Mental Health and Psychosocial Support using the Problem Management Plus (PM+) Approach

PM+ Evaluation Report

December 2020

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Acronyms

ARV	-	Anti-Retroviral Treatment
CCC	-	Comprehensive Care Centre
CHEWS	-	Community Health Extension Workers
CHVs	-	Community Health Volunteers
GBV	-	Gender Based Violence
GHQ	-	General Health Questionnaire
HIV	-	Human Immunodeficiency Virus
IUVP	-	Inter-Sectoral Urban Violence Prevention
MHPSS	-	Mental Health and Psychosocial Support
MoU	-	Memorandum of Understanding
OVC	-	Orphaned and Vulnerable Children
PM+	-	Problem Management Plus
PSYCHLOPs	-	Psychological Outcome Profiles
TOV	-	Torture Organized Violence
WHODAS	-	WHO Disability Assessment Schedule

Introduction

MidRift Human Rights Network has been implementing a mental health project titled '*Strengthening access to community-based MHPSS services to survivors of Torture and Organized Violence (TOV) and Gender Based Violence (GBV)"*. The rehabilitation project was designed to provide Mental Health and Psychosocial Support (MHPSS) support to survivors of GBV. The need for MHPSS was identified during implementation of the Inter-sectoral Urban Violence Prevention (IUVP) project. Implemented in Kenya since 2014, the IUVP project highlighted the need for MHPSS in informal communities.

The Rehabilitation project targeted survivors of torture and violence, especially GBV and domestic violence in the local communities within Rhonda / Kaptembwo (Nakuru Town West sub-county) and Karagita (Naivasha sub-county) in Nakuru County, Kenya. The project was piloted in 2019 with a second phase of the project continuing in 2020. The rehabilitation project utilizes World Health Organization's Problem Management Plus (PM+) approach that is designed to help people who suffer from anxiety, stress or depression in communities that are affected by adversity.

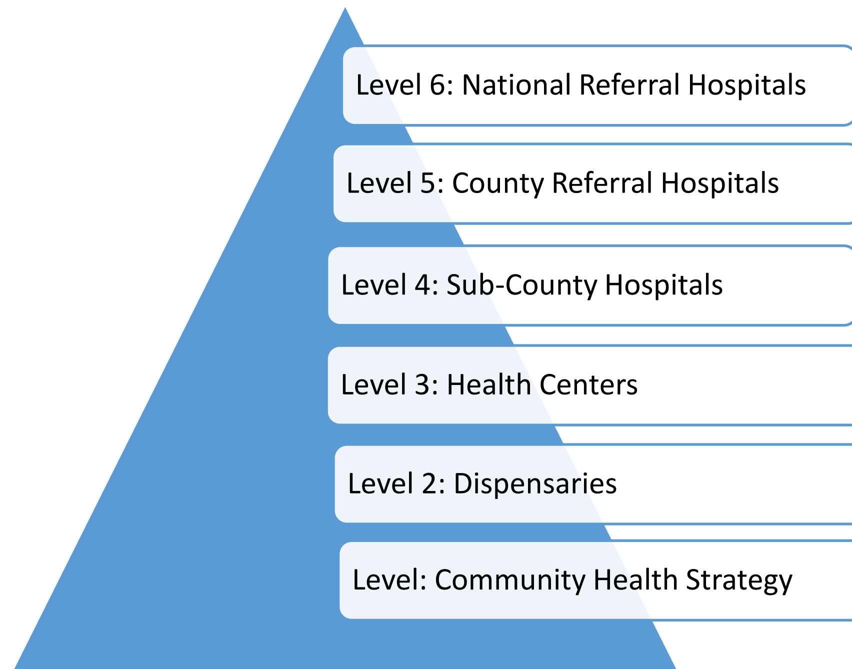
The project had three strategic objectives:

1. To strengthen access to MHPSS services in the local communities of Rhonda and Karagita in the sub-counties of Nakuru and Naivasha (through provision of PM+ by community health volunteers [CHVs])
2. To increase awareness in local communities on mental health and gender-based violence (GBV) and influence policy-makers and decision makers to prioritise access to MHPSS and the development and implementation of gender policies and programmes
3. To reinforce the capacities and position of Midrift as a key actor capable of facilitating access to MHPSS and promote development and implementation of MHPSS services and gender-sensitive policies and programmes

Besides providing direct MHPSS services to victims, the project design sought to enhance Nakuru County's capacity to mainstream MHPSS in service delivery by building the capacity of Community Health Volunteers (CHVs).

In the health care system, CHVs constitute Level I of the health care system and are attached to Level II facilities. In the rehabilitation project, CHVs were trained to serve as PM+ helpers in the project. The project also trained Community Health Extension Workers in Level II facilities on the PM+ approach and supported them to serve as supervisors in the project and established a referral mechanism with community actors to enhance access to community-based MHPSS for survivors of torture and organized violence (TOV) and GBV.

The table below shows the various levels of Kenya's Healthcare System:



To implement the project, Midrift Hurinet built the capacity of 28 helpers, 5 supervisors and 34 referral network members to help 200 GBV and/or TOV victims manage emotional distress and take practical steps to reduce the problems that cause stress, anxiety or depression in their lives.

Cumulatively 72 people had completed the 5-week sessions by June, 2020. 45 more completed the PM+ intervention between June and November, 2020. Having implemented the first phase in 2019 and the second phase in 2020, Midrift Hurinet commissioned an evaluation to determine the effectiveness, challenges and impact of the PM+ approach in providing MHPSS to GBV/TOV survivors. The main objectives of the project evaluation were:

1. To assess the relevance, effectiveness, efficiency, impact and sustainability of the project
2. To identify key achievements, challenges and lessons learned
3. To provide concrete recommendations for future programming and potential for up-scaling.

Evaluation Methodology

Evaluation for the Rehabilitation project was conducted using the DAC evaluation criteria, which focused on five key aspects:

a. *Relevance:* The extent to which the project is consistent with existing priorities and policies of the beneficiaries and donor. For instance, are there synergies and inter-linkages between the PM+ project and other interventions being conducted by other institutions or government? Is the project consistent with other interventions in the same context? This includes complementarity, harmonisation and co-ordination with others, and the extent to which the project is adding value while avoiding duplication of effort.
b. *Effectiveness:* The extent to which the project has attained its objectives and the major factors influencing the achievements or non-achievements of the project. This will include evaluating whether the project has achieved the expected results, including differential results across groups
c. *Efficiency:* The extent to which the project was cost-efficient. This includes evaluating whether objectives were achieved on time, project was implemented in the most efficient way compared to other feasible alternatives in the same context and whether it was implemented within the intended timeframe.
d. *Impact:* The changes produced by the project including evaluating which social effects are longer term or broader in scope than those already captured underr effectiveness
e. *Sustainability:* The extent to which project activities are likely to continue after donor funding has been withdrawn including sufficiency of local capacity and ownership to sustain activities over time

The project evaluation process involved undertaking a desk study of relevant project documents and beneficiary data, as well as collection of primary data from key respondents who participated implementation of the project. The following are details on how informants were selected and sampled, how data was collected and analysed and the ethical standards that were considered during project evaluation.

Selection and Sampling of Informants

The evaluation process involved gathering information from various groups that had been involved in the MHPSS/PM+ project. Evaluation informants were drawn from four broad groups both in Naivasha and Nakuru Town West sub-counties. These are:

- *PM+ Helpers and Supervisors*
- *Referral Networks*
- *Representatives of the local community*
- *County health departments of health and gender*

Informants from each of these groups were selected using the following criteria:

a. *PM+ Helpers and Supervisors:* Names of informants were selected randomly from the pool of helpers who had been actively involved in the project including participation in PM+ trainings, delivery of PM+ sessions and participation in supervision meetings. All supervisors involved in the project, including the DIGNITY supervisor, participated in the evaluation.
b. *Referral Networks:* Informants from this group were selected based on the community or service structures that they represented (for community health extension workers and GBV clusters) and geographic locations (for police gender desks and chiefs)
c. *Representatives of the local community:* Informants from this group were selected based on their participation in Midrift's outreach activities. Community representatives who participated in the evaluation were drawn from community structures such as Nyumba Kumi[1], community policing committees and community health units.
d. *County departments of health and gender:* Informants from the health department were selected based on their awareness of the Rehabilitation project and involvement in project activities, including knowledge of Midrift's MOU with the department of health. Informants from the gender department were selected based on their participation in the GBV technical working group, involvement in Midrift's activities on County gender policy development and advocacy for the County Gender bill.

Mixed sampling was used to identify actual respondents. The following table shows the actual number of respondents who participated in the evaluation:

Stakeholder	Number of Informants
PM+ helpers	23 pax
Referral network members	15 pax
PM+ supervisors	6 pax
County government	2 pax
Local community	12 pax
Midrift staff	2 pax

Data Collection

Evaluation data was collected using the following methods:

a. ***Desk Study:*** A desk study on project documents including the PM+ manual, project document, training materials, beneficiary pre and post assessment data and referral data was undertaken and used to inform the evaluation process.

[1] "Nyumba Kumi" is a Swahili phrase meaning ten households, though not literally. Nyumba Kumi provides a framework that anchors Community Policing at the household/basic level.

b. ***FGDs and Interviews:*** Focus group discussions and key informant interviews were conducted with representatives of key project stakeholders. Semi-structured questionnaires were used to conduct the interviews and guide focus group discussions. Responses were captured through recordings. The table below shows the method used to gather data from various stakeholder groups:

Key Informant Interviews	Focus Group Discussions
Community Health Extension Workers (Supervisors)	Community health volunteers (PM+ helpers)
Select Community health volunteers (PM+ helpers)	Community referral network
Representatives from the County Department Health and a local health facility	Representatives from the Local Community
Police Gender Desks	
Chiefs in the Intervention Areas	
Midrift Personnel	

c. **Data Analysis**

Based on the data gathered through the desk study and interviews, an overall analysis was undertaken to identify key project achievements, challenges and lessons learned. Evaluation data was analysed using the inductive method. Key findings were extracted through thematic and narrative analysis presented in this report. The thematic content analysis was used to establish common patterns while a narrative analysis was used to make sense of informant responses. This report contains the key findings of the evaluation including project outcomes, challenges, lessons learnt and suggested way forward.

Ethical Considerations

The project evaluation complied with the following ethical considerations:

1. *Informed Consent:* Respondents were informed about the evaluation and allowed to make an informed decision on whether to participate in the process or not. They informed of the purpose of the evaluation, the use to which the organization will put the information as well as the findings, and how the findings will be used.
2. *Voluntary Participation:* Respondents were not coerced to participate in the project evaluation. Participation in the interviews and focus group discussions was purely voluntary.
3. *Confidentiality:* Informants were assured of confidentiality. Personal information about them has not been included in this report nor was identifying details that can lead to identification of informants made accessible to third parties, other than Midrift's officers and their partner, DIGNITY. This report has not been worded in a way that

presents opportunity for informants to be identified even without the mention of names.

4. *Do No Harm:* This evaluation was conducted in a manner that does not harm respondents either by causing them stress, anxiety, or pain. Interviews and focus group discussions did not invade informants' privacy or diminish their self-esteem.

Outcomes of the Rehabilitation Project

The evaluation assessed various aspects of Midrift's rehabilitation project to determine its outcomes at various levels. The main aspects that the evaluation assessed included the relevance of the community-based MHPSS, outcomes of the PM+ training, the referral mechanism, the supervision structure, inter-sectoral collaborations and sustainability of the project. This section discusses the outcomes of the rehabilitation project:

Relevance of Community-Based MHPSS

The evaluation of the rehabilitation project showed that community-based MHPSS is very relevant and instrumental in providing survivors of GBV and other forms of violence with coping skills that help them deal with adversity. Evaluation respondents who participated in Midrift's rehabilitation program in Nakuru Town West's Rhonda/Kaptembwo and Naivasha's Karagita settlements confirmed that the need for community-based MHPSS/PM+ is much greater than the project can address.

Most respondents, particularly those that work within the community like PM+ helpers, supervisors and referral networks became aware of the need for community-based MHPSS/PM+ from working and interacting first hand with communities in the target informal settlements communities. This applied to CHVs, CHEWs and referral actors (chiefs, community elders, police gender desk and religious leaders). Others became aware of this need from findings of studies conducted to assess the prevalence and impact of GBV in informal settlements that identified community-based MHPSS as a strategy for helping survivors.

By and large, all respondents who participated in the evaluation agree that the PM+ as an approach to community-based MHPSS empowers survivors with skills to cope with the challenges they face. While Midrift's Rehabilitation project was targeting GBV/TOV survivors, respondents who were drawn from government departments, referral networks and PM+ helpers agree that the PM+ intervention is capable of helping survivors of other forms of violence including survivors of war and post-election violence.

Specific Outcomes of the Rehabilitation Project

The evaluation showed that Midrift's rehabilitation project has generated positive changes at the community and policy levels. Below is an in-depth analysis of the changes that have occurred as a result of the project:

1. PM+ Helpers

The rehabilitation project recruited community health volunteers (CHVs) and a few community volunteers from Midrift's network to serve as PM+ helpers. The CHVs were

taken through a 2-week training on the PM+ intervention and supported to conduct PM+ trainings with clients who had been exposed to adversity in the target informal settlements. The PM+ training, coupled with the experience gained through delivery of PM+ intervention to GBV/TOV survivors, provided CHVs with a new set of helping skills that they didn't have prior to the project. The following are some of the positive changes reported by helpers who participated in the MHPSS/PM+ project:

- *Change in perception towards mental health:* Like anyone else in the community, prior to joining the project, CHVs equated mental health to psychotic disorders that cause people to lose touch with the reality. They did not view mental health as an area that covers a wide range of issues that affect a person's mood, thinking and behavior and didn't know that a person does not have to experience psychotic symptoms to require MHPSS. The helpers also didn't know that mental health conditions can affect anyone and that stress is actually a mental health condition.

  The PM+ training shifted CHVs' perception of mental health. They realized that mental health is actually a state of mental well-being where a person is able to realize his or her abilities, and cope with the normal stresses of life. They also realized that mental conditions can affect anyone and can be triggered by adversity.

- *Ability to detect mental health issues:* Prior to receiving PM+ training, CHVs did not know how to detect mental health issues. This means they could not help any person who had mental health issues or handle clients with mental health problems. Whenever they came across a person who had common mental conditions, they would unknowingly give advice, sympathise or judge them. The PM+ training raised their awareness about common mental health conditions and equipped them with basic helping skills that enable to identify and support people with mental health difficulties.

- *Ability to provide psychosocial support:* Prior to joining Midrift's rehabilitation project, CHVs could not offer any psychosocial support to persons with mental health problems. Despite being in the community and supporting the health care system at the primary level, they could not help anyone who had mental health issues. This has since changed. Through the PM+ training, CHVs acquired knowledge about coping strategies and basic helping skills that enable them to provide psychosocial support to survivors of GBV/TOV.

  According to PM+ helpers, managing stress and managing problems are the two coping skills they find most useful in helping GBV/TOV survivors overcome their problems. They also identified communicating concerns, confidentiality, validating client feelings, setting aside personal values and non-verbal communication as the helping skills they find most effective in supporting GBV/TOV survivors.

- *Understanding and actively using self-care techniques:* PM+ helpers are able to apply the coping and basic helping skills they use during PM+ intervention to address their own problems. By engaging in exercises such as slow breathing and listing problems, they reduce stress and manage their problems better. Helpers also reported using these skills in their homes and with their friends.

- *Increased networking:* The project has enabled PM+ helpers to network with a wide range of community actors that they had not worked with before. Some actors that helpers have been added to their network include the police gender desk, religious leaders, and community policing committees.

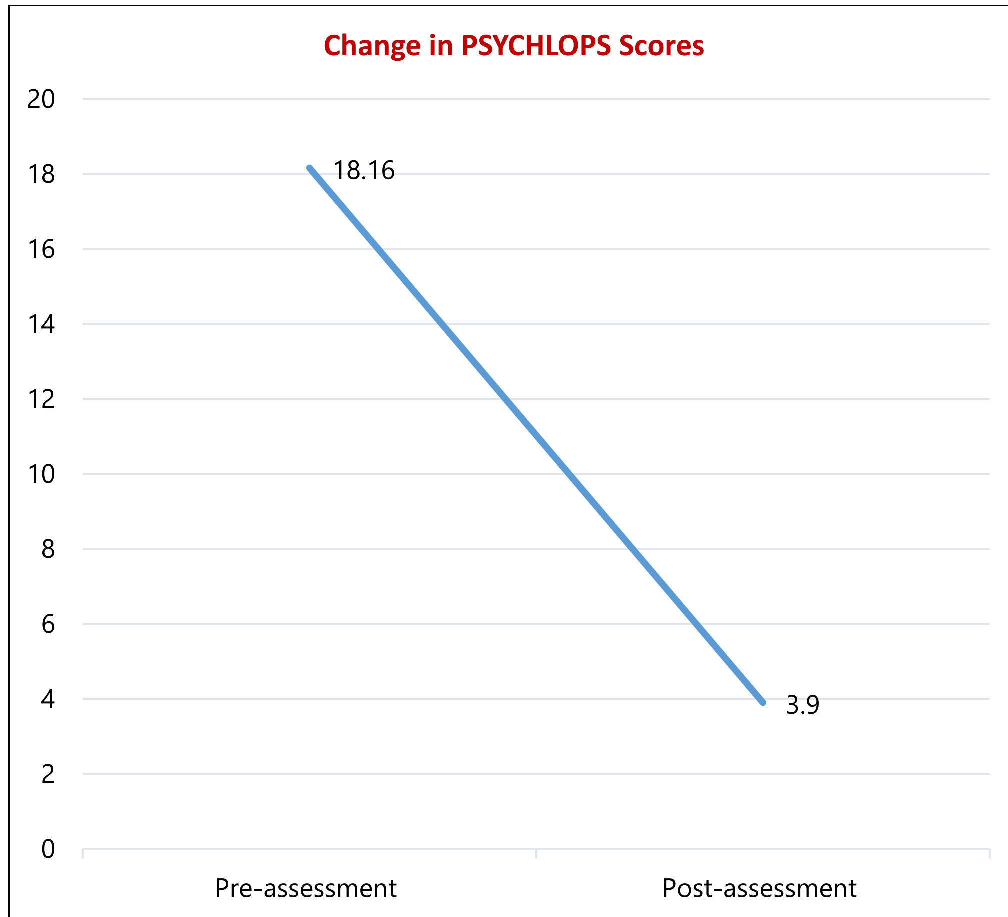
2. PM+ Clients

The evaluation found that the PM+ intervention is extremely effective in helping clients in communities that face adversity cope with challenges better and even find practical solutions to their problems. Clients who go through the PM+ intervention receive training on five coping strategies.

Both PM+ helpers and PM+ supervisors agree that all five coping skills in the PM+ intervention are critical in helping GBV survivors deal with challenges. In their view, the skills empower clients holistically by providing the emotional, practical and social empowerment they need to deal with the challenges they face. The coping skills complement each other - one skill builds on the other. This means removing any of them would weaken the intervention and deny GBV survivors the opportunity to develop in some areas of their lives.

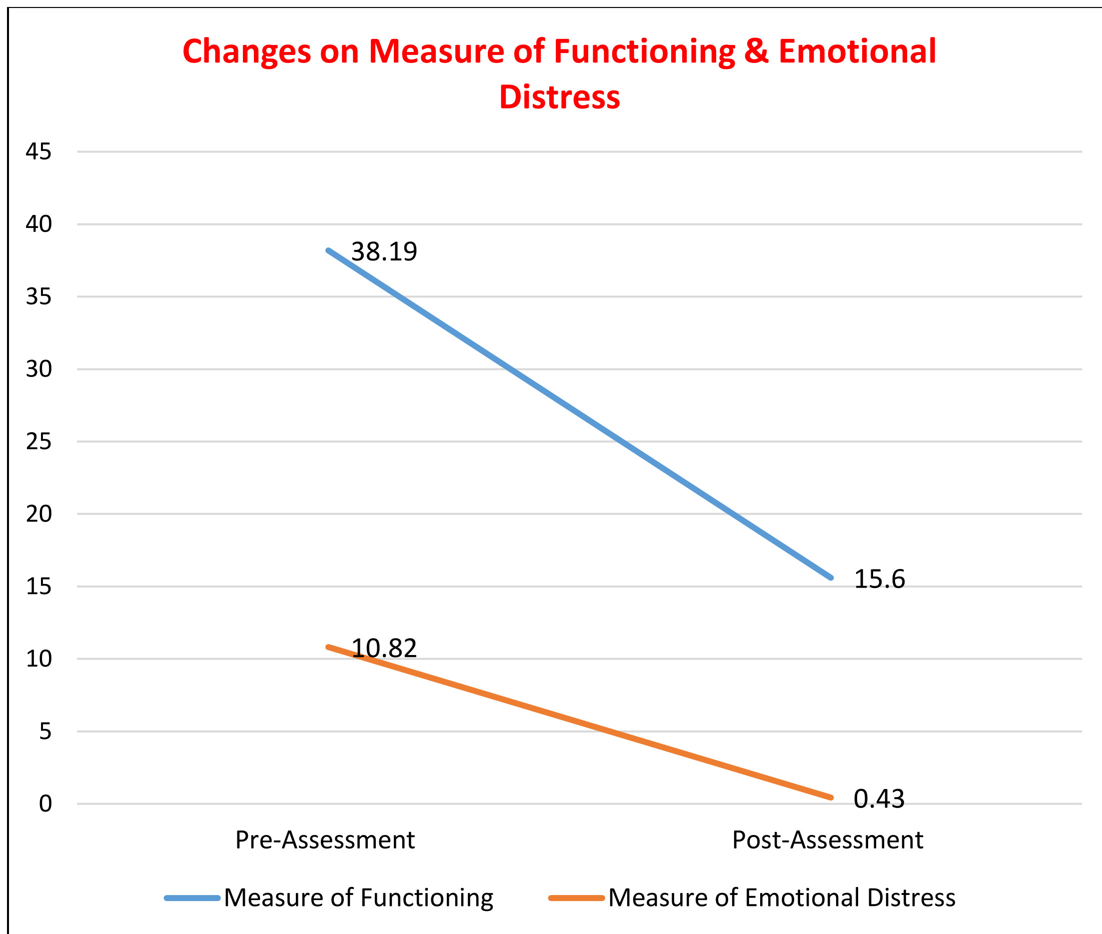
All clients completed assessments of psychological distress (PSYCHLOPS and General Health Questionnaire [GHQ]) and functioning (WHODAS 2.0) before and following PM+ sessions. The evaluation found strong evidence of transformation in the lives of survivors of GBV and other forms of violence who go through the PM+ intervention. On the PSYCHLOPS, clients are asked to identify their most difficult problems and rate on a scale ranging from 0 to 5 how much the problem has bothered them in the past week. Analysis of pre and post assessment data of 72 clients who completed the PM+ intervention in 2019 showed a steep drop in PSYCHLOPS scores.

The mean PSYCHLOPS score for this set of clients was 18.22 at the beginning of the PM+ intervention, just 1.78 shy of the maximum PSYCHLOPS score, which is 20. The score dropped to an average of 3.9 at the end of the intervention. This represents a 72% change in the way the PM+ clients felt about their problems at the end of the intervention. A high PSYCHLOPS score means clients are severely affected by their problems, while a low score means clients are less affected by their problems.



Further assessment of client data revealed significant improvements in client's emotional distress and ability to function as captured in GHQ and WHODAS scores, respectively. The GHQ tool was used to assess the level of emotional distress in PM+ clients while WHODAS was used to assess the functioning difficulties the clients had due to health conditions.

The GHQ score dropped by 10.39 while the WHODAS score dropped by 22.59 as reflected by the graph below. The change in GHQ score means the level of psychological distress among clients reduced and the drop in WHODAS score means clients improved in their daily functioning.



These changes were supported by positive change stories shared by helpers and supervisors during the evaluation. Positive change in clients was reflected by their ability to:

Lower their stress levels: GBV survivors are able to manage stress better using the slow breathing exercise.

Case Study 1:
One woman who was married and had four kids had been experiencing violence in her marriage. From the time she got pregnant with her fourth child, her husband started beating her and leaving her and the children without money to buy food. When she gave birth to the child, life became unbearable. She decided to go back to her parents with her four children. Her mother was did not have the means to take care of her and her children. The financial situation she was in caused her a lot of stress. While in that situation, she met a PM+ helper who took her through the four sessions. Through the intervention, she learnt how to manage stress and began to recover. The problem management session helped her in identifying a solution to her financial problem. She was able to start a small business and is now able to provide for her children.

Case Study 2:

When her husband died, one widow inherited a half an acre piece of land in her rural area. Instead of moving to occupy the land in her rural area, she opted to continue living in a rented house the city. The land she inherited in her rural home was the only inheritance that her children had. It had a small house.

Since she was living in the city, she decided to get someone to live in the house while taking care of her land. In her community, if a person leaves his or her land in the care of another person for more than 3 years, they are required to share the land with the caretaker permanently.

The widow overstayed in the city and before she realized it, the 3 year period had lapsed. This meant she would have to either share her inheritance with the caretaker or raise Kshs. 100,000 for the person to acquire another piece of land. This caused her tremendous stress because she had accumulated three month rent arrears in the city and back home, she was about to lose half of the inheritance that she and her children had.

When a PM+ helper found her, she was in bad shape. She would spend her time lying on the couch. The PM+ helper introduced her to the managing stress session. This enabled her to get up from her depressed state. As the PM+ helper took her through the problem management session, she started noticing many positive things in her life like having a place to call home despite the fact that she'll be required to share the land with her care taker.

Enumerating the positive issues in her life caused her to lighten up as she realized that she had so much to be thankful for compared to many other people.

Manage their problems. This is reflected by client's ability to identify and implement practical solutions to their challenges like getting a job, starting a business, or even make a decision that appeared difficult to make like getting out of an abusive relationship among others.

Case Study 3:

One woman was in a marriage that had caused her great stress as a housewife. She had two children, but her husband was promiscuous. He would sleep with other women and abuse her verbally. He even stopped supporting her financially, making it difficult for her to feed her two children. At the time when a PM+ helper met her, she was pregnant with the third child and was experiencing complications due to the pregnancy.

She had also realized that she had contracted HIV. This made her angry to a point where she had stopped taking ARVs. When the PM+ helper took her through the managing stress session, she felt better and started taking medication. She even started going to the hospital for prenatal care to learn how she could protect her unborn baby from contracting HIV. Time went by and she delivered the baby safely. Her husband left her, but through the PM+ training, she realized that she could start a small business to generate income. She is now able to take care of her 3 children.

Case Study 4:

A single mother who worked in a lodging doing manual cleaning jobs had been forced to leave work due to reduced work load in lodgings following the Covid-19 pandemic. The loss of income made it difficult for her to pay rent and feed her children. This caused her stress as she didn't know what to do to address the problem. While going through the difficult situation, she met a helper who took her through the PM+ intervention.

During the problem management session, she decided to go back to her former employer and ask for a job. When she took this bold step, the employer agreed to her request and took her back. This enabled her to adjust back to her previous life, she is able to pay her bills and feed her children. She's is much happier now and even looks good.

Case Study 5:

One woman considered herself married to a man who was never present in her life or that of her children. The man would go away for two to three years then visit them. He never provided for the family, but he would force her to be intimate with him whenever he visited. At one point, the man infected her with an STI – she had to cater for the cost of treated. His visits would only last a few days, he would not leave anything behind for the children when he left, only promises of bringing them shoes when he visits next.

The situation caused her great stress because neither her needs nor those of her children were being met by her husband. When she met a PM+ helper and started taking the training, she realized the man was actually using her. Through the training, she gained confidence and realized that she could take charge of her life. She decided to leave the marriage, got a new house and moved there with her children. The PM+ training empowered her to make a decision that she had been unable to make for many years.

Change behaviour: There were reports of how clients who engaged in harmful social behaviours like excessive drinking of alcohol had changed to become responsible members of the society.

Case Study 6:

A woman had a husband who had a drinking problem. He would do menial jobs and spend his day's earnings on alcohol. This made it challenging for him to meet the basic needs for his family, an issue that caused frequent quarrels between her and the husband, often ending in physical fights. The woman as taken through the PM+ intervention. The problem management session enabled her to identify a solution to the problem she was encountering due to her husband's behavior of spending all his money on alcohol and not provide for the family.

The woman raised capital. She set up a small grocery shop in her neighborhood and started selling vegetables. This enabled her to raise money to cater for her family's basic needs like food. She stopped quarreling with her husband because she quit asking him for money. When the husband saw the transformation in her, he was inspired to change. The couple started working together better to support their family.

Improvements in depression symptoms: Some clients who had developed depression symptoms like low activity and withdrawal from social activities have registered improvements and resumed ordinary activities after going through the PM+ intervention.

3. PM+ Supervisors

The PM+ intervention has a two-tier supervision structure. The first tier involves supervisors holding weekly supervision sessions with PM+ helpers while the second tier involves Dignity supervisor holding supervision sessions with PM+ supervisors. The evaluation showed that supervision sessions have had a positive impact on PM+ supervisors in the following ways:

1. *Mastery of core MHPSS/PM+ Skills and Strategies:* For PM+ helpers, supervision provides a safe learning space. By holding supervision sessions with PM+ helpers and the Dignity supervisor, PM+ supervisors have mastered the core strategies and skills in the PM+ intervention. Mastery of these skills and strategies has been driven by the interactions supervisors have with helpers, the questions helpers ask, the support they request and the ideas they share during supervision sessions. Supervision also enhances the ability of supervisors to use training materials and the PM+ manual as they address the issues that helpers raise.

Further, supervisors improve PM+ skills and strategies through the supervision sessions they hold with the Dignity supervisor. According to them, the support they receive from listening to each other, practising helping skills, discussing difficult cases they encounter, getting the perspectives of other supervisors, and asking questions enables them to master the PM+ intervention strategies better. Some of the issues that supervisors have received support for include managing difficult issues or situations, handling clients who have multiple problems, referral of clients to higher levels of care and managing workloads.

In addition to learning from interacting with each other and the Dignity supervisor, PM+ supervisors receive additional resources and tools developed by global leaders in the psychology or problem management space that deepen their understanding of MHPSS and the PM+ intervention.

2. *Mastery of supervision skills:* Supervisors have acquired key supervision skills including understanding the role of supervision in the delivery of community-based MHPSS through PM+ and the practical aspects of how to conduct it. During supervision sessions, each supervisor gets an opportunity to respond to a problem. This enables them to sharpen their skills more by knowing the kind of support they need to give helpers to address varying challenges.

3. *Connecting with PM+ Helpers*: The supervision sessions that supervisors hold with helpers provide unique opportunities for them to connect with the helpers, learn about their experiences in delivery of PM+ intervention as well their motivation to provide primary health care. The sessions enable supervisors to know their helper teams better – both collectively and individually.

4. *Self-Care:* Supervision provides PM+ supervisors with spaces for advancing self-care through debriefing. Supervisors receive emotional and psychological support each week after supporting PM+ helpers. They also apply the coping skills in PM+ training to address their own problems. By engaging in exercises such as slow breathing and listing of problems, they reduce stress and manage their problems better.

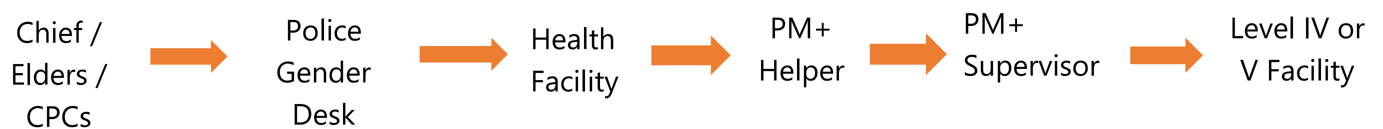
Referral Mechanism

During implementation of the rehabilitation project, Midrift set-up community-based referral networks in Naivasha's Karagita settlement and Nakuru Town West – Rhonda/Kaptembwo area. Based on the evaluation conducted, membership of these networks is largely drawn from chiefs, police gender desks, community policing committees, GBV clusters, community health volunteers, religious leaders (Pastors/Sheikhs),

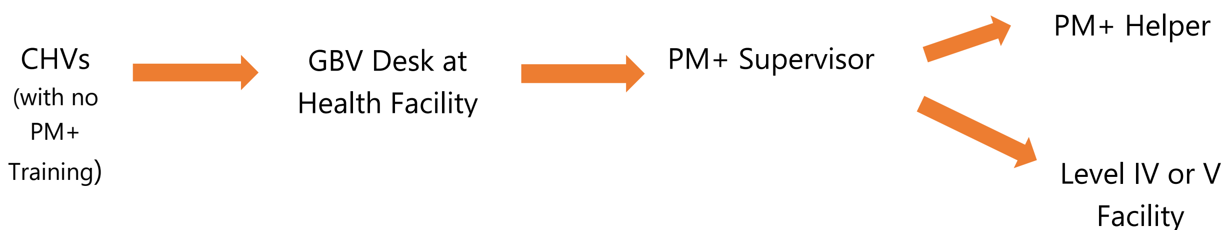
community elders, community health units and representatives from health facilities (mostly Public Health Officers in Level II or III facilities).

Formation of referral networks was initiated by Midrift Hurinet, through PM+ helpers. The networks were part of the strategy that helpers used to get clients after completing the PM+ training. Referral network actors were identified based on the role they play in addressing the GBV problem in the community. They represent places where cases of GBV are reported or places where GBV survivors seek counsel, refuge or treatment. Based on the information gathered during evaluation, the community referral routes are not linear. Clients are referred to and from different actors. The most common referral routes have been mapped below:

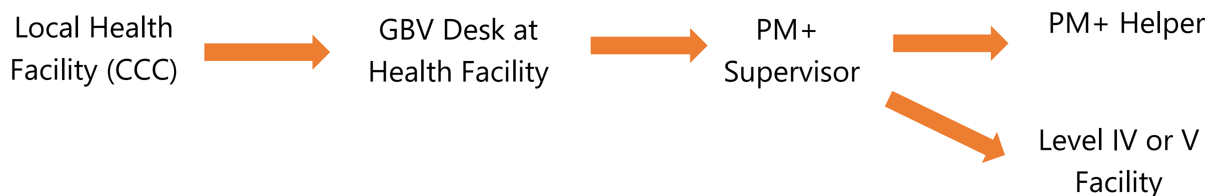
Route I



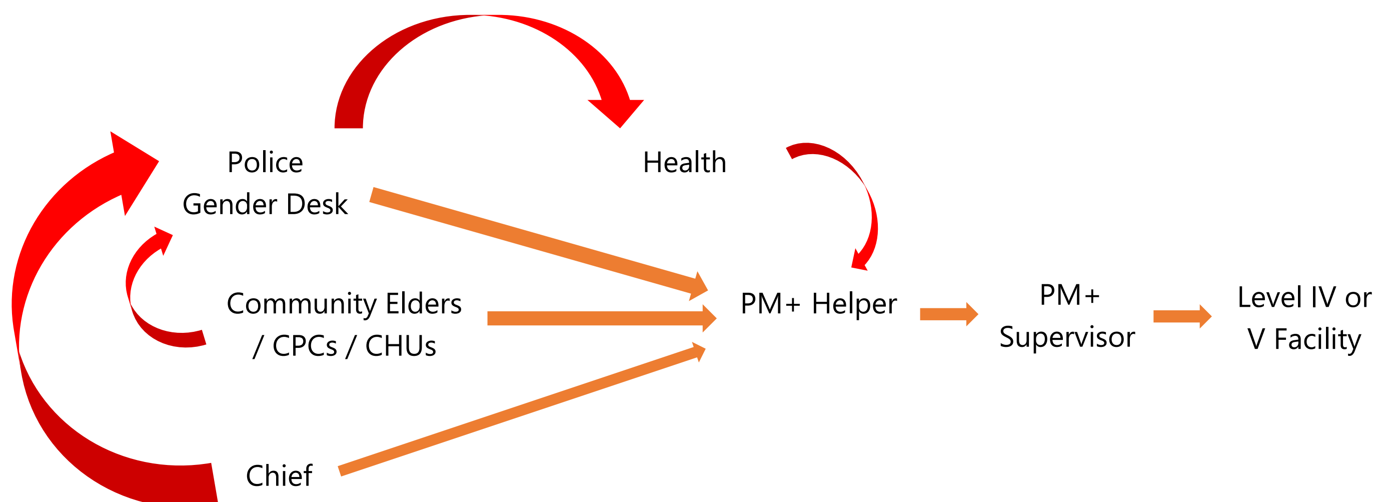
Route II



Route III



Route IV



Referral actors find the referral networks critical to reducing the number of GBV cases that are reported and handled by the police gender desk. They also help in fast tracking referrals to higher levels of care, fostering collaboration between different actors that handle GBV/TOV cases in the community and facilitating information flow among network actors.

Supervision Structure

The rehabilitation project has a robust supervision structure where PM+ supervisors hold weekly supervision sessions with PM+ helpers and supervisors have weekly supervisions with the Dignity supervisor. Both PM+ supervisors and helpers find the supervision structure invaluable in providing the support they need to provide MHPSS services in the target communities. The main reasons PM+ supervisors and helpers consider the supervision structure a critical component of community-based MHPSS include:

a. *Facilitating continuous learning:* Both supervisors and PM+ helpers appreciate supervision sessions as critical spaces for continuous learning. It gives them an opportunity to learn from each other, review training materials and the PM+ manual, get responses to questions and address any issues that emerge from PM+ sessions. The more supervisors and PM+ helpers participate in supervision sessions, the more they find it necessary and relevant to the delivery of the PM+ intervention.

b. *Practicing helping skills:* Supervision serves as a good platform for practising basic helping skills. Supervisors use group discussions and the throwing back question technique to encourage participants to share how they think the challenges or issues that are tabled during supervision sessions can be addressed.

c. *Providing peer support:* The supervision structure serves as a support system for helpers and supervisors. PM+ helpers and supervisors get a chance to support each other as they discuss issues and share thoughts or ideas on how different challenges can be addressed before supervisors on both levels give their advice. The supervision structure also provides space for helpers and supervisors to debrief – they share about the challenges they experience working with clients. In some supervision teams, helpers share their personal struggles and get help on how to manage those challenges/situations from their peers. This builds confidence and trust among PM+ helpers and supervision teams.

Stakeholder and Inter-Sectoral Engagements

In implementing the rehabilitation project, Midrift Human Rights Network engaged various government and community actors. From the evaluation, it was evident that the organization worked closely with the departments of health and gender at county level, national government structures at community level and various community structures. Below are details of how Midrift engaged different actors and what the organization achieved through those engagements:

a. The County Department of Health

Midrift Human Rights Network has a formal working relationship with the Nakuru County's department of health. The relationship has been formalized through a memorandum of understanding (MoU). Under the MoU, the two parties agreed to train a selected number of CHVs (drawn from level 1 of the health care system and attached to level II facilities) to serve as PM+ helpers and CHEWs (drawn from level II and III facilities) to serve as PM+ supervisors.

By training CHVs and CHEWs in the two project sites (Karagita and Rhonda/Kaptembwo) on the PM+ approach, Midrift empowered the department of health in the county to provide community-based MHPSS services to GBV survivors. Though not on a large scale, the CHVs and CHEWs are already providing MHPSS services at the community level and referring cases that require specialized treatment to level IV and V facilities. In total 14 referrals were made to higher levels of care by supervisors. This was not happening before Midrift Human Rights Network initiated the rehabilitation program.

Besides building the capacity of the department on community-based MHPSS, the engagement with the county department of health gave Midrift access to logistical support. For instance, the organization was allowed access to meeting spaces in local health facilities whenever it needed to hold meetings with CHVs or CHEWs.

b. County Department of Gender and Social Services

The project evaluation shows that Midrift Human Rights Network also worked closely with the department of gender and social services. The department convenes the Gender Based Violence Technical Working Group at county level and GBV clusters at sub-county levels. Midrift is a member of the County Gender Based Violence technical working group and does support its meetings.

The organization has leveraged this platform to highlight mental health issues, how they affect survivors of GBV and what needs to be done to enhance access to MHPSS for GBV survivors. As a result of these efforts, organizations like Love and Hope, Center for Enhancing Democracy and Good Governance (CEDGG), The Children's Department, Case OVC (Orphans and Vulnerable Children), and Prince of Wholeness are beginning to pay attention to mental health issues and there is a proposal to set up a mental health technical working group to give MHPSS the attention it deserves.

At the time of evaluation, the county department of gender and social services was in the process of developing the Nakuru County Gender and Development Policy. The draft policy has flagged rising mental health challenges among men and women as one of the problems that needs to be addressed. Midrift is currently supporting the development of this policy and continues to advocate for inclusion of policy actions that address the growing need for mental health services, particularly among GBV survivors and other vulnerable groups.

c. Community Actors

The evaluation shows that Midrift engaged a wide range of community actors during implementation of the rehabilitation project. Most of the community actors constituted the referral mechanism and included representatives from the national government (chief and police), and community structures (community policing committees, community elders, community health units), religious leaders (Sheikhs and Pastors) and other organizations that target GBV survivors present in the GBV technical working group/clusters.

Project Sustainability

There are several aspects that support the sustainability of the rehabilitation project. According to the respondents who participated in the evaluation, these aspects are:

a. Transfer of Skills and Knowledge

The rehabilitation project had an inbuilt mechanism of transferring PM+ skills and knowledge to the local community. This enabled Midrift, with the support of DIGNITY, to train 28 PM+ helpers and 5 Supervisors to enhance access of MHPSS in communities within informal settlements. At the time of evaluation, these teams had successfully delivered the PM+ intervention to 72 clients and were in the process of completing sessions with an

additional 200 clients. These teams have become a community resource that will continue delivering the PM+ intervention in Rhonda/Kaptembwo and Karigata settlements.

b. Collaboration between Midrift Human Rights and the Department of Health

Midrift collaborated closely with the department of health in the implementation of the rehabilitation. This collaboration paved way for Midrift to build the capacity of CHVs and CHEWs to serve as PM+ helpers and supervisors. CHVs and CHEWs form part of the primary health structure and are attached to level I, II and III of the health care system. As such, their involvement in the project anchored the community- based approach to MHPSS to the county health system and provided a unique opportunity for the county department of health to test the model. This experience and the lessons learnt from delivery of the PM+ intervention will enhance the sustainability of the project.

c. Development of a County Gender and Development Policy

Once completed, the county gender and development policy will be instrumental in sustaining the project. The policy highlights the need to address the rising mental health challenges among men and women. The policy seeks to prioritize mental health by mainstreaming MHPSS in the prevention of GBV as well as recovery of GBV/TOV survivors in Nakuru County. With Midrift's active involved in the development of this policy, it is highly expected that the policy actions required to strengthen access to MHPSS by GBV/TOV survivors will be included in the policy.

d. Referral Network Structure

Through the rehabilitation project, Midrift set up a community-based referral network that brings together key actors within the community. The network draws representation from the community, government – both local and county –, religious leaders and non-state actors to share information and enhance access to MHPSS services within the community. Once strengthened, the network will continue referring clients to helpers for PM+ intervention.

e. Unmet Need for Community-based MHPSS Services

Respondents of the evaluation underscored the relevance of MHPSS in empowering GBV survivors to prevent recurrence of violence and helping them deal with their problems. Government officials, including CHVs and CHEWs, trained psychologists, referral actors and community members emphasized the need to replicate the project across the county. According to them, the need to raise public health on mental health is still huge and the need to make community-based MHPSS services accessible to GBV/TOV survivors remains evident.

In addition to GBV survivors, respondents from health and gender departments and the referral networks feel the project should be expanded to other sub-counties in the county to provide MHPSS services to survivors of other forms of violence including post-election violence. In addition to adults, evaluation respondents feel that Midrift should consider providing MHPSS to children and teenagers who are affected by violence directly or indirectly.

Strengths and Limitations of the PM+ Approach to Community-based MHPSS

The evaluation identified several strengths and limitations of the PM+ approach to community-based MHPSS. These are discussed below:

Strengths of Community-based MHPSS

There are several strengths that make community-based MHPSS effective in helping survivors of GBV. These are:

- *Greater Outreach:* Under the rehabilitation project, the PM+ intervention was delivered by CHVs who served as PM+ helpers. Since they are anchored in level I of the health structure, CHVs work within the community and are well known to the local communities. This boosts the confidence and trust of GBV/TOV survivors. CHVs also understand the communities they work in well and are well connected within the community. This enables them to reach more people and makes it easy for them to follow up on clients.

- *Capacity Building:* The community-based MHPSS builds the capacity of locals within the community to provide brief psychological interventions to GBV/TOV survivors. This enhances sustainability of MHPSS within target communities because there is a pool of resource persons with the capacity to provide basic psychological support available within the community.

- *Accessibility of psychosocial support:* The community-based approach to MHPSS increases accessibility to mental health services in informal settlements. Ordinarily, the cost of accessing clinical psychological services is beyond the reach of most people in informal settlement. Community-based MHPSS eliminates these cost barriers, making psychosocial support accessible to anyone who needs it within informal settlement communities. Since helpers live within local communities, PM+ makes access to MHPSS timely for those who need help.

- *Bridges mental health screening gap*: The PM+ approach to MHPSS provides several tools for assessing mental health issues. With tools such GHQ and WHODAS, the intervention

bridges the mental health screen gap that exists in the community due unavailability of mental health personnel in level I to III health facilities.

- *Empowering Beneficiaries:* Through the PM+ intervention, community-based MHPSS empowers GBV/TOV survivors to find solutions to their problems. The fact that survivors who go through the training acquire practical coping skills that enable them to continue dealing with the challenges without developing dependency makes PM+ a sustainable intervention. Clients are also free to share their experiences with other people who face similar situations or refer them for the service.

- *Reducing Chances of GBV Recurrence:* According to the county gender department representative, community-based MHPSS using the PM+ approach addresses the psychological aspect of GBV violence that is often left out whenever survivors are getting help either from the health care system (treatment) or the justice system which involves interventions by police, chiefs or community elders to stop violence. By addressing the underlying emotional problems that GBV survivors experience and helping them find practical solutions to their problems, community-based PM+ plays a critical role in empowering survivors of GBV to prevent future violence.

- *Easy to Train:* As an intervention that is designed for non-specialists, the PM+ intervention is not complex to teach. CHVs who have trainable skills, reading, empathy and communication skills can learn and deliver the intervention to GBV and survivors of other forms of violence.

Limitations of Community-based MHPSS

Several limitations were noted in the design of the community-based MHPSS using the PM+ approach. These include:

- *Material Support to Clients:* The PM+ intervention is designed to help clients find solutions to problems by themselves. Clients are not provided with any form of material or financial assistance. This affects the effectiveness of the intervention because when a client is unable to feed his or her family will find it difficult to concentrate in PM+ sessions.

  For instance, one helper reported going to a client's house to continue the PM+ session. The client was a woman, she had young children. When the helper arrived at her home, her client was lying on the coach, she looked helpless. The helper got her seated but by just looking around, she could tell the family had not had anything to eat for the day. She tried to settle the client down to a session, but the children kept disrupting them as they cried and clung on to their mother.

She could tell they were hungry. When she asked the mother why the children were crying, she said they had nothing to eat the previous night, and had nothing for breakfast. The woman said she didn't know what to do to get food for her children. The helper found it hard to proceed with the session, she postponed it. The intervention may also fail to achieve the desired results where clients identify solutions to problems, but experience difficulties when it comes to raising the resources they need to implement the solution.

For instance, one helper reported that one of her clients wanted to start a small business to solve her financial problems. She identified several family members as part of her social support. But, when she approached them with requests for capital, none of them could help her.

- *Target Audience:* The PM+ intervention only targets adults aged 18 years and above. Children and teenagers, who in most cases are prone to childhood experience adversity due to the direct or indirect exposure to GBV and other forms of violence do not benefit from the intervention.

- *Delivery:* The PM+ intervention is a brief psychological intervention that is delivered by non-specialists. When a case overwhelms PM+ helpers, they have to refer the person to a professional psychologist at a higher level. Based on the information shared by supervisors, 14 cases (6 in Naivasha and 8 in Nakuru Town West) were referred to supervisors for escalation to higher levels of care.

- *Mental Conditions:* Community-based MHPSS using the PM+ approach is designed to help clients who experience common mental health issues like depression, and anxiety. The intervention cannot treat clients who have mental health illnesses or those that have been exposed to intense traumatic events as those require specialized care. Out of the 14 cases referred, 3 were cases of mental health illness – one suicidal case was referred to Naivasha's level 4 hospital while 2 mental health illnesses were referred for psychiatric care in Nakuru Town West.

Key Challenges in Implementation of the Rehabilitation Project

Implementation of the rehabilitation project was not without challenges. These challenges varied from one respondent to another. This section discusses the challenges experienced by various players who participated in the implementation of the PM+ intervention and the lessons learnt:

Challenges Experienced by PM+ Helpers

1. *Introducing clients to PM+ and getting started* – most people in the community are not aware of the PM+ intervention and what it entails. This requires helpers to invest time explaining the PM+ intervention to clients during the first meeting before they are ready to be on boarded for the training.

2. *The safety of PM+ Helpers* – When helpers get a client, they agree on a meeting venue where both are comfortable holding sessions. More often than not, helpers meet clients in their homes, which can compromise their security if a violent spouse or family member comes back home unexpected. In one instance, a helper reported getting a call from a woman client only to find her in the middle of a fight with her husband. When she got into the home, the woman was holding a knife and a 'machete' while the husband was provoking her, asking her to kill him put an end to their conflict. The issue that was fueling the conflict was a cultural one - the man was demanding that his wife and her daughters undergo female genital mutilation. Though the PM+ helper was able calm the couple down and prevent bloodshed, the situation she found herself in put her safety at risk.

3. *Dealing with difficult clients*: Helpers find it challenging to deal with uncooperative clients during the PM+ intervention. Such clients either agree on the meeting time/day but fail to honor appointments, cancel scheduled sessions s at the last minute fail to perform activities scheduled on their calendars, or even fail to follow through with referrals.

   In other instances, clients *need a lot of support to be able to go through the full PM+ intervention*. The reasons for these vary – but generally include emotional manipulation by spouses or reconciliation with spouse where a client and spouse had differences. Another reason why some clients become reluctant to take the intervention is when PM+ does not meet their expectations. There are clients who expect to receive financial or in-kind assistance once they are approached to participate in PM+. .

4. *Intensive paper work*: The key strength of the PM+ training is its practical nature that allows participants to get both the knowledge and practice of PM+. Even so, the training is quite intensive on paper work at all stages of PM+ – the pre-PM+ assessment, during PM+ assessment and post-PM+ assessment. If a PM+ helper is not academically oriented, he or she can experience challenges delivering the PM+ intervention.

5. *Dealing with clients who are stuck*: Sometimes helpers encounter clients who are unable to move forward or those that keep forgetting everything they've learnt in previous sessions. Some instances of stuck clients that PM+ helpers include situations where a client has identified a solution for his/her problem but can't get the help they need to implement the solution from their social support network. Another incidence is where clients feel discouraged after attempting to solve an issue several times with little or no success. Helping such a client build resilience can be challenging for helpers and even require more PM+ sessions than those that are scheduled in the intervention.

6. *Low uptake of PM+ intervention among men:* Majority of PM+ clients are generally women, very few men sign up for the intervention. Out of the 72 clients who completed the PM+ intervention in 2019, only 9% were men. Some ideas that PM+ helpers shared on reaching men include making PM+ helpers an integral part of the mental health awareness campaigns and recruiting more men as PM+ helpers.

7. *Limited ability to detect mental illness early:* PM+ helpers are not trained psychologist. This poses a challenge when it comes to detecting mental illnesses at the onset of PM+ sessions. They therefore run the risk of onboarding clients who suffer from mental illnesses that cannot be managed through the PM+ intervention, only to realize later after they have invested too much time on the client without making significant progress.

8. *Logistical support:* While clients are generally drawn from the project area, there are times when PM+ helpers have to travel long distances to meet clients. Sometimes the directions that clients give are not clear, helpers miss the way and end up spending more on transport when they're meeting the client for the first time.

Challenges in the Supervision Structure

1. *Standardization of Supervision Practice:* The project has five local supervisors – two of these are trained psychologists and three are medics. Based on PM+ helper feedback on supervision sessions, it appears that supervisors user different approaches when conducting supervision. For instance, some helpers stated that they receive a lot of support from their supervisors on personal challenges while others stated that

supervision sessions focus purely on clients – there is no room for helpers to get support or help with their own struggles.

2. *Unclear Referral Pathways:* While referral pathways from PM+ helpers to supervisors are clear, the referral route from supervisors to level IV or V facilities is not clear. Supervisors use their individual linkages in these facilities to refer patients.

3. *Availability of Supervisors:* Supervisors, particularly those that work as medics have primary responsibilities in health facilities. Whenever supervision sessions collide with critical work assignments like ward rounds or meetings, they are forced to prioritize work assignments. This means they miss out on the supervision sessions.

4. *Over-Reliance on DIGNITY Supervisor:* A supervisor from DIGNITY has been supporting Midrift to conduct supervision sessions for supervisors. This is not sustainable in the long run if Midrift was to scale the project up in future.

5. *Meeting Logistics:* Supervision sessions with the Dignity Supervisor are often virtual. This makes them prone to logistical challenges such as poor internet connections.

Challenges in the Referral Mechanism

1. *Undefined referral pathways to higher facilities* – Midrift's referral efforts focused too much on the community to get the clients. The community referral pathway is very clear. For instance, if a client has an issue, it's easy to refer them to PM+ helpers from the chief's office, police gender desk, community helpers or the health facility. However, the pathways are not clear when clients require referral for specialized treatment beyond the supervisors. This is because little focus was put on strengthening referral pathways to higher levels facilities. The organization does not have an established system for referring clients to professionals like psychiatry care. Whenever supervisors need to refer clients for specialized care, they use their own connections in health facilities.

2. *Inability to detect mental health issues* – With the exception of CHVs and CHEWs who have received PM+ training, referral network actors like chiefs, religious leaders, community elders and police gender desks do not have the capacity to detect common mental health issues in clients. This makes it difficult for them to identify people who need psychosocial support, which poses the risk of putting people who may have benefited from PM+ through the justice system. This means that people who may be having common mental issues that PM+ can address find themselves going through the legal process – where they are arrested, presented in court and put in jail for violence or assault.

3. *Frequent transfer of government officials* – this mostly affects police gender desk representatives. In Rhonda/Kaptembwo, a gender desk officer was transferred midway the project and a new officer posted. This interrupted project implementation as Midrift has to find ways to bring the new office up to date every time there is a transfer.

4. *Unstructured operations* – Referral networks do not have a structured way of operating. While they are aware of the project and have been sensitized about the presence of PM+ helpers in the community, they seemed not to have well-coordinated interactions to facilitate flow of information and share learnings or experiences. Instead, the actors meet on a need basis – which means months could go by before a referral meeting is held.

5. *Low awareness of PM+ helper presence in local communities* – The presence of PM+ helpers within local communities is a major strength of the rehabilitation project. However, the level of community awareness about their presence and the kind of help they offer remains low among community members. This limits the number of community members who benefit from PM+ intervention in communities where helpers serve.

6. *Failure of clients to follow through with referrals* – Referral actors play the instrumental role of referring clients to different offices either to file reports or for treatment. For instance, a client who reports a sexual violence or assault case to the police gender desk is referred to a hospital for purposes of getting medical reports and P3 forms signed by a medical professional. However, not all clients follow through with the referrals. This is mostly due to inability to raise transport or the necessary fees, or their decision to pursue justice is influenced by family and friends.

7. *Documentation of referrals* – The project lacks a formal mechanism for documenting referrals as they go through the referral process, from the time they are referred to PM+ helpers by different referral actors to the time they get to referral points in level IV or V facilities.

Challenges in Stakeholder Engagements

1. *High bureaucracy*: Despite having an MOU with the department of health, Midrift has to brief the department about the project every so often. Whenever the organization needs the CHVs/CHEWs to participate in its activities, it has to ask the department to allow them to do so. For instance, the organization has had to postpone activities such as training of PM+ helpers because the department of health felt that having CHVs away for two weeks was too much time. The bureaucracy in the department causes the MoU to appear

irrelevant because there is little or no effort from the county government to do its part hence the need to review it.

2. *High expectations from government officials:* Whenever government officials are called upon to participate in project activities, they appear not to take it as their responsibility to do so because of the partnership that exists between Midrift and the county government. Instead, there is always an expectation that their transport costs will be reimbursed or Midrift would cater for their refreshments. This poses a sustainability challenge to the project because where no facilitation is available, participation of government officials is not guaranteed.

Lessons Learnt from the Rehabilitation Project

The following are key lessons learnt through implementation of the rehabilitation project:

- Community-based MHPSS is highly effective in making mental health services accessible to low income populations that cannot access professional psychological services due to cost barriers.
- Anchoring the PM+ intervention in the public health system is an important strategy for ensuring continuous access to community-based MHPSS services for communities in informal settlements, particularly where government provides stipends to CHVs who serve as helpers under the PM+
- Managing stress and managing problems are the two coping skills that are most useful in helping GBV clients in informal settlements to cope with the challenges they face on a day to day basis.
- Violence, irrespective of type, generates similar emotional reactions in those who experience it. The PM+ intervention can be used to address common mental health challenges that are triggered by any form of violence, not just GBV.
- A strong referral pathway is critical to supporting community-based MPHSS by linking patients who require specialized care with specialists in higher levels of the health care system. For best results, implementation of PM+ related programs must strengthen referrals at both the community level and higher levels of care.
- Demand creation for community-based MHPSS services requires continuous sensitization of the general public on mental health. The more people are aware of mental health issues, the more they're likely to uptake MHPSS services. Clients who have completed the PM+ intervention serve as important awareness and demand creating agents.

Suggested Way Forward

Based on evaluation findings, the following way forward is suggested:

a. Scale the Project Up to Cover More Sub-Counties

The rehabilitation project was implemented in two informal settlements in two sub-counties namely Nakuru Town West and Naivasha Sub-Counties in Nakuru County. Having tested the PM+ intervention in two out of the eleven sub-counties in the county, Midrift should scale up the project to other sub-counties in order to broaden its impact. Scaling the project up means that Midrift should prioritize training of additional CHVs and CHEWs to serve as helpers and supervisors.

b. Strengthen Engagement with the County Department of Health

While Midrift has a MoU with the department of health, the organization experiences challenges in enlisting the department's participation in project activities. To address this challenge, Midrift should strengthen it engagement with the department's leadership. The organization should develop a strategy to ensure the leadership in the department is properly sensitized about project goals, objectives and strategy. Midrift should also consider enhancing the participation of the county department of health's leadership in identifying project areas (sub-counties and settlements) and hold regular briefing meetings with them to enhance ownership.

c. Advocate for Absorption of CHVs by County Government

While CHVs constitute level 1 of the health care system, they work purely on voluntary basis. The county government does not pay them or provide them with stipends to facilitate logistics such as transport or communication. Midrift has been supporting the CHVs with stipends during implementation of the rehabilitation project. However, this is not sustainable in the long run. To ensure that CHVs are able to deliver PM+ intervention in a sustainable way, Midrift should advocate for absorption of CHVs by the county government as part of strengthening its community health strategy.

d. Strengthen Referral Networks

To deliver on their roles effectively, referral networks should be strengthened. Rather than meeting on a need basis, Midrift should facilitate the networks to meet on a regular basis - probably quarterly - to enhance information sharing, and reporting of merging issues. These meetings should serve as debriefing sessions for referral actors who, besides referring clients for PM+, serve as initial points of contacts for survivors of GBV and other forms of violence but have no platform to debrief or receive psychosocial support.

Strengthening of referral networks should also include sensitizing network members on the basics of mental health including defining mental health, common mental health symptoms and how these symptoms manifest and affect men and women to enable them detect common mental health issues and refer clients appropriately. The referral networks should also be provided with formal communication on the PM+ helpers available in their locality and instructions of what to do when they come across a person who needs help.

e. Create Community Awareness on MHPSS/PM+

Midrift should develop a robust strategy to guide its mental health awareness campaign. Community sensitization efforts should include creating awareness about mental health and situations that trigger mental health conditions such as lack of employment, financial challenges, and sickness and court cases. Awareness creation campaigns should also include content on PM+ intervention, the presence of PM+ helpers within the community and how the helpers can be accessed through health facilities or referral actors. To ensure that local communities in the project area, and other areas where Midrift will expand the project to, are adequately sensitized about mental health and the PM+ approach to MHPSS, Midrift should adopt strategies such as:

a. Use of electronic media like community radio to conduct public awareness on mental health and the PM+ approach
b. Liaising with referral network actors to utilize already existing platforms to conduct community awareness in the focus areas
c. Collaborating with the ministry of health to utilize health facilities for awareness creation campaigns. For instance, health facility staff can integrate mental health in their outreach activities, communication with patients, and community meetings. Health facilities can also place posters with mental health and PM+ messages strategically on their notice boards.
d. Conducting community forums that are purely focused on mental health and the PM+ approach to MHPSS
e. Reaching out to teachers and strategic contacts from institutions or organizations that run livelihood programs like the Kazi Mtaani Program, Women Enterprise Fund, the National Disability Fund, the Youth Enterprise Development Fund)

f. Continuous Capacity Building of PM+ Helpers

In addition to supervision sessions, Midrift should conduct refresher trainings for PM+ helpers every six months to cover emerging topics and ensure that they don't forget PM+ basics. The content of these trainings should be based on the challenges that helpers report frequently like handling clients who have multiple problems and handling difficult clients. Midrift should also consider strengthening the capacity of PM+ helpers on personal safety.

Though the PM+ training and PM+ manual does cover this topic, there is need for helpers to be sensitized on personal safety from an expert point of view. For instance, helpers should be trained on how to scan their environments and be aware of safety precautions they need to take as soon as they arrive at a meeting venue. Midrift should also consider developing safety guidelines for use by helpers and supervisors based on their local working environment.

g. Harmonize Referral Pathways to Level IV and V Health Facilities

Midrift should harmonize the referral pathways for clients who need specialized care. The organization should map out all possible referral points like psychiatry departments and GBV desks in level IV and V facilities and establish a working relationship with them to handle cases that go through Midrift. To lay ground for this relationship, the organization should convene a meeting with relevant representatives from the referral points identified to inform them about MHPSS interventions. This meeting should also link PM+ supervisors with the referral points. Details of the referral routes from lower level facilities to level IV and V facilities should be communicated to supervisors formally to ensure the team is on the same page.

h. Strengthen Documentation of Referrals and Digitize PM+ Tools

Midrift should develop referral tools to facilitate documentation of clients as they go through the referral system. One way to do this is to develop a referral book that PM+ helpers, supervisors and referral points can use to document client referrals. Such a tool will enable the organization to track client progress as they move through the referral system. The PM+ training requires PM+ helpers to complete a set of assessment tools and PSYCHLOPS. This makes the intervention quite intensive in the paperwork involved. The organization should consider digitizing the PM+ tools that helpers complete during delivery of the intervention.

i. Support for Extremely Needy Clients

There are clients who are extremely needy to an extent that they cannot afford a single meal a day. This makes it difficult for them to concentrate during PM+ sessions, especially where clients have young kids crying of hunger. Midrift could provide food baskets to such clients to enable them complete the PM+ intervention. However, this support should not be channelled through Midrift. Instead, the organization can identify a third party to deliver the food aid to the client.

j. Strengthen Institutional Linkages

With more than 80% of clients experiencing challenges associated to livelihoods or lack of income, Midrift should map institutions, programs or organizations that are working in this space (like the Kazi Mtaani Program, Women Enterprise Fund, the National Disability Fund,

the Youth Enterprise Development Fund) and inform PM+ about the existence of these programs. This will enable PM+ to provide such information to clients during PM+ training.

k. Develop Selection Criteria for Supervisors and Helpers

Midrift should develop guidelines for selecting CHVs and CHEWs to serve as helpers and supervisors in its rehabilitation project. The guidelines should provide a criteria for recruiting the teams including the soft skills required and availability to participate in project activities. In addition to strengthening selection criteria, Midrift should provide supervisors with guidelines for conducting supervision sessions to standardize the practise across board.

l. Identify a Local Psychologist to Replace Dignity Supervisor

Midrift should initiate the process of recruiting and selecting a local psychologist to take up the role played by DIGNITY supervisor. The organization should enlist the support of the dignity supervisor in the development of a recruitment strategy to ensure that it attracts and hires the most suitable candidate