



PCAF Dining for Women Final Report: February 2018

1. Organization Name: Peter C. Alderman Foundation (PCAF)
Program Title: Community-based Maternal Mental Health Care
Grant Amount: \$49,665
Contact Person: Allan Freedman
Address: 261 Madison Ave, 9th Floor, New York, NY 10016

2. Recap briefly what outcomes the program was designed to achieve.

The Maternal Mental Health (MMH) 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. What was accomplished in connection with this project? Please address each stated objective.

The stated objectives are listed below, along with achievements:

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.* 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, PCAF consulted international guidelines, including the World Health Organization's mhGAP 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, PCAF 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. A program manual was completed and it established the Standard



Operating Procedures (SOP) that have facilitated the program planning for adaptation and expansion in other locations including refugee settlements and in Burundi where PCAF has established a partnership with Village Health Works.

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 total of 20 primary health care workers and 42 community health care workers were trained to screen, provide psychoeducation, monitor symptom progression and identify and refer patients with suicidal ideation and severe depression to PCAF clinicians.
3. *Trained intervention staff will provide workshops in basic self-care and psychoeducation.* PCAF has provided workshops for all health center staff and provided continuous mentorship through apprenticeship and role plays.
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.* The referral system has been strengthened ensuring that all suicidal and severely depressed cases are seen by PCAF clinicians.

4. What challenges did you face in connection with this project? How did you address these challenges?

The major challenges were non-adherence to appointments and loss to follow up resulting from lack of husband support and lack of transport to the health center. To address the first barrier, psychoeducation was modified to include a couple's psychoeducation module to promote the husband's understanding and role in supporting the patient. Health talk posters were developed to guide the health care workers to give targeted talks in the outpatient department during designated antenatal care visit days. These innovations improved both adherence and symptom regression among mothers. To improve follow-up rates, community health workers were given bicycles to conduct home visits for mothers with depressive symptoms who did not return to the health center for reassessment.

5. 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.

6. What were the most important lessons learned?

One of the most important lessons learned was the need to include the women's husbands in the program. Staff had identified that many women were not returning for follow-up appointments. As



a result, they were able to investigate some of the reasons during focus groups and learned that one of the barriers to follow-up was that husbands weren't allowing their wives to return because they did not understand what the program entailed. Since this finding, the program developed a health education and psychoeducation component for couples with the goal to engage the husbands so they can learn more about the program.

7. What has changed within your organization as a result of this project?

The MMH Program served as a model project for how PCAF develops community-based interventions and integrates them sustainably into the primary health care system task shifting the majority of care to trained and supervised community health workers. During the second half of 2017, PCAF developed its IMPACTS intervention, a strategy aimed at securing long-term recovery and fostering sustained community resilience. Research shows that the mental health consequences of violence and the social impacts of war – poverty and family violence -- are mutually reinforcing risks. PCAF has developed and will deploy IMPaCTS in this context, as an innovative multi-sectoral approach that addresses both mental health and its social determinants.

The MMH Program was used to pilot a tablet-based digital data collection and reporting system using the mobile software, CommCare, which will be expanded to use with the IMPaCTS intervention.

8. Describe the unexpected events and outcomes, including unexpected benefits.

Participation in the MMH project helped secure one women's safe delivery of her baby. She had gone into labor while attending an interpersonal group session and since she was already at the health center for the group, she did not have to walk the long distance from her house, which could have put her and her baby in grave danger as she required urgent care.

9. Did you change your strategy as a result of obstacles you encountered? How will you address these challenges in the future?

At the start of the program, PCAF anticipated relying on nurses and midwives to provide most intervention components; however, 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, PCAF 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.

10. Approximately how many lives have been touched both directly and indirectly by the program?



Since the program began implementation in July 2016, over 6,000 women have directly benefited from depression screening at prenatal visits and more than 1,500 mothers have received psychoeducation. More than 1,500 children have indirectly benefited from their mothers' participation in the program, resulting reduction in depression symptoms and improved functioning.

11. What are the measurements used to monitor success and how was this information measured? Be specific and include measurable results.

Staff collect and monitor process indicators throughout the project duration using the mobile software CommCare, which allows for real-time data analysis. The key output indicators include: number of women screened; number of women who received psychoeducation; number of women who received IPT-G; and number of women referred for specialized management. Women's symptoms and functioning levels are also tracked at every level of the stepped care model.

In 2017, the Maternal Mental Health Program screened 4,153 women for depression and yield rates in some communities were as high as 30%. Community health workers delivered psychoeducation to 1,058 patients. After receiving psychoeducation alone, results show that 80% of women report reduced depression symptoms at 1-month follow-up visits. Two hundred women completed interpersonal group therapy and 460 were referred to PCAF clinicians. Upon completion of group therapy, 90% of women had a clinical reduction in their depression symptoms.

12. If the program is ongoing, provide plans and expected results, including projected timeframe.

PCAF is planning to expand the MMH project to new districts in Northern Uganda by scaling up to the Lamwo district in 2018 and another district in 2019. The expansion to these additional districts will be based on a needs assessment; PCAF is exploring Dokolo or Lira as an additional district in 2019. PCAF will conduct a needs assessment in Dokolo or Lira to inform scale up of the program in one of these districts. Both Lira and Dokolo were largely affected by the Lord's Resistance Army (LRA) violence yet there are no mental health and psychosocial support services provided in these areas. Through increased coverage in these areas, the MMH program will expand its reach to the LRA-affected population, but also strategically target the new population of South Sudanese refugees in Lamwo district, the site of a new refugee settlement. This scale-up presents an opportunity to evaluate the implementation of the MMH program in an ongoing humanitarian crisis.

PCAF will also develop systematized strategies for handing over MMH to the government and prepare to exit Kitgum during the first quarter of 2018. The MMH program in Soroti will be fully transitioned to the government by the end of next year.

13. Provide a detailed list of expenses incurred during the grant cycle which have been paid for with the Dining for Women grant.



Budget Category	January 1, 2016 - December 31, 2017 Expenditures
Project Personnel	11,138.51
Training	4,392.50
Local Travel	4,975.79
Equipment (hardware/software)	41.48
Office Supplies	4,712.60
Telecommunications	5,955.15
Other Program-related costs	14,993.27
Indirect	3,456.00
Total	49,665.50

14. Did this grant and relationship with DFW assist your organization in obtaining other funding, partnerships with other organizations, or public recognition in some capacity?

Initial and critical support from the Dining for Women grant assisted PCAF to develop, pilot and refine the MMH project. Once established, the project was able to gain attention from other funders. With funding from Fondation d'Harcourt, the project will expand into more districts and also begin to track longer-term indicators at three, six, nine and one year to assess improvement. The nine-month follow-up will focus on child outcome indicators including breastfeeding, immunizations, child growth, and presence of diarrheal disease and fevers.