The Feasibility and Acceptability of a Combined Parenting and Depression Therapy Package Adapted for Telephonic Delivery in a Rural, Low-income HIV-positive Population in South Africa during COVID-19

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Background

- COVID-19 pandemic exacerbated known risk factors for mental health.
- Continuation of services during the pandemic was key for vulnerable populations, given concerns of the disproportional effects of COVID-19 on their mental health.
- All in-person research activities at the Africa Health Research Institute largely paused between March 2020 and March 2021.
- The Insika Yomama Trial intervention was adapted to telephonic delivery to ensure continuation of therapy for vulnerable. populations (HIV-positive, depressed women in the perinatal period, and their infants).
- To our knowledge, the feasibility and acceptability of evidence-based psychological therapy delivered telephonically has not been evaluated in a rural Sub-Saharan African context.

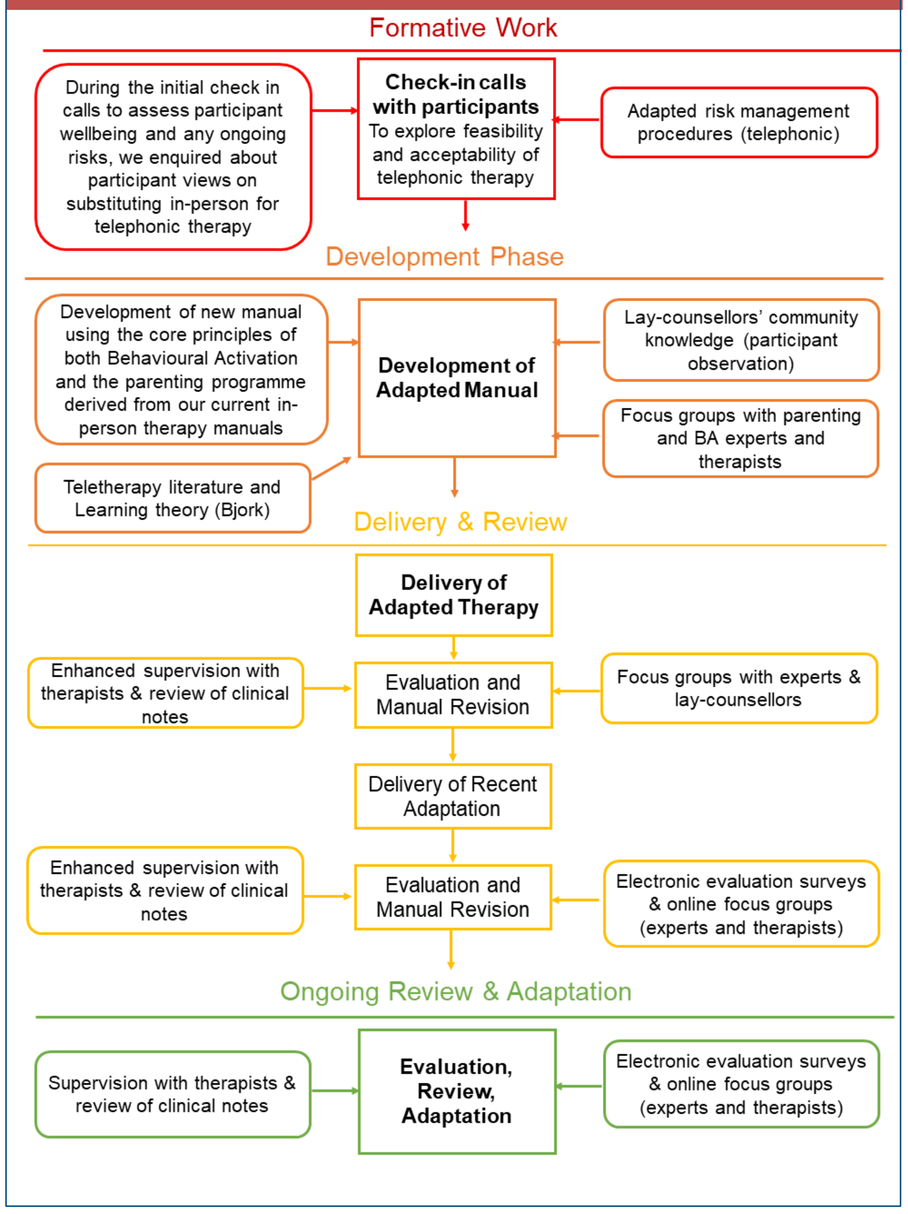
Objectives

1. To adapt a combined Behavioural Activation Intervention for perinatal depression and a parenting programme to telephonic delivery using Action Research.
2. To investigate acceptability, feasibility and implementation of delivering and receiving telephonic therapy.
3. To examine the fidelity of the therapy package delivered telephonically.

Methods

- **Study populations –** Therapy Participants and lay-counsellors on Insika Yomama Trial involved with the telephone adapted therapy package
- **Design –** Mixed methods
- **Quantitative –** Uptake measures and Therapy Fidelity Evaluation of recorded telephonic sessions.
- **Qualitative –** In-depth semi-structured interviews with therapy participants and lay-counsellors on the IY trial. Thematic analysis performed on interview transcripts.

Process of Therapy Adaptation to Telephonic Delivery during COVID-19



Insika Yomama Trial

Cluster Randomised Controlled Trial – investigating the effects of a combined therapy for depression and parenting on child development at 24-months and maternal depression at 12-months postpartum, compared to enhanced standard of care.

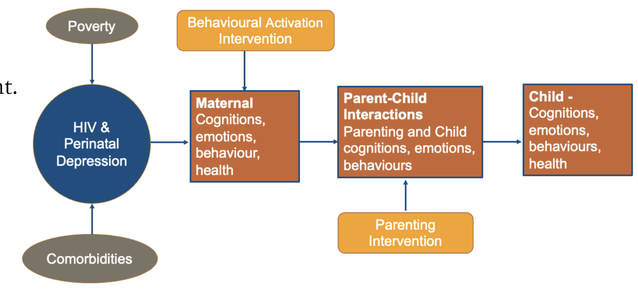
Intervention:

- 10-home based sessions delivered by lay-counsellors (4 antenatal, 6 postnatal) and 1 booster session at 16 months.
- **Therapy** – Two evidence-based interventions:
  - Behavioural Activation for depression
  - Parenting programme adapted from UNICEF/WHO Care for Child Development.

ESoC

- 4 Counselling Support and Advice Calls delivered by lay-counsellors (2 antenatal, 2 postnatal).

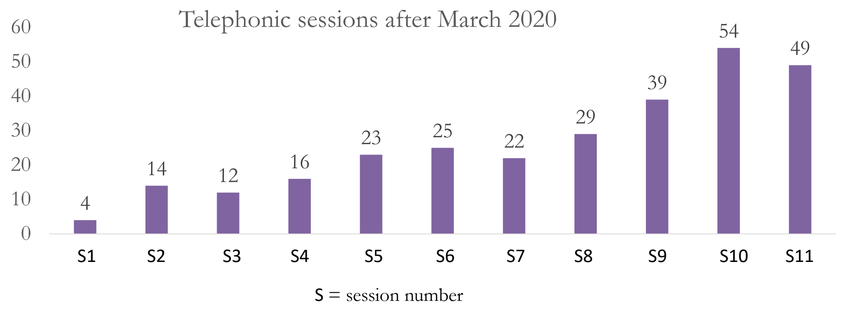
Basic Model of Intervention



Quantitative Results

Uptake

- High level of uptake (therapy retention rates remained high
- 111 participants had at least 1 telephone session; most participants had between 1-3 telephonic sessions and most sessions were postnatal, particularly the last sessions (S9, S10, S11). Average telephone session length – 31min



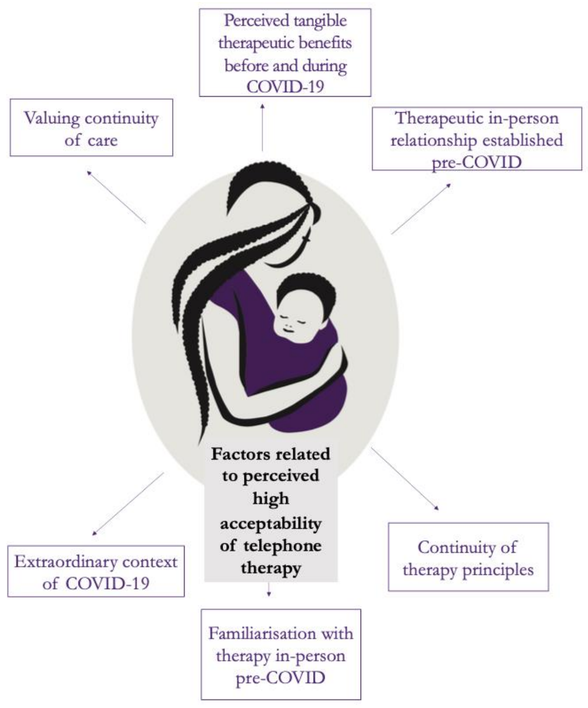
Fidelity to Original Therapy Manual

- Clinical psychologist listened to full session recordings for 24 participants and scored the fidelity to therapy manual.
- **Fidelity Scores –** Over 90%
- **Limitations –** Given the difficulties of recording sessions, the sessions evaluated were not randomly selected.

Qualitative Results

Advantages & Opportunities

- Participants perceived high acceptability of tele-therapy.
- Participants perceived benefits to be maintained telephonically.
- Participants perceived that tele-therapy prevented worsening of metal health during pandemic.
- Tele-therapy addressed new challenges caused by COVID-19 (e.g. job loss, isolation, food poverty, anxiety).
- The core therapy components were perceived to be maintained
- Flexibility – time, location, reduced transport costs for therapists.
- Some participants found telephone therapy more convenient than in-person.
- Some difficult to reach or participants who had moved outside study area were re- engaged.



Challenges:

- Acceptability of telephone therapy linked to having had prior in-person sessions.
- **Structural** – e.g., connectivity, airtime, sound quality, privacy, changing phones.
- **Reduced inter-personal environment –** challenges to feeling connected and trusted.
- **Reduced learning environment –** through lack of direct interaction with therapist.
- **Difficulty in delivery of therapy elements -** e.g., difficulty in monitoring mood checklists; lack of direct observation of the mother-infant interactions; and absence of visual materials, including handouts.

Conclusion

Trial Contributions:

1. First cluster RCT to document and explore the acceptability and feasibility of an adapted telephonic therapy package in a rural Sub-Saharan African context.
2. Developing a manual and materials to support telephonic adaptation of therapy for future use. Potential for use and testing in future trials.

Key findings:

1. Telephone therapy is feasible and acceptable in this context and retains high fidelity to adapted therapy manual which includes the core principles of both interventions.
2. Continuity of mental health support was perceived as critical by participants in crises such as COVID-19, to avoid worsening of mental health.

Outstanding Evaluation

1. The evaluation of the effects of telephone therapy on the primary outcomes awaits full trial completion and data analysis.
2. The Health Economics Analysis of cost-effectiveness of telephone therapy awaits full trial completion and data analysis.

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