the MHPSS intervention in Zamfara (Anka project) and South Sudan (Bentiu project) horizontally within the larger medical activities. MSF-OCA also has created guidelines as a reference for the field. The most updated version has been issued in 2021(25). MSF-OCA MHPSS interventions aim to psycho-stimulate the malnourished child and support the caregivers to be able to do that. Guidelines state that it is important to improve maternal MH which leads to improving the mother-child relationship and encourage the mother to interact with the responsive child. MSF-OCA guidelines recommend providing education on best feeding practices for the malnourished child while working towards preparing the child and the caregiver for discharge by raising awareness of the importance of preventive measures(20,21,26). At the MSF-OCA project level, a decision is usually made to integrate the MHPSS activities and this includes a decision on which package to implement according to the need and resources. Occasionally, the minimum package is implemented at the beginning of the project and a comprehensive package a few months later, if conditions allow. Every package has defined activities. The minimum package (figure 4) would be applied by the medical/nursing team when there is no MH activity manager and no MH team. It could be enough if there are other actors that MSF-OCA can refer patients to for more specialized MHPSS care. The comprehensive package (figure 5) would be implemented when there is an MH activity manager and MH team in the project. (20,25).

For all Settings	ITFC	ATFC
• Ensure the basic space required is set up (child friendly areas for stimulating activities, rest areas for caregivers, etc.). • Raise staff awareness and provide them training on MHPSS principles and activities in relation to nutrition. • Train staff to provide adequate communication between health staff and patients/children and caregivers (emphasize that staff should not blame caregivers). • Provide psychological first aid (PFA) training for staff. • Provide psycho-education messages for caregivers on the principles of the treatment and, in a culturally sensitive way, how to improve caregiver-child interaction and the negative consequences of lack of stimulation. • Identify children and/or caregivers who require referral for specialized care [Recognition of the most frequent presentations of MH conditions].	• Provision of PFA when needed. • Daily psychosocial stimulation activities that promote caregiver-child interaction (caregiver-child play with homemade toys, singing, dancing, massage[11]). • Observe and record in the counselling file notes on interactions between the child and caregiver (holding, caring practice, verbal and non-verbal exchanges) to detect vulnerable pairs and provide support during psychosocial activities (to promote caregiver-child interaction). • Identify caregivers suffering from severe mental disorders (moderate-severe depression, psychosis) and refer to the medical team or person appointed to offer support.	• Daily group psychosocial stimulation activities that promote caregiver-child interaction (psychomotor stimulation, sensory stimulation, caregiver-child play with homemade toys). • Observe and record in the file notes on interactions between the child and caregiver (holding, caring practice, verbal and non-verbal exchanges) to detect vulnerable pairs and provide support during psychosocial activities (to promote caregiver-child interaction). • Identification and management (PFA and referrals for further MH care) for caregivers who present mental disorders or psychosocial problems (social isolation, adolescent caregivers, no family support). • Mobilization of community resources (extended family, neighbours, leaders) to support the family if needed. • Referral to other specialized services if needed.

Figure 4: Minimum package of mental health activities for children and caretakers(25)

For all Settings	ITFC	ATFC
Implement: • Regular multi-disciplinary meetings. • Psycho-education of caregiver on developmental stages of the child and importance of interaction and the relation with malnutrition. • Daily psychosocial stimulation activities that promote caregiver-child interaction. • Support groups for caregivers (tea groups, breastfeeding groups, etc.): ideal places to discuss difficulties in mothering, parenting skills, coping strategies and provide mutual support. • Individual and group counselling (and follow up) for caregivers suffering from common mental disorders. • Identify caregivers suffering from severe mental disorders (severe depression, psychosis) and refer to the psychiatrist/clinician trained in mhGAP-IG for pharmacological adjuvant treatment.	• Observation of caregiver-child interactions with detailed assessment when noting difficult or disrupted relationships. • Psychosocial-stimulation sessions to promote the caregiver-child interaction: during phase 1 emphasize talking to and touching the child; in phase 2: short sessions should be facilitated (20-40 minutes) for small groups of caregivers to play with their child; consult with ITFC manager for best time to schedule these sessions. • During the preparation for discharge, individual counselling and group discussion informing and educating the caregivers on good practices to avoid relapses (topics to discuss include causes and consequences of malnutrition, psychosocial stimulation, appropriate feeding practices and health seeking behaviour).	• Observation of caregiver-child interaction and advice concerning stimulation and interaction. • Monitor psychological well-being of caregiver. • Screening for depression among caregivers (PHQ-9). • Identification of children in need of MH care and referral to MHPSS team. • MH care when MH needs are identified in the child or caregiver. • Referrals when needed. • Daily group psychosocial stimulation activities that promote caregiver-child interaction (psychomotor stimulation, sensory stimulation, caregiver-child play with homemade toys). • Individual caregiver-child psychosocial stimulation sessions.

Figure 5: Comprehensive package of mental health activities (the extra activities)(25)

2. Problem statement and Objectives

2.1. Problem statement and Justification

Small-scale trials and studies show a positive impact of integrating an MHPSS component in malnutrition treatment centers outcomes(27). Although emotional support for SAM cases management was first recommended by WHO in 1969, a study demonstrated that WHO's recommendations were largely based on experts' opinions more than on evidence. This doesn't imply that the recommendations are wrong, it shows the need for more research in this area(28). Similarly, IASC guidelines provide key information about MHPSS. However, best practices are unknown. A broad set of data is essential to understand and compare MHPSS implementation strategies, which would be best done through field research which feeds into data-based recommendation (29). A review of MHPSS studies in the past 10 years highlighted the lack of practical guidance that can be translated in humanitarian settings. The same MHPSS studies review was conducted to reassess the MHPSS research in 2021. It drew attention to the importance of engaging MHPSS providers in research to inform strategies and policies(6). Literature review and implementer's feedback, show limited project scale data. Moreover, the literature indicates a knowledge gap regarding the quality of the service, feasibility of applying the standard guidelines and protocols in emergencies as well as the evidence-based efficacy of such integration(8,30,31). Studies indicate that current emergency nutrition projects that provide MHPSS should be described and evaluated(30).

There is limited literature and research which addresses healthcare providers' perception and experience about the integration of the MHPSS component in nutrition projects within humanitarian settings are limited. MSF-OCA's headquarters (HQ) specialists have given feedback that the perceptions and views of MHPSS providers in the ITFC have not been explored to date about the integration of MHPSS into nutrition projects, the guidance, challenges, and suggestions to improve. Furthermore, the implementation of the MHPSS component in ITFC's in MSF- OCA nutrition projects varies widely which results in varied quality of care. This indicates the need to explore and align the guidance to current practice.

These are the knowledge gaps which researchers and implementers (including MSF-OCA) advocate for further research on. Data and insights gained from this study, in Anka and Bentiu, will contribute to filling the knowledge gap. The study will guide MSF-OCA to reflect and review their protocols and guidelines and to better customize the ITFCs in Zamfara, Anka, and South Sudan, Bentiu for better outcomes. Consequently, the outcome of the research will also be useful for the other MSF-OCA projects, and other MSF sections. The thesis will be shared with the Royal Tropical Institute (KIT) as part of the Master of Science in International Health.

2.2. Study Objectives

- **The General Objective**

To explore factors influencing the quality of mental health and psychosocial support (MHPSS) activities for malnourished children under five years in MSF-OCA inpatient therapeutic

feeding center (ITFC) in Zamfara, Anka and South Sudan, Bentiu from a healthcare provider's perspective. Findings and recommendations will contribute to better practice protocols and guidelines which would be expected to decrease the morbidity and mortality of malnourished children.

- **Specific Objectives**

1. Describe the MHPSS activities
2. Describe the guidance, training, and supervision for MHPSS healthcare providers
3. Describe the resources allocated to MHPSS activities.
4. Explore the barriers and facilitators of the implementation of MHPSS activities in the ITFCs from healthcare provider perspective.
5. Provide recommendations to improve implementation of MHPSS guidance

3. Methodology

3.1. Study Type

Due to the exploratory character of the study, a qualitative design is chosen as little is known about how this program element is implemented. Semi-structured interviews with staff involved in implementing this program element were conducted.

3.2. Study Area

Two study areas were selected by MSF-OCA HQ which are the Anka project in Zamfara and the Bentiu project in South Sudan based on the following criteria:

- Existence of an inpatient feeding program
- Existing MHPSS activities
- Interest and willingness of projects to participate in the research
- Presence of English speaking relevant staff to be interviewed
- Relatively stable projects where staff have time to be interviewed
- Actively operating within humanitarian settings

There are other MSF-OCA projects which could fit into the above criteria. However, the time for the study did not allow to include more than 2 projects. The researcher has collaboration with MSF-OCA. Simultaneously, MSF-OCA collaborates with KIT (Royal Tropical Institute) which supports this study. It serves the objectives to include a project with the minimum MHPSS package/ no MH team (Anka) and the other with the comprehensive MHPSS package/ with the MH team (Bentiu).

3.3. Sampling and Recruitment of Study Respondents

Study respondents were recruited by purposeful sampling in coordination with MSF-OCA. The researcher collaborated and communicated initially with two focal points (The mental health advisor and the nutrition advisor). The 2 focal points connected the researcher to the respondents. The sample size consisted of 14 respondents (Key informants).

Three groups were identified to participate:

1- One external expert
2- Staff implementing MHPSS
3- Staff not directly implementing but responsible for MHPSS activities (Medical and mental health supervisory staff). The medical team could be a nurse, Medical doctor, Medical team leader, Nurse Activity Manager, Medical activity manager, etc.

The study was conducted in the following sequence:

1- Expert level preparation phase (Open interview "unstructured")

An in-depth individual interview with an expert gave the researcher in-depth insight into the perception of experts about MHPSS in MSF-OCA ITFCs. This allowed the researcher to develop the topic guide. The expert is a psychiatrist and former HQ staff. She worked on both projects for a long time and designed the guidelines.

2- Pre-testing the topic guide

The topic guide was tested with the MH advisor and edited accordingly (Annex 8.1).

3- Project-level data collection using semi-structured interviews

Individual interviews with open-ended questions following a topic guide developed according to the objectives, literature, expert's feedback, and the WHO health systems framework.

a) Staff implementing MHPSS activities.
b) Staff not directly implementing, but responsible for or involved in MHPSS activities such as the MH supervisor, Medical Activity Manager, Medical Team Leader, and nursing activity manager.

Exclusion criteria:

1- Service users.
2- Administrative, logistic, supply, human resources, and operational staff.
3- Staff who do not speak English.

3.4. Data collection

Semi-structured interviews were held with staff involved in MHPSS, on implementation and supervision levels. The researcher conducted semi-structured interviews to collect detailed and comprehensive knowledge relating to the research objectives. Semi-structured interviews allowed the researcher to acquire spontaneous information and experiences. The researcher contacted the two MSF-OCA focal points asking for access to the projects. The researcher then was able to use the personal and/or professional email addresses of all the respondents. After that, an introductory email was sent with the consent form to all of them(32)(Annex 8.2). To introduce the respondents to the research, the researcher suggested a phone, audio, or video call for the respondents who did not prefer or use emails or needed further clarification. The researcher then virtually meet some respondents and explicitly mentioned the possibility to ask for clarifications. Once the respondents understood and agreed to the proposals, they each provided a signed consent form. Once the consent form was collected, the researcher then contacted the respondent to agree a time for the interview. Given the COVID-19 situation, interviews were not feasible face to face, they were

done remotely through Microsoft Teams' application which is standard in MSF-OCA projects. All respondents were able to use it on their phones or using MSF-OCA office computers. The audio and/or video recording function was activated with the respondent's consent(33). The researcher asked the respondents for feedback about the interview. The researcher used open-ended questions and was flexible to receive emergent information. Also, changes in the schedule proposed by the respondents were accepted because they work in challenging humanitarian settings.

3.5. Data Processing, analysis, and conceptual framework

The researcher conducted SSIs using a topic guide and the probing technique while being flexible and adapted according to the flow of the conversation. Some questions were changed or added to cover emerging ideas and thoughts. The topic guide was reviewed and adjusted when needed to improve the subsequent interview. The participants consented to video record the interviews. All interviews were transcribed verbatim and subsequently analyzed. The researcher kept a diary for reflections to avoid potential bias. There is no conceptual framework or theory specific for conceptualizing the factors affecting the quality MHPSS in ITFC in the literature. However, the different aspects/elements of the program explored in this study are addressed within the WHO health system building blocks (see figure 6). The interview questions were categorized according to this framework (figure 6).The outcomes part of the framework is not the goal of this study so it was not addressed.

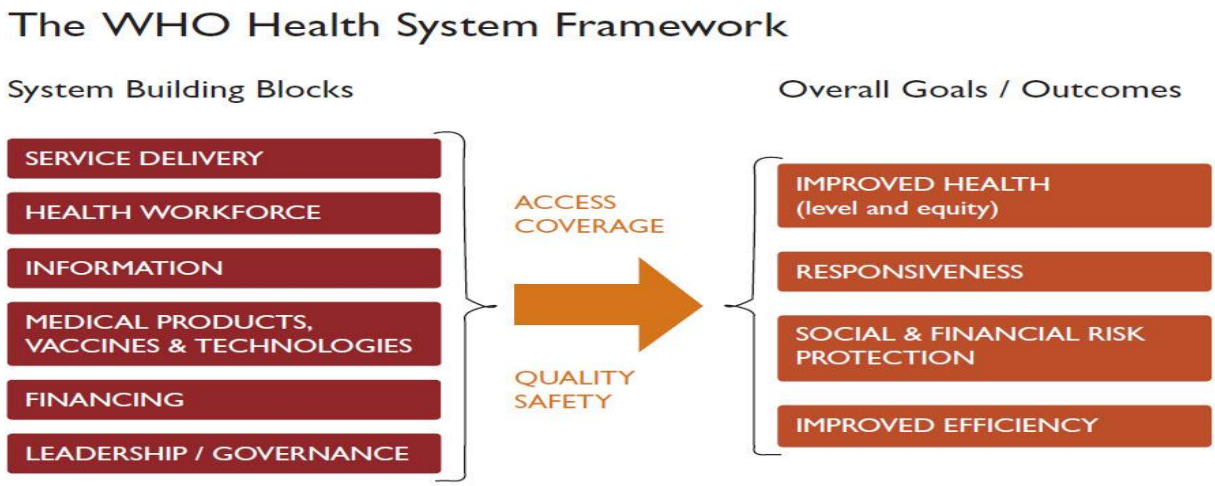

Figure (6): The WHO Health System Framework(34)

Thematic coding of the transcripts was carried out. The researcher created a list of themes based on the WHO framework, then broke down the interviews into groups of data (sentences and paragraphs) using Nvivo software to produce organized data. The researcher labeled each group of data, then gathered the relevant quotes for each theme. Subthemes were created if there were more than one idea in the theme. The findings narrative was written with the support of quotes; emerging themes and data were interpreted to draw conclusions.

3.6. Ethical Considerations

Both the MSF-OCA research committee and the KIT ethical committee approved the research. The recruited respondents were informed about the researcher, research, purpose, approach, and the importance of participation. The researcher collected the consent form from the respondents including the consent to record the meetings. Respondents' names and answers were coded and anonymized manually. MSF-OCA created an MSF account for the researcher, which allowed the researcher to have a Microsoft account. All interviews were conducted through Microsoft Teams, and all research data were kept on password-protected OneDrive on the MSF OCA server. The access is limited to the researcher only. The data will be securely deleted as soon as they are no longer needed for the research purpose. Recordings and transcripts will be destroyed after one year. If MSF-OCA internal documents were consulted, the permission of MSF-OCA was requested. The respondents and their corresponding projects will likely benefit from this research because it is expected to improve the guidance for the MPHSS activity and in general improve the quality of treatment of malnourished children. The burden on respondents is their time for the interview. Although no psychological effects were expected, the contact details of the MSF-OCA psychological support health care unit in HQ were provided. And the same unit was informed about the study, in case they will be contacted.

Power relation and risk on the respondents

The research design considers the "no harm" rule. Respondent's confidentiality, anonymity, right to refuse or withdraw, and voluntary participation were all stated in the consent form. The researcher's professional motivation was explicit in the consent form. The researcher has no authority over the respondents as the researcher has no personal or professional relationship with them. The researcher ensured respect for the respondent's opinions and perceptions.

Conflict of interest statement

The researcher has a professional motivation as the research is part of the researcher's master's program. The researcher has no financial interest and has no personal conviction about the topic.

3.7. Quality Assurance

Quality assurance was built into every step in the research. All respondents are health professionals who speak English. The researcher speaks Arabic which is used in South Sudan as well. The respondents vary in terms of background, positions, and demographic characteristics. The researcher made sure in advance that respondents have Microsoft Teams on their personal computers/ phones. The researcher asked MSF-OCA to ensure respondents were able to access office computers in case the respondent did not have his/ her phone or computer. Using Microsoft Teams for meetings ensured more privacy and less distraction. Video recordings improved the likelihood of high-quality data since all verbal and most of the non-verbal information can be recorded. Quality control checks were done constantly. For

example, unclear recordings due to technical or internet connection issues were managed by repeating the unclear questions and answers. Recordings were named and archived with the date, and code of the respondent.

4. Results

The results manifest different aspects of the MHPSS intervention in the ITFCs of both projects in the light of the 6 building blocks that fulfilled the objectives.

4.1 Respondents

Fourteen field healthcare providers (Seven from Bentiu project and six from Anka project) in addition to the expert were interviewed. Length of experience with MSF-OCA varied and ranging from 4 months to 11 years. Letters were given to indicate the project site. Letter A indicates the respondent is from Anka project and the letter B indicates that the respondent is from Bentiu project. M refers to a medical team member. MH refers to a mental health team member. HP refers to a health promoter. For example, BMH is read that the respondent is from Bentiu project, part of the MH team. Respondents' voices are represented in each theme where appropriate. Information that could identify the respondent was removed. Interviews lasted between 45 minutes to 70 minutes.

4.2 The interview with the expert

The interview with the expert was open (unstructured) and wasn't categorized according to the themes. The expert thought that the research is relevant since it sheds light on staff perceptions of challenges and the support needed. She confirmed that literature about healthcare provider perceptions of MHPSS is limited. She can hardly recall any. She confirmed that psychosocial support is recommended in all international guidelines and it is not a complicated intervention, acknowledging that it is not always effectively implemented. The expert said that one possible explanation, based on her observations during field visits could be the lack of investment in training the staff. In order to have a reasonable impact, staff needs to be trained for at least 2-3 weeks to have a reasonable impact on projects. The staff needs to be trained with 2 objectives in mind. Firstly, to understand the importance of MHPSS and secondly, to know how to do their job in a culturally sensitive way because one size fits all can't work. Training is not necessarily for only the MH team (mental health activity manager, counselor, etc.) but for whoever is working in the ITFC and in a position to provide psychosocial stimulation, for example, nutrition assistants, or medical activity managers. In a field visit to Anka, there was a high interest from the staff in implementing MHPSS activities following a big training. Follow-up is equally important.

The expert thought that the MHPSS information available could be used as data for monitoring and evaluation purposes, rather than collecting separate datasets. She added that the more demand on staff the more they feel overwhelmed and less motivated.

She added that the MHPSS healthcare providers should have a good overview of what other organizations or actors in the area are providing so they can signpost the caregivers for other services.

4.3 Anka Project

4.3.1. Background

According to the World Bank, Nigeria is a lower-middle-income country and the Famine Early Warning System Network classified it as one of the four countries in the world which have an acute food shortage. Nigeria has been undergoing armed conflict since 2011 which has been escalated further two years ago. There are two main armed groups named vigilantes and bandits. They are recruited by the Hausa (farmers) and Fulani (Herders) communities, respectively, and are fighting over the country's natural resources. This causes ongoing instability that has not been brought under control despite the constant attempts by the government. The chaos is associated with ineffective control over the international borders and illegal weapons trade which has led to reactivation of Islamic terrorists and other gangs. Due to criminal activities such as abduction and armed robbery of households, thousands of civilians have been killed and hundreds of thousands have been displaced within and out of Nigeria. The humanitarian situation is particularly worrying in many states where the gangs originally arise from especially in Zamfara State, in the north-west, which is the study area(10,35,36).

Zamfara is among the highest states within Nigeria that suffer from extreme poverty (74%). Thousands have been killed in Zamfara due to the armed conflict mostly men leaving women and children facing the consequences of a devastating situation(15,37).

MSF-OCA is the only international organization with a constant presence in Zamfara. It has had a nutrition project since 2010 with an ITFC operating in a governmental hospital. It treated over 20,000 malnourished children during 2020(38). In Zamfara's-Anka ITFC, MSF-OCA applies the minimum package.

4.3.2. Qualitative data

- **Service Delivery**

Eight health promoters are responsible for MHPSS related activities for the whole hospital, including the ITFC and work on roster. Most health promoters are community health workers who were trained in their formal education to conduct basic MH activities. Health promoters are assigned on daily basis to the different departments by the health promotion (HP) supervisor. The HP supervisor reports to the HP manager, an internationally recruited member of staff.

Respondents (n= 4/6) described providing MHPSS for Sexual and Gender-Based Violence (SGBV) cases in the internally displaced people (IDP) camp as the MSF-OCA first priority. So, recently a MH supervisor and one counselor were recruited in the IDP camp. The medical team respondents (n= 3/6) thought the plan is to gradually expand the MHPSS services to include the hospital and consequently the ITFC. The medical team (n= 3/6) thought that the current activities in the ITFC were not providing even the MHPSS basics. For example, when respondent AM was asked about the current MHPSS activities in the project, said *"We know the mental health is part of the manifestation of the disease. So there have been suggestions*

and things coming at different times to help the children in that line. So the health promoters decided to take that up and start to do some psycho stimulation support for the children such as games and all those things. So it's like an initiative that came up at different times through different people".

Six types of MHPSS activities were mentioned by respondents. **First** (n= 4/6) is MH support for the mothers providing a distraction from their duties out of the hospital by recreational activities. **Second** (n=1/6) is calming the mothers in case of death cases. **Third** is referrals to the MH supervisor (n= 1/6) of more complex cases, that are challenging to handle by health promoters such as HIV positive, depressed or distressed patients. There is no referral policy to an external facility. **Fourth** is to work with the mothers so they understand the need to comply with the medical advice since the medical team does not generally have the time to explore the barriers to compliance/adherence. **Fifth** (n= 4/6) is stimulation in which they play games, provide gentle massage to the child, and play with the caregivers and children. **Sixth** (n= 4/6) is educating the mothers on how to psycho-stimulate their children. The messages are given as part of the HP education. Those activities have been always merged with the health education activities and conducted by the health promoters. Respondents (n=2/6) mentioned that group sessions were the most common option and preferred in the African context but were currently suspended because of Covid-19. Respondents used different names for the different activities. For example, AHP used the term MH support activity, and when she explained she was referring to calming the mothers and educating them. Another respondent refers to MHPSS as kindness towards the patients which is a general MSF-OCA concept and should be provided by all the staff.

Health promoters (n= 2/6) thought that they provide full MHPSS activities and that health promoters do not need the MH team except for rare difficult cases. MH team (n= 1/6) said, that there is no high demand for the MH team because the MHPSS activities are new to the project. So, time is needed to orient the health promoters and to understand the appropriate level of interaction. Supervisor respondents (n= 2/6) highlighted the need to fully integrate MHPSS consciously so it makes sense.

Half the respondents described a positive community perception about the service provided. The other half said that the community is not educated and therefore it is hard for them to understand the MHPSS aspect.

Quality is perceived differently among respondents. Some respondents (n= 3/6) mentioned caregiver's satisfaction. AHP said *"The service should be oriented to what caregivers and children need so they can feel supported through this service.* Others (n= 3/6) referred that the service is of quality when raises the community awareness about MH. One respondent added it is about having a systematic mainstreamed intervention. Another one thought is when staff are well trained and committed and there is a child-friendly space available.

The high number of malnutrition cases admitted allows MSF-OCA an opportunity to provide MHPSS to a high proportion of the community. Respondents (n=2/6) mentioned how challenging it is to deal with difficult situations. For example, a caregiver who disappeared without notification and the team had to deal with the child and the family. Also when the

caregivers start crying due to the absence of husbands while the child needs to be referred to another hospital. This was linked to the security situation which does not allow MSF-OCA to implement outreach activities to follow up the patients/caregivers after discharge. One respondent mentioned that the presence of health promoters in the IDP camp allows kind of community-based preventive measure. Health promoters can identify the malnourished children and manage them earlier. No specific details were given about what kind of management could be done. One supervisor suggested following up with the children discharged from ITFC to the ATFC. There is no data about the MHPSS services provided in the ATFC except that caregivers are reminded of the key messages.

- **Health Workforce**

  <u>Subtheme 1: Human resources set up</u>

  Most respondents (n= 4/6) thought that the number of health promoters should increase to have two working together at night shift so they can approach caregivers better while less distracted. Others (n=2/6) thought that an increase in the number of health promoters should be only after a thorough assessment and planning for the MHPSS needs. Views vary on whether the health promoters accept the MHPSS related tasks or perceive it as an extra task. The majority of respondents (n=5/6) thought that health promoters consider MHPSS part of their job. However, AMH thought that they are not and there is a need to motivate them to do so.

  <u>Subtheme 2: Guideline/ supervision/ support/ Training</u>

  Most respondents (n= 5/ 6) have no or limited knowledge about MSF-OCA MHPSS guidelines. There is no printed version. Few supervisors (n=2/ 5) are aware that the MHPSS guideline is available in the share point folder to which they have access. Health promoters have no access to SharePoint. Although not explicitly stated, health promoters suppose that they follow what MSF-OCA wants. There were contrasting ideas of the need for specialized MH staff. Some respondents (n=4/6) thought that there is no need if there are more, better trained health promoters while others (n= 2/6) thought that there is a need for specialized MH staff. Respondents said that translating the guideline to the local language is a good idea because the health promoters will be able to better understand and explain to the caregivers.

  Half of the respondents (n= 3/6) said that they did not receive any guidance or training. The source of guidance, if any, was through the HP manager. However, the MH supervisor conducts general MH training for the hospital staff, this should raise the awareness of common mental health disorders and the participants were hopeful that this might reflect on their work. The information, education and communication (IEC) materials were updated also recently. There is no data about what the respondents think about the update. The ideas and interest about trainings are varied: most respondents (n= 5/6) were not aware of the opportunities available or did not specify the training needed. One is interested in detachment in other projects and/or missions. One medical doctor was a candidate for MH training, hoping to raise the medical team's awareness about MHPSS. However, he wasn't selected.

- **Medical Products, Vaccines, and Technologies**

  The resources mentioned by respondents as important were, psychostimulation materials, training, space, and human resources. Shortage of psychostimulation materials such as toys has been highlighted by most respondents (n= 5/6). Respondents mentioned that toys have a positive effect on children. Most psychostimulation materials are reusable. The team teaches the mothers how to make some toys, but most toys cannot be made at home because of the lack of raw materials. One respondent wanted to have the capacity (materials) to apply what they have learned. For example, AHP described training that she had *"I attended a training and I saw all those materials. I thought they are going to provide it to us but after that training, everything went with that trainer".* Only one respondent thought that the issue is with managing the psychostimulation materials, not the availability. Delivering the psychostimulation materials to the health promotion team's store takes a long time due to a long supply procedure.

  All participants agreed that there is a lack of sufficient and suitable space for playing and counseling activities. They stated that limited space is a general issue in the hospital. There is no designated counseling room so they conduct counseling in the ward, in their office or at the hospital training room. One respondent supervisor mentioned that once a psychoeducation plan to gather the women caregivers (admitted) with their husbands was canceled because of limited space. One supervisor respondent pointed out that there is an ongoing assessment on how to decongest the hospital to free some space.

- **Information**

  The health promotion team collects data, manually on hard copies, about the number of sessions conducted (for the different activities separately) and how many children/caregivers participated in each session. They also collect the number of sessions for the men (fathers) waiting at the gate and how many participated. There is also an exit survey for caregivers using tablet technology. Later all the data are reported to the HP supervisor who enters it on a weekly basis into the Health Information System (HIS).The health promotion team analyzes the data collected and if they think that something is alarming or needs to be escalated, they report it in the monthly medical report. The analysis is with the project's Epidemiologist. The MH department does not receive any MHPSS related reports or data from health promoters. Respondents (n= 2/6) found it difficult to use the MHPSS data collected by health promoters to assess the MHPSS activities in the ITFC because it is not specific and detailed. Furthermore, MH is not mainstreamed in the project which resulted in being not aware of what to do with the data even if collected.

- **Financing**

  This building block is not relevant to MSF-OCA. The details on MSF financing system of the MHPSS activities integrated in ITFC's is not known. Therefore this item was not explored. However, the priority of allocation can be reflected, indirectly, from the data about materials, training, staffing, etc.

- **Governance and Leadership**

Most respondents (n=4/6) thought that a more concrete and comprehensive service in the hospital including ITFC is still a plan that is under consideration and might start soon. Respondents (n= 4/6) reported that it is not a top priority for now. For example, AM *"I can say that the implementation is ongoing, the strategy has been drafted and will be updated at each step. Priority no 1 is SGBV. Priority no 2 is any kind of violence to provide the PFA (psychological first aid). Priority no 3 is we are now evaluating the need in the hospital to extend the MHPSS activity to the hospital"*.

4.4 Bentiu Project

4.4.1. Background

South Sudan, a low-income country in North Africa, has been affected by political instability and civil war since 1955 which has led to significant humanitarian needs such as food crisis and poverty affecting 60% and 50.6% of the population respectively. South Sudan became independent from Sudan in 2011 and set up its development plans, with nutrition as one of the principal objectives. However, the conflict resumed in 2013 which has aggravated the already existing humanitarian situation(39)(40). United Nations provides protection shelters for the IDP and the Protection of Civilians Site in Bentiu is the largest camp in South Sudan(41). Recently, in 2021, the status of the camp changed to an IDP camp which might have repercussions for resources allocated by the UN(42). According to the Integrated Food Security Phase Classification (IPC), the number of people in South Sudan who are affected by food insecurity increased from 3.5 million to 4 million between 2014 and 2016(40). MSF-OCA reported that malnutrition is one of the top three morbidities among children less than 5 years. MSF-OCA has an ITFC in Bentiu, delivering a comprehensive package, which received 562 SAM cases for children under 5 years in 2020 of which 9% died(41).

4.4.2. Qualitative data

- **Service Delivery**

According to respondents, the MHPSS component was integrated into the hospital, about 4 years ago, as a comprehensive package. MSF-OCA is the referral facility for other organizations. MHPSS activities are perceived by respondents as beneficial and needed.

The MH team in the hospital is composed of 3 counselors and a supervisor. The counselors have a schedule for their regular activities per week as the following:

Day	**Activity**
Monday	Ward round to assess/ counsel
Tuesday	Distribution of toys
Wednesday	Another round to assess/ counsel
Thursday	Distribution of toys
Friday	Music/ Videos in the child-friendly space out of the ITFC ward

Table 1: The weekly schedule for MHPSS activities in Bentiu's ITFC

One counselor is assigned every day to ITFC; on the days when they distribute the toys, 2 are assigned to help with the distribution, to observe how the children are playing with the toys, and how the caregivers are helping in that. Those observations are not documented but it helps the counselors to identify the patient/caregiver who need more support.

Six MHPSS activities were mentioned by the respondents. **First** (n= 5/8) is counseling the caregivers after they have been screened for mental health problems. The patient health questionnaire-9 (PHQ-9) form was mentioned only by one supervisor while other counselors (n=3/6) don't use it. For example, BMH said, *"we don't use a form but we know how to do it"*. Counseling varies according to the need assessed by the counselor. It can be delivered

through recreational group activities or individual sessions. Caregivers are always encouraged to consult the MH. A medical supervisor thought that even if no stimulation is done to the child, the support to mothers is highly appreciated. Furthermore, caregivers are counseled again when discharged if needed (n= 1/8). The **Second** is referral (n= 2/8) of difficult cases to clinical officers for psychiatric care. There is no external referral policy. **Third** (n= 3/8) is the MH team helping the medical team in case mothers refuse medical treatment or want to leave the hospital. According to respondents, this is because the medical team has no time or is not trained to do that. **Fourth** is psychostimulation when the child's health status allows participating in playing activities (n= 6/8) on the scheduled 2 days/week. The selection of toys is according to the counselor's assessment of the child's age and health condition. There is no clear guidance mentioned on this. Most MH team respondents (n= 4/5) thought that the child-caregiver relationship assessment is the medical team's responsibility. And only one said that it is the counselors' responsibility. Only observations were mentioned; no other details were given about what the content of the medical team assessment. **Fifth** (n= 5/8) is psychoeducation in which MH-related topics such as positive parenting skills are explained to the caregivers. Only one supervisor mentioned an example of the child's developmental milestones. Topics are not purely about MH. General health education messages such as the importance of hygiene when requested by the medical team are covered. **Sixth** is emotional support in case of resuscitation process, deteriorating cases, and death cases (n= 5/8). The number of participants in sessions and time allocated varies according to the needs and the topic selected. It could be 8 to 10 or 2- 3 people. It lasts for maximum of 40 minutes. Individual sessions are conducted in the office (20-60 minutes) according to the caregiver's need. To manage the session's time, the counselor needs to inform the caregiver in advance that the time available is limited.

All respondents thought that the MHPSS is needed in ITFC phase two (stabilized cases) and that there is no role at all for the MHPSS team in ITFC phase one (critical cases) except to support the medical team. For example, BMH explained "*In ITFC one we are not providing this support unless we have been called for support for example if the mother refused that the child needs the feeding tube or the child is in critical condition for survival. So, in this case, if we are called we explain for the mother*". At the same time, patients and caregivers are allowed to stay only for a few days in phase 2 which is the time when they can get the greatest benefit of MHPSS, respondents considered the short stay as a challenge to provide quality service.

One respondent mentioned that the MHPSS support is limited to the hospital; although the situation in the camp is difficult, they perceive a gap. People get sick and go to the hospital without any MH awareness. A preventive approach to support depressed or distressed mothers either in the camp or in the community itself is suggested.

Some respondents (n= 4/8) thought that the community perception of the MHPSS service is positive. BMH explained a positive experience *"Acceptability is high. To give you an instance of how MHPSS is considered, what I heard from the counselors that they see some children who were previously admitted in ITFC ask their mothers "take me to MSF-OCA so that I can see the toys""*. However, other respondents (n= 4/8) thought that the community does not understand it and believe only in the medical part of the treatment. Only after a long time and repetition the community accepts and appreciates the MHPSS activities. This is because

of the low level of awareness, poor living conditions, illiteracy, and the unwillingness of some caregivers to engage with MHPSS due to the critical conditions of their children. One BM (supervisor) respondent thought that MH team is not well accepted because they are associated with bad situations such as death. She said "*The nurses call the counselors are usually called for a sad case, like a child that is dying, or a child that has died. And then every now and then they come around with doing some kind of work with stimulation for the children. So they come once a week, once every few weeks to do stimulation to do play therapy for the kids.*

Three aspects were mentioned by the respondents as essential to provision of quality care: the first, availability of resources (mainly trained specialized human resources, materials, and space) (n= 5/8). The second, is raising awareness (for the community and the medical team) (n= 2/8). Third is ensuring caregivers' satisfaction (n= 2/8).

- **Health Workforce**

<u>Subtheme 1: Human resources set up</u>

The respondents had different opinions about the optimum number of counselors needed. Some respondents (n= 3/8) thought that the number of the team is enough because they are always available when called. Some (n= 5/8) thought that the number has to increase especially that MSF-OCA is the only organization providing MH service in a context where MH-related issues have a high prevalence which means that the 3 counselors serve the whole community and cannot meet all the needs. Others suggested a dedicated counselor for ITFC (n=2/8). Respondents (n= 2/8) mentioned how the positive dynamic of the MH team, emphasizing the team is very well integrated, experienced, and respected in the hospital.

<u>Subtheme 2: Guideline/ supervision/ support/ Training</u>

Most of the respondents agreed on the need for more training and capacity building for both mental and medical teams (n= 7/8). The counselors are not specialized yet they are assigned to a wide variety of MH tasks to support the diversity of the activities in the hospital. A training priority is to equip the counselors to be able to deliver basic MHPSS. Respondents in supervisory positions (n= 2/8) pointed out that MSF-OCA formal training exclude counselors since the requirements/eligibility criteria specify the participants should have a psychology or medical background which is not the case for most counselors.

The MH team (n=4/8) mentioned that the daily work routine and circumstances in South Sudan do not allow exploring or reading more about MHPSS. Supervision has been highlighted as a strong point by half the respondents (n= 4/8). They feel it gives them confidence because they can reflect and get immediate guidance when needed (for example, having the flying manager or mental health activity manager in the project). Others (n=3/8) appreciate the HQ support. The number of international staff/ specialists visiting the project is limited due to Covid-19.

The Mental Health Gap Action Program (MH-GAP) training for clinical officers is prioritized because they deal with the referrals. However, the medical team only provides medications. They are not trained to provide basic counseling skills that are required to build a rapport with

the patient. Orienting them, especially nurses, would help the MH team to deliver better patient care.

The respondents named several guidelines on hand which are, the MSF-OCA MHPSS 2021, the guideline for children, MHPSS 2009, psychosocial support for ITFC program guideline, WHO guideline, and UNICEF guideline. Some respondents (n=3/8) were not sure what guideline is used in the project but they thought they were providing relevant support. Others (n= 3/8) believe that the MSF-OCA guideline offers good guidance for basic counseling which is enough to deal with the cases in MSF-OCA. Respondents (n= 2/8) thought that the guideline needs to be translated to local language, especially for the keywords. For example, BMH when asked about the MSF-OCA guideline said "Actually *this is very difficult because the community are not educated and also they are not aware about mental health at all. At the moment if someone is having a mental illness, it is very difficult to explain. And sometimes the patient cannot be taken to the hospital because they have another definition. They say this is not sickness. Sometimes cultural behaviors are contributing to those problems that is why it is very difficult to translate this sickness from English to the local language. If there is a guideline in a local language it can help. This can help in raising awareness".* BMH mentioned how useful and specific the UNICEF guideline is. It is categorized by age and by milestones with pictures and drawings which easily guide the counselor to provide the support that can be extended to home settings. MSF-OCA can benefit from it even if it is for ECD because those children are not only malnourished.

One respondent mentioned that it is difficult for them to cope with daily stressors especially because they get too late notifications to intervene in difficult situations, having several difficult cases the same day (such as death cases), and being involved in non-MH-related issues to support the medical team. Another one mentioned that she is always worried about the cases that leave the hospital since there are no outreach activities.

- **Medical Products, Vaccines, and Technologies**

The resources mentioned by respondents were psychostimulation materials, space, training, and human resources. Management of materials and coordination with the supply department is the MH supervisor's responsibility. Once received, the materials are stored in a big safe box in the MH department and storage boxes in the offices. Type of toys mentioned were cards, balloons, puzzles, plastic cars, ladders, A4 papers for drawings, coloring books, and scooters. Local and international purchasing of materials are not based on specific standards that consider the context and the patient's gender. It depends on what is available in the market locally and internationally. For example, BMH said, *"if MSF-OCA is buying a baby toy to be used in Africa they should consider to buy a black baby toy. This will help in integration and acceptability because when the child is holding a toy he will say "I am holding a white person or a white toy" than saying "I am holding a baby". Children when they have toys. When it is a black toy, the children say "my baby" but when it is a white toy in south Sudan context they will say "I have a khawagah" which means a white person".* One supervisor respondent checked online using google search and thought that the type of toys should be updated. The majority of respondents (n= 7/8) mentioned that there are insufficient play materials because they are taken home, lost, or destroyed fairly quickly. The

materials are also not of good quality. Counselors (n= 3/8) described the importance of the toys in stimulating the children even if very sick. One respondent suggested more videos instead of toys. On the other hand, he mentioned that videos are hard to play in home settings and cannot be given to caregivers when discharged which reduces the chance to continue the psychostimulation at home and contributes to readmissions. No details were mentioned about the type of videos.

Counseling and playing space is a challenge for the whole hospital, especially with Covid. Group sessions are consequently conducted in small numbers and sometimes sessions are given in the ward. The MH team is using the training projector to display their messages and there is no dedicated child-friendly space. Training and human resources are already addressed under the health workforce theme.

- **Information**

Respondents mentioned that the data collected are the number of sessions and participants. Some respondents are aware of which data is collected (n= 3/8). However, there is some awareness that the data collected does not evaluate the quality or efficacy of the interventions. For example, BMH *"The data is there but we are trying to fight to improve the quality" "Let's say 25 caretakers participated in the session and you report! What does it mean? "For example, if we want to say how counselors are improving MHPSS care for children and caretaker? We cannot find it because what we have is figures about participation. So, if we can have a progressive record of individual session for every child so we can track the child while admitted instead of reporting the numbers of people or children who attended the sessions"*. Other respondents (n= 5/8) have no idea about the data collected. Suggestions to improve the quality of data are there but it is not a priority for the project.

- **Financing**

This building block is not relevant to MSF-OCA. The details on MSF financing system of the MHPSS activities integrated in ITFC's is not known. Therefore this item was not explored. However, the priority of allocation can be reflected, indirectly, from the data about materials, training, staffing, etc.

- **Governance and Leadership**

Some of the respondents (n= 3/8) thought that the MHPSS needs are prioritized and supported in the mission strategy. The evidence given was that HQ accepted recruitment and renovation proposals relating to this activity. Respondents suggested that MSF-OCA should look for partnerships with other organizations especially to support social and community-based issues.

5. Discussion

5.1 Discussion

This is an exploratory study aimed to investigate the factors influencing the quality of MHPSS activities for malnourished children under five years in MSF-OCA's ITFCs in Anka and Bentiu projects from a healthcare provider's perspective. It provides a bottom-top insight into the integration of MHPSS in nutrition programs by investigating how the healthcare providers perceive the integrated approach on a project scale within a humanitarian context. Given the scarcity of literature on this topic, the study adds the field perspective coming from 2 different contexts. Results identified four key themes as crucial factors: service delivery, health workforce (guidance, training, and supervision), medical products (resources), and information (data).

1- MHPSS service delivery in ITFC/ Information

MHPSS services are provided by the health promoters in Anka and by lay counselors in Bentiu. Activities conducted are, emotional support for caregivers in individual and group sessions (includes counseling in case of death cases to deal with their loss, and referrals for psychological care), supporting the medical team to encourage the mothers to consistently comply with the medical advice, psychosocial stimulation to children, and psychoeducation. Activities conducted are mostly the same regardless of the level of MHPSS services in the project, having a full package with a full MH team in Bentiu or having a basic package and no MH team in Anka. However, the quality of the activities slightly differs between the two sites. It is more comprehensive and assumed to be of better quality in Bentiu. In Bentiu, the staff provides more MHPSS services to the caregivers which might improve outcomes for the child. Studies described supporting the caregivers as a crucial intervention point in treating malnourished children because it enhances the child-caregiver relationship which makes the child more responsive and more likely to demand food(22). In both sites psycho education gives information to caretakers on the importance and benefits of the mother child bond and ways to improve this engagement. The content of psychoeducation sessions is not planned ahead and is very variable. Furthermore, in Bentiu, psychoeducation sessions consist mainly of MHPSS messages while in Anka, the content focuses more on health promotion. Also, in Bentiu, the staff screens the mothers for MH disorders and in Anka they don't. It was mentioned by one supervisor in Bentiu that they use a screening tool called PHQ-9(43). PHQ-9 might be that the supervisor assumes that it is used while the counselors do the screening but without using the tool.

In addition, in Bentiu, providing the full MHPSS package, psychiatric care is provided, when needed, by clinical officers who are trained (MH-GAP) while there is no professional psychiatric care available in Anka. In Anka, perception of implementation levels varied broadly between the team. Health promoters who deliver the MHPSS services thought that their current activities provide the standard MHPSS services. Managers believe that currently there is not even basic MHPSS but that the team is gradually improving the service in the ITFC with the help of the MH team of the IDP camp MH team. The IDP camp MH team thought that

MHPSS is a recent intervention and it needs time to orient the health promoters. Unlike Anka, Bentiu project has a less varied perception as the team have the same idea about the implementation level.

MSF-OCA is trying to standardize the activities through their guidelines as this proves to enhance projects' implementation processes(44). However, in reality, there is a large variation in activities. Activities, in both projects, are not based on a clear plan, timetable, or the recommendations mentioned in the guideline. As a consequence, it is likely that some MHPSS aspects are missed, such as the lack of systematic screening to identify caregivers who are suffering from severe mental disorders, as seen in Anka. Identification of caregivers in Bentiu depends on the provider's (medical/ MHPSS providers) interpretation and varies from one to another. This leads to providing inconsistent service, misinterpretation, deprioritizing, or neglecting less noticeable or resilient cases. The IASC MHPSS warns about that in its guideline(45). Furthermore explaining medical interventions for caregivers and calling them for the difficult situations such as death, associates the MHPSS providers with negative connotations activities and decreases their acceptance. It also prevents the MHPSS providers from doing their tasks and makes them feel overwhelmed and distracted.

In both locations, the MHPSS service mainly revolves around caregivers and not primarily on the children. The child's appearance, responsiveness, emotional and behavioral status, and development are hardly considered by the MHPSS providers in both projects. While MSF-OCA guidelines recommend interaction with the child in phase one of the nutrition treatment in the ITFC(26), in practice no MHPSS is provided when the child is in phase one. In addition, the staff is probably not trained in providing MHPSS care for critical cases or they don't have enough time to do that. This is apparently due to other competing clinical priorities, unresponsiveness of the child, and perceived reluctance of the caregiver to receive any help. Although there is no specification or definition of what is considered as a reasonable duration for MHPSS sessions, from the providers' perspective, the limited time available for MHPSS affects the quality of care. Furthermore, field staff reported that the child in phase 2 do not stay long enough (only one or two days) to receive enough MHPSS to make a difference when children are more receptive. This is linked to the lack of space and the high number of admissions. In MSF-OCA settings, focusing on MHPSS education for caregivers is understandable because the child will be discharged and there is no outreach team to follow up, so it is always better to, at least, equip the mother with the necessary skills so she can continue taking care of her child at home and prevent relapse.

It is important to mention that respondents in both projects when asked about their perception of the quality of the MHPSS service, did not appear to have hard held opinions on the quality of the intervention. Quality is mainly appraised through caregiver satisfaction, caregiver learning, or raising awareness. This is in line with a study that reviewed psychosocial interventions for children. The study highlighted the importance of caregivers' as a partner in the treatment of malnourished child(26)(8).

The integration of MHPSS in primary healthcare is recognized as beneficial in preventing escalation and relapse of nutrition problems, and is recommended. Therefore, the medical team should consider that MHPSS is part of case management. Nevertheless, according to the

data, medical team's interaction, in terms of MHPSS, with caregivers is insufficient. This might be due to inadequate training and their work overload.

MSF-OCA is collects data/information as one of the main components (building blocks) of any health intervention. Electronic records (HIS) are used to record and monitor the number of sessions and participants in the group and individual sessions (process measures). Although, numbers are transparent markers of what a project delivered and to how many people. However, numbers offer a limited picture of how the work positively changes the health status and development of the child and how it helps the vulnerable caregivers who are highlighted as an urgent need in literature(31). The type of data collected should be improved to capture the outcomes like observations of children's progress while under treatment or exit assessments to enable a retrospective analysis of the intervention to avoid losing years of field experience. Existing data could be useful to lay the ground for establishing a monitoring and evaluation process. There is a reluctance to burden the field by asking them to collect more data, though some respondents believe that the data collected do not show the amount of work they do. A balance must be sought between collecting data for monitoring, evaluation, and advocacy and on the other hand burdening health care workers who are already understaffed.

The picture that arises is that it is unclear what MSF-OCA wants to achieve with the MHPSS in the ITFC especially as there is no monitoring and evaluation of the outcomes of the MHPSS activities in place. This lack of clear objectives leads to staff having different ideas about their MHPSS work even within one project. Furthermore, the MHPSS activities are mainly designed by the team themselves, who are sensitive to the demands of the medical staff, resulting in MHPSS activities which vary content, priority, and quality. To have good quality, consistent MHPSS activities in the ITFC, it is important for the medical leadership in the project and the coordination teams to state clear objectives and communicate them with the staff. A definition of the needed MHPSS package, the level of training, and staff qualification should be clarified. Management and structuring of the intervention according to these objectives, would help in streamlining and prioritizing of the MHPSS activities in ITFC. Given that the focus of the activities in the ITFC is currently on the caregiver's MH, more emphasis should be put also on the mother-child pair interaction and the MH and psychosocial stimulation of the child.

2- Health Workforce (Guidance, training, and supervision for MHPSS healthcare providers)

MHPSS projects use WHO MHPSS guidance on care for psychosocial stimulation as a reference. However, WHO guideline recommendations are not necessarily detailed and specific. For example, "show your child you love him", "follow your child's lead", etc. The MHPSS providers and the caregivers may find difficulties to translate such messages into practical advice (44). A study demonstrated that field or project level practices are consistently below the standard sets placed by guidelines(46). This is also demonstrated in MSF-OCA's projects. Field staff are not fully aware of and hardly refer to MSF guidelines or any other guideline. Even the supervisors are not fully aware of the content. Guidelines haven't been introduced to staff and are usually provided in English while the communication

between the staff involved in MHPSS and the caregivers is always s in local languages. Consequently, introduced keywords can be difficult for the staff to understand and need to be explained to the community. It is recommended that the guidelines used are clearly identified and, adapted to the local context, and translated to the local languages. The MSF-OCA guideline mentions that the activities have to be done in culturally sensitive way which is important and ensured through recruiting local implementers. However, having broad guidance, in English, with no standardized or step-by-step protocols/templates leaves the door open for more variation and less evidence-based practices. Contextualization is highly advocated in the literature. However, the balance between contextualization and standardization of the interventions is key to effective interventions(34).

The training and qualifications requirements for the MHPSS providers are not defined which result in a wide variety of backgrounds of the staff. MHPSS providers, in both projects, are not specialized by profession in MHPSS and are assigned to a variety of MHPSS tasks in the different departments (they are not only assigned to ITFC).

Unfortunately, there are no structured and ongoing workshops and training program. Recently, projects teams received refresher on-the-job training which might reflect understanding the need for training from field management and HQ level. Literature shows that refresher training keeps the staff motivated and enable effective delivery of the service(47). Furthermore, a case study done by MSF-OCA-France to review their MH programs in 4 contexts concluded that having specially trained counselors was key to success in the field(48). According to the MSF-OCA guideline, apart from psychiatric care, the MH activities, do not have to be implemented by professional counselors. Contradictory, the eligibility criteria for participation in MSF-OCA formal training require a psychology or medical background. This makes their career progression impossible and their ability to seek external training a bit hard which in turn lowers the already limited training chances for the lay counselors and health promoters.

They are facing daily stressors that place a burden on them such as dealing with several difficult cases per day, being personally engaged and worried about the cases when they are discharged. They consider that they are often called too late. For example, after a child has died, when the mother is too distressed to be able to engage with them. This was associated with Covid-19 related stress and having less international staff on the ground to support the national staff. The MHPSS providers need to receive help and support themselves.

This research underlines that guidelines are not well-implemented and don’t provide the needed detailed guidance. There is a need for significant improvements in guidance and training to build capacity and empower the staff to implement quality MHPSS activities in ITFC. In addition, detailed job descriptions, necessary education levels, and needed skills of MHPSS staff should be developed.

3- Medical products (Resources allocated to MHPSS activities)

The quality of MHPSS activities was described as not prioritized and not guided which is reflected by the lack of resources available for the MHPSS interventions. Individual counseling sessions are rarely conducted in a private convenient environment due to lack of space. The

data suggested that the playing space is not stimulating and well-prepared with the bright colors and psychosocial stimulation materials such as toys which are significantly important and effective to stimulate sick children. This shortage is due to the poor quality of materials, being destroyed by children, or taken home. According to literature, lack of materials is common. A study conducted in Malawi demonstrated that there is lack of playing and counseling materials in over 40% of nutritional rehabilitation units(49). Materials are purchased, locally and internationally, according to availability in the market which leads to purchasing items that are not culturally adapted. MSF-OCA's and WHO's basic instruction is to make handmade toys with simple available raw materials and to teach the caregivers how to do that(23,25,30). However, this is not happening in the projects. This could be because it takes time to make the handmade toys, some simple raw materials are not even available for the caregiver to make at home, or simply because the plastic toys are more attractive and the caregiver and service provider doesn't want to be undervalued.

5.2 Limitations and strengths

The study was implemented in two MSF-OCA projects. Therefore the results cannot be generalized to other projects beyond these two projects. Also, only provider perspectives are investigated and not the perspective of the caregiver-child pair. Similarly, adding views from community and authorities such as the ministry of health would have led to more insights. However, this would have required a long ethical procedure overruling the timeframe of this research. Given the lack of information on this program element, MHPSS providers' perspective gives valuable insights as well. In addition, although both studies are in MSF-OCA projects, each project is in a different context and has a different setup. Two different contexts enrich the insights provided by this investigation.

The research protocol required the respondents to speak English. There was a risk of excluding key informants which incurs a loss of valuable knowledge. MHPSS providers who are not English speakers might feel devalued. Key informants who speak English are the more educated and vocal. However, their perception doesn't necessarily reflect the perception of other informants who don't speak English. Luckily, when contacting the field, no MHPSS providers were excluded because all respondents can speak English.

None of the respondents had participated before in an MSF-OCA study about this subject and therefore the staff was not having pre-set opinion. All the respondents in this study are field healthcare providers whose perceptions have not been explored before. Not being asked frequently on this subject avoids respondent bias.

Covid-19 regulations limited the possibilities of the way of interview, and the time available for the interviews. However, virtual meetings apps enabled the researcher to meet all the respondents.

5.3 Dissemination and use of data

Given the sensitive contexts, the researcher had shared the research outputs with the MSF-OCA health advisor who advised from their security perspective and context concerns. The Full report will be shared with KIT Royal Tropical Institute and MSF-OCA HQ including the public health department and the scientific committee. As per the consent form, the

researcher will share a summary of the results with the study participants. MSF-OCA entities will decide upon sharing the report and the recommendations with the other OCA projects and within-country partners (including ministries of health) and the community. The research consists of two case studies and findings are context-specific, no generalization can be made.

6. Conclusions, and recommendations

The factors that influence the quality of MHPSS activities in ITFC's were reflected by the description of the daily activities and the challenges faced by the respondents. The MHPSS activities are valued by all respondents, and are clearly addressing a need in the ITFCs.

This MHPSS intervention description gives indications for some key areas to improve MHPSS delivery in the ITFCs of the 2 selected projects. Improvements in the MHPSS intervention focusing on defining service delivery, staff skills/requirements, expectations, detailed guidelines, the need for a more systematic approach, training, and data collection will increase the quality and consistency of care and consequently the effectiveness of the ITFC programs.

Key interventions identified to improve outcomes in MHPSS nutrition interventions are:

Needs assessment/ Setting objectives (MH strategy)

The projects should review and assess the needs and resources in the projects. This is crucial to establish clear informed objectives and action/implementation plan (delivery strategy) for the MHPSS intervention. Later, a refresher orientation meeting for all the relevant staff (MH and medical leadership teams) is essential in which MHPSS objectives, implementation level, and priorities are discussed and clarified.

Structuring the activities/ provision of resources

The staff is committed to providing care for the children and their caregivers. However, they need to be supported to provide better quality MHPSS. Field staff needs to be equipped with detailed, standardized, structured protocols/templates, activity plans, job descriptions including an SOP (standard operating procedures that organize the activities in the project. Also, basic, sustainable, and culturally adapted materials are essential for both demonstration and delivery of care. Staff needs to be reminded that play and counseling materials have to be as basic and homemade as possible. Adaption to the culture should take into consideration the views of both patients and implementers.

Training/ Building capacity/ Guidance

Based on the defined objectives, it is essential to have detailed guidance and training to help in planning and minimize the variation in implementing the activities. Adapting the guideline to the local context and translating it to the local language is needed to ensure that it is more comprehensible by staff and service users. It is equally important to empower and build the capacity of the staff. This could be achieved through the assessment of training needs to build on the existing knowledge and experience. Then, MSF-OCA needs to provide regular and appropriate training and professional development, self-care sessions, mentoring and supervision. A description of minimum educational and skill of newly employed staff is

required, including tools to assess their knowledge and skills. Staff needs to be trained to acquire certain skills such as giving feedback, active listening, observation, and problem-solving. All training needs to be followed by constant coaching. Job descriptions should include a description of the tasks and they should describe the necessary competencies for MHPSS providers. A permanent position for an MH supervisor is advised to be established in Anka whether the minimum or comprehensive package is implemented in order to develop a systematic approach to the MHPSS activities, sensitizing and increasing participation of medical staff, and ensure the basic MHPSS are not missed.

Monitoring and evaluation

MSF-OCA should develop measurable and easily collected indicators for success and failure (outcome indicators) so improvement can be measured. MSF-OCA can use the information generated from this research plus the available HIS data as a starting point for a monitoring and evaluation project for the MHPSS intervention in the two projects. In addition, MSF-OCA needs to actively seek community feedback and record relevant and detailed outcome data related to the children and their caregivers that reflect the impact and quality of the MHPSS intervention. This will help future comprehensive monitoring and evaluation processes that will inform and enable policymakers to understand the challenges and to advocate in case extra support/resources are needed.

It is important that MSF-OCA conduct evaluative studies to understand and strengthen the evidence of the impact, relevance, best practices, and sustainability of MHPSS services. Further exploration is needed to assess the difference in the quality of care according to the MHPSS package implemented. This can be done by involving service users and expanding the research to include other projects.

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8. Annexes

8.1 Interview guide

Some questions were adopted and edited from a pre-validated interview guide in a study on "Integrating psychosocial Early Childhood Development into Reproductive, Maternal, Newborn, and Child Health services in Uganda: perceptions of governance stakeholders and primary healthcare providers" From the University of Queensland- Australia-2019(50). Interview questions have been edited to be much more open/general questions including questions to capture the service providers and supervisors on perspective around the research objectives.

A qualitative study examining factors influencing the quality of mental health and psychosocial support (MHPSS) activities for malnourished children under five years in Medecins Sans Frontieres (MSF) inpatient therapeutic feeding centre (ITFC) in Nigeria, Zamfara and South Sudan, Bentiu - "Healthcare provider perspective"

Interview Guide

(Have been used flexibly)

A- Interview guide for the MHPSS service providers

Opening: How are you? How is your day?

No	Health system building block	Questions
1	**Service delivery**	**1- Could you tell me about your job?** ▪ Probe: Can you describe the MHPSS activities in the ITFC? ▪ Probe: How do you assess the caregiver and child, including attachment between the caregiver and the child, family history, child development, etc.? ▪ Probe: How do you know that the case needs referral? ▪ Probe: Is there a referral possibilities available? If yes, what are they? Can you describe the procedure? ▪ Probe: Are there more activities? E.g. education by you or the IEC (Information, education and communication) team ▪ Probe: What do community think about MHPSS?

		Probe for Group sessions: ▪ Probe: Could you describe the group session? ▪ Probe: How big is the group? ▪ Probe: How long is a session? ▪ Probe: How do mothers and children react? ▪ Probe: Where is it conducted (open air, tent, room, etc.)? Probe for Individual sessions: ▪ Probe: Could you describe individual sessions? ▪ Probe: How are these mothers/children selected? ▪ Probe: do you have informal individual sessions?
2	**Health Workforce**	**2- Could you describe your information sources, guidance, support, and training?** ▪ Probe: What is your background and information resources for delivering psychosocial care in the ITFC? ▪ Probe: Do you refer to a reference or guideline? If yes, which one? How often? Is there any shortcut or key steps that you keep with you? ▪ Probe: Do you think MSF guidelines address local settings? Could you give examples? ▪ Probe: Have you been inspired by other non-MSF guidelines? Or had to use your common sense, instinct, websites, books, friends, or television? When and how? ▪ Probe: Have you been introduced to or trained on using MSF guidelines? ▪ What type of support do you expect (expert's support visits, trainings, support materials)? ▪ Probe: What is good/bad about the support you have? ▪ Probe: What do you think is the adequate number of MHPSS workforce? ▪ Probe: What do you think are human resources areas to improve/ maintain in the MHPSS intervention?
3	**Information**	**3- Could you tell me about the information used for monitoring and evaluation?** ▪ Probe: How do you measure success or failure? ▪ Probe: What kind of data do you collect? ▪ Probe: How do you collect your data? ▪ Probe: Do you make or see an analysis of the collected data? ▪ Probe: Do you think that your work is being reflected in the annual and monthly reports?
4	**Technologies**	**4- What do you think about the resources available to conduct your job?** ▪ Probe: What items do you use (plastic toys, homemade toys, bathing materials, flip over charts, etc.)? ▪ Probe: Do you think that the MHPSS items are managed well? ▪ Probe: Who controls the items "who is accountable"? Are the items stored in a safe place? ▪ Probe: Are the items always available?

		▪ Probe: What is the procedure to receive the materials? ▪ Probe: Where do you do your sessions? Is there a suitable and private space?
5	**Finance**	**Not relevant**
6	**Governance and leadership**	**5- Do you think that the needs to effectively implement MHPSS activities are being prioritized and supported?** ▪ Probe: What do you think about your chances to give a feedback? Do you get feedback on your reports? ▪ Probe: What do you think about the role of the rotation of expat team who have different interest areas and different backgrounds? ▪ Probe: Have there been any recent activities or workshops on MHPSS? If yes can you elaborate on some of the key outcomes?

General improvement/ Closing:

1- In an ideal setting what do you think is quality service? How would you see care for MHPSS being addressed in MSF nutrition projects? Or: What are your thoughts on how to roll out and implement MHPSS so it's efficient, effective and less difficult on current resources?
2- What are the top facilitators and top challenges?
3- Is there anything else I missed that maybe relevant to know?

Thank you for your time and participation. You will receive a summary of the results upon finalizing the research.

B- Interview guide for the supervisors and managers of the MHPSS service providers

Opening: How are you? How is your day?

No	Health system building block	Questions
1	**Service delivery**	**1- Can you describe the MHPSS activities in the ITFC? /Could you tell me about your job?** ▪ Probe: How do you perceive the integration of the mental health component in the nutrition projects in the ITFC? Is it beneficial or useless and why? ▪ Probe: What type of activities are provided? For example, psycho stimulation, mental health awareness, psychoeducation, etc. ▪ Probe: Could you describe your MHPSS experience/role as a team member/ supervisor in the ITFC? ▪ Probe: Do you think that MHPSS will be continued in home environment "sustainability"? Why or why not? ▪ Probe: Is there a referral possibilities available? If yes, what are they? Can you describe the procedure? ▪ Probe: What do community think about MHPSS?
2	**Health Workforce**	**2- Could you describe your information sources, guidance, support, and training?** ▪ Probe: What type of support do you expect (expert's support visits, trainings, support materials)? ▪ Probe: What is good/bad about the support you have? ▪ Probe: How comfortable are you with the staff skills? ▪ Probe: Do you think the non-specialized staff such as doctors and nutrition nurses receive training on how to integrate MHPSS in their activities such as psychoeducation during consultations? ▪ Probe: What do you think is the adequate number of MHPSS workforce? ▪ Probe: Did you have the chance to have a look on MSF guidelines? If yes, what is your perception regarding their implementation potentials? ▪ Probe: Do you think they are adopted to the local context? Can you think of example? ▪ Probe: Do you think the MHPSS guideline and MHPSS section in the nutrition guideline are coherent? Are they interchangeable? Who should read what?
3	**Information**	**3- Could you tell me about the information used for monitoring and evaluation?** ▪ Probe: Can you describe the MHPSS indicators used in the project? How do you measure success or failure? ▪ Probe: What are your thoughts about additional indicators? ▪ Probe: Is there a specific monitoring and evaluation mechanism? If yes, could you elaborate more? ▪ Probe: What data is being collected and how is it collected?

		▪ Probe: In your opinion, how can the monitoring and evaluation mechanisms of MHPSS activities in the ITFC be improved? For example by interviewing caretakers? **4- How are MHPSS activities being captured in the current data collection systems?** ▪ Probe: Are there any methods or tools being used to analyse MHPSS data?
4	**Technologies**	**5- What do you think about the resources available to conduct your job?** ▪ Probe: Do you think that the needs to effectively implement MHPSS activities needs (such as number of staff, enough materials, suitable space, etc.) are being provided and prioritized? ▪ Probe: Do you think that the MHPSS items/materials are managed well? ▪ Probe: Who controls the items "who is accountable"? Are the items stored in a safe place? ▪ Probe: Are the items always available?
5	**Finance**	**Not relevant**
6	**Governance and leadership**	**6- Do you think that the needs to effectively implement MHPSS activities are being prioritized and supported?** ▪ Probe: Do you get feedback on your MHPSS reports? ▪ Probe: What do you think about the role of the rotation of the expat team who have different interest areas and different backgrounds? ▪ Probe: Have there been any recent activities or workshops on MHPSS? If yes can you elaborate on some of the key outcomes?

General improvement/ Closing

1- In an ideal setting how would you see care for MHPSS being addressed in MSF nutrition projects?

Or: What are your thoughts on how to roll out and implement MHPSS so it's efficient, effective and less difficult on current resources on a project level and on MSF level?

2- What are the top facilitators and top challenges?
3- Is there anything else I missed that maybe relevant to know?

Thank you for your time and participation. You will receive a summary of the results upon finalizing the research.

8.2 Consent form

(Source WHO, Reference No 19)

Consent Form

I am Ebtesam Zabara. In the framework of a master's study in International Health (KIT- Royal Tropical Institute), I am investigating how MSF's mental health and psychosocial support (MHPSS) activities for malnourished children can be improved, in your opinion.

The research is titled ***"Factors influencing the quality of mental health and psychosocial support (MHPSS) activities for malnourished children under five years in Medecins Sans Frontieres (MSF) inpatient therapeutic feeding centre (ITFC) in Nigeria- Zamfara and South Sudan, Bentiu - "Healthcare provider perspective"***

I am the principal primary investigator. I am responsible for carrying out the study with support and consultation from MSF research team:

1- **Saskia van der Kam:** The nutrition advisor who is the study coordinator
2- **Raghda Sleit:** The mental health advisor who is the content expert

The study has been reviewed and approved by MSF Ethical committee and KIT ethical committee, to make sure that the research participants, the population and other people of interest are protected from any potential negative effect of the research.

This Informed consent form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.
If this consent form is not clear or contains words that you do not understand, please ask me and I will take time to explain. If you have questions later, you can ask me as well.

I will conduct interviews that helps me get an overview of the MHPSS activities, the guidance, training and supervision for MHPSS healthcare providers, the resources allocated to MHPSS activities, and the barriers and facilitators of the implementation of MHPSS activities in the ITFCs. The aim is to suggest ways to improve the implementation of MHPSS activities in the ITFC.

I invited staff from the coordination levels and implementation level to be interviewed. You are being invited to take part in this research because you belong to the group of interest and your insights and experience in the MHPSS field can contribute.

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Decision to participate or not will not affect your job or job-related evaluations in any way. You may stop participating in the interview at any time that you wish without your job being affected.

You will not be provided any incentive or compensation to take part in the research but your participation is likely to help MSF to reflect and review their protocols and guidelines. The interview will be used only for this research.

Due to Covid restrictions, face to face interviews are challenging. The Microsoft team (MS) will be used for the interviews. The interview will take 45 minutes to maximum 1 hour. I will ensure that the interviews and your responses are treated with the highest confidentiality:

- We need to organise a private environment during interview.
- I intend to record the interview (video/ audio) to enable accurate transcription afterwards. Actually, recording is totally optional and without your permission it will not happen. You can tell the researcher if you do not accept the interview to be recorded at any time, then the researcher will take written notes. The researcher will ask you for written informed consent before and after the recording. Only the researcher will see and/or listen to the audio/video recordings. The researcher will delete the recordings from the computer after the transcription is completed.
- I will give you an opportunity at the end of the interview to modify or remove portions of your remarks.
- Data will be transcribed in text and I will be coming back to you with the transcript for confirmation and clarification. I will remove your name from the text of the interview. Any information referring to your information will have a number on it instead of your name. Only I (the researcher) will know what your number is. The research team will only have access to the anonymized information. Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name.
- The anonymised transcriptions will be stored in a password protected file for the analysis stage.
- After processing, MSF as the owner of the data, will receive the transcribed anonymous data for storage into a secure server for 5 years. However, the data can be accessed only through MSF ethical committee for research purposes.
- The knowledge that we get from this research will be shared with you. Each participant will receive a summary of the results.

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact the researcher. If you have any complaints about the research you can write to Saskia.van.der.Kam@amsterdam.msf.org . In case you need any psychosocial support, please contact the psychosocial support

health care unit "Staffhealthunit.psychosocial@amsterdam.msf.org". The psychological support staff health care unit will be informed about the study in advance, in case they will be contacted.

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Part II:

Consent statement of participant:

I have read the foregoing information, I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____ (Day/month/year)

Statement by the researcher

I have accurately read out the information sheet to the potential participant, and to the best of my ability.
By signing this consent form I confirm the following:

1. The participant was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability.
2. The individual has not been coerced into giving consent and the consent has been given freely and voluntarily.
3. A copy of this consent form has been provided to the participant.

Print Name of Researcher/ _____

Signature of Researcher / _____

Date _____ (Day/month/year)