

SELF-HELP PLUS 360

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ACRONYMS

CBO	Community Based Organisation
DRC	Democratic Republic of Congo
FGDs	Focus Group Discussions
H2RC	Research for Health in Humanitarian Crises programme
HIF	Humanitarian Innovation Fund
HRI	HealthRight International
INGO	International Non Governmental Organisation
JRS	Jesuit Refugee Service
KIIs	Key Informant Interviews
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
M(H)IND	Mental Health Integrated Development
MoH	Ugandan Ministry of Health
NGO	Non Governmental Organisation
RCT	Randomised Controlled Trial
SH+	Self-Help Plus
SH+360	Self-Help Plus 360
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

EXECUTIVE SUMMARY



People in humanitarian crises experience high levels of adversity and stress. Yet scaling mental health and psychosocial support (MHPSS) interventions to meet these needs is challenging due to resource constraints, difficulty in addressing broad psychological distress, shortages of skilled professionals and a focus on singular mental health issues. Recognizing these challenges, the World Health Organization developed Self-Help Plus (SH+) to target larger numbers of people with a wide range of low-level mental health problems, through pre-recorded audio and a self-help book delivered by non-specialised but trained facilitators.

HealthRight International (HRI) has effectively implemented SH+ across several countries, including a long-standing program for South Sudanese refugees in Uganda. The effectiveness of SH+ has been established through three definitive randomised controlled trials, two funded by the EC in Europe and one with South Sudanese refugees in Uganda with Elrha funding.¹

HRI recognised that, for SH+ to be scaled, humanitarian organisations would benefit from technical advice and support. With funding from the Humanitarian Innovation Fund, HRI developed and implemented SH+360, a tailored technical support package to support humanitarian organisations to integrate and sustain the implementation of SH+ within their programming.

HRI has implemented SH+360 in partnership with BRAC Uganda and the Ugandan Ministry of Health (MoH) between 2020 and 2022, within their livelihood programmes and health services respectively. HRI used this implementation period to test assumptions for SH+360 in achieving change across four main areas.

The first area of change was that **people living in crisis would have more tools to deal with stress and mental health problems**. The assumption is that organisations delivering SH+ would have a wider reach and people in crisis-affected areas would have access to SH+ tools to reinforce their learnings from the SH+ sessions. More than 3,000 people participated in SH+ sessions conducted by BRAC and MoH, who also distributed the SH+ self-help book, 'Doing What Matters in Times of Stress' to participants. Use of online materials is limited to people with access to smartphones, computers and the internet.

The second change area was **sustained integration of SH+ among non-MHPSS humanitarian programming**. In Uganda, BRAC, the Ministry of Health and UNHCR have implemented SH+. Where SH+ was implemented as a project alongside existing programmes, its implementation stopped when the funding from HIF ended. However, BRAC and the Ministry of Health are keen to find funding for its continued use. An assumption was that after a period of intense support from HRI, organisations would be able to implement SH+ on their own. While the implementing partners demonstrated confidence and ability to implement SH+ on their own, they prefer to continue to receive technical support from HRI in the future.

The third area of change was that **other organisations would adopt and adapt SH+ and use it within their existing programmes**. There are several organisations that have expressed interest in SH+360. HRI has co-written proposals and consulted with organisations in Uganda, South Sudan, Denmark and Afghanistan. This is supported by a fourth change area, that **the global mechanisms which guide practice will recognise SH+ as an effective intervention** that can be integrated across different

¹ Through Elrha's Research for Health in Humanitarian Crises (R2HC) programme.

programmes. While several organisations recognise the efficacy and potential of SH+, this case study did not find strong evidence of its recognition by global mechanisms.

Implementation of the SH+360 has highlighted four key lessons:

- There is demand for SH+360 and organisations highly value HRI's technical support.
- The nature of the partnership between HRI and organisations influences how HRI provides support; organisational capacity determines how involved HRI will be in the day-to-day implementation of SH+.
- The consultancy model should be flexible and adaptable. HRI is committed to applying a tailored, needs-driven approach to consulting with different organisations.
- While SH+ is seen as a simple and adaptable intervention, SH+360 provides the necessary upskilling for organisations with comprehensive training, supervision and monitoring to ensure that SH+ is delivered effectively.

In conclusion, SH+360 holds the potential to bring SH+ to more people and contribute to meeting the gap between mental health and psychosocial support needs and interventions among people in humanitarian crises. However, this is dependent on sustained integration and adoption by humanitarian organisations, relying on organisation-wide buy-in, ownership from strategic decision makers and sustained funding.



Safina Yusuf (Intervention Team Leader and SH+ Trainer) and Amama Faiza (Intervention Facilitator) catch up. Credit: HealthRight International

INTRODUCTION



The Challenge

Exposure to armed conflict and forced displacement constitute significant risks for mental health. However, existing evidence-based psychological interventions have limitations for scale-up in low-resource humanitarian settings.² In these contexts, many people suffer from broad psychological distress, which is not easy to categorise, and for which stress management may be more appropriate than psychotherapy focusing on specific mental health issues.³ This situation is exacerbated by a significant shortage of clinically skilled professionals, the limited reach of intensive therapies, and high costs of implementation.⁴

To address these problems, in 2015 the World Health Organization (WHO) developed **Self-Help Plus (SH+)**, to target larger numbers of people with a wide range of low-level mental health problems through a self-guided audio and book delivered by non-specialised but trained facilitators. SH+ is a five-session stress management course for large groups of up to 30 people. It is delivered by supervised, non-specialist facilitators who complete a short training course and use pre-recorded audio and an illustrated guide to teach stress management skills.⁵

HealthRight International (HRI) is a global organisation that aims to expand equitable health systems for marginalised communities. It works on four core intersecting health areas: mental health, violence, HIV and reproductive, maternal, newborn, child and adolescent health. As part of its mental health programme area, HRI has become a specialist in SH+ delivery, currently implementing the programme in Uganda, Ukraine, South Sudan and Kenya.

In Uganda, HRI has delivered SH+ to different demographic groups of South Sudanese refugees since 2015. HRI recognised that although SH+ is a relatively simple and adaptable intervention, comprehensive training, supervision and monitoring are necessary to ensure it is delivered effectively. To scale SH+, other organisations would benefit from their technical advice and support, built up over seven years, to integrate SH+ into their existing programmes effectively. In response to this, supported by Elrha's Humanitarian Innovation Fund (HIF), HRI developed **SH+360**, a flexible and adaptable technical support package, in which HRI supports organisations to integrate SH+ into their humanitarian programmes.

² Brown, F. L., Carswell, K., Augustinavicius, J., Adaku, A., Leku, M. R., White, R. G., Ventevogel, P., Kogan, C. S., García-Moreno, C., Bryant, R. A., Musci, R. J., van Ommeren, M., & Tol, W. A. (2018). Self Help Plus: study protocol for a cluster-randomised controlled trial of guided self-help with South Sudanese refugee women in Uganda. *Global mental health* (Cambridge, England), 5, e27. <https://doi.org/10.1017/gmh.2018.17>

³ Tol, W. A., Augustinavicius, J., Carswell, K., Brown, F. L., Adaku, A., Leku, M. R., García-Moreno, C., Ventevogel, P., White, R. G., & van Ommeren, M. (2018). Translation, adaptation, and pilot of a guided self-help intervention to reduce psychological distress in South Sudanese refugees in Uganda. *Global mental health* (Cambridge, England), 5, e25. <https://doi.org/10.1017/gmh.2018.14>

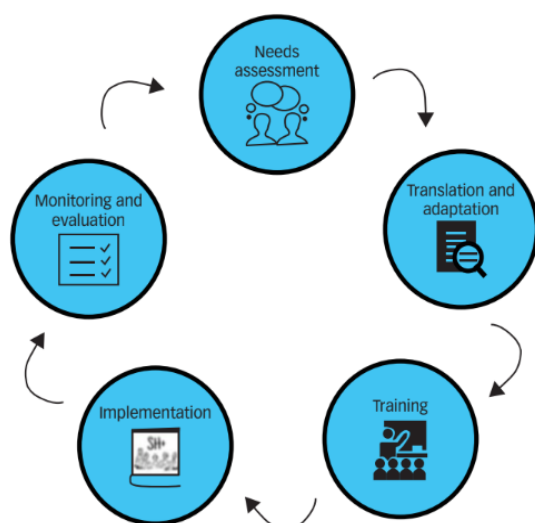
⁴ Leku, M., Ndlovu, J., Bourey, C., Aldridge, L., Upadhaya, N., Tol, W., & Augustinavicius, J. (2022). SH 360: Novel model for scaling up a mental health and psychosocial support programme in humanitarian settings. *BJPsych Open*, 8(5), E147. doi:10.1192/bjo.2022.533.

⁵ Self Help Plus Toolkit, World Health Organisation, September 2021. Available at: <https://www.who.int/publications/i/item/9789240035119>

Figure 1. SH+ and SH+360 development and Elrha funding breakdown

Innovation	Description	Developed by	Elrha support
SH+	A stress-management course for large groups, delivered by non-specialist facilitators	World Health Organization	R2HC – Grant title: Addressing the “access” and “scale” challenge: effectiveness of a new WHO guided psychosocial self-help programme. Dates: October 2015 – April 2018 Elrha funding: £456,713
			R2HC – Grant title: Improving the mental health of refugee men through guided self-help: A scalable intervention for a critical link in humanitarian programming. Dates: September 2018 – August 2022 Elrha funding: £587,779
SH+360	A technical support package, to help organisations integrate SH+ in their humanitarian programmes	HealthRight International	HIF – Grant title: Scaling up Self-Help Plus (SH+) through humanitarian partnerships. Dates: December 2020 – December 2022 Elrha funding: £580,000

Figure 2. SH+360 core support components



SH+360 core components align with the programme cycle in which SH+ is embedded. Firstly, HRI facilitates a needs and resource assessment with the organisation to understand how SH+ could be integrated into the specific services or training programme. Then they aid with translation and adaptation of SH+ materials and train SH+ facilitators. In the implementation phase, HRI supports screening, recruitment and referral in the target population, oversight of SH+ delivery and SH+ supervision to facilitators. HRI also supports monitoring and evaluation (M&E) activities.

The HIF funded the piloting and implementation of SH+360 in Uganda. **This case study focuses on the implementation of SH+360 in Uganda**, as well as drawing on experiences and examples from other organisations who are working with HRI to provide technical support through their SH+360 model.

As part of Elrha's commitment to accountability and learning, this case study provides evidence of the impact achieved through the organisation's grant-making activities and insights into "what works" when supporting humanitarian innovation. The case study explores the reasons why change has (or has not) occurred in relation to the innovation's intended outcomes and seeks to identify relevant learnings for actors developing and scaling humanitarian innovations, using Uganda as a test case for the innovation.

Summary of Methodology

The case-study explores six primary research questions:

1. How **relevant** is the innovation to addressing the specific humanitarian problem it focuses on?
2. How **effective** has the innovation been in reaching its intended objectives?
3. What is the **cost** associated with delivering the innovation?
4. What **impact** has the innovation achieved so far?
5. What is the potential for the innovation to achieve further impact in the future and effectively address the problem at **scale**?
6. What **key learning** has emerged from the innovation? In particular, what can this case-study tell us about enablers and inhibitors of innovation in humanitarian settings?

Data collection began with a review of all relevant academic and grey literature. We then held a series of consultative meetings with the HRI team to understand the innovation better, its current status, its vision, change areas and underlying assumptions of how the HRI team perceived change to come about.⁶ We used a purposive sampling criteria to invite participants for an interview or focus group discussion (FGD). We conducted 12 key informant interviews (KIs) with HRI, implementing partners in Uganda, adopters and potential adopters. We also conducted two in-person FGDs with a total of 11 facilitators from BRAC in Arua and the Ugandan MoH in Kampala. KIs and FGDs were guided by a semi-structured template with open-ended questions.

We used thematic analysis, coding the primary data against the research questions, change areas and key assumptions to identify the key trends to inform the findings. The secondary data supported the triangulation processes. Analysis included exploring whether assumptions held true or not during the implementation of the innovation. We then presented the initial findings to Elrha and HRI for validation and further information on gaps arising from the primary and secondary data. More details on the methodology and informants can be found in Annex 1.

⁶ The HRI team did not have a full theory of change developed. Therefore, we facilitated a discussion with the team to reconstruct their change areas and underlying assumptions from the start of working with BRAC and the MoH in Uganda.

HUMANITARIAN PROBLEM



The Problem

Mental health and psychosocial support (MHPSS) is a recognised need among populations in humanitarian crises. The WHO estimates that about 22% of people affected by crisis experience mental health concerns in their lifetimes, often arising from encounters with violence, poverty, and violations of their human rights.⁷ In Uganda, HRI conducted a needs assessment which highlighted that male and female South Sudanese refugees rank psychological distress (“overthinking”) highly among their greatest concerns.⁸

Despite this sector-wide recognition, current evidence-based MHPSS interventions, such as face-to-face psychotherapeutic treatments, are too resource-intensive and too specialised to address the problem on a large scale.⁹ Humanitarian organisations have limited capacity to address mental health and psychosocial concerns in these settings.¹⁰ In addition, the majority of current MHPSS interventions are intended for health sector implementation, counter to the Inter Agency Standing Committee MHPSS guidelines for emergency settings guidelines which recommend integration into all sectors.¹¹

Addressing the Problem

To address the mental health needs of people affected by crisis, the WHO developed SH+ as a brief, locally relevant and feasible MHPSS intervention that can be delivered by non-specialist facilitators at scale. The innovation consists of two components: a self-help audio-recorded course, and an illustrated book, ‘Doing What Matters in Times of Stress’. The audio material can be adapted to the local context and delivered in five 90-minute sessions for groups of 20 to 30 participants.

SH+ addresses the gap left by traditional interventions through its accessibility, affordability, and ability to address symptoms across multiple mild to moderate mental health disorders. These characteristics make it well-suited for environments with limited resources to address mental health. SH+ can be used as a preventive measure, designed to assist people in managing stress before it evolves into advanced mental health issues. It is complementary to other mental health interventions, for example it can be used as a first step in a care programme, or it can be delivered alongside broader community programming.

SH+ has proven to be a relevant and effective solution to reduce psychological distress and prevent the onset of mental health disorders through three randomised controlled trials (RCTs). An RCT with female South Sudanese refugees in Uganda found improvements on mental health outcomes after three months of SH+ intervention;¹² an RCT with 459 refugees and asylum seekers in Europe

⁷ Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet*, 394 (10194): 240–248, [https://doi.org/10.1016/S0140-6736\(19\)30934-1](https://doi.org/10.1016/S0140-6736(19)30934-1).

⁸ Adaku, A., Okello, J., Lowry, B., Kane, J.C., Alderman, S., Musisi, S. & Tol, W.A. (2016). Mental health and psychosocial support for South Sudanese refugees in northern Uganda: a needs and resource assessment. *Confl Health* 10, 18. <https://doi.org/10.1186/s13031-016-0085-6>.

⁹ Leku, et al. (2022). SH+ 360: novel model for scaling up a mental health and psychosocial support programme in humanitarian settings, cit.

¹⁰ Tol WA, Augustinavicius J, Carswell K, Leku MR, Adaku A, Brown FL, et al (2018). Feasibility of a guided self-help intervention to reduce psychological distress in South Sudanese refugee women in Uganda. *World Psychiatry*. 17(2): 234–235. doi: 10.1002/wps.20537.

¹¹ Inter-Agency Standing Committee (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

¹² Tol, W.A., Leku, M.R., Lakin, D.P., Carswell, K., Augustinavicius, J., Adaku, A., Au, T.M., Brown, F.L., Bryant, R.A., Garcia-Moreno, C., Musci, R.J., Ventevogel, P., White, R.G., van Ommeren, M. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial. *Lancet Global Health*, 8(2): E254–E263, [https://doi.org/10.1016/S2214-109X\(19\)30504-2](https://doi.org/10.1016/S2214-109X(19)30504-2).

demonstrated that SH+ led to significant reduction in frequency of current mental disorders,¹³ and an RCT with Syrian refugees in Turkey found that SH+ was associated with positive effects on participant's symptoms of depression, personally identified psychological outcomes and quality of life after six months.¹⁴ Two feasibility RCTs have been conducted as well. These were smaller scale studies conducted to explore the acceptability of the intervention protocols in preparation for definitive studies. The first feasibility study was conducted as part of the RCT with female South Sudanese refugees in Uganda; the second was carried out in 2018 with male refugees in northern Uganda, leading to positive findings and demonstrating that SH+ could be suitable for male refugees as well.¹⁵

Remaining Challenges

Despite SH+ being an open access tool, uptake is challenging due to limited organisational capacity and expertise to integrate SH+ into existing non-MHPSS humanitarian programming. HRI recognised that few organisations have the expertise to implement and integrate SH+ across the programme cycle, especially outside of the health sector. In addition, materials are only publicly available in English, Arabic, Juba Arabic, Spanish, Turkish and Ukrainian,¹⁶ thus presenting barriers for speakers of other languages.

It is also important to note that SH+ may not be the right treatment for all participants. Because it is delivered by non-experts, there is a risk that individuals with more advanced distress could be included in SH+ groups, and therefore not receiving adequate treatment for their mental health needs. Therefore, adequate training and supervision of facilitators, alongside effective screening and referral systems, are needed to ensure that participants receive the right interventions they need.

¹³ Purgato M, Carswell K, Tedeschi F, Acarturk C, Anttila M, Au T, Bajbouj M, Baumgartner J, Biondi M, Churchill R, Cuijpers P, Koesters M, Gastaldon C, Ilkkursun Z, Lantta T, Nosè M, Ostuzzi G, Papola D, Popa M, Roselli V, Sijbrandij M, Tarsitani L, Turrini G, Välimäki M, Walker L, Wancata J, Zanini E, White R, van Ommeren M, Barbui C. (2021). Effectiveness of Self-Help Plus in Preventing Mental Disorders in Refugees and Asylum Seekers in Western Europe: A Multinational Randomised Controlled Trial. *Psychotherapy and Psychosomatics*, 90 (6): 403-414. doi: 10.1159/000517504.

¹⁴ Acarturk C, Uygun E, Ilkkursun Z, et al (2022). Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomised controlled trial. *World Psychiatry*. 21(1):88-95. doi: 10.1002/wps.20939.

¹⁵ Elrha Research Snapshot: Improving the life of mental health of male refugees, <https://www.elrha.org/researchdatabase/research-snapshot-improving-the-mental-health-of-male-refugees/> (Accessed 18 September 2023).

¹⁶ WHO (2021). A group-based stress management course for adults. Available at: <https://www.who.int/publications/i/item/9789240035119> (Accessed 18 September 2023).

THE INNOVATION: SH+360



Addressing the Remaining Challenges

In 2020, in response to the challenges outlined above, HRI developed SH+360, a flexible consultancy model that supports organisations to integrate SH+ as a routine component of their humanitarian programming. Through SH+360, HRI provides tailored technical support to humanitarian organisations to develop the necessary infrastructure to integrate and sustain the implementation of SH+ within their programming. HRI services include MHPSS needs and resource assessments, facilitator and enumerator training, tailoring pre-screening tools, determining referral pathways, technical advice and supervision for the delivery of SH+, and M&E support.

SH+360 is intended to be flexible and adaptable, responding to the needs of the organisations that HRI works with. This means that there are different levels of support available, from light-touch advisory work to long-term intensive collaborations lasting multiple years. Currently HRI is still exploring different financial models of funding SH+360. So far, technical support has been delivered through traditional grant funding attained by HRI, such as the grant from the HIF to implement SH+360 in Uganda and as a technical consultancy service paid as a contractor, such as for the United Nations High Commissioner for Refugees (UNHCR) Uganda and for the Mental Health INtegrated Development (M(H)IND) consortium in South Sudan. HRI is also exploring a consortium model that involves jointly applying for funding with other organisations to deliver SH+360. Annex 2 provides an overview of organisations HRI has worked with, types of support provided, and how this support was funded.

With the HIF funding (2020–2022), HRI developed and piloted the SH+360 for the first time with its partners, BRAC Uganda and the Ugandan MoH, providing the following support:

- Worked closely with BRAC and the MoH to understand the needs and resources to deliver SH+ within their programmes;
- Provided the SH+ audio recordings and the ‘Doing What Matters in Times of Stress’ booklet and the tools to conduct screening and data collection;
- Trained the SH+ facilitators and enumerators;
- Pre-session screening of potential participants, continuous support to the programme staff and facilitators and referrals of participants and overall supervision;
- Co-designing an M&E plan to ensure quality assurance and capture evidence on SH+ delivery and its effectiveness.

Through this support from HRI, BRAC implemented SH+ sessions to male and female South Sudanese refugees¹⁷ participating in one of the three livelihood programmes being implemented in Rhino Camp in Northern Uganda: Financing for refugees; Strengthening safety, protection, and peaceful coexistence; and Employment in livelihood for adolescent girls. The Uganda MoH facilitated SH+ sessions to health workers in 13 public, private and not-for-profit religious based health facilities in Kampala and Wakiso districts.

SH+360's relevance to humanitarian organisations is rooted in its holistic approach, providing technical advice and supervision not only to deliver SH+, but also how to integrate it into existing programming

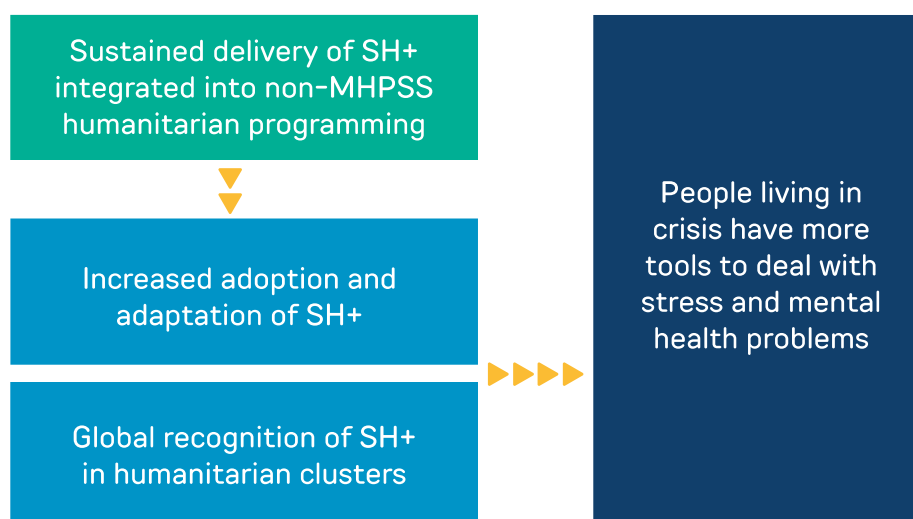
¹⁷ Number of participants and disaggregation of demographic data was unavailable.

and work within the organisation's existing operational systems in place. In order to do this, HRI needs to develop and maintain strong trusting partnerships – something that all organisations consulted in this study felt had been achieved. By supporting the integration of SH+, organisations can offer consistent mental health support without the need for specialised experts. Humanitarian organisations valued this approach, especially as resources and funding are constrained. Potential adopters recognised SH+360 as a way to contribute to meeting MHPSS needs of the communities at a lower cost.

Change Areas and Assumptions

HRI's vision for SH+360 is to reduce the burden of mental health problems among at least two thirds of those living in humanitarian settings through SH+ delivery by leading humanitarian organisations around the world by 2040.¹⁸ This vision is underpinned by three main change areas as indicated below in Figure 3. The underlying assumptions within each change area and a summary of whether the assumptions held true for each change area are summarised in Annex 3.

Figure 3. SH+360 Change areas



Development and Testing Costs

SH+ development and testing cost

WHO developed the SH+ guide in 2015, at a cost of approximately £80,000 (self-funded). This included costs for the SH+ author (Russ Harris), illustrator, project management and focus group testing.

In order to test SH+'s efficacy, WHO secured funding for three RCTs. Through its Research for Health in Humanitarian Crises (R2HC) programme, Elrha funded one definitive RCT in Uganda with South Sudanese female refugees,¹⁹ from 2015–2018, costing £456,713. The RCTs in Turkey²⁰ and Western

¹⁸ HRI SH+ 360 Scaling Plan, September 2020.

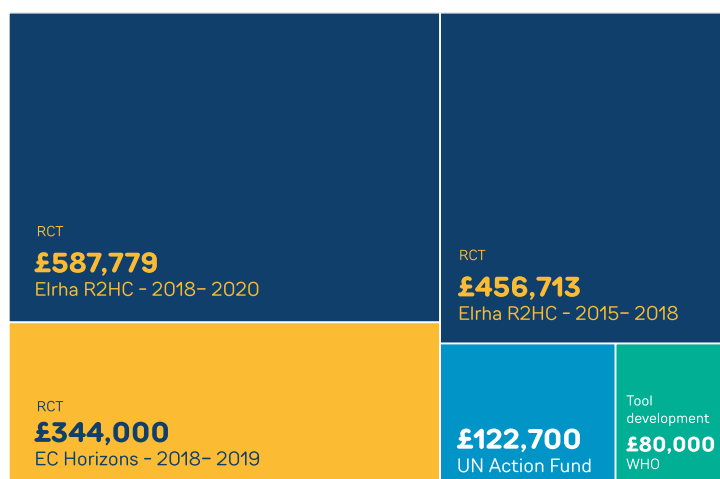
¹⁹ ToI, W.A., et al. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial, cit.

²⁰ Acarturk C, et al (2022). Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomised controlled trial. Cit.

Europe²¹ were funded by EC Horizons (2018–2019) costing approximately £344,000. With additional R2HC funding (£587,779) WHO commissioned another RCT feasibility study (2018–2022) focusing on male Somali refugees based in northern Uganda,²² validating the efficacy of SH+ with different target audiences and in different contexts.

As shown in Figure 4, the total cost of developing and testing SH+ was approximately **£1,591,400**.²³ Elrha's contribution – through R2HC – amounted to £1,044,492 (66% of the total development costs).

Figure 4. SH+ development costs

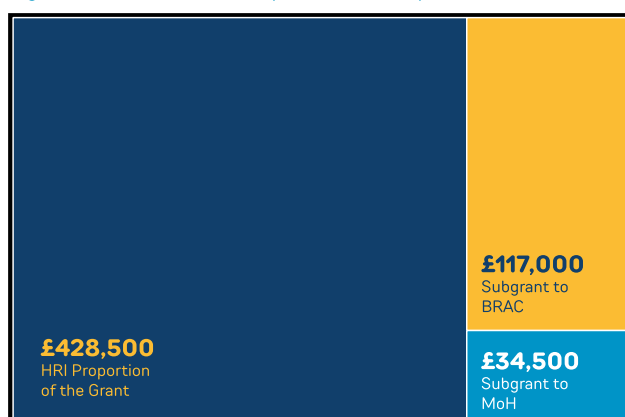


Cost comparison of SH+ with alternative MHPSS interventions is not straightforward. Alternative interventions typically offer more in-depth support. A comprehensive cost-effectiveness analysis of SH+ against other interventions has not been conducted, and was beyond the scope of this case study. Organisations perceive SH+ to be cost-effective due to its simpler training, reduced supervision, wide reach and ripple effect (participants taking training materials and practising techniques with their families and friends).

SH+360 development and piloting costs

HRI, funded by the HIF through its Journey to Scale challenge fund (2020–2022), developed and tested SH+360 for the first time. The funding (£580,000) covered the internal costs for HRI to develop the model and to implement and pilot the technical support service through a partnership with BRAC and the MoH in Uganda, whereby both partners received a sub-grant from HRI to implement SH+ within their programmes. The HIF also provided five training workshops on topics such as marketing and adoption, to help HRI improve the innovation's scalability and develop its scaling strategy.

Figure 5. SH+360 development and implementation costs



HRI's proportion of the grant (£428,500) mainly went towards staff costs to develop the model internally, facilitate co-design processes, provide training, technical, translation costs, initial dissemination workshops and supervision support.²⁴ HRI has earmarked £7,000 for publication and dissemination costs for the SH+360 implementation study, scheduled in 2024.

²¹ Purgato M, et al. (2021). Effectiveness of Self-Help Plus in Preventing Mental Disorders in Refugees and Asylum Seekers in Western Europe: A Multinational Randomised Controlled Trial, cit.

²² Elrha Research Snapshot: Improving the life of mental health of male refugees, <https://www.elrha.org/researchdatabase/research-snapshot-improving-the-mental-health-of-male-refugees/> (Accessed 18 September 2023).

²³ Estimates were provided in US Dollars which we have converted into British Pounds.

²⁴ HRI financial records are in US Dollars, so figures are approximate based on currency conversions.

From this HIF funding, BRAC received a sub-grant from HRI of £117,000 to deliver SH+ alongside three different programmes they were delivering in Rhino Camp and the MoH received £34,500 to facilitate SH+ sessions for health workers in selected facilities around Kampala and Wakiso districts. This funding covered staff time, facilitator stipends, transport, supplies and materials, capital equipment and communication costs.

It is worth noting that BRAC also contributed £1,200 to cover facilitating additional meetings, printing additional booklets and materials and printing certificates for research assistants and facilitators. To cover these additional expenses, funds were redirected from existing programs into which SH+ had been incorporated.²⁵

Benefits of the Development Costs

Development of SH+

The main benefit of developing SH+ is that there is now an open-access evidence-based low-cost MHPSS intervention available for organisations to download, with guidance and materials available in six languages. SH+ has also been used as a treatment for mild to moderate psychological distress across several countries.²⁶ The funding has also been used to validate its efficacy within different contexts and target audiences.

Development of SH+360

The main benefits of HIF's investment in HRI's capacity to deliver SH+360 include HRI's internal development of a technical support hub and scaling strategy for SH+360. The implementation and testing of the model have also increased the technical capabilities of BRAC and the MoH to deliver SH+, in turn enabling more people to access stress management techniques. This also resulted in a strong partnership between HRI, BRAC and the MoH.

Anticipated Scaling Costs

SH+ in Uganda

BRAC Uganda anticipates an annual expenditure of approximately £400,000 to integrate SH+ across their three livelihood programmes in humanitarian contexts to reach between 5,000–10,000 individuals annually nationwide. This includes delivering SH+ within ongoing projects in refugee camps and at-risk districts like Kasese district and Karamoja region that experience insecurity, heightened cases of gender-based violence (GBV) and drought. This budget covers the direct costs of delivering a full cycle of SH+ (five sessions) within each of the three ongoing programmes and distribution of the 'Doing What Matters in Times of Stress' booklet to programme participants. This would also cover initial participant screening costs, additional facilitator and research assistants' salaries and training, equipment procurement, refreshments for participants, supervision and other operating expenses. It does not include the management and organisations overheads costs to support the intervention or follow-up assessments with participants after the sessions have been completed.

²⁵ This cost is in addition to the total grant of £580,000.

²⁶ It was out of scope of this case study to identify the total number of organisations using SH+ and the number of participants who have undertaken the sessions. As SH+ is an open-source, freely accessible, downloadable resource, understanding the reach of SH+ is not possible as this data is not captured when organisations download SH+ resources.

The Ugandan MoH anticipates an expenditure of approximately £2,000 to implement one cycle of SH+ for each facility, reaching 25–30 participants. This would cover operational costs such as transportation of equipment, printing, facilitator and MoH supervisor wages and refreshments during the sessions.

There are some cost efficiencies for BRAC and MoH scaling as they can continue to utilise existing trained personnel or community volunteers. Also, they already have materials translated into Juba Arabic, useful for South Sudan refugees in Uganda and for some parts of South Sudan.

SH+360 scaling costs

HRI anticipates costs related to training existing staff with relevant consulting skills for them to deliver technical support across different programme types and contexts, alongside recruiting and training additional staff to meet demands.

Additionally, the consultancy costs will mostly depend on the specific needs of each partner. Those with limited expertise will require more direct support from HRI, for example with training their facilitators and enumerators, direct supervision and day to day support. This will require more consultancy hours, compared to other organisations with more SH+ experience, for which light touch support – such as ad hoc guidance – will suffice.

The financial costs to scale SH+360 are currently not available. HRI initially estimated that the average cost of supporting each partner would be £141,000 for 2020–2022; however, this has not been proven. HRI recognised that more analysis is needed to understand their day rates and levels of effort for different types of organisations and support needs. HRI is in the process of refining their consultancy offer and developing their financial modelling using their experiences thus far to develop an overarching understanding of anticipated costs for 2023–2040.

IS SH+360 EFFECTIVE?



Objectives and Achievements

HRI has made significant progress towards all five of its major objectives for SH+360 in 2023:²⁷

1. **Expanded reach of SH+360 in Uganda.** HRI has implemented SH+360 through partnerships with four agencies, BRAC, the MoH, UNHCR and the Jesuit Refugee Service (JRS), in different sectors including livelihoods, peace-building, health and protection.
2. **Generated an evidence base for SH+360.** HRI has gathered an evidence-base for the efficacy of the SH+360 model through implementation with BRAC and MoH. HRI is currently writing up the findings of this approach, to be published in 2024.
3. **Established that global demand exists.** Several organisations implementing programmes in Afghanistan, Ghana, Kenya, Liberia, Sudan, Ethiopia, Somalia, India, Palestine, Ukraine and Uganda have consulted HRI on implementing SH+. For example, Water Trust and War Child Holland in Uganda have co-written and submitted proposals with HRI to implement SH+

²⁷ HRI SH+ 360 Scaling Plan, September 2020

through the SH+360 advisor model, and the United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) have consulted HRI on using the SH+360 model to support their partners in integrating SH+.

4. **Developed an understanding of humanitarian organisations' perceptions of value for SH+360.** HRI has developed their partners' capacity to deliver SH+, and the partners are now more confident in handling mild to moderate MHPSS issues. HRI noted that it has received fewer MHPSS referrals from BRAC during the project period; this highlights BRAC's confidence in dealing with participants and making referrals directly to other services.
5. **Expanded SH+360 beyond Uganda:** HRI has supported the Mental Health INtegrated Development (M(H)IND) consortium in South Sudan to implement SH+ through training facilitators, continuous technical advice, and JRS to co-develop their implementation plan for SH+ among their programmes in the Democratic Republic of Congo (DRC) and South Sudan.

Enablers of Success

Complementarity of SH+ with existing programmes. Programme staff noted that SH+ seamlessly complemented their programmes and met an existing need for their participants.

“Mental health or post traumatic experiences was one of the factors that we saw in the communities as being a trigger to violence and conflict. Our regular youth peacebuilding programme has a module on stress management, so we saw SH+ as a way to broaden it.”

- Adopter.

Additionally, having already mobilised participants as part of existing programmes simplified implementation. This alignment with existing efforts allowed for a more efficient and effective implementation of SH+360.

Enthusiasm and intrinsic motivation from implementing organisations. BRAC and the MoH recognized SH+360 as an opportunity to enhance their services for target populations. For example, BRAC viewed SH+ as a valuable addition to their livelihoods programme whose participants experienced distressing circumstances, such as GBV and unemployment. They also acknowledged their limited capacity in the field of MHPSS and were therefore eager to collaborate with HRI who possessed the necessary technical expertise. This motivation served as a driving force behind their commitment to adopting SH+.

Unintended Consequences

Unintended consequences of SH+

From the interviews conducted, programme staff and facilitators in Rhino camp noted improved results for livelihood projects in which SH+ participants engaged, for example improved savings among their community groups and management of livestock. They attributed this to improved focus of the participants and goal setting.²⁸

Beyond the participants, through the interviews and FGDs, SH+ facilitators and staff within partner organisations utilised SH+ and reported positive changes in their own wellbeing. All the facilitators in

²⁸ This feedback was not validated during this study.

the FGDs reported learning through leading sessions on how to manage their own stress and one key informant was hoping to provide SH+ regularly to their own staff.

Unintended consequences of SH+360

SH+360 implementation resulted in the building of new partnerships and networks, and the improving of existing ones. Within the MoH, the implementation of SH+ in private facilities helped the identification of key contacts and the creation of new strategic partnerships, improving communication and collaboration, for example in non-government facilities like Mengo and Nsambya hospitals. Ministry staff said that identifying facilitators from these institutions enabled them to interact and develop those partnerships which they believe will be useful in delivering other services.

This research did not identify significant negative consequences associated with SH+360 and SH+ for both participants and organisations. While there is potential for participants to not receive the right treatment if screening and referral systems are not in place, this study did not find any cases where that had happened. The implementing partners were careful about screening all participants, only admitting to the sessions those who fit the criteria, and referring people with advance needs to more appropriate care. Additionally, the light-touch nature of SH+ minimises potential for adverse effects, especially when addressing mild distress.

“There is little that can go wrong. Participants can easily disengage if they feel uncomfortable, and unlike one-on-one relationships, where irreversible discussions might occur, SH+ is characterised by its gentle and reversible nature.”

- HRI project staff member

However, one key informant did raise a concern that as SH+ supports individuals with coping mechanisms, this could inadvertently lead implementers to overlook the crucial community support mechanisms of MHPSS interventions. Mass adoption of scalable MHPSS interventions like SH+ carry the risk of reshaping actors’ understanding of the fundamental principles of MHPSS, including recognising the significance of community and family support in improving people’s well-being. Therefore, equal emphasis should be placed on MHPSS interventions for individual, family and community levels. To mitigate this, implementing organisations should integrate SH+ across both community and individual level programmes to prevent it from being treated as a separate intervention and ensure a holistic approach to MHPSS.

Challenges

While there was significant progress towards achieving the objectives of SH+360, the innovation faced some notable challenges in integrating and delivering SH+.

Language barriers. Language was the most recurrent challenge. In Rhino camp, despite translating the audio materials into Juba Arabic, not all South Sudanese refugees were fluent with the language and the translations didn’t cater for host communities’ languages, leaving a significant gap. For example, one informant pointed out that in some areas, refugees only spoke Nueri and translating from Juba-Arabic to Nueri was necessary and time-consuming. To overcome this, facilitators worked with translators who translated the audio content into other languages. In Kampala, the facilitators also needed translations into local languages in some instances, which they managed by themselves.

“The issue of language was challenging, especially for me as I was dealing with the host communities. The audio was recorded in Arabic and English and not all of them understand English. Luckily, I speak their language too and was able to translate and help them understand better.”

- SH+ facilitator

Competing priorities between SH+ sessions and programme activities. Facilitators and participants in health services found it challenging to balance pre-existing commitments with the SH+ sessions, as they had to deliver sessions alongside their duty to patients. This challenge was evident in Rhino camp as well. One facilitator mentioned *“at times the programmes (SH+ and livelihood programmes) were at the same time, on the same days leaving the participants conflicted. This of course affected attendance.”*

Delays in implementation due to COVID-19. The original plan was that HRI would provide intensive support for a one-year period. However, with COVID-19 restrictions leading to logistical and contractual delays, actual implementation was only six months. There was not enough time to support full integration within existing programmes.

Siloed implementation. SH+ implementation appears to be ‘projectised’ at present, with SH+ delivered alongside projects rather than as a component of the projects themselves. Unlike UNHCR where SH+ has been included as a module within the peacebuilding programme, BRAC and the MoH implemented it as a complementary project. This impacted how it was resourced, as a project in itself, rather than integrated into core funded business.

Sustainability and continued integration into current programmes. HRI intended for full adoption and integration to have taken place after 1–2 years of intensive support. The six months of implementation was not enough for organisations to integrate SH+ into their programmes. This was exacerbated by the lack of continued funding after the implementation phase ended. So, although organisations have an aspiration to continue to deliver SH+, neither BRAC nor the MoH have found or prioritised funding to do so yet.

Ethical Standards and Vulnerable Groups

While in principle SH+ is only aimed at individuals with “low-level” mental health problems, there is a risk that it could be delivered to individuals who need more advanced and specialised treatment. An informant noted that the manualized nature of SH+ combined with non-specialised facilitators could lead to mistakenly including people who would require specialised care in SH+ sessions. An integral component of SH+360 is having good screening practices of participants and clear referral systems, where facilitators can identify and guide participants with severe issues to more appropriate and specialised care. In Rhino camp, for example, the six facilitators in the FGD had referred three participants to more appropriate care. HRI stressed that participation in SH+ doesn’t negate the need for specialised care: those requiring more extensive assistance must be referred. However, as noted above, specialised support services may not be available, or may have limited capacity to respond to demand, therefore impacting the effectiveness of the referral system.

Additionally, informants noted a power imbalance between refugees and humanitarian actors which may lead to social bias in providing feedback, where SH+ participants feel compelled to attend all sessions and provide positive feedback based on previous support received from the organisation or

fear of exclusion from future projects, rather than because they find the intervention useful. Consistent technical advice from HRI – for example through co-designing processes, sharing M&E tools and monitoring of SH+ sessions – aimed to mitigate these challenges.

Barriers to access and use of SH+ include long distances to SH+ session venues, social limitations for women, language barriers and limitations for audio and visual impaired groups. To eliminate these barriers, facilitators held SH+ sessions at communal locations like youth centres, conducted door-to-door mobilisation to encourage participation, screened everyone who fit the criteria for SH+ and conducted the sessions with two facilitators to cater to participants who needed more time, translation or support with materials provided.

IMPACT OF SH+360 IN UGANDA



The total number of individuals who completed the SH+ course under the HIF funded project was **3,109**.

In BRAC, HRI trained 20 facilitators and eight enumerators. In turn, the facilitators reached 2,578 participants in Rhino Camp.²⁹ These participants were all Rhino Camp residents who were involved in BRAC's livelihood programmes.

For the MoH, HRI trained 31 facilitators including five MoH staff (who also functioned as enumerators, having been trained in the use of screening tools) in 13 health facilities. In turn, these facilitators run SH+ sessions with 531 (129 male and 402 female) participants. These participants were health workers.

Table 1: overview of reach of SH+ in Uganda

BRAC Uganda	20 facilitators, 8 enumerators trained	2,578 participants	Individuals who completed the SH+ course: 3,109
MoH	31 facilitators trained	531 participants	

HRI supported BRAC and the MoH in Uganda to deliver SH+ leading to the following impacts:

Positive Changes for People Affected by Crisis³⁰

Increased community participation and social cohesion. In the FGDs, facilitators reported that the sessions left participants more social, connected and engaged. Facilitators noted that participants exhibited improved social outcomes, including an increase in community engagement. These positive changes for participants were consistent with the findings of previous research, which highlighted that gathering in groups enabled the participants to build relationships as they shared lessons in managing stress.³¹

²⁹ Disaggregated demographic data was unavailable.

³⁰ The impact of SH+ described below is based on qualitative data (KIs and FGDs) collected for this case study, which has not been validated. HRI is currently synthesising quantitative and qualitative data from the 2020 – 2022 implementation period which is expected to be published in 2024.

³¹ WHO (2018). Addressing the “access” and “scale” challenge: effectiveness of a new who guided psychosocial self-help programme (sh+).

"After the sessions, previously isolated participants began actively participating in community activities, attending community and committee meetings and even church services. I distinctly noticed this change in three initially reserved individuals."

- SH+ facilitator

Improved mechanisms to deal with stress. The timing of SH+ implementation within BRAC and the MoH was particularly important as it coincided with World Food Programme's (WFP) food prioritisation exercise in Rhino camp and COVID-19 recovery. In 2023, due to resource constraints, WFP instituted a needs-based approach in Uganda, which segmented refugees based on their vulnerability and adjusted their cash and food rations accordingly. This restructuring intensified uncertainties and stress levels among the refugees and host communities. Without adequate stress management mechanisms in place, there was a risk of increased depression, violence or substance abuse amongst populations already dealing with trauma. In these circumstances, BRAC and UNHCR's implementation of SH+ offered participants tools for immediate stress alleviation. In Kampala, the MoH began implementing SH+ with health workers right after COVID-19 when health workers had experienced distressing periods. This is supported by research conducted in 2020 which highlighted improvements on psychological distress among South Sudanese female refugees in Uganda.³²

Increased motivation, resulting in better resilience and increased productivity among participants. According to the facilitators, the SH+ sessions provided participants with the space and tools to alleviate their stress and build mental resilience, for example through the modules that encouraged them to think about and practise their values. Facilitators and implementing partners believed this translated into being more energised and productive, for example some participants having more motivation to take up small scale subsistence farming.

Improved savings culture and participation in livelihood activities among participants. Facilitators reported consistent attendance and an increased interest among participants to learn. They believed this led to participants having more motivations to engage in livelihood activities. Additionally, there was increased saving among the groups which suggests that participants have become more proactive in understanding and managing their challenges.

Positive Changes for Organisations Receiving Support from HRI

Capacity building for staff and facilitators. HRI trained 20 facilitators and eight enumerators from BRAC, 31 facilitators through the MoH partnership, as well as 17 facilitators from the M(H)IND consortium in South Sudan. Additionally, through specialised support and guidance, programme personnel reported increased skills to manage SH+ implementation.

Reduced dependence on HRI for SH+ delivery. Adopters and implementing partners noted that with the extensive capacity building provided by HRI, they were now capable of delivering SH+ without HRI's direct involvement. For instance, an implementation partner expressed confidence that their team could design and execute an SH+ implementation, monitor and evaluate the activities and were prepared to do it on their own with minimal input from HRI.

³²Tol, W.A., et al. (2020). Guided self-help to reduce psychological distress in South Sudanese female refugees in Uganda: a cluster randomised trial, cit.

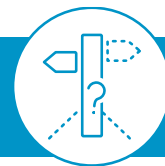
Barriers to Sustained Organisational Integration

One of the key assumptions underpinning the SH+360 change areas is that after intensive support from HRI, organisations will continue to implement SH+ as part of their wider humanitarian programmes.

Continued need for capacity-building. Although both BRAC and the MoH felt confident in their capacity to deliver SH+ independently, they felt more support would be beneficial in conducting assessments, M&E and facilitator training.

Difficulties in securing funding. So far neither BRAC nor the MoH has managed to secure further funding to continue SH+ delivery. The MoH identified opportunities for integrating SH+ within routine and emergency health care for the public and through routine facility engagements for health workers such as continuous medical education. The barrier that remains is incorporating SH+ into the budget planning cycle, which they say they are committed to do. Similarly, BRAC expressed commitment to including SH+ into new proposals in the future.

WHAT NEXT?



Adoption of SH+ Through SH+360

To date, there are a number of key examples of organisations using SH+360 to integrate SH+ into their existing non-MHPSS programmes:

- UNHCR Uganda hired HRI as consultant to support them in incorporating SH+ into their peacebuilding programme, especially targeting young refugees in Rhino camp. SH+ is now a core component of their peacebuilding manual used to deliver their programme.
- The M(H)IND consortium in South Sudan is implementing a standalone SH+ programme through their partner, Caritas. They hired HRI to train facilitators in June 2023 and HRI continually provides ad-hoc support as they prepare for implementation.
- JRS have implemented SH+ in Uganda and South Sudan for almost two years and recognise the benefits for their participants. They are planning to use SH+360 to integrate SH+ efforts within their protection, GBV, peacebuilding and reconciliation and pastoral care programmes in South Sudan. HRI will train staff within these programmes as facilitators and also equip them with tailored knowledge for SH+ integration and implementation across the programme cycle. HRI and JRS have co-written proposals for funding for these programmes. In the meantime, HRI is providing ad hoc technical advice to JRS (free of charge) about SH+ implementation and M&E.

Enablers of Adoption of SH+360

Recognised priority need. Humanitarian non-governmental organisations (NGOs) acknowledge that their target populations experience psychological distress and that SH+ is useful in providing stress-management support. Adopters and potential adopters saw SH+ as a valuable tool in supporting their programme participants' mental health, and in turn impacting programme outcomes positively. For example, Shabaka UK are interested in using SH+ to address the mental health requirements of their programme participants in Sudan and wish to use SH+360 to build their capacity to deliver SH+.

HRI's strong reputation. HRI has established a strong reputation as SH+ experts. This is demonstrated by the increasing number of approaches for advice over the recent years. Although this has not yet translated into an established consultancy income source, having a trusted reputation and being a go-to agency for SH+ advice is a first step.

Limited capacity among organisations to implement SH+. As highlighted in HRI's SH+360 scaling plan, large NGOs lack the technical capacity to deliver SH+. Recognising this, organisations are wishing to collaborate with HRI through SH+360 and work together to add SH+ to their programmes. In addition, although BRAC and the MoH feel confident in implementing SH+, they wish to continue receiving support from HRI to deepen their knowledge and provide quality assurance.

Barriers to Adoption of SH+360

Need for involvement of key decision makers in SH+ integration and programming. Due to the nature of large humanitarian organisations, different parts of the organisation in different countries may be involved with developing overarching programme frameworks or fundings. For example, BRAC Uganda partners with different BRAC affiliates for fundraising and technical advice in the US, UK and Bangladesh. Further work is needed to ensure that different parts of the organisation – beyond BRAC Uganda – are aware and support SH+ integration. UNHCR also highlighted the importance of securing support from key departmental stakeholders as a prerequisite for SH+ integration. Developing an advocacy plan with each global organisation of who needs to be involved to enable scaling at the start of each project might be a useful exercise to overcome this barrier.

Competing priorities for funding. Although there is a clear demand for SH+360, funding in the humanitarian sector tends to be ‘projectized’. So far, HRI has taken a flexible approach attaining funding through fee-based consultancy where possible, but also through time-consuming traditional consortium and partnership funding applications, incorporating SH+ and their technical support package into the proposals. They have also provided ad hoc technical advice for free. This flexible and adaptable approach to SH+360 helps to address this barrier of a difficult funding environment, but has yet to be proven sustainable.

Building the evidence-base for SH+ as an integrated component of different types of programmes. Although there is a strong evidence-base for the efficacy of SH+ as a programme in itself, more research is needed into how integrating SH+ into other programmes (such as livelihoods or peacebuilding) impacts programme’s core outcomes (or not). UNHCR noted that highlighting the comprehensive benefits of SH+, such as its potential in protection and conflict mitigation, would garner further support for integrating SH+. The MoH noted that robust evidence of success from this initial implementation highlighting best practice for managing operational logistics such as assigning roles and implementation timelines was important to gain support for further adoption.

The nature of the projects impacts the integration and sustainability of SH+ within a programme. With BRAC and the MoH, SH+ was implemented alongside their core programmes or as a separate programme. It was not fully integrated into how BRAC implements livelihood programmes as a core component. Conversely, the work with UNHCR to integrate SH+ into their youth peacebuilding programme manual means that, once integrated, it will be delivered as one of the core components of their youth peacebuilding programme. This implementation period suggests that programmes with a training or curriculum delivery style provide a more straightforward opportunity for integrating SH+ as an additional module to existing curriculums, whereas those with a different structure might struggle to achieve full integration.

Plans for Scale

HRI foresees meeting the growing demand for SH+360 through:

- Recruiting additional personnel to support partners and train facilitators.
- Developing a financial model for SH+360 which will provide a framework for flexible consultancy packages, catering for diverse organisational needs, from community-based organisations (CBOs) to national NGOs or international non-governmental organisations (INGOs).

- In addition to offering technical expertise as consultants and co-writing proposals to deliver SH+, HRI is also seeking contracts to partner with donors such as USAID to support their grantees on integrating and implementing SH+. This is a new approach to the consultancy model.
- Training other organisations to be able to provide SH+360 services, for example Amref Health Africa. HRI is also currently working with the WHO to develop the African Centre of Excellence for SH+ delivery where other organisations will be trained to provide SH+360 services.

At scale, HRI intends to deliver SH+360 as a paid technical consultancy, where partner organisations meet all the costs of SH+ and SH+360, through the advisor and contractor business models. With the advisor model, HRI provides support over 1–2 years and SH+360 is funded through grant co-application with partner organisations. The contractor model takes a longer term approach, where HRI partners with large international organisations over 5–10 years and SH+360 is funded directly by the partner organisation.³³

To continue to support SH+360 uptake, Elrha has awarded HRI an additional dissemination grant of £14,678 (from July–December 2023) to develop new communication products to increase uptake of SH+360 by other organisations. HRI also received a small grant from WHO Geneva to develop SH+ training videos to be used to support organisations implementing SH+360.³⁴

Potential Long Term Implications of SH+360

The adoption of SH+360 by humanitarian organisations has the potential of reducing the gap between the huge mental health needs and the limited supply of mental health professionals in humanitarian contexts by enabling non-MHPSS organisations to support their target populations in managing mild psychological distress using SH+.

For HRI, SH+360 is its signature initiative. HRI intends to become an SH+360 technical support hub and innovator in the mental health sector, and aims to incorporate SH+ into all future grant and project proposals across all sectors.

BRAC aims to gain global recognition for its integrated approach to SH+. This could change the way BRAC thinks about the mental health component of its livelihood programmes for refugees. The end of BRAC's strategic plan in 2023 presents a timely opportunity to add SH+ into their new strategy for the next five years.

³³ HRI SH+ 360 Scaling Plan, September 2020

³⁴ Humanitarian Innovation Fund. Final Project Report. HIF J2S 2020 SH+ 360: Scaling up an evidence-based mental health intervention.

WHAT HAVE WE LEARNED?



Implementation of SH+360 Highlighted Three Key Learnings:

The nature of partnerships influences the support HRI offers in implementation of SH+360. There is no “one size fits all” as organisational needs determine how involved HRI will be in the day-to-day implementation of SH+. While some have more expertise in implementing wellbeing programmes and may not require more hands-on involvement, others, like BRAC may require more direct involvement.

SH+360 should be flexible and adaptable to the organisation’s needs. The SH+360 consultancy supported organisations to implement SH+, however, while it worked well with some partners, like UNHCR, it may not be compatible with others in its current form. HRI intends to apply a more tailored, needs-driven approach to consulting with different organisations to match their dynamics and requirements through three main models; fee-based consultancy, co-writing grant and project proposals and working as part of a consortium.

Quality control through SH+360 is central to effective delivery of SH+. While SH+ is seen as a simple and adaptable intervention, adopters recognised the importance of comprehensive training and monitoring. They acknowledged that as SH+ gets adopted more widely, maintaining its quality will become challenging. Consistent technical advice from HRI, for example through co-designing processes and sharing M&E tools, could mitigate these challenges.

Gaps in Evidence

Effectiveness of integrating SH+ within other programmes. The formative research provides strong evidence of the efficacy of SH+; the next step is to understand the effectiveness and impact of SH+ when integrated within other programmes. Key questions include understanding which specific elements are beneficial to target populations and how they work, the limit to the number of programmes or activities that can be effectively merged and the risks therein. This is in line with a key research priority of the R2HC-funded MHPSS consensus-based research agenda to understand how a multi-sectoral approach can break patterns of adversity across multiple domains of wellbeing.³⁵

Effectiveness of SH+360 as a financially sustainable business model. While there is substantial evidence on implementation of SH+ there is a gap in evidence on how to scale these interventions effectively.³⁶ Implementation research is needed on SH+360’s function and effectiveness in enabling organisations to integrate SH+, as well as identifying the most effective consultancy models and implementation best practices. HRI’s forthcoming research will contribute towards filling this gap.

³⁵ Tol, W.A., Le PD, Harrison SL, et al (2023). Mental health and psychosocial support in humanitarian settings: research priorities for 2021–30. The Lancet Global Health, 11(6): E969–E975, DOI[https://doi.org/10.1016/S2214-109X\(23\)00128-6](https://doi.org/10.1016/S2214-109X(23)00128-6).

³⁶ Leku, M. et al. (2022). SH 360: Novel model for scaling up a mental health and psychosocial support programme in humanitarian settings, cit.



ANNEXES

Annex 1: Methodology

We developed the case study through the following steps:

1. Inception

We held an inception meeting with Elrha to finalise the research questions, agree on the methodology and develop the data collection tools.

2. Document review

We reviewed all relevant documents, both academic and grey literature. We used a structured template to synthesise the information against each research question to enable further analysis and triangulation of different data sources. The document review was used to analyse the existing evidence available which was later triangulated with the primary data collected.

3. Introductory and assumptions meetings

We held introductory meetings with the HRI team to understand the innovation better, its current status and identify any further research undertaken. We also facilitated an assumptions meeting with the HRI team to understand the changes they envisioned SH+360 making and the assumptions on how this change would happen. This enabled the team to understand whether their assumptions held true or not during implementation.

4. Key informant interviews (KIIs)

We conducted remote and in person KIIs to generate detailed qualitative information on the research questions. Interviews were guided by a semi-structured template with open-ended questions that lasted 45–60 minutes. HRI identified the interviewees.

5. Focus group Discussions (FGDs)

We conducted two in-person FGDs with 5–6 facilitators from BRAC and the MoH in Arua and Kampala respectively. The purpose of these FGDs was to gain the facilitator's perspective of delivering SH+. We undertook FGDs with this group rather than a single KII to hear from more facilitators, giving us a wider data collection point. FGDs followed a structured guide including reflection action tools.

We conducted 12 interviews and two FGDs as indicated in the table below.

Table 2. Case study participants breakdown

Category	Organisation	No. of representatives
KIIs		
Grantee team	HealthRight International	4
Implementing partners in Uganda	BRAC Uganda	2
	Ministry of Health	2
Adopters	UNHCR Uganda	1
	M(H)IND consortium in South Sudan led by AMREF with Caritas, BBC Media Action and the University of Verona.	1
Potential adopters of SH+360	Jesuit Refugee Service	1
	Shabaka Social Enterprise CIC	1
FGDs		
Facilitators	BRAC Uganda	1 female, 5 male
Facilitators	Ministry of Health	3 female, 2 male

6. Validation meeting

We presented emerging findings from the data collection to the HRI and Elrha teams for reflection, validation and feedback.

Limitations

Developing this case study had four key limitations:

- As SH+360 did not have a fully defined theory of change, we retrospectively reconstructed its change pathways and underpinning assumptions which were subjective and open to misinterpretation of what was known at the beginning, presenting the risk of inaccurately perceiving the change that has happened. The case study focused on how change happened and whether the innovation teams' assumptions held true.
- We interviewed a small number of key stakeholders in each category and were not able to interview people from the "external stakeholder" category, making it difficult to draw definitive conclusions.

- The research questions contained several sub questions which made it challenging to thoroughly analyse specific key areas within the timeframe and budget. We reflected broadly on the questions.
- The data available was insufficient to fully answer research question 3 on costs. The costs of development and implementation are estimated as provided by HRI, BRAC and MoH.

Annex 2: SH+360 – Types of Support and Funding Model

Table 3. SH+360 – types of support and funding model

Organisation	Type of support offered by HRI	Funding model
MoH	Intensive direct support over 6 months across the programme cycle	Traditional grant funding through HRI grant (HIF funding)
BRAC	Intensive direct support over 6 months across the programme cycle	Traditional grant funding through HRI grant (HIF funding)
M(H)IND consortium in South Sudan	Ad hoc support towards preparation to implement SH+ programme, training of facilitators	Consultancy model (HRI charged a symbolic consultancy fee as the consortium did not have enough budget to cover the full range of consultancy fees. AMREF met all costs of training facilitators.)
UNHCR	Direct support to UNHCR and training facilitators.	Consultancy model (UNHCR paid HRI to provide this support)
JRS	Consultation and contribution to proposal for funding SH+ implementation across their existing programmes DRC	Free
Shabaka Social Enterprise CIC	Consultation and contribution to proposal for funding SH+ implementation in new programme in Sudan	Free
Premiere Urgence Internationale Afghanistan	Provided consultation support to develop proposal in SH+360 model	Free

Annex 3: Change Areas and Assumptions

Table 4. Change areas and assumptions.

Change area	Assumption	Does it hold true?
People living in crisis have more tools to deal with stress and mental health problems.	SH+ participants would continuously access the tools to reinforce their learnings from the SH+ sessions.	Yes , participants use the books at home.
	Screening of participants to determine who can use it effectively and referral for people with more serious mental health challenges	Yes , screening done before SH+ sessions, referrals made.
	SH+ tools would be translated into the relevant languages for people in crisis, while maintaining cultural awareness and sensitivity.	Partially - language barrier is still a major barrier.
	SH+ is readily available for people in crisis to use as a tool to manage their stress and mental health challenges.	Partially - available to programme participants.
	People in crises will have the means to access SH+ tools eg, smartphones to download audio files and booklets	Partially - limited to people with smartphone or internet access.
Delivering SH+ becomes a sustained and integrated component of non-MHPSS humanitarian programming.	HRI partners would eventually make SH+ tools available to the targeted people within all their programmes.	Yes - partners distribute books.
	INGOs will implement and scale up SH+ across their programmes and countries of operation, such as lobbying for funding, writing grant applications or prioritising it within their core funding.	Yes - partners seeking funding independently.
	Partners will pay HRI to train them in the implementation of the SH+360 model.	Yes - UNHCR paid for HRI to train facilitators.
	Facilitators trained within partner organisations would train others, reducing dependence on HRI for technical support.	Yes -ToT of facilitators from the M(H)IND) consortium in South Sudan.

More organisations adopt and adapt SH+ and use it within their existing programmes.	Partners interested in contracting HRI to help them test and implement SH+.	Yes , but constrained by funding.
	Partners will use the publicly available SH+ tools within their existing programmes.	No , they prefer to be guided by HRI.
	Large organisations will integrate SH+ into their programmes (after support and with budget available).	Yes , implemented alongside existing programmes.
	INGOs & UN agencies replicate SH+ integration across their organisations.	Little evidence of organisation-wide replication.



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ABOUT ELRHA

Elrha is a global organisation that finds solutions to complex humanitarian problems through research and innovation. The innovations funded through our Humanitarian Innovation Fund (HIF) identify, nurture and share more effective and scalable solutions to some of humanity's most difficult challenges. The HIF is funded by the UK Foreign Commonwealth and Development Office (FCDO), the Netherlands Ministry of Foreign Affairs (MFA), and the Norwegian Ministry of Foreign Affairs.

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