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Scaling up mental health service provision through multisectoral integration: A qualitative analysis of factors shaping delivery and uptake among South Sudanese refugees and healthcare workers in Uganda

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Abstract

Background

There is a growing need for mental health and psychosocial support (MHPSS) interventions that can feasibly be provided to larger groups of people, particularly in humanitarian settings. However, scaling up mental health interventions is notoriously difficult. There are therefore growing calls for integrating mental health outside traditional health structures, both to increase reach and to address social determinants of mental health. The objective of this study is to explore barriers and facilitators of Self-Help Plus (SH+), an MHPSS innovation implemented through multisectoral integration. We explore delivery and uptake at the scale of SH+ and aim to understand intervention adaptation needs when integrating SH+ within other health and non-health sectors in Uganda.

Method

We conducted a qualitative study using in-depth interviews in two phases: first for a needs and resource assessment, and second for a process evaluation. We conducted 50 in-depth interviews with BRAC Uganda and MoH partner staff, intervention facilitators, and target impact group members between July and December 2022. A thematic network analysis process was used to identify barriers and facilitators of SH+ delivery and uptake at scale in Uganda.

Results

We identified five major factors that should be considered when scaling through multisectoral integration, namely: (1) adaptivity, (2) funding mechanisms, (3) social capital, (4) participation, and (5) sustainability. Within these factors,

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there were varying degrees to which a factor was a facilitator or barrier, depending on participants' perceptions of the intervention.

Conclusions

Our findings suggest that multisectoral integration of SH+ into sectors both inside and outside of health may be a viable means to scale SH+ and increase reach. However, funding, partnerships, co-creation, and adaptability need to be further explored to facilitate better and more sustainable integration.

Plain Language Summary Title

Improving mental health services for South Sudanese refugees and healthcare workers in Uganda: understanding key factors for success.

Plain Language Summary: There is a growing need for mental health programs that can be offered to more people affected by crisis. However, expanding mental health programs is challenging. In this study, we investigate factors that affect expanding one mental health program, Self Help Plus (SH+), when it is expanded by integrating it with other sectors in Uganda. Data were collected through 50 interviews at the beginning and at the end of the project. People interviewed included staff at BRAC Uganda and MoH, intervention facilitators, and the people that the partners work with (South Sudanese refugees, host communities, and healthcare staff). We analyzed our data by looking at relationships and patterns to identify positive and negative factors that affect expansion of SH+ through integrating with other sectors. We found five major factors that should be considered when expanding SH+. These are (1) simplicity of SH+ makes it easier to adjust parts of the program for integration, (2) challenges in funding make it harder to meet high needs, (3) social connections and relationships help in motivating people to participate, (4) being engaged and involved helps to better integrate, and (5) including ways of building long-lasting programs from the beginning helps continuation of programs in the future. Our findings suggest that integrating SH+ with other sectors may be a helpful way of scaling up SH+. However, finding how people and organizations work together and ways of adjusting the program to better help communities still need to be further explored for better and more sustainable integration.

Keywords

multi-sectoral integration, Self-Help Plus, Self-Help Plus 360, humanitarian settings, scaling

Introduction

Over 20% of people affected by humanitarian crises experience significant mental health concerns in their lifetime (Charlson et al., 2019). Conflict and disasters are commonly associated with a broad range of psychological and social suffering (Tol, Ager et al., 2020). A growing population is affected by humanitarian crises globally. Estimates suggest that 339 million people will need humanitarian assistance in 2023, a marked increase from 274 million in 2022 (Global Humanitarian Overview, 2023).

With such large and growing numbers of people who could benefit from mental health and psychosocial support (MHPSS) in humanitarian settings, there is a need for support that can feasibly be provided to larger populations. However, current MHPSS interventions that have shown the strongest evidence are difficult to scale (Rathod et al., 2017). They require skilled specialists, who are very few in low resource settings. Efforts have been made to "task shift," to reduce the burden on skilled specialists (Yankam et al., 2023). However, the interventions are still resource intensive, and require significant training and supervision (Tol et al., 2015). These interventions also reach individuals or very small groups of up to five people at a time (Charlson et al., 2019; WHO, 2020). Current MHPSS interventions also tend to address one mental health problem at a time (WHO, 2017).

In response to these limitations, the World Health Organization (WHO) has developed potentially scalable psychological interventions such as Self-Help Plus (SH+), to directly address challenges in scaling (Epping-Jordan et al., 2016). SH+ is a low intensity, guided self-management course that provides strategies for managing psychological distress and coping with adversity broadly (Park et al., 2022). It consists of pre-recorded audio sessions and a self-help book. Overall, there are five sessions in SH+, with one session running per week. Groups of up to 30 people can be accommodated in a session. SH+ was developed to be delivered by briefly trained non-specialists for feasible implementation, scale-up, and integration into existing services (Park et al., 2022). Developed in 2015, SH+ has been translated, adapted, and implemented in Uganda, Turkey, and other European countries and demonstrated clinically meaningful improvements on mental health outcomes (Acarturk et al., 2022; Purgato et al., 2021; Tol, Leku et al., 2020). Overall, SH+ was found to be safe, effective, acceptable, feasible, and relevant in these studies (Tol et al., 2018). As a follow-up from these studies, there is a need to evaluate whether SH+ can be scaled up in real-world settings.

Scale-up strategies for MHPSS interventions have historically been divided into *vertical* "institutionalizing innovations through policies" and *horizontal* "replicating innovations for new populations or areas" pathways (Rathod et al., 2017). Recently, there has been a shift toward integrating activities across sectors in humanitarian settings to enhance these strategies, aiming for sustainable MHPSS programming (OECD, 2021). This approach (integrated multisectoral approach) involves prioritizing mental health across sectors such as nutrition, protection, and education, and recognizes the complex interplay between mental health and its social determinants (Tol, 2020). These are further influenced by broader contextual factors (i.e., structural determinants of mental health, such as vulnerabilities conferred on the basis of gender, ethnicity, and socioeconomic status) that are often neglected (Andersen et al., 2020). Integrating mental health into other sectors (multisectoral integration) provides an opportunity to address mental health needs and social determinants while simultaneously increasing reach. Currently, not much is known about multisectoral integration of SH+, even though this is a consensus-based research priority (Tol et al., 2023).

In 2020, HealthRight and university partners developed the Journey to Scale (J2S) project. The project aimed to help humanitarian partners in Uganda integrate SH+ into their routine non-mental health-oriented programming as a means of scaling SH+ (multisectoral integration). This was achieved through a model coined "SH+ 360." The "360" refers to tailored MHPSS oriented technical support that is offered to partners throughout the project cycle (Leku et al., 2022). In the J2S project, SH+ was integrated with two types of programming. *First*, SH+ was integrated with livelihood programming, specifically a Financing for Refugees project, and the Safety, Protection And Peaceful Co-Existence (SPACE) project in partnership with BRAC Uganda, an international NGO. The Financing for Refugees project focuses on empowering women economically through income-generating activities. The SPACE project works with women and youth through mentorship and support on topics such as gender-based violence. *Second*, SH+ was integrated with health care programming in partnership with the Ministry of Health (MoH) in Uganda, providing psychosocial support to healthcare staff who had been on the frontlines during the COVID-19 pandemic. This study seeks to explore factors shaping SH+ delivery and uptake at scale during the J2S project and to understand intervention adaptation needs when integrating SH+ within other health and non-health sectors in Uganda. This study was guided by the following research questions: (1) What are the reported barriers and facilitators to the implementation of SH+ 360 by organizations new to providing SH+ (BRAC Uganda and MoH) in Uganda? (2) How do these barriers and facilitators inform the selection and further study of implementation strategies for scaling up SH+ through multisectoral integration? We framed our data collection design using the "barriers and facilitators" language. However, we opted to be broader in presenting our results, as the factors we identified were potentially applied across both aspects of barriers and facilitators.

Method

A qualitative study design was used to explore factors shaping SH+ delivery and uptake at scale as part of the larger J2S project (Figure 1). Data were collected as part of routine program activities by HealthRight. Ethical clearance was obtained from the Mildmay Uganda Research Ethics Committee (MUREC-2022-143) to use program data as secondary data for this study. All participants provided written informed consent.

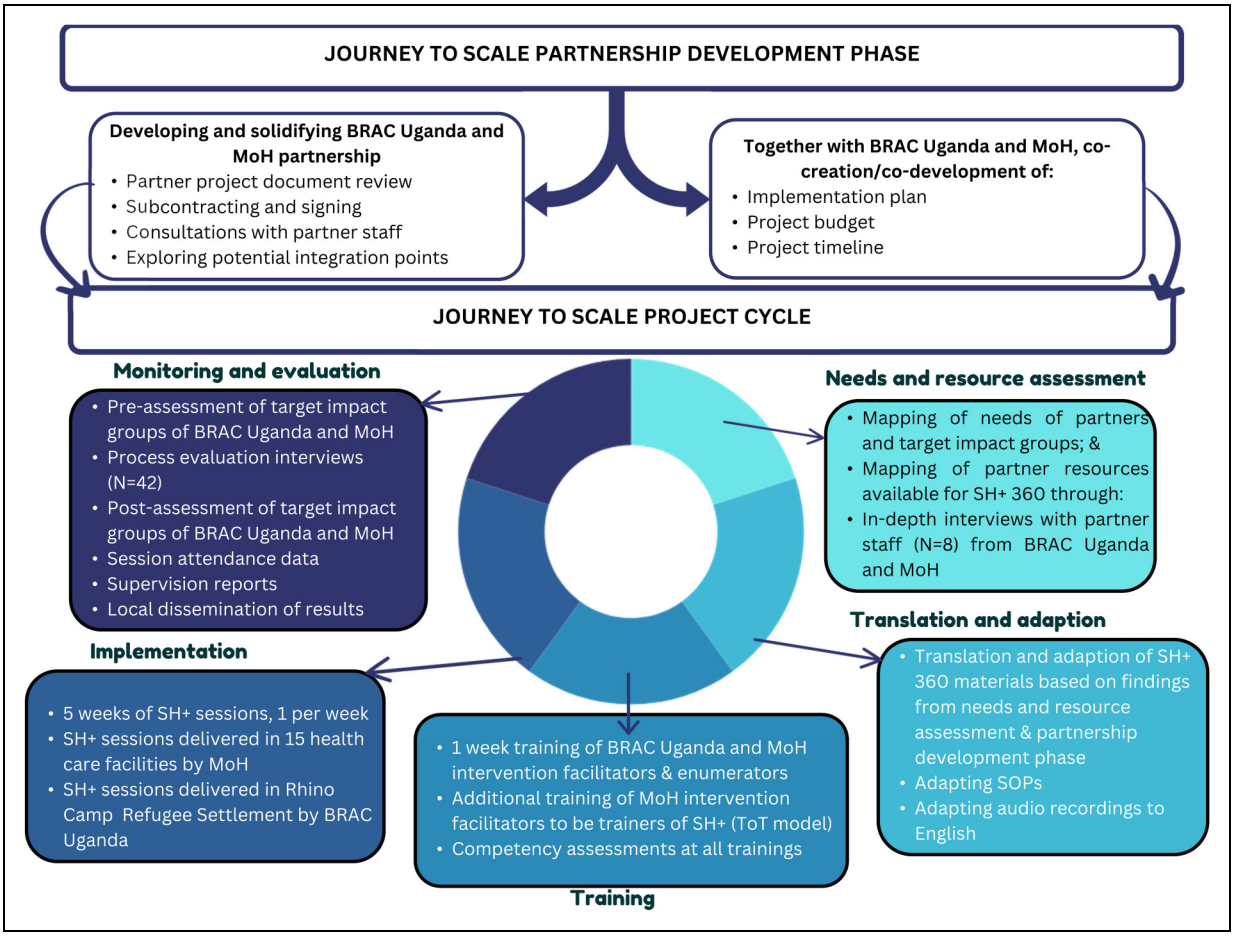
Setting

This study was conducted in two locations within Uganda. First, research was conducted in the context of BRAC Uganda's programming in Rhino Camp refugee settlement in northern Uganda. The settlement hosts about 136,000 refugees, with over 90% of refugees coming from South Sudan (Uganda—Refugee Statistics, 2022). BRAC Uganda programming in northern Uganda targets South Sudanese refugees and local host communities who predominantly use Juba Arabic or Lugbara, respectively. Secondly, research was conducted in the context of the Government of Uganda's MoH COVID-19 programming in 15 healthcare facilities in the capital Kampala. The heath facilities in Uganda are designated into seven levels; Health Centre (Levels 1–4), general hospitals, regional referral hospitals, and national referral hospitals. Intervention and research activities took place in regional and national referral hospitals and lower-level facilities. Healthcare workers were disproportionately affected by the COVID-19 pandemic as they were at greater risk of infection and death due to inadequate access to proper protective clothing.

Participants

Participants overall included people who were interviewed as part of process evaluation, that is, partner staff, intervention facilitators, and target impact group members (Table 1). At the beginning of the J2S project, process evaluation interviews were conducted with staff from BRAC Uganda and MoH as part of needs and resource assessment. The roles of the partner staff were mainly in finance, monitoring, and evaluation (M&E) and programming. The same partner staff also took part in process evaluation interviews at the end of the project. Process evaluation interviews were also done with intervention facilitators from BRAC Uganda and MoH. Intervention facilitators from BRAC Uganda consisted of volunteers from the community working under the Financing for Refugees project and the SPACE project. Intervention facilitators from MoH included psychiatric clinical officers, counsellors, and nurses with experience in

Figure 1
Journey to Scale Project Overview



Note. MOH = Ministry of Health; ToT = Trainer of Trainers; SOPs = Standard Operating Procedures; SH+ = Self-Help Plus.

running community outreach programs. Process evaluation interviews were also conducted with target impact group members served by BRAC Uganda (refugees and host communities) and MoH (staff at healthcare facilities).

Recruitment and Sampling

Purposive sampling of participants was used to identify and select participants based on guidance for conducting implementation research (Hamilton & Finley, 2020). Target impact group members were selected based on how many SH+ sessions they had attended to have representation of views. Target impact group members were purposefully sampled based on the following criteria related to SH+ participation: (1) attended two or less sessions, (2) attended three or four sessions, and (3) attended all five sessions. All BRAC Uganda and MoH staff who were involved in day-to-day intervention activities were interviewed. Trained research assistants from the J2S project contacted potential participants who were either partner staff, intervention facilitators, or target impact group members, with an invitation to participate in process evaluation interviews.

Procedures

Needs and resource assessment interviews were conducted between July and August 2022 and process evaluation interviews were conducted between November and December 2022. Topic guides were developed by JNN and MRL and reviewed by the research team. Implementation outcomes (Proctor et al., 2011) were used to broadly guide enquiry on topic guides (Joffe, 2011). Topic guides in the needs and resource assessment phase included questions related to foreseeable integration points, needs of the organization and target impact groups, and existing implementation processes of projects that SH+ was intended to be integrated with. In process evaluation, we focused on perceptions of different stakeholders on SH+ 360 delivery and implementation processes. The topic guides were adapted for each of the participant categories prior to the interviews.

Table 1
Socio-Demographic Information of Participants

Characteristics	Number of recorded interviewees	Percentage of recorded interviewees
Gender		
Female	24	57
Male	18	43
Organization		
BRAC Uganda	25	60
MoH	17	40
Nationality		
Uganda	22	52
South Sudan	7	17
N/A	13	31
Needs and resource assessment phase ($N = 8$)		
BRAC Uganda partner staff	4	50
MoH partner staff	4	50
Process evaluation phase ($N = 42$)		
Partner staff	8	18
Intervention facilitators	17	41
Target impact group members	17	41
Number of SH+ sessions completed (target impact groups)		
Session 2	1	6
Session 3	3	8
Session 4	4	23
Session 5	9	53

Participants who had consented to be interviewed were contacted by trained research assistants, who conducted the interviews. Interviews were conducted in person, via video call and via telephone depending on mobility and availability. All interviews with partner staff and intervention facilitators were conducted in English. Interviews with most of the target impact group members from BRAC Uganda were conducted in Juba Arabic, with a few exceptions depending on individual preference. Interviews lasted approximately an hour and were audio recorded with permission. All interview transcripts were transcribed verbatim by the research assistants without use of software. Transcripts were anonymized and data without any personal information were then shared with the research team. Interviews conducted in Juba Arabic were first translated and then transcribed into English. All participants provided written or verbal informed consent prior to the interviews.

Data Analysis

Two authors (JNN and SO) familiarized themselves with the dataset and assigned initial codes to the dataset. These codes captured key concepts related to research questions and were generated deductively, based on interview guide themes. Inductive codes were then added with more interaction with the dataset. The two authors co-developed a coding framework, and JNN then proceeded to code the entire dataset using NVivo 14 (Lumivero, 2023). The codebook is included as Additional File 1. No framework or theory was applied at this stage. We used a thematic network analysis approach to better understand perceptions, needs, and overall influencing factors to consider to improve multisectoral integration of SH+ (Attride-Stirling, 2001). Thematic network analysis is a valuable qualitative research approach for handling complex data by identifying overarching themes and their relationships (Attride-Stirling, 2001). We used this approach as it offers a structured way for exploring patterns, and it enables transparent communication of findings. An initial thematic network analysis revealed 23 themes that were perceived to influence implementation of SH+ 360. We then reviewed and clustered these into 12 basic themes. Using our knowledge and experience from the J2S project, and implementation outcomes that had guided the development of topic guides, we grouped the 12 basic themes into five organizing themes. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was used to assess the study design, analysis, and findings (Additional File 2) (Tong et al., 2007).

Results

In this section, we first describe factors influencing scalability of SH+ through multi-sectoral integration, as reported by participants (partner staff, intervention facilitators, and the target impact group members). Participant characteristics and backgrounds are displayed in Table 1. The total number of participants interviewed for this study was 50. Eight in-depth interviews were conducted with partner staff at the beginning of the J2S project as part of needs and resource assessment, and at the end of the project. A total of 17 process evaluation interviews were done with intervention facilitators. Another 17 interviews were conducted with target impact group members. Overall, participant ages ranged from 23 to 55 years, with more women participants. Participants were either from South Sudan or were Ugandan. Over half of the target impact group members had completed all five SH+ sessions. The Results section comprises five main themes: (1) adaptivity, (2) funding mechanisms, (3) social capital, (4) participation, and (5) sustainability (Table 2).

Adaptivity: The Simplicity of SH+ Enables Flexibility in Co-Creatively Adapting the Intervention for Integration

SH+ was designed as a relatively simple intervention that is supposed to be easy to implement, even in resource limited settings. Partner staff reported finding SH+ easy to adopt and integrate with their non-mental health programming. Intervention facilitators also felt that it was

easy to deliver SH+ sessions because one could easily adapt exercises in the SH+ manual to better fit diverse audiences. The adaptations that intervention facilitators made were mostly examples that the target impact group members could relate to. This helped target impact group members to better understand the content and concepts of sessions. Intervention facilitators also spoke about their minimal role during sessions, corroborating ease of facilitation:

> Delivering SH+ is so easy, you can deliver knowledge and information for someone without deviating from the meaning because it is audio recorded. It makes someone understand better. (BRAC Uganda Intervention Facilitator 002, female aged 55)

Overall, the SH+ English or the Juba Arabic versions were found to be acceptable and easy to understand. However, some target impact group members across partners preferred for the sessions to be delivered in their own mother tongue, such as Lugbara for host communities. In those cases, a community member translated the audios during the SH+ sessions as per the request of the target impact group members. Although SH+ was largely considered simple to use and adapt for integration, the meaning of integration varied across BRAC Uganda stakeholders. From BRAC Uganda partner staff perspective, SH+ was well integrated into their programming:

> Handling of money is not all that good [before the integrated intervention] but with the implementation of SH+ and its integration with the livelihood activities with these groups, you will find that women are more serious and even more focused within their saving groups [after the intervention]. (BRAC Uganda Program Staff 1, female aged 29)

On the other hand, BRAC Uganda target impact groups did not see connections between the programs that they were participating in under BRAC Uganda programming. This is evidenced below where a participant requested for livelihood activities which they were already a part of, in addition to SH+:

> I suggest that BRAC Uganda comes up with livelihood activities like businesses or any income generating activities for us the youth. Many a time I get stressed because there is nothing to eat. (BRAC Uganda Participant 001, male aged 23)

The addition of a mental health component was of importance particularly to BRAC Uganda, which previously did not structurally include mental health into programming in this setting. In needs and resource assessment interviews, partners recognized the need for mental health programming by highlighting mental health challenges that their target impact group members were experiencing. Partners also advised on how mental health directly affects their existing programs. This made the transition from siloed programming to integrated approaches much easier for partners:

> Without a person having [a] clear mind they cannot handle anything given to them very well. They will not be able to keep the goats that you support them with and even when you talk about protection, GBV [gender- based violence] and so on, someone may not be able to handle them very well unless you support them with mental health and psychosocial support. (BRAC Uganda Program Staff 1, female aged 29)

On the other hand, the target impact group members were only involved in SH+ 360 much later at implementation. Thus, the connection between the existing programs that they were involved in and the newly incorporated SH+ intervention was not well understood. BRAC Uganda participants felt that although they benefited from learning ways to cope with adversity, their other needs that contributed to them being distressed were not addressed. The lack of participation of the target impact group members at the needs assessment stage was reflected in tensions between requests for material support and the inability of the project to provide it:

> The facilitators said that BRAC doesn't give material support or money during the [SH+] session and I felt bad because if we gain the knowledge and lack some of the basic needs like food, clothes and others including money, how can we overcome stress? (BRAC Uganda Participant 004, male aged 54)

Funding Mechanisms: Constraints in Funding Systems and Structures Undermine Support Needs

Although partner staff recognized the mental health needs of their target impact groups, they reported that they had previously been unable to address this as they lacked internal capacity and resources. Partners found that the integration of SH+ into their routine programming bridged this gap, and enabled them to build capabilities of delivering mental health components alongside the services they were already providing for communities.

Recent health related pressures in Uganda, such as the COVID-19 pandemic and Ebola, exacerbated mental health challenges across the country. Partners reported an increase in needs, indicated by very high volumes of people interested in being part of the J2S project. A maximum number of participants per session were recruited, but other people in surrounding communities and hospitals also turned up for sessions after hearing the content from those who had attended past sessions. Although this highlighted how much such an intervention was needed, it led to staff being overwhelmed due to unexpectedly high numbers:

Table 2
Thematic Network of Factors Influencing SH+ 360 Delivery and Uptake at Scale.

Emerging themes	Organizing themes	Overarching story (global themes)	Example of quotes
Ease of delivering sessions SH+ 360 structure and materials Meaning of integration	Adaptivity: The simplicity of SH+ enables flexibility in co-creatively adapting the intervention for integration	Factors influencing SH+ 360 delivery and uptake at scale	"When I followed the manual, it exactly stipulates what is in the training manual; that is easy to deliver to the participants, no words to be added by facilitators." MoH Intervention Facilitator 002, female aged 36
Adaptability of SH+ 360 intervention components Language and translations			"In some villages like Katiku where we had the Nuers who don't understand English nor Arabic, it was hard to translate so we would ask one of them to translate in Nuer for the other colleagues to understand." BRAC Uganda Intervention Facilitator 002, male aged 34
Financial support from an organizational and target impact group perspective	Funding mechanisms: Constraints in funding systems and structures undermine support needs		"I would be glad if we were given money as a group to start up a project, or some start up kits for our group to start a business also on top of the training." BRAC Uganda Participant 01, female aged 22
Organizational and target impact group needs and prioritization External policies			"More resources like funds should be mobilized to fund the intervention and if possible even locally through fund raisings." MoH Program Staff 014, female, age not disclosed
Networks and communication Intra and inter stakeholders Supervision of SH+ sessions	Social capital: Social capital heightens motivation and promotes better monitoring and evaluation		"I think what worked well was the many meetings (both back and forth), good communication and training from HealthRight team." MoH M&E staff 11, female aged 26
Motivation for integration of SH+ and being part of SH+ 360 Incentives SH+ 360 facilities and proximity			"I experienced love and accepted responsibilities unlike before, I am now able to take care of my family and have always felt happy about what the future will bring." BRAC Uganda Participant 001, male aged 31
Participation in SH+ 360 intervention activities Training and SH+ sessions Roles and characteristics of individuals	Participation: Engagement and active involvement strengthen chances of adoption of SH+ and facilitate better integration		"It was good and participants were active because this too was much practical in daily life and it had many illustrations and interesting exercises." BRAC Uganda Intervention Facilitator 002, female aged 31
Stress management			"This helped me come out of stress, most especially after coming out of covid 19 and now Ebola that is causing stress to people." MoH Participant, male aged 46
Continuity	Sustainability: Incorporating sustainable development processes from conceptualization optimizes future continuity		"It is very impactful because it deals with the mind which is the engine behind productivity and development and so I would wish that the project continues and not only for short while but should be a continuous intervention to ensure constant mental health among the people." BRAC Uganda Intervention Facilitator 002, female aged 31

(Continued)

Table 2
(Continued)

Emerging themes	Organizing themes	Overarching story (global themes)	Example of quotes
Capacity development			"I learnt public speaking, I learnt class management skills, I learnt mobilization skills, guidance and counselling skills, team building skills." BRAC Uganda Intervention Facilitator 002, female aged 31
Cocreation of integrated intervention (SH+ 360)			"Need to involve all the stake holders and different sectors on the board." MoH Program Staff 003, female aged 23
Tailoring strategies			
Partnership development			"We had to deal with the health in chargers who were a bit difficult and not welcoming though after us explaining what SH+ was all about, they finally changed and became okay with us visiting any time and some helped us in mobilization." MoH Program Staff 014, female, age not disclosed

> You find that in one facility where the number was supposed to be 15, [but] it goes up to 50 which was so overwhelming. (MoH M&E Staff 11, female aged 26)

The great need, as highlighted above, links closely to sustainability and continuity, which partners reported was greatly influenced by funding systems and structures.

Social Capital: Social Capital Heightens Motivation and Promotes Better Monitoring and Evaluation

We found that supportive relationships developed through multi-sectoral partnerships facilitated better integration of SH+. The newly established networks between partners, HealthRight, and service providers helped facilitate for better monitoring and evaluation of outcomes. BRAC Uganda target impact groups also described having strengthened social relationships with families and communities. These strengthened links between communities and more powerful organizations contributed to improved connections and relationships at a community level. MoH target impact groups also reported that they had formed stronger relationships in their intervention groups.

Motivating factors were variable across target impact groups, but many agreed that incentives were an important facilitator of SH+ delivery. Among motivating factors, it appears that tangible materials such as the SH+ book motivated target impact group members to participate. They were able to bond over the book in their homes and communities by sharing knowledge or reaching out for help in reading the book, building their social capital further:

> Sometimes I would think like committing suicide. But since I got the [SH+] training, if I feel that it is too much, I will get the book that was given to me and give it to my friend who can read and ask her to help me, then she will tell me that it is written like this. Then my heart will cool down and I will feel happy. (BRAC Uganda Participant 003, female aged 25)

Mentorship also played a role in motivating intervention facilitators. Facilitators spoke about how supervision strengthened their skills and helped them to address challenges in a timely manner. Other motivating factors, such as the duration of sessions, had mixed reports, as target impact group members from the two partners had very different backgrounds. Some of the MoH target impact group members who had a health background found the length and duration of sessions to be too long. These particular target impact group members were not motivated to attend and continue sessions as they found them repetitive with their previous training. On the other hand, BRAC Uganda target impact group members spoke about increasing the number of sessions and time

duration, as they felt that by the last session, they could now better understand the intervention and were just beginning to see the positive effects the coping strategies were having in their life:

> It's like giving food and as people get interested to eat, the food is taken away. (BRAC Uganda Participant 004, male aged 31)

Participation: Engagement and Active Involvement Strengthen Chances of Adoption of SH+ and Facilitate Better Integration

Intervention facilitators at both partner organizations reported that the trainings that they received were conducive in facilitating better implementation of SH+ 360, considering their varied experiences and knowledge. The intervention facilitators also reported that target impact group members found the participatory structure of the sessions interesting:

> It was very interactive, we shared a lot of experiences with my colleagues in the group, and participated in all the sessions as the facilitator could make us practically do some of the activities. (BRAC Uganda Participant 003, male aged 31)

Other activities in the implementing contexts (i.e., settlements and health facilities), coupled with life situations such as illness, interrupted implementation, or prevented participation. BRAC Uganda target impact group members missed some sessions due to food distribution and other mandatory settlement activities. As these activities are highly important and prioritized, sessions were rescheduled where possible. In other cases, target impact group members who missed sessions appreciated that the audio recordings started each session with a recap of the last session, which helped to bring them up to date. Others who had attended the previous sessions, however, found the recaps repetitive. Healthcare workers also faced challenges in participation as they were often called for other hospital-related activities while attending the sessions.

Target impact group members experienced different stressors related to their unique circumstances, ranging from financial to social challenges. MoH target impact group members faced challenges in their work, exacerbated by the COVID-19 pandemic and Ebola crisis, and in their personal lives. They all reported experiencing feelings of relief after attending SH+ sessions and being at a better place to attend to their patients and families:

> I used not to pay attention especially to my young daughter when she needed my attention. I thought she was disturbing me, but now with the [SH+] trainings, I now know how to talk to her and I can focus well. (MoH Participant 12, male aged 46)

Although intervention facilitators were not the target impact group, some reported that training and delivering SH+ sessions were beneficial for them as individuals in terms of dealing with distress:

> Giving myself therapy on my own as I do to others was the best skill after the sessions and this has made me to involve my husband and family and I have a solution for myself because of the skills [I have] in case of a bad experience. (MoH Intervention Facilitator 002, female aged 55)

Sustainability: Incorporating Sustainable Development Processes From Conceptualization Optimizes Future Continuity

As SH+ was designed from the outset to be potentially scalable, we were interested in learning the different dynamics influencing scalability through multi-sectoral integration. Partner staff from BRAC Uganda pointed out that integrating SH+ into more of their programming beyond livelihoods, such as education for example, would enhance their impact as an organization. MoH staff also shared the same views, expressing the need to reach more healthcare workers across the country:

> Just imagine if we were to expand SH+ to other places and for more years. It would really have an impact on the people because MHPSS is one of the areas that is less implemented and not really been taken seriously and yet is very important. (BRAC Uganda Partner 1, female aged 29)

BRAC Uganda target impact group members also spoke about the need to offer SH+ sessions to other people in their communities. They felt that others should also have an opportunity to benefit from SH+ as they had themselves. Although partner staff had the will to continue delivering sessions beyond the project, there was a need to apply for funds to continue delivering SH+. Both partners agreed that they had the internal capacity to deliver SH+ on their own after SH+ 360. MoH staff reported that they also had the expertise to train more of their healthcare staff as the initial cohort of intervention facilitators had been trained as trainers in a trainer of trainers (ToT) model. Although there were financial limitations to sustainability, facilitators, such as capacity development, were reported by target impact group members as well:

> It built our capacity as community members, and it generally made us learn a lot about understanding others people's situation and creating an accommodative room. (BRAC Uganda Participant 003, male aged 23)

Closely linked to co-creation, partners also identified the development and sustainment of partnerships as

important facilitators of SH+ 360 delivery. Partners reported that although the partnership phase at the beginning was time-consuming, it opened communication channels and made implementation much easier. MoH staff reported investing time and resources to meet and collaborate with Health-In-Charges at healthcare facilities to gain access to healthcare workers. In health facilities where these collaborations were made, healthcare staff participated better as they had full support from their management. BRAC Uganda, on the other hand, collaborated with community leaders and other figures of authority in the settlements. This helped better mobilize participants.

We also identified how the nature of SH+ 360 and partnering for scale facilitated sustainability. Integrating SH+ into already running programs was reported to facilitate easier implementation. BRAC Uganda partner staff reported that it was easier to mobilize participants since their target impact groups were already arranged in groups as per their projects. BRAC Uganda had been partnering with these groups for some time, and their presence was well known in the communities. The groups had also been working together for some time. They reported that familiarity made it easier to participate in the SH+ sessions and to mobilize themselves every week for the sessions.

Discussion

This study sought to explore factors shaping SH+ delivery and uptake at scale during the J2S project and to understand intervention adaptation needs when integrating SH + within other health and non-health sectors in Uganda.

Our main finding points toward a need for a broader understanding across stakeholders of multisectoral integration as a concept. In our study, we proposed integrating SH + into partner programming to enhance access to mental health care and address the interlinked connections between mental health and social determinants of mental health. As overall mental health is influenced by varied social determinants (Bialowolski et al., 2021; Chisholm et al., 2019), we sought to address these challenges holistically by offering an integrated intervention (i.e., mental health services together with a livelihood intervention, for example). Previous studies that have used multisectoral integration in mental health, although limited, have shown good perceived outcomes in both the mental health component and the non-health component (Greene et al., 2022; Weine et al., 2021). This was also reflected in our study, although perceptions differed in terms of the extent.

The minimal role of intervention facilitators and strong supervision during SH+ 360 suggests potential for scalability and broader applicability of multisectoral integrated interventions across diverse populations. This is also an indicator that highlights good practice to maintain fidelity during adaptations (Augustinavicius et al., 2018). The ease of delivery of SH+ 360 is particularly relevant for feasibility and appropriateness of SH+ 360 in this context. The simplicity and adaptability of SH+ not only enhanced integration but also contributed to more effective delivery. Additionally, the flexibility of SH+ allowed for easier integration, which is a key learning for future work on multi-sectoral integration. These findings are particularly relevant for partners, funders, and policymakers seeking holistic interventions that can be easily adapted, adopted, implemented, and scaled in diverse settings and populations.

During the COVID-19 pandemic, healthcare workers showed an increase in symptoms of anxiety, such as insomnia, and general psychological distress (Hall, 2020; Sheraton et al., 2020). Given these and other occupational stressors healthcare workers face, the mental wellbeing of healthcare workers should be prioritized. Also, studies have shown that healthcare workers' performance increases when their mental wellbeing is taken care of (Søvold et al., 2021). Thus, investing in the mental health of healthcare workers through allocating resources for low-intensity interventions such as SH+ may provide longer-term benefits to overall healthcare system strengthening.

In this study, we found that social capital significantly enhanced individual and collective motivation, as well as monitoring and evaluation of SH+ 360. Social capital has been shown to promote stronger relationships, which benefit implementation and impact (Edelman et al., 2004). Supportive relationships established through multi-sectoral partnerships may facilitate better integration and assessment of outcomes, as shown by our findings. Overall, research supports the ideas that social capital can significantly influence health outcomes by promoting supportive networks and shared resources (Kawachi et al., 2008).

Partners reported having internal capacity to independently deliver SH+ following SH+ 360. This self-sufficiency has also been reported in other studies (DeCorby-Watson et al., 2018; Kasprowicz et al., 2023). The trainer of trainers (ToT) model, which we used with MoH, was well established, and has shown to have beneficial cascading effects (Jack et al., 2020). The ToT model has also shown challenges such as questions on how to sustain quality beyond the duration of projects. We also grappled with this challenge in the J2S project. Financial constraints, however, played a major role in discussions around partners' abilities to increase their reach past the project's initial scope. This echoes the need for innovative solutions and alternate financing mechanisms to ensure the sustained impact and scalability of SH+ 360, as is also seen in other studies (Shi et al., 2023).

Our findings also corroborate the importance of developing and sustaining collaborative and mutually beneficial partnerships (Nakanjako et al., 2021). Our collaborative approach allowed partners to actively engage and adapt SH+ 360 according to their needs while also ensuring alignment with overall programming. Partners had a targeted, strategic approach on how best to leverage limited resources to have the most meaningful impact within their

programming. There is also a need to meaningfully involve target impact group members, as this could inform better and deeper integration of programs (Skovlund et al., 2024). However, partners may not always have the capacity, time, and resources to invest in extensive partnership processes or co-creation (Davis et al., 2012; Dennis et al., 2015).

Our study highlights key factors in sustaining multisectoral integrated interventions beyond initial funding periods. Partners showed a strong interest in expanding SH+ integration but faced significant funding challenges. The mental health sector experiences inadequate financial support, particularly for scaling interventions, despite political interest (Chisholm et al., 2019). Innovative funding methods are needed (Sridhar, 2012). Effective communication of the added benefits of multisectoral integration to funders and policymakers is crucial. WHO's "Building Back Better" shows that investments in people and services, rather than infrastructure, are more effective for mental health (WHO, 2013).

Political prioritization toward mental health can be swayed by adopting this "Building Back Better" approach. This involves presenting evidence on prevalence, economic impact, and societal burden of mental health issues to attract further support and funds (WHO, 2013). Highlighting the economic costs of untreated mental health conditions and cost-effectiveness of interventions may also appeal to policy makers. Additionally, integrating mental health into broader development agendas and raising public awareness may generate public and political support (WHO, 2013). Our findings corroborate this, to a certain degree, with both government and NGO partners showing their willingness to further integrate SH+ with other sector programming models. However, there is still a need to collaborate across sectors and advocate for more integrated services to ensure sustained prioritization in recovery and rebuilding efforts.

When implementing and scaling MHPSS interventions, it is important to consider barriers to late-stage translation, which focuses on adapting evidence-based practices to real-world settings. These barriers are often influenced by problems in the outer setting, such as policy constraints, funding limitations, and sociocultural dynamics (Damschroder et al., 2009). These external factors can hinder adaptation and sustainability of interventions by affecting resource availability, stakeholder engagement, and alignment with local needs and values. Addressing these outer setting issues is crucial for the successful implementation and scalability of MHPSS interventions.

Our study has limitations that deserve mentioning. Firstly, we did not have the opportunity to interview target impact group members during the needs assessment phase due to operational reasons. Their input would have been helpful in shaping the intervention to better meet their specific needs. Secondly, our analysis is based on views of a small number of people from similar settings; thus, their views were largely aligned. Substantial differences were, however, noted across categories (partner staff, intervention facilitators, and target impact groups). Lastly, our study only focuses on time points when the intervention was either running or soon after the intervention ended. We therefore do not have longer-term perspectives, which might shed more light into whether effects are sustained over time.

Conclusion

In summary, multisectoral integration may be a viable and complementary pathway to scale SH+. Multisectoral integration may also be adopted in other MHPSS programming models, although factors such as funding, partnerships, co-creation, and adaptability need to be further explored. Future efforts should focus on exploring sustainable funding models and refining capacity development strategies to empower partners in delivering multisectoral integrated interventions. These findings contribute valuable insights for academia, practitioners, funders, and policymakers and offer a foundation for further exploration of SH+ 360 as a pathway to scale multisectoral interventions.

Abbreviations

IASC	Inter Agency Standing Committee
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MUREC	Mildmay Uganda Research Ethics Committee
NGO	Non-Governmental Organization
SH+	Self Help Plus
SOP	Standard Operating Procedure
SPACE	Safety, Protection and Peaceful Co-existence
ToT	Trainer of Trainers
WHO	World Health Organization

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Availability of Data and Materials

All data generated or analyzed during this study are included in this published manuscript (except for interview transcripts due to confidentiality).

Consent for Publication

All participants gave informed consent for publication.

Contributorship

WAT, JLA and NU conceptualized and designed the overall project. JNN and SO analyzed the data. JNN developed and wrote the full drafts of the manuscripts. WAT, JLA, MS, and NU reviewed and supervised the manuscript drafts and provided

input. All authors (JNN, SO, MRL, KKO, HS, BN, NU, MS, JLA, and WAT) critically reviewed and approved the final version of the manuscript.

Contributions to Literature

- We describe the first study that evaluated scaling of a psychological intervention through multi-sectoral integration in a humanitarian setting.
- We identified five critical factors that may hinder or strengthen the potential for psychological interventions to be brought to scale in under-resourced humanitarian settings.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics Approval and Consent to Participate

The data used in this study were collected as part of routine program activities by HealthRight Uganda. Ethical clearance was obtained from the Mildmay Uganda Research Ethics Committee (MUREC-2022-143) to use the program data as secondary data for this study. All participants provided informed consent for participation.

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Supplemental Material

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