Rebuild. Recover. Thrive.
PETER C. ALDERMAN FOUNDATION

PCAF Dining for Women Interim Progress Report: December, 2016

1. Organization Name: Peter C. Alderman Foundation (PCAF)
Program Title: Community-based Maternal Mental Health Care
Grant Amount: $49,665
Contact Person: Allan Freedman
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2. Recap briefly what outcomes the program was designed to achieve.

The maternal mental health program will result in fewer mothers suffering from perinatal depression as a result of psychoeducation. These women will show improved wellbeing and functioning as mothers and individuals, ensuring that they will take better care of themselves, their new babies and their families and participate in work to support their families and communities. New babies will be born healthier, and will receive better nutrition, parenting, health monitoring and will have a greater likelihood of thriving. Communities will become sensitized to perinatal depression and anxiety, which will result in earlier identification, more referrals and decreased stigmatization. The Ugandan perinatal healthcare system will begin to incorporate screening and identification of perinatal depression and anxiety into their routine care, eventually resulting in a greater awareness of the problem and reduction of its occurrence.

3. Has funding changed for this program?

Fondation d'Harcourt awarded PCAF $90,000 in funding for the maternal mental health program for 2017.

4. Is your organization or program situation different than presented in the approved proposal?

In October of 2015, Allan Freedman joined PCAF as its new Executive Director. In 2016, the Board of Directors approved the adoption of a new mission statement and strategic direction. The new mission builds on the agency's focus on survivors of conflict and crisis and keeps to the founder's vision of mental health healing for those who experienced traumatic events. PCAF will continue to serve the same population, developing specific solutions that are practical, cost-effective and based on the strongest possible evidence.

5. What challenges are you facing as you move forward with this project? How are you approaching these challenges?

One major challenge we have faced with this project has been working with primary health care workers (nurses and midwives) who are overworked. We had anticipated relying on nurses and midwives to provide most intervention components; however, our initial meetings with these members indicated that they do not have time to adequately fulfill their roles due to the already overwhelming demands of working at busy and inadequately resourced rural health centers. Thus, we had to improvise and task-shift many of these responsibilities to trained community health care workers. Nurses and midwives still conduct the initial two-question screener at the antenatal care visit, which ensures the intervention is integrated into the maternal and child health care system. They then refer the women to a community health care worker who does a more in

depth screening and carries out psychoeducation, if necessary. Community health care workers have the flexibility and motivation to focus solely on our project and are able to give women all of their attention. They have also received extensive classroom and on-the-job training allowing them to become experts in the intervention. We will continue to assess the feasibility, sustainability and effectiveness of this model of care, but at this point the results are promising.

6. Have you revised your original objectives since the project began? If so, why? What are your new objectives?

The original objectives have not changed since the project began.

7. What progress have you made toward achieving your objectives? Please address each stated objective.

The states objectives are listed below, along with the progress toward achieving them:

1. Develop an evidence-based, manualized stepped-care model that will bring psychosocial and mental health care from PCAF's hospital based clinics into the community.
    a. This objective has been achieved. The stepped-care model is based both on community priorities and international guidelines. In a formative research phase conducted in 2015, the community identified perinatal depression as the most important mental health problem for women who are pregnant or have just given birth. Based on this feedback, we consulted international guidelines, including the World Health Organization's mhGAP guidelines and the National Institute for Health Care Excellence (NICE) guidelines. These guidelines recommended developing a stepped-care model for depression that integrates services into the existing antenatal care system. Thus, we developed a model with the following steps: 1) every woman who attends antenatal care at the village/sub-county level is screened using a primary, two-question screener (the Patient Health Questionnaire-2); 2) Women who screen positively on this 2 question instrument are referred to community health care workers to conduct a more in depth, 9 question screener (the Patient Health Questionnaire-9); 3) Women who screen positively using the Patient Health Questionnaire-9 receive psychoeducation that informs them about depression and gives them recommendations of things they can do to help themselves at home; 4) women come back for a follow up one-month after psychoeducation and are re-assessed using the patient health questionnaire-9. If this screening instrument indicates that they are still depressed, they are referred to PCAF staff for intermediate psychosocial therapy (Group Interpersonal Therapy) and; 5) women are again assessed after Group Interpersonal Therapy. If they are still depressed, they are referred for specialized management by a PCAF Psychiatric Clinical Officer, who may consider medication. We are currently working to manualize this stepped-care model.
2. Train community health care workers, nurses and midwives at the lower level health centers in providing psychoeducation and how to screen and refer for signs of maternal depression and other forms of mental health problems.
    a. This objective has been achieved. So far, 36 community health care workers and 30 primary health care workers have been trained in the intervention.
3. Trained intervention staff will provide workshops in basic self-care and psychoeducation.

   a. Community health care workers provide psychoeducation to all patients who have screened positively for depression. From July 2016 to the time of this report, a total of 728 women have received psychoeducation.
4. Primary or community health care workers will refer women with initial high levels of symptoms and those not improved following psychoeducation to PCAF specialized professional staff for group therapy, individual counseling and psychiatric intervention.
   a. This objective is currently being met. Any patients who either had severe depression symptoms or suicidality at the start of the intervention were referred directly to PCAF staff. Also, if patients do not improve after psychoeducation they are referred to PCAF staff for group interpersonal therapy (IPT-G). Currently, one IPT-G group has been completed and four are ongoing. Each group has between 8 and 12 members. Additionally, patients who do not recover from IPT-G are referred to the PCAF Psychiatric Clinical Officer (PCO). At this point, only 4 patients have required referral to a PCO. Prior to initiating IPT-G, 31 patients received individual counseling by a PCAF staff member.

8. Do you anticipate any difficulties in completing your project in the timeframe outlined in your proposal?

Though the project was slightly delayed in order to allow enough time for the formative research phase and developing intervention materials, we expect that we will be able to complete the project in the timeframe outlined in our proposal.

Financial Report

Budget Category	January 1- November 30, 2016 Expenditures	
Project Personnel	$	10,248
Training/Travel/Accomodation/ Per diem	$	5,668
Local Travel	$	4,557
Equipment (hardware/software)	$	76
Office Supplies	$	220
Telecommunications	$	1,476
Other Program-related costs	$	529
Indirect	$	1,084
Total	**$**	**23,859**

Due to the timing of this report, December 2016 expenditures are not included.