Mental Health & Psychosocial Support Interventions during Covid-19

ދިވެހި ރެޑް ކްރެސެންޓް
Maldivian Red Crescent

unicef
for every child

Mental Health & Psychosocial Support Interventions during Covid-19

© 2022 by Maldivian Red Crescent (MRC)

Suggested Citation:

Maldivian Red Crescent and UNICEF Maldives. 2022.

Mental Health and Psychosocial Support Interventions during Covid-19

Key Contributors:

Maldivian Red Crescent
Afaa Mohamed, Consultant
Mariyam Ifshan Ahmed, Consultant
Fathimath Inasha Abdulla, Programme Coordinator – Health & Inclusion
Aishath Shaiba, Programme Officer – Mental Health and Psychosocial Support Services
Maeed Mohamed Zahir, Manager – Programmes & Services
Ibrahim Shameel, Planning, Monitoring, Evaluation and Reporting Coordinator
Aishath Zaha Mohamed, Programme Officer – Communications and Advocacy

Layout & Design

Published By

Maldivian Red Crescent and UNICEF Maldives

Contact Information:

Maldivian Red Crescent
Maldivian Red Crescent Building
2nd Floor, Plot number 11493, Mirhi Magu, Hulhumale',
Maldives
Tel: +960 3347009 Email: info@redcrescent.org.mv
www.redcrescent.org.mv

Acknowledgement

This report is developed by Maldivian Red Crescent (MRC) as part of the Mental Health and Psychosocial Support Interventions during Covid-19, supported by UNICEF Maldives. MRC thanks Afaa Mohamed and Mariyam Ifshan Ahmed for their significant technical contributions in the development of the report. MRC also thanks Maeed Mohamed Zahir, Fathimath Inasha Abdulla, Afaa Mohamed, Mariyam Ifshan Ahmed and Aishath Shaiba for their contributions in conceptualizing, implementing, and managing the overall project and interventions. Special thanks to MRC's team of PSS Call Agents, Trainers and incredible volunteers who supported the implementation of MRC's Mental Health and Psychosocial Support Service work as part of its Covid-19 response operation between 2020 – 2022.

MRC would also like to recognize the contributions by the Ministry of Health, Health Protection Agency, other government ministries, agencies as well as other stakeholders involved from the National Emergency Operations Center (NEOC) and Health Emergency Operations Center (HEOC) for their guidance, support, and contribution to the overall implementation of MRC's Mental Health and Psychosocial Support Service interventions.

Foreword - MRC

Times of upheaval and uncertainty have exacerbating effects on mental health, especially for those who are already vulnerable. This phenomenon was prominent during the COVID-19 pandemic, as many individuals endured extended periods of isolation, fear, and stress. It was evident that there was limited access to Mental Health and Psychosocial Support Services (MHPSS), and there was an urgent need to provide PSS support to the public.

The Maldivian Red Crescent has advocated for better provision of and access to MHPSS since the inception of the National Society in 2009. The MRC Strategic Plan 2019-2030, focused on building resilience, emphasises the need to strengthen Psychosocial Support Services (PSS) and the promotion of health and wellbeing in a changing environment. Guided by these strategic priorities, with the establishment of National Emergency Operations Center (NEOC) to respond to COVID-1919 pandemic MRC fulfilled its auxiliary role to the State by forming the PSS call centre within the NEOC in early 2020 as local communities began to experience the negative impacts of the COVID-19 pandemic and the ensuing drastic changes to their lives.

MRC has remained steadfast in carrying out MHPSS initiatives over the past two years, continuously adapting to address the ever-changing circumstances brought by the COVID-19 pandemic, working towards the betterment of the emotional wellbeing and mental health of the general population. The Psychosocial Support Helpline 1425, established by MRC on 08th March 2020 to reach out to people in quarantine or isolation and then expanded to receive calls from the public on 25th April 2020, received over 3000 calls between March 2020 to December 2021, with around 5500 outreach calls being made. In addition, social media posts developed under the social media campaign "Gulhaalamaa 1425" were viewed over 1,181, 330 times across Twitter, Instagram, and Facebook. Focusing on building the capacity of MRC volunteers and stakeholders in the long-term in terms of mental health, MRC also collaborated with partners and the state to conduct Psychological First Aid training sessions and capacity development sessions for over 540 volunteers and an additional 10,485 participants, including 6426 teachers and staff of schools across Maldives. These efforts increased the resilience of the communities to sustainably bounce back from disasters and emergencies.

The provision of our MHPSS would not have been possible without the support of our partners. We would like to thank UNICEF for the technical, financial, and practical assistance provided in reaching the most vulnerable groups in our community and in increasing mental health awareness to build a more inclusive, accessible, and resilient society. Furthermore, we are extremely appreciative of Dhiraagu, our Corporate Member, for the continued technical support in delivering our services via our PSS Helpline 1425.

We would like to take this opportunity to appreciate the support extended to us by various state authorities such as the Ministry of Health, Health Protection Agency, National Mental Health Programme, the Health Emergency Operations Centre (HEOC), National Emergency Operation Centre (NEOC), Centre for Mental Health, and the Ministry of Education for their assistance in training numerous individuals on the provision of MHPSS and assisting us in building our capacity to provide MHPSS services in the Maldives.

Our National Society has received invaluable guidance and technical and financial resources from the International Federation of the Red Cross and Red Crescent Societies (IFRC) in the provision of MHPSS services to the Maldivian community. It is only by way of this constant support that we have been able to persevere in addressing the mental health and wellbeing of our community and assisting those who need it the most, helping alleviate human suffering in all avenues.

Our volunteers and staff function as the heart of all the work we do, bringing hope to our communities. It is their kindness and courage that has empowered us to overcome and adapt to all the hardships we have faced in increasing mental health awareness and making MHPSS more accessible throughout the COVID-19 pandemic. I would like to thank our volunteers- in the face of the physical and mental strain that comes with volunteering during such a strenuous time, your commitment in serving the most vulnerable people in the community is truly commendable.

Fathimath Himya
Secretary General

Foreword - UNICEF

The global COVID-19 pandemic hit us hard, with the most vulnerable at the forefront of its impacts. It has been an especially challenging time for children, young people, their families, and communities with lockdowns and other unprecedented restrictions posing severe impacts on physical and mental health and wellbeing.

While mental health issues, unmet needs, and demand for services were persistent issues even prior to the crisis, its consequences further exacerbated the situation, raising concerns for the mental health of an entire generation of children and young people, their parents, and caregivers. Unfortunately, this may represent only the tip of the iceberg in this long-embedded challenge faced by the country.

In the Maldives, over 86,000 children were directly impacted by safety measures to address the pandemic, including school closures and the halting of sports and recreational activities. This has brought about many negative impacts on their psychosocial wellbeing as well as confronting them with further delays in accessing the required care and support. The situation of children in the greater Male' area was worse, where cases were widespread and children were unable to learn in classrooms and confined to their homes for longer periods at a time, depriving them of their everyday interactions with friends and loved ones.

The two-year partnership between Maldivian Red Crescent (MRC) and UNICEF has been instrumental in expanding and enhancing community-based Mental Health and Psychosocial Support Services (MHPSS) and Systems provided in the Maldives, as part of a more strategic psychosocial and mental health approach, where together, they aimed to strengthen existing individual and community resources, capacities and resilience. MRC's niche of community-based engagement, combined with PSS technical support positioned it firmly as a strong and valued agency providing MHPSS early interventions and support closer to people at the level 1 & 2 of the Inter-Agency Standing Committee (IASC) MHPSS intervention pyramid of the continuum of care and services for people's recovery and wellbeing in emergencies and beyond. Additionally, psychosocial support through Psychological First Aid (PFA) and other interventions are at the heart of foundation level - community support and resilience building - which will contribute to ultimately fewer people needing specialized services.Further, MRC's contribution to sensitize and build the capacity of teachers and the school workforce on psychological first aid and children in distress had direct and indirect benefits for children and the school community, helping them to better implement and manage the challenges of virtual learning while being sensitive to the psychosocial aspects and emotions of children. Overall, the efforts around school intervention, promotional activities, and the psychosocial support helpline made positive contributions to enhance community MHPSS for children and adolescents.

MHPSS prevention is central to promoting children's optimal development and wellbeing. In recent years, since the onset of the pandemic, the UNICEF Maldives Country Office, in collaboration with its partners, has worked to help safeguard the mental health and psychosocial wellbeing of children, adolescents, parents, and caregivers, with a special focus on those left furthest behind. This complements UNICEF's long-standing work across different sectors including child protection, education, and health. Hence, given the importance of cross-sectoral interventions, UNICEF has prioritized MHPSS promotion, positive parenting, and social emotion learning as key priorities to support the Maldives within the next five years.

Empowering children to reach their full potential is fundamental to UNICEF's mission – and supporting the mental health and well-being of children and adolescents is an organizational priority globally. UNICEF Maldives reaffirms its commitment to continue working with the Government and other key partners to promote positive mental health and wellbeing and create a happier, healthier, and safer future for every child, every adolescent, and every family.

Mr. Paulo Sassarao
Deputy Representative (OIC Representative)

Executive Summary

Following the emergence of Covid-19 in the Maldives, MRC initiated MHPSS response activities to address the significant psychological distress caused by the novel coronavirus and the subsequent restrictions placed on the population. This document reports on the MHPSS interventions conducted from the beginning of MRC's Covid-19 response till December 20201. MRC established a call centre to provide psychosocial support to people who were isolated and quarantined and for first responders as well at the start of the operation. From April 2020, a helpline was opened to the public.

During this period, about 5500 calls were made to people in isolation and quarantine and 3000 calls were received to the helpline. About 90% of outreach calls made and 30% of helpline calls received were within the first three months. Majority of people who received psychosocial support were young adults (between ages of 19 - 35 years) and of Maldivian nationality. Volunteers were engaged in the call centre mainly from April to July 2020. Part-time call centre coordinators were hired from September 2020 onwards and many activities were undertaken to support their work (e.g., conducting sessions on suicide prevention, SGBV, continued professional development sessions, establishing supervision mechanisms) and ensure the quality of service provided (e.g, reviewing and developing procedures as required).

In addition to this, a major activity was conducting PFA training sessions to build the capacity of MRC volunteers and external stakeholders from various organizations. Training and Capacity development work was carried out during the response with the aim to strengthen psychosocial support provision by enhancing the knowledge and skills of MRC volunteers and staff. MRC adapted training guides developed and published by International Federation of Red Cross (IFRC) Psychosocial Centre to conduct a wide range of training and brief capacity development sessions. During March 2020 till December 2021, MRC conducted 21 PFA trainings and 27 capacity development sessions for MRC volunteers across branches. A total of 540 volunteers participated in these training sessions . MRC also provided support to external stakeholders to build the capacity of staff and volunteers working in the NEOC operation. Hence, MRC conducted 36 PFA trainings and 99 capacity development sessions for stakeholders, reaching over 10,485 participants. In order to maintain quality of training, two part-time PFA Trainers were hired for 3 months starting September 2020. Additionally a training standard operating procedure was formulated and training materials were also standardized.

With the help from a local consultant a social media campaign titled "Gulhaalama 1425" was initiated in December 2020, with the aim to promote seeking behavior and create mental health awareness. Various digital materials including posters, flyers, animation videos, interviews and stickers were designed and developed and circulated across various platforms including Facebook, Twitter and Instagram. Over the campaign period, a combined reach of 1,181, 330 were achieved across all three platforms.

From the beginning of the operation, MRC focused on the wellbeing of staff and volunteers working tirelessly. Support for volunteers and staff were provided by arranging various stress releasing activities. MRC also conducted surveys to better understand the need of volunteers. One key activity carried out was Caring for Volunteers training conducted from 13 – 14 July 2021, with the goal to strengthen MRC's volunteer management by training key staff, volunteers, team leaders, managers. A total 19 participants completed this training, gaining the knowledge to understand psychosocial needs and to plan and implement support strategies necessary for the wellbeing of staff and volunteers.

Focus group discussions and meetings were held with key volunteers who were actively participating in the response activities to identify challenges and difficulties they faced. Some key challenges highlighted by volunteers include the lack of preparedness for MHPSS response activities, lack of ICT resources and tools to manage information (including service provision, training, and volunteer management), lack of appreciation and recognition of volunteers, and difficulties with remote training sessions. Recommendations are proposed to strengthen MHPSS activities in the future; these include developing MHPSS guidelines for response within the organization, planning for and utilising electronic tools to manage information and other aspects of response work (e.g., volunteer management), and strengthening support systems for volunteers.

List of abbreviations

COVID-19
Coronovirus Disease

HEOC
Health Emergency Operation Centre

HPA
Health Protection Agency

HRCM
Human Rights Commission of the Maldives

ICRC
International Committee of Red Cross

IFRC
International Federation of Red Cross and Red Crescent

MHPSS
Mental health and psychosocial support

MNU
Maldives National University

MoE
Ministry of Education

MoGFSS
Ministry of Gender, Family and Social Services

MRC
Maldivian Red Crescent

NDMA
National Disaster Management Authority

NEOC
National Emergency Operation Centre

OTJ
Ombudsperson's Office for Transitional Justice

PFA
Psychological First Aid

UNICEF
United Nations International Children's Emergency Fund

WHO
World Health Organization

List of tables and figures

List of tables

Table 1. Service rate of helpline for each month 20

Table 2. Number of callers and people outreached via services 22

Table 3. Demographic information of callers and people outreached via services 24

Table 4. Description of trainings conducted by MRC 30

Table 5. Description of additional training and capacity building sessions conducted 31

Table 6. Social media posts for Gulhaalama campaign and their average reach and engagement of Twitter, Facebook and Instagram 39

List of figures

Figure 1. Number of referrals received to the call center between March 2020 – December 2021 18

Figure 2. Number of outreach calls made between March 2020 – December 2021 18

Figure 3. Number of calls received to the helpline between April 2020 – December 2021 21

Figure 4. Number of Covid-19 cases, calls received to the helpline and outgoing calls made between April 2020 – December 2021 21

Figure 5. Number of calls with vulnerable individuals 23

Figure 6. Percentage of concerns reported by people between March 2020 - December 2021 25

Figure 7. Percentage of signs of distress reported by people between March 2020 - December 2021 26

Figure 8. Percentage of callers who indicated efficiency of callsber 2021 27

Figure 9. Percentage of trainees from external organizations between March 2020 - December 2021 33

Figure 10. Total social media reach and helpline calls 40

Figure 11. Number of call center volunteers meetings 44

Table of contents

10

Background and context

11

- Purpose of documentcontext
- Methodology

12

Overview of MHPSS response activities

16

Call Centre
- Recruitment and management of volunteers 17
- Quality assurance 17
- Overview of outreach calls 17
- Overview of helpline 1425 18
- Demographics and concerns of people 22
- Feedback regarding helpline 26

28

Training and capacity building

36

Social media campaign

Engagement in social media
- Twitter 38
- Facebook 38
- Instagram 38
- Social media campaign and helpline calls 40

42

Caring for volunteers' activities
- Volunteer Survey 43
- Caring for Volunteers Training 43
- Support strategies 44
- IEC materials for volunteer wellbeing 45

46

Challenges and lessons learned

48

Recommendations Volunteer Survey
- Short term 48
- Long term 49

50

References

Background and context

The emergence and spread of the highly infectious novel coronavirus disease in December 2019 led to significant health and socioeconomic consequences around the world. Following this, the WHO declared a global Covid-19 pandemic on 11 of March 2020. To curb the spread of the virus, many countries imposed varying degrees of restrictions on populations including curfews, border closures, lockdowns where businesses were shut down, government offices and schools were closed.

The first cases of Covid-19 in the Maldives were reported on the 7th of March 2020. These were from individuals who had travelled to resorts in the Maldives. The first case of community transmission was reported in the capital city of Male' on 15 April 2020. The government of Maldives imposed a lockdown following the community outbreak in Male' which lasted till June 2020[1] . The lockdown was eased in a phased approach starting at the end of May 2020. Government offices and schools started gradually reopening on 1 July 2020. From 13th March 2022 onwards, the state of public health emergency was removed, and many restriction measures were eased including mandatory mask wearing and PCR testing for domestic travel. As of 15 April 2022, 178,313 positive cases and 298 deaths have been recorded in the Maldives[2].

The emergence of Covid-19 resulted in marked fear and psychological distress due to physical, social, psychological and economic consequences and the significant disruptions it has caused in normal lives and routines. These conditions increase vulnerability of affected populations to mental health problems including stress, anxiety and mood disorders, and sleep problems. During the first year of COVID-19 pandemic, WHO reported an increase of 25% in global prevalence of anxiety and depression[3] . The implementation of movement restriction and quarantine measures further elevate stress levels as it affects economic and social lives of communities. This can lead to increased feelings of loneliness, depression, substance use behaviours and self-harm and suicidal behaviours[4] . To help mitigate distress faced by people during Covid-19 and to promote safety and recovery, MHPSS interventions can play a key role in promoting resilience of affected individuals, groups, and communities.

MRC is an independent, voluntary, humanitarian organisation, established on the basis of the MRC Law [Law 7/2009]. The International Committee of the Red Cross (ICRC) recognized MRC as a full-fledged member of the International Federation of Red Cross and Red Crescent Societies (IFRC) on 9 November 2011. Subsequently, MRC became the 187th member of the IFRC on 23 November 2011. Over the last 12 years MRC has been at the forefront of humanitarian work in the Maldives. MRC has established itself as the largest humanitarian organisation in the Maldives.

MHPSS is one of key areas in which MRC provides assistance to affected populations in the Maldives and is among the priority areas in the current Strategic Plan of Action (2019 – 2030), which includes the strengthening of psychosocial support services during emergencies. During Covid-19 MRC played a key role in delivering MHPSS services to the community[5] . From 7th March 2020 MRC initiated MHPSS response activities which are discussed later in this report.

MRC partnered with UNICEF in July 2020 to expand and strengthen the psychosocial operation carried out as a part of COVID-19 response. The expected result of the project is for women, young people and vulnerable groups to have improved access to community MHPSS services in a gender and age-sensitive manner. The target population was everyone from 18 years and above.

1 Ministry of Economic Development & United Nations Development Fund. (2020). RAPID LIVELIHOOD ASSESSMENT - IMPACT OF THE COVID-19 CRISIS IN THE MALDIVES. Ministry of Economic Development, Government of Maldives and United Nations Development Programme. Retrieved from https://www.undp.org/sites/g/files/zskgke326/files/publications/UNDP-MV-Rapid-Livelihood-Assessmentt-Impact-of-COVID-19-Crisis-in-the-Maldives-2020-Summary.pdf

2 Worldometers. (2022, April). COVID-19 CORONAVIRUS PANDEMIC. Retrieved from Worldometers website: https://www.worldometers.info/coronavirus/#countries

3 WHO. (2022, March). Wake-up call to all countries to step up mental health services and support. Retrieved from WHO website: https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

4 WHO. (2022). Mental Health and COVID-19. (2020). Retrieved from WHO website: https://www.euro.who.int/en/health-topics/non-communicable-diseases/mental-health/data-and-resources/mental-health-and-covid-19

5 Maldivian Red Crescent. (2020). Annual Report 2020. Male': Maldivian Red Crescent. Retrieved from https://www2.redcrescent.org.mv/storage/2021/05/MRC-Annual-Report-2020.pdf

Purpose of document

The purpose of this document is to report on the project named "Mental health and psychosocial support interventions during Covid-19" funded by UNICEF. Specifically, this report aims to provide an overview of MHPSS response activities conducted by MRC during Covid-19 and describe the outcomes of these activities. It also includes a summary of key lessons learned and offers recommendations to strengthen MHPSS response activities in the future.

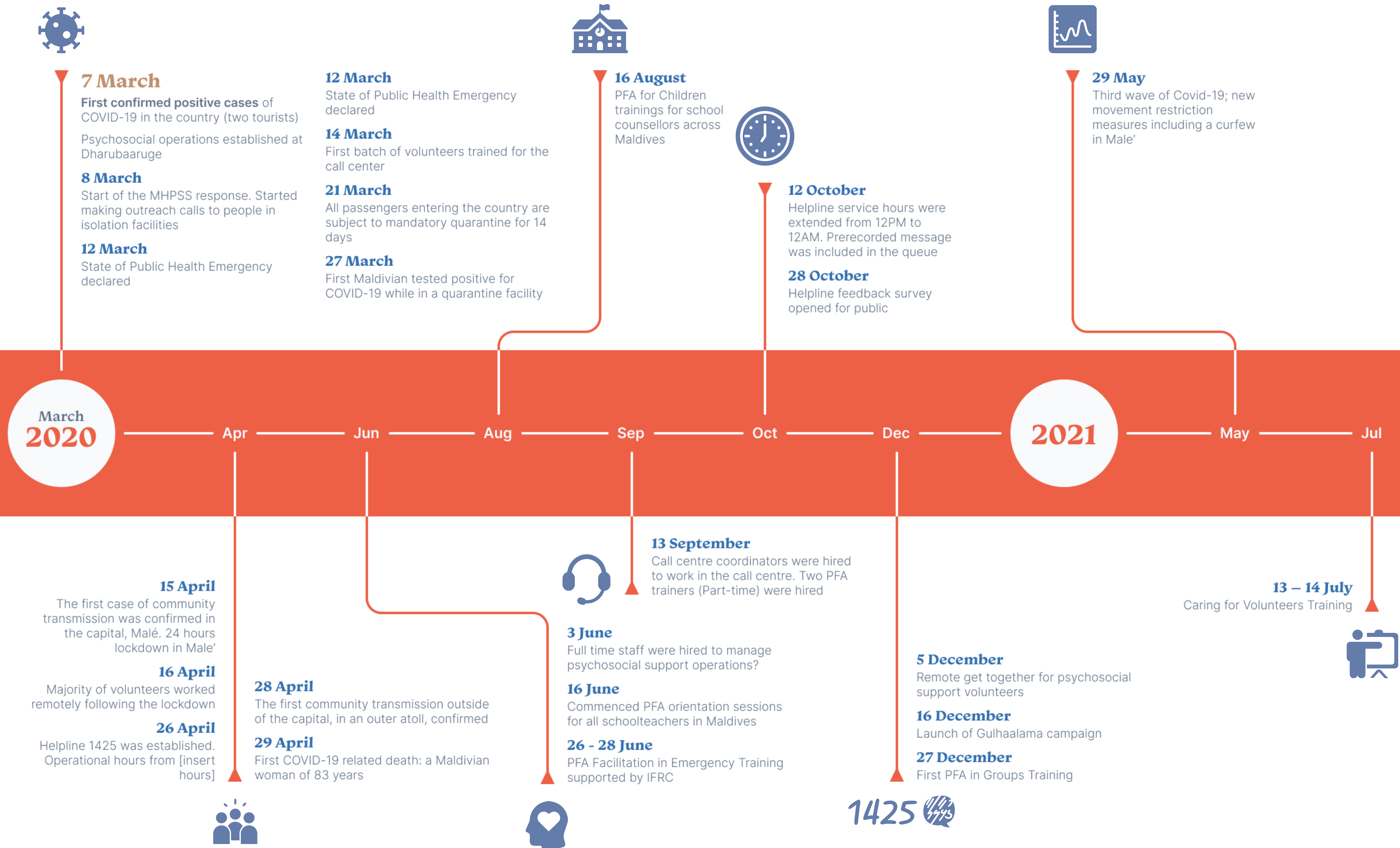
Methodology

This report is compiled based both primary and secondary sources of information. It is based on raw data collected during outreach and helpline calls about callers demographics and key concerns, internal reporting documents (including monthly reports and quarterly reports), training database and feedback form responses, and various survey reports.

Additionally, there were five focus group discussions held in April 2022 to gather volunteer and staff feedback and lessons learned during the response. These interviews and sessions were recorded with consent, and later summarised for purposes of this report. For volunteers who were unable to attend the sessions, an online feedback form was developed with discussion questions used in the group sessions. Key interview questions were as follows and they were adapted based on volunteer groups:

1. What was your role in the call center?
2. What went well in your work in the call center? - How do you know that it went well? - What facilitated it to go well?
3. What do you think about the significance of the work that you are/were doing?
4. What motivates/ed you to work in the call center? - When was the last time you volunteered? - How often do you volunteer now? Why?
5. What were the challenges you faced while working/volunteering? - How did these challenges impact you? How did it impact operations/work?
6. What can be done to overcome these challenges/improve for a similar operation in the future? Specifically, what can be done by MRC? How is this important?

Overview of MHPSS response activities



MRC initiated the psychosocial support response on March 7th, 2020, after the first individual tested positive for Covid-19. The response operation was initially managed by a team of lead volunteers under the guidance of the head of operations of MRC's Covid-19 response. There were three areas of activities identified: delivering PFA, conducting PFA trainings, and conducting awareness and advocacy activities. In addition to this, volunteers also worked in other areas including administration, data and information management and logistics.

PFA was initially delivered remotely to quarantined or isolated individuals via targeted outreach calls. Subsequently the service was opened to the general public through the helpline 1425. As the number of quarantined individuals in such facilities increased between April and June, group sessions were also conducted for those in quarantine facilities by technical volunteers (e.g., counsellors and therapists with knowledge of PFA) remotely via Zoom. The objective of these sessions was to provide people in quarantine and isolation with a safe space to express their concerns and provide opportunities to engage with others in similar situations and facilitate peer support within these groups. Sensitive issues and basic needs identified during these meetings and through outreach calls were also highlighted in NEOC meetings to advocate for dignified and humane approach in delivering aid and necessities. The first group session for people in quarantine facilities were conducted on 31st March 2020. In total, 14 sessions were conducted for different facilities from 31st March 2020 to 17th May 2021 with 111 participants in attendance.

Activities were also conducted to address MHPSS needs among first responders and to promote self-care and wellbeing within the NEOC. In this manner, relaxation/yoga and breathing sessions were carried out by MRC volunteers (fitness/yoga instructors) for staff and volunteers between March – April 2020; there were 17 relaxation sessions with about 400 participants in attendance. Additionally, group support sessions were carried out (remotely and in person) between April 2020 and July 2020 for first responders who were working in the NEOC to provide them with a safe space to express and share their experience, provide and receive support from peers, and to psychoeducate regarding helpful coping strategies. These sessions were conducted by technical volunteers (e.g., counsellors and therapists with knowledge of PFA). A total of 14 sessions were conducted from 30th March 2020 to 7th July 2020 with about 69 participants. After initial six sessions in April 2020, no sessions were conducted in May 2020. When sessions resumed in June 2020, number of participants in these group sessions declined with an average of 3 participants in each session so sessions were ended. A survey was conducted in August 2020 to inform the further development of MHPSS activities among staff and volunteers[6], however no particular activities were later conducted. Yoga sessions were resumed September – December 2020 and four sessions were conducted, after which due to poor attendance sessions were again ended. In 2021, few breathing sessions were conducted by volunteers on request from the NEOC.

PFA trainings were conducted for MRC volunteers and stakeholders from 13th March 2020 onwards to build capacity of volunteers and first responders. Trainings and capacity building activities are discussed in detail later in this report.

One key activity by MRC was to initiate the establishment of an MHPSS cluster within the NEOC in collaboration with NDMA. This was an important step taken to address existing gaps in the MHPSS system within the country, ensure that MHPSS services are sustained in the community, and to establish efficient referral pathways during the Covid-19 pandemic. The main objective of forming a cluster is to develop a strategic plan to coordinate MHPSS services and interventions during Covid-19 and to advocate for MHPSS considerations among government, private and civil society stakeholders.

The first cluster meeting was held on 31st March 2020 with over [xx] participants in attendance. The cluster was led by MRC till the scaling down of HEOC operations in July 2020. During this period [xx] cluster meetings were held, with 37 members from government and international agencies, private mental health services and other relevant civil societies. Working groups were formed to provide members with opportunity to combine skills and expertise, improve coordination among members and to carry out tasks efficiently. Cluster was reformed after scaling down of HEOC and was incorporated within the National Mental Health Program under HPA.

To facilitate self-help and positive coping in the community, social media posts were circulated. Volunteers and staff with MHPSS training also made media appearances on television and radio shows to convey messages around positive coping and to promote MHPSS activities conducted by MRC. For individuals who were isolated and quarantined in various facilities, an information sheet about mental health and wellbeing was distributed. Being a member of NEOC provided MRC with a platform to advocate for MHPSS considerations, particularly among vulnerable groups such as migrant workers, in the provision of basic services and support. In December 2021, a social media campaign was also initiated to strengthen awareness and advocacy efforts related to MHPSS which are discussed later in this report.

6 Maldivian Red Crescent. (2020). Staff Wellbeing at HEOC - Survey Report. Male'.

Call Centre

On March 8th 2020, MRC set up a call centre at [insert hall name], Dharubaaruge to make outreach calls to all quarantined or isolated people who were referred by different clusters and working groups within the NEOC.

Recruitment and management of volunteers

Volunteer call agents were recruited to the call centre from the existing PFA trainee pool and also by advertising on social media platforms. New trainees were provided with training and guidance and were required to complete a training of 12 hours which included PFA and supportive communication. All recruits to the call centre were required to complete information sessions on Covid-19 including transmission and its prevention, MHPSS needs during Covid-19 and an orientation of MRC.

Volunteers working in the call centre were provided with (1) a brief needs assessment form, (2) a script to guide their conversation, and (3) information about different services and facilities to aid with necessary referrals, and also provided with information sheets about common problems such as sleeping difficulties, anxiety and worrying etc. For documentation purposes, each individual referred to the call centre was registered and given a serial number, and case sheets (including a call log, and assessment form) were maintained on paper. As the case load increased, records were maintained digitally using freely available platforms. Hard copy documents that had been used earlier were also entered to google forms and stored electronically.

All volunteer call agents worked in shifts (4 to 6 hours) and their duties were managed on a duty roster. At the beginning and end of each shift, volunteers were required to brief and debrief with a supervisor or peer. Lead volunteers with relevant experience and background were identified and assigned as call centre coordinators to supervise and guide call agents in their assigned tasks. Following the lockdown on 15th April 2020, some volunteer call agents worked remotely from home and others continued to work in the emergency operations centre.

Quality assurance

Standard operating procedures for the call centre were also developed by 15th March 2020 and revised frequently in response to changing circumstances and developments in the operation. These procedural documents were initially reviewed by technical and expert volunteers in the advisory group for psychosocial support within MRC.

MRC also sought support from technical volunteers to provide supervision and support for those working as call agents and coordinators in the call centre. Terms of reference for these positions were also developed and only few volunteers were recruited and engaged for a short duration.

Overview of outreach calls

The aim of these outreach calls was to check in with quarantined and isolated people and assess their needs, provide psychosocial support, and help them cope with quarantine and isolation. During these calls a brief needs assessment was conducted, and necessary support was provided, and referrals were made accordingly. Follow up calls were also made to all individuals to monitor their wellbeing and address any concerns identified during their quarantine or isolation period; follow up calls were made with verbal consent. The types of needs and common problems identified during these calls are further discussed later in the report.

The first call was made on 9th of March 2020. As the number of people travelling into the country increased, the number of referrals for psychosocial support also increased. Large number of referrals were received at the same time as shown by the frequent spikes in the Figure 1 below. These were, for the most part, sent in as lists of people who were registered at different quarantine and isolation facilities or in home isolation. Over the three months (March to May 2020), an overwhelming number of cases were received (about 3050 referrals) and it became increasingly challenging to make outreach calls and conduct regular follow ups to all people in quarantine or isolation, with a limited number of volunteers and resources. About 900 referrals (30%) were unattended and about 1726 (56%) individuals were successfully contacted by volunteers. Some individuals were referred with incomplete information (e.g., without contact numbers or with wrong contact numbers) (6%) or were non-responsive to calls (8%) so volunteers were unable to reach them.

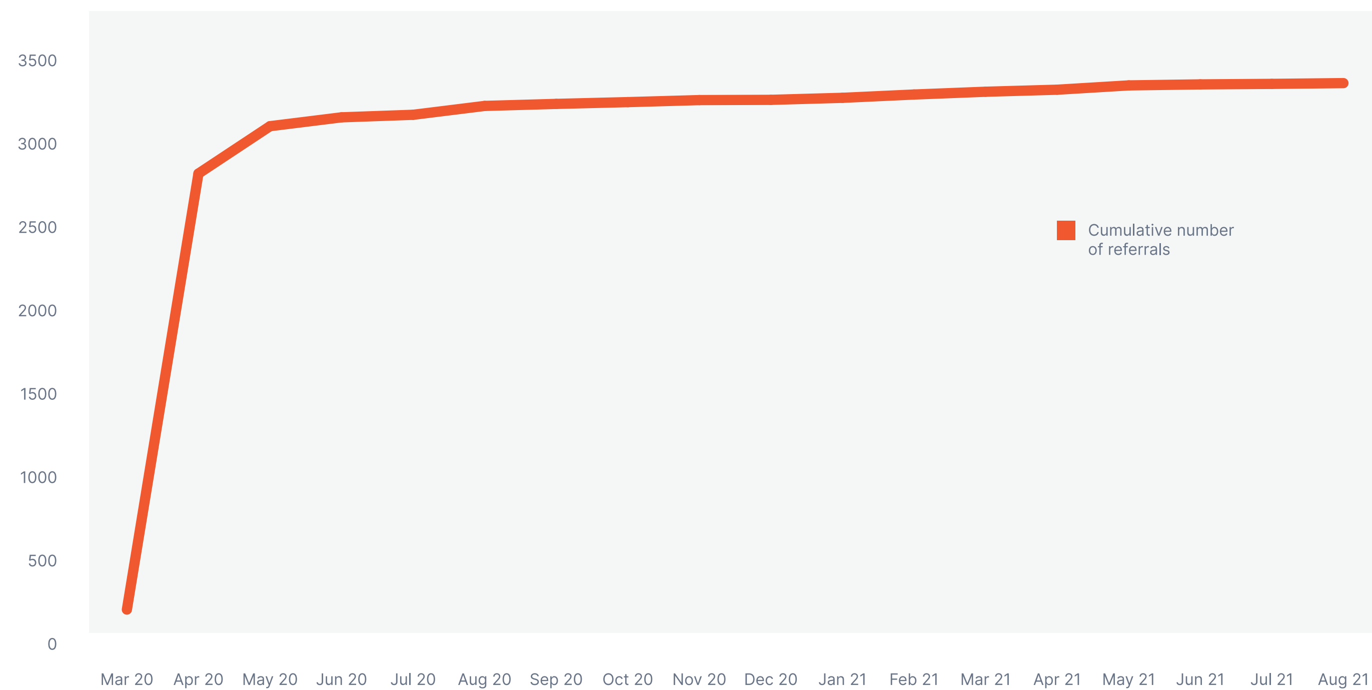


Figure 1. Number of referrals received to the call center between March 2020 – December 2021

Volunteer call agents made over 5500 outreach calls between March 2020 and December 2021. Majority of these calls (90%) were made between March 2020 and May 2020 as seen in Figure 2.

From 1st of June 2020 onwards, outreach calls to all quarantined or isolated persons were ended, and targeted outreach calls were made to only those individuals identified by clusters within NEOC to be experiencing Covid-19 related distress.

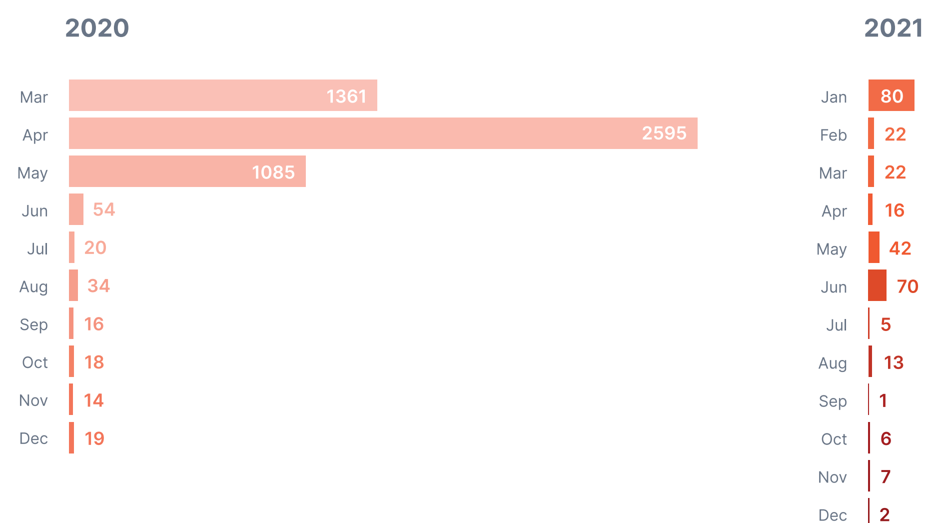


Figure 2. Number of outreach calls made between March 2020 – December 2021

Overview of helpline 1425

The call centre activities expanded from 25th April 2020 onwards following the launch of a toll-free helpline allowing individuals from the community to call in to seek support. The helpline was managed with the 3CX phone system. Information collected (e.g., demographic information, their concerns and needs etc.) were documented digitally and used for monitoring and evaluation purposes. The helpline was available all days except Fridays from 12pm to 5pm and from 8pm to 12am between April to September 2020.

In June 2020 three staff were recruited to implement psychosocial response activities. As measures were implemented to phase out the lockdown, volunteers also returned to work and started to adjust to a new normal which led to a decrease in the volunteer pool. From June 2020 to September 2020, the call centre was staffed by a small pool of volunteer call agents and coordinators. During this time, there was an increase in the number of abandoned calls and consequent decrease in service efficiency.

In mid-September 2020, part-time coordinators were hired to the call centre to ensure the continuity and efficiency of service provided. Following this, operational hours of the helpline were extended from 12pm to 12am. The main focus of work since June 2020 was strengthening the call centre. In this regard, continued capacity building sessions were conducted for call agents and part-time call centre coordinators, procedures and guidelines were reviewed, peer supervision was initiated, and referral networks with relevant stakeholders (e.g., Victim Support Unit, National Drug Agency were established). An FAQ was also developed and posted on the MRC website from 10th October 2020 onwards to better inform the public of the helpline 1425.

By the end of December 2021, there were a total of 2,953 calls received to the helpline. Out of this, 2230 (76%) calls were answered. 17% of calls were abandoned by callers within 10 seconds of connecting with a call agent (these are considered to be short abandons) whereas 7% of calls were abandoned by callers after 10 seconds and these are essentially missed opportunities to intervene and provide support to callers. Table 1 below shows the service level for each month. Service level refers to the percent of calls answered by a call agent within 10 seconds of connecting to the call agent[7] . The 10 seconds here is determined considering the volume of calls and number of staff available to attend to calls. Service level is one of the metrics that indicate the efficiency of service and overall performance, and it is calculated for the 1425 helpline by the following formula. A high service level indicates that callers receive timely support from call agents. The average service level for the call centre is 64.7%.

$$\text{Service level} \downarrow \quad \frac{\text{total no. of calls answered within 10s}}{\text{(total no. of calls answered + total no. of calls abandoned after 10s of connecting to the psychosocial support queue)}}$$

Calculations were made after taking into account the length of pre-recorded message on the helpline which was set up after 11 October 2020. In October the length of this message was 67 seconds, and this was shortened in March 2021 to 38 seconds.

7 National Suicide Prevention Lifeline. (2019). Crisis Call Centre Metrics - Part 1: Service Efficiency

Month	No. of calls answered within 10 seconds	Total no. of calls answered	Number of calls abandoned 10 seconds after the pre-recorded message	Service level
Apr-2020	73	126	5	55.7%
May-2020	251	417	10	58.8%
Jun-2020	94	146	6	61.8%
Jul-2020	62	115	35	41.3%
Aug-2020	39	103	20	31.7%
Sep-2020	43	112	20	32.6%
Oct-2020	37	106	9	32.2%
Nov-2020	60	90	4	63.8%
Dec-2020	52	71	7	66.7%
Jan-2021	52	78	2	65.0%
Feb-2021	48	67	0	71.6%
Mar-2021	84	100	5	80.0%
Apr-2021	37	50	1	72.5%
May-2021	120	120	8	93.8%
Jun-2021	190	190	16	92.2%
Jul-2021	70	70	13	84.3%
Aug-2021	42	42	15	73.7%
Sep-2021	54	54	9	85.7%
Oct-2021	74	74	15	83.1%
Nov-2021	79	79	12	86.8%
Dec-2021	20	20	1	95.2%

Table 1. Service rate of helpline for each month

About 30% of total calls were received between April and June 2020 as shown in Figure 3. This period was characterized by heightened sense of fear and anxiety in the community, with the emergence of covid cases in the community and subsequent lockdown measures which are likely to result in increased distress[8]. In May 2020, the number of calls received was 424, and

8 Musthafa, H. S., Riyaz, A., Moosa, S., Raheem, R. A., & Naeem, A. Z. (2020). Determinants of socioeconomic experiences during COVID-19 pandemic in the Maldives. The Maldives National Journal of Research, 8(2), 76-88.

this number had decreased by 64% in June 2020. Since then, number of calls ranged between 206 – 21 calls from July 2020 to December 2021. There are two spikes in calls observed during this period; an increased number of calls were observed around 22 November 2020 which was in response to a bulk SMS sent out via telecommunication providers to all local number regarding the helpline feedback survey.

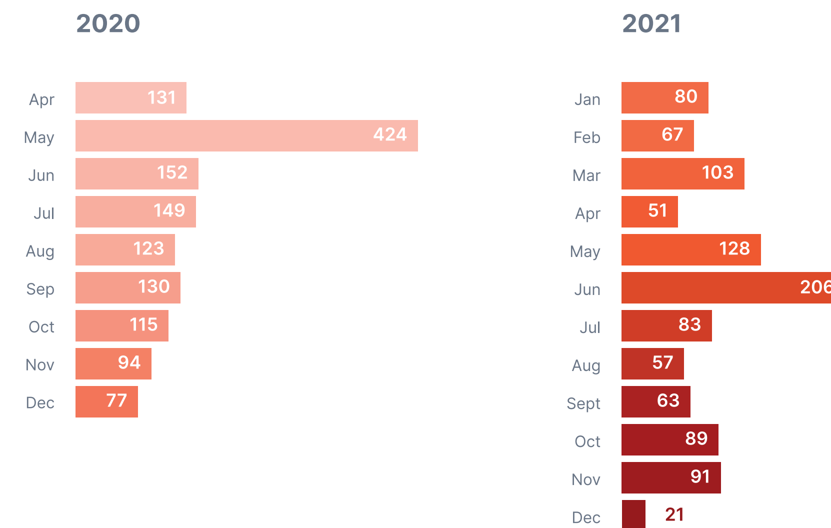


Figure 3. Number of calls received to the helpline between April 2020 – December 2021

After this, calls decreased and then again increased around May – June 2021, which is likely to correspond to the increase in Covid-19 cases since late April and peaking in May 2021. Following this surge, again restrictive measures were introduced around 29th May 2021 with extended curfews which were eased from August 2021. Calls seem to increase with extended curfews and lockdowns as seen in the Figure 4 below.

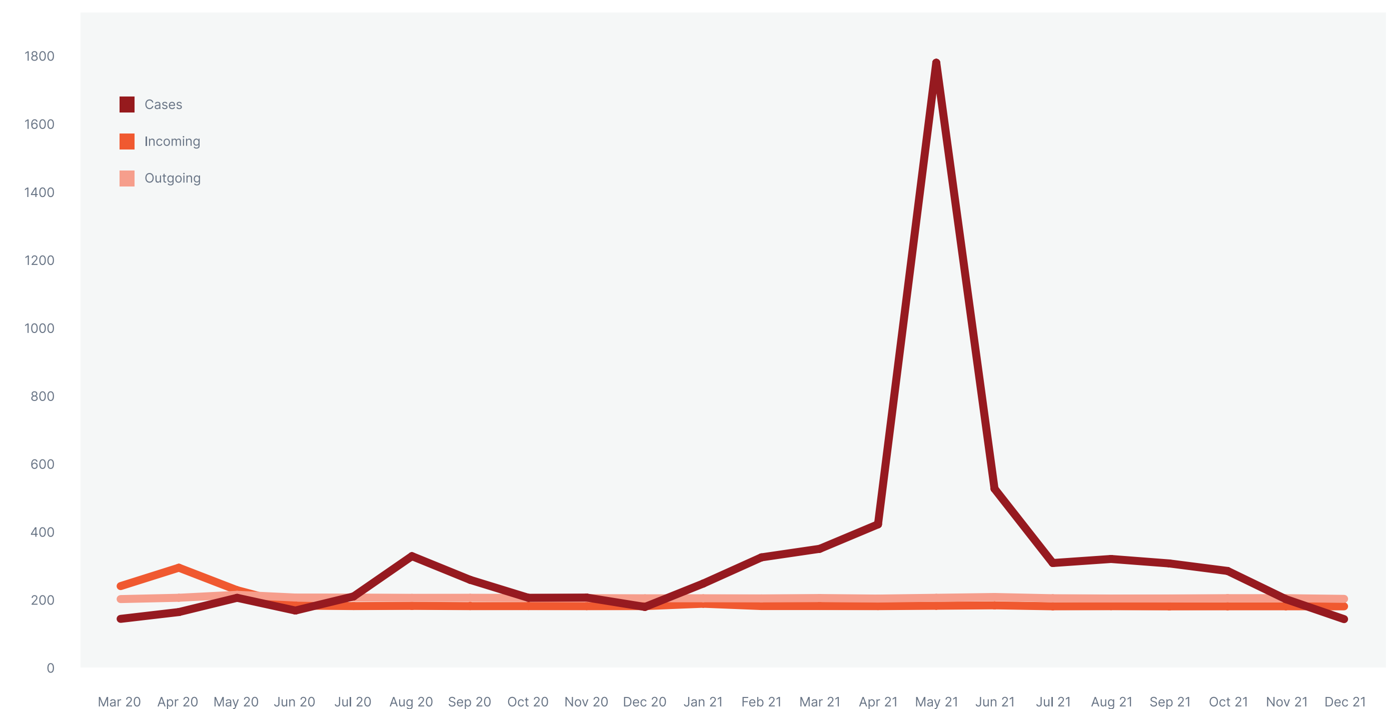


Figure 4. Number of Covid-19 cases, calls received to the helpline and outgoing calls made between April 2020 – December 2021

Month & Year	Helpline		Outreach Call	
	No. of calls	No. of callers (*)	No. of calls	No. of successfully contacted persons (**)
Mar-2020	0	0	1,361	229
Apr-2020	131	93	2,595	1,326
May-2020	424	283	1085	171
Jun-2020	152	92	54	29
Jul-2020	149	76	20	9
Aug-2020	123	60	34	25
Sep-2020	130	53	16	8
Oct-2020	115	37	18	6
Nov-2020	94	58	14	7
Dec-2020	77	41	19	1
Jan-2021	80	42	177	8
Feb-2021	67	50	22	12
Mar-2021	103	70	22	11
Apr-2021	51	29	16	8
May-2021	128	81	42	17
Jun-2021	206	129	70	4
Jul-2021	83	17	5	1
Aug-2021	57	19	13	3
Sep-2021	63	30	1	0
Oct-2021	89	41	6	0
Nov-2021	91	45	7	0
Dec-2021	21	8	2	0
TOTAL	2,434	1,354	5,599	1,875

Note. (*) no. of callers was calculated by identifying the number of unique numbers that called the helpline (**) number of successfully contacted people are calculated by identifying the number of referred individuals who were contacted and provided with support.

Table 2. Number of callers and people outreached via services

The number of individuals who had directly received psychosocial support via outreach calls or had sought support by calling in to the helpline shown in Table 2. There was a total of 3229 individuals (roughly 0.6% of the population) who were provided with psychosocial support via outreach or helpline service. Among callers to the helpline, 55.6% of calls are received from people who have called in at least once before.

Demographics and concerns of people

Demographic information regarding callers and outreached individuals are presented in the Table 3 below. A large portion of demographic data for outreach calls are missing as those fields were left blank when referrals were received and/or when data was entered to digital forms. Available data show that for outreach calls, majority of people were males (30.1%) compared to females (26.1%). Whereas for helpline calls, this difference in sex was smaller (M = 48.1%, F = 50.0%). 37% of individuals from helpline and 23.6% of people contacted via outreach calls were between ages 19 – 35 years.

For both outreach and helpline calls, majority of people were Maldivians (96.2% and 51.6% respectively). For outreach calls, the percentage of foreigners were greater (6.7%) compared to helpline calls (1.8%) as many tourists and migrant works in hospitality were referred to MRC for psychosocial support. Less calls from foreigners to the helpline could indicate that the service is less accessible or used by foreigners perhaps because they are unaware of the service. It is also important to note that almost all volunteers in the call centre were also Maldivians and only spoke either English or Dhivehi, and few spoke Hindi so there may be language barriers also that could make this helpline less accessible to migrant workers or foreigners. During outreach calls, most callers reported being quarantined or isolated (50%) in contrast with helpline calls, where most callers were not quarantined or isolated (54%). With regards to the locations of individuals, helpline calls were received mostly from Greater Male Area (50.2%), followed by central atolls (15.1%). Among outreach calls, most of the calls were made to individuals in central atolls (40.6%) reflecting the many quarantine facilities that were set up in the central atoll. Only 11.5% of callers to the helpline were from Northern and Southern parts of the country where access to MHPSS services are likely to be limited.

Of the total calls, 190 calls were documented to be made with vulnerable individuals such as people with special needs, those living with chronic illnesses, with substance use issues or recovering from substance use issues, single parents, and those who were homeless (see Figure 4 below).

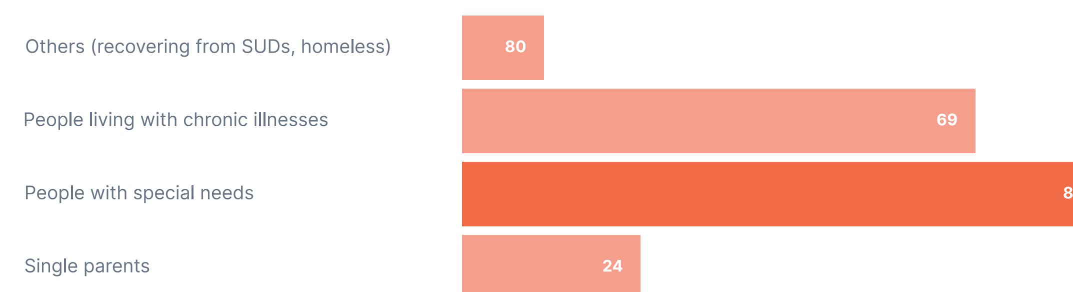


Figure 5. Number of calls with vulnerable individuals

Item	Category	Helpline	Frequency Outreach	Total	Helpline	Percentage Outreach	Total
Gender	Female	1093	1468	2561	49.95%	26.06%	32.75%
	Male	1053	1694	2747	48.13%	30.07%	35.12%
	Missing Data	42	2471	2513	1.92%	43.87%	32.13%
Age	Below 13	20	195	58.8%	0.91%	3.46%	2.75%
	13-18	112	142	215	5.12%	2.52%	3.25%
	19-35	810	1330	254	37.02%	23.61%	27.36%
	36-64	749	769	2140	34.23%	13.65%	19.41%
	Above 64	39	93	1518	1.78%	1.65%	1.69%
	Missing Data	458	3104	132	20.93%	55.10%	45.54%
Nationality	Maldivian	2105	2906	5011	96.21%	51.59%	64.07%
	Foreigners	39	392	431	1.78%	6.96%	5.51%
	Missing Data	44	2335	2379	2.01%	41.45%	30.42%
Isolation status	In isolation/quarantine	350	2814	3164	16.00%	49.96%	40.46%
	Not in In isolation/quarantine	1181	200	1381	53.98%	3.55%	17.66%
	Missing Data	657	2619	3276	30.03%	46.49%	41.89%
Location	Central atolls	331	2288	2619	15.13%	40.64%	33.49%
	Southern atolls	101	124	225	4.62%	2.20%	2.88%
	Nothern atolls	152	33	185	6.95%	0.59%	2.37%
	Greater Male' area	1099	597	1696	50.23%	10.60%	21.69%
	Missing data	505	2591	3096	23.08%	46.00%	39.59%

Note. N = 7821, total number of incoming calls = 2188. Total number of outgoing calls documented = 5633.*Successful calls are defined here to be calls where qualifying information was gathered, and support provided without calls being disconnected due to connectivity issues or transferred.

Table 3. Demographic information of callers and people outreached via services

Concerns of callers and signs of distress

Concerns reported by callers varied across the response timeline as shown in Figure 5. At the beginning in March 2020, most frequently cited concerns were (1) lack of information regarding how and where to seek help or access to services (38.7%), (2) concerns about health and safety of loved ones (17.7%), and (3) concerns around health issues e.g., worries about medical treatment for physical illnesses including diabetes, high blood pressure, high cholesterol (14.5%).

With the lockdown (April 2020 – June 2020), majority of concerns were around basic needs (18.6%) such as food where people expressed dissatisfaction with the food being provided as they were not appropriate for their particular dietary requirements and preferences e.g. not being able to have fried food, due to allergies. Other concerns were similar to those in March 2020 as seen in Figure 5 below. After the ease of first lockdown measures and as people started returning to a new normal, most calls to the helpline were primarily around mental health concerns (e.g., complaints regarding mood, sleep, anxiety).

The most common signs and symptoms of distress reported by people are shown in Figure 6 below. These include feelings or anxiety and worry, low mood characterized by persistent sadness and lack of interest/pleasure in doing things, and difficulties related to sleep.

Feelings of boredom were reported frequently by people in March 2020 and April to June 2020 (22.4% and 13.7%) possibly due to being in isolation or quarantine. During this time, 8.42% of individuals who were quarantined or isolated reported fear regarding re-integration with families and communities (i.e., scared of how people are going to react when they go back home, whether people are going to be scared of them) which could indicate experience of Covid-19 related stigma.

Complex reactions such as suicidal behaviours are more frequently reported since October 2021. There was also a higher percentage of callers who were identified to have a history of mental health difficulties from July 2021 onwards (between approximately 30% to 55%) compared to March 2020 (2.5% in March and 16.8% in July 2021). Available data indicate that at the beginning of response, concerns of people were more practical and related to basic needs and support. After the acute response phase, when people presumably started

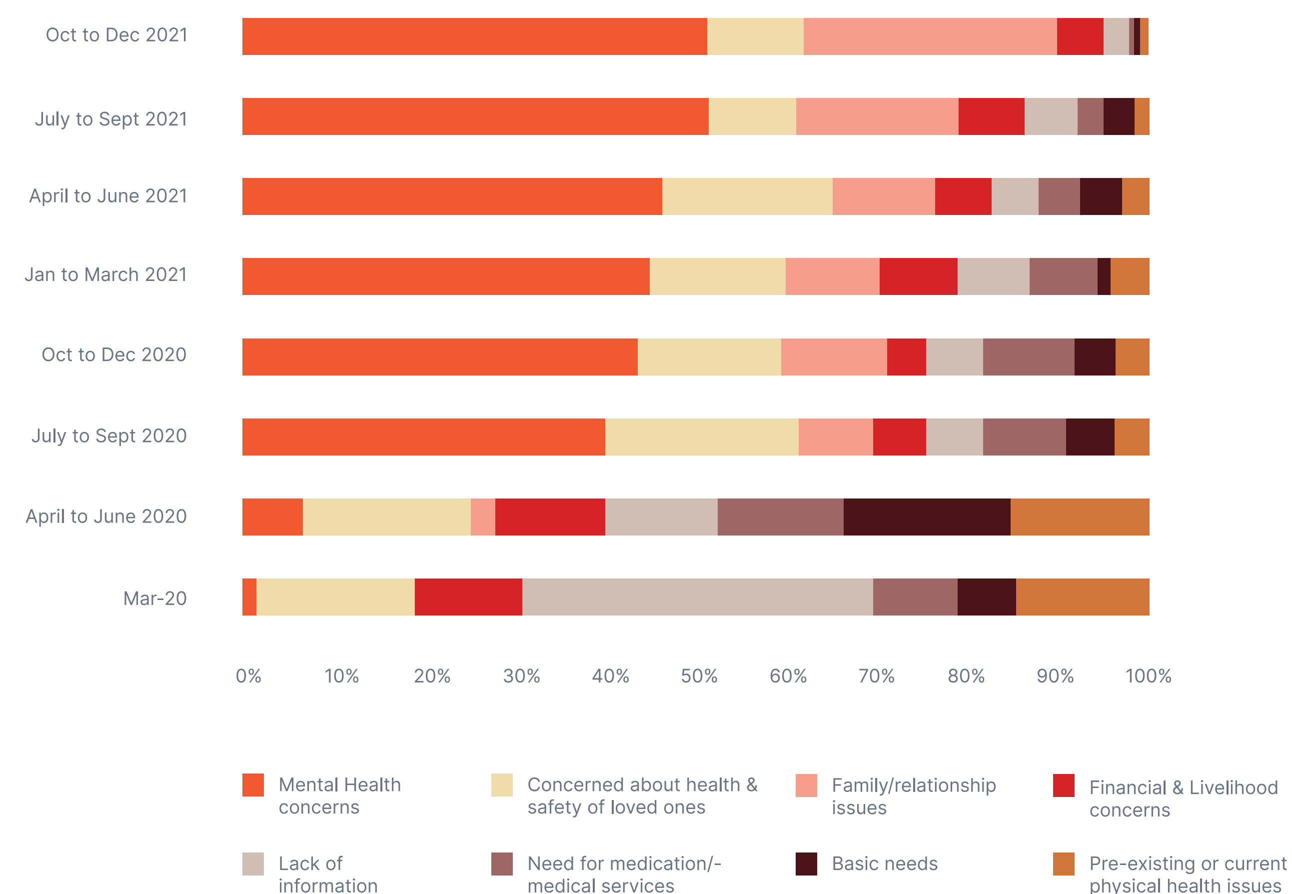


Figure 6. Percentage of concerns reported by people between March 2020 - December 2021

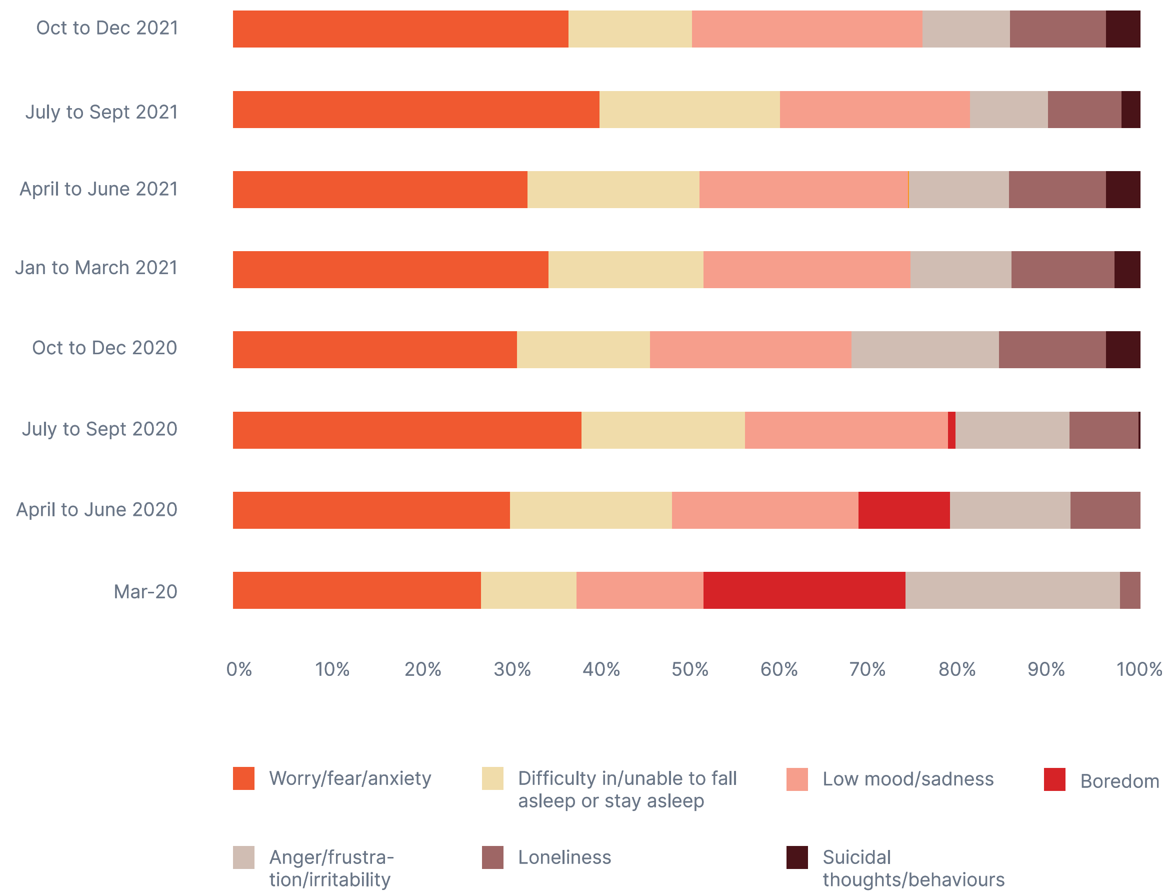


Figure 7. Percentage of signs of distress reported by people between March 2020 - December 2021

Feedback regarding helpline

A survey was conducted between November – October 2020 to explore the perceived effectiveness and satisfaction with the helpline 1425 among users. Among 50 respondents who reported using the helpline, 66% of participants were satisfied with the service and agreed that is a useful service.

Call agents are also required to complete a call outcome section after each call. This form is adapted from the Crisis Call Outcome Form[9] . It identifies four behaviours that are observed from service users during effective helpline calls. Data shows that majority of users expressed a feeling of gratitude (72.2%), express their feelings (62.3%) and receive needed information (67.2%) during calls. About 56% of service users express feeling relieved during the call as seen in Figure 7. This information should be interpreted considering that response biases may be present in the perception of such behaviors from callers.

9 Echterling, G. L., & Hartsough, M. D. (1989). hases of helping in successful crisis telephone calls. Journal of Community Psychology, 17(3), 249–257. Retrieved from https://doi.org/10.1002/1520-6629(198907)17:3<249::AID-JCOP2290170307>3.0.CO;2-M

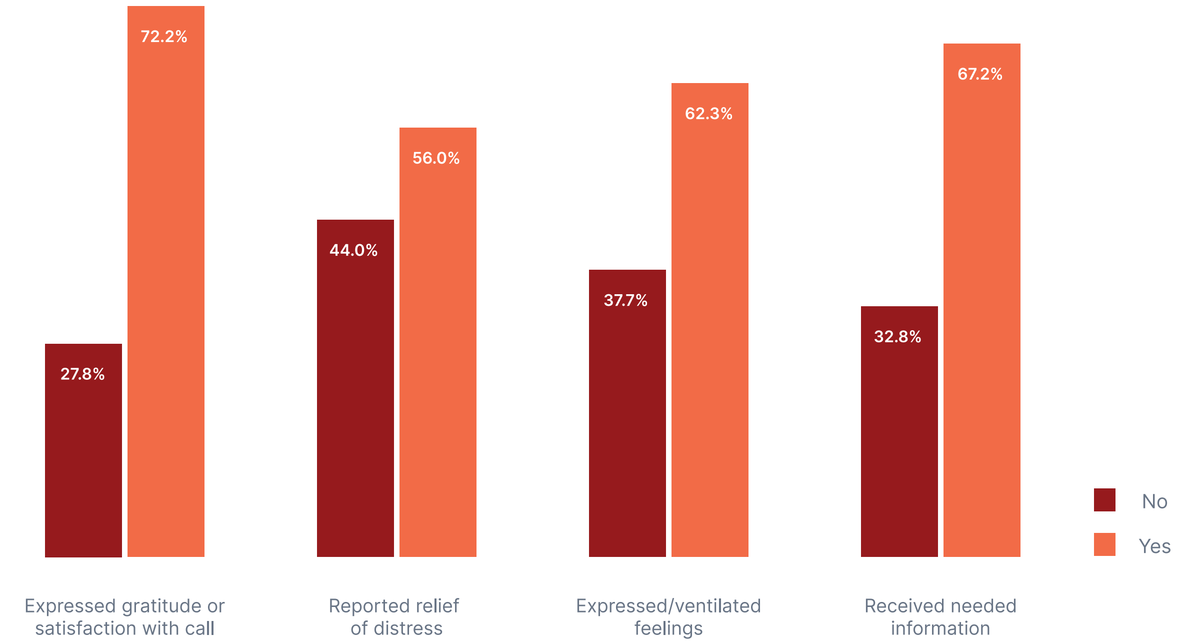


Figure 8. Percentage of callers who indicated efficiency of calls

Training and capacity building

Training and capacity development sessions were one key task which were carried out as a part of the COVID-19 response. One major goal of training and capacity building activities were to strengthen psychosocial support provision by enhancing the knowledge and skills of MRC volunteers. Information and awareness sessions aimed to increase community awareness and acceptance of mental health challenges faced due to COVID-19 and to promote helping and help seeking behaviours among individuals and community.

MRC adapted training guides developed and published by International Federation of Red Cross (IFRC) Psychosocial Centre according to local Covid-19 context and remote delivery where needed, to conduct a wide range of training sessions. Training documents used include the following[10–15] :

1. Psychological First Aid in the COVD-19 outbreak response
2. Remote psychological first aid during COVID-19
3. Loss and Grief during COVID-19
4. Remote supportive communication during COVID-19
5. Psychological First Aid for Children on the COVD-19 outbreak response
6. Suicide prevention during COVID-19

10 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 1 - An Introduction to PFA. Copenhagen: IFRC Reference Centre for Psychosocial Support.

11 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 2 – Basic PFA. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-module-2-Basic.pdf

12 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 3 - PFA for Children. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-3-Children.pdf

13 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 4 - PFA in Groups – Support to teams. IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

14 IFRC Reference Centre for Psychosocial Support. (2021). Suicide Prevention. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2021/09/suicide_prevention_sept_21.pdf

15 IFRC Reference Centre for Psychosocial Support. (2015). Sexual and gender-based violence – A two-day psychosocial training. Training guide. Copenhagen: IFRC Reference Centre for Psychosocial Support.

These guides and training modules were used to design and develop training and sessions based on the need of the operation. Priority was given to conduct Psychological First Aid training and remote supportive communication training for both volunteers and frontline workers in the operation. Trainings offered and conducted by MRC during the operation are described in Table 4.

Training Name	Duration	What is the training about
Psychological First Aid Training of Trainers	5 days (35 hours)	Introduces basic psychological first aid skills and present a range of situations faced by adults and children, their reactions to crises, and how helpers may respond appropriately when providing PFA individually. This training will also focuses on developing facilitation and communication skills, highlighting on roles and responsibilities of a trainer.
Introduction to Psychological First Aid Training	1 day (5 hours)	Introduces participants to basic psychological first aid skills including identifying distressing events and reactions to crises. This training also incorporate how to providing PFA individually.
Basic Psychological First Aid Training	1 day (8 hours)	Introduces basic psychological first aid skills and presents a range of situations faced by adults, their reactions to crises, and how helpers may respond appropriately. This training also offers practical component to practice basic PFA skills.
Psychological First Aid for Children	1 day (8 hours)	Focuses on children's reactions to stress, and effective ways to communicating with children, their parents/ caregivers. This training also offers practical component to practice PFA skills.
Psychological First Aid in Group	3 days (24 hours)	This training guides on how to provide PFA support to individual and team at the same time. Psychoeducation in group setting, establishing peer support and managing group dynamics are important concepts that are covered in this training. This training also offers practical component to practice facilitating support meetings.

Table 4. Description of trainings conducted by MRC

In addition to these trainings, MRC conducted a Caring for Volunteers Training[16] as part of activities aimed at addressing wellbeing of staff and volunteers; this is discussed later in this report. MRC also offered short capacity development sessions for volunteers and stakeholders to encourage further development of knowledge and skills as described below in Table 5. The aim of these sessions were to better equip volunteers and frontline workers to deal with complex situations that may arise during the response. These sessions were included after discussing with volunteer call agents about challenges they are currently facing while providing psychological first aid. These sessions emphasized ways to cope with stress during a pandemic and how to take care of oneself during a long-term response operation. To strengthen capacity building and training work, two part-time trainers were hired from September 2020 to December 2020 to support the Trainings and Capacity Development Officer.

A total of 21 trainings in MHPSS interventions (Introduction to Psychological First Aid, Basic Psychological First Aid, Psychological First Aid in Groups) were conducted with 259 MRC volunteers and staff. Feedback form responses were available for 9 trainings, which showed that 94.4% of participants reported gaining knowledge and skills of MHPSS interventions and 85.0% reported being confident in applying this knowledge and skills to provide support after completing the training. Participants were also required to complete a practical evaluation to meet certification requirements as a psychological first aider in MRC; 233 participants (89.96%) were certified after training evaluation. Out of these trained individuals, about 55 volunteers were actively involved in providing remote psychosocial support during Covid-19 between March 2020 and June 2020. Majority of training participants were female (71.8%) and from Male' branch (76.3%).

To increase the pool of available, competent, and committed trainers, MRC conducted 4 training of trainers. A total of 37 participants took part in these training sessions (Males = 5, 13.5%, Females = 32, 86.5%). Structured feedback forms were not utilised for these trainings. Feedback provided from some participants during the training indicated that participants found the training to be effective and valuable, and believed having the opportunity to provide PFA in real situations in addition to case studies would better equip them as trainers.

Session Name	Duration	What is the training about
PFA Orientation	2 hours	Introduces participants to basic psychological first aid skills including identifying distressing events and reactions to crises. This session also covered PFA principles and importance of self-care.
Supportive Communication	2 hours	Supportive Communication session covers the basic skills and knowledge including range of listening and responding skills and have insight into the values, ethics, and boundaries of their work as psychosocial support helpers.
Stress and coping	2 hours	This session introduces to types of stress, various coping strategies and how to assist someone to cope.
Loss and grief	2.5 hours	Session on loss and grief focus on creating an understanding on various reactions to loss and how to support someone who is grieving.
Helping people with suicidal thoughts	6 hours	This session aims to provide an understanding on suicide, common risk factors and how to identify and support individuals having self-harm behaviour, suicidal thoughts. This session also includes assessing risks and how to make a safety plan.
Helping survivors of Sexual Gender based Violence	6 hours	This session introduces sexual gender-based violence and how to provide assistance to a survivor of SGBC keeping in mind the impact and possible challenges.

Table 5. Description of additional training and capacity building sessions conducted

16 IFRC Reference Centre for Psychosocial Support. (2015). Caring for Volunteers: Training Manual. Copenhagen: IFRC Reference Centre for Psychosocial Support.

"The Psychological First Aid (PFA) Training conducted by Maldivian Red Crescent was a wonderful program, which enables us to learn how to be there for people who really need help in a catastrophic event. The content of the program was very good and meticulous. It was very clearly explained with real life case scenarios. The best parts of the program were the practical part and the evaluation process used to ensure that the participants were ready for PFA. As a participant of PFA, I personally believe that it is a very important and useful program that must be completed by all the teachers working in a school as it is a program that provides teachers guidelines on how to speak with students who have undergone an emergency event or disaster that has disrupted the learning environment. With the help of the program, teachers will be able to reduce distress and facilitate students' learning by stabilizing the emotions and behaviour of students."

- Nasheeda Ali (a leading teacher of Huravee School) -

I really appreciate the PFA in group training. It has been very helpful for me. I enjoyed and learnt a lot as the whole dynamic of the training was active and interesting. It was very well organized and got to hear so many great experiences. Many thanks for the opportunity.

- Maryam Anees (Call centre coordinator/Training participant) -

The training was held with social distancing and extra measures, but the sessions were very well planned and interactive. The facilitators used online tools (Miro board) and resources very well and ensured the content was delivered in an effective and memorable way. The roleplays showed participants how relevant PFA in groups is for our volunteers, particularly during a long and drawn response.

- Mubeen (Volunteer, Training participant) -

Additional capacity building sessions were also conducted to facilitate continued development of psychosocial support providers. In this manner, a total of 27 sessions were conducted from March 2020 to December 2021 with 281 participants. Topics covered in these sessions include stress and coping, loss and grief, supportive communication, how to help someone suicidal, how to help survivors of SGBV, which are also adapted from IFRC resources[17–18]. For call agents working in the call centre, 5 sessions on dealing with sensitive issues (e.g. Self-harm behaviour, SGBV, aggressive behaviour, suicidality etc..) were also held from February to July to equip them with additional knowledge and insight to enhance their sensitivity towards these issues. To sharpen their skills, practice calls were completed with volunteers and recorded. These recordings were later viewed and reflected on to identify strengths and areas for improvement. These were discussed in debriefing with call coordinators by supervisors.

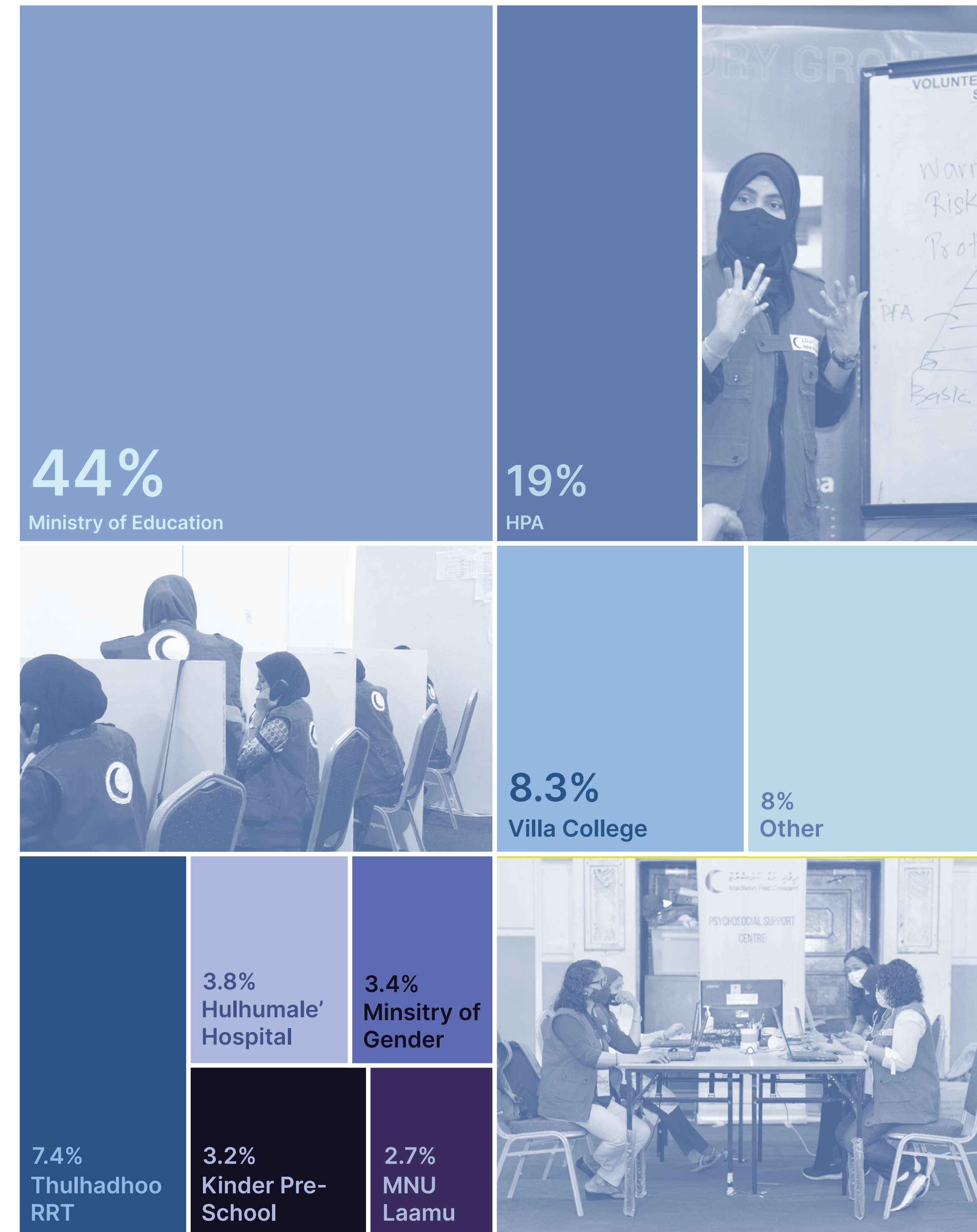


Figure 9. Percentage of trainees from external organizations between March 2020 - December 2021

17 IFRC Reference Centre for Psychosocial Support. (2020). Loss and grief during COVID-19. Copenhagen: IFRC Reference Centre for Psychosocial Support.

18 IFRC Reference Centre for Psychosocial Support. (2012). Lay Counselling - A Trainers Manual. Copenhagen: IFRC Reference Centre for Psychosocial Support.

For external stakeholders 36 trainings in MHPSS interventions were conducted with 534 participants. Feedback form responses were available for 37 trainings, which showed that 78.9% of participants reported gaining knowledge and skills of MHPSS interventions and 73.6% reported being confident in applying this knowledge and skills completing the training. Participants were from a variety of organisations including Health Protection Agency, Ministry of Gender, Family and Social Services, public schools in collaboration with Ministry of Education and UNICEF, Hulhumale' hospital, Maldives Blood Services and others (for details of all training sessions conducted see appendix A). As shown in the Figure 8 below, the majority of trainings for external stakeholders included schoolteachers and staff (44.2%) from the Ministry of Education.

In addition to training, 99 short sessions on PFA, supportive communication and mental health at workplace were conducted for stakeholders with approximately 6555 participants.

Orientation sessions on psychological first aid were conducted remotely on a mass scale for all school teachers and staff. These were brief sessions introducing how people react to distressing events and the basic concepts of psychological first aid. Approximately 9891 teachers were invited to join the sessions out of which 6426 (65.0%) participants attended the session. Total 82 orientation sessions were conducted over a time span of 2 months.

During the MHPSS response activities, training materials adapted were standardised and packaged for use by trainers. These training packages included PowerPoint slides, training evaluation forms, handouts, and other useful templates. A training menu was also developed for corporate trainings to facilitate the generation of revenue. In order to maintain quality and standard of trainings, a standard operating procedure (SoP) for trainings was written which included the procedures to follow when conducting a training and the roles and responsibilities of trainer, co-facilitator and MRC personnel overseeing the training. This SoP was in effect from August 2020. To encourage growth of trainers, a trainer pathway was also developed which set the minimum number of co-facilitation hours required to become a lead trainer. Training database was also developed and maintained to record trainees' information.

Social media campaign

To increase the number of users and calls to the help line, and to promote help seeking behaviours by creating awareness of mental health problems and addressing stigma around mental health a social media campaign titled "Gulhaalama 1425" was initiated. Local consultants were hired who created content and materials for the campaign and also provided their technical guidance to increase engagement with the media platforms. Content was developed around promotion of helpline 1425, common mental health problems, positive coping strategies, addressing stigma and promotion of volunteerism. Gulhaalaama 1425 campaign was kicked off in December 2020. Various digital materials including posters, flyers, animation videos, interviews and stickers were designed and developed for the campaign. These were circulated on MRC's different social media platforms including, Facebook, Twitter and Instagram. Other communication platforms such as MRC Viber groups, radio, TV channels and public screens were also utilized to increase the outreach.

There were different types of post developed each month:

1. Volunteerism related post – to promote volunteerism and appreciate volunteers.
2. Tips for coping and self-care – these were practical suggestions on positive coping strategies and self-care to alleviate stress and promote wellbeing
3. Stigma related posts – these were posts addressing stigma around mental health
4. Staff and volunteer interview spots – these were video spots by volunteer or staff talking about the helpline 1425 service
5. Situation specific posts – these were developed around key themes e.g., anxiety and worry, loneliness, dealing with changes, stress management, Covid-19 specific challenges such as vaccination anxiety and physical distancing measures.
6. Helpline promotion posts – these were around helpline 1425 service.
7. Explanation videos – these were video spots developed around key themes e.g., anxiety and worry, loneliness, dealing with changes, stress management
8. Calming/relaxation posts – these were animated breathing exercises and calming videos of nature with helpful reminders to breathe and relax.

Materials were developed both in English and Dhivehi to enhance reach and accessibility of content to a wider population. Additionally, 7 posts were also printed (1425 promotion post, tips on dealing with vaccine anxiety, soothing children's worries, coping with stress and worries, reaching out to friends, mental health stigma, and how to support your friend) with the support from UNICEF and disseminated among numerous island communities including Addu, Hdh. Kulhudhuffshi, Lh Hinnavaru, M. Kolhufushi, Ga. Gemanafushi, Gdh Thinadhoo, Gdh Gahdhoo and Gn. Fuvamulah. About 800 printed copies were distributed to each of these communities.

To promote the helpline 1425, call centre coordinators and call agents made outreach calls to mental health focal points of all islands assigned by HPA and shared information regarding the helpline service and provided information about identifying people who may be distressed, supporting them and linking them with mental health services. A total of xx calls were made to atoll mental health focal points in October 2020 and in xx.

Feedback regarding helpline

Twitter

Over the campaign period (i.e., from December 2020 to December 2021) MRC published 80 posts on Twitter (44 unique content posts, some of which were reposted), with a total 228,042 impressions. The average engagement rate on Twitter is 3.2%. Followers on Twitter increased by 697 followers (56.9 %) since the campaign. A total of 1,109 likes and 725 retweets were received for the posts. The average impressions and engagement rate on Twitter are higher for posts in English (2,826 impressions and 3.25% engagement rate) compared to posts in Dhivehi (3,044 impressions and 2.61% engagement rate). Engagement rate was highest (6.8%) for the introductory video spot about the helpline 1425 likely because it was a promoted tweet.

Overall, engagement and impressions on average are higher for volunteers/staff interviews and video spots followed by helpline promotion content compared to other types of posts as shown in Table 6. On average, 1.5 posts per week were published on Twitter throughout the campaign.

Facebook

On Facebook, MRC uploaded 62 posts reaching a total of 178,832 people. The average engagement rate is 3.1% on Facebook and MRC's follower base increased by 1522 (5.6%) since the campaign. A total 1,259 likes and 503 shares were received for the posts. The average reach and engagement rate on Facebook are similar, although slightly higher for posts in English (2,922 reach and 3.07% engagement rate) compared to posts in Dhivehi (2,535 impressions and 3.02% engagement rate). The engagement rate was highest (11.6%) for the same post as on Twitter i.e., for the introductory video spot about the helpline. The situation specific posts had the highest average reach however video content had more engagement on Facebook as seen in Table 6 below. On average, 1.1 posts per week were published on Facebook throughout the campaign.

Instagram

On Instagram, MRC uploaded a total of 57 posts reaching a total of 12,635 users. The average engagement rate is 3.5% on Instagram. A total 1548 likes/reactions and 449 shares were received for the posts. On Instagram the engagement rate was highest (14%) for grounding technique animated video, indicating that users found this post to be valuable. This was followed by a high engagement rate for tips post on physical signs of mental ill health (8%) and the for the introductory video spot about the helpline 1425 (8%). Although more people seemed to have seen the explanation videos, overall, average engagement was highest for stigma related posts (5.4%) and staff and volunteer interview spots (4.9%) and tips on coping and self-care (4.2%) as seen in Table 6 below. On average, 1 post per week were published on Instagram throughout the campaign.

Types of Posts	Twitter			Facebook			Instagram		
	No. of Posts	Average engagement rate	Average number of impressions	No. of Posts	Average engagement rate	Average number of impressions	No. of Posts	Average engagement rate	Average number of impressions
Volunteerism related post	1	2.6%	718	0	0	0	1	2.3%	199
Tips for coping and self-care	30	3.3%	1660	23	2.2%	2,326	22	4.2%	203
Stigma related posts	3	2.5%	2176	2	2.0%	1,132	2	5.4%	298
Staff/volunteer interview spots	2	4.2%	12,531	2	8.6%	6,220	2	4.9%	110
Situation specific posts	16	2.7%	2,328	14	1.5%	5,098	13	2.4%	124
Helpline promotion posts	11	2.2%	6,994	7	3.0%	2,352	7	3.1%	154
Explanation videos	8	3.5%	2,014	6	5.5%	3,042	6	3.6%	580
Calming/relaxation posts	9	4.3%	1,738	8	5.4%	568	4	2.6%	246
Grand Total	**80**	**3.2%**	**2,851**	**62**	**3.1%**	**2884**	**57**	**3.5%**	**222**

(*) Data presented here do not include the reach and engagement on Facebook and Instagram from ads. Ads were posted on 27th October 2021 and 23rd – 25th January 2021 which resulted in a total of 728,511 reach and 1,710 engagements.

Table 6. Social media posts for Gulhaalama campaign and their average reach and engagement of Twitter, Facebook and Instagram

Social media campaign and helpline calls

As mentioned above, one of the main objectives of the social media campaign was to promote the helpline 1425 and help-seeking behaviours, and to increase the number of users and calls to the helpline. When the campaign started, calls to the helpline were decreasing to an average of 23 calls per week during the quarter as seen in Figure 9. After the campaign started, during the first quarter of 2021 (Jan – Mar 2021), calls continued to decrease to an average 18 of calls per week. Around end of day May 2021 during the extended curfew, the number of posts increased and subsequently number of impressions from end of May to mid-June 2021, which coincides with an increase in number of calls around this time. During this quarter (April – June 2021), the average number of calls increased to 30 calls per week.

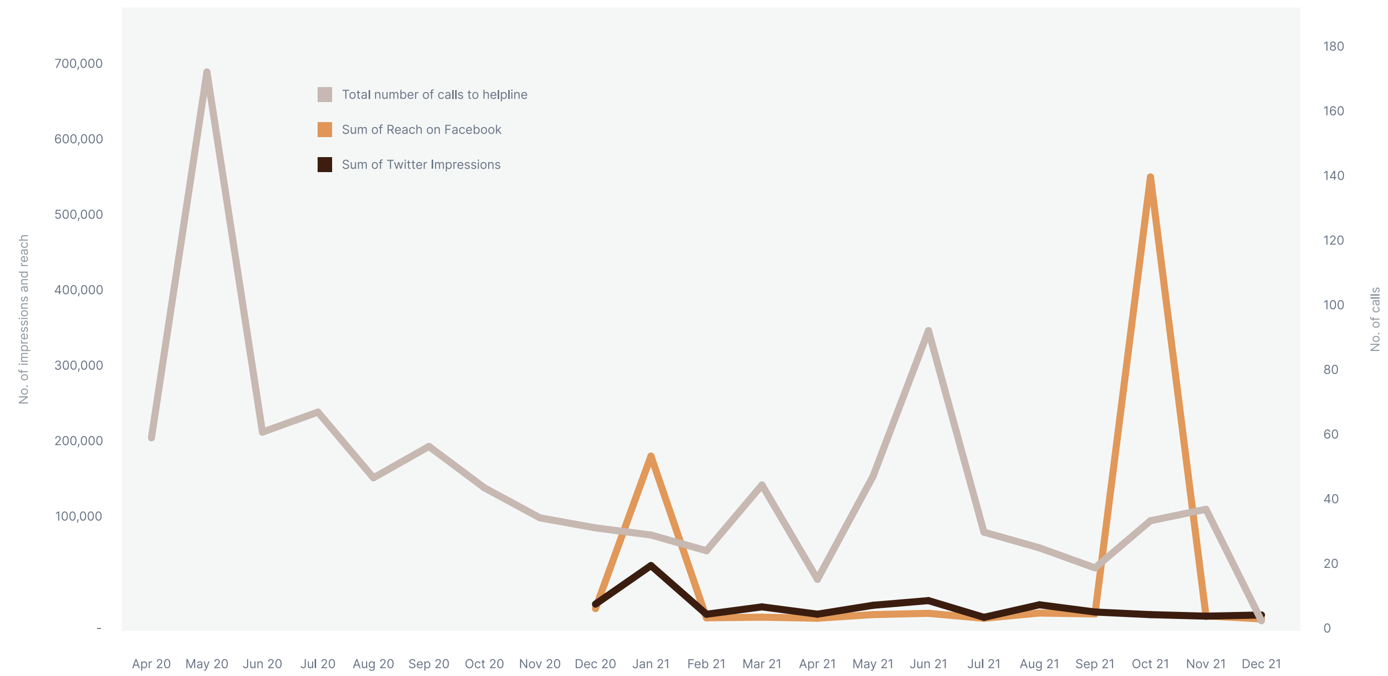


Figure 10. Total social media reach and helpline calls

Caring for volunteers' activities

Volunteers serve to be the backbone of MRC and are key to all activities and programs implemented by the organization. Volunteers working in crisis and emergencies face various risks to their health and wellbeing. These include unrealistic expectations resulting in feelings of guilt about taking breaks and prioritizing self-care, challenges in working with colleagues who may also be stressed, having to perform stressful tasks e.g., providing psychosocial support, supporting rapid response teams, etc., and also risks related to organizational issues such as lack of role clarity, briefing and debriefings, and unsupportive work environments (IFRC Reference Centre for Psychosocial Support, 2019). Providing psychosocial support to volunteers is an essential part of fulfilling the organization's responsibility to care for its volunteers.

Volunteer Survey

To better understand current practices and inform the development of additional support strategies for volunteers, a needs assessment survey was conducted[19] . A total of 169 individuals participated in the survey. Majority of participants were female (53.3%) and youth between the ages of 18-34 (70%). More than third (73%) of participants also reported to have achieved tertiary level of education (attended university, colleges, or a vocational institution). Almost half of participants were fully employed (49%) while a third (33%) report being unemployed. Volunteers in the Covid-19 response reported signs of stress including feeling guilty about taking breaks and resting (31%), fearing for their own safety and wellbeing (24%), feeling overwhelmed by work assigned to them (20%), feeling stressed (15%) and frustrated (12%) in their work. Some signs indicating extreme stress and burn out were also reported among a smaller percentage of volunteers including feeling exhausted by work (9%), not caring about what happens to people they help (7%) and feeling insensitive and uncaring towards people they help (5%).

Participants reported engaging in support such as briefings/debriefings, stress management activities such as volunteer gatherings/celebrations, relaxation activities such breathing and yoga, group chats and online meetings, and iftar meals and eating together. Volunteers also reported having knowledge of stress and ways to manage stress. The survey report concluded with detailed recommendations for the organization to consider in volunteer management and care.

Caring for Volunteers Training

A Caring for Volunteers training was conducted 13 – 14 July 2021, with the objective to strengthen MRC's volunteer management by training key staff, volunteers, team leaders, managers with responsibility for the well-being of teams. Through this training participants were able to understand the psychosocial needs of staff and volunteers, plan and implement support strategies and understand the importance of peer support, and availability of psychosocial support for staff and volunteers. The content for the training was adapted from the IFRC Caring for Volunteers training manual[16] . The training duration was 16 hours (2 days) training from 8:30 – 5:00. The training was conducted in person at Mookai hotel.

A total 19 participants (F = 13, 68.4% and Males = 6, 31.6%) including MRC staff and volunteers completed the training. Verbal feedback indicated that participants enjoyed the training overall. Some participants who had more experience as volunteers and staff, noted that they felt uncomfortable sharing their difficult and challenging experiences because some new volunteers were also among the participants, and they reported feeling worried about giving them an impression that work is overwhelming. Participant experiences, background and roles were very contrasting which made some participants hesitant to share openly and really engage in the training.

> *The training was a very insightful and useful in understanding the importance of establishing a proper mechanism to address the psychosocial support needs of volunteers and staff during programming and emergencies.*
>
> **– Shameel Ibrahim, Training participant/ PMER Coordinator-**

16 IFRC Reference Centre for Psychosocial Support. (2015). Caring for Volunteers: Training Manual. Copenhagen: IFRC Reference Centre for Psychosocial Support.

19 Maldivian Red Crescent. (2020). Volunteers Survey Report. Male'.

Support strategies

From the beginning of the response activities in Dharubaaruge, self-care and wellbeing of volunteer call agents were emphasized and promoted. Taking regular breaks and managing personal stress was encouraged, and regular check ins were done with volunteers by lead volunteers. Relaxation and breathing activities were done during debriefing sessions. While efforts were made to recruit technical volunteers to supervise call agents, no formal and regular supervision meetings were conducted with volunteers at the beginning of response activities. After volunteers started working remotely following the lockdown in April 2020, in addition to regular briefing and debriefing meetings after each duty shift at call centre, weekly self-care sessions were also conducted until July 2020. The aim of these sessions was to provide volunteers with a platform to socialize and to provide and receive emotional support from peers. Sessions were facilitated by a pair of volunteers each week, and included games, meditation and relaxation activities etc. By July 2020, the number of volunteers who were taking part in these meetings were low and informal feedback gathered indicated that there was little time to attend self-care sessions as most had resumed previous routines. Call centre meetings facilitated by lead volunteers (and staff after their recruitment) with volunteer call agents were organized to discuss operational and administrative challenges and issues. There were 10 call centre meetings, documented with meeting minutes, held between June 2020 and November 2020 as seen in Figure 10 below. These meetings were ended as number of active volunteers decreased.

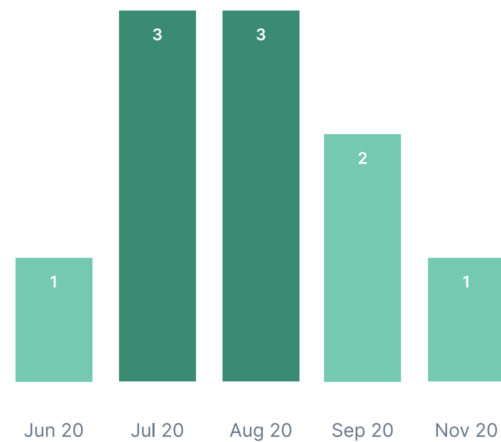
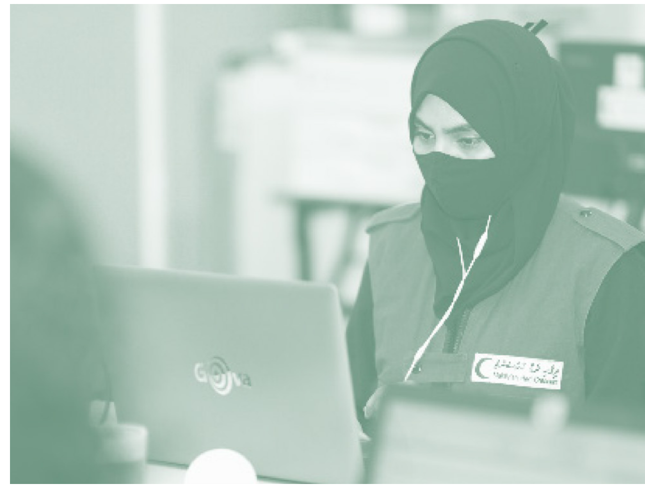


Figure 11. Number of call center volunteers meetings

On 5th December 2020, a remote get together, supported by UNICEF, was organized and held to celebrate volunteer's day. A small was delivered to each volunteer's home and meeting was conducted via Zoom with games and activities.



Procedures related to volunteers' wellbeing were also documented in standard procedures of call centre for example setting limits for consecutive hours of volunteer work, requirements to take part in regular briefings and debriefing meetings, doing supervised work etc. As the number of callers reporting suicidal behaviours, self-harm and in more distress increased, staff and volunteers also reported feeling distressed by the nature of these calls and indicated a need for supervision. Due to limited availability of regular clinical supervision in the community, peer supervision mechanisms were set up within the call centre. From November 2020, peer supervision meetings were held among part time call centre coordinators. Based of feedback from staff regarding the effectiveness of these meetings, standard of procedures was established to assure the quality of supervision meetings. A total of 15 meetings were conducted by the end of December 2021, with 6 part time call centre coordinators. Since there were very few volunteers engaged from July 2020 to December 2021, and none engaged regularly in psychosocial support provision, they were provided with the option to seek individual supervision from one of the supervisors on a need basis.

IEC Materials for volunteer wellbeing

Printed materials with information on volunteer wellbeing, such as brochures, were also developed and made readily available to help ensure that volunteers were provided the support they need.

Challenges and lessons learned

After discussions and interviews with key volunteers, challenges faced during the response work are summarized below.

Lack of detailed MHPSS preparedness plans for response

While preparedness activities were initiated for the overall Covid-19 pandemic response within MRC, more preparedness is required in the area of MHPSS to effectively respond to emergencies and specially large-scale disasters and emergency situations. Response preparedness activities could have included formulation of a detailed action plan with clear objectives and direction, PFA trainings for volunteers and stakeholders e.g., those in contact tracing and sample collection, and planning and setting up a call centre, and planning information management procedures beforehand.

Lack of technological infrastructure to manage a large-scale response.

Limited equipment (e.g., laptops and tablets) and software created challenges in managing data more efficiently and running the operation smoothly. After response activities were made remote and call agents worked from their homes, many volunteers noted difficulties in internet connectivity due to which calls were dropped or interrupted. This was cited as a major challenge across the duration of the response.

Lack of information management tools

Lack of existing electronic tools and systems to manage large volumes of data securely proved to be a significant challenge for volunteers during re¬sponse work. Data was initially managed manually which was inefficient and time consuming. Deci¬sions regarding what information is to be collected was also made impromptu with evolving response activities so procedures were also evolving rapid¬ly, particularly at the beginning of the response, which was challenging for volunteers to adapt to.

Lack of volunteer management infrastructure and systems

There was no proper system established within the organization to manage volunteers (includ¬ing volunteer profiles, training history, volunteer hours, other relevant information). Volunteers were required to have their hours logged in manually to the sign in sheet which was time consuming and difficult for volunteers. These sign-in sheets then had to be entered to a Google Sheet man¬ually as hard copies were difficult to manage. Many volunteers were unable to complete sign in sheets which led some volunteers to feel a lack of appreciation and value. There was also no effi¬cient internal mechanism to cross check trainings completed by volunteers before assigning roles for volunteers.

Poor coordination between different stake¬holders within the broader NEOC operations

Poor communication of roles and responsibilities and work done among stakeholders working in the NEOC operation led to duplication of activities and inefficient use of resources. For example, other clusters within the NEOC/HEOC were also con¬ducting similar activities as check in and wellbeing calls to those in quarantine and isolation. Many people expressed frustration due to receiving many calls from whom they perceive to be the same organization. It was also challenging for call agents to provide accurate information to callers and outreached people regarding services and updates from the NEOC due to this lack of com¬munication.

Poor communication within the MRC team MHPSS team and role confusion among volunteers

MRC MHPSS team faced challenges due to internal communication among team mem¬bers which led to poor communication towards MHPSS volunteers on their roles and responsibilities resulting in repetition and delay in work assigned. Collaborative decision making and commu¬nication of decisions to and among volunteer are areas which can be improved and would have allowed for a more effective and efficient response.

Limited volunteers, high workload, and lack of appreciation for volunteers

Due to the limited number of PSS trained volunteers, challenges faced in finding trained volunteers to provide necessary services. This led to some volunteers experiencing increased workload, with long hours under high pressure situations resulting in extreme stress and exhaustion. Some volunteers also took up multiple roles which also added to their stress. The response was an emergency of a scale never experienced before, which highlighted key gaps within MRC and the need to be better prepared for an emergency of such a scale to ensure timely service provision and ensure volunteer wellbeing during such a response.

While attempts were made to host volunteer appreciation activities and events once the Covid-19 restrictions were eased, volunteers reported feeling demotivated and underappreciated for their continuous tiring work in the MHPSS operation. They noted the lack of appreciation events and acknowledgement of their work during the response. Some also noted feeling a lack of closure since the response activities end¬ed without it being marked or recognized.

Covid-19 related stigma and discrimination

Volunteers faced Covid-19 related stigma and dis¬crimination while volunteering at MHPSS operation which created a hostile working environment for volunteers likely to have had detrimental impact on their mental health and wellbeing.

Racial prejudices and discrimination

Stigmatizing attitudes and discriminatory be¬haviors were displayed during the operation towards migrant workers during the operation which is a risk to their mental health and wellbeing.

Lack of screening for volunteers

Due to the scale of response and immediate need for volunteers to support interventions, challenges faced in the recruitment of trained volunteers with relevant background, interest, and commitment for the MHPSS Operation. A better screening process would have allowed the recruitment of volunteers who could better support the interventions improving the MHPSS operations of the response as only very few who completed the PFA training volunteered for the operation.

Conducting trainings remotely

Remote trainings were challenging as participant engagement was low and internet connection was unstable. Some trainers failed to prepare for the training, and were not thorough with content, activities and materials used in the training. Train¬ers also reported difficulties in ensuring quality of the training conducted remotely. Challenges were faced while preparing, organizing and conduct¬ing training due to poor communication among co-trainers.

Recommendations

Short Term

Debriefing and lesson learnt workshop

A proper debriefing and lesson learnt workshop after response is an essential element of response activities that contributes towards overall preparedness work. This would provide opportunity for volunteers to identify what the organization did well and challenges they faced during their time of volunteering and can help mark the end of response and provide a sense of closure as well.

Continuing to build capacity of existing staff and trained volunteers

While the organization has very few staff and trained volunteers working in the area of psychosocial support programs, seeking opportunity to continuously develop capacities of existing staff and trained volunteers on MHPSS in emergencies can aid in strengthening the service. MRC should consider integrating MHPSS in other areas of work and services such as disaster management, migrant support, first aid, patient transport and youth engagement.

Continuing to build capacity of call agents

Identifying areas of need and conducting training and sessions to build capacity of volunteers and staff working in call center is recommended. Conducting practice call sessions for call coordinators and regular volunteers to practice PFA skills especially in complex situations. Additionally, continuing currently developed capacity building sessions regularly as refreshers for volunteers and staff working in the call center may be helpful.

Increase advocacy and community awareness on mental health

It is indicated that social media campaigns slightly contributed to an increased number of people reaching the 1425 helpline. Increasing advocacy and community awareness messages on mental health can help reduce stigma and discrimination in the society and promote help-seeking behaviors, particularly among people in remote islands who may have limited access to MHPSS services. Exploring alternative ways to reach these communities (e.g., door to door campaigns) may be helpful to ensure that people are aware of the helpline. MRC can also benefit from training staff and volunteers on advocacy and communication skills to strengthen this area of work.

Strengthening monitoring and evaluation of MHPSS trainings

Periodical review of MHPSS training SoP, trainer pathway and training resources including training reports can help maintain the quality of the training offered by MRC. This also includes meeting trainers to gain in-depth understanding of challenges and changes required to strengthen the training.

Addressing stigma and discrimination faced by marginalized groups and volunteers in the community

strengthen existing policies related to volunteering and health and wellbeing to further emphasize the need for advocacy and awareness to mitigate stigma and discrimination faced by vulnerable groups (e.g., migrant volunteers).

Long Term

Develop and formalize guidelines on MHPSS activities within MRC during emergencies

This includes detailed outline of units and its functions during the emergency, any other supporting documents such as policies and procedures, linking MHPSS with other response work within organization and collaboration with relevant stakeholders. Guidelines should emphasize that MHPSS is a cross-cutting area that is relevant to other areas of work (e.g., health, education, nutrition, livelihood) in all crisis and emergency settings and that no one agency or cluster can be responsible for MHPSS work. It is recommended that MHPSS interventions are integrated to existing mechanisms or services (e.g., primary care, in schools, social services, contact tracing teams and rapid response teams as front liners) instead of delivering it as a stand-alone program to improve accessibility, mitigate stigma and barriers to access and to avoid duplication of work.

Develop an Information Management System and strengthen ICT tools within the organization to manage information

These tools can be used within the organization to manage information related to service provision, training and volunteer work. Having an information management system can further improve operational efficiency and provide better service in a timely manner. Existing systems (e.g., Bensys?) should also be better integrated across all activities and programs.

Strengthen support mechanisms for volunteers

Strengthen support mechanisms for volunteers' health and mental wellbeing after evaluating common risks faced by volunteers. This can include regular support meetings, facilitating contact with mental health professionals when needed, and establishing grievance mechanisms. Caring for Volunteer training with key management staff and lead volunteers and members of MRC can enable the process of developing a detailed action plan that is relevant to the organization.

References

1 Ministry of Economic Development & United Nations Development Fund. (2020). RAPID LIVELIHOOD ASSESSMENT - IMPACT OF THE COVID-19 CRISIS IN THE MALDIVES. Ministry of Economic Development, Government of Maldives and United Nations Development Programme. Retrieved from https://www.undp.org/sites/g/files/zskgke326/files/publications/UNDP-MV-Rapid-Livelihood-Assessmentt-Impact-of-COVID-19-Crisis-in-the-Maldives-2020-Summary.pdf

2 Worldometers. (2022, April). COVID-19 CORONAVIRUS PANDEMIC. Retrieved from Worldometers website: https://www.worldometers.info/coronavirus/#countries

3 WHO. (2022, March). Wake-up call to all countries to step up mental health services and support. Retrieved from WHO website: https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

4 WHO. (2022). Mental Health and COVID-19. (2020). Retrieved from WHO website: https://www.euro.who.int/en/health-topics/non-communicable-diseases/mental-health/data-and-resources/mental-health-and-covid-19

5 Maldivian Red Crescent. (2020). Annual Report 2020. Male': Maldivian Red Crescent. Retrieved from https://www2.redcrescent.org.mv/storage/2021/05/MRC-Annual-Report-2020.pdf

6 Maldivian Red Crescent. (2020). Staff Wellbeing at HEOC - Survey Report. Male'.

7 National Suicide Prevention Lifeline. (2019). Crisis Call Centre Metrics - Part 1: Service Efficiency

8 Musthafa, H. S., Riyaz, A., Moosa, S., Raheem, R. A., & Naeem, A. Z. (2020). Determinants of socioeconomic experiences during COVID-19 pandemic in the Maldives. The Maldives National Journal of Research, 8(2), 76-88.

9 Echterling, G. L., & Hartsough, M. D. (1989). hases of helping in successful crisis telephone calls. Journal of Community Psychology, 17(3), 249–257. Retrieved from https://doi.org/10.1002/1520-6629(198907)17:3<249::AID-JCOP2290170307>3.0.CO;2-M

10 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 1 - An Introduction to PFA. Copenhagen: IFRC Reference Centre for Psychosocial Support.

11 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 2 – Basic PFA. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-module-2-Basic.pdf

12 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 3 - PFA for Children. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-3-Children.pdf

13 IFRC Reference Centre for Psychosocial Support. (2018). Psychological First Aid: Module 4 - PFA in Groups – Support to teams. IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2019/05/PFA-Module-4-Group.pdf

14 IFRC Reference Centre for Psychosocial Support. (2021). Suicide Prevention. Copenhagen: IFRC Reference Centre for Psychosocial Support. Retrieved from https://pscentre.org/wp-content/uploads/2021/09/suicide_prevention_sept_21.pdf

15 IFRC Reference Centre for Psychosocial Support. (2015). Sexual and gender-based violence – A two-day psychosocial training. Training guide. Copenhagen: IFRC Reference Centre for Psychosocial Support.

16 IFRC Reference Centre for Psychosocial Support. (2015). Caring for Volunteers: Training Manual. Copenhagen: IFRC Reference Centre for Psychosocial Support.

17 IFRC Reference Centre for Psychosocial Support. (2020). Loss and grief during COVID-19. Copenhagen: IFRC Reference Centre for Psychosocial Support.

18 IFRC Reference Centre for Psychosocial Support. (2012). Lay Counselling - A Trainers Manual. Copenhagen: IFRC Reference Centre for Psychosocial Support.

19 Maldivian Red Crescent. (2020). Volunteers Survey Report. Male'.

Annex 1

Trainings conducted for MRC staff and volunteers from March 2020 – December 2021

Table 7 – PFA Training of Trainers

Organization	No. of training	Certified	Males	Females
Maldives Red Crescent	1	19	1	18
Maldives Red Crescent	1	4	2	2
Maldives Red Crescent	1	11	2	9
Total 2020	**3**	**34**	**5**	**29**
Maldives Red Crescent	1	3	0	3
Total 2020	**1**	**3**	**0**	**3**
Total (2020 & 2021)	**4**	**37**	**5**	**32**

Table 8 – Basic PFA Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
MRC – Male' Branch	1	21	21	11	5	16
MRC – Male' Branch	1	11	11	9	1	10
MRC – Male' Branch	1	11	11	10	1	10
MRC – Male' Branch	1	13	13	9	3	10
MRC – Male' Branch	1	23	23	21	7	16
MRC – Male' Branch	1	20	9	9	8	1
MRC – Lh. Branch	1	20	10	10	1	9
MRC – Migrant	1	17	12	12	5	7
MRC – PSS Call Centre	1	20	12	12	3	9
MRC – Ga. Branch	1	20	8	5	0	8
MRC – Seenu Branch	1	22	9	8	4	5
MRC – Hadhal Branch	1	18	13	10	5	8
MRC – Male' Branch	2	13	13	13	4	9
Total 2020	**14**	**229**	**165**	**139**	**47**	**118**
MRC	1	21	12	12	3	9
MRC	1	4	4	4	0	4
MRC	1	22	20	20	4	16
Total 2021	**3**	**47**	**36**	**36**	**7**	**29**
Total (2020 & 2021)	**17**	**276**	**201**	**175**	**54**	**147**

Table 9 – PFA in Groups Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
MRC	1	20	17	17	6	11
Total 2020	**1**	**20**	**17**	**17**	**6**	**11**
MRC	1	21	12	12	3	9
Total 2021	**1**	**21**	**12**	**12**	**3**	**9**
Total (2020 & 2021)	**2**	**41**	**29**	**29**	**9**	**20**

Table 10 – Introduction to PFA Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
MRC - Male' Branch	2	40	29	29	10	19
Total 2021	**2**	**40**	**29**	**29**	**10**	**19**

Table 11 – Caring for Volunteers Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
MRC	1	20	19	19	4	15
Total 2021	**1**	**20**	**19**	**19**	**4**	**15**

Table 12 – Supportive Communication Sessions

Organization	No. of training	Invited	Attended	Certified	Male	Female
MRC – Male' Branch	1	20	18	18	4	8
MRC – Male' Branch	1	20	11	11	1	10
MRC – Male' Branch	1	20	11	11	1	10
MRC – Male' Branch	1	20	8	8	5	3
MRC – Male' Branch	1	21	21	21	5	16
MRC – Male' Branch	1	18	9	9	8	1
MRC – Migrant	1	12	10	10	6	4
MRC – PSS Call Centre	1	20	12	12	3	9
MRC – Male' Branch	1	20	11	11	2	9
Total 2020	**9**	**171**	**111**	**111**	**35**	**70**
MRC	1	22	20	20	4	16
Total 2021	**1**	**22**	**20**	**20**	**4**	**16**
Total (2020 & 2021)	**10**	**193**	**131**	**131**	**39**	**86**

Table 13 – Capacity Building Sessions

Organization	Session	No. of ses-sions	Participants	Male	Female
MRC - PSS Call Centre	Suicide prevention	2	18	0	18
MRC - PSS Call Centre	Loss & Grief	2	22	1	21
MRC - PSS Call Centre	SGBV	2	19	1	18
MRC Staff	Mental health in workplace	1	20	1	19
MRC Volunteers	Refresher session	3	26	4	22
Total 2020	-	**10**	**105**	**7**	**98**
MRC - PSS Volunteers	Refresher session	1	10	0	10
MRC - PSS Volunteers	How to help people who are suicidal	1	8	0	8
MRC - PSS Call Centre	SGBV	1	6	0	6
MRC - PSS Call Centre	Case Discussion	1	6	0	6
MRC - PSS Call Centre	Case Discussion	1	5	0	5
MRC - PSS Call Centre	Case Discussion	1	5	0	5
MRC - PSS Call Centre	Case Discussion	1	5	0	5
Total 2021	-	**7**	**45**	**0**	**45**
Total (2020 & 2021)	-	**17**	**150**	**7**	**143**

Annex 2

Trainings conducted for Stakeholders from March 2020 – December 2021

Table 14 - Basic PFA Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
Blue Hearts	1	9	9	9	0	9
HPA (Rapid Response Team)	6	120	73	49	8	65
Hulhumale' Hospital	1	20	18	18	4	14
MoGFSS	1	20	11	9	2	9
Villimale	1	20	5	4	4	1
Care Society	1	10	10	10	0	10
Total 2020	**11**	**199**	**126**	**99**	**18**	**108**
HPA	1	22	10	8	2	8
HPA	1	8	8	5	4	4
Maldives Blood Services	1	11	11	11	2	9
HPA	1	11	11	6	5	6
HPA	1	8	8	7	1	6
MoGFSS	1	18	18	17	5	13
OTJ	1	13	12	7	2	5
Total 2021	**7**	**91**	**78**	**61**	**21**	**51**
Total (2020 & 2021)	**18**	**290**	**204**	**160**	**39**	**159**

Table 15 – PFA for Children Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
MoE	12	260	233	214	35	179
Total 2020	**12**	**260**	**233**	**214**	**35**	**179**
Kinder Pre-School	1	17	17	11	0	17
Total 2021	**1**	**17**	**17**	**11**	**0**	**17**
Total (2020 & 2021)	**13**	**277**	**250**	**225**	**35**	**196**

Table 16 – Introduction to PFA Training

Organization	No. of training	Invited	Attended	Certified	Male	Female
Villa College	1	22	22	22	5	17
Villa College	1	23	23	23	5	18
MNU (Laamu Campus)	1	14	14	14	6	8
B. Thulhaadhoo (Task-Foce)	1	21	21	21	0	21
HRCM	1	18	0	0	0	0
Total 2021	**5**	**98**	**80**	**80**	**16**	**64**

Table 17 – Supportive Communication Sessions

Organization	No. of sessions	Invited	Attended	Male	Female
HPA	1	20	7	2	5
MoGFSS	1	20	11	2	9
Island Aviation Services	1	20	14	9	5
Total 2020	**3**	**60**	**32**	**13**	**19**
MNU (Laamu Campus)	1	14	14	6	8
B. Thulhaadhoo (Task-Foce)	1	21	21	0	21
OTJ	1	21	20	9	11
Total 2021	**3**	**56**	**55**	**15**	**40**
Total (2020 & 2021)	**6**	**116**	**87**	**28**	**59**

Table 18 – PFA Orientation Sessions

Organization	No. of sessions	Invited	Attended
HPA	2	76	22
MoE	88	9715	6332
Island Aviation Service	1	100	72
Total 2020	**91**	**9891**	**6426**
MNU (Laamu Campus)	1	13	13
Total 2021	**1**	**13**	**13**
Total (2020 & 2021)	**92**	**9904**	**6439**

Table 19 – Mental Health at Workplace Session

Organization	No. of trainings	Invited	Attended	Certified	Male	Female
OTJ	1	29	29	29	10	19
Total 2021	**1**	**29**	**29**	**29**	**10**	**19**