REPORT

MENTAL HEALTH & PSYCHOSOCIAL SUPPORT PROVIDED BY FRONTLINE HEALTH WORKERS FOR MOTHERS OF NUTRITIONALLY AT-RISK INFANTS UNDER 6 MONTHS OF AGE.

Mapping of interventions, activities, resources and tools used by frontline health workers to provide non-specialized mental health and psychosocial support to mothers enrolled in the MAMI Care Pathway.

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INTRODUCTION

Background

The youngest infants, those under six months of age (u6m), are at the greatest risk of death from malnutrition. Globally, approximately **1 in 5 infants u6m are malnourished** with 18% born low birthweight, 20% underweight, 21% wasted and 17% stunted. Despite the substantial number of malnourished infants u6m worldwide, strategies for preventing and managing infant growth failure have been largely overlooked as an area for action with malnourished infants u6m left neglected.[1] The MAMI Global Network developed the **MAMI Care Pathway** to guide the Management of small and nutritionally At-risk Infants less than 6-months and their Mothers (MAMI).

The global MAMI community has recognized that progress to date has largely focused on care of the infant, with interventions targeting "Mothers in MAMI" requiring more attention. Growing evidence shows a wide range of maternal factors influence vulnerability, risk and outcomes of infants under 6 months of age, with poor antenatal and postnatal care and maternal malnutrition associated with adverse neonatal and infant outcomes. A systematic review documenting the impacts of maternal-focused interventions on feeding and growth of infants under 6 months of age identified several maternal interventions that were effective in improving infant growth or feeding outcomes including: breastfeeding promotion, education, support and counselling interventions; maternal mental health support; and antenatal macro and micronutrient supplementation. They concluded that greater inclusion of mothers in holistic packages of care could help small and nutritionally vulnerable infants to survive and thrive.[1]

Building on Save the Children (SC)'s *MHPSS Technical Guidance: Nutrition sector-specific recommendations*[2] and with the goal to determine which activities and interventions are implemented in different contexts, SC took a deep-dive on MHPSS resources for non-specialist health/nutrition workers.

Aim

The aim was to document and explore what is currently being used by MAMI practitioners who are not MHPSS specialists to provide non-specialized MHPSS to mothers of infants under 6 months enrolled in the MAMI Care Pathway in humanitarian contexts. This information was intended for determining gaps and

[1] *ENN/UCL/ACF. (2010). Management of Acute Malnutrition in Infants (MAMI) project. Emergency Nutrition Network, UCL Centre for International Health & Development, Action Contre la Faim. Available from: http://www.ennonline.net/mamitechnicalreview*

[2] https://scintegratemhpss.com/tools/nutrition/

opportunities as well as a mapping of available, utilised tools and resources to support MAMI practitioners in their provision of MHPSS to mothers.

Research Questions

1. Within MAMI programmes, what MHPSS activities/interventions, tools and resources are currently being used by MAMI practitioners without an MHPSS qualification to support the mental health and psychosocial wellbeing of mothers of infants less than 6 months enrolled in the MAMI Care Pathway?
2. How feasible and acceptable do MAMI practitioners perceive the activities/interventions, tools and resources they are using to support maternal mental health to be?
3. What programming infrastructure and resources are required to implement/use identified maternal MHPSS activities/interventions, tools and resources within the MAMI Care Pathway?

More information on the empirical background of this review can be found in the protocol (Appendix 1).

METHODOLOGY

Data Collection

Sampling

The respondents / key informants were selected using purposive sampling through the MAMI Advisor at Save the Children, the MAMI Global Network and a post shared by the Emergency Nutrition Network (ENN), as well as other relevant contacts. Additional respondents were identified via snowball sampling. A minimum of 20 respondents was sought, with as much diversity regarding their organisation and country of implementation as possible.

Survey

One survey (see Appendix 2) was completed by one or, jointly, by several MAMI practitioner(s) per organization. It included informed consent (see below section on Data Protection & Confidentiality), demographic data and a question of whether respondents include activities/interventions in their implementation of the MAMI Care Pathway that support mothers' mental health and psychosocial wellbeing beyond/ **in addition to** providing Psychological First Aid (PFA) and basic relaxation techniques. If respondents answered "no" to this question, the survey was finished, and they were excluded from any further data analysis. If respondents answered "yes", the survey continued, with questions on the following topics:

- Description of MAMI programme elements targeting mothers, including services for mothers' mental health and psychosocial wellbeing, within the MAMI Care Pathway
- What MHPSS activities/interventions the respondent is implementing for mothers within MAMI
- Acceptability of the MHPSS activities/interventions as perceived by mothers and staff
- Tools/ resources used to implement the MHPSS activities/ interventions
- Feasibility of using the tools/ resources as perceived by staff
- Any other relevant information on MHPSS for mothers in respondents' implementation of the MAMI Care Pathway

Interviews

Where survey responses resulted in the need for follow-up questions/ discussions, respondents were selectively invited to participate in a key informant interview. The 1-hour interviews with individuals or teams from selected organizations were conducted using a semi-structured interview guide (see Appendix 3). Respondents were asked more detailed follow-up questions based on their survey replies regarding the activities, interventions, resources and tools they use to provide MHPSS to mothers. After receiving permission from all participants, interviews were recorded and written notes were taken of the information shared by respondents verbally (see below section on Data Protection & Confidentiality). In the one case where language was a barrier, a colleague assisted with interpretation between English and Spanish during the interview.

Data Protection & Confidentiality

Prior to completing the survey, SC sought informed consent from all respondents. This included the information that their responses would be stored confidentially and no names collected. By clicking "submit" at the end of the survey, respondents consented to their responses being stored and used for data analysis.

For the interviews, key informants were asked for permission before the online calls started to be recorded. All persons consented to this verbally. The recordings were then stored safely and deleted after completion of the data analysis stage. Prior to deletion, one group of respondents received a copy of their interview recording to allow a staff member who had missed the interview to watch the recording.

During data analysis, the names of respondents and their organizations were withheld from specific responses to protect their privacy in the final report. However, it is possible to reach out to respondents via the Save the Children focal point if any follow-up questions or requests arise from this report.

Data Analysis

The survey responses and written interview notes were combined for the data analysis. Based on the research questions, data categories were developed in order to group themes together and structure the data.

RESULTS

Demographics

A total of 23 respondents replied to the survey, of which some were excluded at the cut off question, resulting in a total of 16 survey responses included in the data analysis. Of the 16 respondents, 8 participated in key informant discussions/ interviews. The following 10 organizations are represented in the data set: Action Against Hunger (ACF), ADRA, Concern Worldwide, GOAL, International Rescue Committee (IRC), Medair, Save the Children, Syria Relief, USAID/MOMENTUM Integrated Health Resilience Program (MIHR), Welthungerhilfe. The staff members/ teams that participated from the above organizations are based in the following 15 countries: Bangladesh, Colombia, Ethiopia, Kenya, Mozambique, Niger, Nigeria, Pakistan, Somalia, South Sudan, Sudan, Syria, Uganda, Venezuela, Yemen. A list of all respondents' organizations and countries can be found in Appendix 4.

Research Question 1 – Activities, interventions, tools and resources currently being used by MAMI practitioners to provide MHPSS to mothers of infants under 6 months enrolled in the MAMI Care Pathway

Psychological First Aid

Psychological First Aid (PFA) was highlighted by respondents as a very common approach used in their programming. As seen in the below overview, there were three key resources used for PFA provision across organizations, and most respondents reported having trained their staff and volunteers in PFA.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings*:
Psychological First Aid	• Following look-listen-link steps • Identifying mothers in distress • Communication techniques to help mothers feel calm and supported • Linking mothers with further support/services	• Save the Children's Psychological First Aid Training Manual for Child Practitioners (simplified by two Save the Children teams) • Guide to Psychological First Aid, IFRC (reported by one organization) • Psychological First Aid: Guide for Field Workers, WHO (reported by one organization) • PFA training for staff and volunteers, contextualized/adapted

**It is important to note that for any technical training which staff receive, a certain level of follow-up support and supervision is required in order to safely implement a specific intervention or technique. This applies to all the training materials included in this report.*

Relaxation techniques

Considering that the MAMI Care Pathway Package includes health worker tools for counselling on relaxation techniques for mothers, this intervention was widely referred to by respondents as being a part of their MHPSS for mothers. As outlined below, organizations make use of a variety of self-designed and existing tools for guiding mothers on relaxation. Some respondents from Save the Children mentioned providing MAMI/ Infant and Young Child Feeding in Emergencies (IYCF-E) - MHPSS trainings to their staff members, which also cover relaxation techniques.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Relaxation techniques	• Back massage • Squeeze-hug technique • Breathing exercises • Mindfulness / grounding techniques	• MAMI Counselling and Support Actions Cards 5 and 6 (pages 74-77) • Videos on back massage technique, deep breathing, squeeze-hug technique and progressive muscle relaxation • Music for relaxation • Relaxation exercise tools / guidelines, self-developed • Save the Children's MAMI MHPSS Training Package • Save the Children's IYCF-E MHPSS Training Package

Psychoeducation / awareness-raising (one to one)

Several respondents highlighted psychoeducation as an existing method they were using for one-to-one awareness-raising on MHPSS for mothers. In some cases, organizations reported using existing IYCF corners or baby-friendly spaces to provide this intervention. The resources being used by MAMI Practitioners for psychoeducation are varied and contextualized, detailed below in the table. The previously mentioned Save

the Children MAMI/ IYCF-E - MHPSS trainings also prepared health workers to provide psychoeducation to mothers.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Psychoeducation / MHPSS awareness-raising at individual level	• Inform and sensitize mothers about their mental health and psychosocial wellbeing • Providing psychoeducation in IYCF corners / baby-friendly spaces	• Individual psychoeducation materials created for context based on interactions with mothers • 4 psychoeducational videos for mothers on mental health, depression, anxiety and suicide prevention • Informational brochures targeting mothers to motivate their care-seeking • Save the Children's MAMI MHPSS Training Package • Save the Children's IYCF-E MHPSS Training Package

Awareness-raising (group / community level)

Alongside individual psychoeducation, group/ community-based awareness-raising on mental health was another intervention mentioned by respondents. Considering that the impact of such activities heavily relies on context-specific content, respondents mentioned involving community members and leaders for mental health awareness-raising. This also meant that (training) resources weren't used in their original form, but they were customized to suit the context, as seen in the two examples below.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Awareness-raising on mental health at community level	• Behavioural change communication teams doing home visits and cascading information in communities • Activities to avoid spread of harmful myths and misconceptions among community members • Including religious leaders in community-level awareness-raising activities	• WHO mhGAP HIG, contextualized • Customized resources and training on early childhood care and development (ECCD) and psychosocial support (PSS) for MAMI counsellors, based on UNICEF, WHO, SCI resources on attachment enhancement, understanding child's emotional needs and issues around maternal health

Strengthening support networks

Several respondents indicated that they implement interventions to strengthen mothers' support networks in the family and wider community. This includes considering gender-related influences on mothers' mental health. One organization mentioned a specific guidance tool to implement such activities; another organization referred to cross-sectoral program collaboration, as outlined below.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Strengthening support networks	• Integrating supportive family and/or community members to provide needed support to mother with mental health problems • Support groups/ networks (mother to mother and father to father) • SC Safe Families program collaboration to promote equitable caregiving responsibilities, improve distribution of caregiving tasks at home and address root causes of family violence (often related to gender and power) • Home visits for care group participants in communities and following up	• MHPSS MAMI Support Group Session for Nursing Mothers: Step by Step Guide for Facilitators / Health workers • Save the Children Safe Families Common Approach resource

Psychological counselling

Approximately half of the respondents listed individual and/or group psychological counselling as interventions they provide to mothers. In cases where MHPSS-qualified staff are lacking in programme teams, respondents referred to trained health workers who provide the counselling sessions. It is important to note that some of the techniques listed in the middle column below are too complex to be delivered by non-specialized MHPSS staff and only organizations with qualified MHPSS staff reported applying these techniques in their programmes, e.g. behavioural activation. Overall, respondents referred to a variety of self-developed and existing guidance documents and trainings to provide MHPSS counselling in groups or one to one.

Intervention / Modality:	Technique / Activity*:	Resources / Tools / Trainings:
Psychological counselling (individual or group)	• Anger management • Behavioural activation • Conflict resolution training • Emotional identification & regulation • Stress management • Resignification of experiences • Strengthening of socioemotional skills at home • Coping mechanisms • Discussion of irrational ideas • Self-care promotion	• MHPSS Counselling Guide, self-developed, individual/group • MHPSS Individual Counselling Guideline, incl. content from IFRC resources • Save the Children's MAMI MHPSS Training Package • Save the Children's IYCF-E MHPSS Training Package • Mental health counselling training resources co-developed by MAMI RISE research project partners • Basic counselling skills training and on the job supervision by MHPSS technical staff

**It is important to note that the above techniques / activities require varying degrees of MHPSS technical expertise to be facilitated, from non-specialist to specialist. For some techniques, such as resignification of experiences and*

behavioural activation, the staff in charge must have an MHPSS background. In other cases, non-MHPSS qualified health and nutrition staff can lead the activities if they are sufficiently trained. In an ideal case, the implementing organization would receive advice from an MHPSS expert on which activities are safe to implement by whom.

Referrals to services

All organizations reported having various referral pathways in place, which in some cases also included their own mapping of available services. The referrals made do not only link mothers to more specialized MHPSS services, but also to services meeting mothers' other, multidisciplinary needs, such as protection and livelihoods. Some respondents mentioned community-level volunteers making such referrals. The referral-related resources were reported to be organization-specific or from inter-agency level, most often relevant for usage across different sectors.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Referrals, including service mapping	• Promotion of basic services that foster sense of security in mothers • Mapping of available specialized MHPSS services, updated regularly • Sharing information about places that offer MHPSS services • Referrals to other services, incl. legal services, protection, health facilities/ hospitals, specialized MHPSS / psychiatric services for more severe cases, livelihood interventions • Financial support provided to mothers to reach referral services • Referral follow-up: health centre makes referral, drops patient with car at hospital, engages in face-to-face contact with hospital, assesses case of patient in detail with focal persons	• List of criteria for MHPSS referral by other teams, specifically for pregnant and lactating mothers • Referral forms / guide, adapted and contextualized • Inter-agency referral form, cross-sectoral, not specific to MAMI or MHPSS • Save the Children's MAMI MHPSS Training Package • Save the Children's IYCF-E MHPSS Training Package

Specialized MHPSS

Specialized MHPSS services for mothers enrolled in the MAMI Care Pathway were beyond the scope of this mapping. However, noted below are the interventions of some organizations who reported being able to provide this level of care, including some of the resources they use.

Intervention / Modality:	Technique / Activity:	Resources / Tools / Trainings:
Specialized MHPSS services for mothers with moderate/ severe mental health conditions	• Clinical management • Psychotropic medication • Individual session with psychologist or psychiatric nurses • Care for survivors of SGBV • Suicide prevention	• Internal protocol on care for SGBV survivors • Internal protocol on suicide prevention • Training on mental health and suicidal risk signs and referral of cases • Training on identification of SGBV signs

Additional resources / tools

In addition to the above-mentioned resources and tools, some respondents reported using other MHPSS-related guidelines, either specific to their contexts or overarching/ inter-agency guidelines that are not linked to one specific intervention in the above tables. These are:

National guidelines/ strategies related to mental health support:

- National health ministry's tool *"FICA BEM"* ("Stay Well") (Mozambique)
- National strategy for mainstreaming MHPSS in Colombia (Colombia)

General inter-agency resource for designing MHPSS interventions:

- IASC *Guidelines on Mental Health & Psychosocial Support (MHPSS) in Emergency Settings* - core principles used as basis of MHPSS interventions

General, organization-owned MHPSS guidance:

- Save the Children's *Technical Guidance for Integrated Mental Health and Psychosocial Support (MHPSS) Programming*, section on nutrition

Practical guidance documents for MHPSS implementation / integration:

- *Contextualized SOP for Integrated Early Childhood Care and Development (ECCD) and Psychosocial Support (PSS) Service Provision* by Concern, World Vision and UNICEF
- Manual/ guidelines on MHPSS within IYCF and MAMI programming adapted to Yemen context, developed with local partners (Ministry of Health), UNICEF, SCI and Nutrition Cluster, translated into Arabic and other languages
- WHO *mhGAP Humanitarian Intervention Guide (mhGAP-HIG)* and *mhGAP HIG training of health/nutrition staff and community workers*, used by several organizations, content adapted by one organization

Other MHPSS-related trainings mentioned:

- MHPSS training for 60 community workers in MAMI (developed for Mozambique)

If you would like access to any of the resources and tools referred to in this report, SCI's MAMI focal point Alice Burrell (alice.burrell@savethechildren.org) may be contacted to enable the connection with the relevant respondents, where feasible.

Research Question 2 – Acceptability of MHPSS activities and interventions and the feasibility of the tools and resources used by MAMI practitioners

Activities/ interventions particularly accepted by staff/ mothers

The following is a summary of activities and interventions which respondents noted as particularly accepted by mothers in their programmes.

- Assessing mothers' mental health status (using PHQ2 and PHQ9) and enrolling them in the MAMI Care Pathway program
- Psychoeducation
- Psychological counselling (individual & group)
- Support groups
- Relaxation techniques (among the most accepted overall)
- Conflict resolution training
- Discussion of irrational ideas
- Emotion identification and regulation
- Resignification of experiences
- Deep breathing (noted by one respondent as more accepted by educated mothers)
- Squeeze-hug (noted by one respondent as more accepted by educated mothers)

In addition to the above, respondents provided explanations for why certain activities and interventions are more accepted by mothers than others. The following factors were shown to positively influence / increase acceptability of MHPSS interventions for mothers.

Perceived benefits

One respondent mentioned that mothers can be initially hesitant to attend counselling sessions due to the lack of material goods for the mother/family. However, with time, mothers' acceptability increases as their perceptions change to see the value of attending counselling. Similarly, another organization faced initial resistance from mothers regarding how individual counselling would help them and their caregiving abilities, but over time mothers realised that it is helpful to have an environment for sharing opinions and gaining knowledge about their symptoms through psychoeducation. This organization also found that for many mothers, the simple act of being welcomed by staff, getting water and having a quiet room where they can talk already helps them feel at ease. Some mothers are reportedly more likely to accept the services overall if they are able to see improvements in their infant.

Familiarity with staff and/or services

It was reported that mothers in MAMI are more likely to accept MHPSS services if they are familiar with health workers early on. It helps if community workers are a mother's first contact for mental health support, as well as familiar health workers already working within MAMI services, especially female staff. Mothers particularly accept MHPSS services if familiar nutrition staff explain to them what kind of interventions are possible and how they will help. One respondent mentioned a mental health technician regularly supporting MHPSS activities in the community, which mothers find acceptable because the person is already known in the community. Moreover, where MAMI is integrated in primary health care centres, mothers are directed by the MAMI team to MHPSS services; receiving integrated services reportedly reduces feelings of stigma in seeking MHPSS.

Tailored approaches

Approaches tailored to the mothers' needs were reported to be more likely to be accepted by mothers. One respondent mentioned a context-specific assessment that is done to check the suitability and applicability of proposed MHPSS interventions for mothers prior to implementation in South Sudan. This organisation reported that feedback from mothers was that the following interventions were well accepted: Psychological First Aid, psychoeducation, mental health awareness-raising in communities, home visits by behavioural change communication teams for care groups and follow-up in communities, psychological counselling and referrals.

In another organization in Kenya, the gender of staff was reported to affect service provision, with a strong preference for female staff. Due to predominantly male staff being available, this organisation has been sensitising mothers on receiving care from male staff, which is a complex process that has taken time. As a result, they have succeeded at reducing mothers' shyness and resistance to meet with male nurses.

Family and/or community involvement

With regards to mental health awareness-raising and training, one organization emphasized that involving families, communities and health professionals is essential for an enhanced understanding and early identification of mental health problems as well as access to help and support for mothers. Another organization mentioned involving well-known community members such as religious leaders as mothers are more likely to listen to religious leaders on mental health related topics. This organization also emphasized that mothers most strongly accept counselling where other family members and neighbours are involved as it helps them understand how to interact with and support the mothers. The strengthening of support networks was mentioned by another respondent as a particularly accepted activity, and the Save the Children Safe Families Common Approach was named as an example of a tool to implement this beneficial approach.

Activities/ interventions particularly unaccepted by staff/ mothers

Respondents highlighted that some MHPSS activities and interventions are less accepted by mothers. The following factors were shown to negatively influence/ decrease acceptability of MHPSS for mothers.

Cultural barriers & stigma

One of the biggest barriers to mothers' acceptability of MHPSS was reported to be stigma. More than five respondents/ organizations emphasized that mothers avoid seeking MHPSS services due to the stigma and shame attached to mental health issues in their community. They appear to fear being labelled, e.g. "psychopath", being singled out, accused or frowned upon. Another cultural barrier to MHPSS for mothers was related to gender issues. One respondent mentioned that mothers do not accept massages because the health workers demonstrating the techniques are usually men and physical contact with a woman is frowned upon in their community.

Lack of perceived benefits

According to some respondents, the benefits of MHPSS are typically not understood by mothers and, in one case, health workers. One respondent indicated that if mothers aren't provided with food or utilities, they believe they won't benefit from MHPSS, while another respondent explained that mothers reject any suggested activities that could involve a cost (either financial or relative to the caregiver's time), such as calling or visiting a person or accessing healthy food and spaces that provide comfort. Additionally, one respondent highlighted that some health workers do not believe that counselling and psychotherapy have an effect even though they are well educated about this. As observed by another organization, mothers' lack of awareness of the importance and benefits of referrals lead them to reject referrals to specialized MHPSS services. Lastly, it was reported that some mothers are reluctant to practice certain MHPSS activities at home or they do not follow the correct procedures, e.g. progressive muscle relaxation and deep breathing.

Lack of awareness and understanding of mental health conditions and/or services

Linked to the above points, respondents also reported a lack of understanding and awareness of mothers with regards to mental health issues and MHPSS services, causing their resistance to several of these services. In some cases, referrals to psychiatric services are complicated because mothers are not willing to accept MHPSS and the reality of needing support, rarely admitting that they don't feel good when health workers ask them. Moreover, a resistance to counselling was reported due to mothers' confusion caused by lack of clarity of staff in communicating and sharing information with them. One response indicated that mental health is still too medicalized in their context. On the other hand, another respondent highlighted that because MHPSS is seen as a more abstract type of support, being not primarily physical or medication-focused, it is difficult for mothers to understand the concepts that staff are explaining to them.

With regards to awareness and understanding of mental health at community level, one organization found MAMI too centred on the infant/mother, lacking activities that strengthen community members' ability to

recognize risk situations and provide support to mothers when needed. Related to this, social support of mothers by husbands and other family members was reported to be quite low in some cases, which could be due to the general lack of understanding of mental health issues.

Tools / resources particularly feasible and practical for staff

Respondents highlighted some MHPSS-related tools and resources that were particularly feasible and practical for usage during implementation. For instance, counselling cards and videos made it easy for health workers to demonstrate to mothers the steps of relaxation techniques, such as progressive muscle relaxation. Self-designed and contextualized psychoeducational videos by one organization were practical for staff to initiate conversations with mothers related to depression and anxiety. Similarly, concise booklets containing images and practical information helped staff of this organization to facilitate the delivery of information related to mental health support.

Respondents additionally mentioned the use of techniques such as real-life stories, metaphors, manual activities, art and active listening to enhance MHPSS for mothers. With regards to MHPSS-related guidelines, the *Guide to Psychological First Aid* by IFRC was regarded as simple and helpful by one organization, while another respondent mentioned that SC's *Technical Guidance for Integrated MHPSS Programming* (nutrition section) worked well for them. Several respondents emphasized that the tools they use are feasible for implementation because they were adapted to the context of each programme location.

Tools / resources particularly unfeasible and impractical for staff

Several respondents claimed that none of their tools and resources are unfeasible. However, other respondents named some tools and resources (or lack thereof) that are less feasible and practical in their usage. These are described in more detail below. The following factors were shown to negatively influence/ decrease the feasibility of tools and resources during implementation of MHPSS services for mothers.

Dependence on electronic devices

One respondent emphasized that their usage of counselling videos during MHPSS activities with mothers is only feasible if there is consistent electricity supply. This is a challenge in their context, because the videos are shown on tablets, which cannot be charged during the frequently occurring power cuts.

Lack of suitable / accessible tools for frontline health workers

Some respondents indicated that the feasibility of providing psychological counselling to mothers was limited by the lack of practical guidance tools or manuals designed for frontline health workers to use and refer to. Regarding more specific resources, one respondent said their organization found the *IASC Guidelines on MHPSS in Emergency Settings* too long and difficult to put into practice. For another organization, the content

of the *mhGAP HIG* manual was found to be too complex, resulting in adaptations and breaking down of content in order for mothers in their context to understand the concepts.

Due to the low literacy level of frontline staff of another organization, text-heavy resources on ECCD and PSS were found to be difficult to understand and administer. This organization emphasized the need to simplify and contextualize tools for low-literacy audiences so that they are more feasible to use. Language barriers were named as a limitation by one respondent, highlighting that several tools exist in English only and had to be translated into Spanish for use in their context. Examples: *General Protocol for Suicidal Risk*, *Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services.*

Unavailability of take-home resources

Due to a shortage of materials at one organization's health centre, mothers were not able to take home any resources on counselling topics. This limited the reinforcement of mothers' learning and practicing of certain techniques at home, such as relaxation.

Logistics of support groups / counselling

Another challenge highlighted by one respondent relates to the logistics of organizing mother to mother support groups. As mothers typically do not have their MAMI follow-up appointments on the same day, it is difficult to group them together at the same time to set up regular support group sessions. In another context, it was reported that due to dispersed communities it is difficult to group several mothers at the same facility for group counselling, as planned, and therefore 1-1 counselling is facilitated. Where services and communities are located closer to each other, up to six mothers are grouped together to take part in group counselling in a location that they can all easily access, a more efficient support methodology for a busy health worker.

Research Question 3 – Programming infrastructure and resources required for implementation of MHPSS for mothers in MAMI

Respondents outlined several challenges, needs and recommendations relevant to the infrastructure and resources required in their programmatic contexts. These are summarized below, with a focus on the needs in MHPSS staffing and expertise as well as other important factors that affect programming.

MHPSS technical staff / expertise

To operationalize MHPSS, responses showed that organizations require at least a few MHPSS technical staff or support from an MHPSS consultant. Respondents reported one to several MHPSS technical staff being present in their teams, in some cases rotating between the different locations where MAMI programmes are being implemented. This includes positions titled (MH)PSS counsellors, MHPSS supervisors, mental health

volunteers, technicians or focal points, as well as professional psychologists. These staff were reported by respondents to have varying levels of experience and technical backgrounds related to MHPSS/ psychology. Some respondents indicated that even when there are MHPSS technical staff in place, these are not sufficient in number to cover all the mental health related needs of mothers.

Generally, gaps in MHPSS technical staffing and expertise were among the main programmatic challenges reported. For instance, in Northwest Syria, there are only two psychiatrists in the entire region and specialized psychologists are also lacking. One respondent indicated that there is a general need for increasing staff's knowledge and capacity for attending to mothers' mental health issues, especially depression, while another respondent emphasized this need applies to the administration of psychotropic medication. Most respondents reported the critical need of recruiting more technical MHPSS staff to firstly, conduct MHPSS-related trainings for non-specialized staff such as health and nutrition workers in their MAMI programmes and secondly, provide technical oversight and supervision to non-specialist staff.

It is important to note that without some degree of MHPSS staffing/ expertise in place, it is challenging to directly implement certain MHPSS interventions within MAMI programmes, such as counselling, ensuring quality and safety of care. Ideally, at least one dedicated MHPSS staff/ focal point should be present in each MAMI programme / location to provide technical oversight and accountability. As a minimum, each organization should have the capacity and expertise to provide technical trainings on MHPSS, likely facilitated by the aforementioned MHPSS focal point, to their frontline health and nutrition workers, or a consultant where this permanent role does not exist. The specific training needs are outlined in the below section.

Building MHPSS capacity of non-specialist staff

As mentioned above, several organisations/ agencies implementing the MAMI Care Pathway lack MHPSS technical staff/ expertise and the implementation of MHPSS services for mothers in MAMI therefore heavily relies on non-specialist staff. Some of these staff, as mentioned by respondents, are community health workers, clinical nurses, MAMI/IYCF counsellors, nutrition support workers, nutrition assistants and community health and nutrition volunteers. They take on the community- and facility-level identification and screening of mothers' mental health issues, interpreting the screening, and, depending on the mothers' needs and staff's capacities, either providing basic MHPSS interventions or referring mothers to other services, where they exist. Severe cases are always referred. In some instances, these staff cover the responsibilities of PSS workers when they are not present at facilities. This means that these non-specialist staff should be supported through skill acquisition and capacity building to be able to provide these MHPSS-related tasks, which ideally includes training and technical supervision/ on the job coaching from MHPSS technical staff. MHPSS training needs for non-specialist staff were identified by participants as follows:

- Training on screening mothers' mental health using mental health screening/assessment tools (e.g. PHQ-9), classification of results and referring/ supporting accordingly

- Training on MHPSS interventions, such as counselling
- Training to more strongly guide health workers on the linkage between health, nutrition and MHPSS
- Training content with a focus on perinatal mental health
- Training on MHPSS tools for the community-based support of mothers
- Training to enhance staff's attitudes and skills for interacting with mothers, e.g. empathy, respect, active listening, confidentiality, to help fight stigma and discrimination and reduce mothers' resistance related to mental health issues and services

Participants identified that regular trainings on MHPSS in the healthcare sector are needed e.g. training at least one health worker per facility who is responsible for providing MHPSS services, ensuring one qualified individual is always available to meet mothers' MHPSS needs. Additionally, the need for qualified MHPSS staff to conduct all trainings, including potential follow ups / refreshers, was identified by many participants. Given the gap of MHPSS technical expertise in many organisations/ contexts/ agencies, one participant identified the need for conducting a Training of Trainers (ToT) on MHPSS to create a pool of qualified trainers who can effectively disseminate knowledge and skills in MHPSS across different locations.

Understaffing and frequent staff turnover of non-specialist staff was also mentioned by several respondents as a challenge, resulting in reduced impact of capacity building initiatives and lower-quality MHPSS service provision. A recommendation by one respondent was to try and employ cadres of staff on a more permanent basis for delivering MHPSS, e.g. community volunteers, to address the issue of understaffing and allow more consistent MHPSS service provision for mothers.

Sufficient funding

Several respondents commented on limited funding as a challenge, especially for MHPSS. It has been established that there is an essential need to include MHPSS as a key component in MAMI programmes, which requires allocating sufficient funding, increasing MAMI budgets overall. Funding is needed specifically for addressing the above-mentioned staffing gaps but also to have qualified MHPSS staff provide MHPSS trainings to health and nutrition non-specialist staff in MAMI programmes. Allocating more funding to recruitment and training is therefore fundamental for increasing the expertise that is required to implement MHPSS for mothers in MAMI. One respondent suggested disseminating MAMI/MHPSS success stories to generate more awareness on this programmatic component and advocate for donors to fund this aspect.

Integrated, multisectoral services

One reported challenge at an early stage of programming is that only a fraction of mothers in need of MHPSS are properly identified and referred to services by staff. According to the respondent, this is because MHPSS is still too linked with Child Protection and not sufficiently embedded in health and nutrition services in one particular context. Secondly, two respondents emphasized unaddressed economic and nutritional needs of mothers which add to their stress and affect the extent to which MHPSS services can improve their wellbeing. Thirdly, several respondents mentioned mothers' difficulties in accessing MHPSS with different services

being offered at separate, faraway locations that cannot easily be reached (e.g. health and nutrition services being separate).

The above challenges underline the need for integrated Health, Nutrition and MHPSS services alongside/ with linkages to existing services to meet families' basic needs; already a key concept of the MAMI Care Pathway. Moreover, if MHPSS is better integrated at health and nutrition facilities, staff are in a stronger position to identify mothers in need and offer them support at the same visit. If mothers' non-MHPSS needs can be addressed at the same location, this enhances the effectiveness of MHPSS services for mothers' wellbeing. Lastly, it is more feasible and safer for mothers to access only one facility with multisectoral services, rather than different services being spread out, especially when they have a young infant.

Sufficient suitable space at healthcare / nutrition facilities

A number of respondents reported that the lack of a suitable, confidential space hindered the delivery of MHPSS services for mothers in health and nutrition facilities. More rooms or spaces with ensured privacy and less external distractions are already required for MAMI/IYCF-E services, but even more so for MHPSS provision, which isn't yet prioritized enough. This would help staff and mothers to focus better on certain MHPSS activities, such as breathing exercises, and ensure mothers feel safe to disclose confidential information.

Culturally appropriate staffing

As outlined earlier in this report, in some cultural contexts, the acceptability of MHPSS services for mothers within MAMI is limited by staff being primarily male. Respondents outlined the need for better gender balancing among staff, requiring the recruitment of more female volunteers and staff to provide breastfeeding counselling and MHPSS services. At a bare minimum, it is recommended that at least one female staff is present at a facility where MHPSS services are offered to mothers to help address potential cultural and gender sensitivities related to mental health and other services.

Functioning referral system

As outlined under Research Question 1, referrals to MHPSS services make up a large component of the MHPSS provided through existing MAMI programmes. However, many challenges of referral processes were reported. One frequently mentioned challenge is referring mothers when there are no, limited or faraway services, especially for mild and moderate cases of MHPSS needs. According to respondents, more solid referral pathways are required to help speed up the process of making referrals for mothers, especially to specialized MHPSS services. In line with the above-mentioned staffing needs, it was emphasized that certain services require more staff in order to function properly and allow follow-ups with mothers after they are referred, especially at institutional level. Consequently, other NGOs may need to be mapped out and relied on for making referrals and follow-ups. Moreover, in more remote settings, support must be provided to

mothers, particularly the displaced and ethnic minorities who already face access barriers, to reach referral services, including for follow-ups.

Increased prioritization, investment and guidance at national level for maternal mental health support

In some of the countries where respondents and their organizations are based, mental health is not prioritized at national level which poses challenges for their programming, for instance in Ethiopia. Ideally, more effort and resources are put in at national levels to collect accurate and up to date data on mothers' mental health issues in country contexts, to get a better understanding of their MHPSS needs and to address these. It is recommended that existing advocacy efforts are supported to strengthen MHPSS at national levels. Sharing case studies and success stories could help exemplify best practices and the impact they are having. This generates the potential to achieve optimized MHPSS policies and investments at national levels.

Data Collection Limitations

It is important to note that while the data presented and discussed in this report represents a range of organizations in different regions, there were some limitations with regards to the sample and data collection method. Firstly, at the stage of purposive sampling, it was difficult to find participants to agree to take part in this review as the response rate was slow, staff turnovers were frequent or relevant staff were on annual leave or generally unavailable. This reduced the number of participants included and hence the representativeness of the data.

In one case, the respondent was HQ-based and so not involved directly in MAMI implementation in country. They were unable to consult colleagues based in country as the project was closed and the team had moved away. This may have limited the information on practical challenges experienced by health and nutrition staff from this particular respondent. Similarly, some respondents were not fully aware of the exact MHPSS tools and resources used in their MAMI programmes and in these cases, it was difficult to get a clear, complete picture of this programmatic element. Contradictory responses were provided in the survey and interview by one organization, as staff from the same team had different perceptions/ insights about their programme, but a follow-up was not possible as one of the staff had left the organization. Lastly, for some organisations, they had just started MAMI programmes and so were unable to provide details regarding the acceptability and feasibility of MHPSS for mothers, considering this was a new component.

CONCLUSION

Summary & Conclusion

This report provides a comprehensive overview of the data collected from 16 MAMI programmes across five regions.

Research question 1 focused on the activities, interventions, tools and resources that MAMI practitioners, without MHPSS qualifications, currently use to provide MHPSS to mothers of infants enrolled in the MAMI Care Pathway. Some common interventions and approaches which respondents reported included Psychological First Aid, relaxation techniques, strengthening support networks, individual and group counselling as well as referrals to other services. A range of tools was reported to be used by respondents, including organization-specific / contextualized tools such as SOPs and videos and inter-agency tools such as the mhGAP HIG. Reference was also made to trainings that were either tailored or based on existing manuals, such as the IYCFE-MHPSS and MAMI-MHPSS training packages created by Save the Children.

Research question 2 focused on the acceptability of MHPSS activities and interventions by communities as well as the feasibility of the tools and resources for MAMI practitioners to provide MHPSS for mothers. Respondents highlighted that most activities and interventions were seen as acceptable. Factors that increased mothers' acceptance of an intervention included if they better understood the benefits of MHPSS, were familiar with the staff providing MHPSS, received support tailored to their needs and had involved family or community members. Factors that negatively affected mothers' acceptability were cultural barriers, especially stigma related to mental health, and a general lack of understanding of mothers and community members regarding mental health and the benefits of MHPSS. Most tools and resources were reported by respondents to be feasible and practical, especially when they were adapted to the context. This included resources like counselling cards, self-designed/ contextualized psychoeducational videos and concise booklets with images and practical information. What limited feasibility was the dependence on electronic devices for counselling videos in a context with frequent power cuts, the low literacy of some staff administering the tools and the text-heaviness/ complexity or unavailability of certain MHPSS resources like manuals.

Research question 3 focused on the overall programming infrastructure and resources required for implementing non-specialised MHPSS for mothers in MAMI. Respondents highlighted many challenges that hinder their implementation of MHPSS. Based on these, recommendations were made regarding filling the most critical gaps. Considering that MHPSS technical/ specialist staff and expertise is limited in some MAMI programmes, building the MHPSS capacity of non-specialist staff such as health and nutrition workers is crucial for safe and effective implementation of MHPSS. Other important factors mentioned include sufficient funding for MHPSS, provision of integrated, multisectoral services for mothers and their families,

suitable spaces for MHPSS provision in health and nutrition facilities, culturally appropriate MHPSS staffing and a functioning referral system. Lastly, engaging in advocacy efforts to increase prioritization and investment on maternal mental health at national levels is an important step.

To conclude, integrating MHPSS for mothers in the MAMI Care Pathway through non-specialist staff is challenging but possible, and happening. A variety of tools and resources exist to support MAMI practitioners in providing non-specialised support. MAMI practitioners in different country contexts face varying challenges but are doing as much as they can with often limited resources. The addition of even a few MHPSS qualified staff benefits teams greatly, through provision of trainings and the possibility for supervision and technical oversight. Well documented challenges with provision of MHPSS were evident, such as continued stigma, service access constraints and lack of integration. These are not specific to MAMI implementation.

If you would like access to any of the resources and tools referred to in this report, SCI's MAMI focal point Alice Burrell (alice.burrell@savethechildren.org) may be contacted to enable the connection with the relevant respondents, where feasible.

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APPENDICES

Appendix 1 – Protocol

MENTAL HEALTH & PSYCHOSOCIAL SUPPORT (MHPSS) FOR MOTHERS ENROLLED IN THE MAMI CARE PATHWAY

Mapping of utilized activities, interventions, resources and tools.

BACKGROUND

The global MAMI community has recognized that progress to date has largely focused on care of the infant, with interventions targeting "Mothers in MAMI" requiring more attention. Growing evidence shows a wide range of maternal factors influence vulnerability, risk and outcomes of infants under 6 months of age, with poor antenatal and postnatal care and maternal malnutrition associated with adverse neonatal and infant outcomes. A systematic review documenting the impacts of maternal-focused interventions on feeding and growth of infants under 6 months of age identified several maternal interventions that were effective in improving infant growth or feeding outcomes including: breastfeeding promotion, education, support and counselling interventions; maternal mental health support; and antenatal macro and micronutrient supplementation. They concluded that greater inclusion of mothers in holistic packages of care could help small and nutritionally vulnerable infants to survive and thrive.[2]

SC's own programming experience has highlighted some existing gaps in the MAMI Care Pathway for the support of mothers in MAMI. Two notable gaps include: (1) guidance on quality maternal mental health support and what to do when referral mechanisms do not exist for severe mental health conditions and (2) guidance on evidence-based interventions to address maternal malnutrition where treatment programs do not exist. This protocol will focus on the first identified gap: maternal mental health and psychosocial support for mothers in MAMI.

Building on Save the Children's MHPSS Technical Guidance: Nutrition sector-specific recommendations[3] and with the goal to determine which activities and interventions are implemented in different contexts, Save the Children propose to take a deep-dive into MHPSS resources for non-specialist health/nutrition workers. The aim is to document and explore what is currently being used by MAMI implementers to provide MHPSS to mothers* enrolled to MAMI, including activities, interventions, resources and tools used as well as what programming infrastructure was required to put this support into place e.g. staffing profiles, staffing

[2] Victoria S, Eilise B, Marko K. et al. Maternal-focused interventions to improve infant growth and nutritional status in low-middle income countries: A systematic review of reviews. Plos One, August 18, 2020

[3] Nutrition - Save the Children - MHPSS (scintegratemhpss.com)

numbers, resources, means and funding and the successes and limitations of these implementation approaches, resources and tools.

Through the process, gaps will be noted and highlighted to the MAMI Implementers Group / Global Network to support the further evolution of the Care Pathway.

SCOPE

A documentation of activities/interventions, tools and resources focused on non-specialized mental health and psychosocial support for mothers* of infants under 6 months enrolled to the MAMI Care Pathway, which MAMI practitioners (non-specialists) are currently implementing and using, including exploring their feasibility and acceptability. The mapping will focus on resources used in humanitarian/ fragile state contexts.

Objectives

1. Identify and map activities/interventions, tools and resources currently being implemented/used by MAMI practitioners without an MHPSS qualification to support the mental health and psychosocial wellbeing of mothers enrolled in the MAMI Care Pathway.
2. Understand perceptions of MAMI practitioners about the feasibility and acceptability of the activities/interventions, resources and tools, that they are using to support maternal mental health, including benefits/successes and limitations of their implementation/use.
3. Document the programming infrastructure and resources required to implement/use the identified MHPSS activities/interventions, tools and resources within the MAMI Care Pathway.

Research Questions

1. Within MAMI programmes, what MHPSS activities/interventions, tools and resources are currently being used by MAMI practitioners without an MHPSS qualification to support the mental health and psychosocial wellbeing of mothers of infants less than 6 months enrolled in the MAMI Care Pathway?
2. How feasible and acceptable do MAMI practitioners perceive the activities/interventions, tools and resources they are using to support maternal mental health to be?
3. What programming infrastructure and resources are required to implement/use identified maternal MHPSS activities/interventions, tools and resources within the MAMI Care Pathway?

METHODOLOGY

A survey with some initial questions will be completed by MAMI programmers or their team members. Depending on the level of MHPSS provided to mothers in their MAMI programmes, selected respondents will be invited to additionally participate in key informant interviews. These will include more detailed follow-up questions on the activities, interventions, resources and tools the respondents are currently using for mothers in MAMI/ mothers of infants <6 months.

The survey respondents and key informants will be selected using purposive sampling. Through the MAMI Global Network and a post shared on Emergency Nutrition Network (ENN), as well as other relevant

platforms, a list of MAMI practitioners will be developed. Additional survey respondents and key informants can be identified via snowball sampling. A minimum of 20 stakeholders will be sought, with as much diversity of organisation and context as possible in those selected.

Interviews will be conducted using a semi-structured interview guide, either with individuals or a group from the same organization. Interviews will be recorded, and notes will be taken. Names will be withheld to protect privacy.

Where language is a barrier, respondents will be asked if there is someone in their organisation who could assist with interpretation during the interview, or an interpreter will be organized through other means.

OUTPUT

The mapping/review will result in a summary report with an overview of the different activities, interventions, tools and resources currently implemented/used for providing MHPSS to mothers in MAMI, including the perceptions of staff implementing/using these. This will be used to help inform the design of safe, feasible and locally implementable activities and interventions targeting MAMI mothers' mental health and psychosocial wellbeing in primary healthcare settings.

Appendix 2 – Survey

Please respond to the below survey questions in as much detail as possible. Your responses will be stored confidentially and no names collected. If several staff members are completing the survey together, please choose one person to take the lead, including for the responses to questions 1-7 on demographics. By clicking submit at the end of the survey, you consent to your responses being stored and used for this mapping/review. Thank you very much for your participation and support.

(Section 1)

1. Which organization do you work for?
2. How long have you been working for this organization? (Less than 2 years / 2-5 years / More than 5 years / Other)
3. Which country, district and city/town/village do you work in?
4. What is your position/title in the organization?
5. Is a colleague or anyone else supporting you with completing this survey? If yes, please list their position(s)/title(s) below.
6. How long have you been working in MAMI programming? (I haven't directly worked in MAMI programming / Less than 2 years / 2-5 years / More than 5 years / Other)
7. Are you directly involved in implementing activities/interventions to support the mental health and psychosocial wellbeing of mothers in your MAMI programme? (Yes / No / Other)
8. In your MAMI programme, do you and your team include activities/interventions that support enrolled mothers' mental health and psychosocial wellbeing **in addition to** providing Psychological First Aid (PFA) and basic relaxation techniques? (Yes / No --- *If you responded **yes** to this question, please proceed to the next section. If you responded **no** to this question, please skip the remaining questions and click "submit".)*

(Section 2)

The following are more detailed questions on maternal mental health support in MAMI. Please note that the information you provide will **not** be used as a reflection of the effectiveness or quality of your work.

9. Please provide a **short description** of the **MAMI service/programme** you provide for **mothers**, including for their **mental health and psychosocial wellbeing** (if possible, please also include information about the number and types of staff, related trainings, location, frequency/duration, resources and partners).
10. Please list below all the **activities/interventions** that you have implemented or are implementing in your MAMI programme to directly **support** the **mental health and psychosocial wellbeing** of **mothers** (in addition to PFA and basic relaxation techniques). (*Please note that some activities/interventions supporting mothers' mental health and psychosocial wellbeing may also target their babies. If this applies in your programming, please also list these activities/interventions below.)*
11. Among the **activities/interventions** that you listed above, did you find any of them **particularly acceptable/suitable** for your context? If yes, please state which one(s).
12. Among the **activities/interventions** that you listed above, were there any that enrolled **mothers very much accepted** in your context? If yes, please state which one(s).

13. Among the **activities/interventions** that you listed above, did you find any of them **particularly unacceptable/unsuitable** for your context? If yes, please state which one(s).
14. Among the **activities/interventions** that you listed above, were there any that enrolled **mothers did not accept at all** in your context? If yes, please state which one(s).
15. Please list below all the **tools/resources** you used or are using to implement each of the above-listed activities/interventions, including their **benefits and limitations**.
16. Among the **tools/resources** that you listed above, did you find any of them **particularly feasible, practical and easy to use** in your context? If yes, please state which one(s).
17. Among the **tools/resources** that you listed above, did you find any of them **particularly unfeasible, impractical and difficult to use** in your context? If yes, please state which one(s).
18. If you would like to add anything else to your above responses, please write in the below text box.

Appendix 3 – Interview Guide

1. **Benefits/successes:** Of all the activities, interventions, tools and resources you mentioned in the survey, which ones worked particularly well for you during implementation and use, and why?
2. **Challenges/limitations:** Of all the activities, interventions, tools and resources you mentioned in the survey, which ones did not work so well, challenged or limited you during implementation and use, and why? (e.g. a specific manual that you found difficult to understand or use?)
3. **Acceptability:**
    a. In the survey, you indicated that you found the activity/intervention [enter name/title] particularly acceptable/suitable for your context. Could you please elaborate on why?
    b. In the survey, you indicated that mothers very much accepted the activity/intervention [enter name/title] in your context. Could you please elaborate on why?
    c. In the survey, you indicated that you found the activity/intervention [enter name/title] particularly unacceptable/unsuitable for your context. Could you please elaborate on why?
    d. In the survey, you indicated that mothers did not at all accept the activity/intervention [enter name/title] in your context. Could you please elaborate on why?
4. **Feasibility:**
    a. In the survey, you indicated that you found the tool/resource [enter name/title] particularly feasible, practical and easy to use in your context. Could you please elaborate on why?
    b. In the survey, you indicated that you found the tool/resource [enter name/title] particularly unfeasible, impractical and difficult to use in your context. Could you please elaborate on why?
5. **Contextualization:**
    a. Did you change any of the content from the tools or resources when implementing activities/interventions in order to better suit the local context? If yes, please elaborate on why and how.
    b. Did you select and pick out parts from the tools or resources when implementing activities/interventions in order to better suit the local context? If yes, please elaborate on why and how (e.g. the entire manual was too long / not feasible so only parts were selected).
6. **Accessibility/availability:**
    a. Were there any activities/interventions that you and your team wanted to implement but couldn't? If yes:
        i. Which ones?
        ii. What prevented you from implementing them?
        iii. What would you need to potentially implement them in the future?
    b. Were there any tools/resources that you wanted to use but that weren't available in your local language?
        i. If yes, which ones and what language?
7. **Referrals:**
    c. Did you or your colleagues come across mothers in need of support that you weren't providing within the MAMI programme, e.g. specialized MHPSS? If yes:
        i. What did you do to help these mothers find a way to address their needs?
        ii. If you referred mothers to specialized MHPSS services, what tools, resources and guidance did you use to make the referrals?
8. **Programmatic infrastructure:**
    d. Please share anything else that might be relevant to follow up on your survey response about the programmatic infrastructure in which you implemented the activities/interventions.
    e. Was there anything missing in your programme for you to start / continue implementing certain activities/interventions?

9. **Wrapping up:** Is there anything else you'd like to add with regards to activities/interventions for maternal mental health and wellbeing in your MAMI programme? It can be about benefits/successes and limitations/barriers relating to the activities and interventions you implemented and tools and resources you used, or future support needed with regards to setting up MHPSS services.

Thank you very much for participating. Your time and effort are very much appreciated. We will reach out with follow-up actions after the mapping/review is completed.

Appendix 4 – List of Organizations and Locations

Action Against Hunger (ACF), Pakistan

Action Against Hunger (ACF), Uganda

ADRA, Yemen

Concern Worldwide, Bangladesh

GOAL, Ethiopia

International Rescue Committee (IRC), Kenya

Medair, South Sudan

Save the Children, Colombia

Save the Children, Mozambique

Save the Children, Nigeria

Save the Children, Somalia

Save the Children, Venezuela

Save the Children, Yemen

Syria Relief, Northwest Syria

USAID/MOMENTUM Integrated Health Resilience, Niger

Welthungerhilfe, Sudan

Mother and Infant enrolled in MAMI
Credit: Save the Children Mozambique