MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN HEBRON LEARNING FROM PROGRAMMATIC SHIFTS IN LONGSTANDING CONFLICT (2018–2024. MSF OCBA)

Vienna Evaluation Unit

PURPOSE

This review examines MSF's Mental Health and Psychosocial Support (MHPSS) programme in Hebron, focusing on how the project adapted its service delivery over time to remain operational amid recurring access constraints, violence, and COVID-19. It looks at how repeated programme shifts (e.g., decentralization/mobile modalities, telehealth, role changes, and integration of MHPSS with medical care) affected access, quality, equity, and sustainability. The main review period covers 2018–2024, supported by routine clinical data analysis spanning 2018–2024 with some indicators extending into 2025.

KEY FINDINGS

- Integrating MHPSS into medical services and using mobile clinics helped maintain access to care amid escalating conflict and movement restrictions, but access for underserved groups can be improved.
- The program was highly adaptive during emergencies, providing services through mobile clinics and offering brief interventions to maintain access, though sustaining longer-term care for patients became more difficult. These quick adaptations also put staff under constant strain, which interfered with learning, consistent supervision, and recovery.
- MSF showed a strong commitment to supporting staff capacity strengthening through training and supervision; however, staff couldn't consistently engage in them due to perceived heavy workloads, insecurity, and other staff constraints.
- MSF's MHPSS program is trusted by the community and offers specialized mental health services during system disruptions, but it often prioritizes individual care models over group or community approaches, which are needed to meet the community's demand for mental health services.
- MSF's MHPSS program responded to ongoing instability and new demands with initiatives at both the programming and staffing levels; however, these increased the program's operational complexity and posed challenges for maintaining consistent service delivery.
- Rapid leadership decisions helped keep the program operational, but frequent changes required staff to continuously adapt. These shifts were felt most at the team level, increasing workload, stress, and coordination challenges for frontline staff.

CONCLUSIONS

The programme's core strength is its **ability to adapt** delivery models to **keep services running under severe constraints**. However, many shifts appear reactive rather than planned, limiting structured learning and creating operational complexity that affects continuity of care and staff wellbeing. The evidence suggests a drift toward shorter, high-throughput contacts, alongside increasing loss to follow-up for therapy/counselling—raising concerns about sustaining meaningful engagement for people needing longer-term care.

Equity gaps persist despite decentralization and integration, priority/underserved groups remain insufficiently reached, and community/group approaches are fragile in periods of insecurity. Strengthening participatory leadership, institutionalized supervision, and clearer pathways between modalities would support both quality and sustainability while improving the project's ability to translate evidence into practice.

METHODOLOGY

- Developmental/formative review using the Health Equity Implementation Framework (HEIF).
- 14 semi-structured staff interviews & Document Review
- Triangulation with a separate retrospective quantitative analysis of routine clinical data (2018–2024; some indicators reported into 2025)
- Key limitation: no beneficiaries were interviewed, constraining conclusions on user experience and acceptability.

RECOMMENDATIONS

- Protect decentralized outreach/mobile modalities through contingency planning and minimum operating standards for "stable" vs "emergency" periods.
- Strengthen equity and inclusion through stakeholder-informed analysis, better disaggregated monitoring, and targeted approaches for underserved groups.
- Institutionalize supervision/training and staff wellbeing supports, with attention to national staff workload and "dual exposure."
- Rebalance the service mix toward scalable group/community and time-limited interventions, while maintaining specialized care for severe cases.
- Clarify roles and patient pathways across modalities to reduce duplication and improve continuity of care.
- Improve participatory leadership and feedback mechanisms, including trauma-informed management practices that support learning and follow-through.
- Strengthen collaboration with local actors and longer-horizon planning, including an exit/legacy perspective where relevant.

Contact and further information: *evaluation@vienna.msf.org* | *Full report available upon request*