Zero to Five Challenge Refinement Q&As for "Born to Bond"

Responses to Questions from the Amplify Team

Question: Thank you for addressing the issues of maternal mental health in difficult contexts and linking this actively to children and their broader development as well as the overall happiness of the mother and her family. The focus on parents and play are welcomed and, if this works, it could potentially be translated to many different settings. You also do a great job of identifying clear next steps. Areas that you could explore in more detail are how to make sure the package is cross-sectoral to include nutrition, hand washing and breastfeeding etc., as well as psychosocial support. To think about who else can deliver it in addition to health workers, how you'd bring the service to people who might not easily access healthcare and who else the service applies to, such as fathers. You could anchor your plans more explicitly around insights from people and their social networks. Open and maintain the conversation with end users to learn and adapt.

Answer: We agree that this material could be translated and adapted to many different settings. It is for this reason that we wish to firmly establish the approach as an evidence-based one so that future scale up has greater potential. I'd like comment that the standard Timed and Targeted Counselling (ttC) program, which currently exists and was researched with successful impacts in West Bank (under the project titled "Towards Nourished Infants") already includes aspects of nutrition (initially support for exclusive breastfeeding and later, gradual introduction of nutritious solid foods), hygiene, vaccinations and other key messages related to the physical health of the mother and infant. These elements will remain, but the additional 'enhanced' elements will include the psychosocial support for maternal mental health and infant play and stimulation. The project intends for Enhanced ttC (EttC) to indeed be a multi-sectoral approach.

The original intent and research initiative will target Community Health Workers (CHWs) as the delivery agents of the program. However, this is intended to be indicative of any lay persons being able to receive training and provide these services in other settings. In essence, the research needs first and foremost to establish the evidence base for delivery by lay personnel. Ideally, the home-visitor model is critical to the people available to provide the EttC program to women and their families as this will help to alleviate healthcare support, notably mental health care support, which is in short supply in many settings.

Inclusion of fathers and other extended family members was a need that emerged strongly in our refinement research and key informant interviews. Currently, this aspect of the program requires greater attention; but we believe the project design process, particularly the development of the EttC materials will provide opportunity to ensure we address this need. Similarly, this process will also allow us to explore options for 'anchoring' social support plans for mothers and their infants, potentially using social media which was another finding key informant interviews suggested. Indeed, having local mothers and CHWs part of the design process, including development to the materials will help ensure local insights are maintained.

Question: Congratulations on making it to the Zero to Five Challenge Refinement list, Andrew! We are intrigued by the fact that your idea integrates mother mental health and play for children and are interested in learning more. Particularly, we are interested to know what engagement with women and families would look like as part of this program. For example, would the support be delivered one-on-one? In groups? It would be helpful if you filled out a User Experience Map to

help us understand how this intervention could play out http://ideo.pn/0to5-map. We see that you have outlined a pilot as a way to test your idea, but wonder whether there are less intensive ways to initially test some of the assumptions behind it. For example, would women identified as having mental health issues readily present themselves for such an intervention? What role do you anticipate stigma around mental health issues playing? Another thing we'd like to understand better is the scope of this project. Are you affiliated with World Vision Australia? Are you seeking support for all or part of this project? How long do you anticipate this project running for? If it was successful, what would happen next? Is there another organization that would take it on? Check out tips for Refinement http://ideo.pn/0to5-tips-refine.

Answer: We are so excited to be shortlisted! Thanks for your enquiry. The support would be delivered one-to-one. The Community Health Workers (CHWs) would be visiting women and their infants in their homes, which is a model the original ttC program proved to be highly beneficial and we believe, will mitigate the stimga associated with mental health care. Home visits by CHWs will not be obvious within the community as a mental health care support function, so privacy of mothers will be maintained throughout their support. The pilot study would be an essential precursor to the full research, because it will ensure we are able to reach the mothers and their infants in their homes. Inclusion to the program would be via outreach approaches using existing community networks (e.g. local health facilities) rather than trying to attract women to 'come to' receive the service and support. So the pilot will help us determine the viability of this approach and whether we will be able to access the necessary numbers for the rollout. But having said this, we're interested in whether others have suggestions about less intensive ways to test some of our assumptions and I will seek more advice on this and keep you posted!

On other questions. Yes, we are affiliated with WV Australia but part of the wider WV partnership that includes WV International technical support experts (such as me - who is based out of WV Australia) and our colleagues in WV West Bank. We would be seeking support for the whole project initially.

We anticipate the project would run for approximately 3 years in total. One year for set up and pilot, 18 months for research (because we need to follow women from third trimester of pregnancy through to infants tuning 1-year old) and the remaining 6 months for analyses and findings. If it was successful, we would be updating all of WV International's ttC approaches and packaging this EttC approach for other iNGOs and community based organisations to implement. The potential scale-up is substantial.

<u>Responses to Questions from the OpenIDEO community</u>

Question: Great idea here, especially the component addressing post-partum depression. Can you kindly give an insight into what are detail components of counseling method you hope to adopt. Research has shown that once there are established symptoms of post-partum depression, a multiphase BioPsychoSocial approach to management is recommended and counseling only might not achieve the aim of symptoms resolution. Kindly let me know your thoughts.

Answer: The *Thinking Healthy Program* is the title of the counselling and psychosocial support approach intended to be used to support mothers' mental health. This program has effectiveness evidence from research in Pakistan, but is yet to be tested in this type of integrated program. Thinking Healthy Program uses a 5-pillars approach where CHWs are trained to use strong

empathic listening skills, and support family engagement, behavioural activation and problem solving through a series of pictorial guided discovery processes. The grounding theory of the program is based on cognitive behavioural therapy approaches to maternal psychosocial wellbeing, which have a strong evidence base globally, including in low-resource settings. Should some women not improve from a purely 'talking therapy' and supportive approach, they will still have CHW assistance to be referred for biological interventions if deemed necessary. The advantage of these stepped approaches is that the least intensive and costly approaches can be tested with clients first. I strongly appreciate that the best treatment options for depression, including post-partum depression, can be a hotly debated topic across the professions, but low-resource settings command for us to ensure we take the most culturally relevant, least stigmatizing and more socially supportive approaches as a first line of treatment given the likely challenges for individuals to be able to sustain any medium to long term medication-based interventions. I hope this goes some way to addressing your concerns.

Question: Has enhanced ttC been used before as a treatment modality for PPD in women? (apologies if this is already answered above...).

Answer: *Enhanced ttC (EttC) has not yet been created (and therefore not yet tested). We have ttC and we have the other materials for supporting PPD (this being the thinking health program tested with effectiveness in Pakistan via one of our proposed partners), and we have the materials for Learning Through Play and the Nipissing District Development Screeners (NDDS). The EttC will be created to combine these evidence-based resources and approaches into one program for delivery in a holistic way. So we are proposing a research project in order to test its impact. We know the components, individually applied, are evidence-based, but we don't yet know the extent of impacts if they are all combined into one program and delivery approach.

Question: Is this a model that is specific to World Vision or is it a model that World Vision is adopting or adopting/adapting to local context?

Answer: *ttC is a World Vision model, though many organisations use similar home-visitor approaches. West Bank has already adapted this for their local context. The Thinking Healthy Program, learning Through Play and NDDS approaches are all approaches used by WV-partners (not specific to WV) that will require some cultural adaptations. So we'll join together to create EttC and test its impact. The adaptations are another justification for taking a research approach.

Question: I wonder what the differences would be for moms who received this intervention during the third trimester of pregnancy vs. moms who start it postnatally. Do you anticipate that it might be protective? that these moms may not develop PPD?

Answer: *The pre-birth interventions are more about physical health and preparing the mother for what's to come post-birth. We don't hypothesise a protective element to the program, but certainly, this could be analysed as part of the data.

Question: Do you anticipate any resistance from moms regarding enrolling in Enhanced ttC vs. ttC alone? How will the diagnosis of PPD be made and who in the family will the diagnosis be shared with? as ttC is a model which involves the extended family do you anticipate that this may be an obstacle for Enhanced ttc?

Answer: *ttC has shown wide acceptability in this culture, because it is a private home visitor approach. We therefore don't anticipate resistance to the other 'Enhanced' elements. *PPD will not be formally diagnosed by the CHWs. They will simply have an indication of women who are high on the spectrum of symptoms (or low). If they are especially high, they will be required to support a referral, which is where the full diagnoses will take place. The EPNDS would be used as a measure of maternal wellbeing than as a diagnostic tool.

Question: I am very curious about your comment that ttC had the unintended benefit to improve mother to mother in law and sister in law relationships. Do women go to live in their husband's home with his extended family after marriage? What is your sense as to why this intervention improved these relationships? Was their any effect on the relationship with the mom and her mother? or was this not examined as her mother was not involved in the program?

Answer: *ttC has proven effective BECAUSE it can be both CHW to mother directly, but we also encourage other family members to participate - we're going to describe this in our story board, currently underway... watch this space! This is why ttC has shown improved relationships, because various members of the family are receiving the same information. This is especially important in the Palestinian context where women go to live with their husband's family, who can sometimes be highly critical. Usually, the mother's mother (maternal grandmother to the child) is not directly involved in the raising of the infant - at least not to the same extent as the in-laws. In previous ttC interventions, this wasn't measured because the maternal grandmother is rarely at the household during the CHW visits.

Question: Do you have an existing network of organizations on the ground to facilitate this trial? Are you affiliated with an NGO there?

Answer: WV has a local office in West Bank, where we already have a trained and existing cohort of ttC community volunteers, all linked with the local Ministry of Health (MoH). So for the trial we would be working through them rather than a CBO, but this is beneficial because the links with the MoH have huge potential for sustainability. We also have a partnership with the local Al Quds University, where we would utilise students for the data collection and seek their input and support to the data analyses.