The acceptability of peer volunteers as delivery agents of a psychosocial intervention for perinatal depression in rural Pakistan: a qualitative study

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Najia Atif

School of Nursing, Midwifery and Social Work


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### List of abbreviations

- **CBT**................. Cognitive Behaviour Therapy
- **HIC**................. High Income Country
- **LHS**................ Lady Health Supervisor
- **LHW**................ Lady Health Worker
- **LMIC**.............. Lower and Middle Income Country
- **MRC**.............. Medical Research Council
- **PHC**............. Primary Health Care
- **PV**............... Peer Volunteer
- **RCT**............. Randomised Control Trial
- **SHARE**........ South Asian Hub for Advocacy, Research and Education
- **THP**............... Thinking Healthy Programme
- **THPP**........... Thinking Healthy Programme Peer Delivered
Abstract

Background: In Pakistan, the prevalence of perinatal depression is high and is associated with adverse outcomes in both the mothers and their infant. Although effective psychosocial interventions have been developed for such settings, the scarcity of trained mental health professionals means that the majority of such women do not receive any intervention. The aim of this study was to explore the acceptability of peer volunteers (PVs) - volunteer lay women from the community with shared socio-demographic and life experiences with the target population – as delivery agents of a psychosocial intervention for perinatal depression in a rural area of Pakistan.

Methods: This qualitative study was embedded in the pilot phase of a cluster randomised control trial. Participants included the entire sample of the pilot study: mothers (n=21), PVs (n=8), primary health care staff (n=5), husbands (n=5) and mothers-in-law (n=10). Data were collected, from these key stakeholders, through in-depth interviews and focus group discussions. Data analysis was underpinned by Framework Analysis involving five key stages: familiarisation, development of thematic framework, indexing, charting and interpretation.

Results: All stakeholders viewed the PVs as acceptable delivery agents of a psychosocial intervention for perinatal depression. The PV’s personal attributes such as being local, empathic, trustworthy, approachable and of good reputation within their communities contributed to their acceptability. Their linkage with the primary health care system was vital to their legitimacy and credibility. Factors such as appropriateness of the intervention, effective training and supervision, perception of personal gain from the programme, and endorsement from their families and the community were motivational for them. Likely barriers to their work were women’s lack of autonomy, cultural beliefs around the perinatal period, stigma of depression, lack of some mothers’ engagement and resistance from some families.

Conclusion: PVs are a potential human resource for the delivery of a psychosocial intervention for perinatal depression in this rural area of Pakistan. The use of such delivery agents could be considered for other under-resourced settings globally, and for other mental health conditions.

Key terms: Perinatal depression, peer volunteers, low and middle income countries, psychosocial interventions, Pakistan
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Dedication

To all mothers of the world, whose strength and resilience enables them to do the best for their children, even when faced with adversity.

Acknowledgements

I would like to express my deepest gratitude to all those who contributed to this work:

First and foremost my principal supervisor Professor Karina Lovell, for her invaluable guidance, immense knowledge, support and encouragement for which I will always be extremely thankful and indebted.

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The admin and the research staff at the Human Development Research Foundation, Pakistan for all their practical and emotional support without which my field work would not have been possible.

Finally, I owe my gratitude to my husband, children, all my friends and family for their invaluable support during all these years.
About the author

The author was born in Pakistan and completed her Masters in Applied Psychology from University of the Punjab in 1990 before emigrating to the United Kingdom in 1992. She interrupted her education and career for seven years, raising two young children during this time. In 1998, she joined the Pakistani Resource Centre (PRC), a charitable organisation in Manchester, working initially as a volunteer, and later, on a number of mental health projects targeting South Asian communities. She worked for 12 years with PRC. During this time she qualified as a counsellor and completed a certificate in Cognitive Behavior Therapy, for which she was awarded a distinction. She also worked as a counsellor for three years with the Roby Centre in Longsight.

During this time, she resumed her interest in research – participating in a prevalence study of postnatal depression in Rawalpindi and working with the University of Manchester on NIHR funded research programmes aiming to improve access to mental health services for ethnic minority communities of the UK. Her initial experiences of working at the grass-root level, as well as her clinical work, stimulated further interest in research on women’s mental health. Her work in Pakistan and in the UK with South Asian communities made her aware of the barriers to accessibility of mental health services and how these could impact the recognition and management of perinatal depression. In 2012, she joined the South Asian Hub for Advocacy, Research and Education (SHARE), a consortium of UK and South Asian institutions collaborating on task-shifting strategies to reduce the treatment gap for perinatal depression in Pakistan and India. She worked with the Pakistani team as a qualitative researcher, helping design, deliver, analyse and interpret the formative phases of the project. In 2012-13, she refined the ideas for her PhD study, and formally registered at the University of Manchester in September 2012 as a PhD student at the School of Nursing, Midwifery and Social work.

The author’s PhD journey has been a challenging but rewarding experience. She has had a steep learning curve, but has been fascinated by the remarkable potential of peer volunteers to contribute to their communities in rural Pakistan. They have both inspired, and stimulated her, to continue to research on the use of peers to deliver mental health care in low-income settings.
Chapter 1: Introduction

This chapter describes the background to this PhD study, provides some salient facts about Pakistan’s demography, briefly introduces the study area, and discusses the health and social systems of Pakistan. This information will provide the contextual background to the study.

1.0 Background to the study

The perinatal period is generally considered to begin at pregnancy and extend to one year after giving birth. An episode of depression experienced during this period is classified as perinatal depression (Gaynes et al., 2005, Austin, 2004). Perinatal depression is a public health concern due to its high prevalence, ranging from 4-13% in high income countries (HIC) (Gavin et al., 2005). Epidemiological studies conducted in low and middle income countries (LMIC) have reported higher weighted mean prevalence of perinatal depression than HICs, at 15.6% during pregnancy and 19.8% during the postpartum period (Fisher et al., 2012). Perinatal depression has been found to be associated with adverse outcomes for mothers and infants (Parsons et al., 2011).

Recent systematic reviews have indicated evidence of psychosocial and psychological interventions for the prevention and treatment of perinatal depression (Rahman et al., 2013, Dennis and Dowswell, 2013). However, in LMICs, the majority of the women with perinatal depression do not receive psychosocial interventions. The lack of financial and human resources are major reasons for people requiring support outweighing the availability of mental health care, and therefore resulting to a ‘treatment gap’ (Saxena et al., 2007). One way of tackling this problem is through ‘task-shifting’ which is defined as ‘delegating tasks to existing or new cadres with either less training or narrowly tailored training’ (Fulton et al., 2011. p.2). Delivery of the task is shifted from highly qualified health workers to health...
workers with fewer qualifications or creating a new workforce with specific training for a particular task.

In Pakistan the rate of perinatal depression is 25.8% during pregnancy and 38.3% during the postpartum period (Husain et al., 2011). Infants of depressed mothers have low birth weight (Rahman et al., 2007a, Patel and Prince, 2006), growth retardation (Rahman et al., 2004) and delayed cognitive and motor development (Ali et al., 2013). There is a large treatment gap for perinatal depression in Pakistan due to scarce mental health specialist services, especially in the rural areas of Pakistan where 67% of Pakistan’s population resides (PSLM, 2013). This highlights the need for evidence-based interventions which could be delivered through non-specialists.

In the last decade, a number of psychosocial interventions delivered by non-specialists have been developed and evaluated (Rahman et al., 2013). In Pakistan, the Thinking Healthy Programme (THP) is one such intervention (Rahman et al., 2008). The intervention was delivered through lady health workers (LHWs) – local women employed by government community health workers’ programme to work on the mother and child health agendas – to mothers experiencing perinatal depression. The intervention halved the rate of depression compared to a control group receiving usual care, and improved disability and social functioning in the treated mothers. These effects were sustained after one year. THP has been adopted by World Health Organization as a low intensity psychological intervention for perinatal depression (WHO, 2015).

An important limitation to scale-up of this approach is that in Pakistan, LHWs have multiple roles and heavy workloads leaving them no capacity to deliver the intervention as part of their routine work (see Section 1.3.2.1 below). Thus it is necessary to examine the potential role of other human resources, such as peer volunteers (PVs) – volunteer lay women from the community with shared socio-
demographic and life experiences with the target population – in the delivery of psychosocial interventions. The SHARE study in Pakistan (see ‘about the author’) has adapted the THP to make it deliverable through PVs. The pilot phase of the Thinking Healthy Programme-Peer Delivered (THPP) successfully concluded in 2014. This PhD study was embedded in the pilot phase.

Prior to the pilot study, the literature review (Chapter 2), identified a gap in knowledge about the experiences of key stakeholders involved in peer-delivered mental health programmes in LMICs. Thus, a major concern in using PVs for the delivery of THPP was if they would be acceptable to these key stakeholders in the context of rural Pakistan.

1.1 Introduction to Pakistan

Pakistan is located in South Asia and has a population exceeding 182 million, making it the sixth most populous country in the world (The World Bank, 2013). The fertility rate is 3.8, life expectancy is 65 years, and 21% of its population lives below the poverty line (UNPD, 2013). According to the Pakistan Social and Living Standards Measurement (PSLM), more than 67% of the population reside in rural areas with limited access to the health and educational provisions. The adult (ages 15 and over) literacy rate is 57%, with a significant discrepancy between literacy rate in urban (74%) and rural areas (47%), with the lowest literacy rate among rural women (33%) (PSLM, 2013).

The administrative units of Pakistan consist of five provinces namely Punjab, Sindh, Khyber Pakhtunkhwa, Baluchistan, Gilgit-Baltistan and a federal capital called Islamabad. Each province is divided into districts, sub-districts (tehsils) and union councils. A union council is the smallest administrative unit comprising of 10-15 villages and a population of around 15,000-20,000.
1.2 Introduction to the study area

The study was conducted in the rural sub-district of Rawalpindi called Potohar, located in the province of Punjab, Pakistan (Figure 1). Potohar is one of the seven sub-districts of Rawalpindi and is located 65km southeast of Rawalpindi city (Figure 2). The data was collected from the two union councils of Potohar called Banda and Jatha Hathiyal.

Figure 1: Map of Pakistan showing Rawalpindi City

Figure 2: Map of sub-districts of Rawalpindi showing Potohar
The local dialect of Potohar is Potohari and its economy is agrarian based, but 35% of people are also engaged in non-farm jobs, such as working as unskilled or semi-skilled labourers and self or government employers or serving the army. Both union councils have similar gender distribution (48% male and 52% female) and educational status (40% men and 34% women - education up till 10th grade) (Federal Bureau of Statistics, 2010). 85% of the households have brick construction and 90% have electricity. Figure 3 shows a typical rural house and Figure 4 shows a crop field in the study area.

Figure 3: A house in Banda

Figure 4: A crop field in Jatha Hathiyal
Each union council has a Basic Health Unit (primary health care facility shown in figure 5), delivering primary health care (PHC) services (Section 1.3.2.1 below). It is staffed by a physician, midwife, vaccinator, LHWs and their supervisors.

Figure 5: Basic Health Unit in Jatha Hathiyal

To provide contextual background to the findings and their interpretation salient features of Pakistan’s health system and its social structures relevant to the current study are described below.

1.3 Introduction to the health system in Pakistan

1.3.1 Current health scenario

Pakistan’s health system faces serious challenges due to a rapidly expanding population and burden from communicable and non-communicable diseases. Multiple factors such as limited health budget (The World Bank, 2013), lack of health specialists (Economic Survey of Pakisan, 2013-2014), environmental risks, poor governance and health status reinforce the consequences of ill health (MDG, 2013). Pakistan also faces major challenges of mother and child mortality and morbidity - especially for underprivileged population living in urban slums and rural areas (Akram and Khan, 2007). Pakistan is ranked at 26 in list of countries
with the highest infant mortality rates in the world (UNICEF, 2014). The maternal mortality rate is also high and is associated with illiteracy, malnutrition, high fertility rate, lack of skilled birth attendants and access to obstetric care services contributing to high maternal morbidity (WHO, 2007). Over the past few decades there have been some improvement in maternal mortality, contraception usage and proportion of births attended by skilled birth attendants (MDG, 2013). Despite this progress, a substantial improvement in maternal health is required to achieve targets set by Pakistan Millennium Development Goals (2013). Table 1 below lists these health indicators.

Another burden to the Pakistan health system is the high prevalence of common mental disorders (mean=34%) (Mirza and Jenkins, 2004). Mirza and Jenkins review also found women at a higher risk of anxiety and depression as compared to men: 29-66% for women and 10-33% for men. Furthermore the recently increased violence and exposure to traumatic events has put an additional burden on the mental health problems in Pakistan (Khalily et al., 2011). The small mental health budget of £5.96 million (which is 0.40% of health budget) is grossly insufficient to address the burden of mental illnesses (WHO, 2009).
## Table 1: Demographic and socioeconomic variables of Pakistan

<table>
<thead>
<tr>
<th><strong>Demographics Variables</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Fertility rate</td>
</tr>
<tr>
<td>Life expectancy</td>
</tr>
<tr>
<td>Population living in rural area</td>
</tr>
<tr>
<td>Adult literacy rate for the population</td>
</tr>
<tr>
<td>Infant mortality</td>
</tr>
<tr>
<td>Child mortality (under five)</td>
</tr>
<tr>
<td>Underweight children due to malnourishment</td>
</tr>
<tr>
<td>Maternal mortality</td>
</tr>
<tr>
<td>Contraception usage</td>
</tr>
<tr>
<td>Births attended by skilled birth attendants</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Socioeconomics Variables</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable</strong></td>
</tr>
<tr>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>Health budget</td>
</tr>
<tr>
<td>Doctor patient ratio</td>
</tr>
<tr>
<td>Mental Health Budget</td>
</tr>
<tr>
<td>Population living below the poverty line</td>
</tr>
</tbody>
</table>
1.3.2 The health care structure in Pakistan

The health care structure of Pakistan comprises of public and private sector.

1.3.2.1 The public health sector

The public health sector provides services through a four tier system: community based activities, PHC facilities, secondary and tertiary care.

Community health care services: The community based activities focus on mother and child health agendas, delivered through LHWs. LHWs are local women employed by PHC under the National Programme for Family Planning and PHC initiated in 1994. Their work responsibilities include multiple tasks ranging from antenatal and postnatal care and referral, immunisation services, support to community mobilisation, control of locally epidemic diseases, provision of family planning and basic curative care (Hafeez et al., 2011). There are 100,000 LHWs covering 83% of the total population of Pakistan mainly residing in rural areas (MDG, 2013). Each LHW is responsible for approximately 150 household and visits five to seven houses daily. In addition, people come to their Health House (the house of each LHW has been declared as a Health House) to receive basic treatment and guidance. They maintain records for all women in their catchment areas by updating family registers and keeping notes of medical histories and health conditions (Hafeez et al., 2011).

Primary health care services: The PHC facilities include Rural Health Centres, Basic Health Units and government dispensaries. They form the core of PHC and provide the out-patient services to local communities. Each union council has a Basic Health Unit which, apart for delivering health care, are the local hubs for the training of LHWs. The primary care facilities are proportionately few (see Table 2 below), in comparison to the population size. They are underfunded and lack in basic
amenities. The quality of care in these facilities varies from centre to centre but is generally regarded as poor (Nishtar, 2006).

The secondary and tertiary health care services: The secondary care facilities provide both out-patient and in-patient care through district and sub-district hospitals. The tertiary level health care includes teaching hospitals, intensive care units and advanced diagnostic centres. They are scarce (Table 2 below) and are mainly located in major cities. This makes them inaccessible to majority of the population living in the rural and remote areas. These hospitals are overburdened with the increasing number of patients each year, due to population growth and rural to urban migration. The Health Facility Assessment conducted in 2012 reported these hospitals are lacking in health specialists, technicians, equipment, drug supplies and quality of care (TRF, 2012).

1.3.2.2 The private sector

The public and private health sector run parallel in Pakistan with the private sector playing a major role in the provision of health care. 77% of the population seek private health care through clinics, hospitals, nursing homes, chemist and medical stores, homeopathic and tibb (treatment through natural remedies) dispensaries (Akram and Khan, 2007). They are also the leading source of maternal and child health services (Economic Survey of Pakistan, 2013-2014). A comparison of service quality between private and public hospitals has indicated better health services in private hospitals (Irfan and Ijaz, 2011). However, the private health sector is not properly regulated increasing the risk of unethical and illegal practices such as over-charging, over-prescription, and unnecessary referrals for clinical tests to make their profits (Nishtar, 2006).
1.3.2.3 Mental health care in Pakistan

Mental health care is provided through both the public and the private sector. Doctors and nurses located in PHC are lacking in mental health training and patients are referred to secondary and tertiary care for treatments (WHO, 2011). However, the referral system is inefficient resulting in patients either directly accessing secondary/tertiary facilities or private sector facilities (Gilani et al., 2005). According to the Mental Health Atlas (2011) there are few public mental health facilities and the ratio of professionals to patients is poor (Table 2 below). The scarcity of public resources and the un-affordability to access the private run facilities due to out-of-pocket expenses, has made the mental health services inaccessible to the majority of the population (Khalily, 2011), especially those residing in rural areas. The above problems are compounded by the social stigma associated with mental illnesses, lack of knowledge about its nature and causes and lack of awareness of treatment options such as talking therapy. There is common misconception of attributing them to supernatural causation such as evil eye, black magic and jinn possession (Khalily, 2011, Qidwai and Azam, 2002, Rahman, 2007). The traditional and faith healing practices constitute a significant portion of the private mental health sector both in the rural and urban areas. The healers are frequently approached for the treatment of mental illnesses due to their easy accessibility and social acceptance (Karim et al., 2004, Gilani et al., 2005).
Table 2: Health care facilities in Pakistan

<table>
<thead>
<tr>
<th>Health care facilities</th>
<th>Number</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Health Units</td>
<td>5527</td>
<td>Economic survey of Pakistan 2013-2014</td>
</tr>
<tr>
<td>Rural Health centres</td>
<td>650</td>
<td>Economic survey of Pakistan 2013-2014</td>
</tr>
<tr>
<td>Public hospitals</td>
<td>1096</td>
<td>Economic survey of Pakistan 2013-2014</td>
</tr>
<tr>
<td>Mental health outpatient facilities</td>
<td>3729</td>
<td>WHO, 2011</td>
</tr>
<tr>
<td>Psychiatric beds in general hospitals</td>
<td>3231</td>
<td>WHO, 2011</td>
</tr>
<tr>
<td>Mental hospitals</td>
<td>5</td>
<td>WHO, 2011</td>
</tr>
</tbody>
</table>

**Ratio of health professionals to patients**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor patient ratio</td>
<td>1:1099</td>
<td>Economic survey of Pakistan 2013-2014</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1: 541,000</td>
<td>Mental Health Atlas Pakistan, 2011</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1: 386,000</td>
<td>Mental Health Atlas Pakistan, 2011</td>
</tr>
</tbody>
</table>
1.4 Introduction to the social systems in rural Pakistan

The section below briefly discusses the social systems, which determine and dictate behaviour of Pakistani citizens especially rural women, who are the focus of this study.

1.4.1 Social class boundaries

Social status in Pakistan is generally defined in terms of power, privilege and prestige (Hafeez, 1985). A study conducted in rural Pakistan to investigate the impact of social status on determining and maintaining poverty, indicated that there are subtle processes of social ordering. This social ordering or hierarchy is based on religion, caste, colour, tribe, *biradri* (clan), and family and lead to the creation of social stratification (Mohmand and Gazdar, 2007). Mohmand and Gazdar found that the social stratification in rural Pakistan is maintained through practices and systems, which limit the opportunities and create social exclusions for those at the lower end of social ordering such as agricultural labourers and women. Islam (2004) has also indicated certain values and traditions high in Pakistani culture, such as exhibiting tolerance to members of higher social stratification and valuing an individual’s identity as a member of cohesive group (Islam, 2004). Such norms can contribute to maintain the social class boundaries and overshadows the individualism, which encourages taking responsibility, managing one’s own self and taking pride in one’s own achievements.

1.4.2. Kinship or *biradri* system

The ideology of collectivism is reflected through clan and kinship structures which are central to the social structures of Pakistan. Many authors have observed that the clan based kinship or the *biradri* system is particularly dominant in the rural areas and is a most significant marker of one’s identity and status (Mohmand and Gazdar, 2007, Chaudhry et al., 2014). However, many believe it restricts mobility within
groups, dictates certain practices and behaviours and demands loyalty. According to Islam (2004), loyalty towards one’s clan is demonstrated by openly supporting it, giving favours (nepotism) and preference to its members. It has been argued that the biradri system reinforces marriages within one’s clan to ensure blood purity and to retain/strengthen resources and power (Lefebvre, 2013). At times, whole villages comprise of a single biradri, which then forms closely knit communities.

1.4.3 Hierarchal family structure

The majority of extended families in rural Pakistan live jointly such as grandparents, parents, and their male off-spring, living together with their spouses and children. Mohmand and Gazdar (2007) pointed out that the patrilineal nature of descent in these communities makes the head males of the families dominate, control the families’ resources and are the main decision maker in the families including the health care decisions. It has been argued that such patriarchal and hierarchical family structures place women at a subordinate and disempowered position. This has been explored by several sociologists indicating high prevalence of gender disparity in Pakistan, exhibited through seizing women’s power to make personal decision, limiting their access to resources, constraining their freedom of movement (Jejeebhoy and Sathar, 2001, Mohmand and Gazdar, 2007), restricting their opportunities for education (Ghazi et al., 2011) and depriving them of economic autonomy, despite their contribution in household economy (Sathar and Kazi, 2000). This sociological perspective also argues that these societal structures are linked to expectations that women ought to lead their lives as prescribed by societal and family expectations. It has been suggested that they are regarded as the custodian of the family’s honour and several restrictions are imposed on them in the name of guarding their sexuality and preventing them from engaging in perceived immoral activities, to protect family honour (Afshar, 1989).
1.4.4 Gender discrimination and women’s mental health

Global studies in the field of mental health have explored the impact of discrimination and repression on women’s mental health. Some studies have shown that women experience significant mental distress due to bearing injustice and abuse, for the sake of family honour and facing consequences for bringing shame and dishonour to their family (Gilbert et al., 2004). This can range from being disowned by the family and community to serious penalties such as honour killings (Patel and Gadit, 2008). These cultural restrictions, along with the particular interpretation of religious concepts such as purhad (to veil oneself from men of different baradri), result in the segregation and discrimination against women (Mohmand and Gazdar, 2007). Most contemporary scholars of gender issues in Pakistan argue that factors such as these place women in socially disadvantaged position (Roomi and Parrott, 2008, Rehman and Roomi, 2012, Ghazi et al., 2011). The Government has initiated plans to promote gender equality through eliminating disparity in education and employment (MDG, 2013). This has led to some improvement, for instance female youth (ages 15-24) literacy has increased from 0.51 in 1991 to 0.81 in 2012, this still falls short of the target of 1.0 set for 2015.

1.5 Summary

Pakistan is a lower middle income country which is currently experiencing several challenges such as overpopulation, poverty, illiteracy and political instability. The review of health system has indicated significant shortfalls at the administrative and delivery level, causing major health challenges such as high level of mother and child mortality and morbidity. It has also been argued that social systems of rural Pakistan are hostile to women’s autonomy leading to gender disparities and placing women at a disadvantaged position. Such factors can predispose women to poor mental health.
Chapter 2: Literature Review

This chapter reviews the literature about perinatal depression including prevalence, associated risk factors and its impact on mothers and infants in Pakistan. It identifies the barriers to the delivery of mental health care in resource constrained settings and discusses the evidence for the use of peer volunteers (PVs) in delivery of psychosocial interventions for perinatal depression in both high income countries (HICs) and low and middle income countries (LMICs).

2.0 Introduction

Reviews are necessary to make evidence yielded from primary studies manageable, establish reliability and external validity of these findings, and incorporate the results of original studies into practice (Cipriani and Geddes, 2003). They are also important for identifying gaps in knowledge, thus establishing areas for further research. Literature reviews differ in their scope – a systematic review uses a comprehensive unbiased search to obtain convincing, powerful and precise conclusions, while a narrative review gives a broader perspective on a topic through identifying what has been written on the subject and generally using examples of best practice (Tranfield et al., 2003, Cipriani and Geddes, 2003).

Prior to reviewing the literature relevant to this study, a brief discussion on the definition of perinatal depression is given below.

2.1 Definition of perinatal depression

Although perinatal depression is now considered to be an important public health problem (Prince et al., 2007), the mental health field does not have a clear definition of the disorder. Classification systems for psychiatric disorders define the problem rather narrowly (Wisner et al., 2010, Edge, 2011), and focus on the postnatal period. Postnatal depression is a diagnosis used for all depressive episode occurring during
The International Statistical Classification of Diseases (ICD-10) and the Diagnostic & Statistical Manual (DSM-V) has set the onset for postnatal depression within six and four weeks after childbirth respectively.

Postnatal depression vary in their severity from postnatal blues to postnatal psychosis. Postnatal blues is relatively mild transient state occurring within 4-7 days following delivery. Postnatal psychosis is the rare and most severe of the perinatal mental illness, onset during 1-4 weeks and is characterised by acute psychotic state (Sit et al., 2006). Postnatal depression in relation to its severity lies somewhere between postnatal blues and postnatal psychosis and includes symptoms such as depressed mood, anxiety, appetite and sleep disturbance, decreased concentration, feeling of worthlessness and suicidal ideation (American Psychiatric, 1994).

Over the last decade, researchers have begun to describe postnatal depression as a continuation of the depressed state which may have had its onset during pregnancy or even beyond (Rahman et al., 2003, Evans et al., 2001, Austin, 2004, Gaynes et al., 2005, O’Hara and Swain, 1996). Indeed, psychological symptoms during pregnancy are the strongest predictors of postnatal depression globally (Fisher et al., 2012, Robertson et al., 2004). Several studies have indicated that women who were postnatally depressed had its onset during the prenatal period (Green and Murray, 1994, Verkerk et al., 2002). Evidence such as the above, have led clinicians and researchers to use the term ‘perinatal depression’ for depression during both pre and postnatal periods. According to Golbort (2006. p.121) “the breadth of this nonpsychotic experience can occur anywhere along the continuum of the pregnancy - antenatally as well as after delivery”. Most policy-makers and practitioners agree that from a public health perspective, perinatal depression can occur at any time during pregnancy and until one year postnatal.

postnatal period (Gaynes et al., 2005, Austin, 2004).
2.2 Methodology of the review

The purpose of this review is to explore the literature related to the aims of the study, i.e. to explore the acceptability of PVs as delivery agents of a psychosocial intervention for perinatal depression in rural Pakistan. The review as shown in figure 6 below focused on the following areas:

1. Prevalence and risk factors for perinatal depression in Pakistan
2. Impact of perinatal depression
3. Barriers to delivery of mental health care in LMIC
4. Use of peers in the delivery of mental health interventions
   a. Peer-delivered mental health interventions in HIC
   b. Peer-delivered mental health interventions in LMICs.
5. Systematic review of peer-delivered maternal health interventions in LMICs (Chapter 3)

Figure 6: Structure of literature review

- Prevalence, risk factors and impact of perinatal depression in Pakistan (Section 2.3)
- Barriers to delivery of mental health care in LMIC (Section 2.4)
- Use of peers in the delivery of mental health care (Section 2.5)
  - Peer-delivered mental health interventions in HIC (Section 2.5.2)
  - Peer-delivered mental health interventions in LMICs (Section 2.5.3)
- Systematic review of peer-delivered maternal health interventions in LMICs (Chapter 3)
To review the literature relevant to the above broad areas, the following methods were used. For area 1 and 2 above, in addition to the studies identified in Fisher et al., (2012) systematic review, on the perinatal depression in LMICs, recent studies were systematically searched using the same search strategies and including the term ‘Pakistan’. For area 3, a narrative review was conducted, drawing on studies and reviews that have been undertaken in the last 10 years. For area 4-a, studies relevant to the author’s topic were discussed from Fuhr et al., (2014) systematic reviews on effectiveness of peer-delivered interventions for severe mental illness and depression. For area 4-b, a search strategy was developed and literature was systematically searched. The following academic databases were used for the above reviews CINHAL, PsychINFO, PubMed, ASSIA, SCOPUS and Web of Science.
2.3 Prevalence, risk factors and impact of perinatal depression

2.3.1 Prevalence of perinatal depression in Pakistan

Systematic reviews examining evidence from diverse cultures across LMICs suggest that rates of perinatal depression are higher in these countries compared to HICs (Parsons et al., 2011, Fisher et al., 2012). Figure 7 below from Parson et al., (2011) presents geographical prevalence map of perinatal depression across LMICs (Pakistan is indicated in red among the countries with highest prevalence).

Figure 7: Geographical prevalence map of perinatal depression across LMIC (Parson et al., 2011).
Fisher et al’s (2012) systematic review suggested the weighted mean prevalence of depression during prenatal and postnatal period is 15.6% and 19.8% respectively in LMICs. In order to estimate the prevalence of perinatal depression in Pakistan, the studies from Pakistan which were included in the review were used. This review included studies up to November 2010. To identify prevalence studies after this period, the literature was systematically searched between December 2010 and January 2015, using the same search strategy adopted by Fisher et al., and including the term ‘Pakistan’.

Box 1: Search strategy to identify studies for prevalence of perinatal depression in Pakistan

| 1. Prenatal OR antenatal OR pregnancy OR postnatal OR postpartum |
| 2. Mental disorder OR adjustment disorder OR affective disorder OR dysthymic disorder OR psychiat* OR behaviour control OR psychological phenomena OR depression OR mental health OR stress disorder OR anxiety disorder OR maternal welfare OR maternal health |
| 3. Pakistan |

Combined terms: 1 AND 2 AND 3.

Databases searched: CINHAL, PsychINFO, Medline and Web of Science

A total of 225 studies were retrieved; CINAHL (34 hits), PsychInfo (27 hits), Medline (80 hits) and Web of Science (84 hits). Out of them, five prevalence studies from Pakistan were identified (Husain et al., 2011, Shaikh et al., 2011, Shah et al., 2011, Ali et al., 2012, Humayun et al., 2013). These, in addition to the studies already included in Fisher’s review (Karmaliani et al., 2007, Husain et al., 2006, Rahman et al., 2003), are discussed below. The studies are summarised in Table 3 below.
### Table 3: Prevalence of perinatal depression in Pakistan

#### Prevalence of prenatal depression in Pakistan

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Study area</th>
<th>Sample size</th>
<th>Assessment time</th>
<th>Assessment instrument</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Humayun et al., 2013)</td>
<td>Tertiary care hospital, Lahore</td>
<td>506</td>
<td>3rd Trimester</td>
<td>EPDS</td>
<td>64.6%</td>
</tr>
<tr>
<td>(Ali et al., 2012)</td>
<td>Tertiary care Hospital, Karachi</td>
<td>165</td>
<td>Not specified</td>
<td>HADS</td>
<td>16.8%</td>
</tr>
<tr>
<td>(Husain et al., 2011)</td>
<td>Private antenatal clinic, Karachi</td>
<td>1357</td>
<td>3rd Trimester</td>
<td>EPDS</td>
<td>25.8%</td>
</tr>
<tr>
<td>(Shaikh et al., 2011)</td>
<td>Tertiary care hospital, Karachi</td>
<td>132</td>
<td>2nd and 3rd Trimester</td>
<td>CES-D</td>
<td>40.9%</td>
</tr>
<tr>
<td>(Shah et al., 2011)</td>
<td>Northern Pakistan</td>
<td>128</td>
<td>1st, 2nd and 3rd trimester</td>
<td>EPDS</td>
<td>48.4%</td>
</tr>
<tr>
<td>(Karmaliani et al., 2007)</td>
<td>Civil hospital, Hyderabad</td>
<td>1000</td>
<td>2nd Trimester</td>
<td>AKUADS</td>
<td>11.5%</td>
</tr>
<tr>
<td>(Rahman et al., 2003)</td>
<td>Rural sub-district, Pakistan</td>
<td>632</td>
<td>3rd Trimester</td>
<td>SCAN</td>
<td>25%</td>
</tr>
</tbody>
</table>

#### Prevalence of postnatal depression in Pakistan

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Study area</th>
<th>Sample size</th>
<th>Assessment time</th>
<th>Assessment instrument</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Husain et al., 2011)</td>
<td>Antenatal clinic, Karachi</td>
<td>763</td>
<td>12 weeks postnatal</td>
<td>EPDS</td>
<td>38.3%</td>
</tr>
<tr>
<td>(Husain et al., 2006)</td>
<td>Rural sub-district, Pakistan</td>
<td>149</td>
<td>12 weeks postnatal</td>
<td>EPDS</td>
<td>36%</td>
</tr>
<tr>
<td>(Rahman et al., 2003)</td>
<td>Rural sub-district, Pakistan</td>
<td>541</td>
<td>10-12 weeks postpartum</td>
<td>SCAN</td>
<td>28%</td>
</tr>
</tbody>
</table>

Centre for Epidemiology Studies Depression Scale (CES-D), Edinburgh Postnatal Depression Scale (EPDS), Schedule for Clinical Assessment in Neuropsychiatry (SCAN) Aga Khan University Anxiety Depression Scale (AKUADS), Hospital Anxiety and Depression Scale (HADS) Self Reporting Questionnaires (SRQ).
Eight studies were conducted in Pakistan between 2003 and 2013 involving 5373 participants. These studies showed that the prevalence of perinatal depression ranged from 11.5% to 64.6% during pregnancy and 28% to 38.3% during postpartum period. The wide range of prevalence rates may be explained by methodological differences. These studies varied in their settings, sample sizes, instruments used to measure depression and type of assessor.

The screening tools used in primary studies were Edinburgh Postnatal Depression Scale (EPDS) (Husain et al., 2011, Shah et al., 2011, Husain et al., 2006, Humayun et al., 2013), Hospital Anxiety and Depression Scale (HADS) (Ali et al., 2012), Centre for Epidemiology Studies Depression Scale (CES-D) (Shaikh et al., 2011) and Aga Khan University Anxiety Depression Scale (AKUADS) (Karmaliani et al., 2007). The EPDS (Rahman et al., 2005), HADS (Mumford et al., 1991), CES-D (Karim et al., 2014) have all been translated and validated for use in Pakistan. The AKUADS was developed in Urdu at a local University (Ali et al., 1998). Only one study used a diagnostic tool, the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (Rahman et al., 2003). Assessments were carried out by mental health professionals in only two studies (Rahman et al., 2003, Ali et al., 2012), the remainder of the studies used non-mental health professionals such as community health workers (Shah et al., 2011, Husain et al., 2006, Karmaliani et al., 2007) and researchers (Husain et al., 2011, Shaikh et al., 2011). Assessments were carried out either during the second or third trimester of pregnancy. The use of different assessment tools, period of assessment and assessors with different levels of training and qualification could contribute to the differences in scores.

Furthermore the samples size included in the studies vary. The studies reporting higher prevalence of prenatal depression (48.8%) (Shah et al., 2011) and postnatal depression (36%) (Husain et al., 2006) had small sample sizes of only 128 and 149 women respectively. Participants in the reported studies were recruited from different settings, i.e., five of the eight studies had samples drawn from clinical
settings (Husain et al., 2011, Shaikh et al., 2011, Karmaliani et al., 2007, Ali et al., 2012, Humayun et al., 2013) and the remaining three studies were community based (Husain et al., 2006, Rahman et al., 2003, Shah et al., 2011). It is relevant to note that more than 67% of the population in Pakistan live in rural areas, and a majority of them have either limited or no access to health care facilities (for more information refer to Tables 1 & 2). This means that the clinical-based studies were less representative of the overall population. There were also subtle differences in culture and demography of different regions where these studies were conducted. For example, while the female literacy rate is higher in urban localities (66%) as compared to rural areas (33%), social support may be better in rural settings. The risk factors are discussed below and should be kept in mind when examining the differences in reported prevalence rates.

When the above factors are considered, it is difficult to assess the prevalence rates of perinatal depression in Pakistan with any precision. However, taking into account the differences in methodology and settings, it might be reasonable to assume that up to a quarter of the women in Pakistan suffer from depression during the perinatal periods.

2.3.2 Risk factors for perinatal depression in Pakistan

Considering the relatively high prevalence of perinatal depression in Pakistan, it is important to examine its contributing risk factors. Out of the eight studies in the review, six reported associated risk factors. Table 4 summaries the significant risk factors for perinatal depression identified in these studies.
Table 4: Risk factors for perinatal depression

<table>
<thead>
<tr>
<th>Author and year</th>
<th>Study area</th>
<th>Study type</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humayun et al., 2013</td>
<td>Tertiary care hospital in Lahore</td>
<td>Cross-sectional study</td>
<td>Separation from husband, Fear of childbirth</td>
</tr>
<tr>
<td>Ali et al., 2012</td>
<td>Tertiary care hospital, Karachi</td>
<td>Cross-sectional study</td>
<td>Age of women ≥ 35, Total live births, Adverse pregnancy outcome, Respondent’s lack of role in the household decision-making</td>
</tr>
<tr>
<td>Husain et al., 2011</td>
<td>Private antenatal clinic, Karachi</td>
<td>Cohort Study</td>
<td>Low family income, Low education, Nuclear family, Unemployed husband, Husband away from home for more than 1 month, Problem during the previous delivery, Medication during pregnancy</td>
</tr>
<tr>
<td>Shah et al., 2011</td>
<td>Northern Pakistan</td>
<td>Cross-sectional study</td>
<td>Physical abuse, Sexual abuse</td>
</tr>
<tr>
<td>Husain et al, 2006</td>
<td>Rural sub-district, Pakistan</td>
<td>Cross-sectional study</td>
<td>Domestic violence, Lack of social support, Stressful life events in the previous years</td>
</tr>
<tr>
<td>Rahman et al., 2003</td>
<td>Rural sub-district, Pakistan</td>
<td>Cohort study</td>
<td>Significant other made redundant, Financial difficulties, Housing difficulties, Major arguments and relationship difficulty, Serious marital problems, Having ≥ 2 children under 7, Having ≥ 2 girls, Husband illiterate/unemployed</td>
</tr>
</tbody>
</table>
The risk factors indicated in these studies were collated and synthesised to produce the following broad categories:

- Socioeconomic and cultural factors
- Interpersonal relationships
- Life events

### 2.3.3.1 Socioeconomic and cultural factors

The reviewed studies found an association between low literacy (Husain et al., 2011), financial difficulties (Husain et al., 2011, Rahman et al., 2003), housing difficulties (Rahman et al., 2003), and lack of empowerment (Ali et al., 2012) with perinatal depression. Further association of perinatal depression is indicated with husband’s unemployment and illiteracy (Rahman et al., 2003, Husain et al., 2011), lack of social support due to living in a nuclear family (Husain et al., 2011) and fear of childbirth (Humayun et al., 2013). These findings are consistent with evidence from other LMICs where poor socioeconomic conditions such as poverty (Wan et al., 2009, Chandran et al., 2002), lack of a permanent job (Fisher et al., 2004), illiteracy (Faisal-Cury et al., 2004) and lack of social support (Fisher et al., 2012, Fisher et al., 2004, Chandran et al., 2002) are identified indicators of perinatal depression.

Rahman et al’s study (2003) has indicated that rapidly changing traditional family structures and practices increases the risk of depression in women. For instance in rural Pakistan, not practising the traditional ‘chilla’ ritual (post-delivery confinement period of 40 days, where the women is taken care of by other female members of the family) increases the risk of depression during the postnatal period. However studies conducted in China provide less consistent evidence on confinement practices as a protective factor for postpartum depression (Wong and Fisher, 2009, Gao et al., 2010).

In Pakistan a mother with two daughters was found to be at a higher risk of perinatal depression (Rahman et al., 2003) which is consistent with other cultures
where there is a preference for male offspring (Chandran et al., 2002, Patel et al., 2002a, Nakku et al., 2006, Abiodun, 2006, Jain et al., 2014).

2.3.3.2 Interpersonal relationships

The reviewed studies found poor marital relation (Rahman et al., 2003), physical and sexual abuse (Shah et al., 2011), domestic violence (Ali et al., 2012, Husain et al., 2006) and husband away from home for more than a month (Husain et al., 2011) as indicators for perinatal depression. Similar associations are found in studies conducted in other LMICs which indicated poor marital relationship; including perceived unsupportive partner (Adewuya et al., 2007), lack of intimate relationship (Fisher et al., 2004), low spouse involvement during perinatal period (Wan et al., 2009), abusive partner (Agoub et al., 2005) along with poor interpersonal relationship with in-laws as determinants of perinatal depression (Abiodun, 2006, Chandran et al., 2002, Gausia et al., 2009, Imran and Haider, 2010).

2.3.2.3 Life events

Adverse life events increase the risk of perinatal depression. The above review showed the association between perinatal depression and life events such as complication with previous pregnancy (Husain et al., 2011), adverse pregnancy outcomes (Ali et al., 2012), significant other made redundant (Rahman et al., 2003) and separation from husband (Humayun et al., 2013). These findings are consistent with evidence from LMICs indicating stressful life events such as health complications during and after pregnancy, having a previous history of stillbirth (Adewuya et al., 2007, Gausia et al., 2009), unplanned or unwelcome pregnancy (Fisher et al., 2004, Nakku et al., 2006), financial difficulties, separation or divorce (Adewuya et al., 2007) and bereavement (Gausia et al., 2009) as risk factors for perinatal depression.

In summary, this section shows that various cultural, social, psychological and financial factors contribute to the high prevalence of depression in LMIC. The risk
factors for perinatal depression in Pakistan are not different from those reported in other LMIC.

2.3.3 Impact of perinatal depression

Perinatal depression has serious consequences for mothers, their infants and families (Fisher et al., 2012, Meltzer-Brody, 2011). This section discusses the impact of perinatal depression on both mother and infant.

2.3.3.1 Impact on mother

An untreated prenatal depression increases the risk of postnatal episode. Prevalence studies which measure perinatal depression during and after pregnancy indicated a strong association between them (Rahman et al., 2003, Husain et al., 2006, Husain et al., 2011). Furthermore, studies conducted in Pakistan have indicated that perinatal depression is associated with mothers’ significant disability (Husain et al., 2011), and negative cognitions about oneself, significant others and in relation to their newborns (Rahman, 2007). The risk of suicidal thoughts and attempts are also significantly higher among such women in Pakistan (Ali et al., 2012), especially among those who experience domestic abuse (Shah et al., 2011).

This is consistent with findings from other LMICs, indicating depression during pregnancy a strong predictor of postnatal depression (Robertson et al., 2004). It is found to increase the risk of suicidal thoughts and attempts (Lindahl et al., 2005) and could lead to a significant number of women continuing to experience depressive symptoms for months or years after the birth of a child (Goodman, 2004).

It is also associated with obstetric complications (Chung et al., 2001, Arck, 2001), such as preterm birth (Dayan et al., 2002) and spontaneous abortion (Nakano et al., 2004). Mothers who are perinatally depressed tend not to seek prenatal care, have impaired decision-making capacities, poor self-care, perception of decreased social support and increased life stresses (Rojas et al., 2010, Sadat et al., 2014, Zuckerman
et al., 1989). These compounded with low self-esteem (Ritter et al., 2000), causes significant parenting difficulties (Albright and Tamis, 2002).

2.3.3.2 Impact on infant

Perinatal depression impacts on the wellbeing of infants in Pakistan in a number of ways including lower birth weight (Rahman et al., 2007a), lower rates of immunisation (Rahman et al., 2004), higher rates of diarrhoea per year (Rahman et al., 2007b) and growth retardation (Rahman et al., 2004). Another recently conducted study on a sample of 420 Pakistani depressed mothers found a significant association of postnatal depression with delay in child’s cognitive and motor development (Ali et al., 2013).

A review of evidence from LMIC has indicated that perinatal depression is a significant risk factor for poor child developmental outcomes (Parsons et al., 2011). Likewise a meta-analysis has shown significant association of perinatal depression with low birth rate and stunting (Surkan et al., 2011, Grote et al., 2010). Importantly, the latter analysis reports that 23% to 29% fewer children would not be underweight or stunted if not exposed to maternal depressive symptoms. Such findings are significant for Pakistan where infant mortality rates (6.9%) and malnourishment in children (31.5%) are relatively higher (see Table 1, p.24).

Evidence such as that outlined above indicates the need for developing effective intervention strategies to address perinatal depression.
2.4 Barriers to delivery of mental health care in LMICs

Despite the evidence of high prevalence of perinatal depression in Pakistan and its adverse impact on the mother and infant, the availability of mental health care is poor (WHO, 2009). This is due to scarcity of human and financial resources, non-existent community-based mental health care and concentration of health facilities in urban areas (see Table 2, p.28).

This is consistent with evidence from other LMICs. Reviews of mental health care in LMICs has identified scarcity of resources, their inequitable distribution and inefficiencies in their use as main obstacles to delivery of mental health care (Kakuma et al., 2011, Saxena et al., 2007). Most countries in Africa and Southeast Asia spend less than 1% of their small health budgets on mental health services (Saxena et al., 2007). It is also reported that there is a shortage of 1.18 million mental health workers in 144 LMIC (WHO, 2011). Hence the treatment gap for mental disorders is much higher in LMICs (76–85%) as compared to HICs (35–50%) (Demyttenaere et al., 2004). Figure 8 below, taken from Saxena et al (2007), shows the number of mental health workers per 100,000 population in low income countries group significantly less as compared to high income countries group.
Evidence suggests that ‘task shifting’ is an effective and feasible approach to alleviate health workforce shortage (Kakuma et al., 2011, Eaton et al., 2011). It involves delegating tasks to either already existing workforce (such as community health workers, birth attendants) or creating a new cadre of workers through providing specific training for a particular task. These workers could be family members, local residents, carers, peers, volunteers or affected individuals. Through appropriate training, supervision and management they can be used as a potential resource in reducing the treatment gap in mental health services in LMICs.

In the next section the literature on the use of peers in the delivery of perinatal depression interventions will be reviewed.
2.5 Use of peers in delivery of mental health interventions

Peers have been widely used for preventative and treatment interventions (Doull et al., 2008) and evidence suggests that peer support can enhance positive health outcomes (Repper and Carter, 2011), reduce mental distress (Dennis et al., 2009, Druss et al., 2010) and help people to deal with chronic disease (Medley et al., 2009).

2.5.1 Definition of a peer

Different terms have been used to describe non-professionals working in the mental health care such as lay workers, community workers, lay volunteers and lay counsellors. Lay workers have been defined as ‘any person carrying out functions related to healthcare delivery, trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificate or tertiary education degree’ (Lewin, 2010. p.7).

When the term ‘peer’ is applied to the above, e.g., peer volunteer or peer counsellor, this generally indicates a person who fulfils the above criteria and has the added element of ‘being a peer’. The word peer has been used in the context of healthcare for those who have similar socio-demographic characteristics as the target population and/or use their own experience of overcoming an illness to help others (Davidson et al., 2006, Dennis, 2003, Repper and Carter, 2011). These common characteristics may include: age, gender, health concern, socioeconomic status, religion, ethnicity, locality, culture or education. Such commonalities enable the recipients to relate with the peers (Doull et al., 2008, Giblin, 1989), perceiving them to be ‘similar’ to themselves and having a greater understanding of the issues they face (Singla et al., 2014).
Peers operate at different levels. Peer support could be informal (natural lay helpers i.e. family members/friends), peers participating in peer-run programmes and peer employees (Davidson et al., 1999, Solomon, 2004). The support could be provided in diverse community or clinical based settings through individual sessions, group sessions or via telephone or computer.

The following sections will review peer-delivered perinatal depression interventions to understand the effectiveness of such interventions and factors contributing to their acceptability and feasibility.

2.5.2 Peer-delivered interventions for perinatal depression in HIC.

A systematic review aimed to assess the effectiveness of peer-delivered mental health interventions was conducted by the SHARE team (see ‘about the author’) including the author (Fuhr et al., 2014). The detailed protocol is attached in Appendix 22. The author was involved in the development of the protocol, and quality assessment using Cochrane risk of bias tool (Higgins et al., 2011). The systematic review is not part of this PhD study.

The review identified 14 RCTs (4 depression studies and 10 severe mental illness studies) in which mental health interventions were delivered through peers (Table 5). All trials identified were conducted in HIC. The meta-analysis of these trials suggested a small positive impact favouring peer-delivered interventions. Three out of the 14 studies evaluated interventions for perinatal depression (Dennis, 2003, Dennis et al., 2009, Letourneau et al., 2011). The other studies focussed on severe and persistent mental illness (Cook et al., 2012a, Cook et al., 2012b, Davidson et al., 2004, Solomon and Draine, 1995, Ludman et al., 2007, Rivera et al., 2007, Forchuk et al., 2005, van Gestel-Timmermans et al., 2012) and substance abuse (Sells et al., 2008). Since the focus of this thesis is perinatal depression, the three peer-delivered interventions targeting this disorder are discussed in further detail.
Table 5: Peer-delivered mental health interventions in HICs

<table>
<thead>
<tr>
<th>Study Setting and design</th>
<th>Delivery Agent</th>
<th>Sample</th>
<th>Intervention</th>
<th>Training</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dennis, 2003 Canada Pilot-RCT</strong></td>
<td>Peer volunteers: Not part of the mother’s own family or immediate social network, had experienced postpartum depression and had similar socio-demographics as the mothers.</td>
<td>N=42 8 to 12 week postpartum mothers who scored more than 12 on EPDS</td>
<td>Telephone based peer support</td>
<td>4 hour training session</td>
<td>Significant difference in EPDS scores were found at 4 weeks (p 0.008) and at 8-week assessment (p 0.006). 16 mothers in the experimental group who evaluated the intervention, 87.5% were satisfied with their peer-support experience.</td>
</tr>
<tr>
<td><strong>Dennis et al., 2009 Canada RCT</strong></td>
<td>Peer volunteers: ability to speak and understand English and self-reported history of and recovery from postnatal depression.</td>
<td>N=701 First 2 weeks postpartum mothers who scored more than 12 on EPDS</td>
<td>Telephone based peer support – minimum of 4 contacts</td>
<td>4 hour training session</td>
<td>At 12 weeks 14% of women in the intervention group had an EPDS score &gt;12 compared with 25% in the control group (p &lt; .001). No significant group differences found in EPDS or SCID scores at 24 weeks. 221 women in the intervention group who received and evaluated their experience of peer support, over 80% were satisfied with their peer support experience.</td>
</tr>
<tr>
<td><strong>Letourneau et al., 2011 Canada RCT</strong></td>
<td>Local mothers who had experienced and recovered from postpartum depression</td>
<td>N= 60. Mothers with a baby less than 9 months of age who scored greater than 12 on EPDS</td>
<td>Home-based peer support for 12 weeks.</td>
<td>8 hour training</td>
<td>EPDS scores improved in both groups over time (p &gt; 0.001) but favouring the control condition (p = 0.02).</td>
</tr>
</tbody>
</table>
All three trials were community based and conducted in Canada. Peers following their training provided telephone (Dennis et al., 2003 & 2009) and home-based support (Letourneau et al., 2011) to mothers experiencing postpartum depression (EPDS > 12). In Dennis’s (2003) trial there was significant decline in depression favouring the intervention arm. However the sample size was small (n=42) and there was no long-term follow-up. The most robust trial (Dennis et al., 2009), found improvement in depressive symptoms at 12 week but these improvements were not sustained at 24 weeks. In Letourneau et al., (2011) trial, EPDS scores improved in both groups, but favouring the control arm. In this trial, in addition to the methodological limitations indicated, other explanations attributed to the outcomes were the considerable perception of support in the control arm, peers’ inadequate training, difficulty in the delivering of mother-child interaction component and the likely possibility of mothers feeling judged leading to their increased guilt and anxiety. However peers and mothers’ experiences were not directly evaluated in this study.

While the evidence about the effectiveness of peer-delivered perinatal interventions is uncertain, mothers and peers reported higher satisfaction rates with peer-delivered interventions (Dennis, 2010, Dennis, 2012). Dennis evaluated participant mothers’ and peers’ experiences using peer support evaluation inventory and peer volunteer experience questionnaire respectively. Findings indicated mothers’ high level of satisfaction. Most mothers felt their peer was able to provide them with emotional, informational and appraisal supports. They appreciated peers sharing similar life experiences, being listened to, and not being judged. A large proportion of mothers stating feeling less isolated, more confident, and more in control of their situation (Dennis, 2010). Dennis (2012) found peers’ high levels of satisfaction; peers in her study reported volunteering contributed to their personal development and showed their willingness to become peer volunteer again. Consistent with the above findings, Repper and Carter’s (2011) review also indicated the positive impact of
peer support on the lives of both the peers and the recipients. Only some peers in Dennis’s study reported experiencing time constraints, frustration over not receiving a response to their phone calls and initial lack of confidence over their personal skills.

The above findings were obtained through self-administered questionnaires and therefore may have lacked in depth. It is also important to note that above studies were conducted in Canada and excluded mothers who did not speak English. Therefore generalisability is limited to only English speaking population of a HIC.

2.5.3 Peer-delivered mental health interventions in LMICs

The systematic review summarised above used narrow criteria to define the scope of the peer-delivered intervention (i.e., the primary outcomes were mental health related) and their evaluation (RCTs and other controlled evaluations). Furthermore, all the studies identified were conducted in a HIC. As the focus of this study is on the use of peers in the delivery of mental health intervention in LMICs, it would be important to further search the literature for any adult peer-delivered mental health studies conducted in the LMICs, using broader inclusion criteria.

Using the key terms outlined in Box 2 below, the following databases were searched in December 2014: PsyINFO, Web of Science, PubMed and CINHAL and ASSIA.

Box 2: Search strategy to identify mental health interventions in LMICs

<table>
<thead>
<tr>
<th>Search Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer (volunteer* or support worker or counsel* or buddies or facilita* or educator or mentor*) AND</td>
</tr>
<tr>
<td>Common Mental Disorder or depression (prenatal or postnatal or postpartum) AND</td>
</tr>
<tr>
<td>Low middle income countries or developing countries or third world countries or Africa or Asia or South America or Pakistan or south Asia</td>
</tr>
</tbody>
</table>
Five studies including 25,645 participants, conducted in Bangladesh (Clarke et al., 2014), Zimbabwe (Chibanda et al., 2014), India (Tripathy et al., 2010), Pakistan (Ali et al., 2010) and South Africa (Futterman et al., 2010) were identified. Of the five studies, two were quasi-experimental studies (Futterman et al., 2010, Ali et al., 2010), and the remaining three were RCTs. The key features of these studies are presented in Table 6 below.
Table 6: Peer-delivered mental health interventions in LMICs

<table>
<thead>
<tr>
<th>Study setting and design</th>
<th>Delivery agent</th>
<th>Sample</th>
<th>Training and supervision</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark et al., 2014 Rural Bangladesh Cluster-RCT</td>
<td>Local women of reproductive age with some high school education</td>
<td>N=6275. Women of reproductive age, especially pregnant and newly married women.</td>
<td>Not specified</td>
<td>Women’s participatory action and learning groups (n=13), to facilitate the development and implementation of strategies to address maternal and new-born health problems.</td>
<td>The cluster mean SRQ-20 score was lower in the intervention arm (mean 5.2, standard deviation 1.8) compared to control (5.3, 1.2), the difference was not significant (b 1.44, 95% CI 0.28, 3.08).</td>
</tr>
<tr>
<td>Chibanda et al., 2014 Urban and peri-urban Zimbabwe RCT</td>
<td>Peer counsellors, HIV positive and had disclosed their illness to partner or family member.</td>
<td>N=58. Postpartum mothers who were clinically depressed</td>
<td>2 Day training. Weekly supervisions provided by the psychiatrist.</td>
<td>Group problem solving therapy (PST) delivered twice weekly for 6 weeks verses pharmacotherapy</td>
<td>The drop in the mean EPDS score was greater in the PST group (8.22, SD 3.6) compared to the pharmacotherapy group (10.7, SD 2.7), and this difference was statistically significant (P ¼ .0097).</td>
</tr>
<tr>
<td>Tripathy et al., 2010 Rural India Cluster-RCT</td>
<td>Local woman, able to speak the local language and</td>
<td>N=19030. Women aged 15–49 years, residing in the project area, and</td>
<td>7 Day residential training course. Fortnightly meetings with</td>
<td>Women’s participatory action and learning groups (n=13), to facilitate the development and implementation of</td>
<td>Neonatal mortality was 32% lower in intervention clusters (odds ratio 0·68, 95% CI 0·59–0·78) during the 3 years, and 45% lower in years 2 and 3 (0·55, 0·46–0·66). Overall, reduction in moderate</td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Participants</td>
<td>Study Design</td>
<td>Intervention</td>
<td>Outcomes</td>
</tr>
<tr>
<td>-------</td>
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<td>--------------</td>
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<td>----------</td>
</tr>
<tr>
<td><strong>Ali et al., 2010</strong>&lt;br&gt;Urban, Pakistan Quasi experimental study</td>
<td>Local women aged 18 years and over, able to read and write Urdu and willing to be trained</td>
<td>N=122. Pregnant mothers who were depressed</td>
<td>Weekly one-hour counselling sessions including basic cognitive behavioural therapy, supportive and problem-solving counselling for eight weeks.</td>
<td>A significant decline in level of anxiety/depression was found in both the counselled and the non-counselled groups at 4 and 8 weeks (p-value &lt; 0.001) but the counselled group fared better than the non-counselled for recovery, reduction in the rate of recurrence and increase in the duration before relapse.</td>
<td></td>
</tr>
<tr>
<td><strong>Futterman et al., 2010</strong>&lt;br&gt;Urban, South Africa Quasi experimental study</td>
<td>Mentor mothers, HIV positive, had a child recently, had used PMTCT services, and were coping positively.</td>
<td>N=160. Pregnant or new mothers living with HIV</td>
<td>Cognitive Behaviour Intervention delivered in group setting (n=8)</td>
<td>Improved social support, availability scores increased 9.3 points more for the intervention as compared to the control group (p_0.01). Improved CES-D scores significantly more than women in the control group (14.0 to 5.6 vs. 9.0 to 5.0; p_0.008). Decline in frequency of depression among intervention participants was not statistically significant.</td>
<td></td>
</tr>
</tbody>
</table>

- no mobility issues had given birth during the study.
- district coordinators strategies to address maternal and new-born health problems
- depression was 57% in year 3 (0.43, 0.23–0.80). Findings were not significant.
The above studies used locally based lay women to deliver the interventions. In all papers, apart from Chibanda et al (2014), they were not referred to as peers. However the geographical, gender and linguistic similarity with the target population, along with no formal qualification and training, qualify them to be called peers (see Section 2.5.1 for definition of a peer). In two studies (Chibanda et al., 2014 and Futterman et al., 2010), women who delivered the interventions to HIV positive mothers were also service users.

Apart from two interventions, which targeted women with perinatal depression (Chibanda et al., 2014, Ali et al., 2010), the other interventions targeted all women in the perinatal period. Likewise, their focus also varied, for example the interventions used in Tripathy et al., (2010) and Clarke et al., (2014) were aimed to reduce neonatal mortality and did not explicitly address mental health issues. The former study included maternal depression as a trial outcome in the second year and only in year three, a reduction in moderate depression (57%) favouring the intervention cluster was detected. The latter study used the same intervention, but did not produce any significant change in maternal depression. The likely reason indicated was less significance of neonatal mortality as a predictor of maternal depression in Bangladesh and the intervention failing to address significant factors associated with maternal depression such as domestic violence, marital relationship and lack of education (Gausia et al., 2009).

It has also been argued that interventions that have an active psychotherapeutic ingredient (such as CBT or IPT) are more likely to be effective, and have a sustained effect, even when delivered by non-specialists (Rahman et al., 2013). Chibanda et al., (2014) and Futterman et al., (2010) studies used Problem Solving Therapy (PST) and Cognitive Behaviour Therapy (CBT) based group interventions respectively, and produced significant outcomes favouring the intervention arms. There is also evidence indicating that such interventions when delivered individually have a greater effect size (Sörensen et al., 2002). In Ali et al., (2010) study a CBT based
intervention was delivered to depressed mothers at home and showed positive outcomes in relation to reduction in the rate of recurrence and increase in the duration before relapse.

There were a number of limitations with these studies. Three out of five (Clarke et al., 2014, Tripathy et al., 2010, Futterman et al, 2010) relied only on screening tools which are less accurate in diagnosing depression than detailed interviews (Fisher et al, 2012). The sample size of the study conducted in Zimbabwe was small and there was no long term follow-up (Chibanda et al., 2014). In Bangladesh and India, the intervention and the surveillance teams were un-blinded to the intervention arm, which could have introduced assessment bias. Additionally, the inter-cluster migration between the intervention and control arm could have resulted in spillage of information (Clarke et al., 2014, Tripathy et al., 2010). A study conducted in Pakistan, used counsellors as assessors which un-blinded them and comparison between counselled (n=59) and non-counselled group participants (n=12) was small. Furthermore, in this study, follow-up assessments did not include those enrolled towards the end of the study; this might have contributed for a lower recurrence rate (Ali et al., 2010). In Futterman et al., study depression in intervention arm at the baseline was only 38% and was not prevalent in the control arm. Apart from two studies (Tripathy et al., 2010, Clarke et al., 2014) all studies were conducted in urban areas. Due to cultural and socioeconomical differences between rural and urban settings in LMICs these findings are most likely not generalisable to LMIC’s rural population.
2.6 Summary

This literature review, focusing on Pakistan, has described the public health importance of perinatal depression, both in terms of its prevalence and impact on the mother and infant. Studies conducted in other LMICs have identified sociocultural and economic risk factors for perinatal depression, which are consistent with the evidence from Pakistan. The barriers to service provision in such settings have been highlighted. Scarcity of resource, specifically trained workforce, has been identified as one of the main obstacles to mental health care in LMICs. This highlights the need to explore other human resources in the communities, such as peers, to overcome the treatment gap. Peers have been used globally in the delivery of maternal mental health care and the evidence from eight quantitative studies (three from HIC and five from LMIC) discussed above has indicated some positive outcomes from the peer interventions delivered. However, there is a lack of research regarding the experiences of peers and mothers who have received such interventions, especially in the LMICs.

The in-depth exploration of mothers’ and peers’ experiences would be necessary to develop peer-delivered intervention models which are sustainable. Such evidence, helps to understand the intervention related factors which can influence the outcomes. Furthermore, it enables contextual understanding of the barriers and facilitators in intervention delivery and to establish criteria for the selection of the peers - which could play a significant role in their acceptability. A systematic review was therefore carried out by the author, to explore such experiences from qualitative studies conducted in LMICs - where peers have been used to deliver care in any maternal health related settings, instead of restricting it to mental health. This is detailed in Chapter 3.
Chapter 3 Systematic review of qualitative studies on peer-delivered maternal health interventions in LMIC

This chapter describes the methods and findings of the systematic review. It aimed to identify, appraise and summarise findings from qualitative studies, which investigated the experiences of stakeholders involved in peer-delivered maternal health care in LMIC.

3.0 Introduction

In recent years, a number of qualitative studies in the health sciences and practice disciplines have been conducted. Systematic reviews of such studies are being increasingly utilised as a valuable source of information leading to evidence based recommendations for practice guidelines. A systematic review emphasises the importance of using standardised scientific methods, to reduce bias and random errors to produce robust evidence. A properly conducted systematic review synthesises the evidence from all relevant studies, concisely and transparently, to provide reliable and accurate results (Moher et al., 2009). It has clearly stated aims and objectives and a pre-defined eligibility criteria for the inclusion of relevant studies. The literature is systematically searched to identify studies that meet the eligibility criteria and then explicitly assessed to ensure the validity of their findings (Detsky et al., 1992). Quality assessment is usually based on an appraisal of study design, methods and analysis and additionally reports methodological weaknesses and risk of bias (Moja et al., 2005). The findings of the primary studies are systematically presented and synthesised to provide reliable findings. The rationale, methods and the findings of the systematic review carried by the author follow.
3.1 Rationale for this systematic review

A systematic search of use of peers in the delivery of adult mental health interventions in LMICs, identified very few quantitative studies (Clarke et al., 2014, Tripathy et al., 2010, Futterman et al., 2010, Ali et al., 2010, Chibanda et al., 2014) and no qualitative studies. Given this paucity of evidence in mental health, the author conducted a scoping exercise on qualitative studies for peer-delivered maternal health interventions in general, rather than mental health services. This revealed a number of such studies. The information in these studies was found to be relevant to the author’s study objectives, as it provided an insight into perspectives, attitudes and beliefs of the recipient group (mothers), receiving peer-delivered services, and how peers conceptualised their experiences and gave meaning to their roles. A systematic review of such studies would provide useful information to design the current study and provide a context for comparing the findings of the current study with other relevant literature on the subject. The robust methodology of a systematic review would provide a systematic, transparent, and reproducible synthesis of the findings.

It was anticipated that the findings would shed light on the factors which could contribute to the acceptability of the PVs delivering psychosocial intervention for maternal depression in rural Pakistan, while acknowledging the contextual similarities and differences in which the primary studies were conducted.
3.2 Methods

This aim of this systematic review of qualitative studies was to explore the experiences of peers delivering maternal health care, and recipients of such interventions in LMICs

3.2.1 Criteria for considering studies for the review

The criteria for the inclusion of studies are determined at the start of the study and are guided by the focus of the review. The criteria aimed to; a) narrow the focus of the review b) help locate all relevant studies, c) reduce bias in the selection of the studies and d) determine whether a study should be included at each stage of assessment (Detsky et al., 1992). The criteria for this systematic review are given below.

3.2.1.1 Types of studies

All studies that used qualitative methods of data collection and data analysis were included. Details of the types of studies included are summarised in Table 7.

3.2.1.2 Type of participants

Studies that focused on the experiences of peers and stakeholders about peers delivering maternal health care to adult women were included. Participants could include peers, mothers and their families, programme managers, supervisors, other health workers or any others involved in or affected by the programmes.

3.2.1.3 Type of interventions

Studies of programmes that had used peers (for operational definition of peers see Section 4.1.2) including peer volunteers, peer support workers, peer counsellors, buddies and peer mentors to deliver interventions that were intended to improve maternal health.
3.2.1.4 Type of setting

All studies conducted in urban, peri-urban and rural settings in LMICs, as defined by World Bank country income categories, were included.

3.2.2 Search strategy

The search strategy for the current review was guided by the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool for qualitative data synthesis (Cooke et al., 2012). This tool is reported to generate search terms more suitable to qualitative research terms. The key terms of the search strategy for this review using the SPIDER tool are summarised in Box 3 below.

Box 3: Search strategy for the systematic review

| S-Sample | Peer or peer volunteer* or peer support worker or peer counsel* or buddies or peer facilita* or peer educator or lay worker or peer mentor* and low middle income countries or developing countries or third world countries or Africa or Asia or south America or Pakistan or south Asia |
| PI- Phenomenon | Peer delivered (health care or education or intervention or service or mental health service or maternal services or psychoeducational or psychosocial intervention) or peer (group or support or counselling) or peer led health intervention |
| D-Design | Interviews or focus group or observation or case study or group discussion |
| E-Evaluation | Acceptability or feasibility or barriers or facilitators or views or experience or attitudes or opinion or understanding or perception |
| R-Research Type | Qualitative |

(S AND P of I) AND ((D OR E) AND R)
3.2.2.3 Systematic searches

The following databases were used to conduct the searches: SCOPUS, ASSIA, Web of Science, PubMed and CINHAL. The databases such as Web of Science and SCOPUS are multidisciplinary research platforms which enables cross searching of a range of data bases. SCOPUS is the largest database of peer reviewed literature (20% more than Web of Science), it has 5000 publishers including the main international publishers of scientific journals. Other databases such as ASSIA and CINHAL includes subjects such as mental health, nursing, social work, education and other health services, relevant to the topic of the systemic review. In addition to the electronic searches, references lists of included studies were searched.

The search was conducted from the inception of the databases to 15th November 2014. 1353 papers were generated by the preliminary search of all the databases combined SCOPUS (585 hits), ASSIA (329 hits), Web of Science (244 hits), PubMed (182 hits) and CINAHL, EbscoHost (13 hits). 167 were duplicates and were excluded. Out of the remaining 1186, 1120 were excluded because they were either irrelevant (n=1105) or the abstract was not available (n=15). 66 abstracts were selected for further review, of which 58 were excluded based on quantitative methodology and wrong subject matter. 7 papers were included in the review from electronic search. The process is shown in Figure 9 below.
Figure 9: Flow chart for papers inclusion exclusion

3.3 Results

Seven studies, including a total of 1524 participants, met the inclusion criteria. Summaries of the included studies are given in Table 7 below. They were published from 2006-2013. Three were conducted in South Africa (Daniels et al., 2010a, Nkonki et al., 2010, Andreson et al., 2013), two in Uganda (Nankunda et al., 2010, Nankunda et al., 2006), one in India (Alcock et al., 2009) and one in Zimbabwe (Shroufi et al., 2013).

Participants in the studies included peer facilitators, peer counsellors, peer supporters, mentor mothers, buddies, community leaders, peer supervisors, health
care staff, recipient mothers and their families. The peers in all studies were local literate women and in four studies they were mothers themselves (Shroufi et al., 2013, Alcock et al., 2009, Nankunda et al., 2010, Nankunda et al., 2006). Their training varies ranging between five (Nankunda et al., 2006) and 14 days (Daniels et al., 2010a). The peers were used in different capacities to deliver maternal health services. In India, they conducted community groups to encourage learning about perinatal care, childbirth and neonatal care (Alcock et al., 2009). In Uganda, peer counsellors supported breastfeeding mothers (Nankunda et al., 2010, Nankunda et al., 2006), while in South Africa peer counsellors promoted exclusive breast feeding to avoid the risk of mother-to-child transmission of HIV (Daniels et al., 2010a, Nkonki et al., 2010, Andreson et al., 2013). In Zimbabwe, peers called mentor mothers provided support and health education to mothers on safe sex practices, birth planning and infant feeding (Shroufi et al., 2013).

The data in primary studies were collected through conducting interviews (Daniels et al., 2010a, Shroufi et al., 2013, Andreson et al., 2013, Nankunda et al., 2010), focus groups (Alcock et al., 2009, Nankunda et al., 2006, Nkonki et al., 2010) and participatory observation (Alcock et al., 2009, Nankunda et al., 2006). Different analytical approaches such as Framework Analysis (Alcock et al., 2009), Thematic Analysis (Nkonki et al., 2010, Shroufi et al., 2013) and Content Analysis (Andreson et al., 2013) were utilised. The key features of these studies are presented in Table 7 below.
Table 7: Peer-delivered maternal health interventions in LMICs

<table>
<thead>
<tr>
<th>Study and setting</th>
<th>Role of peer</th>
<th>Characterises of peers</th>
<th>Training and supervision</th>
<th>Sample</th>
<th>Data collection method</th>
<th>Analytical approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcock et al., 2009 Urban slum, Mumbai, India</td>
<td>Female facilitators called <em>Sakhis</em> paid to establish and strengthen community groups and to facilitate participatory discussions on pregnancy, childbirth, postpartum care and new-born health.</td>
<td>Locally resident literate mothers. Had willingness to learn, contextual understanding, rapport with community women, no mobility issues and acceptance by family members.</td>
<td>12 days induction programme. Weekly meeting with project manager.</td>
<td>Female facilitators (n=24).</td>
<td>Interview with female facilitators (n=12), Focus groups (n=3; 23 participants), Observation of women’s group (n=3).</td>
<td>Framework Analysis</td>
</tr>
<tr>
<td>Nankunda et al., 2006 Lganga (rural district) in Uganda</td>
<td>Peer counsellors support breastfeeding mothers in the communities.</td>
<td>Woman aged 24–35 years, a regular resident of the area, literate (seven years of schooling) and breastfed a child, literate in local language and acceptable to the community.</td>
<td>5 day training. Fortnightly individual supervision and monthly group supervision.</td>
<td>Peer counsellors (n=15), Mothers (n=15), Husbands of mothers who received support (15).</td>
<td>Focus group with peer counsellors (n=2), mothers (n=2) and husbands (n=2). No of participants in focus groups not specified.</td>
<td>Approach not specified</td>
</tr>
<tr>
<td>Nankunda et al., 2010 Mbale District (both urban)</td>
<td>Peer counsellor identified women and delivered one-to-one sessions on different aspects of breastfeeding.</td>
<td>Local women aged between 18 and 45 years with personal experience of breastfeeding. Literate, and</td>
<td>6 days of the WHO breastfeeding counselling course.</td>
<td>Mothers who received peer support (n=370).</td>
<td>Interviews (n=370).</td>
<td>Approach not specified</td>
</tr>
<tr>
<td>Study</td>
<td>Description</td>
<td>Attributes</td>
<td>Data Collection</td>
<td>Analysis Method</td>
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<tr>
<td><strong>Daniels et al., 2010a</strong></td>
<td>Peri urban and rural sites at South Africa Peer counsellor paid to recruit women, give information about breast feeding and dangers of mixed feeding.</td>
<td>Good reputation in the community. Regular supervision.</td>
<td>Interviews (n=3)</td>
<td>Approach not specified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nkonki et al., 2010</strong></td>
<td>Rural, peri-urban and urban sites South Africa Peer Supporters paid to conduct home visits to support infant feeding and promote child health.</td>
<td>12 years of schooling, interest in child health, prior experience of community involvement and local resident.</td>
<td>Focus group (n=3; 19 participants.</td>
<td>Thematic Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Andreson et al., 2013</strong></td>
<td>Eastern Cape Province, South Africa Feeding buddies to accompany HIV positive mothers to clinics and counselling sessions on safe infant feeding.</td>
<td>Over the age of 18 and willing to accompany mothers to attend clinical visits.</td>
<td>Interviews (n=24).</td>
<td>Conventional Content Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shroufi et al., 2013</strong></td>
<td>Urban districts of Bulawayo, Zimbabwe Mentor mothers provide support, health education and advice to access health and psychosocial support services.</td>
<td>Not specified.</td>
<td>Interviews (n = 79)</td>
<td>Thematic Analysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.3.1 Thematic synthesis

Thematic synthesis was used to combine the studies’ findings and identify key themes. According to Thomas and Harden (2008, p.1) ‘thematic synthesis enables us to stay ’close’ to the results of the primary studies, synthesising them in a transparent way, and facilitating the explicit production of new concepts and hypotheses’. Thematic synthesis has three steps: 1) coding of the finding of primary studies; 2) organisation of codes into related areas for the development of descriptive themes, and; 3) generation of analytical themes. These analytical themes are developed under the theoretical structure provided by the review aims and are therefore appropriate to address the review question (Thomas and Harden, 2008).

The findings of the seven studies retrieved were coded by the author. These codes were then examined for similarities and differences in order to group them in related areas to facilitate development of descriptive themes. The descriptive themes were analysed, in light of the review questions, to develop analytical themes (Table 8 below). Five analytical themes relating to the experiences of stakeholders in relation the peers and their work emerged: likeability and acceptability of peers; their approachability and accessibility; adequacy of peers training and supervision, benefits to the community and self and barriers to their work.
Table 8: Development of themes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Descriptive themes</th>
<th>Analytical themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustworthy; friendly; patient; helpful; being a mother; similar experiences; could relate and talk freely to; courteous; sharing personal information; jolly; polite and calm; role model; popular and acceptable; prior acquaintances.</td>
<td>Perceived positive characteristics of peers</td>
<td>Likeability and acceptability of peers</td>
</tr>
<tr>
<td>Establish and maintain relationship; giving quality and ample time; helping beyond their job role; respond appropriately to mothers’ queries; keep mothers engaged and interested; more approachable as compared to professionals; ensuring mothers’ family approval and involvement; give relevant and useful information; offer practical and additional help; acknowledge women’s experience and give alternative explanation.</td>
<td>Perceptions about peers’ work and its delivery</td>
<td>Approachability and accessibility of peers</td>
</tr>
<tr>
<td>Training and supervision enhancing peer credibility; supervision ensuring peers’ support; mentoring; motivating; safety; technical competencies; emotional wellbeing.</td>
<td>Peers’ training and supervision support</td>
<td>Adequacy of peers’ training and supervision.</td>
</tr>
<tr>
<td>Mothers’ increase in knowledge; feeling empowered; discloser of their HIV status to family; improved feeding practices; improved access to health services. Peers improved self-esteem; peers increase in knowledge; empowerment; improved status;</td>
<td>Perceived impact of peers’ work on mothers and on oneself</td>
<td>Benefits to the community and self</td>
</tr>
<tr>
<td>Mothers finding peers’ visit inconvenient; mothers’ accessing help from traditional healers; mothers experiencing economic problems; lack of awareness; preoccupation with life stresses; finding the information inadequate; difficulties in supporting the mothers’ due to non-disclosure of illness; stigma of HIV positive status; mothers’ lack of trust. Peers’ experiencing difficulties in accessing mothers; risks of travelling to mothers; setting professional boundaries; experiencing work related stress; feeling frustrated; disappointment and demotivation.</td>
<td>Difficulties in performing role</td>
<td>Barriers to peers’ work</td>
</tr>
</tbody>
</table>
3.3.2 Description of analytical themes

3.3.2.1 Likeability and acceptability of peers

Most studies have highlighted peers’ personal characteristics which were important to their role. It was acknowledged that someone local who had experienced similar circumstances and life events, could relate better to the recipients and their issues (Alcock et al., 2009, Nankunda et al., 2006, Shroufi et al., 2013). In addition, peers who were mothers themselves, were perceived to be experienced and willing to share their personal learning to benefit other mothers (Alcock et al., 2009, Nankunda et al., 2006, Shroufi et al., 2013, Nankunda et al., 2010). Generally peers were perceived as trustworthy and friendly (Alcock et al., 2009, Andreson et al., 2013), who acted in recipients’ best interest (Alcock et al., 2009, Nankunda et al., 2006). They were described as ‘patient’ (Nankunda et al., 2006, Nkonki et al., 2010), ‘jolly’ (Nankunda et al., 2006) ‘polite’ and ‘courteous’ (Nankunda et al., 2010). They were generally viewed as good role models (Nankunda et al., 2006, Shroufi et al., 2013) and were recommended to other women in the community (Nankunda et al., 2006), indicating their popularity and acceptance (Nkonki et al., 2010).

3.3.2.2 Approachability and accessibility of peers

In most studies peers were perceived as approachable, supportive (Alcock et al., 2009, Nankunda et al., 2006, Andreson et al., 2013), receptive (Shroufi et al., 2013) and preferred over health professionals because of these qualities (Alcock et al., 2009, Shroufi et al., 2013). In all studies, recipients acknowledged the role of peers as ‘educators’ in their communities, who were imparting contextually relevant information relating to safe delivery, child feeding practices, neonatal care (Alcock et al., 2009) and safe sex (Shroufi et al., 2013).
To facilitate their work, peers formed relationships with the mothers by using their empathic skills (Alcock et al., 2009, Nkonki et al., 2010), acknowledging their issues (Alcock et al., 2009) and facilitating and supporting the mothers in making informed decisions (Nankunda et al., 2006, Daniels et al., 2010a). They were good at motivating (Nkonki et al., 2010), giving mothers ample time and attention (Alcock et al., 2009, Nankunda et al., 2010) and offering additional support such as accompanying to health facilities, helping to obtain ration cards (Alcock et al., 2009) and filling in their social grant forms (Nkonki et al., 2010). The time and effort which peers invested in their roles was appreciated by the mothers and consequently they were approached to seek advice on the range of health problems (Alcock et al., 2009). To ensure endorsement of mothers’ significant family members such as husbands and mothers-in-law, peers encouraged their involvement in all key decisions (Alcock et al., 2009, Nankunda et al., 2006, Shroufi et al., 2013, Nkonki et al., 2010).

### 3.3.2.3 Adequacy of peers’ training and supervision

Studies have indicated effective training and supervision as essential to the peers’ work. Training and supervision were reported to increase peers’ credibility in their communities (Alcock et al., 2009) and provided them with continuous learning and motivation (Nankunda et al., 2006). This further helped to acknowledge the importance of their job, address any work related issues, reassure their technical competencies, and help them deal with the challenging situations (Daniels et al., 2010a). Peers regarded their training as a means to gain relevant knowledge and feel empowered to fulfil their roles efficiently (Nankunda et al., 2006). Field supervision helped to assess their competencies and provide support and assistance to improve their work (Daniels et al., 2010a).
3.3.2.4 Benefits to the community and self

Mothers in the studies reported an increase in knowledge about child feeding practices (Alcock et al., 2009, Nankunda et al., 2006, Nankunda et al., 2010, Andreson et al., 2013), which resulted in improved exclusive breast feeding and child caring practices (Nankunda et al., 2010, Andreson et al., 2013). Mothers felt empowered and confident (Shroufi et al., 2013, Nankunda et al., 2010), for instance in negotiating family planning with their partners, and had more control over safe sex practices (Shroufi et al., 2013). The peers’ openness about their HIV status contributed in overcoming the stigma of HIV (Shroufi et al., 2013, Andreson et al., 2013), leading to mothers’ disclosure of their HIV status to their families - with peers acting as mediators (Shroufi et al., 2013).

Studies have also reported that working as peers not only benefitted mothers, but also contributed towards peers’ own feeling of empowerment, enhanced confidence and self-esteem and improved knowledge of health related issues. (Alcock et al., 2009). It also improved their social status and mobility within their communities (Alcock et al., 2009, Nankunda et al., 2006).

3.3.2.5 Barriers to peers’ work

Studies have indicated recipients’ cultural and socioeconomic factors causing barriers to peers’ work. The stigma of HIV status prevented the recipients engaging with peers due to fear of raising suspicion in their communities and/or disclosing their illness (Shroufi et al., 2013, Nkonki et al., 2010), especially when peers were from within their own communities or related to them (Alcock et al., 2009, Nankunda et al., 2006). Other barriers included lack of trust leading to doubting peers’ intentions and questioning their credibility (Nkonki et al., 2010). In some cases, dissatisfaction over the amount of information and time given and inconvenience caused due to peers’ visits caused a barrier to engagement.
(Nankunda et al., 2010). In other cases, it was the recipients’ preoccupation with their socioeconomic problems which made them less receptive to peers’ intervention (Nankunda et al., 2010, Nkonki et al., 2010). A few mothers in the Shroufi et al., (2013) study expressed a preference to professionals over peers due to their formal training and qualification.

Some studies highlighted deeply embedded traditional practices which created barriers to peers’ work such as preventing anyone outside the family to see the baby during the initial weeks (Shroufi et al., 2013) and first time mothers spending three months at their parents’ home (Nkonki et al., 2010). Other practices such as using traditional healers for illness instead of a health professional (Nkonki et al., 2010) and giving new born ‘muti’ (porridge) to ward off evil (Shroufi et al., 2013) were contradictory to messages delivered by peers.

Other challenges to peers’ work included difficulties in accessing mothers due to lack of transport facilities and travelling long distances on foot (Nankunda et al., 2006, Nkonki et al., 2010), along with the risk of assault or attack in high risk areas (Nkonki et al., 2010). In Nankunda et al., (2006) study peers demanded a bicycle for commuting at work. Some studies reported peers’ frustration when failing to bring change in mothers’ feeding practices and/or when their information was disregarded (Nkonki et al., 2010). The mothers’ disclosure of their HIV status was also reported to cause distress in peers especially where professional boundaries were not clearly established (Nkonki et al., 2010).
3.4 Quality assessment

The quality of each study included in the review, was assessed using the Critical Appraisal Tool (Hawker et al., 2002). The decision to use this tool was based on its comprehensive scoring methods for assessing the quality of studies. It has a clear numerical scoring system, which has been found to have high inter-rater reliability. It allows to calculate a summed score, indicating the methodological rigor of each study and sub-scores indicative of strengths and weaknesses in following areas: 1) abstract and title 2) introduction and aims 3) method and data 4) sampling 5) data analysis 6) ethics and bias 7) findings 8) generalisability 9) implication and usefulness. Each item is scored on a scale ranging from 0-4, giving a maximum overall score of 36.

The quality assessment was carried out by the author and her supervisors (KL & NH), independently using the same tool. Any discrepancies in the scores were discussed and mutually agreed during the supervision. Table 9 provides the results of the quality assessment. The overall quality of the studies was satisfactory. Most studies provided an abstract with adequate information and introduction sections providing a good background and clear statement of the aims, and appropriate description of the methods. However, majority of the studies either lacked a clear description of how themes were derived, or provided only minimal details. In most studies (apart from Andreson et al., 2013), findings were supported by sufficient data and were related directly to the results. They also suggested ideas of future research or implications for policy/practices. Some studies lacked description of context and settings (Alcock et al., 2009 and Andreson et al., 2013), restricting comparison with others contexts and settings.
Table 9: Quality assessment of the studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Abstract &amp; Title</th>
<th>Introduc tion &amp; Aims</th>
<th>Method &amp; Data</th>
<th>Sampling</th>
<th>Data Analysis</th>
<th>Ethics and bias</th>
<th>Findings</th>
<th>Generalisability</th>
<th>Implications &amp; usefulness</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Alcock et al., 2009)</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>22</td>
<td>Method of data collection and analysis not mentioned in abstract. Data collection methods not justified, lacking in details of study area and procedures for data analysis, ethical approval was not mentioned. Clearly suggested implication for policy and practice</td>
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<td>(Nankunda et al., 2006)</td>
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<td>25</td>
<td>Lacking in details about the topic guide, participants, data analysis methods, ethical issues. Did not suggest enough ideas for future research. Provided full and concise background and up-to-date literature review.</td>
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<td>(Nankunda et al., 2010)</td>
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<td>30</td>
<td>Method of data collection, analysis and number of participants not mentioned in abstract. Did not suggest ideas for future research. Clearly presented descriptive sampling details, ethic and biases and results supported with sufficient data.</td>
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<td>(Daniels et al., 2010b)</td>
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<td>29</td>
<td>Lacking in details about information of topic guide or justification of using chosen method of data collection. Did not specify which analytical approach was used. Mentioned a few but not all biases. Sample size is small. Adequate abstract, comprehensive sampling information and</td>
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<td>Study</td>
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<td>(Andres on et al., 2013)</td>
<td></td>
<td>Lacking in information about topic guide, study area, sample and biases. Data analysis and findings methods very briefly described. Findings not supported by data.</td>
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<tr>
<td>(Nkonki et al., 2010)</td>
<td></td>
<td>Abstract did not mention number of participants and data analysis method. Lacking in information about study area and participants and did not mention area for future research. Description of data analysis procedures and findings were clearly and explicitly presented.</td>
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<td>(Shroufi et al., 2013)</td>
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<td>Lacking in details about the training and supervision procedures and biases. Findings clearly described and supported by data.</td>
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3.5 Conclusion

The review above provides evidence that peers working in the domains of general maternal health are approachable and acceptable to the community. They had contextual awareness, giving them an advantage in relating to and supporting their recipients. Furthermore, the fact that these studies are carried out in low income settings support the idea of extending such delivery to the field of mental health.

People with mental illness are more stigmatised than those with physical illnesses (Saxena et al., 2007) and their family members tend to hide the condition due to the fear of being discriminated by their communities (Leong and Lau, 2001, Thara et al., 2003). Knowledge about the causes of mental illness is poor in LMICs (Gureje et al., 2005), at times attributed to supernatural phenomena (Dein et al., 2008, Razali et al., 1996) or insufficient will-power or stress (Stein et al., 1997). These beliefs could result in poor compliance to pharmacological/psychological treatment (Razali et al., 1996). It often resulted in seeking alternative treatment such as accessing spiritual healers (Dein et al., 2008). Therefore, working in a mental health setting in LMICs requires effective communication skills to ‘sell’ the intervention and initiate relationship with recipients. It also requires forming a trustworthy and empathetic relationship before any personal issues are disclosed (Rahman, 2007). Lastly working with clients experiencing mental illness could expose peers to stress which might impact upon their own mental health adversely (Repper et al., 2011).

The factors above, and other possible unknown factors, may influence the experiences of peers working with depressed mothers in the community (and vice versa) differently from those of peers working with general health problems. It is therefore important to obtain an in-depth understanding of the stakeholders’ views prior to conducting a trial and implementing such services. The study aimed to fill in this gap in knowledge. The following chapter outlines the rationale, aims and objectives of the study.
Chapter 4: Summary of study background, rationale, aims and objectives

This chapter summarises the background information which led to the conceptualisation of the research question posed by this study.

4.0 Background

The UK Medical Research Council (MRC) framework for developing and evaluating complex interventions recommends that it is essential to understand contextual factors that can influence the delivery and adherence to the intervention, prior to a definitive trial (Craig et al., 2008). These contextual factors include characteristics of the target population, their health system, socioeconomic and cultural factors, prevalence and severity of illness and who is delivering the intervention, are crucially important as they can influence outcomes and implementation. These factors need to be investigated during different phases of development and evaluation of interventions, but most importantly during the exploratory phase of the study (Campbell et al., 2000). In line with MRC framework, this study aimed to understand the factors linked to the acceptability of the ‘delivery agent’ of the complex intervention before its effectiveness is evaluated through a definitive randomised control trial (RCT).

In previous research in rural Pakistan, a psychosocial intervention for perinatal depression called Thinking Healthy Programme (THP) was delivered by LHWs and was tested for its acceptability and effectiveness (Rahman et al., 2008). However, the use of PVs to deliver such mental health interventions in Pakistan had not been previously investigated. It is evident that if PVs are not acceptable as delivery agents of the intervention to the mothers, their families, and the health system, it would be difficult to implement such a programme. Therefore prior to an expensive
effectiveness trial of such an approach, it was important to understand acceptability issues at both the community and health systems level. This study aimed to explore in depth, the factors which facilitated or hindered the PV’s role as delivery agent of a psychosocial intervention. The findings of the study led to the refinement of the intervention delivery approach and method before the main trial.

The study was nested within the pilot phase of a RCT which aimed to test the feasibility and acceptability of the Thinking Healthy Programme-Peer Delivered (THPP). The THPP is described below in the context of the current study.

4.1 The Thinking Healthy Programme-Peer Delivered (THPP)

The original THP is an evidence-based psychosocial intervention for mothers experiencing perinatal depression (Rahman et al., 2008). The LHWs were provided a three day bespoke training and monthly group supervision to deliver this intervention. Sessions were organised into five modules covering the period from the third trimester of pregnancy to the first year of an infant’s life. Each module focused on three areas – the mother’s personal health, the mother-infant relationship, and the psychosocial support of significant others. In total 16 sessions were offered to mothers at their homes.

The THP employed the core principles and techniques of cognitive behaviour therapy (CBT), such as building an empathetic relationship, focusing on the here and now, behaviour activation and problem solving. A manual (Figure 10 below) was developed to facilitate LHW in the delivery of the intervention.
The manual included instructions for the delivery of the session and had culturally appropriate pictorial illustrations (Figure 11 below) aimed at helping mothers reflect on their thinking process and encouraging their family support. Pictures were especially useful as female literacy rate in the study setting was low, at 33% (PSLM, 2013).

Figure 11: Pictorial illustration to demonstrate significance of family support
Barriers to engaging with participants caused by stigma and a lack of awareness of ‘talking therapies’ in rural Pakistan (see Section 1.3.2.3) were overcome by promoting the intervention as targeting ‘mother and child health’ rather than ‘maternal depression’ (Rahman, 2007). Highlighting the agenda of optimal child development and linking infant’s wellbeing with the mother, allowed the LHWs to deliver the intervention without receiving much resistance from mothers’ families (see Section 1.4.3 for significance of family approval). The family members, especially mothers-in-law, were encouraged to attend the sessions. This was to help them overcome any paranoia linked to the intervention, to get their approval, and to ensure their support for the mothers.

To evaluate THP effectiveness, a cluster RCT was conducted in rural areas in Pakistan with a total of 900 mothers experiencing perinatal depression. The intervention more than halved the rate of perinatal depression in the intervention arm, compared to the participants in the control group. In addition to symptomatic relief, the women receiving the intervention had less disability and better overall social functioning. These effects were sustained at 12 month follow-up (Rahman et al., 2008). THP has been adopted by World Health Organization as low intensity psychological intervention for perinatal depression (WHO, 2015).

4.1.1 Addressing barriers to scaling up of THP

Evidence of the impact of THP on perinatal depression has indicated the potential for its integration into the health system. However, despite this evidence there are barriers to the scaling up of THP.

The LHWs who delivered THP are overburdened with multiple tasks assigned to them. Each LHW is responsible to deliver essential PHC services to a population of 1,000 people at their doorstep (Hafeez et al., 2011). Though the scope of their work includes covering all aspects of maternal and child health care, mental health is not on their current agenda. In order to address this barrier, the SHARE programme
(see ‘about the author’) aimed to evaluate the effectiveness of an adapted version of the THP for delivery by PVs.

4.1.2 Definition of a PV

In the context of this programme, a PV was defined as a local woman who shared either similar experiences (such as being a mother, or similar psychosocial adversities) or similar characteristics (such as age, religion, ethnicity or socioeconomic status) as the target population and functioned voluntarily as a delivery agent of the THP.

4.1.3 Adaptation of THP for delivery by PVs

In order for the intervention to be comprehensible to and deliverable by PVs, who had no prior experience of delivering health care, the content of the manual and the delivery processes required simplifying. As part of this adaptation process, more emphasis was placed on behaviour and less on cognition; which complimented the cascade model of training and supervision, adopted by Thinking Healthy Programme-Peer Delivered (THPP). The intervention material was supplemented by job-aids (materials to aid the delivery of a session). The intervention was delivered both through home-based individual sessions and group sessions. The key changes made to the THP are outlined in the Table 10 below.
Table 10: Key features of THP adaptation

<table>
<thead>
<tr>
<th>THP</th>
<th>THPP</th>
<th>Rationale for adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format of delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 individual sessions delivered at home.</td>
<td>10 individual sessions delivered at home. 4 group sessions delivered at the Health House.</td>
<td>Fewer individual sessions as period of delivery was shorter for THPP, as compared to THP. The THPP formative research findings along with the evidence from the literature indicated that groups could be helpful for mothers experiencing depression.</td>
</tr>
<tr>
<td>Training</td>
<td></td>
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<tr>
<td>Training of LHWs: 3 days classroom training conducted by the psychiatrist trained in CBT, who developed the intervention.</td>
<td>Training of PVs: 5 days classroom training and field training conducted by the THPP facilitators. Training of THPP Facilitators: 4 day classroom training and 6 month internship period conducted and supervised by the mental health specialist.</td>
<td>In order to develop a more sustainable model, PVs were trained by non-specialist THPP facilitators. Field training was introduced to assess PVs’ competency and fidelity to the intervention.</td>
</tr>
<tr>
<td>Intervention material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference manual. Health Calendar.</td>
<td>Reference manual for individual sessions. Reference manual for group sessions. Health Calendar. Job aids.</td>
<td>Separate reference manuals for individual and group sessions were developed. Reference manual for group session includes culturally appropriate stories to facilitate discussions during group sessions. The job aids contain step-by-step instructions to facilitate PVs’ in delivering of their sessions.</td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
<td></td>
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<tr>
<td>LHWs were supervised through monthly group supervisions by the mental health specialist who trained them.</td>
<td>PVs were supervised by the THPP facilitators through monthly group supervisions and field supervisions. THPP facilitators were supervised fortnightly by the mental health specialist.</td>
<td>Cascade model is a relatively sustainable model because it requires fewer specialist workers. PVs received frequent field supervisions to ensure continuous experiential learning, fidelity to the intervention and to maintain their motivation.</td>
</tr>
<tr>
<td>Focal point</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More discussion during supervisions and sessions delivery on cognitions.</td>
<td>More emphasis during supervisions and sessions delivery on behaviour.</td>
<td>To make the intervention comprehensible to and deliverable by PVs with no prior experience of delivering health care. To facilitate PVs’ supervisions through non-mental specialist, requiring less specialist skills.</td>
</tr>
<tr>
<td>Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHWs were paid a regular salary to deliver sessions to mothers.</td>
<td>PVs were paid only the sustenance allowance.</td>
<td>For the sustainability of the programme and to keep the spirit of volunteerism alive.</td>
</tr>
</tbody>
</table>
4.1.4 Piloting of THPP

Following the adaptation of THP, piloting of the intervention commenced from October 2013. The pilot study aimed to test all operational elements of the intervention and qualitatively evaluate the acceptability and feasibility of the intervention and its delivery agents. Participants for the study were PVs and mothers.

4.1.4.1 Linkage of the PVs with the PHC System

The PVs were a new workforce introduced to deliver the intervention. They needed an identity and organisational structures for their support and functioning in the villages they served. The programme engaged with the PHC system through formal letters of understanding. The LHWs and their supervisors, called lady health supervisors, working in the PHC system were most appropriate to provide this assistance. LHW’s were well embedded in their communities and were trusted to provide mother and child health care. In addition to their supporting role to the PVs, they assisted in PVs’ identification, recruitment and introduction to the mothers and their families.

4.1.4.2 Delivery of the intervention

Following the training PVs delivered the intervention to mothers recruited to the pilot study. All mothers were offered seven fortnightly home-based individual sessions (Figure 12) and three monthly group sessions (Figure 13) over a period of four months, delivered by the PVs (Table 11). The current study was embedded within this pilot phase, its aims and objectives are described in the section below.
Table 11: Schedule for the delivery of THPP sessions

<table>
<thead>
<tr>
<th>Individual Sessions</th>
<th>Period of delivery</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30\textsuperscript{th} gestational week</td>
<td>Introduction and engagement</td>
</tr>
<tr>
<td>2</td>
<td>32\textsuperscript{nd} gestational week</td>
<td>Mother’s personal health.</td>
</tr>
<tr>
<td>3</td>
<td>34\textsuperscript{th} gestational week</td>
<td>Mother’s relationship with significant others</td>
</tr>
<tr>
<td>4</td>
<td>36\textsuperscript{th} gestational week</td>
<td>Mother’s relationship with a child</td>
</tr>
<tr>
<td>5</td>
<td>2\textsuperscript{nd} week postnatal</td>
<td>Mother’s personal health.</td>
</tr>
<tr>
<td>6</td>
<td>4\textsuperscript{th} week postnatal</td>
<td>Mother’s relationship with significant others</td>
</tr>
<tr>
<td>7</td>
<td>8\textsuperscript{th} week postnatal</td>
<td>Mother’s relationship with child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Sessions</th>
<th>Period of delivery</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33\textsuperscript{rd} gestational week</td>
<td>Mother and child wellbeing</td>
</tr>
<tr>
<td>2</td>
<td>10\textsuperscript{th} week postnatal</td>
<td>Mother and child wellbeing</td>
</tr>
<tr>
<td>3</td>
<td>14\textsuperscript{th} week postnatal</td>
<td>Mother and child wellbeing</td>
</tr>
</tbody>
</table>

Figure 12: A PV delivering an individual session.

Figure 13: A PV delivering a group session.
4.2 Aims and objectives of the study

The overall aim of the study was to explore the views of multiple stakeholders, to gain an in-depth understanding of the issues pertaining to the acceptability of the PVs, delivering a psychological intervention for perinatal depression in a rural Pakistan.

The acceptability of PVs, as delivery agents of a psychosocial intervention was explored from the perspectives of the following stakeholders:

a) Mothers recruited to participate in THPP pilot study.
b) Significant family members of all mothers recruited to participate in THPP pilot study.
c) PVs trained to deliver the THPP intervention.
d) Local PHC staff working in partnership with the PVs.

The specific objectives of the study are better conceptualised as research questions which are elaborated below.

4.3 Research Questions

A research question should be defined in such a way that an appropriate methodological approach can be agreed (Flick, 2002). For instance ‘where’, ‘what’, ‘who’ and ‘when’ questions are more adequately answered by quantitative research methodologies, whereas questions about ‘why’ or ‘how’ targeted at gaining an in-depth understanding can be explored using a qualitative approach (Srivastava and Thomson, 2009). A research question demarcates the specific areas or issues to be explored. Furthermore, research questions need to be informed by existing literature and should have the potential to make a contribution to knowledge (Lewis, 2003).
The research questions which this study aimed to address were:

1. Are PVs, who deliver a psychosocial intervention in rural Pakistan, acceptable to perinatally depressed mothers and their family members?

2. Are PVs, who work in partnership with the local PHC system, acceptable to the PHC staff (LHWs, lady health supervisors, and primary care physicians)?

3. What are the barriers and the facilitators experienced by PVs in the delivery of a psychosocial intervention for perinatal depression?

### 4.4 Summary

In order to ensure the scalability of an evidence-based THP, it was adapted to be delivered through PVs and to be evaluated through RCT in rural Pakistan. The MRC framework guidelines recommend the contextual understanding of the factors that can influence trial outcomes. This compounded with the lack of evidence of the stakeholders’ views on the use of PVs in the delivery of mental health care in LMICs, necessitates investigating the acceptability of the PVs as delivery agents of this psychosocial intervention during the pilot phase of the trial. An in-depth exploration of this subject formed the basis for the author’s study - the methodology of which is described in the following chapter.
Chapter 5: Methodology

This chapter discusses the range of qualitative approaches and different methods of sampling, data collection and analysis used in qualitative research. It explains the theoretical rationale for the qualitative approaches employed, the methods used for data collection and analysis, and steps taken to ensure the rigor of the study.

5.1 An overview of research designs

‘Research design refers to the logic of the study - the what, how and why of data production’ (Green and Thorogood, 2009 p.34). A good research design has a clearly defined purpose, coherence between the research question and the research methods (Lewis, 2003) and harmony in its components (Maxwel, 2013). Research methodologies can be broadly divided into either quantitative or qualitative approaches. Each approach has a different set of philosophical assumptions and principles.

5.1.1: Quantitative approaches

Quantitative approaches aim to ‘investigate the social world in ways which emulate the scientific method as used in the natural sciences with the emphasis on hypothesis testing, causal explanation, generalisation and prediction’ (Snape and Spencer, 2003. p.14). It is a positivist approach, which attempts to maintain objectivity, for the precise measurement of variables and arrives at conclusions through the process of deduction (Neuman, 2000). Quantitative studies are either observational or experimental. In observational studies such as case-studies, case control, cohort and longitudinal studies, variables are measured without intervening. In experimental studies such as before-after studies or RCTs, some form of intervention is introduced and variables are measured before and after the intervention to test hypothesis (Hopkins, 2008). Quantitative researchers usually employ probability
sampling to enhance the validity of their findings. The data is usually obtained from a relatively large number of participants, in order to produce generalisable results (Marshall, 1996).

### 5.1.2 Qualitative approaches

Qualitative approaches are interpretive. Such approaches are described as ‘a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live’ (Holloway 1997, p.1). Qualitative methods allow an in-depth exploration of the experiences of participants in their social context (Pope and Mays, 1995). Unlike a quantitative approach, where objectivity is pivotal, the interpretive researcher does not operate from a detached position. Social processes are taken into consideration, to analyse and interpret the data obtained and to gain in-depth understanding of experiences (Neuman, 2000). It is an inductive approach, in which theory is generated from the data. The number of participants selected for qualitative studies are fewer than most quantitative studies. The smaller sample size enables the qualitative researcher to gain an in-depth and holistic understanding of the phenomena under investigation (Neuman, 2000).

Whether or not a qualitative approach is used depends on the study objectives. Ritchie has suggested that a qualitative approach is used to gather information or evidence around a phenomena that is either too complex, sensitive or deeply rooted within the participants’ personal knowledge (Ritchie, 2003). Furthermore, it is used for subject matters which require clarity either before being subjected to statistical inquiry, or more evidence or understanding is needed on them. A key strength of qualitative research is its flexibility to explore unexpected issues as they emerge (Lewis, 2003). Therefore the methods and approaches used in qualitative research are constantly reviewed and modified in response to the new developments, resulting in a non-linear relationship among qualitative research design
components (Maxwel, 2013). This flexibility, however, does not compromise the rigor of the planning for the conducting the qualitative research at any stage.

5.2 Rationale for using a qualitative approach for this study

This study aimed to generate findings through a process of induction. It involved an exploration of the experiences of the mothers, their significant family members, PHC staff and the PVs, to develop a deeper understanding of factors pertaining to the PVs’ acceptability as delivery agents of the psychosocial intervention in rural Pakistan. A qualitative research approach was the most appropriate method to answer the research questions and is discussed below.

5.3 An overview of theoretical approaches to qualitative research

Qualitative research is an overarching term used for a range of approaches with many similarities and overlapping methodologies. These can broadly be categorised as theory-driven research or applied research.

5.3.1 Theory-driven qualitative research

Theory-driven qualitative research is primarily concerned with either testing existing theory or generating new theory (Ritchie, 2003). Commonly used theory-driven research approaches are phenomenology, ethnography, narrative research, and grounded theory (Starks and Trinidad, 2007).

5.3.1.1 Phenomenological approach

The basic purpose of phenomenology is to ‘capture the meaning and common features, or essences, of an experience or event’ (Starks and Trinidad, 2007 p.1374). The researcher collects data in relation to the phenomena under investigation and develops a composite description of the lived experience. Beyond its research methods, it is more of a philosophical approach, which draws heavily on the writings of Edmund
Husserl (1859-1938), a German philosopher. Husserl believed that knowledge stems from conscious awareness and in order to expose the true essence of the ‘lived experience’ it is necessary to put aside all preconceptions (McConnell-Henry et al., 2009). This is achieved through the process of ‘bracketing’, that is when preconceptions and judgments are ‘filtered out’ and the research question is approached with a clear and open mind. (Koch, 1995). This provides a true and valid description of the phenomena (Groenewald, 2004). Phenomenologist researchers such as Colaizzi, Van Kaam and Giorgi base their work on Husserl’s philosophy and developed the most frequently used method of descriptive phenomenology involving description, reduction and looking for essential structures (Giorgi, 2000).

Another approach to phenomenology is Hermeneutic phenomenology. It allows analysis and interpretation of data rather than purely description. A leading proponent of this approach was Heidegger (1889-1976), a student of Husserl (Groenewald, 2004). He believed that it is intrinsically impossible to bracket out pervious knowledge as suggested by Husserl (McConnell-Henry et al., 2009); in order to describe experiences, relevant theoretical and personal knowledge is required (Koch, 1995). In his view, understanding a lived experience is reliant on repetitive yet progressive acts of interpretation, which he referred to as Hermeneutic Circle (McConnell-Henry et al., 2009). Influenced by Heidegger’s approach, Gadamer (1900-2002), developed a method in which the researcher gains an understanding of the lived experience of participants through personal involvement in a reciprocal process of interpretation. Researchers who follow the Gadamerian phenomenology approach validate their findings by obtaining feedback from study participants (Fleming et al., 2003). Other phenomenologists such as Van Manen (1990) used method influenced by both Husserl and Heidegger. Van Manen uses the terms description to include both interpretive as well as the descriptive phenomenological element (Dowling, 2007).
The phenomenological method is of interest to health and social researchers, due to the value that it places on understanding people and their lived experience (Balls, 2009).

5.3.1.2 Ethnography

Ethnography is grounded in anthropology (Borbasi et al., 2005). It is concerned with understanding the ways of life, events, beliefs and relationships of different social and cultural groups and has been used to understand health and illness related experiences (Borbasi et al., 2005, Allen, 2004, Briggs et al., 2003). Ethnographic methods involve the researcher immersing themselves in the field-work and observing the social processes under investigation. Observations are transformed and translated into written documents for identifying, analysing and interpreting themes (Thorne, 2000). Ethnographic methods used to analyse data can be either descriptive or critical. Descriptive ethnography aims to increase knowledge through producing detailed descriptions of observations. Critical ethnography has a propensity to inform policies and practices through deeper analysis of social processes observed to understand the underlying issues, power dynamics, ulterior motives and political agendas. (Thomas, 1993).

5.3.1.3 Narrative research

Narratives are detailed stories or life events, given meaning by their interpretation and construction, in participants’ mind. Narrative research involves capturing these series of events and using a variety of analytical practices such as narrative and discourse analysis to understand their meaning. Narrative interviews allow the researcher to reconstruct biographic processes (Flick, 2002 p.201).

Narrative analysis defines language as ‘the socially and culturally constructed device for creating shared understanding of the experience’ (Thorne, 2000 p.69). It involves exclusion of all segments which are not part of the narrative, and analysing the
narrative text in a sequence. This analysis allows the researcher to gain an understanding of the participants’ perception, emotions and actions.

Discourse analysis, on the contrary, argues that ‘language and words, as a system of signs, are in themselves essentially meaningless; it is through the shared, mutually agreed-on use of language that meaning is created’ (Starks and Trinidad, 2007 p.1374). Therefore, a discourse analyst will analyse speech while considering the social and political influence on how people express themselves. The findings from discourse analysis are specific to the cultural and social context in which it take place (Holloway, 1997).

5.3.1.4 Grounded Theory

Grounded theory aims to develop a theory of social processes. It is a creative process that is appropriate in cases where there is a lack of knowledge of a topic (Glaser and Strauss, 1967). Grounded theory helps to understand social realities - how individuals perceive their world and how they interact with each other and interpret their interactions (Starks and Trinidad, 2007). These meanings or core categories facilitate the development of theory. A good theory is comprehensive, relevant and provides guidelines for future action (Holloway, 2005).

In Grounded Theory data is collected and analysed simultaneously. The iterative process of data collection and analysis facilitates development of categories through the process of induction and testing, and verification of hypotheses through the process of deduction makes this approach both inductive and deductive (Holloway, 2005).

There is a growing interest in using qualitative research to understand social and public policy issues. Whilst grounded theory will generate policy relevant findings, such findings are not the prime aim of this approach (Green and Thorogood, 2009). Furthermore, the processes of analysing qualitative data in the approaches
described above are criticised for lacking in clarity and transparency (Ward et al., 2013). On the contrary, applied qualitative research is concerned with answering research questions specific to social and public policy issues using rigorous methods to produce accessible findings (Ritchie and Spencer, 1994). This approach is described below in more detail.

5.3.2 Applied qualitative research

Applied qualitative research has gained increasing popularity because of its wide reaching objectives (Smith and Firth, 2011). It is used to understand and explore a variety of questions posed by health and social researchers, to answer policy relevant questions and to make recommendations to address social issues (Ritchie, 2003).

In the context of applied health services research, ‘qualitative research methods enable health science researchers to delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions’ (Starks and Trinidad, 2007 p.1372).

Applied qualitative research uses explicit research methodology and transparent analytical processes to make recommendations for implementing policies. The accessibility of the analytical process allows commissioners and funders to critically appraise the findings and make informed decisions about the extent to which they can be implemented (Furber, 2010).

The Framework Analysis approach has been developed as a robust approach to analyse data for applied qualitative research.
5.3.2.1 Framework Analysis approach

Framework Analysis has become an ‘established and rigorous method of analysing qualitative data in health services research’ (Furber, 2010 p.97). It is becoming increasingly popular because of its systematic method of analysing data, which allows the reviewer to audit trail the findings.

Framework Analysis is explicitly geared towards developing policy and practice oriented findings through using systematic and transparent methods (Ward et al., 2013). It was developed at the National Centre for Social Research, UK (Ritchie and Spencer, 1994). It has become an established and rigorous method of analysing data because of its methodical process of analysing data, which involves summarising and classifying contents within a thematic framework (Ward et al., 2013, Smith and Firth, 2011). The thematic framework provides a structure into which data can be compared and contrasted robustly, enabling the researcher to gain an in-depth understanding of the issues and produce credible findings (Gale et al., 2013). In particular this method has gained credence in health services research in the UK, as it complements NHS health agendas - where a lot of emphasis has now been laid on understanding and valuing patients’ experiences and working in collaboration with them (Department of Health, 2007).

The approach has its critics - it has been criticised for not being rooted in a traditional qualitative theory-driven approach such as phenomenology, ethnography or grounded theory (Smith et al., 2011). It is an approach focussed on data analysis rather than a research paradigm and borrows its theory from different qualitative research traditions (Ward et al., 2013). According to Ritchie and Lewis (2003 p.19), ‘this eclecticism can be a significant strength’. The emphasis on the use of rigorous and unbiased methods, prescribed by the epistemologist to ensure objectivity, is also the objective of the social policy researcher. Objectivity is achieved by taking rigorous measures during data collection, such as asking non-
directing questions, not disclosing any personal information and systematically analysing the data (Snape and Spencer, 2003). The researcher using Framework Analysis also takes on board the ontological perspective of understanding the participants’ interpretation of experience in light of their own understanding of the phenomena. In order to ensure rigor, field notes and journals are kept and are referred to during all stages of analysis. Furthermore, a researcher’s interpretation of a participant’s experience is made explicit to its reader and the findings and interpretations can be traced back to the original data. Framework Analysis could also be used to develop theories as in the grounded theory approach, but is focused more on specific and current issues. Furthermore unlike grounded theory, data is generated from a predetermined sample to produce actionable results (Ward et al., 2013, Srivastava and Thomson, 2009, Smith and Firth, 2011). The key features, as outlined by Ritchie and Spencer (1994, pg.176), are detailed below in Box 4.

Box 4: Key features of Framework Analysis (Ritchie and Spencer, 1994, pg.176)

“**Grounded or generative:** it is heavily based in, and driven by, the original accounts and observations of the people it is about.

**Dynamic:** it is open to change, addition and amendment throughout the analytic process.

**Systematic:** it allows methodical treatment of all similar units of analysis.

**Comprehensive:** it allows a full, and not partial or selective, review of the material collected.

**Enables easy retrieval:** it allows access to, and retrieval of, the original textual material.

**Allows between- and within-case analysis:** it enables comparisons between, and associations within, cases to be made.

**Accessible to others:** the analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst”
5.4 Rationale for using Framework Analysis for this study

This study is considered under the remit of health services research and aimed to answer a pragmatic question – the acceptability of PVs as the delivery agents of the psychosocial intervention (THPP). It did not have any explicit theoretical aims to generate a new theory, as in grounded theory; neither was it aimed at giving a detailed account of the way of life of PVs or mothers, as in ethnography. Rather, the analysis was aimed to find those features which enhanced or hindered the acceptability of PVs as ‘delivery agents’ within the community. Hence, Framework Analysis was the appropriate approach underpinning this research. According to Ward et al (2013 p.2425) “It is a pragmatic approach for real world investigations”. This well-defined, pragmatic, systematic, comprehensive, rigorous and transparent methods of analysing data (Furber, 2010, Green and Thorogood, 2009, Ritchie and Spencer, 1994) provided a robust approach for addressing the research questions posed in the study.

Furthermore, the rationale for the use of research procedures should be clear and guided by the theoretical approach adopted by the researcher. Framework Analysis was adopted as the approach underpinning the study and provided the guiding principle for all research procedures described below.
5.5 Research Procedures

Research procedures are tasks necessary to execute a study following a chosen design. They include employing methods of sampling, data collection and data analysis which will allow the full exploration of the subject matter under investigation and answer research questions adequately (Ayres, 2007). They are discussed below.

5.5.1 Sampling

The data for research is usually collected from a sample of cases rather than the entire population (Marshall, 1996). It is an important component of any piece of research as it could influence the outcome of a study. The sampling procedures for quantitative and qualitative research are approached differently with the key distinction made between probability and non-probability sampling (Neuman, 2000). In probability sampling (such as simple random sampling), most commonly used in quantitative research, the probability of selection of each item is known in advance and all members of the defined population have an equal chance of inclusion in a sample. Probability sampling reduces the risk of selection bias and is considered to be more accurate and rigorous as compared to non-probability sampling.

Non-probability sampling, on the contrary, does not involve random selection and therefore sample may or may not represent the population well. Qualitative researchers tend to use non-probability sampling because their objective is to gain an in-depth understanding of a social process or situation (Tongco, 2007, Polkinghorne, 2005, Marshall, 1996, Ayres, 2007). Thus, qualitative research requires a more pragmatic and flexible approach to sampling (Marshall, 1996). There are different types of non-probability samplings including convenience sampling, snowball sampling, theoretical sampling and purposive sampling.
5.5.1.1 Snowball sampling

Snowball sampling involves identifying and exploring the experiences of participants with relevant characteristics and asking them to identify other individuals with similar attributes, thus creating a list of possible participants (Polkinghorne, 2005). This strategy is especially helpful in identifying hard to reach participants and/or exploring topics of sensitive nature (Marshall, 1996).

5.5.1.2 Convenience sampling

In convenience sampling, the sample is selected on the basis of ease of access. This strategy is usually taken due to pragmatic reasons, though it can result in missing out on key informants (Neuman, 2000). Therefore it is important to evaluate the appropriateness of using this method of sampling (Berg, 2001).

5.5.1.3 Theoretical sampling

Theoretical sampling is the principle sampling strategy for grounded theory research (Glaser and Strauss, 1967). In grounded theory, the process of data collection and data analysis is iterative. The researcher analyses the data, collected from an initial sample of cases, and draws out emergent themes - which then guide the selection of further sample cases (Ayres, 2007). It is important to ensure diversity within sample cases by including ‘negative cases’ Negative cases are those which do not support or contradict patterns or explanations that are emerging from data analysis. Their inclusion facilitates testing, elaborating and refining emerging themes for the development of grounded theory (Marshall, 1996).
5.5.1.4 Purposive sampling

Purposive sampling involves the researcher selecting the sample purposefully. It is used where particular, unique or specialised participants are needed for deeper understanding of a phenomena (Neuman, 2000). The selection criteria is guided by a number of factors, such as the aims and objectives of the study, the researcher’s previous experience, and information provided by the literature review (Marshall, 1996). It allows the deliberate inclusion of participants to incorporate a range of variables, to investigate their impact on the issue under investigation (Ritchie et al., 2003).

5.5.2 Procedures for sampling in this study

The study undertaken was embedded within the pilot phase of THPP (Section 4.1.4) prior to a full-RCT. The participants for the current study were identical to the pilot study. Participants for the pilot study were selected through purposive sampling, for the reasons described in Section 5.5.1.4 above. Further details of the participants are given below.

5.5.2.1 Peer volunteers

For PVs, a list of characteristics, based on previous formative work (Singla et al., 2014), were drawn. These included education of at least 10 years, being local, and able to work in the community. LHWs were asked to identify women meeting the above criteria. These PVs were trained in THPP intervention.

5.5.2.2 Mothers experiencing perinatal depression

For mothers, the criteria were to be of child-bearing age (between 18-45), be in their third trimester of pregnancy or have a child less than 3 months old, planned to reside in the study area for one year, and have a score of 10 or more on the PHQ-9. PHQ-9 is a nine item screening instrument, score ≥10 had a sensitivity of 88% and a
specificity of 88% for major depression (Spitzer et al., 1999). It has also been validated for the identification of depression among the South Asian population (Patel et al., 2008).

Women fulfilling the above criteria were assessed by a trained researcher, and those who were suicidal, experiencing psychosis, a complication of pregnancy or serious medical conditions requiring ongoing medical treatment were excluded from the study.

5.5.2.3 Local PHC staff

The THPP was linked with the PHC system, though a formal letter of understanding, in order to provide them institutional support (see Section 4.1.4.1). The THPP pilot study included local PHC staff members including a medical officer, two lady health supervisors and three LHWs, who assisted the PVs in their work.

5.5.2.4 Significant family members

The head of the family makes the majority of the decisions, including those involving the health care of family members (see Section 1.4.3). Therefore, it was important to understand their views regarding the acceptability of PVs to work with mothers. Participant mothers were asked to identify the significant member of their family; based on their identification family members were included in the sample.
5.5.3 Recruitment

The process of recruitment of participants into a research study involves approaching the participants, informing them about the study, and obtaining informed written consent. The ‘opt-in’ approach is preferred, as it involves only contacting those patients who have indicated that they would like to be actively involved in the study (Wilkie, 2001). It is also favoured by research ethics committees who regard it as more acceptable than assuming that all individuals would want to participate.

5.5.4 Procedures for recruitment in this study

Participants from the THPP pilot study were recruited into the study in-line with the ‘opt-in’ approach. The author sought permission to approach all participants in the pilot study via the THPP research team. On obtaining their assent, the author gave them an Urdu version (language, commonly understood in the study area) of an information sheet (Appendix 1: English Version, Appendix 2: Urdu Version) and consent form for interviews (Appendix 3: English Version, Appendix 4: Urdu Version) or consent form for group discussion (Appendix 5: English Version, Appendix 6: Urdu Version), at least 24 hours prior to their interview. For participants unable to read, the author read out the information sheet, at the time of handing it out to them and questions were invited and answered. Participants were informed of their right to accept or refuse to take part and/or to withdraw at any time. Those participants who agreed to take part were asked to sign, give their thumb impressions or provide witnessed verbal consent, depending on their preference. Where witnessed verbal consent was obtained, an independent family member witnessed the consent. Following the consent the author invited the participants at the venue of their convenience for the interviews and focus group discussions. The details of data collection strategies and procedures are discussed below.
5.5.5 Data collection

‘The purpose of data collection in qualitative research is to provide the evidence for the experience it is investigating’ (Polkinghorne, 2005. p.138). The data for the qualitative studies can either be ‘naturally occurring data’, such as obtained through observing a phenomena in its natural setting (Borbasi et al., 2005), or ‘generated data’ which involves the recalling, reprocessing and recounting of experience by the participant (Ritchie, 2003). The data gives an insight into the participants’ interpretation of the social phenomena. This type of data is most commonly gathered through in-depth interviews and focus group discussions.

5.5.5.1 In-depth interviews

In-depth interviews are the most commonly used methods for data collection in qualitative studies. They are simply defined as a ‘conversation with a purpose’ (Holloway, 1997. P.94). They provide a ‘first person account of the experience’ and are important for the contextual understanding of the social phenomena (Polkinghorne, 2005. P.138). They are more likely to be used when the subject matter is highly personal and its in-depth understanding requires deep probing or when it is preferable to collect responses without the group influence factor.

Conducting in-depth interviews requires establishing a certain level of rapport-building with the participants. This could be facilitated through making use of counselling skills such as empathetic listening (Polkinghorne, 2005). However, an interviewer should maintain objectivity while using such techniques, as the goal is to reveal participants’ experiences without influencing their views (Ayres, 2007). Furthermore, it is important for the interviewer to think logically and remember information for probing and assisting participants, in order to generate in-depth information (Legard et al., 2003).
5.5.5.2 Focus groups

Focus groups are typically used to obtain a broad range of perspectives around participants’ knowledge and experience on a topic under investigation in a social context (Sandelowski, 2000, Kitzinger, 1995, Powell and Single, 1996). This is achieved through group interactions. Group interactions help participants to reflect, clarify and express their views in the context of other participants’ views and generate different dimensions of information (Kitzinger, 1995, Ayres, 2007). They are used when the interviewer believes that group dynamics will add to the findings.

Focus groups might not be suitable when using qualitative approaches such as the phenomenological and ground theory as they are primarily aimed towards investigating participants’ views in the context of views of others, rather than generating full account of their lived experiences (Kitzinger, 1995). Furthermore, they are more appropriate for gathering information to answer research questions which are fairly specific (Powell and Single, 1996, Ayres, 2007). They can help to reduce the power dynamics between interviewer and participant, which is advantageous when investigating norms, cultural values, attitudes and shared experiences (Ayres, 2007). Moreover, focus groups are time efficient as data can be gathered from a number of participants over a relatively short time period. However, good organisational and mediating skills are required to plan and facilitate discussions in the group.

5.5.5.3 Topic guide

Topic guides are used to facilitate data collection. A topic guide is an ‘aid-memoire’ for the researcher, which includes the areas of interest to be explored (Burgess, 1984). ‘A well-constructed topic guide facilitates the exploratory and reflective nature of the qualitative research’ (Arthur and Nazroo, 2003. p.155). Usually it includes probes,
which potentially help participants to reflect deeply, think of alternative perspectives and give diverse responses (Ayres, 2007). However a balance is required between too much probing and giving participants the space to express themselves (Holloway, 2005). Polkinghorne has suggested that the ‘participant remain the author of the description’ and the role of the researcher is only to facilitate the process (Polkinghorne, 2005. p.143).

Since most in-depth interviews and focus groups involve capturing data through digital-recording, field notes are generally taken either during data collection or soon after. They are the written accounts of the researcher’s experiences and observations and help the researcher remember the setting and context in which the data was collected (Holloway, 1997).

5.5.6 Procedure for collecting data in this study

This study used both in-depth interviews and focus groups to collect data. Basic demographic information of all participants was collected, prior to conducting their interviews, on the demographic sheet (Appendix 7) developed for this purpose. In-depth interviews were conducted with the mothers, PVs and PHC staff. They were aimed to gain a thorough understanding of participants’ experiences, without group influence factors. Interviews allowed the author to probe the participants on issues which were of personal nature, while assuring confidentiality of the information disclosed. All participants were given the choice to be interviewed either at their homes or Basic Health Unit. Interviews of all participants, who gave their consent, were recorded and were transcribed verbatim. Those who did not give their consent for recording, notes were taken during the interview.

Focus groups were conducted with the husbands and mothers-in-law of the participant mothers. Focus groups were used to explore their attitude towards PVs working in their communities and to obtain multiple perspectives on the subject
matter. The focus group format allowed the author to facilitate discussions among the participants. It helped to explore the issues from various dimensions, add to the findings, and affirm or disaffirm information obtained through other sources. Focus groups were conducted at the Basic Health Unit by the author (Figure 14 below). They were recorded and transcribed by the trained transcriber.

**Figure 14: The author conducting a focus group**

Separate topic guides were developed in English and translated into Urdu for mothers (Appendix 8: English Version, Appendix 9: Urdu Version), PVs (Appendix 10: English Version, Appendix 11: Urdu Version), the PHC staff (Appendix 12: English Version, Appendix 13: Urdu Version) and mothers’ significant family members (Appendix 14: English Version, Appendix 15: Urdu Version). They contained a series of open-ended questions, guided by the research question and informed by the literature review and the author’s past experience. The author’s experience included conducting research on the prevalence and associations of perinatal depression in similar setting in Pakistan (Husain et al., 2006) and working with clinically depressed women both in Pakistan and in the UK. These experiences contributed to a greater understanding of issues faced by women in these settings, facilitating development of the topic guides. They were pilot tested, which comprised of testing, refining and finalising the topic guides on interviews. Pilot
testing was done in the field with a mother and a LHW. Additional probes were included in guides after piloting and some words were also rephrased to make them more culturally appropriate.

Parallel to the process of data collection, data analysis was conducted and is described below.

5.5.7 Data analysis

Framework Analysis (Section 5.4) was used to analyse the data. In this approach, data can be analysed either simultaneously with data collection or afterwards (Srivastava and Thomson, 2009). It has five analytical stages, which are both distinct and interconnected (Ritchie and Spencer, 1994).

5.5.7.1 Familiarisation

The first stage of analysis is familiarisation - and as the term suggests, this process helps the researcher to familiarise themselves with the data. This is achieved through immersion in the details of each data transcript (Srivastava and Thomson, 2009), leading to the identification of key ideas and recurring themes. However, identification of the themes requires an understanding of the context in which the opinion or idea has been expressed. This is facilitated through reading the field notes (Ward et al., 2013). During this stage, the researcher also refers back to the aims and objectives of the study to ensure that the data generated relates to them (Spencer et al., 2003).

5.5.7.2 Development of the thematic framework or index

Following familiarisation with the data, recurring themes and ideas identified form the basis of the thematic table. Similar themes and ideas are gathered in groups and organised in the thematic framework. The thematic framework allows the flexibility of shifting and sorting the sub-themes and themes as more themes emerged from
the data. It is more than a mechanical process - it requires good analytical thinking alongside a deep understanding of the context, relevance and meaning of an issue or idea. The framework, along with giving an overview of the data, ensures that the research questions are fully addressed. If there is more than one set of participants, either a separate thematic framework could be developed for each set of participants, or a common framework for all participants could be maintained which helps to see the similarities and differences between themes (Ritchie and Spencer, 1994). Each theme and its categories in the thematic framework are given an index number to facilitate the process of indexing, described below.

5.5.7.3 Indexing

In this stage, the thematic framework is systematically applied back to the data. This involves reading all the data, identifying sections of the data and referencing it in accordance with the thematic framework. Ritchie and Spencer (1994) suggest that annotations can be recorded on the margin of each transcript, and can either be textual or numerical (an index number representing each theme/category in the thematic framework). Another method for indexing is to copy and paste sections of the transcript corresponding to a theme/category into a word document (Furber, 2010). The process of indexing helps the researcher to further refine themes and categories in the thematic framework as categories are merged and new categories identified (Spencer et al., 2003).

5.5.7.4 Charting

This stage allows the researcher to see data as a whole on charts with headings and subheadings of themes and categories identified and refined in previous stages. During this stage, indexed data was lifted from the transcript, summarised and placed on the chart. Ward et al (2013) suggest that the right amount of information needs to be included in the chart; it should neither be too extensive nor lacking in information, and should make sense without the reader having to refer to the
original text. All summaries included in the chart are referenced for locating them back in the transcript, making this process transparent and replicable (Ward et al., 2013, Srivastava and Thomson, 2009).

Some decisions need to be made before the process of charting can begin; for instance whether the charts need to organise the data by theme or by case. In the former, charts are made for each theme across all respondents, and in the latter, charts are made for each respondent across all themes (Ritchie and Spencer, 1994).

### 5.5.7.5 Interpreting the data

The final stage of the analysis includes mapping out key findings systematically and interpreting them. The interpretations should reflect the participants’ experience truthfully and address the research questions accurately. Mapping out key findings involves reviewing the charts to check the summaries against the original data in order to ensure that they are true to participants’ descriptions and further merging of themes and categories until the final theoretical table is established (Ritchie and Spencer, 1994). It also involves searching for key dimensions and themes, comparing and contrasting them with each other and looking for links and associations. This process, if the data are rich enough, provide not only the description of phenomena but also describes relationships and causalities, makes predications and identifies gaps in the provision of health services (Gale et al., 2013).

The above stages of Framework Analysis, distinct yet interconnected; clearly demonstrate the systematic, transparent and accessible analytical procedures available in this approach. For health services research, the requirement to use a rigorous analytic approach to improve the credibility of the findings can be met by Framework Analysis (Ward et al., 2013). It is an excellent tool to inform policies and practices through findings, that can be audit trailed to the original data, collected from the very people that they affect (Srivastava and Thomson, 2009).
**5.5.8 Procedure for analysing data in this study**

The process of data collection and analysis were carried out simultaneously for the study. All interviews were transcribed in Urdu by a trained transcriber, and were manually analysed by the author in the same language. Analysing data in the interviewee’s language was advantageous as finer details and nuances of expression were not lost in translation. It also cut out considerable effort required in translation. However, a sample (about one-third) of the transcribed interviews were translated into English by the author to facilitate supervision by both supervisors. The reliability of the transcripts and their translations were randomly assessed by the supervisor NH, who was fluent in both English and Urdu. The supervisor KL provided feedback at all stages of the data collection and analysis.

Data analysis employed all five steps of the Framework Analysis approach described above. Once an interview was transcribed it was read and re-read. This enabled the author to become familiar with the data, and facilitated identification of emerging themes. These emerging themes were noted in the margin of the transcript. A sample of transcript below (Table 12) from an interview demonstrates how emerging themes were identified and noted. At this stage, these themes were mostly descriptive.

Alongside the process of identification of emergent themes, the development of a thematic framework was initiated. Since there was more than one set of participants, a separate thematic framework was developed for each set of participants i.e. mothers (Table 17, p.123), PVs (Table 19, p.141), PHC staff (Table 21, p.158) and mothers’ significant family members (Table 24, p.166). Similar themes and ideas were clustered in groups and organised in the thematic framework. Each theme and its sub-theme in the thematic framework were given an index number.
Table 1: Sample of a translated transcript from an interview with a PV

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Emerging themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interviewer:</strong> Alright, xx would you like to share with me your thoughts about what made you decide to work as a peer volunteer…?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> ...it was related to mothers’ (health). I am also a mother and I have experienced similar problems. I wanted to benefit other women in my community, so what could be a better thing for me to do than this</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Hmm. So you were willing because you thought you could benefit other mothers.</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> Yes.</td>
<td>PVs motivation: To share learning from her experience to help others</td>
</tr>
<tr>
<td><strong>Interviewer:</strong> How far do you think your expectations have been met?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> I can’t say much but I think most mothers have benefitted from it.</td>
<td></td>
</tr>
<tr>
<td>(At least) that is what they have said. Some were not sure because they were facing many problems. However most mothers started paying more attention to their diet and their children’s health. They had regular check-ups. They learnt from me the things they did not know before.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Alright.</td>
<td>Mothers reporting improved wellbeing/Increased knowledge.</td>
</tr>
<tr>
<td><strong>PV:</strong> There are some women who eat (well) during pregnancy but ignore their diet after childbirth. They believe that when the child is born, there is no need for a proper diet. But we have told them that if you will eat (well), you will be able to breast-feed the child properly…and you will remain healthy, and your child’s health will improve.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Right. And how did they respond?</td>
<td>Some mothers experiencing multiple problems</td>
</tr>
<tr>
<td><strong>PV:</strong> They listened and followed my advice.</td>
<td>Mothers’ lack of knowledge/PV raising awareness</td>
</tr>
<tr>
<td><strong>Interviewer:</strong> And were there women who did something different?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> Yes.</td>
<td>PV’s health related message taken on board</td>
</tr>
<tr>
<td><strong>Interviewer:</strong> And the ones, you were saying didn’t benefit from it, what was the reason?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> hmm…there was just one (such case). She wasn’t listening to me attentively. I used to tell her everything. I felt that whatever I was telling her, had not had any effect on her.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Alright.</td>
<td>Mother’s lack of engagement</td>
</tr>
<tr>
<td><strong>PV:</strong> I used to ask about her mood… I used to first show her the mood chart after the initial greetings, she used to say, ‘It’s just alright. Just alright’. She seemed very disinterested. I said (thought) she would improve after perhaps two to three sessions but there wasn’t any change in her.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> and how did that made you feel?</td>
<td>Mother’s lack of interest in receiving intervention</td>
</tr>
<tr>
<td><strong>PV:</strong> I was upset, but she was the only one. The rest of the three were alright. I had four.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Right. You had four mothers, how did cope seeing them all?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> It was not bad, I used to visit all four of them after fifteen days.</td>
<td></td>
</tr>
<tr>
<td><strong>Interviewer:</strong> Okay…every fifteen days… and approximately how much time did you spend with them?</td>
<td></td>
</tr>
<tr>
<td><strong>PV:</strong> Sometimes forty to forty-five minutes and sometimes it would take more than an hour as well. We had become such good friends that they would say, ‘Baji (sister) do come over again’. I told them, ‘not every day but I will visit you after fifteen days’.</td>
<td></td>
</tr>
<tr>
<td><strong>PV upset</strong></td>
<td>Befriending</td>
</tr>
</tbody>
</table>
Following the development of the thematic framework, the process of indexing was undertaken. It helped to refine themes and categories in the thematic framework, as some sub-themes were merged and new sub-themes identified. In addition to indexing the transcripts, each indexed section of transcript was translated and placed in a separate word document, with reference to its theme or a sub-theme.

Following the process of indexing, separate thematic charts for each set of participants i.e. mothers (Appendix 18), PVs (Appendix 19), PHC staff (Appendix 20) and mothers’ family members (Appendix 21) were made. This involved summarising indexed transcripts and placing it in a chart in correspondence to the theme (Table 13 below is a thematic chart for theme 2.0 for a PV). This allowed the data to be viewed as a whole on charts, with headings and subheadings of themes and sub-themes identified and refined in the previous stages. It was ensured that the right amount of information was included in the chart to make them explicable without making them too complicated. All summaries included in the chart were referenced, allowing them to be located in the transcripts, to make this process transparent.

In addition to the thematic charts, summary charts were also developed for all participants. These summary charts (an example of which is shown in Table 14) condensed the data further and were helpful to identify any patterns that were missed in the larger set of thematic charts.

At the final stage of analysis, key elements of the charts from all set of participants were critically examined to understand key links and associations which facilitated the interpretation of the data.
Table 13: Example of a thematic chart for theme 2.0 for a PV

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Theme 2.1: Ability to relate to the mother</th>
<th>Theme 2.2: Being local</th>
<th>Theme 2.3: Linkage with the health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>33PV</td>
<td>The PV, being a mother herself, felt she had</td>
<td>The PV felt that the mothers would feel comfortable talking to someone local, as only a local person will have an in-depth understanding of their issues. They would feel reluctant to talk to someone who was not local. For example during the training the PV reported not participating in discussions fearing that she might be misunderstood or say something wrong and be mocked. Likewise mothers would only talk openly to someone who is locally based (pg. 20). The PV felt that it would be convenient for her to work in her own village; however for the mothers it would be better if a PV belonged to the neighbouring village. This was because the mothers living in the same village as the PV would worry about their information being disclosed and other people making fun of them (pg. 18).</td>
<td></td>
</tr>
<tr>
<td>Age: 40</td>
<td>The PV used to tell mothers the problems she had experienced when her children were young and how she had managed to overcome them, hoping that it might strike their cord (pg. 12). The PV gained the mothers’ trust through ensuring them that she had received the training, showed them the training material, and reassured them that it was for their benefit. This helped the mothers overcome their initial hesitation (pg. 27-28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status: Married</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of schooling: 10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PV: Peer Volunteer

Table 14: Example of a Summary Chart for a PV

<table>
<thead>
<tr>
<th>Summary Chart</th>
<th>Theme 1: Reasons to continue working as a peer volunteer</th>
<th>Theme 2: Acceptance of the peer volunteer and factors contributing to it</th>
<th>Theme 3: Appropriateness of intervention</th>
<th>Theme 4: Peer volunteers’ perceived problems in delivering the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index no</td>
<td>1.1</td>
<td>1.2</td>
<td>1.3</td>
<td>1.4</td>
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<td>Sub-themes</td>
<td>Personal Gains</td>
<td>Peer volunteers’ families endorsement</td>
<td>Community and families’ acceptance</td>
<td>Adequacy of training and supervision</td>
</tr>
<tr>
<td>33PV</td>
<td>Job satisfaction</td>
<td>PV’s husband supportive</td>
<td>Mothers’ families welcoming and supportive</td>
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</tr>
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</tr>
<tr>
<td>Years of schooling: 10</td>
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</table>
5.6 Rigor in qualitative research

Qualitative research, when compared with the strict validity and reliability criteria applied in quantitative research, is often criticised for lacking in rigor (Mays and Pope, 1995, Krefting, 1999, Sandelowski, 1986). Qualitative researchers argue that the same rigid criteria cannot be applied to qualitative research due to the theoretical and methodological difference in the two approaches (Sandelowski, 1986, Mays and Pope, 1995, Krefting, 1999, Davies and Dodd, 2002). However, rigor in qualitative research is now emphasised and various strategies have been suggested. Meyrick has developed a practitioner-focused framework for assessing the rigor of qualitative research. It is a pragmatic guide for applied research, focusing on two core principles of quality: transparency and systematicity (Meyrick, 2006). This framework provides techniques that help to establish rigor at each stage of the research.

Other procedures that help to facilitate rigor are triangulation and reflexivity (Krefting 1999). Triangulation involves the use of multiple approaches in order to achieve a greater understanding of the phenomenon under study, so that there is an enhanced confidence in the results (Bryman, 2004). According to Denzin (1970), such approaches that lend themselves to triangulation include: a) generating data using a variety of people (Data Triangulation), b) use of more than one researcher for data collection and analysis (Investigator Triangulation) c) use of more than one theoretical approach for data analysis (Theoretical Triangulation) and d) use of more than one method for data collection (Methodological Triangulation).

Reflexivity is the process through which the researcher reflects on and assesses the influences of his/her background, experiences, perceptions, characteristics, and interests on data collection and data analysis (Krefting, 1999). This is critical for a qualitative researcher because he or she is the main research tool, i.e., the researcher uses the self as an instrument for data collection and analysis.
5.6.1 Strategies to ensure rigor of this study

Meyrick’s (2006) framework was used as a step by step guide to ensure rigor of the qualitative studies. The framework was adhered to throughout the study. The initial conditions for rigor were met by the clear ‘aims and objectives’ (Section 4.2) of the study. The qualitative research design was appropriate to achieve the stated aims and objectives of the proposed study (Section 5.3). Data was collected through conducting interviews and group discussions (Section 5.5.6) with all the pilot study participants. This aimed to ensure full representation of the sample and to facilitate generation of multiple perspectives around acceptability issues. Data collection and data analysis (Section 5.5.8) were carried out simultaneously and informed each other. The transcripts of the interviews were shared and discussed with the supervisors (KL & NH) to address any biases introduced during data collection. Field notes were consulted for reference during analysis.

The five distinct and interconnected steps of Framework Analysis were followed during analysis of the data to ensure systematicity, transparency and accuracy of findings. In order to ensure that the thematic framework was representative of the data, each theme was analysed in light of its context and relevance. The summaries of the transcript placed on the charts were checked against the original data to make sure that they are true to the participants’ description. The charts were shared with the supervisor KL and critically reviewed. All the steps, from data collection to data analysis, could be traced back through an audit trail. Thus, the themes and sub-themes could be traced back to their original source where they were indexed. This approach ensured rigor during analysis.

Two further procedures that were used to add to rigor to this study were triangulation and reflexivity. Triangulation of data sources was achieved through collecting data from different sets of participants such as mothers, their husbands and mothers-in-law, PVs and PHC staff and were analysed for the similarities and
differences to establish the ‘trustworthiness’ of the findings. Reflexivity is maintained through the author being aware of the research processes and reflecting on her assumptions and their influences on these processes. She was born in urban Pakistan and has been living in the UK for the past 23 years. She was trained as a counsellor and worked for several years with the South Asian communities settled in the UK on different mental health initiatives. Experiences such as the above could influence the way in which the data were collected, analysed and interpreted. For instance, being a counsellor could impact upon her interaction with the participants during interviewing, likewise being exposed to different cultures and having developed a broader world-view could influence interpretation of the data. Therefore, to ensure reflexivity, field notes were kept, issues were discussed openly with the supervisors and regular discussions were held with the research team in Pakistan. This assisted the author in reflecting upon and assessing her preconceptions, to ensure analysing information from the participants’ context, while keeping a check on personal biases. This helped to enhance the credibility of the study findings.

5.7 Research Ethics

All research should be conducted in accordance to moral standards in keeping with ethical guidelines (Davies and Dodd, 2002). While conducting health research, ethical considerations regarding the appropriateness of the research design, informed consent, confidentiality, researcher-participant relations, methods of data collection and analysis, data management and storage, and final reporting of the findings need to be taken into account (Orb et al., 2000, Holloway and Wheeler, 1995).
5.7.1 Ethical considerations for this study

This study followed key standards in research ethics. Ethical approval for the study was obtained from the University of Manchester Ethics Committee dated 02/12/13 (Appendix 16) and the local ethics committee at the Human Development Research Foundation, Islamabad dated 15/11/13 (Appendix 17).

The author obtained informed consent from all participants before conducting her interviews. The information sheet and the consent form was provided at least 24 hours prior to the interview, along with a verbal explanation of the study to all participants (see Section 5.5.4 for recruitment procedures). Participants were informed of their right to withdraw from the study at any time. Those who gave consent were interviewed at a venue of their choice. In any situation where privacy during the interview was compromised, participants were given the choice of re-scheduling the interview. In order to ensure confidentiality during the focus groups, a confidentiality clause was included in the consent form (see clause 6, Appendix 5) and ground rules were established before the start of the group to further reinforce it.

During transcription of interviews, all identifiable information was anonymized. All participants were assigned an ID which was used for referencing. The transcriptions were filed and placed in the locked cabinet. All computerised data was password protected. Any exchange of data through email between the author and her supervisors was made using a password protected computer.

Plans were put in place to deal with any untoward effects such as a participant getting distressed during the interview or disclosing matters of serious nature. For instance, in case of discomfort or distress participants were offered the opportunity to stop or break from the interview or to speak to another member of the research team, trained in counselling skills. Likewise disclosure of domestic abuse, suicidal
ideation or child abuse was informed to the THPP clinical coordinator, who would then refer and assist the participant in accessing the appropriate services.

5.8 Summary

The study aimed to gain an in-depth understanding of the issues pertaining to the acceptability of the PVs, delivering a psychological intervention for perinatal depression in a rural Pakistan. Ethical approval of the study was obtained from the University of Manchester UK and from the ethics committee in Pakistan. Data was collected through in-depth interviews and group discussion from the mothers who received the intervention, their families, PVs and PHC staff. Data analysis were underpinned by the Framework Analysis involving five key stages: familiarisation, development of thematic framework, indexing, charting and interpretation. This approach was used because of its robust and systematic method of analysing data, which allowed audit trial of main findings. Strategies were put in place to ensure the rigor of the study.
Chapter 6: Results

The chapter presents the results from the analysis of the data collected from the study participants in four interconnected sections. This first section will present the findings from the in-depth interviews with mothers, which will be followed by the findings from the PVs’ in-depth interviews. The next section will then present the findings from the in-depth interviews with health professional, followed by the findings from focus group discussions with significant family members of the mothers. The final section will present a synthesis of the findings.

6.1 Results: Mothers

Recruitment of mothers took place from January 2014 to May 2014. In total 22 mothers were approached to participate in the study (see Section 5.5.2.2 and 5.5.4 for sampling and recruitment procedures). One mother declined due to personal circumstances. 21 mothers were interviewed at their homes and most (n=16) agreed to the recording of their interview. Those who refused notes were taken during the interview. Interviews lasted between 30 to 60 minutes. The characteristics of the mothers are detailed in Table 15 below; all were married, aged from 21 to 45 years with an average number of three children. Years of schooling averaged 6.6 years and most were living in a joint family system.
Table 15: Characteristics of the mothers

<table>
<thead>
<tr>
<th>Mothers’ reference No</th>
<th>Age</th>
<th>No of children</th>
<th>Marital Status</th>
<th>Years of schooling</th>
<th>Family structure*</th>
</tr>
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<tbody>
<tr>
<td>02M</td>
<td>25</td>
<td>1</td>
<td>Married</td>
<td>14</td>
<td>Joint</td>
</tr>
<tr>
<td>03M</td>
<td>31</td>
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<td>Married</td>
<td>5</td>
<td>Nuclear</td>
</tr>
<tr>
<td>04M</td>
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<td>1</td>
<td>Married</td>
<td>8</td>
<td>Joint</td>
</tr>
<tr>
<td>06M</td>
<td>24</td>
<td>2</td>
<td>Married</td>
<td>10</td>
<td>Joint</td>
</tr>
<tr>
<td>08M</td>
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<td>Joint</td>
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<tr>
<td>09M</td>
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<td>Joint</td>
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<tr>
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<td>29</td>
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<td>Married</td>
<td>5</td>
<td>Nuclear</td>
</tr>
<tr>
<td>11M</td>
<td>28</td>
<td>2</td>
<td>Married</td>
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</tr>
<tr>
<td>12M</td>
<td>26</td>
<td>2</td>
<td>Married</td>
<td>5</td>
<td>Joint</td>
</tr>
<tr>
<td>13M</td>
<td>25</td>
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<tr>
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<td>Joint</td>
</tr>
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</tr>
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<td>Joint</td>
</tr>
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<td>Married</td>
<td>5</td>
<td>Joint</td>
</tr>
<tr>
<td>25M</td>
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<td>Married</td>
<td>5</td>
<td>Joint</td>
</tr>
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<td>Married</td>
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<td>Nuclear</td>
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<tr>
<td>34M</td>
<td>21</td>
<td>1</td>
<td>Married</td>
<td>12</td>
<td>Joint</td>
</tr>
</tbody>
</table>

*Joint family structure consists of multiple generations; parents, their children, and the children’s spouses and offspring, living in the same house.

*Nuclear family structure consists of one married couple and their children.
Table 16 below shows the number of session mothers received of the seven individual and three group sessions. 14 (66%) mothers received all seven individual sessions and more than 85% received five or more individual sessions. Attendance at the group sessions was relatively low, with only 47% mothers attending two or more group sessions. The mothers’ observance of the chilla ritual (post-delivery confinement period of 40 days) was the most common reason for the low attendance of groups.

Table 16: Adherence to the intervention

<table>
<thead>
<tr>
<th>Mothers’ reference No</th>
<th>Individual sessions</th>
<th>Group sessions</th>
</tr>
</thead>
<tbody>
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<td>3</td>
</tr>
<tr>
<td>03M</td>
<td>5</td>
<td>1</td>
</tr>
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<td>04M</td>
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<tr>
<td>06M</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>08M</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>09M</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>10M</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>11M</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>12M</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>13M</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>16M</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>17M</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>18M</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>20M</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>21M</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25M</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>26M</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>29M</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>30M</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>32M</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>34M</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>
Analysis of the data generated four themes and nine sub-themes (Table 17). These themes indicate factors which directly or indirectly influenced the mothers’ perception of the PVs’ acceptability as delivery agents of a psychosocial intervention for perinatal depression.

**Table 17: Thematic Framework- Mothers**

<table>
<thead>
<tr>
<th>Index no</th>
<th>Thematic Framework- Mothers</th>
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<tbody>
<tr>
<td>1.0</td>
<td>The factors affecting the mothers’ wellbeing during perinatal period</td>
</tr>
<tr>
<td>1.1</td>
<td>Main concerns during pregnancy</td>
</tr>
<tr>
<td>1.2</td>
<td>Ongoing marital and interpersonal issues</td>
</tr>
<tr>
<td>2.0</td>
<td>Acceptance of the PVs and factors contributing to it</td>
</tr>
<tr>
<td>2.1</td>
<td>Being local and other personal characteristics</td>
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<tr>
<td>2.2</td>
<td>Endorsement from the mothers’ family</td>
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<tr>
<td>2.3</td>
<td>Peer volunteer’s linkages with the health system</td>
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<td>3.0</td>
<td>Approval of the intervention</td>
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<tr>
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<td>User friendly and intuitive</td>
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<tr>
<td>3.2</td>
<td>Perceived positive Impact</td>
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<tr>
<td>4.0</td>
<td>Barriers in receiving intervention</td>
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<td>Mothers’ lack of engagement with the PVs and the intervention</td>
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<tr>
<td>4.2</td>
<td>Resistance from family</td>
</tr>
</tbody>
</table>

**6.1.1 Factors affecting the mothers’ wellbeing**

This theme provides the contextual understanding through describing those factors which affect the mothers’ wellbeing during their perinatal period. The analysis revealed two sub-themes: a) main concerns during pregnancy, and b) ongoing issues about marital and interpersonal relationships.
6.1.1.1 Main concerns during pregnancy

Mothers had a number of concerns related to their pregnancy and impending childbirth. These were clustered into two main areas: concerns about physical health during pregnancy and safe delivery, and concerns about gender of the child.

Concerns about physical health during pregnancy and safe delivery: There was scarcity of quality maternal health care facilities in the study area, as is typical of rural Pakistan (see Section 1.3.2) The majority of mothers receive little or no perinatal care at the Basic Health Units and Rural Health Centres. The staff are often not well trained and the facilities not adequate to deal with complex problems. Therefore several mothers expressed concerns about possible complications during their pregnancy and/or surviving childbirth.

*I used to think a lot, whether I will survive my pregnancy or not? I was unsure and scared, everyone used to say that I did not look very well.* 08M

Approximately half of all births in rural Pakistan occur at home, mainly due to the inaccessibility of public and private health facilities. They are attended by traditional birth attendants (personnel with no formal training or certification but with traditional skills attained from working as apprentices with more experienced birth attendants) known as Dais. At times a mother is taken to the health facility quite late, when a complication has led to significant signs and symptoms, or when there is an obstetrical emergency. In these close-knit communities, mothers reported incidents where things had gone wrong, and this evoked anxiety. Many women were worried about where they would give birth and about their and their child’s wellbeing.

*I was feeling very worried; I used to wonder what is going to happen to me and my child, whether my baby will be delivered at home or in the hospital.* 26M
Even among mothers who had access to a health care facility, there were concerns about the obstetric practices in these facilities. For example, women expressed the view that private health care facilities were carrying out unnecessary caesarean sections for financial gain rather than medical reasons (see Section 1.3.2.2). Five mothers interviewed said that their physician had indicated the likelihood of a caesarean section without clearly explaining the reasons. The perceived risk associated with delivery through caesarean section and the financial repercussions caused considerable stress. One mother spoke of her regret of conceiving when informed that she would require a caesarean section and began to avoid her routine antenatal check-ups.

*During my last month of pregnancy the doctor told me that my baby will be delivered through C-section, this made me really worried and I used to feel anxious all the time. I was not ready for the operation, I was thinking I might die, I used to avoid going for check-ups. I did not feel like talking to anyone. I used to think I would have been better off not getting pregnant.* 03M

In this study, mothers’ health related concerns remained largely unaddressed as many women did not have adequate information about their healthcare, and did not know where to seek such information. This was especially the case when a mother developed some form of a complication requiring treatment. The Basic Health Units were understaffed and physicians had little time to explain details of treatments to patients. This resulted in some mothers unsure about the impact of medical intervention on their growing foetus, as illustrated in the following quote.

*When I was pregnant I started having spotting after just three months. I was taking so many medications that I was worried about its effect. I was very tense thinking whether my baby will be born normal or disabled. I stopped meeting people. You know how people gossip here, and make stories, hearing them was making me feel tenser. I used to sit alone and worry all the time.* 18M
Concerns about gender: The majority of women discussed how they were preoccupied with the gender of their child, particularly first time mothers and mothers who had only daughters (see Section 2.3.3.1). Preference for boys over girls is culturally embedded in Pakistani communities. It is commonly perceived that giving birth to males strengthens the marriage and improves the mother’s status in her family. More than half of mothers hoped for a male child, as they felt obliged to provide their family with a male heir, and were worried of the consequences if they failed to do so.

She (PV) used to talk to me about my wellbeing and showed me nice pictures but all I could think of was that I had given birth to a baby girl. Everyone in my house pestered me about not having a baby son…. Even though it is Allah’s will, I feel bad about not having a baby boy. 09M

In keeping with the commonly held cultural belief that the infant’s gender was the responsibility of the mother, some mothers described how they had been mistreated by their husbands or mother-in-law because they gave birth to a girl. Conversely, in most cases, the mothers reported a considerable improvement in their mood following the birth of a son, as a result of relief from pressure and of preferential treatment from their family following the birth of a male offspring.

When I was pregnant with my second child my mother-in-law said that she wanted to have a grandson this time. 30M

When she (PV) came, I was pregnant, I used to get very upset, thinking whether it will be a baby girl or a baby boy. Since he was born, I am very happy; my family is very happy, they all take care of me. 13M

6.1.1.2 Ongoing issues

Two other factors identified, highlight issues related to a woman’s life inside their homes and in society: poor marital and interpersonal relationships, and a lack of female empowerment.
Marital and interpersonal problems: As discussed in Section 1.4.3 the majority of families in rural Pakistan live in a joint family system. Over 75% of mothers were living in a joint family, and most reported marital and interpersonal problems. Relationship problems were commonly associated with perceived unnecessary restrictions and ill treatment by the husbands’ parents and a lack of practical and emotional support from their spouses.

My mother-in-law is very harsh to me, she argues with me. My husband never supports me. He wanted me to put up with her behaviour and not to argue with his elderly mother. Since my children have died, I am very upset. Sometimes I lose my patience and answer back but most of the time I keep quiet. 20M

Many mothers reported feeling isolated and were reluctant to share feelings or disclose problems to family members. The reasons for this ranged from fear of upsetting family members, being judged, being misunderstood, avoiding confrontations and fearing rejection by the family. This resulted in most mothers suffering in silence as illustrated in the quote below.

Women are afraid of arguments in the house. Some have very strict husbands while others have strict mothers- in- law. Because of this they don’t openly disclose their problems and keep their issues to themselves. They are not sure who to tell and keep on sulking without telling anyone. Women know that they have to tolerate this because if they argue they might be asked to leave home. In that case where will they go with their children? This leaves them with no option other than to stay quiet and be compliant. 32M

Lack of empowerment: Mothers described a lack of empowerment (see Section 1.4.4). Over half of the mothers expressed feelings of helplessness due to the restrictions imposed upon them in making important decisions. This included decisions about their health care and marriage and other significant matters of their lives. This is illustrated in the following quotes where a mother’s marriage was arranged for her at a young age:

I only had one menstrual cycle and I was married off. I cursed my mother for marrying me off at such a young age. I was very naïve at the time of my marriage. My husband is a lot
older to me. I had my first daughter within a year then another daughter, two sons and a daughter again. 09M

Most mothers felt constrained, as they were not allowed to leave the home without seeking permission from the head of the family or without being accompanied by a male kin. Such restrictions were imposed more on younger mothers who were perceived as vulnerable to gossip, for example regarding their reputation, and hence could potentially damage their families’ honour.

_The things which really pull you down are the restrictions, don’t do this, don’t do that, this stops you from doing anything (at your own will). Even a tree can’t grow well under the shade and we are only humans. I can’t do things I want to do ….my husband is very strict._ 02M

6.1.2 Acceptance of the PVs and factors contributing to it

This theme captures those factors which contributed towards the acceptance of the PVs. These are clustered into three sub-themes: being local and other personal characteristics, endorsement from the mother’s family and linkage with the health system.

6.1.2.1 Being local and other personal characteristics

All PVs recruited, for the study, were local. There was the general consensus among the mothers that the PVs being local enhanced their acceptance. They felt that it allowed the PVs to relate to the mothers and their issues and increased their perceived trustworthiness.

**Being able to relate to the mothers:** The local PV was perceived to have an in-depth understanding of social and cultural issues faced by the mothers and an ability to relate to both mothers and the issues they faced. The mothers described the PVs as receptive to their problems and sensitive to family dynamics. In contrast, an urban PV would struggle to relate to them due to her liberal thinking and ways of life. It
was believed that a local PV would be able to assess the mothers’ circumstances accurately and make suggestions to them accordingly, as illustrated in a quote below.

*A local person is better because she is aware of our cultural norms and is alike us. As soon as she enters our house, she could assess the family’s dynamics of interpersonal relationship. She could tell how much time I can spare from my domestic responsibilities and would stay there accordingly. In cities circumstances are different, people are liberated and women have no restrictions, I don’t think that they could relate to us.* 34M

Another significant factor which helped PVs to relate to mothers was their experience of motherhood. Most mothers felt comfortable discussing their issues with a local married PV, knowing that she had gone through similar life experiences and therefore information imparted by her would be authentic.

*It gave me the opportunity to off load myself. Only a mother, who has gone through similar problems, can understand how another mother is feeling. We consider each other as sisters. She said that it is important to share ones concerns and problems because only then they can be resolved.* 32M

**Trustworthiness:** The local PVs were successful in conveying a sense of trustworthiness. Over three-quarters of the mothers expressed confidence that their PVs would keep their information confidential, which they felt was important for their relationship.

*I have trust in her; otherwise it would have been difficult. I listen to her and share my problems with her. I never feel that the information I am disclosing to her will be breached.* 06M

While there was consensus on the preference for a PV who was local, there was a division of opinion on whether a PV should belong to the mother’s village. The commonly reported advantage of the PVs belonging to the same village was their prior acquaintance or family ties with mothers’ family, which enhanced their trustworthiness. Generally families in villages know each other, if not on a personal
level then through extended families (see Section 1.4.2). Three out of four mothers felt they would trust a PV from their own village more than one from outside.

*My mother-in-law is very strict, she does not like any outsider coming to our house. If she would have belonged to the other village, it would have been difficult for me to receive this programme. However xx (PV) lived in our neighbourhood, she knew her and had a soft corner for her and let her come. 30M*

However, one in four mothers perceived working with a PV from a different village a safer choice, mainly due to confidentiality and also because of the opportunity to develop new social links.

*It would be better that she was from a different village. It would give me the opportunity to meet someone I was not acquainted with from before… if she (PV) is from my village, she can disclose information to my family members or to someone else… either way it can cause problem. 06M*

**Other personal characteristics:** Apart from being perceived as trustworthy and able to relate, most of the mothers found their PVs’ empathic to their issues. They developed a positive relationship with their PVs, felt valued and motivated to self-care. Moreover, the majority of mothers were able to identify attributes such as being humble, kind, friendly and respectful in their PVs.

*Nobody gives me much attention; they (family) think I am pretending to avoid housework. However, when someone gives you attention you feel like paying attention to yourself. She asks about my problems and listens to me. It feels good, disclosing to her what is in my heart and mind. It makes me feel better and helps me to overcome my worries. 08M*

*Her nature and style of talking was really good. She was like a friend. Her company used to make me feel happy. When she used to leave, I felt someone close to me has gone. 29M*

The PVs were not different from the mothers in terms of their socioeconomic and cultural background. They had had similar experiences as the participants, and having coped with these, were able to inspire participants to be able to do the same.

*I said to xx (PV) that I wanted to be like her, healthy and well. 04M*
6.1.2.2 Endorsement from the mother’s family

Due to the nature of rural family structures it would have been difficult for PVs to engage with mothers without first engaging significant family members (see Section 1.4.3). Over three-quarters of the mothers believed that PVs were able to gain their families’ endorsement. Most husbands and their parents gave approval for the PV for delivering the intervention, believing that the information given was useful for both mother and child. Some mothers reported their mothers-in-law and sisters-in-law joining in the session to gain information.

No, nobody stopped her from coming, when she used to come, we (family) all sit together, listen to her advice and respond to her. She takes time out to visit us for our betterment so we have to take time out from our housework to listen to her. 08M

6.1.2.3 Linkages with the health system

The PVs delivering psychosocial intervention, was a new initiative. In order to give PVs an identity, the programme was linked to the local health care system (Section 4.1.4.1). This sub-theme describes how a linkage with the health system was facilitative to the PVs’ acceptability. LHWs working for the health system are already embedded into their communities and are trusted to provide mother and child related health care. They introduced the PVs to the families. The majority of mothers believed that this enhanced the PVs’ credibility and acceptability.

First Mrs x (LHW) came, I know her, she has been coming to my house for quite some time, she introduced her (PV) to me. She told me the nature of her work. If she would have come on her own, I might have felt uneasy about it, not knowing her well enough. 10M
6.1.3 Approval of the intervention

This theme captures the mothers’ views about the various aspects of the intervention. These views were largely positive. There are two sub-themes illustrating key reasons for approval of the intervention: These are: a) user-friendly and intuitive nature of the intervention and b) perceived positive outcomes.

6.1.3.1 User friendly and intuitive

The PVs were not health professionals and had no experience of working in mental health. Additionally, due to the low literacy rate in rural Pakistan (see Section 1.1), some mothers were lacking in literacy skills. The intervention was tailored to these realities, regarding both the participants and PVs. This sub-theme captures the mothers’ positive views about: the intervention format, its material and the relevance of its key messages to their current issues.

Format of delivery: The intervention was delivered to the mothers through individual home-based sessions (n=7) and through group sessions (n=3).

Rural women are primarily responsible for looking after their home, children, farm and livestock. In addition, and as previously described most were living with and caring for the extended family which added to their already excessive domestic responsibilities and left them with little spare time to pursue their own activities. Therefore, mothers appreciated that the home-based individual sessions. The mothers responded by making an effort to allocate time out of their daily routines to receive the intervention. They enjoyed the PVs’ company and appreciated the opportunity to discuss personal matters in privacy.

*Even though I have lots of domestic responsibilities, when she comes, I leave everything to sit and talk to her. Once when she came, I had a lot of washing to do, which I left to sit down with her.* 09M
During the individual sessions you are on your own with the PV so you can say what is in your heart. If you have any problems or tension you can tell her, knowing that there is no one else listening. 02M

Group sessions were held at the Basic Health Unit. Almost half the mothers reported receiving at least two or more group sessions. The mothers described attending groups as an enriching experience. The aspects of the group sessions most appreciated were the opportunities to learn from each other’s experiences and to develop social networks.

When she used to come to my home the only issue was, it was one to one - one person to ask question and one person to respond. In groups you understand different perspectives, which was more beneficial. Even though there were only three group sessions but I found them more helpful and they left a greater impact on me. 34M

**Intervention material:** As stated in Section 4.1, culturally appropriate pictorial illustrations and stories were used to engage mothers. The majority of mothers reported that the information provided was effective and helped them to gain insight into their difficulties and helped them explore solutions. The mothers felt that the pictures were particularly helpful for those who could not read. In addition the mothers retained the pictures’ images, which function as constant reminders and motivators to engage in useful activities.

*I think the pictures in the workbook were most effective. The majority of the mothers in our village are not able to read, so just by looking at the pictures they can tell what is happening. Like in one picture a mother is sitting with all the things scattered around her, facing in one direction and her husband facing the other. Just by looking at it you can tell the whole story.* 02M

**Relevant and appropriate messages:** As stated in Section 4.1, the intervention aimed to improve the mother’s personal health, her interaction with people around her and the mother-child relationship. The majority of mothers highlighted the significance of these messages as relevant and appropriate to their circumstances. More than 80% of the women felt more motivated to take better care of themselves.
For example one mother described how she had embraced the message of engaging with others.

_\textit{She told me not to sit alone, but rather seek the company of others and talk to them because then the tension will go away.} 10M_  
The intervention helped most mothers understand the significance of their health, feel motivated and gain family support. Mothers recalled being given information about the importance of paying attention to their child’s needs and found this information in line with traditional practices.

_\textit{She makes me understand that I have only one daughter, if I am in this state, how will I look after my daughter? I will have to take care of myself first in order to take care of my daughter.} 04M_  

_\textit{All those old practices, which elders tell us, how a mother should interact with her baby while feeding, show her affection, talk to her child - she was telling the same. It reminded me how a mother should interact with her child.} 16M_  

Some mothers reported that their PVs suggested simple solutions, achievable and non-threatening to their family dynamics.

_\textit{She used to ask me about my health and give me advice - she told me to eat fruit. I said to her how I can I eat when I have so many children. She said cut apple in slices and share it.} 09M_  

### 6.1.3.2 Perceived positive outcomes

This theme captures the perceived positive outcomes mothers have narrated from receiving the intervention. These positive outcomes are clustered into mothers’ improved wellbeing and improved child care.

**Mothers’ improved wellbeing:** The majority of mothers reported some level of improvement following the intervention, including feeling more able to cope with life and family stressors as illustrated below.
While I was pregnant with my second daughter, my mother-in-law used to scold me all the time and wanted me to give birth to a son. I was worried, used to cry and was ignoring my health. If she taunts me now, I don’t take it to my heart. 30M

Most mothers reported improvement in their physical wellbeing, and they continued to do so after the intervention ended.

She told me that each time I feed my child I should be having something to eat, that will keep me healthy and to take rest for one or two hours between housework so that I don’t get tired. I am following her advice. I have egg, paratha (buttered chapatti), bread etc for my breakfast. 17M

Mothers also felt that their family relationships had improved. They were more inclined to interact with their family and friends and this in turn enhanced their social support.

I did not feel like meeting others but now I have developed an interest in meeting people. Before if anyone used to visit us, I never used to sit with them, but now it is different, I talk to them and offer them tea. When I feel lonely, I go and visit people to keep myself busy. Since he is born, there has been considerable improvement in my mood. 12M

**Improved child care:** The intervention was designed to improve mother-infant interactions. One in three mothers reported that the intervention led to them taking better care of and spending more quality time with their children. They also began to prioritise their children’s need over domestic responsibilities and felt more motivated to breastfeed them.

Now I leave my housework to give him time, make him go to sleep, hold him in my lap, play with him, talk to him and sing him poems while feeding him so that he recognises my voice and I can express my love to him. 02M

**6.1.4 Barriers in receiving intervention**

Analysis of the data collected from the mothers, helped in identifying barriers in receiving the intervention. These are clustered into two key areas: a) factors linked to the mothers and b) factors linked to their families.
6.1.4.1 Mothers’ lack of engagement with the PVs and the intervention

Factors impacting mothers’ engagement with their PVs included personal factors, such as a lack of trust in their PVs, time and financial constraints, stigma of depression and sociocultural factors such as cultural expectations.

Lack of trust: As described earlier, trusting the PVs was important, and although most women did trust them, perceived risk in sharing confidential information stopped or limited one in five mothers from discussing personal issues, as they felt this would potentially lead to conflict with their in-laws if they found out.

If I will share the problem with her (PV), then it is possible that she will tell my sister-in-law or my mother-in-law and then eventually my husband will find out. 11M

Time and financial constraints: Some mothers felt that their excessive workload and responsibilities left them with little spare time to engage in the individual sessions.

I had to leave my housework to sit with her, so I stopped her from coming. 13M

She (PV) used to say take a break and rest for half an hour, but what can I do? I can’t help it. I work from dawn till late without resting. My sister-in-law has four children, I have six children, we have livestock - a buffalo, two goats, a calf, a sheep and lambs, we take care of all of them. How can I rest? 09M

Poverty in Pakistan is higher in rural areas (see Section 1.1). A few mothers reported financially driven concerns and anxiety that prevented them from fully engaging with their PVs to receive the intervention.

My husband is unwell, he has hepatitis C and I am worried about him. His business is not doing well, financially we are struggling, we have children to look after, we have the responsibility to marry them off and give them dowry etc, all these worries are pulling me down. Talking to xx (PV) can’t help me. 09M

Stigma of depression: As stated in Section 1.3.2.3, there is stigma surrounding depression in Pakistan. Low literacy rate especially among women, leads to lack of
knowledge about the nature and causes of mental illness. In an attempt to counter this stigma, the intervention was promoted to target *mother and child health* rather than maternal depression (Section 4.1). However, one mother withdrew her consent after her PV inadvertently told her that she had depression. The mother was worried that she would be labelled ‘mad’. In another case, a mother who was aware that the intervention was for perinatal depression, chose not to disclose it to her family due to the fear of being stigmatised.

*I wanted to take part in this programme, but when xx (PV) came she told me that the assessment has indicated that I have depression. She used the word depression, which was wrong.* 21M

*No one else other than my sister-in-law knows about her reason of coming to me. If someone asks me, I say for my children.* 26M

**Cultural barriers to group sessions:** At a greater societal level, cultural traditions such as *chilla* (post-delivery confinement period of 40 days) came across as an important barriers to going out of the home to attend a group session. Moreover, mothers are expected to take extra precautions during the *chilla* period to avoid any harm coming to them or to their child, and to follow certain practices which could impact upon their day to day activities.

*She (PV) invited me (for group session) but I refused because I was in chilla period at that time.* 13M

*My husband stopped me from reading the book, because I was in my chilla period and he said that it can affect my eye sight.* 13M

Another cultural barrier was the perceived necessity for a female to be escorted by a male kin (see Section 1.4.4). However, the conformity to this practice varied. For instance mothers who were *Pathans* (an ethnic group which tends to be very conservative) did not leave home without being escorted by a male kin. This stopped a 38 year old mother of six from attending group sessions.
I could not go to attend groups; it is not a custom in Pathan families for women to visit other people’s homes unaccompanied. If I will go and my husband will find out he will get upset. 09M

6.1.4.2 Resistance from family

**Lack of awareness regarding the PV’s role/psychosocial intervention:** As stated in Section 1.3.2.3, there is generally a lack of understanding of depression as a mental illness and unfamiliarity with the concept of ‘talking’ therapies. Depression is often attributed to fate or supernatural causes such as evil eye or black magic and help is sought from spiritual or traditional healers. In cases where it is perceived to be linked with personal life circumstances, outside help is considered unnecessary. The above reasons led some families struggle to understand the role of the PV or fully appreciate the intervention. This was evident as some mothers reported their families’ objection to the PV coming to visit them, fearing that she might corrupt the mother, instigate negative feelings towards in-laws, or that PV was simply wasting mother’s time.

*He (husband) was saying that this information is not that important and I should stop seeing her as she is wasting my time. My mother-in-law was also saying that you have received information from her once so what is the point of meeting and chatting to her again and again.* 20M

*No my mother-in-law did not like it. She used to think that she (PV) might provoke me or made me go against her.* 30M

Some families felt that a ‘psychosocial intervention’ meant some material aid, for example, in the form of money, medicines or household items. They felt information on childcare and development was better imparted by the family’s elders, and hence the PVs’ involvement was not necessary. Some felt that suggestions, such as improving the mother’s diet, could only be implemented with monetary assistance.

*They (in-laws) say that isn’t it obvious that if she is coming to poor people like us, she should be helping us out by giving some tangible incentives, she just comes, sits and talks, what is
the point in that? Other people could give the same information, people who are older than me like my mother-in-law, who knows all about these things. 10M

**What happens at home should stay at home:** Families generally tend to discourage daughter-in-laws or wives disclosing their problems to anyone, and prefer to keep matters within the family (see Section 1.4.4). This is because if a mother is unwell or distressed, this would lead to fingers being pointed at the family for not looking after her needs. Some mothers reported the experience of other women in their communities who were discouraged from disclosing their depression to friends or neighbours to avoid embarrassment. They believed that such families would discourage the PV’s involvement as they would be worried that their personal affairs might be made public. For example, a mother was asked by her family to refuse intervention after she was told that she had depression.

*People in our village consider it (depression) as an illness. When my husband and mother-in-law found out, they said that she (PV) will go around in the village, telling other people and the word will spread. People will than gossip saying what her (mother) issues is, why she is on medications, why are women visiting her home and what problems she is experiencing at home. 21M*

*Most women when they are experiencing depression, they don’t tell others. You never know maybe they have issues at home and their families doesn’t allow them to disclose or maybe women are too afraid to tell. It does happen in villages. 32M*
6.2 Results: Peer Volunteers

Recruitment of PVs took place from January 2014 to May 2014. In total eight PVs took part in the pilot study (see Section 5.5.2.1 and 5.5.4 for sampling and recruitment procedures). All were interviewed at home and consented to be recorded. The characteristics of PVs interviewed are summarised in Table 18. All PVs except one were mothers and on average had two children, age ranged from 26 to 40 years, and years of schooling ranged from 10 to 14 (equivalent to GCSE and A-levels).

Table 18: Characteristics of the PVs

<table>
<thead>
<tr>
<th>Reference No</th>
<th>Age</th>
<th>No of children</th>
<th>Marital Status</th>
<th>Years of schooling</th>
<th>Family Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDI-01PV</td>
<td>29</td>
<td>1</td>
<td>Married</td>
<td>14</td>
<td>Nuclear</td>
</tr>
<tr>
<td>IDI-05PV</td>
<td>30</td>
<td>3</td>
<td>Married</td>
<td>10</td>
<td>Joint</td>
</tr>
<tr>
<td>IDI-07PV</td>
<td>35</td>
<td>1</td>
<td>Divorced</td>
<td>14</td>
<td>Joint</td>
</tr>
<tr>
<td>IDI-14PV</td>
<td>32</td>
<td>3</td>
<td>Married</td>
<td>10</td>
<td>Joint</td>
</tr>
<tr>
<td>IDI-15PV</td>
<td>37</td>
<td>3</td>
<td>Married</td>
<td>10</td>
<td>Joint</td>
</tr>
<tr>
<td>IDI-22PV</td>
<td>26</td>
<td>0</td>
<td>Divorced</td>
<td>10</td>
<td>Nuclear</td>
</tr>
<tr>
<td>IDI-28PV</td>
<td>34</td>
<td>1</td>
<td>Married</td>
<td>14</td>
<td>Joint</td>
</tr>
<tr>
<td>IDI-33PV</td>
<td>40</td>
<td>4</td>
<td>Married</td>
<td>10</td>
<td>Joint</td>
</tr>
</tbody>
</table>

The data analysis revealed four themes and eleven sub-themes (table 19 below). They represent factors that are pertinent to PVs’ acceptability, as well as motivation, in their role as delivery agents of a psychosocial intervention for perinatal depression.
Table 19: Thematic Framework –PVs

<table>
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<th>Index no</th>
<th>Thematic Framework –Peer Volunteers</th>
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</thead>
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<td>Reasons to continue working as a PV</td>
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<td>1.1</td>
<td>Personal gains</td>
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<tr>
<td>1.2</td>
<td>Endorsement from PV’s family</td>
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<td>1.3</td>
<td>Community’s acceptance</td>
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<td>1.4</td>
<td>Adequacy of training and supervision</td>
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<tr>
<td>2.0</td>
<td>Acceptance of the PV and factors contributing to it</td>
</tr>
<tr>
<td>2.1</td>
<td>Ability to relate to mothers</td>
</tr>
<tr>
<td>2.2</td>
<td>Being local</td>
</tr>
<tr>
<td>2.3</td>
<td>Linkage of PVs with the health system</td>
</tr>
<tr>
<td>3.0</td>
<td>Appropriateness of the intervention</td>
</tr>
<tr>
<td>3.1</td>
<td>Simple-to-deliver and intuitive intervention</td>
</tr>
<tr>
<td>3.2</td>
<td>Positive feedback reported or observed from mothers</td>
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<td>4.0</td>
<td>Challenges in working as a peer volunteer</td>
</tr>
<tr>
<td>4.1</td>
<td>Lack of engagement of some mothers</td>
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<td>4.2</td>
<td>Stigma of mental illness</td>
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<td>4.3</td>
<td>Resistance from mothers’ families</td>
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</tbody>
</table>

6.2.1 Reasons to continue working as a PV

If the delivery of any intervention through peers is to be sustainable, it is important to explore if the women who initially volunteered would continue this role, and if so what motivated them to continue working. These are clustered into four main areas: a) PVs’ personal gains from volunteering, b) the PVs’ families’ endorsement, c) the community’s acceptance and d) the adequacy of training and supervision. These are described in detail below.


6.2.1.1 Peer Volunteer personal gain from volunteering

PV’s were fundamentally motivated by wanting to help others or that they would be rewarded by God in their afterlife for being useful to others.

*I am also a mother and I have experienced similar problems. I wanted to benefit other women in my community, so what could be a better thing for me to do than this.* IDI-PV05

*We are otherwise sinful because we are so busy in worldly activities that we don’t get time to engage in humanitarian acts or to offer our prayers, so doing this act of kindness and will be rewarded by God.* IDI-33PV

In this setting, women generally have limited opportunities to work outside the home. For those who aspired to personal and professional development, the role of a PV was particularly attractive. Some PVs expressed future interest in a regular job, and one PV reported having applied for a vacant LHWs’ post in her area and hoped that her volunteering experience would improve her chances of getting this job.

*It has given me an opportunity to learn and gain experience. I hope I can get LHW’s post, as I would like to contribute to house income and want my daughter to feel proud of me.* IDI-07PV

Furthermore, it advanced their knowledge about maternal depression and its associated factors. This understanding, along with the opportunity to work with the depressed mothers, helped them to gain an insight into their own issues and how to resolve them. More than half of the PVs reported improvement in their own mental health.

*I have learned a lot through training, reading manuals and meeting other people. Now I know that there are many people facing problems and I am not the only one. Relatively speaking my problems are nothing as compared to them.* IDI-28PV

The improvement in PVs mental health had a favourable impact on other aspects of their wellbeing. The PVs provide information to mothers on improving their health and enhancing their social support. This information was a source of inspiration for
the PVs themselves - as they recognised the necessity of being a good role model to the mothers. A few PVs reported increased socialising and the majority have mentioned valuing themselves more and taking better care of their diet.

Before, I was reluctant to talk to many people and I didn’t like visiting others. I have now started visiting my sisters. IDI-14PV

You can only make the other person feel better if you are well yourself. I have experienced that. I improved my health and thinking and when I was alright, I started giving information to mothers. They listened and followed my suggestions. IDI-22PV

While almost all the PVs found the experience rewarding, one PV reported feeling upset when a mother refused to receive any further sessions.

I got tensed, I didn’t speak to anyone…why did she behaved like this…why she stopped me from coming…I was upset. IDI-14PV

6.2.1.2 Endorsement from PV’s family

Individual aspirations and desires are frequently trumped by collective family needs, with the head of family generally making all major decisions (Section 1.4.2 and 1.4.4). All PVs who signed the consent form had their family’s elders’ endorsement - which the PVs considered an achievement in itself.

My family is good, without their support, I would not have done this work. It would have been really difficult to leave housework and children. IDI-01PV

The importance of such endorsement from the family was also apparent in the case of one PV who did not disclose her role to her brother knowing he would be obstructive, despite having her mother’s permission.

I have not told my brother, because he would have not allowed me. He doesn’t allow me to go anywhere. My mother has no objection and she gave me permission. We kept it secret from my brother. IDI-22PV
6.2.1.3 Community’s acceptance

Equally important for the PVs’ motivation was acceptance and appreciation of her role by the mothers’ families and of the communities they served. Acceptance, and in many cases appreciation, gave the PVs an enhanced social status and reassurance of the usefulness of their role. The PVs reported being questioned by their community members about the programme on several occasions; this curiosity was motivated by their need for reassurance on the nature of the PVs’ role. The majority of the PVs did not experience any resistance and have reported approval of their role by their communities.

_They ask us about our programme, about our role, where we have received our training, how do we operate, what do we do? I told them that our programme is called Thinking Healthy and we are trained to give information about mother and child health. This satisfied them knowing that we are doing this work with an objective._ IDI-PV05

Equally important for the PVs to continue functioning was acceptance by their target families. Generally, families in rural Pakistan are hospitable and welcoming to their guests. This was helpful as it provided an opening to meet the family, prove the value of the programme and gain their endorsement. Seven out of eight PVs were able to establish a personal relationship with most of the families they were working with. They reported achieving this by highlighting the agenda of optimal child development (see Section 4.1), being courteous to all family members, involving them during the sessions and gaining their trust.

_When we go there, we sit and talk to the family. Even if there is some tension going on between them (mother-in-law and daughter-in-law), they sit together with us. This helps us in gaining their trust. They might not be interested in the mother but when we talk about the child everyone gets interested. This common interest brings everyone close to each other._ IDI-14PV

_Xx’s mother-in-law was very happy and cooperative to me. She was saying that her daughter-in-law takes care of her diet only when I ask her. Even now when she meets me in the field, she greets me happily and invites me to visit her house._ IDI-33PV
6.2.1.4 Adequacy of training and supervisory support

PVs were given four day training, which focused on understanding and practicing counselling skills and content delivery through lectures and role plays. Most PVs found the training environment friendly and the topics comprehensively explained to them. They felt it increased their knowledge, made them feel motivated and adequately prepared them to face potentially challenging situations during their work. A PV mentioned understanding through the training, problems women experience, the link between mood and cognitions and the realisation of her own thinking patterns - which she felt helped her in overcoming her depression.

I like the training…the trainers were friendly…the way they explained the content was very good. I didn’t experience any problems in understanding it…I didn’t think that there was anything missing. I felt ready and willing to help mothers going through a difficult time after receiving training. IDI-14PV

Through this training I found the way women are treated, some are upset because of financial difficulties, others are upset because the way they think. It makes me realize that I was also thinking like that (when I was pregnant). I liked it (training) because through it I have learned a lot, which helped me to overcome my depression. IDI-15PV.

However, some felt that a longer training was required to make sure that everyone had understood and was confident in their peer volunteering role. Furthermore ongoing training would enable them to learn ways of dealing with diverse and challenging situations occurring during the course of their work. One PV reported that because of her training she was perceived as trustworthy and was consequently asked advice on a range of health related issues, therefore she felt training needed to incorporate more holistic health related information.

We had four days of training, it might not have been sufficient for some. As some felt slightly longer training would be better. Moreover we did this work for over 4 to 5 months; there should be some on-going training because the real work started when we actually went in the field and found every case unique. IDI-01PV
They knew that we have received the training so they trusted us and asked us about a range of health related problems, but we were not trained on that. Our training should include medical advice because women here needed help. IDI-07PV

The PVs received monthly group supervisions and field supervisions (see Table 10) conducted by the intervention facilitators at the PHC centre. Most PVs felt that the supervisory support was adequate and supervisors managed to deal with their issues effectively. They felt that the field supervision, in which the facilitators accompanied PVs in the field, was particularly helpful because when the participants saw them with a member of the research team they recognised the authenticity of their work and took them more seriously.

The supervisors encouraged us to discuss any problems we are experiencing openly with them and to look for solutions through group discussions. I had my supervisor’s contact number; she said I can contact her in case of any concern. IDI-PV05

Sonia (supervisor) is nice. When she accompanied me, mothers took me more seriously and shared their concerns more openly knowing that I have been properly trained and supervised. IDI-15PV

Some felt the need for more frequent supervisions, as it would have reassured them of their input to mothers, also would provide them the opportunity to discuss any concerning issues, which could not be discussed elsewhere.

More frequent supervision was needed because at times there were issues that needed discussion, matters we cannot discuss with our family members. Also at times some clarification or information was needed. IDI-07PV

Overall, the above factors played a role in giving the PVs’ job satisfaction and provided them with the motivation to continue their work on voluntary basis. This was reflected through the retention of all the PVs (n=8) throughout the study period of six months.
6.2.2 Acceptance of the PV and factors contributing to it

While the above theme elaborates the factors that contributed to the PVs’ motivation to continue in this role, this also needed to be reciprocated by the family and mother’s acceptance and perception of the role as useful and worthy of their time. This theme captures those factors which contributed to the PVs’ acceptance. They are clustered into three sub-themes: a) ability to relate to the mothers, b) being local and c) linkage with the health system.

6.2.2.1 Ability to relate to the mothers

The sub-theme describes the PVs’ perceptions about their ability to relate to mothers. The majority of the PVs expressed their ability to relate to the mothers by using their personal experiences as the basis of forming a relationship with them, befriending the mothers and gaining their trust.

Experience of being a mother: There is a tradition of expectant and new mothers seeking advice from more experienced mothers in their families and neighbourhood. Hence to perceive a PV, who was a mother, in a helping role was not an unusual phenomenon. All PVs, except one, were mothers themselves and about a quarter revealed that they had experienced perinatal depression. These experiences provided the PVs with good understanding of the mothers’ issues and the ability to empathise with them. The majority of PVs felt that being a mother was facilitative to their role and reported sharing their personal experiences with the mothers.

*When they were telling their problems, I used to tell them that I had similar circumstances but God has helped me to overcome it. Time never stays the same, I was stressed when my children were young, now my tension is gone. Mothers used to benefit from my experiences.*
IDI-33PV
Gaining mothers’ trust: A PV gaining a mother’s trust was crucial before a significant relationship could be established. The majority of the PVs reported gaining the trust of most of the families they were working with. This was achieved because they could relate to the mothers, gently assuring them of confidentiality and giving them time to build trust before making any attempt to talk about the sensitive issues.

It’s all about maintaining confidentiality, if we reassure them of confidentiality, we will be able to gain their trust... gaining trust is everything, once we gain their trust then everything else will become effortless. IDI-07PV

Befriending: The PVs’ acceptability was enhanced through befriending with the mothers. The majority of these mothers were socially isolated and were experiencing loneliness (see Section 6.1.1.2). The PVs provided them the opportunity to develop new relationships and participate in social activities through attending group sessions. More than half of the PVs recalled forming a friendly relationship with the mothers, who were similar age to them, by not just having a purely professional relationship with them, but by befriending them, sitting alongside them, being friendly with their families and even sharing their own personal information.

They were same age as me, I was friendly with them. I told them that I have been through all this. I used to sit side by side with them, if they were sitting on floor I used to sit on floor, then they listened attentively to you and took things on board. These are poor rural people; they listen to you and regard you as their well-wisher. IDI-33PV

6.2.2.2 Being local

Geographical proximity to the mothers was another key factor facilitating acceptance. Like the mothers (see Section 6.1.2.1), PVs expressed advantages to being local, such as their social, cultural and linguistic awareness, their knowledge of the local community and even personal knowledge of the families that they would serve. PVs believed that this made the mothers feel at ease to express their
issues. Additionally, their linguistic compatibility with the mothers enabled the latter to speak freely in their local dialect (Potohari).

Mothers will only talk openly to someone who is locally based. It is a fact that only a local person can understand their problems because she has gone through similar problems. Here in village people have different circumstances and almost everyone is experiencing problems of some sort. IDI-33PV

In addition to helping the mothers share their personal issues, the PVs further helped mothers to address their problems by making use of their understanding of local psychosocial sensitivities. This knowledge provided the PV with the right tools to explore appropriate solutions to their problems. With PVs not being local, there could be a risk of proposing an option which was either not implementable or against the rural norms.

Not everyone has resources to look after their diet as suggested, so I review diet chart with them in accordance to their circumstances, otherwise it will be no good. For example if they can’t afford to take full glass of milk I suggest them to take half a glass. IDI-01PV

She (mother) wanted to attend the group sessions. I tried to convince her family, but they didn’t give permission. So I held the group at her house. It was very useful for her. IDI-28PV

From the above, it is clear that the PVs’ being local greatly enhanced their acceptability. However, the preference for a PV belonging to the same, or a different village, was more a matter of personal choice for mothers and their families (also see Section 6.1.2.1). The PVs generally felt that working with the mothers from the same village was advantageous, primarily because of their convenience in making a visit, but also because of her prior acquaintance with the mothers and their families. Most PVs felt that familiarity from living in the same village reinforced their perception of trustworthiness and enhanced their acceptability.

Apart from the convenience of working in your own village, you do not experience issues such as introducing yourself or building a trusting relationship with mothers, whereas
working in the different village would have taken some time to build trust with them. IDI-01PV

However, some PVs felt that familiarity can reduce the ‘professional’ status of PVs, with less value given to their knowledge and skills. Moreover, sometimes a long-standing family feud might involve the PV and her client’s family, and in such cases it would be difficult, if not impossible, to fulfil this role. Lastly, the perceived risk of breach of confidentiality is also higher if the PV and the mother both reside in the same village.

A mother living in the same village as her PV might not pay much attention to what she is being told. Whereas if a PV is from a different village, she will think that she has come from far and acknowledge her better. Moreover if she is from same village, mother might or might not have good relationship with her. If the families have interpersonal conflicts, the PV might feel uncomfortable visiting them. IDI-PV05

I was from a different village so they trusted me. They felt comfortable knowing that I didn’t know anyone in the village and therefore their information was safe with me. IDI-28PV

6.2.2.3 Linkage of the PVs with the health system

The programme engaged with the PHC system through formal letters of understanding (see Section 4.1.4.1). The PVs were introduced to the mothers and their families through the local LHWs, employed by the PHC system and working in their respective communities for several years. Seven out of eight PVs felt that the introduction through the LHWs was helpful, as it facilitated their engagement with the families and avoided the reference to common family links generally used to establish individual relationships. The linkage reassured the families of the PVs’ role, which was essential in that setting.

Nobody knows about us whereas LHWs are working for the last 18-19 years. It would be really difficult for the PVs to work without their involvement. IDI-33PV

Being accompanied by the LHW was really useful. She helped me to approach mothers and introduced me to them. Otherwise I would have to explain to them that I am so and so’s
daughter and granddaughter, which might have helped them to feel at ease with me. IDI-28PV

For majority of PV’s (six out of eight), it was their first experience of getting involved in any community work. Most of the PVs reported that LHWs were a good source of support for them. Being local they were approachable and their understanding of local issues provided useful guidance to them. In addition, being linked to LHWs increased their credibility and acceptability as also discussed in the mothers’ results (Section 6.1.2.3).

It would have been a bit difficult (without LHWs involvement). They (families) would have questioned, where have I been trained and what have I learned. When she accompanied me, they realised that I am trained and belonged to an organization, so they trusted me. She also helped me in conducting the group, asking women to come and attend sessions. IDI-15PV

6.2.3 Appropriateness of the intervention

This theme captures the PV’s experience of delivering the intervention to the mothers and its perceived impact on them. They are clustered into two sub-themes: a) simple-to-deliver and intuitive intervention and b) the perceived positive outcome of the intervention on mothers.

6.2.3.1 Simple-to-deliver and intuitive intervention

The content of the intervention was simple and intuitive (Section 4.1.3). The key messages given were relevant to the mothers’ current circumstances and intuitive to both its receiver and deliverer. They were targeted to improve mothers’ wellbeing and were delivered in a sensitive and culturally appropriate manner.

We say to mothers, they know everything, but usually they are so busy in raising their children and housework that they tend to ignore their health. We remind them the importance of taking good self-care in order to remain healthy and to look after their family. IDI-01PV
As stated in Chapter 4, the intervention uses the power of imagery and narratives to encourage mothers to become more active. Similar to the views expressed by the mothers (Section 6.1.4), the majority of PVs felt that both the story and pictures were effective tools for communicating, the mothers could relate to them and they were motivational in improving mothers’ wellbeing.

_Mothers who cannot read understand the information through looking at these pictures in the manual. I ask them what is happening in these pictures. They talk about the pictures but actually they channel out their problems, likewise Rashida’s story (story narrated during group session) gave them good insight into their problems._ IDI-01PV

Almost all PVs’ appreciated the mixed method of delivery and expressed views similar to the mothers. Most PVs felt the groups facilitated learning from each other experiences and individual sessions allowed sharing personal experiences which could not be discussed in a group setting due to the fear of disclosing information and the concerns of bringing shame and embarrassment to their families.

_In the group they get the opportunity to learn from each other and understand that other women are going through similar problems. I think this understanding helped them in certain ways._ IDI-14PV

_They do not share personal information during group sessions. In villages they believe that if others will find out about their domestic issues, they will gossip about it which will dishonour their family. They only shared such information with us at their homes._ IDI-15PV

### 6.2.3.2 Positive feedback reported or observed from mothers

Another factor important for the motivation of the PVs was the positive feedback reported or observed from mothers or their families. During each session the PV assessed the mother’s mood through recording her response on the mood chart (pictorial illustrations representing mood on a 5-point scale ranging from very sad to very happy). In addition they relied on accounts given by the mothers and their family members about their general wellbeing. Almost all PVs reported noticeable
improvement in the mothers’ mood because of the support they were receiving from them. In addition, their improved mood was both the cause and effect of their improved interactions with their family and better care of their diet and rest.

*In every following session I used to ask her about her mood and daily routine. She used to tell me what she has done, how she has taken care of her baby. This makes me realise that she is following my suggestions. Moreover the improvement in her says it all.* IDI-01PV

*Her mother-in-law says that she is thankful that such help has been offered to them. The mother has now started talking to them, before she was keeping herself to herself. All the time she used to sit quietly, neither eating nor asking for anything else. She is so happy now that it seems magical.* IDI-15PV

PVs also reported mothers’ improved interaction with their children. Half of the PVs talked about how mother-child bonding messages were taken on board and resulted in mothers paying more attention to their children’s emotional needs. There were increased mother-child playful activities and demonstrations of affection.

*A mother told me that while breastfeeding, she never looked or talked to her baby, now she plays with him, hold his hand and is feeling closer to him.* IDI-PV05

### 6.2.4 Challenges in working as a peer volunteer

This theme captures the challenges which PVs experienced during delivery of the intervention to the mothers. The challenges identified are clustered into three sub-themes: a) a lack of engagement, b) stigma of depression and c) resistance from the mothers’ family.

#### 6.2.4.1 Lack of engagement

This sub-theme describes factors which the PVs perceived as impacting their engagement with the mothers. These factors were mainly linked to: the mothers’ lack of interest in receiving the intervention, and their fear of sharing personal information with their PVs.
**Lack of interest:** The PVs described various reasons which they believed lead to the mothers’ lack of interest in the intervention. Some PVs felt that lack of familiarity with the talking therapy combined with the lack of material incentives made the intervention less attractive to some mothers. Another reason could be a mismatch of educational qualifications; for example one PV felt that her skills were undermined by two mothers who possessed higher educational qualifications than her, resulting in a lack of engagement. Some PVs felt that the lack of interest could also be the manifestation of some underlying issues such as their denial of mental health problems, time constraints or family pressures. However, at times these reasons were not disclosed to the PVs, with the mothers making excuses to avoid receiving sessions.

*She demanded for some monetary help. She seemed more interested in money and asked me what will I give her and how otherwise are my visits helpful for her? I said that I will give you information about mother and child health, but she seemed more interested in tangible gains.* IDI-PV05

*Initially they were not engaging with me. Both were graduates and more educated than me. They made it clear to me that they were more qualified.* IDI-15PV

**Lack of trust:** As discussed in Section 6.1.4.1, the PVs being local and working in close knit communities led to a perception of risk of disclosure of information to the person/s known both to the mother and her family. Most PVs felt, this preoccupied some mothers and created a barrier to their work. The PVs acknowledged mothers’ fears of information being relayed back to their families resulting in domestic conflicts or word being spread in the neighbourhood resulting in bringing shame and disgrace to the family. In both cases a mother would be held answerable to her in-laws.

*Women do not express their concerns because of fear of information being disclosed. Often the nature of domestic issues is such that mothers feel disclosure will disgrace their family’s standing in the community and will lead to family confrontation or argument.* IDI-01PV
6.2.4.2 Stigma of mental illness

The stigma of depression posed a major risk to the acceptability of the PVs who were working with the depressed mothers. During the training the PVs were made aware of the stigma of depression as a significant barrier to engagement and they were trained to deal with the issue sensitively. The majority of them were able to deal with the issue when it arose, avoiding unnecessary stress or embarrassment to the mothers, or resistance to the intervention. PVs discussed how they had tackled this issue, rather than how it had acted as a barrier. However in one case, a PV failed to address the issue sensitively, leading to a mother’s withdrawal from the study.

They will deny or worry about being unwell. This will impact their mood adversely. Moreover some people feel ashamed of it, believing that it is either their family or their circumstances to be blamed of... as poverty is the biggest cause of depression. IDI-07PV

She got upset when I told her that the assessment indicated that she has depression. She said that she is not mad and stopped me from coming when I went for my next visit. IDI-22PV

6.2.4.3 Resistance from mothers’ families

Another likely challenge for the PVs was resistance from the mothers’ family. The mothers tended to abide by the decisions made by the elders in the family and therefore their approval of the PVs was crucial. There were several factors indicated by PVs which could influence the family’s opinion about them. In Pakistan, the perception of corruption is quite high and has resulted in citizens’ general mistrust of both the government and non-government organisations. New initiatives such as the one under which PVs were working can be looked at with suspicion. This can in turn undermine the PV’s role. Some PVs have reported the families’ misconceptions about their role, for example, the PVs corrupting their daughter-in-laws, instigating hatred towards them or encouraging them to go against their family’s wishes.
She (mother) said that her husband was saying that they (research team) have taken all the money and therefore just doing talking with us, without any monetary assistance. IDI-15PV

If a family don’t know anything about a PV they might start doubting her intentions. They will wonder why she has come, what she is talking about, is she making the mother go against them or encouraging her to get a job. This made them worry about her housework responsibilities. IDI-07PV

Resistance could also be linked to cultural beliefs, practices and superstitions. For example the *chilla* period was perceived to be a vulnerable period for the mother and therefore she was discouraged from attending the group sessions. If a baby is born prematurely extra precautionary measures are taken by the family. For example, families do not allow anyone to meet the mother or her baby, believing that it will bring harm to them. This could then stop a PV being able to contact the mother during this period.

Two mothers who were in their chilla period did not get permission from their families to attend group. IDI-07PV

A baby was born to xx (mother) one month and five days early. In our village if a child is born before full term, family do not let anyone see the mother or the baby. They fear that it will cast a shadow which can make the baby grow weak and unwell. Some families believe that a mother shall not get near her child after combing her hair, or taking a bath neither do any other women during her menstrual cycle. IDI-15PV

Lastly conflicts or strained relationships between a PV’s family and a mother’s could cause a barrier to the delivery of the intervention. Such feuds can be very long-standing and destructive to individual relationships. One mother refused to see her PV because her in-laws were in dispute with the PV’s in-laws, and therefore her intentions for coming to their home were viewed with suspicion.

I went to her house twice but they didn’t like me coming to their house, especially her mother-in-law because of our family feud. She used to think that I am coming to spy on them. IDI-33PV
6.3 Results: Primary Health Care (PHC) Staff

In total six members of the local PHC staff were approached, out of which five agreed to be interviewed (see Section 5.5.2.3 and 5.5.4 for sampling and recruitment procedures). One Lady Health Supervisor (LHS) declined due to time constraints. The remaining five included: one Medical Officer (MO), one LHS and three LHWs (Table 20 below). The participants varied in their number of years of work experience ranging from 5 to 18.

Table 20: Characteristics of the PHC staff

<table>
<thead>
<tr>
<th>Reference no</th>
<th>Job title</th>
<th>Years of work experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDI-19LHW</td>
<td>Lady Health Worker</td>
<td>8</td>
</tr>
<tr>
<td>IDI-23LHW</td>
<td>Lady Health Worker</td>
<td>8</td>
</tr>
<tr>
<td>IDI-24LHW</td>
<td>Lady Health Worker</td>
<td>18</td>
</tr>
<tr>
<td>IDI-31LHS</td>
<td>Lady Health Supervisor</td>
<td>5</td>
</tr>
<tr>
<td>IDI-27MO</td>
<td>Medical Officer (Male)</td>
<td>12</td>
</tr>
</tbody>
</table>

The data analysis generated four themes (Table 21 below). These themes demonstrate how the PVs’ characteristics, their linkage with the health system and the intervention, influenced their overall acceptability. In addition, analysis also revealed potential challenges to the PVs’ role, as perceived by the local PHC staff.
Table 21: Thematic Framework - Local PHC Staff

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<th>Thematic Framework - Local PHC Staff</th>
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</thead>
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</tr>
<tr>
<td>1.1</td>
<td>The LHWs’ role in legitimisation and facilitation of PVs</td>
</tr>
<tr>
<td>1.2</td>
<td>The PVs’ programme supplementing the LHWs’ programme</td>
</tr>
<tr>
<td>2.0</td>
<td><strong>Acceptance of the PVs and factors contributing to it</strong></td>
</tr>
<tr>
<td>2.1</td>
<td>Positive views about the PVs</td>
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<td>Being local and other necessary characteristics of a PV</td>
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<td>3.0</td>
<td><strong>Approval of the intervention</strong></td>
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<td>3.1</td>
<td>Perceived positive impact on PVs</td>
</tr>
<tr>
<td>3.2</td>
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<tr>
<td>4.0</td>
<td><strong>Challenges in delivery of intervention</strong></td>
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<tr>
<td>4.1</td>
<td>Resistance from mothers and their families</td>
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<tr>
<td>4.2</td>
<td>Stigma of mental illness</td>
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</tbody>
</table>

6.3.1 **Partnership with local PHC**

This theme describes the significance of PVs’ partnership with local PHC. The findings are clustered in two sub-themes: a) the LHW’s role in legitimisation and facilitation of the PVs and b) the PVs’ programme supplementing the LHWs’ programme.

6.3.1.1 **The LHW’s role in legitimisation and facilitation of PVs**

The PVs were a new workforce and needed an identity and organisational structure. This was provided through linking them with local PHC (Section 4.1.4.1). They were introduced to the families and supported by the LHSs and the LHWs. In addition, they assisted in PVs’ identification and recruitment. Due to their community work and knowledge of the households in their respective catchment areas, LHWs were the best people to identify potential PVs. This also allowed the LHWs to have some degree of ‘ownership’ over the PVs’ programme.
They asked us to identify woman who are preferably married, have received at least 10 years of schooling. I gave it a good thought, someone who can work outside home, clever and can interact tactfully. I suggested xx (PV) because she was most suited for this role. IDI-19LHW

The LHWs also introduced the PVs to the mothers and their families. This was aimed at establishing their professional role and helping them become acquainted with the mothers and her family. All PHC staff felt that it helped in legitimising the PVs’ work and facilitated the process of engagement with the families and gaining their trust.

IDI - LHW

This LHWs’ programme was resisted by its target population during its initial phase, due to common negative perceptions about professional women and because of the programme’s agenda of promoting family planning. However, with time people’s attitude changed. Two out of three LHWs felt that they paved the way for the PVs, referring to their struggle in changing communities’ attitudes. Additionally the LHWs reported providing ongoing support through facilitating the group sessions at their health houses and helping them to deal with any arising issues.

IDI - LHS

6.3.1.2 The PVs’ programme supplementing the LHWs’ programme

The intervention’s key messages, focused on mother and child wellbeing, were in line with the LHW’s programme aims to improve maternal and child health. All LHWs felt that the PV’s programme was helpful as it reinforced the key health messages they were delivering to their target population. In addition, they felt that
the PVs, working on similar agenda, eased their workload by addressing those issues effectively.

*I like this programme… first we give health related information to the mothers then PVs go and give similar information. Consequently mothers recognize their health issues and appreciate help provided to them.*  IDI-19LHW

The training delivered to the PVs was also attended by the LHSs and the LHWs. This was mainly to help them gain understanding of the intervention in order to facilitate the PVs’ work effectively. All LHWs and LHS felt that the training has enhanced their understanding of the perinatal depression and its associated factors and ways of dealing with it. They felt that this learning could be incorporated in their practice to improve the quality of their work.

*This programme is good. We were informed and trained on things we were not aware of. Before we were not watchful of symptoms of mental distress, now we have understood that mothers can experience it so we keep an eye on their mood.*  IDI-23LHW

6.3.2 Acceptance of the PVs and factors contributing to it

The PHC staff were a crucial link between the PVs and the families they served. Therefore, it was important that the PHC staff had a positive perception of PVs. The analysis revealed two sub-themes indicating a) the PHC staff’s positive views about the PVs and b) factors perceived to be contributing to their acceptability.

6.3.2.1 Positive views about the PVs

The PVs were already known to the LHWs, as their relatives, friends, neighbours or clients. However, having them as colleagues, working side by side on similar agendas, could impact their relationship. This was addressed by giving the LHWs ownership of the programme and actively involving them in mentoring the PVs’ work. All LHWs expressed positive views about the PVs. They appreciated their commitment to work and their ability to deal with mothers’ issues. In addition the
PVs were generally complimented for their personal attributes such as empathy, problem-solving skills and for sharing their personal experiences.

*PVs worked with depressed mothers who were fed up with their circumstances, they have too many children and limited resources. It is difficult for LHWs to sit and talk about their problems. PVs helped them to solve their issues. They have done this work gladly without considering it a burden. They have given their 100% and have worked with interest and honesty.* IDI-31LHS

6.3.2.2 Being local and other personal characteristics of a PV

**Being local:** The locality of the PV has been discussed as a prominent sub-theme from other participants (Section 6.1.2.1 & 6.2.2.2). Similar to the mothers and PV’s the staff felt that a local person would be perceived to be more trustworthy, aware of local psychosocial issues, linguistically and culturally similar to the mothers and have the ability to relate to their issues.

*In my opinion women from cities can come to supervise them but at the grassroots level work can only be done by a local woman. Anyone other than her, cannot do it properly because her approach will be different and her understanding of the local problems will be limited.* IDI-27MO

In addition to being local, all LHWs highlighted the importance of a mother belonging to their catchment area. They felt their prior acquaintance could facilitate the engagement between the families and their PV. The LHWs felt that without any references or associations, PVs will experience problems in terms of explaining their role and gaining the community’s trust.

*If a PV is given mothers from different village or from an area out of my catchment then it will be difficult for her, because people will neither be acquainted with her nor with me. It is better to work with people you already know as there will be fewer issues.* IDI-23LHW

**Peer volunteers’ personal characteristics:** The PHC staff described characteristics which they felt were essential for a PV, similar to those identified by the other participants. The experience of motherhood was given a high priority by all the staff
for two main reasons. Firstly, it was reported to give the PV a deeper understanding of mothers’ issues and enhance her ability to relate to the mothers (also see Section 6.1.2.1 & 6.2.2.1). Secondly, married woman in villages experience less mobility issues as compared to unmarried woman, therefore for logistic purposes a married PV will be more appropriate to deliver home-based sessions. In addition a good ‘reputation’ was felt to be important in rural communities; a person with a blemished reputation is perceived as a bad influence and therefore not welcomed in the house. Furthermore, it was important that a PV belonged to a family that did not have any conflicts with the other villagers - family feuds can be long-standing and pernicious. Other significant characteristics included being married, educated, similar age to the mother, able to maintain confidentiality, having good communication skills, and being optimistic.

Most importantly, she should be married and of similar age to the mother. Similar age will ensure that she has been through similar experiences and being married will make it easier for her to make home visit. It will be difficult for an unmarried girl in rural setting to deliver such information. IDI-24LHW

She should have a good reputation and her family should be in good terms with other families in the village, only then she will be perceived trustworthy. IDI-27MO

6.3.3 Approval of the intervention

The analysis of the data from the PHC staff interviews revealed perceived positive outcomes for both the mothers and the PVs, as described below:

6.3.3.1 Perceived positive impact on PVs

PHC staff in most cases were previously acquainted with the PVs. During the study period they worked closely with them and it was likely that any change in PVs wellbeing would have been noticed by them. Similar to the findings revealed from the PVs themselves (6.2.1.1), there was a general agreement that the role gave the PVs an opportunity to gain knowledge, experience and improved social status. The
staff felt that the PVs had applied the knowledge, gained during the course of their work, to benefit themselves and their families. Consequently, it had improved their emotional wellbeing, confidence and motivation to take better care of themselves.

Before they were sitting at home, only focusing on their children and domestic chores, now working with other women has changed their thinking for the better. It had provided them the opportunity to interact with women in their neighbourhood, which has enhanced their social interaction. IDI-19LHW

It has helped PVs to gain knowledge and experience. For example xx’s (PV) attitude started changing from the day she received training. Following the training she told me that she suffered this illness and decided that she would practice healthy activities before delivering the intervention to others. I am glad to see change in her. IDI-24LHW

6.3.3.2 Perceived positive impact on mothers

As stated in Section 1.3.2.1, LHWs maintain records for all women in their catchment areas by updating family registers and keeping notes of their medical histories and health conditions. As a result they are well aware of health problems women in their areas were experiencing and most likely to be the first one to notice an improvement in their wellbeing. All LHWs felt that the mothers who received the intervention showed improvement in their mood, relationships and increased attention to child care.

PVs visits have left a positive impact on mothers. It had helped them to overcome distress and they have started taking care of their health and of their children… lastly they stopped arguing with their husbands, resulting in a peaceful home environment. IDI-24LHW

6.3.4 Challenges in delivery of intervention

The analysis of the data revealed challenges, perceived by the PHC staff, in delivery of the intervention. These are clustered in two sub-themes: a) resistance from the mother and their families and b) the stigma of depression.
6.3.4.1 Resistance from mothers and their families

The PHC staff expressed several reasons for resistance from some mothers and their families. Some of these barriers are a result of old beliefs, unchallenged due to lack of awareness of mental health issues (see Section 1.3.2.3). For example, in this rural society, the symptoms of mental illness could be wrongly attributed to an evil eye, black magic or Jinn possession (an entity that is neither human nor a spirit of a deceased person, and is mentioned in the Muslim’s holy text). A LHW reported that when mental illness is attributed to supernatural powers, help is usually sought from faith healers. Other concerns raised by the PHC staff were similar to those raised by the mothers and PVs, such as a lack of clarity of the PV’s role, leading to the perception of PV as an intruder, or instigating hatred in women towards her in-laws, or empowering them for the wrong reasons. Lastly, some families were of the view that if a talking therapy could not solve their financial problems, then it is of no benefit to them (also see Section 6.1.4.2 & 6.2.4.3).

They say that she (mother) is being possessed, so instead of medicines they go for talisman (spiritual treatment). IDI-19LHW

A mother-in-law might think that she (PV) is instigating hatred and suggesting mother to be disrespectful towards her or she might have come just to explore their personal circumstances. IDI-31LHS

Women can say that you are talking to us but this is not the solution of our financial problems. IDI-27MO

6.3.4.2 Stigma of mental illness

The data from PHC staff interviews indicated that the stigma of depression is closely linked to lack of awareness of mental health problems, causing a barrier to accessing mental health services (also see sub-theme 6.1.4.1 and 6.2.4.2). Generally, there was a perception that the family was to blame for the woman’s depression, making them feel guilty, or being judged by others (Section 6.1.4.2). Therefore, they
try to deny or avoid disclosing mental health problems to others. The PHC staff felt that this could result in refusing or resisting any help offered to address such problems. At an individual level, being labelled ‘depressed’ induced fear and apprehension, which could lead to worsening of their condition. The LHWs recognised this potential for stigma and avoided using the term depression or tension with their clients and their families and referred to their condition as feeling worried or isolated.

In rural communities most people have no understanding of mental illnesses. If you refer a patient to a psychiatrist, they will refuse it straight away saying that they are not mad and they do not need to see a doctor who treats crazy people. I only refer literate patients to psychiatrist, the rest I treat myself for depression and anxiety. IDI-27MO

If a word mental distress is used there could several repercussions. People will wonder what has happened to her and will gossip about it. Some might think that her mother-in-law or husband has ill-treated her or too many domestic responsibilities have prevented her from self-care. Her family will get upset blaming themselves for her condition. IDI-31LHS

6.4 Results: Mothers’ significant family members

Two focus group were conducted, one with the mothers-in-law on 04/02/14, and one with the husbands of the participant mothers on 08/02/14. They lasted for 90 and 75 minutes respectively. Ten mothers-in-law and five husbands attended separate groups (see Section 5.5.2.4 and 5.5.4 for sampling and recruitment procedures). The characteristics of the participants (Table 22 and 23) shows that majority (n=12) were living in a joint family system. Most mothers-in-law were 50 and over, eight out of ten had not received any schooling, and they had 6.5 children on average. The majority of the husbands had eight years of schooling and had fathered 3.5 children on average.
Table 22: Characteristics of the Mothers-in-law

<table>
<thead>
<tr>
<th>Reference no</th>
<th>Age ≤ 50</th>
<th>Age ≥ 50</th>
<th>No of children</th>
<th>Years of schooling</th>
<th>Family structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ML-01</td>
<td>√</td>
<td></td>
<td>6</td>
<td>0</td>
<td>nuclear</td>
</tr>
<tr>
<td>ML-02</td>
<td>√</td>
<td></td>
<td>3</td>
<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-03</td>
<td>√</td>
<td></td>
<td>7</td>
<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-04</td>
<td>√</td>
<td></td>
<td>9</td>
<td>8 years</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-05</td>
<td>√</td>
<td></td>
<td>5</td>
<td>5 years</td>
<td>nuclear</td>
</tr>
<tr>
<td>ML-06</td>
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<td></td>
<td>9</td>
<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-07</td>
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<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-08</td>
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<td>8</td>
<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-09</td>
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<td></td>
<td>2</td>
<td>0</td>
<td>Joint</td>
</tr>
<tr>
<td>ML-10</td>
<td>√</td>
<td></td>
<td>7</td>
<td>0</td>
<td>Joint</td>
</tr>
</tbody>
</table>

Table 23: Characteristics of the Husbands

<table>
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<tr>
<th>Reference no</th>
<th>Age: 25-34</th>
<th>Age: 35-45</th>
<th>No of children</th>
<th>Years of schooling</th>
<th>Family structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-01</td>
<td></td>
<td>√</td>
<td>4</td>
<td>8 years</td>
<td>Joint</td>
</tr>
<tr>
<td>H-02</td>
<td>√</td>
<td></td>
<td>3</td>
<td>8 years</td>
<td>Joint</td>
</tr>
<tr>
<td>H-03</td>
<td>√</td>
<td></td>
<td>2</td>
<td>8 years</td>
<td>Nuclear</td>
</tr>
<tr>
<td>H-04</td>
<td></td>
<td>√</td>
<td>3</td>
<td>8 years</td>
<td>Joint</td>
</tr>
<tr>
<td>H-05</td>
<td></td>
<td>√</td>
<td>5</td>
<td>10 years</td>
<td>Joint</td>
</tr>
</tbody>
</table>

The analysis of the data revealed three themes, outlined in the Table 24 below

Table 24: Thematic Framework - Significant Family Members

<table>
<thead>
<tr>
<th>Index no</th>
<th>Thematic Framework - Significant Family Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Acceptance of the PVs and factors contributing to it</td>
</tr>
<tr>
<td>1.1</td>
<td>Positive views about the PVs</td>
</tr>
<tr>
<td>1.2</td>
<td>Being local and other necessary characteristics of the PVs</td>
</tr>
<tr>
<td>2.0</td>
<td>Approval of the intervention</td>
</tr>
<tr>
<td>2.1</td>
<td>Perceived positive impact on mothers</td>
</tr>
<tr>
<td>3.0</td>
<td>Barriers in receiving the intervention</td>
</tr>
<tr>
<td>3.1</td>
<td>Resistance from mother’s family</td>
</tr>
<tr>
<td>3.2</td>
<td>Expectation for material gains</td>
</tr>
</tbody>
</table>
6.4.1 Acceptance of the PVs and factors contributing to it

The majority of the mothers (n=17) were living with their in-laws and were obliged to conform to the decisions made by their husband’s parents (see Section 6.1.1.2). Analysis of the data obtained from the significant family members revealed two sub-themes: a) positive views about the PV and b) PV’s being local and other essential characteristics.

6.4.1.1 Positive views about the PVs

Due to the overwhelming influence of family members on the mothers’ choices, their involvement was highlighted as an important component of the intervention. In order to make the intervention attractive to them, it was advertised as a *mother and child wellbeing* intervention rather than intervention for perinatal depression and the family members, especially the mothers-in-law, were encouraged to attend the sessions (also see Section 4.1). Consequently, the majority of the mothers-in-law from the joint families attended the sessions. This gave them an opportunity to form personal relationships with the PVs. Most mothers-in-law welcomed them in their homes and some expressed affectionate feelings towards them. They appreciated the wellbeing messages given by the PVs, and a few encouraged their daughters-in-law to attend sessions. Most of the mothers-in-law attended the first few sessions and, after they began to trust the PV, their involvement lessened.

*She used to tell us good things about mother and child health. There was nothing objectionable in it.* FGD-01ML

*I told my daughter-in-law that you should get some time out to attend group sessions. Housework is a daily routine, whereas the PV does not ask to attend the group every day.* FGD-01ML

There is certain degree of shame associated with female reproductive health matters and such issues are not discussed in front of the male members of the family. In addition, men generally tend not to entertain female guests. For both reasons,
husbands did not attend sessions delivered by the PVs. They formed their opinion on the PVs through brief meetings when they visited their homes, getting feedback from their family members, or looking at the intervention material. A majority of them felt that the information given to their wives was helpful and wanted the PVs’ to continue their home visits on a regular basis.

They (mothers) have learned a lot through this programme. I don’t want it to end, it is important for my wife that her PV continue visiting her at least every two to three months. FGD-02H

6.4.1.2 PV’s being local and other personal characteristics

**Being local:** Analysis of the data, collected from all sets of participants, has revealed the locality of the PV as a matter of great significance (see Section 6.1.2.1, 6.2.2.2 & 6.3.2.2.) to their acceptability. Likewise, the significant family members believed that local women can be trained as PVs with relative ease due to their deep understanding of rural traditions and rituals, and will function better because of their ability to relate to mothers. Furthermore, participants felt that prior acquaintance with the locally based PV would instigate trust, and made them felt more secure in such company. Most mothers-in-law, as they knew the PVs from before, welcomed them warmly and were hospitable.

A local PV can relate to mothers and understands their problems. She can be trained easily and can explain and guide mothers better. FGD-02H

Familiarity is very important. If a stranger walks into your house you wonder, what is going on and what should I do. Programme has appointed PVs from our village which has given us a peace of mind. If they are visiting our houses we have no issue with that. FGD-02H

**PV’s personal characteristics:** A good reputation (being of good character; well-respected) clearly indicated as a necessary characteristic for a PV. Other characteristics highlighted were the PV’s experience of motherhood in order for her to relate to the mothers, and be mature enough to help them deal with their issues.
An educated PV was given preference, as long as her education and social status had not made her egotistical.

*We like only that woman to come to our house who is humble and very particular about her modesty. Her reputation should be unblemished and her character should be good.* FGD-02H

*A PV should be mature, a young girl does not know much without being married and becoming a mother, and will not be able to help mothers.* FGD-01ML

*She should have received at least ten years of schooling, so that she can make people understand things intelligently. However, some women who are educated and belong to good families become arrogant. It should not be like that, a PV should be humble.* FGD-02H

### 6.4.2 Approval of the intervention - Perceived positive impact on mothers

As discussed above (Section 6.1.3.2, 6.2.3.2. and 6.3.2.1), acceptance of the PV was dependent on the perceived positive impact of the intervention she was delivering. Usually any improvement in the symptoms of a person experiencing depression is noticed by close relations/carers, before they get acknowledged by the patient. In this case all mothers were living with their husbands, and the majority with husbands’ families. Therefore, any change in their mental state was most likely to be noticed by them before anyone else. These perceptions would then form the basis for approval of the intervention. During the focus group discussion, the husbands and the mothers-in-law mentioned observing an improvement in the mothers’ mood. The mothers became less irritable and more social in their interactions, they started to value their personal health and had improved interaction with their children.

*My daughter-in-law used to get irritated over minor issues. She is now communicating better with us and seems less annoyed.* FGD-01ML

*Her self-care has improved and she is treating her children lovingly. I have felt the difference in her behaviour at home.* FGD-02H
6.4.3 Barriers in receiving the intervention

The exploration of the barriers in delivering and receiving the intervention from mothers’ family revealed two sub-themes: a) resistance from mother’s family and b) expectation for material gains.

6.4.3.1 Resistance from mother’s family

In rural Pakistan, cultural values and traditions define the values of shame and dishonour (Section 1.4.4). Often, unacceptable behaviour, especially from the female members of the family, is perceived as bringing disgrace to the whole family and their actions are closely scrutinised to ensure that they are not compromising the honour of the family. Some mothers-in-law mentioned that it would be regarded as an instance of unacceptable behaviour, if a daughter-in-law discloses her domestic problems to her PV, and she could be reprimanded for doing this. Consequently, several mothers suffer in silence due to this restriction imposed upon them. The mothers-in-law expressed that those families who have ongoing issues would be extra vigilant with the PV. They would discourage her involvement, fearing it would bring shame to the family, as word would spread in the community.

There is a lot of difference between urban and rural life. In cities everybody minds their own business whereas in villages, if information is disclosed to an outsider, then family members will not tolerate it. Especially those who are mistreating their daughter-in-laws, to avoid facing embarrassment. Therefore daughters-in-law just bear and keep things to themselves. FGD-01ML

Some husbands mentioned rural communities’ resistance to taking on board new knowledge and initiatives, primary due to low literacy rate, and therefore may resist the intervention delivered by the PVs. Furthermore, concerns were expressed about wives leaving home to attend groups and the time spent on receiving the intervention might impinge on their domestic responsibilities.
People living in rural areas are rigid; it is difficult to make them understand things. There is a local proverb that if a dog’s tail is kept in a pipeline even for hundred years it will still be curved (a leopard never changes its spots). FGD-02H

Groups are held outside; our women observe the veil and do not go out. FGD-02H

Elders in the family might object thinking that the mother is wasting her time sitting and talking to the PV instead of doing her housework. She might fail to prepare meal on time to feed her family. FGD-02H

6.4.3.2 Expectation for material gains

The rural communities of Pakistan are disadvantaged because of low literacy rate and marked socioeconomic adversities, impacting all aspects of their lives (see Section 1.1). Most family members felt that financial problems and a lack of awareness of psychosocial interventions blur the ability to appreciate help that is not centred around material gain (see Section 6.1.4). This could then create a barrier to the PV’s acceptance in delivering a psychosocial intervention. Some mothers-in-law felt that they had the motherhood experience to guide their daughters-in-law, and therefore PVs’ practical support would be more beneficial. Similar views were expressed by some husbands, who felt that priority should be given to providing tangible benefits as talking alone is not the solution to the problems.

Some families are financially struggling and would like to receive more than just the information given by the PV. I have the experience of upbringing five children, I can give her the information she needs. What is difficult for me is to buy fruits and medications for her, so if the PV can help with buying what is required to keep her well, it will be appreciated. FGD-01ML.
6.5 Synthesis of findings

The issue of acceptability of delivery of the psychosocial intervention (THPP) through PVs in the community involved four key stakeholders: the intervention recipients (mothers); the intervention delivery agents (PVs); families of the intervention recipients; and the key maternal and child health-providers in the community. For the programme to be successful, all stakeholders would need to accept the PVs’ role while the barriers would need to be minimalized. The findings indicate that, by and large, the peer-volunteering role was acceptable to all these stakeholders, and barriers sufficiently minimal, to make this a feasible strategy (Figure 15).

**Figure 15: Facilitators and barriers to the PVs’ acceptability**

- Partnership of PVs with PHC enhanced their credibility and legitimacy
- Mothers found the PVs trustworthy and empathetic, and the intervention useful
- PVs were motivated to undertake this role and found it beneficial for mothers and for themselves
- The families felt positively about the PVs and the intervention
- Personal or societal barriers to the role
6.6 Using study findings to develop a matrix for a PV’s acceptability

Three out of these four key stakeholders, the mothers, their families, and community health workers, can be conceptualised as ‘the community’ (Figure 16) that might have a varying level of acceptability for the PVs. This level of acceptability would, in turn, be dependent on the peers’ own attributes and abilities, a large part of which would be a reflection of their level of motivation for the work they are undertaking. Thus, one useful way to organise the above findings would be in the form of a matrix illustrated in Figure 17.

Figure 16: Key stakeholders
Figure 17: Matrix for the acceptability of a PV

High community acceptability

High levels of need
Ease of access
Desirable PV characteristics
Intervention perceived beneficial
Being local
Good links with local health system
Personal gain
PV’s family endorsement
Mother’s family approval

Low PV Motivation

Mothers’ lack of engagement
Resistance from mother’s family
Good training and supervision
Poor matching
Undesirable PV characteristics
Societal and Cultural barriers
Stigma of depression

Low community acceptability

Lack of personal gain
Community disapproval
Good PV mother matching
Poor training and supervision
Intervention ineffective
Lack of credibility
Lack of organisational support

High PV Motivation
The upper right quadrant depicts an ideal peer-delivered interventional programme, where there is a high level of community acceptability and a high level of PV motivation. Key factors contributing to such a programme would be PV’s desirable personal characteristics, being local and having an ability to form a trustworthy and empathetic relationship with the mother and family. It would be important for the intervention to be effective. At the peer level, there would need to be sufficient levels of perceptions of personal gain (altruistic, opportunity or wellbeing) and endorsement from their own families and communities. PVs would need to have good links with the local health system and be supported through good training and supervision. The findings appear to indicate that the THPP, by and large, falls within this quadrant. Other variations to this matrix are described below.

The lower right quadrant depicts a programme where levels of peer motivation, their training and supervision are all good, but the programme is not acceptable to the community because the characteristics of the peers selected are not desirable, or unmatched to the community they are serving (e.g., they are perceived to be ‘foreign’ to the culture). Other key factors that could undermine the programme are the stigma from depression that could potentially block access to the mothers, or the intervention is perceived to be ineffective. Thus, it is possible to have motivated well-trained PVs but a programme that doesn’t work.

The upper left quadrant shows that, in the absence of any service, many families were willing to receive any type of support, regardless of the quality or motivation of its workforce. This was especially true in resource constrained settings. Peers were considered non-threatening and easy to access. However, the sustainability of such a service would be questionable.
Lastly, the **lower left quadrant** shows that a programme with poorly motivated unsupported PVs who lack any credibility in the community, combined with ineffective interventions that do not address stigma and cultural barriers would lead to programmes that are not only unacceptable, but could be harmful for the recipients.

### 6.7 Summary

The analysis of the data collected from the mothers, their families, PVs and the local PHC staff revealed that volunteer lay women from the community, with shared socio-demographic and life experiences with the mothers, were acceptable as delivery agents of the psychosocial intervention. Based on the synthesis of the findings, a matrix for the acceptability of these PVs was developed. It consisted of these two dimensions, with varying levels of acceptability and motivation, lying across a matrix. On one dimension, their level of acceptability was dependent upon a number of key factors, including the PVs’ personal characteristics (e.g., empathy and trustworthiness), being local and linked to the health system, and the intervention perceived as beneficial. A second dimension, the PVs’ level of motivation, was a key aspect of this role, and thus their acceptability. Their motivation was related to perceived personal gain from the role, their community endorsement, and good training and supervision.

The next chapter discusses these key findings in the light of published literature.
Chapter 7: Discussion

In this chapter, the key findings will be highlighted and discussed in light of existing literature. The implications of the findings, future research in this area and the study’s strengths and limitations will be discussed.

7.0 Overview

This study was conducted in rural Pakistan, where there is high prevalence of perinatal depression. Scarcity of mental health professionals and facilities has led to a large treatment gap. Consequently, there is a pressing need for alternate solutions to overcome the treatment gap. The THPP deployed PVs to deliver an evidence-based psychosocial intervention to the mothers experiencing perinatal depression.

The overall aim of this study was to explore the acceptability of the PVs as delivery agents of this psychosocial intervention, from the perspective of four key stakeholders – the mothers receiving the intervention, their families, community health providers and the PVs themselves.

The main findings indicate that in a rural community in Pakistan, PVs are acceptable in this role to all the key stakeholders.

The study identified factors which contributed to the PVs’ community acceptability and motivation. The PVs were local women, who were perceived trustworthy by the mothers and their families. Their personal characteristics such as being a mother, empathetic, friendly, approachable and of good repute were important. They had the contextual understanding of the sociocultural norms and had experiences similar to their recipients. They were perceived by mothers as ‘role models’, who could relate to their issues and could suggest relevant problem-solving strategies. All stakeholders felt that PVs linkage with the PHC system
contributed to their approval, as it made the service more attractive to the families, legitimised their role and enhanced the integrity of their work. Furthermore the intervention was perceived to be culturally acceptable and relevant to the mothers’ needs, thus contributing to the acceptability of its delivery agent. Its format of delivery, simple and intuitive key messages and culturally appropriate pictorial illustrations were perceived as improving the mother’s mood, increasing interaction with their child as well as their own self care and social skills.

The PVs’ level of motivation was also important to maintain their role. The study found that PVs’ motivation was associated with their families’ endorsement, approval from the mother’s family, their willingness to help others, aspiration for personal development and their improved physical and emotional wellbeing. Other significant factors included adequate training and supervisory support and their overall job satisfaction.

In addition to the above, the findings have also identified factors, which if not addressed, could lead to problems with the PVs’ acceptability and their levels of motivation. For instance deeply embedded cultural and societal barriers (such as lack of women’s autonomy, rituals and beliefs) and stigma of depression could be a threat to the PVs’ acceptability. Furthermore mothers’ lack of engagement (due to their pressing needs or confidentiality issues) and resistance from mothers’ families (due to lack of awareness or undue expectations), could make the PVs feel demotivated.

The findings have been discussed below with reference to the evidence obtained from the existing literature.
7.1 Discussion in light of current literature

In the synthesis of the results, the findings were organised along the two key dimensions - community acceptability and peer motivation (Figure 17). Each dimension had factors spread along a spectrum ranging from high to low. Each factor is discussed below in relation to current literature.

7.1.1 Factors contributing to high levels of community acceptability

7.1.1.1 High levels of need

Almost all mothers interviewed recognised the contribution of psychosocial factors (marital and interpersonal problems, child gender preference, lack of empowerment, their own concerns about health and safe delivery) to their well-being, and the lack of attention to it by health professionals. This was an overarching factor reflecting the high prevalence of depression in the study area (Rahman et al., 2003) and the lack of mental health treatment available (WHO, 2011). Global surveys have found similar levels of unmet needs in other LMICs (Demyttenaere et al., 2004). In the absence of any specialist mental health services, non-specialist lead services are likely to be the only alternative in low income settings (Patel, 2009, Kakuma et al., 2011, Eaton et al., 2011, Chowdhary et al., 2014). Where tried, such strategies have been found to be acceptable to the community. A review of qualitative studies on lay health worker-delivered programmes, conducted in low income settings, indicated a high level of acceptability with the programmes including its delivery agent (Glenton et al., 2013). Likewise, interventional studies conducted in Zimbabwe, Pakistan and South Africa have showed positive outcomes for mothers receiving mental health intervention through peers (Chibanda et al., 2014, Ali et al., 2010, Futterman et al., 2010). In the current study, participants described high levels of unmet psychosocial needs which would contribute to acceptability of a non-specialist, i.e., peer-delivered intervention.
7.1.1.2 Ease of access

Ease of access refers to both physical as well as psychological accessibility. The physical accessibility of mental health services is poor in rural areas, as these services are mainly concentrated in big cities (WHO, 2011). Furthermore restrictions imposed on women’s mobility (Shaheed, 1990) make health services much less accessible. A survey of 1036 rural Pakistani women reported more than 70% were not allowed to go unaccompanied even to their local health centres (Sathar and Kazi, 2000). In this study, the majority of the mothers appreciated the intervention being delivered at their doorstep.

The PVs were local women who were perceived to be easily accessible. They were willing to give their time and attention to the mothers desperate for help, which was appreciated. This is consistent with findings from other studies in which peers were used to deliver maternal health interventions in low income settings and were appreciated because of their accessibility and availability (Glenton et al., 2013), for providing emotional and practical support (Alcock et al., 2009, Nankunda et al., 2006, Andreson et al., 2013) and for giving mothers the quality time (Murphy, 2008). In some cases peers were preferred over health professionals due to their accessibility (Alcock et al., 2009, Shroufi et al., 2013). Conversely, in settings where health facilities were easily accessible, preference was given to the health professionals over lay health workers (Kaufmann and Meyers, 1997, Khan et al., 1998).
7.1.1.3 Desirable PV characteristics

Glenton et al’s., (2013) meta-synthesis identified the importance of empathy, trust, respect and kindness in building relationships between lay health workers, delivering maternal and child health interventions, and their recipients. Likewise, in this study, the PVs’ trustworthiness and empathy towards the mothers were key facilitators to their engagement. The PVs’ knowledge of the psychosocial and cultural dynamics of the area and shared experiences with the participants allowed them to relate and empathise with the mothers. They established relationships by sharing their motherhood experiences and befriending with the mothers. This non-threatening persona helped mothers to overcome their initial reluctance and discuss issues in a friendly environment. This is consistent with findings from other studies in which peer-mentors offered friendship and shared their personal experience with mothers (Murphy, 2008). They used their empathic skills to build rapport (Alcock et al., 2009, Nkonki et al., 2010, Walker and Bryant, 2013) and were a source of emotional and social support for them (Glenton et al., 2013).

The PV was perceived as a trustworthy person. Being local was a very significant factor contributing to their trustworthiness. Rural communities generally tend to trust their fellow villagers compared to ‘outsiders’, as they are perceived non-threatening to cultural norms. In comparison, an urban PV could be perceived to be too ‘modern’ and a potential threat to their societal and family norms. A number of qualitative studies from LMICs indicated preference for local peers, to deliver maternal health services because it enhanced trustworthiness and facilitated openness about sharing problems (Alcock et al., 2009, Nankunda et al., 2006, Shroufi et al., 2013).

Another characteristic that contributed to the PVs’ acceptability was their perceived ‘good reputation’ in the eyes of the family elders. The PVs in this study had been carefully selected with this criterion in mind. A study conducted in Uganda also
highlighted the importance of perceived good reputation of peer counsellors in enhancing their acceptability (Nankunda et al., 2010).

7.1.1.4 Good matching

Dennis (2010) recommended matching of peer-mentors to mothers based on their age, number of children, and breastfeeding status. In this study, the comparison of demographic information revealed many similarities between the mothers and PVs in terms of their age group, language, ethnicity, number of children, gender and family structure, which contributed to their acceptability. This is consistent with findings from other studies showing that age, gender (Johnson and Caldwell, 2011) and language matching (Flaskerud, 1991) was necessary to enhance clients’ satisfaction. In the current study, other areas of significance for matching were literacy and social status. For instance a husband felt that a PV who was highly educated could be arrogant. It was also identified that a PV from a relatively lower socioeconomic status experienced difficulties in engaging mothers who were from higher socioeconomic backgrounds than them. The evidence from the literature also suggests that therapist status should be considered carefully as a potential influence on therapeutic outcome (Lasky and Salomone, 1977).

7.1.1.5 Good links with local health system

The PVs were a new cadre of workers in their communities. In order to provide legitimacy to their role and organisational support, the peer programme worked in partnership with the existing PHC system, which was the gateway to community-based health care. The partnership proved beneficial for both parties; it provided the PVs’ with an identity and enhanced the credibility of their role and gave PHC ownership of the programme and facilitated task sharing. Glenton et al.’s., (2013) meta-synthesis also identified the advantages of partnerships between health professionals and lay health workers. They surmised that the adoption of a
collaborative model was found to enhance lay health workers’ legitimacy and credibility and helped in reducing the health professionals’ workload. An evaluation of a community based partnership with health system, to promote healthy activities in USA, pointed out the critical importance of involving the latter in all stages of the programme (Pinto et al., 2014). In the current study, the LHWs facilitated the entire process - from assisting with PVs’ identification and recruitment, to their introduction and embedment in the community. Visible support from the LHWs played a significant role in engaging families with the PVs. In the absence of such a partnership, Murphy (2010) in his study of a peer-mentoring programme for first-time mothers in the UK, found that even though the PVs were from the same locality, they still had problems in engaging the mothers at the initial stages. Pinto et al’s (2014) study also specified the significance of synergy between programmatic and key organisations’ goals to strengthen the partnership. In the current study, both the PV and LHW worked on a maternal and child care agenda. The LHWs’ valued the work of the PVs because they found it relevant to their own functions, and fulfilled a gap in their service.

7.1.1.6 Intervention perceived beneficial

While the above factors serve an important function in gaining acceptance, it cannot be fully assured unless the participants approved the intervention. For a psychological intervention to be acceptable, emphasis has been laid on its cultural appropriateness, contextual relevance and usefulness to the target population (Chowdhary et al., 2014). The original Thinking Healthy Programme (delivered through community health workers) took into account the individual and sociocultural context of the patient’s problems and produced significant positive outcomes (Rahman et al., 2008). The same intervention, with minor adaptations, when delivered by the PVs, was found to be culturally acceptable and relevant to the mothers’ needs, thus contributing to the acceptability of its delivery agent. There
are examples of other peer-delivered interventions that were successful because of being contextually relevant to their recipients, (Chibanda et al., 2014, Tripathy et al., 2010, Futterman et al., 2010), and others that failed because this critical element was not addressed (Clarke et al., 2014, Letourneau et al., 2011). The intervention was found beneficial in improving the mothers’ mood, social skills and overall wellbeing. Reviews of the qualitative literature on peer support in adult mental health services, have also indicated increased wellness amongst people in recovery as a result of receiving with peer support workers delivered interventions (Walker and Bryant, 2013, Repper and Carter, 2011).

7.1.2 Factors contributing to low levels of community acceptability

7.1.2.1 Stigma of mental illness

Stigma against mental illness has been described as a key barrier to treatment-seeking (Saxena et al., 2007). In a review of studies from LMICs, it was found that stigmatisation towards people with mental illness was more common in Asia as compared to Western countries, and social disapproval and devaluation of families with mentally ill individuals were widespread (Lauber and Rössler, 2007). Studies conducted in Pakistan have also shown that stigma of mental illness leading to discrimination against education, employment, health care, social opportunities (Karim et al., 2004) and marriage prospects (Suhail, 2005). Therefore, individuals with mental illness are often hidden away from view and the family prefer to seek alternative and traditional methods of treatment due to their social acceptance (Karim et al., 2004, Gilani et al., 2005). In the current study, similar views were voiced by health providers who described reluctance from patients and their families to be referred to mental health facilities for fear of being labelled as ‘mad’. Similarly both PVs and LHWs felt, labelling a mother with depression would add on to her anxiety because of fear of being stigmatised.
The original THP addressed this barrier by shifting the emphasis from mental illness to maternal psychosocial wellbeing, and relating this to the optimal development of the infant (Rahman, 2007). Thus, the PVs were trained not to use terms such as depression or mental illness, but to focus on issues and stressors that might affect the maternal role. Despite these measures, a small minority of families did not engage for fear of stigma.

7.1.2.2. Societal and Cultural barriers

In traditional societies, knowledge about the causes of mental illness is poor (Gureje et al., 2005) and they are generally attributed to supernatural causes (Dein et al., 2008, Razali et al., 1996), insufficient will-power (Stein et al., 1997) or moral weakness (Suhail, 2005). Studies from rural Pakistan found that mental illnesses were attributed to possession by jinn (27%) and black magic (67%) (Kausar and Sarwar, 1999, Khalily et al., 2011). In the current study, similar views were expressed by some participants, who also indicated a preference for interventions for mental health problems by faith healers, using talisman and traditional remedies. This finding is consistent with other research from Pakistan indicating that the faith healers are frequently approached for the treatment of mental illnesses (Karim et al., 2004, Gilani et al., 2005).

Other traditional believes also impacted on the intervention delivery. For example the 40-day confinement period after child birth called chilla is firmly observed in rural communities. In this study many mothers failed to attend group sessions as they were observing chilla. The chilla is associated with many superstitions (Khadduri et al., 2008), one being the mothers’ vulnerability to supernatural forces - for example, a PV was not allowed to visit the mother because the family feared she might cast a shadow on the mother. A similar example was found in Zimbabwe culture where outsiders are prevented to see the baby during the first week (Shroufi et al., 2013).
Rahman (2007) reported that even where depression is recognised, it is largely attributed to life circumstances and interpersonal problems and not seen as a problem that requires ‘outside’ intervention. This is consistent with findings from the current study where many participant mothers indicated that domestic and financial problems were impacting their mental health, and did not see how talking to somebody might help. Thus careful and culturally appropriate psychoeducation would be necessary as part of the intervention.

Another societal barrier is the lack of autonomy and decision-making that many women face living in a hierarchical joint family system (Jejeebhoy and Sathar, 2001, Sonuga-Barke and Mistry, 2000). They are economically and socially dependent on significant members of their families (husband, mother-in-law, own parents) and conform to the norm of their approval for all key decisions (Mohmand and Gazdar, 2007, Sathar and Kazi, 2000). This was reflected in the current study in two ways. Firstly, PV needed her family’s endorsement to volunteer and secondly needed approval from mother’s family, greatly influenced by her husband and his parents, to work with her. Any resistance from either families would impact the PV’s acceptability and along with her motivation to work (as discussed below). For example in Bangladesh, female workers experienced their community’s disapproval because of restrictions imposed on women’s mobility and felt reluctant to make home-visits (Khan et al., 1998, Rashid et al., 2001). Such societal beliefs and values can cause a barrier to the initiation, implementation and acceptance in the lay health worker delivered services in the community (Glenton et al., 2013).
7.1.3 Factors contributing to high levels of PV motivation

7.1.3.1 Families endorsement

In the current study, all PVs expressed the significance of their families’ endorsement, initially of their decision to take on volunteering role and later for working in their communities. Similarly they highlighted the importance of approval from the mothers’ families, as it was fundamental to delivery of the intervention. The approval and active support from the families, would play a critical role in the level of motivation of a peer to take on this role (Glenton et al., 2013).

Traditionally, in this conservative agrarian society, women working outside their homes would be looked down upon (Mohmand and Gazdar, 2007). However, over time, this has changed, an example is the LHWs. In this study, LHWs expressed that during their initial stages of work, they faced number of challenges due to stereotypical gender work roles. However, over the years they have gained their communities’ trust and have contributed towards changing their attitude, towards women working outside their homes. They believed this has contributed towards the PVs gaining acceptability in the volunteering role from their families and communities. Other influences include economic pressures and demands on women to step out of their traditional ‘house-maker’ roles to waged labour. The PVs’ role could have been perceived as an opportunity to gain future jobs (such as a LHW) and therefore was favoured by their families. This is consistent with the findings from other HICs where peer support worker role was perceived as a stepping-stone into employment (Doherty et al., 2004, Mowbray et al., 1998)

In this study, the PV ensured the approval from mothers’ families, through highlighting the agenda of optimal child care, building rapport and involving them at all stages of intervention delivery. A USA based study, in low income setting, also
indicated that providers who established relationship with the families and involved them in establishing goals were more likely to keep them engaged (Thompson et al., 2007). Similarly there are examples of maternal health programmes in LMIC, which stressed on husbands and mothers-in-law involvement to overcome any potential resistance from the families (Alcock et al., 2009, Nankunda et al., 2006, Shroufi et al., 2013, Nkonki et al., 2010).

### 7.1.3.2 Personal gain

Personal gains that voluntarism might provide, can be conceptualised at several levels. According to Clary et al., voluntarism serves the function of expressing altruistic values, enhancing knowledge and experience, improving social network and career opportunities and satisfying egoistic needs (Clary et al., 1998). In the current study, these factors were mentioned by the PVs, both as a stimulus to their volunteering initiation and later as motivators for the continuity of their work. These are discussed separately below.

**Altruism and volunteering:** The majority of the PVs indicated betterment of their community and willingness to help other mothers as significant motivational factors. This is consistent with the evidence from the literature, indicating both altruistic factors (helping others) and the egoistic factors (feeling good through helping those less fortunate) as major motivators in volunteering (Dennis, 2012, Withers et al., 2013, Black and Living, 2004). Some PVs also perceived volunteerism as a mean of gaining reward from God. Reviewers have identified that religion can be a major driving force behind volunteering (Stijn and Graaf, 2006).

**Enhancing knowledge and experience:** In Glenton et al’s (2013) meta-synthesis, a selection criteria for the lay health workers, in most programmes, included their willingness to learn and work. In rural Pakistan the opportunities for learning and gaining new experiences are rare, especially for women (Mohmand and Gazdar,
2007), therefore opportunities for getting involved in such initiatives, sanctioned by the community and the family, permits new learning experiences. In the current study, most PVs were eager to learn and reported improvement in their knowledge about maternal health. In line with the above findings, a number of studies have indicated that peers participating in such programmes find these useful to increase social and personal knowledge (Dennis, 2012, Primavera, 1999) and for using this knowledge and skills to enhance their future prospects for employment (Repper and Carter, 2011).

**Improved psychological wellbeing:** In this current study, most PVs applied that learning to gain insight into their own emotional issues and improved their overall wellbeing as a consequence, likewise some PVs realised that they had perinatal depression and found the work beneficial to resolve their own experiences with depression. Most studies included in Walker and Bryton (2013) review also found that peers, with the personal experience of the problem, found support work beneficial for their own recovery.

In this study, most PVs reported being appreciated for their work, which enhanced their confidence, and self-esteem and made them feel empowered due to their perception of improved social status in their communities. According to Raine, “for women living in disadvantaged areas, opportunities for self-advancement are few, this type (feeling valued) of outcome should not be underestimated” (Raine, 2003. p.468). The PVs’ enhanced self-value was reflected in their day to day functioning (improved diet, and rest, sharing concerns with family and friends) and was noticeable to their family and LHWs. Consistent with the above findings, Repper and Carter (2011), in a review of peer support found enhanced self-esteem and empowerment among peers, as a significant theme in most of the papers reviewed. This is because of the appreciation peers received by those helped (Salzer and Shear, 2002) and perception of oneself as a ‘valued and contributing citizens’ (Hutchinson et al., 2006. p.206).
Furthermore, in the study, PVs got opportunities for social interactions and developing social network through engaging in a worthy activity. Peers, particularly from LMICs such as India, South Africa and Bangladesh found the social aspect of volunteerism as one of the motivators for sustained input (Alcock et al., 2009, Rashid et al., 2001, Nankunda, 2006).

7.1.3.4 Good training and supervision

In order for the peers to have the adequate skills and continuous motivation, adequate training and supervisory support is essential for any programme. A meta-synthesis of 27 published studies found that effective training and supervision, were vital for the success of the peer support role (Walker and Bryant, 2013). In the current study, the organisation which deployed PVs, delivered a four day bespoke training of the intervention (THPP) and provided fortnightly supervision sessions (Table 10, p.83). All PVs liked their trainers/supervisors and described them as ‘nice’ and ‘approachable’. While most PVs, following the training, felt adequately prepared for the volunteering role, some felt that a longer training with more health information would have equipped them better to deal with the diverse health issues, mothers were experiencing.

PVs felt supervision sessions provided experiential learning and ample emotional and practical support which kept them motivated and helped them to deal with forthcoming challenges. The emotional support provided through supervision was particularly helpful in settings where lay workers had not previously worked outside of their own homes (Daniels et al., 2010b).

The PVs identified added advantages of training and supervision sessions. Firstly, as they were held at the Basic Health Unit, it strengthened the PVs’ links with the PHC providers. Secondly, during field supervisions, supervisors accompanied the PVs in the community, which they felt enhanced their credibility. These study
findings are consistent with the evidence from other LMIC. For example, a study conducted in Nepal showed that increasing training and supervision sessions was effective in sustaining community health volunteers’ interest and motivation (Curtale et al., 1995). In India, training and supervision was helpful in increasing peers’ credibility in the community (Alcock et al., 2009), in Uganda, it provided them with continuous motivation (Nankunda et al., 2006), and in South Africa it helped them deal with the challenging issues (Daniels et al., 2010b).

7.1.4 Factors contributing to low levels of PV motivation

7.1.4.1 Lack of engagement of the mothers

In the current study some reasons for mothers’ lack of engagement with their PVs were identified – these included fear of breach of confidentiality, lack of awareness of benefits of talking therapies, denial of psychological problems, and time constraints. Mechanic and Meyer (2000) found mental health patients are more concerned about confidentiality issues as compared to patients with physical health problems. Confidentiality issues become more significant when working in closely-knit rural communities (Brems et al., 2006, Gilbert et al., 2004, Singla et al., 2014). In this study, the participant mothers were residing in villages, which were usually comprised of a single or a few closely-knit clans. This made some mothers fear that personal information might be disclosed to other relatives, leading to domestic conflicts. Some mothers therefore indicated a preference for PVs from neighbouring villages rather than their own. Studies conducted in South Africa, India and Uganda have also indicated reluctance of disclosure, when peers were from within their own communities or related to them (Van Dyk and Van Dyk, 2003, Alcock et al., 2009, Nankunda, 2006). Rahman (2007) said that in close knit communities certain level of trust needs to develop before information will be disclosed. He also recommended that therapeutic approaches that relied less on sensitive information being disclosed were preferable, e.g., Behavioural Activation.
Some mothers in the study expressed denial or minimisation of the problem to avoid being criticised or judged by others. Other close knit communities experience similar issues, for example Latino communities in USA did not engage well with mental health-provider, because of similar reasons and also believing that they should help themselves (Uebelacker et al., 2012).

Another reason for lack of engagement was the perception by some mothers that their problems were related to their domestic or social situations and could not be addressed through a ‘talking therapy’. In some cases, the seemingly insurmountable problems that preoccupied these mothers and their lack of engagement with the intervention demotivated the PVs. Mothers from Uganda and South Africa have also felt that preoccupation to their pressing issues, made them less receptive to intervention (Nankunda et al., 2010, Nkonki et al., 2010).

In this rural agrarian community, women’s domestic responsibilities and additional responsibilities such as managing livestock and working in farms were identified as potential barrier to the mothers’ engagement (Singla et al., 2014). Similarly, in this study, mothers reported their excessive responsibilities as a barrier to receiving intervention. Time and schedule constraints have also been identified as one of the barriers to engagement in prevention programmes for low income parents in HICs (Garvey et al., 2006, Spoth and Redmond, 2000, Gross et al., 2001). In South Africa, it was identified that mothers found their peers visit inconvenient due to work priorities (Nankunda et al., 2010).

Lack of engagement for reasons described above is part of any therapeutic programme, but with PVs, it had to be ensured that they did not feel that it was a failure on their part and thus being demotivated. This was addressed in training and supervision.
7.1.4.2 Resistance from family

The hierarchical structure of rural families, gender differences and the power of in-laws over married women can lead to their subordination (Jejeebhoy and Sathar, 2001). In this study resistance from some families to allow mothers to engage with PVs was also identified as a challenge. For instance, some families perceived PV’s involvement as intrusion to their households’ privacy and felt that disclosure of their personal matters to public would risk their honour and status. Consistent with the above finding, a qualitative study on South Asian women living in Derby, UK also indicated fear of bringing shame to family and loss of izzat (honour) as a key barrier to their use of mental health services (Gilbert et al., 2004).

Some families lacked awareness of talking therapies (Naeem et al., 2012) and felt that simply talking to the mother would not be helpful unless supplemented by monetary or other tangible incentives such as medicines or dietary supplements. A UK based study has also identified the importance of incentives to motivate participation in low-income families (Gross et al., 2001).

Linked to the families’ lack of awareness of psychosocial interventions was their ambiguity about the PV’s role. They felt that female elders of the families were best to educate mothers on maternity and child-rearing practices and PV was not required. In some families there was fear that PV might corrupt the mother and hence her contact with the mother should be supervised. In such families usually a mother or a sister-in-law sat during the session. The family members’ perceived suspicion of the peers was indicated as a barrier to the intervention delivery in Singla et al, (2014) formative study.

Although such families were in the minority, they could potentially be vocal and even rude to PVs. Such lack of appreciation for their efforts was demotivating for PVs, and had to be addressed in training and supervision.
7.1.4.3 Other demotivating factors identified in the literature

The current study was conducted in an agrarian community in rural Punjab, Pakistan over a period of six months. The context and duration are important considerations when generalising the findings. The evidence from the other health services research, in which peers were employed for longer and in other contexts, have indicated additional factors that impact their work.

**Incentivisation:** The PVs in the current study were recruited as volunteers and were paid only a small sustenance allowance to attend their training course (approx. £15) and monthly supervision sessions (approx. £5). This could have an impact on their long term motivation, as the evidence from other contexts indicates, monetary benefit was the most significant factor for peers’ motivation (Walker and Bryant, 2013). The studies included in Walker and Bryant’s review were conducted in developed and urbanised settings. In a formative study exploring peer-delivered care in urban Goa and rural Rawalpindi, it was found that the context played a key role in the expectation of peers for monetary compensation for their work (Singla et al., 2014). In Goa there was a greater demand for a fixed salary, whereas in Pakistan the emphasis was not the financial return, but on the goodwill generated in the community through the peers’ work. Some degree of material recognition was required (such as certificates, mobiles, and travel allowance) to supplement their volunteering role, but a salary was not a key demand. Singla (2014) has attributed these differences, to the socioeconomic conditions of the two populations. In urban Goa, society has become more individualised, in comparison to rural Rawalpindi, where traditional societal values are more prevalent and the helping roles are perceived as social investment. Other studies have also identified the urban societies’ emphasis being more on personal gain and less on communal benefits (Inkeles, 1997), and relatively smaller communities are more appreciative of helping behaviours as compared to their urban counterparts (Steblay, 1987). Such findings
highlight the significance of giving careful consideration to the contextual differences when peer-delivered programmes are considered for implementation – this applies especially to the concept of volunteerism – a ‘one size fit all’ approach may be inappropriate for diverse contexts (Maes et al., 2010).

**Risk of burn-out:** There is evidence of job related stress amongst peers working in delivery of mental health care. Studies on peers working in mental health in USA and UK found that such long-term work led to feelings of being overwhelmed and in some cases, reoccurrence of symptoms (Chinman et al., 2006, McLean et al., 2009). Another study found that peers became much stressed, and felt inadequately skilled when patients did not cooperate with them or had higher level of needs (Mowbray et al., 1998). However, in all these studies, peers were ex-service users and working with severe mental illness. In the current study, apart from one PV, who mentioned feeling upset when a mother refused to see her, no unpleasant feelings were reported. Nevertheless, this is an important issue to monitor and address in supervision.

Practical issues, especially in LMICs such as lack of transport facilities and travelling long distances on foot (Nankunda et al., 2006, Nkonki et al., 2010), along with the risk of assault or attack in high risk areas (Nkonki et al., 2010) and no safety measures in place (Daniels et al., 2010b, Woodgate et al., 2007) have been found to also contribute to peers’ stress in some studies. In this study, the PVs were working in socioeconomically deprived areas with high levels of psychosocial risk factors for women and lack of health facilities. Over the longer-term, working under such adverse conditions, could lead to job related stress, impacting both their performance and motivation. Such stresses, if not addressed through robust training, supervisory support and appropriate incentivisation could impact peers’ own wellbeing over the period of time, leading to their high turnover. This was

**Professional boundaries:** In this study, the PVs in order to engage with the mothers, befriended, and shared personal information with them. Over time, this is likely to lead to friendships, with the potential to create ambiguity in PV’s role. In Mowbray’s study, peer support specialists were perceived by their long-term clients as *friends* and requests (such as borrowing money) were made which were beyond their role. Difficulties in managing professional boundaries could impact peer-client relationship within the work context (Mowbray et al., 1998) and can cause emotional stress, preventing peers from doing their job properly (Glenton et al., 2013).

**Power dynamics:** In some studies, peers reported experiencing unequal relationships at their work place, either because they felt staff members perceived them to be less educated or lower in status (Mowbray et al., 1998), or felt unfairly treated by them (more as ex-patients than as professional equals) (Davidson et al., 1999, Doherty et al., 2004). Likewise, some health professionals expressed their concerns about lay health workers who were either unskilled or overconfident and therefore posed a threat to their authority (Curtis et al., 2007) or added to their workload (Woodgate et al., 2007). In the current study, the LHWs played a significant role in the recruitment and embedment of the PVs, and were in daily contact with them. The PVs looked up to the LHWs as their mentors, who were more experienced in their work. The findings indicated that with time, the PVs gained confidence in their skills and abilities. In a long run, as the PVs become more independent and empowered, this might change the existing power dynamics between the PVs and LHWs.
7.2 Further development of the Matrix of PV’s acceptability

In Section 6.6, a matrix was developed to synthesise the findings in this study, with four quadrants along two dimensions – the community’s acceptability of the PVs, and the PVs’ own level of motivation to engage in this work (Figure 16, p.173). The discussion of the findings in light of the current literature on the subject lead to an elaboration of the initial matrix (see Figure 18 below). Four factors have been added onto the initial model (incentivisation, burn out, power dynamics and professional boundaries) based on the evidence from the literature, that supports the current findings has been indicated. The matrix provides a useful synthesis of the current knowledge on the issue of PVs’ acceptability for delivery of interventions for mental health. Based on this synthesis, a checklist has been developed to guide implementers, and is described in Section 7.3.1.
Figure 18: Complete Matrix of the acceptability of a PV

High community acceptability

High levels of need 2, 6, 8, 18, 20, 22, 26, 34, 56, 61
Ease of access 1, 3, 26, 37, 41, 50, 52, 68, 70, 71, 84
Good PV mother matching 17, 21, 32, 42

Desirable PV characteristics 1, 26, 51, 52, 53, 54, 71, 83
Intervention perceived beneficial 6, 8, 9, 22, 44, 62, 66, 80, 83
Being local
Good links with local health system 26, 50, 57

Incentivisation 30, 45, 72, 75, 83
Personal gain 1, 4, 10, 16, 26, 29, 48, 52, 58, 63, 64, 66, 67, 83, 85
PV family endorsement 1, 19, 26, 48, 49, 52, 54, 71, 79
Mother’s family approval

Societal and Cultural barriers 15, 24, 26, 28, 31, 35, 38, 39, 40, 41, 48, 60, 64, 65, 68, 71, 73, 76, 78
Stigma of depression 24, 35, 43, 60, 69, 78

Low community acceptability

Low PV Motivation

Mother’s lack of Engagement 1, 5, 23, 25, 47, 52, 54, 60, 72, 74, 81
Resistance from mother’s Family 27, 31, 55, 72

Poor training and supervision
Intervention ineffective
Lack of credibility
Lack of organisational support

High PV Motivation

Good training and supervision 1, 11, 13, 52, 52
Poor matching
Undesirable PV characteristics
1. Alcock et al 2009  
3. Anderson et al 2013  
4. Black and living 2004  
5. Brems et al 2006  
6. Chindba et al 2014  
7. Chinman et al 2006  
8. Chowdhary et al 2014  
9. Clark et al 2014  
11. Curtale et al 1995  
13. Daniels et al 2010  
14. Davidson et al 1999  
15. Dein et al 2005  
16. Dennis 2012  
17. Dennis, 2010  
18. Doherity et al 2004  
20. Flaskerud, 1991  
21. Futterman et al 2010  
22. Garvey et al 2006  
23. Gilani et al 2005  
24. Gilbert et al 2004  
25. Glenton et al 2013  
27. Gureje et al 2005  
29. Jejeebhoy and Sathar 1997  
30. Johnson and Caldwell, 2011  
31. Johnson and Caldwell, 2011  
32. Kai and Crosland, 2001  
33. Kakuma et al 2011  
34. Karim et al 2004  
35. Kaufman et al 2004  
36. Kaufmann and Meyers 1997  
37. Kausar and Sarwar 1999  
38. Khadduri et al 2008  
39. Khalily 2011  
40. Khan et al 1998  
41. Lasky and Salomone, 1997  
42. Lauber and Rossler 2007  
43. Letourneau et al., 2011  
44. Maes et al 2010  
45. Melean et al 2009  
46. Mechanics and Meyer 2000  
47. Mohmand and Gazdar 2007  
49. Murphy 2010  
50. Murphy et al 2008  
51. Nankunda et al 2006  
52. Nankunda et al, 2010  
53. Nkonki et al 2010  
54. Naseem et al 2012  
55. Patel et al 2009  
56. Pinto et al., 2014  
57. Primavera 1999  
58. Qidwai and Azam 2002  
59. Rahman 2007  
60. Rahman et al 2003  
61. Rahman et al., 2008  
62. Raine 2003  
63. Rashid et al 2001  
64. Razali et al 1996  
65. Sathar and Kazi 2000  
66. Saxena et al 2007  
67. Shaheed 1990  
68. Shourfi et al 2013  
69. Singla et al 2014  
70. Sonuga-Barke and Mistry 2000  
71. Spoth and Redmond 2000  
72. Steblay 1987  
73. Stein et al 1997  
74. Stijn and Graaf 2006  
75. Suhail 2005  
76. Thompson et al 2007  
77. Tripathy et al., 2010  
78. Uebelacker et al 2012  
79. Van Dyk and Van Dyk 2003  
80. Walker and Bryant 2013  
81. WHO 2011  
82. Withers et al 2013  
83. Woodgate et al 2007

7.3 Implications of this research

The study findings have implications at several levels:

1. Peer-delivered mental health programmes might find the recommendations useful for their planning.

2. The findings will be of interest to health planners working in settings where shortage of health professionals is a barrier to treatment and task shifting strategies are being explored.

3. The findings add on the global mental health and suggest strategies that could be employed.

4. The findings will be of interest to women development programmes in settings where women have limited opportunities for progression.

5. Finally, the study findings lead to interesting questions that may be the subject of future.
7.3.1 Implications for peer-delivered mental health programmes

Chapter 2, Section 2.5 shows that PVs are an underused and under-researched human resource in maternal mental health care in LMICs. The study findings (see Section 6.5 and 6.6 for synthesis of findings) and the evidence from the other relevant literature identified a number of factors that can improve the chances of success of peer-delivered programme. These factors have guided the author in developing a checklist that can be used for this purpose. This is illustrated in Table 25. Each area of the checklist and its relevance to the implementers is discussed below.

7.3.1.1 Checklist for Acceptance and Motivation of Peer-volunteers (CHAMPS)

The Checklist for Acceptance and Motivation of Peer-volunteers (CHAMPS) is aimed to assess the community acceptability and motivation of the PVs (Table 25). It covers six relevant areas for their appropriateness: intervention, selection, linkage with the local health system, training, supervision and incentivisation.

Area 1: Appropriate Intervention

Before the implementation of the programme, it should be ensured that the intervention has been tested for its appropriateness and effectiveness, on a population, similar to the PVs’ target population. It is also worth considering, if the intervention requires any adaptations, to make it deliverable through the PVs. For example, simplifying complex concepts and using jargon-free language; adding supplementary intervention materials, such as job-aids with step-by-step instructions; flexibility in the delivery of intervention, in terms of its location and format.
Area 2: Appropriate Selection

Consideration of which segment of the population PVs will be drawn from should begin at the project conceptualisation phase. Matching with the target population on relevant characteristics (such as the age, gender, socioeconomic status and language) and similar life experiences (life events, psychosocial stresses, shared experience of illness or condition etc) will play a significant role in building rapport with the target group. The pre-selection process should also take into consideration the community’s opinion about the PVs. Implementers should consider those who are local, perceived trustworthy and respected by their target population and show eagerness to learn and work. This will contribute towards their community acceptability.

Area 3: Appropriate links with the local health system

Before the implementation of the programme, its implementers need to invest in developing links with the local health system. Badging the PVs with existing systems will enhance PVs’ legitimacy and credibility, leading to greater acceptance by their target population. The implementers should remain engaged with local providers throughout the programme, keeping them informed of the progress of the programme and involving them in decision making.

Area 4: Appropriate training

The organisers of peer training programme should ensure that the training is appropriate to the level of the PVs’ capacity and qualification. Furthermore, the trainers should have good communication and motivation skills, along with awareness of psychosocial and cultural dynamics of the area. This will enhance the PVs’ motivation and learning experience.
Area 5: Appropriate supervision

The programme implementers should reflect on how supervision could cater for the PVs’ individual needs (practical and emotional) and address any specific challenges that PVs experience during the course of their work. Furthermore, the supervisors need to have contextual understanding, to enhance the PVs’ experiential learning and ensure their job satisfaction. The supervision should also include regular measures to check fidelity of delivery of intervention. Supervision procedures should be planned in advance and in consultation with PVs.

Area 6: Appropriate incentivisation

The PVs’ expectations of what they hope to achieve from the programme should be matched with their incentivisation from the outset. Before the implementation of the programme, the implementers should explore the PVs’ expectations and build-in incentivisation at all stages of the programme.
Table 25: Checklist for Acceptance and Motivation of Peer-volunteers (CHAMPs)

**Checklist for Acceptance and Motivation of Peer-volunteers (CHAMPs)**

This checklist is designed to help implementers assess if their peer-delivered programme takes into account factors that are likely to improve the community acceptance and motivation of peer-volunteers in their role. Any ‘No’ response should be discussed as a potential barrier to programme implementation.

<table>
<thead>
<tr>
<th>Area 1</th>
<th>Appropriate intervention</th>
<th>Yes/ no</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Is the intervention evidence-based?</td>
<td></td>
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<tr>
<td>2</td>
<td>Has the intervention been adapted for delivery by the PVs?</td>
<td></td>
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<tr>
<td>3</td>
<td>Has the intervention been adapted for cultural relevance?</td>
<td></td>
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<tr>
<td>4</td>
<td>Does the intervention allow flexibility of delivery (in terms of format, location)?</td>
<td></td>
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</tbody>
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<table>
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<tr>
<th>Area 2</th>
<th>Appropriate Selection</th>
<th></th>
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<tbody>
<tr>
<td>5</td>
<td>Are the PVs locally based?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do PVs exhibit eagerness to learn and work?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are the PVs matched to the target population? (gender, age, socioeconomic status, language etc)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do the PVs share life-experiences with the target population? (similar life events, psychosocial stresses, shared experience of illness or condition etc)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do the PVs enjoy the trust and goodwill of the target population?</td>
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<tr>
<th>Area 3</th>
<th>Appropriate links with local health system</th>
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<tr>
<td>10</td>
<td>Is the PV programme supported by local health providers?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are local health providers involved in the identification, recruitment, training and embedment of PVs in the community?</td>
<td></td>
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<tr>
<td>12</td>
<td>Are local health providers kept up-to-date with progress of the programme?</td>
<td></td>
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<table>
<thead>
<tr>
<th>Area 4</th>
<th>Appropriate Training</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>13</td>
<td>Is the training appropriate to the level of PVs qualifications and capacity?</td>
<td></td>
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<tr>
<td>14</td>
<td>Are the trainers well-informed of the psychosocial and cultural and dynamics of the area?</td>
<td></td>
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<tr>
<td>15</td>
<td>Do the trainers possess good communication and motivation skills?</td>
<td></td>
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<thead>
<tr>
<th>Area 5</th>
<th>Appropriate supervision</th>
<th></th>
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<tbody>
<tr>
<td>16</td>
<td>Is supervision adequate to the needs of the PVs?</td>
<td></td>
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<tr>
<td>17</td>
<td>Does supervision facilitate group and experiential learning?</td>
<td></td>
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<tr>
<td>18</td>
<td>Does supervision cater to individual PV needs?</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Are the supervisors well-informed of the psychosocial and cultural dynamics of the area?</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Does supervision include regular measures to check fidelity of delivery of intervention?</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Does supervision include regular measures to address specific challenges? (e.g. ensuring confidentiality, emotional needs and motivation of PVs)</td>
<td></td>
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</table>

<table>
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<tr>
<th>Area 6</th>
<th>Appropriate incentivisation</th>
<th></th>
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<tbody>
<tr>
<td>22</td>
<td>Are PVs’ own families supportive of their role?</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Is the community approving of the PVs’ role?</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Are PVs’ incentives matched to their expectations? [e.g. fixed monetary incentives (salary), other monetary incentives (vouchers, allowances), opportunities for personal development, appreciation from the community]</td>
<td></td>
</tr>
</tbody>
</table>
7.3.2 Implications for task shifting

The literature review identified that the key human resource for task-shifting in many LMIC is the community health workers. It was also noted that the community health workers had excessive workload due to a rapidly expanding population and burden from communicable and non-communicable diseases in their target areas. Thus, an exploration of alternative human resource was required.

The findings from this study indicated that PVs are a valuable human resource, acceptable to their communities, to deliver mental health care in Pakistan. Investing in peer-delivered care through recruitment of appropriate PVs, provision of effective support, training and incentivisation, and establishment of a strong partnership with the primary care health system, could help in scaling up of mental health services. This model has potential to be applied to other countries in similar situations. This would require specialists to broaden their clinical role and transfer their expertise by actively participating in the planning, training and supervision of the PVs to ensure the effectiveness of peer-delivered services.

7.3.3 Implications for global mental health

The literature review (Section 2.4) indicated a large treatment gap in mental health care in LMICs. The high prevalence of mental health problems and lack of services necessitates the need for urgent measures to make help accessible in the communities. The current study successfully used PVs to provide help to mothers experiencing perinatal depression in Pakistan. These findings add to the growing body of knowledge that PVs can be used as a substantial resource to narrow the treatment gap for not just perinatal depression but other mental health conditions.
7.3.4 Implications for women’s development

The study findings (Section 6.2.1.1 and Section 6.3.3.1) indicate that working as PVs improved their confidence, self-esteem and social status and contributed towards their feeling of empowerment. In the literature review, it was also highlighted that opportunities for women to develop in roles outside of their homes are very limited (Section 1.4.3 & 1.4.4). By taking part in a professional role, learning new skills, and using them effectively, is likely to increase their capacity to undertake other professional roles. This has implications for most LMICs, and may open doors for women development programmes in such settings. Further research (see below) could explore this potentially important implication.

7.3.5 Implications for future research

The current study was conducted in one rural area of Pakistan. Due to sociocultural differences between rural and urban communities and between rural communities within a country, future peer research programmes should explore the differences in peer acceptability in different contexts.

Future qualitative studies of peer-delivered programmes should consider exploring the long-term impact of peer volunteering. Knowledge of factors, which could impact PVs’ engagement in programmes over time such as level of motivation, supervisory support and job stress, could help to plan long term peer-delivered programmes.

Another area of research could be exploring how PVs have progressed over time in terms of their personal development, autonomy and career progression, and how this might contribute to the women development agenda (see above) in low income settings.
Future research should also consider exploring the viewpoint of policy makers, programme managers and community leaders. This could give a better understanding of factors that could either facilitate or hinder the establishment and management of peer-delivered health programmes – leading to better planning.

7.4 Strengths and limitations of the study

7.4.1 Strengths

The study applied robust qualitative research methodology. The interactive relationship between the author and the participants allowed for flexibility and in-depth collection of the data for deeper understanding of the topic. The author had the same linguistic and cultural background as the participants, which eased access and communication with the participants and facilitated data collection and analysis in participants’ first language.

Framework Analysis allowed for a systematic, transparent and robust analysis of the data, which enhanced both credibility and trustworthiness of the study. In addition, the reflexivity was ensured to maintain the author’s objectivity during data collection and data analysis process. This was achieved through regular discussions with the supervisors and the research team based in Pakistan and reflecting on personal experiences and views influencing the research process.

The study was embedded within the pilot phase of a large-scale study. Participants for the pilot study were recruited from the community via LHWs. All mothers who fulfilled the inclusion criteria agreed to take part in the study. Hence making the sample representative of the rural population. All mothers who took part in the pilot study, apart from one, agreed to be interviewed, therefore the chances of participation bias were minimal.
Interviews were conducted not only with the intervention recipients (mothers) and the intervention delivery agents (PVs), but also with the families of the intervention recipients; and the key maternal and child health health-providers in the community. Despite the sample being relatively small, the emergent data was rich enough to cover a wide range of views and the recurrence of a number of themes provided indications of saturation.

7.4.2 Limitations

A major limitation was that it was a short-term study covering a period of six months in which the PVs were deployed in this role. Therefore the long-term consequences of volunteering could not be explored and some significant questions remained unanswered. These include the impact of longer-term work without a regular salary on motivation; the emotional impact (such as burnout) of working with depressed mothers over an extended period; their longer-term relationship with the families and health providers. These issues have implications for future research (see Section 7.3.4).

Another limitation was in relation to generalisability of the findings. The study was conducted in one specific rural area of Pakistan. Therefore, the findings need to be generalised with caution to other settings.

Social desirability might have influenced the responses of the participants. This could have led the participants to respond in a manner they believed the author would desire. Furthermore, the PVs’ aspirations for continued community work could have resulted in them painting a more positive picture of their experience to give a good impression of their work. Furthermore, some significant members of the mothers’ family failed to attend the focus groups, hence their views remain unexplored. The author’s own biases might also have affected the data collection.
and analysis process. A thorough process of reflexivity described earlier, addresses this limitation, but the findings may have still been influenced.

**7.5 Logistical challenges in conducting the study**

One of the main challenges was maintaining privacy during the interview. There were several reasons why privacy was compromised. Firstly, in keeping with the traditions of hospitality in rural Pakistan, the interviewer was treated as an honoured guest. The female head of household, often elderly, felt obliged to provide company to the interviewer as a sign of respect. Requesting the elderly person to leave the room would have been considered discourteous and against tradition. At times, it was felt by the author that some members of the household stayed behind because of curiosity, or even from a lack of trust about the purpose of the interview. This posed a challenge for the author, which was overcome by pacing the interview so that the first half was a general discussion on neutral issues. Most bystanders would leave and the author was able to conduct the remainder of the interview.

Another challenge was maintaining confidentiality about the identity of other participants taking part in the study. The study area was a close-knit community, and family members could easily detect the author’s movement in the neighbourhood. On a few occasions, a participant asked the author about her preceding visit, or two participants would ask to be interviewed in the same house in the neighbourhood. Neighbours or relatives would sometime arrive to meet the author. Extra time had to be devoted to each interview to allow for these social and logistical concerns to be addressed in a sensitive way.

Finally, some ethical challenges required attention. For instance, the ethical principal of autonomy was upheld by obtaining informed written consent from the participants. However, for the majority of the participant mothers, the decision required to be collective than individual. Fortunately, all women and their heads of
family agreed to the interviews. However, in a few cases, there were strong objections to the interviews being audio recorded. In these cases, interview notes had to be taken.

7.6 Conclusion

In Pakistan, the prevalence of perinatal depression is high and is associated with adverse outcomes in both the mothers and their infants. Although effective psychosocial interventions have been developed for such settings, the scarcity of trained mental health professionals means that the majority of such women do not receive any intervention. This study explored the acceptability of PVs as delivery agents of a psychosocial interventions.

Qualitative data from a rural area of Pakistan showed that the PVs were acceptable as delivery agents of a psychosocial intervention for perinatal depression, to all the stakeholders. The PVs’ personal attributes such as being local, approachable, empathic, trustworthy and of good reputation within their communities contributed to their acceptability. Their linkage with the PHC system was found vital to their legitimacy and credibility. Factors such as intervention appropriateness, effective training and supervision, perception of personal gain from the programme, and endorsement from their families and the community were motivational for them. Likely barriers to their work were women’s lack of autonomy, cultural beliefs around the perinatal period, stigma of depression, lack of some mothers’ engagement and resistance from some families. The findings are supported by studies conducted in other LMICs that have used peers as delivery agents for maternal health conditions.

Thus, it can be concluded that PVs are a potential human resource for delivery of a psychosocial intervention for perinatal depression in this rural area of Pakistan. However, programmes intending to use PVs as delivery agents for psychosocial

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interventions should be cognisant of six areas encompassing 24 key factors that could greatly facilitate the acceptability of PVs in such programmes.
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Appendices
Appendix 1: Participants’ Information Sheet

Participants’ Information Sheet - Mothers

Version 1: September 2013

Lay title: The acceptability of women volunteers to deliver wellbeing interventions to mothers experiencing depression during or after pregnancy

Introduction:
You are being invited to take part in a research study, before you make any decision to participate in this study, it is important for you to have a good understanding of why this research is being carried out and what it will involve. Please read the information below either yourself or if you need any assistance, it will be read out to you. If you need any of the information explained to you no matter what that might be or if you need further information please feel free to ask me. Please take your time to decide whether or not you want to take part in it.

What is the purpose of the study?
In countries like Pakistan where health professionals are few in number we need to look for volunteers who are able to provide support to persons experiencing health related issues. Peer volunteers are individuals from within their own communities. They do not have formal training or any recognised qualifications but they are trained in the area of healthcare where their services are needed. Peer volunteers can play a key role in supporting mothers who are experiencing low mood whilst pregnant or after giving birth. However the most important question linked to peer volunteering, is their acceptability, by those who are receiving the support, other significant members of their family and community. This study aims to explore the acceptability of peer volunteers who are providing support for mothers experiencing low mood or depression either during or after the birth of their baby. I am interested in studying the views of mothers, their family members and local health care providers about the acceptability of peer volunteers working with such women. I am also interested in understanding from peer volunteers what barriers and facilitators they experience in terms of their acceptability whilst working in the community.
Why have I been chosen?

You have been chosen because you are a mother\(^1\) who has been offered to receive the support from a peer volunteer.

Do I have to take part?

It is entirely your decision whether you want to take part in the study or not. If you decide to take part, but later change your mind and want to withdraw you are free to do so. Your decision of not taking part in the study or withdrawing at any stage will not affect the standard of care you receive now or in the future.

What will happen to me if I take part?

If you agree to take part in it, you will be interviewed by a trained researcher for up to one hour. Interview will be audio recorded and notes will be taken during the interview. The reason for doing so is to ensure that we do not miss any significant information you are giving to us.

What are the possible benefits of taking part?

By participating in this study, you will get the opportunity to share with us, your experiences in relation to peer support and discuss anything on your mind. It will help us to understand the issues which are linked to the acceptability of the peer volunteers. The finding from my study will be used to give suggestions to the Thinking Healthy Programme-Peer Delivered on how the peer volunteers can work effectively in your community to help other mothers in similar situation.

What are the possible disadvantages and risks of taking part?

This study does not involve any physical risks or harm. However sometimes, talking about your experiences and feeling may be difficult and can cause emotional upset. The following steps will be taken if you will experience any discomfort or emotional distress:

If you do not feel comfortable answering any question you have a right to refuse to answer that question or to stop the interview at any stage. If you get distressed you can stop the interview without giving any reason or if you wish you can express your concerns to your interviewee. In that case you will be offered to speak to another member of the research team trained in listening skills. The meeting will be organized by the researcher and you will get the opportunity to discuss any issue of concern with her.

\(^1\) Identical information sheets were prepared in both English and Urdu for the PVs, primary health care staff and mothers’ significant family members.
Will my information be kept confidential?

All the information I will collect from you will be strictly confidential. Any information which will have your name and address will be removed so that you cannot be recognised it. The information will be identified by the study number given to each participant. Information will be stored, in a locked cabinet, in a locked office in our main office, with access available to only research team members. The information will be stored for ten years, following the end of the programme in 2017, it will be destroyed.

Confidentiality will only be breached if there is a disclosure of child abuse, domestic abuse, and deterioration of your mental health or any other serious risk of harm to you or to the others because of you. Under these conditions I will inform the Project Coordinator and your General Practitioner. For severe cases the Project Coordinator will make the referral to the Institute of Psychiatry at the Rawalpindi General Hospital so that urgent help can be provided to you. The Social Services Department at the Institute of Psychiatry has social workers who can help you with these problems. If needed, travel facilities will be arranged for you by the Project Coordinator to attend the appointment.

I am a student at Manchester University. My study forms a part of the programme and will lead to the award of a PhD degree if successfully concluded. During the study I will be supervised by a Prof Karina Lovell and Dr Nusrat Husain, based at Manchester University, UK and Dr Siham Sikander based at Human Development Research Foundation, Islamabad, Pakistan. I will be sharing the information with them. I might also use the quotes from the transcript of your interview for writing my thesis or papers or doing presentations at conferences. However all information will be anonymized and your identity will not be revealed to anyone at any stage.

Who is organising and funding the research?

My study is part of a larger programme called the Thinking Healthy Programme-Peer Delivered which aims to test the effectiveness of a peer-volunteer delivered psychosocial intervention for mothers experiencing perinatal depression. It has been funded by the National Institute of Health, USA, and is being conducted by an organisation called the Human Development Research Foundation (HDRF) Islamabad. As part of this programme, the HDRF is conducting a smaller study (pilot study) to assess the feasibility of using peer volunteers to deliver a psychosocial intervention. I am carrying out my study on the same participants who take part in that study, but I am not receiving any direct funding from the NIH or HDRF for this work.
What if something goes wrong?

If you have any concerns or complaints you can discuss them directly with me or can speak to my supervisor Dr Siham Sikander or to the Project Coordinator Ikhlaq Ahmed based at the Human Development Research Foundation trust. You can contact any one of us by ringing on 009251 2656172-3, Mon-Fri between 9am to 5pm. Your concerns or complaints will be taken very seriously and necessary action will be taken after discussing with you.

What do I do now?

Please feel free to discuss this information with others (e.g. your family or your lady health worker) before deciding whether or not to take part. If you agree to take part in it you will be asked to sign the contact form and consent form and return them to me. This will suggest that you have agreed to take part in it. I will than arrange a time and place with you for an interview. The interview can be arranged either at your house or the ‘health house’ in your area depending on your choice and convenience.

How can I contact you?

You can contact me during the week by ringing on HDRF number 0092512656172 and leaving a message. Your call will be returned within 24hrs.
Appendix 2: Participants’ Information Sheet – Urdu Version

[Content of the document in Urdu]
کھیپوں کی طرح کھیل والوں کی مثال کا ایک ہے، جو کتمی کی کھیل والوں کے ہاتھوں سے ایک بہت زیادہ دلچسپی لیتے ہیں۔ یہ کھیپاں کی تاریخ کا بہت بڑا حصہ ہے، جو ایک چھوٹی سی پرچم ہے جسے مختلف موسموں میں مختلف رنگوں میں رنگائی گیا جاتا ہے۔ یہ کھیپاں کے خاصیتیں یہ ہیں کہ وہ بہت زیادہ تیزی سے پڑھا جاتا ہے اور ایک دن کے کھیپ کے دن کہیں جواب دینے کے لئے بہت زیادہ پڑھا جاتا ہے۔

کھیپوں کے کئی انواع ہیں جن میں ایک ہے کھیپاں کے لئے خاص برگہ۔ یہ برگہ کھیپاں کو ذہن میں رکھنے کے لئے استعمال ہوتا ہے۔ کھیپاں کے برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خواہش مندی نہیں ہے۔

کھیپوں کے برگہ کے لئے بہت زیادہ تیزی سے پڑھا جاتا ہے اور ایک دن کے کھیپ کے دن کہیں جواب دینے کے لئے بہت زیادہ پڑھا جاتا ہے۔ یہ کھیپاں کے برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خاص برگہ کھیپاں کے لئے خواہش مندی نہیں ہے۔
آپ جگہ کی کتنی جگہانہ ہیں؟

آپ کو جگہ کی خصوصیات جوہر کی؟ (5-2668172-2051-0051) کلر کے اپنے پر 24 جگہ کی ہر جگہ کی پہچان ہے۔
Appendix 3: Consent form for interview

Consent form for interview

Version 1-September 2013

Participant identification no:

Researcher Name:

Lay title: The acceptability of women volunteers to deliver wellbeing interventions to mothers experiencing depression during or after pregnancy

Please initial all boxes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I confirm that I have read and understood the information sheet (version 1 dated September 2013) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</td>
</tr>
<tr>
<td>2.</td>
<td>I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.</td>
</tr>
<tr>
<td>3.</td>
<td>I understand that the data collected during the study may be looked at by the research team and by supervisors from the University of Manchester. I give them permission to have access to my records.</td>
</tr>
<tr>
<td>4.</td>
<td>I agree to take part in interview</td>
</tr>
<tr>
<td>5.</td>
<td>I agree to interview being recorded</td>
</tr>
<tr>
<td>6.</td>
<td>I agree to anonymized quotes being used in reports and thesis</td>
</tr>
<tr>
<td>7.</td>
<td>I agree to my General Practitioner being informed of my participation in the study.</td>
</tr>
<tr>
<td>8.</td>
<td>I agree that the disclosure of information of serious risk of harm to me or to others will be disclosed to my General Practitioner and Project Coordinator</td>
</tr>
<tr>
<td>9.</td>
<td>I agree to take part in the above study.</td>
</tr>
</tbody>
</table>

Name of participant          Date                   Signature
......................................   ........................................  ........................................

Name of person taking consent Date                   Signature
......................................   ........................................  ........................................
Appendix 4: Consent form for interview – Urdu Version

<table>
<thead>
<tr>
<th>کenty</th>
<th>1</th>
<th>علاقوں کے کانفرنس</th>
<th>2</th>
<th>برنامہ کے کانفرنس</th>
<th>3</th>
<th>سیک ورکنگ گروپ</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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<tbody>
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<td></td>
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<td></td>
<td>کانفرنس موافقہ</td>
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<td>کانفرنس موافقہ</td>
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<td></td>
<td>کانفرنس موافقہ</td>
</tr>
</tbody>
</table>

شعلہ ہوٹل کمانڈر

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Appendix 5: Consent form for focus group

Consent form for focus group

Version 1-September 2013

Participant identification no:

Researcher Name:

Lay title: The acceptability of women volunteers to deliver wellbeing interventions to mothers experiencing depression during or after pregnancy

Please initial all boxes

1. I confirm that I have read and understood the information sheet (version 1 dated June 2013) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that the data collected during the study may be looked at by the research team and by supervisors from the University of Manchester. I give them permission to have access to my records.

4. I agree to take part in discussion

5. I agree to discussion being recorded

6. I agree to keep the information disclosed during the group confidential.

7. I agree to anonymized quotes being used in reports and thesis

8. I agree to my General Practitioner being informed of my participation in the study

9. I agree that the disclosure of information of serious risk of harm to me or to others will be disclosed to my General Practitioner and Project Coordinator

10. I agree to take part in the above study.

Name of participant Date Signature

................................. ......................... .................................

Name of person taking consent Date Signature

................................. ......................... .................................
Appendix 6: Consent form for focus group – Urdu Version

<table>
<thead>
<tr>
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<td>1</td>
<td>تاہم، ماں اور بیٹے کو میں نے غیر معمولی طور پر معاہدہ کیا ہے؟</td>
</tr>
<tr>
<td>2</td>
<td>میں نے معاہدے کی زمانہ کی تربیت کی؟</td>
</tr>
<tr>
<td>3</td>
<td>میں نے معاہدے کی صلاحیت کی؟</td>
</tr>
<tr>
<td>4</td>
<td>میں نے معاہدے کی بیانات کی؟</td>
</tr>
<tr>
<td>5</td>
<td>میں نے معاہدے کی بیانات کی؟</td>
</tr>
<tr>
<td>6</td>
<td>ماں اور بیٹے کو میں نے غیر معمولی طور پر معاہدہ کیا ہے؟</td>
</tr>
<tr>
<td>7</td>
<td>میں نے معاہدے کی صلاحیت کی؟</td>
</tr>
<tr>
<td>8</td>
<td>میں نے معاہدے کی بیانات کی؟</td>
</tr>
<tr>
<td>9</td>
<td>ماں اور بیٹے کو میں نے غیر معمولی طور پر معاہدہ کیا ہے؟</td>
</tr>
<tr>
<td>10</td>
<td>ماں اور بیٹے کو میں نے غیر معمولی طور پر معاہدہ کیا ہے؟</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>تذکرہ</th>
<th>نام</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>نام</th>
<th>تذکرہ</th>
<th>نام</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>
Appendix 7: Participants’ demographic sheets

### Demographic sheet for mothers

<table>
<thead>
<tr>
<th>Date: ………………</th>
<th>Reference no: ………………………………………………………..</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participant’s Name: ………………………………</td>
<td>2. Age:</td>
</tr>
<tr>
<td>18-25............</td>
<td>26-35............</td>
</tr>
<tr>
<td>36-45............</td>
<td></td>
</tr>
<tr>
<td>3. No of children: ……………………………………</td>
<td></td>
</tr>
<tr>
<td>4. Literacy level:</td>
<td>None............</td>
</tr>
<tr>
<td></td>
<td>Up till level 5............</td>
</tr>
<tr>
<td></td>
<td>Up till level 10............</td>
</tr>
<tr>
<td></td>
<td>Up till level 12............</td>
</tr>
<tr>
<td></td>
<td>Higher education............</td>
</tr>
<tr>
<td>5. Living with:</td>
<td>Joint family............</td>
</tr>
<tr>
<td></td>
<td>Nuclear family............</td>
</tr>
<tr>
<td>6. Household income (optional): ………………………………</td>
<td></td>
</tr>
</tbody>
</table>
Demographic sheet for PVs

Date: ……………

Reference no: ……………………………………………………

1. Name: ………………………………………………………

2. Age:
   18-25.............
   26-35.............
   35 or over...........

3. Literacy level:
   Up till level 5........
   Up till level 10........
   Up till level 12........
   Higher education........

4. Previous work experience
   Yes.................
   No................

5. Marital status: ………………………………………………. 

6. Living with:
   Joint family........
   Nuclear family......

7. No of children (if any): ………………………………………

8. Household income (optional)……………………………..
Demographic sheet for significant family members

Date: …………………………

Reference no: ……………………………………………………………..

1. Name: ………………………………………

2. Age:
   18-25..........  
   26-35..........  
   36-45..........  
   46 plus

3. Relationship with mother: ……………………………………………

4. Literacy level:
   None................
   Up till level 5.............
   Up till level 10............
   Up till level 12............
   Higher education...........

5. Living with:
   Joint family............... 
   Nuclear family...............
Demographic sheet for PHC staff

Date: ............................

Reference no: ..............................................................

1. Name: .................................................................

2. Job title: ...............................................................

3. No of years of work experience: ..............................
Appendix 8: Topic guide for mothers

Topic Guide for Mothers

Introduction and background information: Hello, my name is Najia. I am part of the Thinking Healthy Programme-Peer Delivered research team. I am a PhD student at the University of Manchester, UK, and work with the Human Development Research Foundation in Rawalpindi.

As you know, our research team have been working in your area for the last 12 years in relation to mother and child health. Recently we have been delivering an intervention called ‘Sayhathmund sooch programme’ (Thinking Healthy Programme-Peer Delivered) through peer volunteers. Peer volunteers are locally based women who are trained to deliver THPP. They are visiting mothers at home who are experiencing zahne dabao (depression) and helping them to overcome it. They have also been running groups with Lady Health Workers in your village.

I am collecting information of your experience of working with a peer volunteer. The information you give will greatly help us to make recommendations for improving the programme, so that other mothers can be helped through it. However, I can assure you that your identity will be kept confidential. I may use some quotes from the interview but they will all be anonymized. Could I please remind you that this interview will be audio-recorded. This interview will not take more than an hour of your time, please let me know if you need a break during the interview.

Do you have any questions? Can I start the interview now?

Q: I am interested in knowing your experience of working with a peer volunteer, let me start by asking you about her visits to your house?

Probes: Tell me how often did she visit you in the last few months? What were your expectations from her? What was your experience of working with her?

Q: Did you attend group sessions? If not, why? If yes how often?

Probes: Tell me what were your expectations from the group? What was your experience of attending the group? Which did you prefer—groups or home visits? Why?

Q: Did peer volunteer’s involvement have any impact on you? If so what and how?

Probes: What problems you were experiencing during your perinatal period? Did you receive any information/advise if so how did it affect you? Did her involvement bring any change in your behaviour/thoughts? What else did she do that made you feel better?
Q: How was peer volunteer’s attitude towards you and your family?

Probes: How did she interact with you? Tell me how she interacted with your family? Did her interactions with you and your family have any impact?

Q: What was your and your family’s perception and attitude towards her?

Probes: How did you feel meeting her? What were the reasons for that? How was your families’ behaviour towards her? What were the reasons for that? What personal characteristics of peer volunteers were most/least favoured by mothers and their families?

Q: What in your opinion was community’s perception/attitude towards peer volunteers in general and what were the reasons for their attitude?

Probes: Tell me more what forms the basis of their attitudes?

Q: Your peer volunteer was introduced to you and your family by lady health worker and their work was monitored by them. Did this have any effect on how their role was perceived?

Probes: Tell me why?

Q: If you were given the choice of selecting another peer volunteer, would you have chosen another person if so why?

Probes: Tell me how would that person be different from your peer volunteer?

Q: If your friend/family member is going through similar experiences would you recommend/not recommend a peer volunteer to her? If so why?

Is there anything else about the peer volunteer that you think is important to tell me?

Is there anything you want to ask me? Thank you for this very useful information.
Appendix 9: Topic guide for mothers – Urdu Version

1. کاپ اچ پنے کی چھتیں کیا ہے؟ کیا یہ باہم نگاہ ہے؟
2. جن میں سے کبھی چاند اچ کی چھتیں ہے؟
3. کہ اچ کی چھتیں کہاں ہے؟
4. کیا اچ کی چھتیں کہاں ہے?
5. کیا اچ کی چھتیں کہاں ہے؟
6. کیا اچ کی چھتیں کہاں ہے؟
7. کیا اچ کی چھتیں کہاں ہے?
8. کیا اچ کی چھتیں کہاں ہے?
9. کیا اچ کی چھتیں کہاں ہے?
10. کیا اچ کی چھتیں کہاں ہے?
11. کیا اچ کی چھتیں کہاں ہے?
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17. کیا اچ کی چھتیں کہاں ہے?
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97. کیا اچ کی چھتیں کہاں ہے?
98. کیا اچ کی چھتیں کہاں ہے?
99. کیا اچ کی چھتیں کہاں ہے?
100. کیا اچ کی چھتیں کہاں ہے?

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سوالات 8 کوئی ہے کہ دیکھا جائے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 7 کوئی ہے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 6 کوئی ہے کہ دیکھا جائے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 5 کوئی ہے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 4 کوئی ہے کہ دیکھا جائے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 3 کوئی ہے جن سے معلومات حاصل کی جا سکتی ہیں؟

سوالات 2 کوئی ہے کہ دیکھا جائے جن سے معلومات حاصل کی جا سکتی ہیں?

سوالات 1 کوئی ہے جن سے معلومات حاصل کی جا سکتی ہیں؟
Appendix 10: Topic guide for PVs

Topic Guide for PVs

Introduction and background information: Hello, my name is Najia. I am part of the Thinking Healthy Programme-Peer Delivered research team. I am a PhD student at the University of Manchester, UK, and work with the Human Development Research Foundation in Rawalpindi.

As you know, our research team have been working in your area for the last 12 years in relation to mother and child health. Recently we have been delivering an intervention called ‘Sayhathmund sooch programme’ (Thinking Healthy Programme-Peer Delivered) through peer volunteers. Peer volunteers are locally based women who are trained to deliver THPP. They are visiting mothers at home who are experiencing zahne dabao (depression) and helping them to overcome it. They have also been running groups with Lady Health Workers in your village.

I am collecting information of your experience of working as a peer volunteer. The information you give will greatly help us to make recommendations for improving the programme, so that other mothers can be helped through it. However I can assure you that your identity will be kept confidential. I may use some quotes from the interview but they will all be anonymised. Could I please remind you that this interview will be audio-recorded. This interview will not take more than an hour of your time, please let me know if you need a break during the interview.

Is there anything you want to ask me?

Can I start the interview now?

Q: What motivated you to become a peer volunteer?

Q: How was your experience of working as a peer volunteer?

Probes: What inspired you to take on the role of peer volunteer? How was your experience of receiving training and supervision? Tell me why did you think this role was important? Tell me if working as a peer volunteer has any affect (consequences) on you?

Q: Is your experience of working in group different from working in 1-2-1 setting? If so how?

Probes: What factors facilitated/hindered your work in 1-2-1 setting? What factors facilitated/hindered your work in group setting?
Q: What did you do during home visits and in groups?

Probes: How did it affect them? What else did you do to make mothers feel better?

Q: Have you experienced any difficulties/barriers in your role? If yes what were those barriers how did you manage to overcome them?

Probes: Practical and psychological barriers

Q: Did working as peer volunteers have any impact on your personal selves?

Probes: What impact did their work had on your own mental and physical health?

Q: What was the attitude of mothers, their family members and community health workers towards you and why?

Probes: Tell me what were their expectations from you? Tell me how did they interact with you? What could be the likely reasons for their attitude/behaviour towards you? How did their attitude/behaviour affect your relationship/work with them?

Q: Which of your characteristics/attributes played a significant part in developing relationship with mothers and their families to deliver the intervention?

Probes: Tell me how did it help? Tell me were any of your characteristics hindered the development of relationship with mothers and their families?

Q: Would you recommend any changes to improve the status of peer volunteers?

Probes: Tell me how those changes will have the impact on her status?

Q: If you will be given the opportunity to work again as peer volunteer will you accept/refuse to do this job? What would be reasons for that?

Is there anything else that you think is important to tell me?

Is there anything you want to ask me? Thank you for this very useful information.
Appendix 11: Topic guide for PVs – Urdu version

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Appendix 11: Topic guide for PVs – Urdu version

کا پچھلا کچھ کہاں ہے؟ ایک چیز کی سماعت کے لیے ہر کسی بھی کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے۔

کچھ کا پچھلا کچھ کہاں ہے؟ ایک چیز کی سماعت کے لیے ہر کسی بھی کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے۔

کا پچھلا کچھ کہاں ہے؟ ایک چیز کی سماعت کے لیے ہر کسی بھی کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے۔ ایک کسی کی درپیش ہے。

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سول: کا بہانہ ہے؟ ہم گدار وکھری اور مشکل کوش اور مذہب کے حوالے میں کیا کہتے ہیں؟

سول: یہ چھٹی کا چیز ہے یا کسی دیگر؟

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?

سول: یہ کس بندی کا کام ہے؟ یہ چھٹی ہے یا کسی دیگر کارکردگی?
Appendix 12: Topic guide for PHC staff

Topic Guide for PHC Staff

Introduction and background information: Hello my name is Najia. I am part of the Thinking Healthy Programme-Peer Delivered research team. I am a PhD student at the University of Manchester, UK, and work with the Human Development Research Foundation in Rawalpindi.

As you know, our research team have been working in your area for the last 12 years in relation to mother and child health. Recently we have been delivering an intervention called ‘Sayhathmund sooch programme’ (Thinking Healthy Programme-Peer Delivered) through peer volunteers. Peer volunteers are locally based women who are trained to deliver THPP. They are visiting mothers at home who are experiencing zahne dabao (depression) and helping them to overcome it. They have also been running groups with Lady Health Workers in your village.

I am collecting information of your experience of working in partnership with peer volunteers. The information you give will greatly help us to make recommendations for improving the programme, so that other mothers can be helped through it. However I can assure you that your identity will be kept confidential. I may use some quotes from the interview but they will all be anonymized. Could I please remind you that this interview will be audio-recorded. This interview will not take more than an hour of your time, please let me know if you need a break during the interview.

Is there anything you want to ask me?

Can I start the interview now?

Q: Did you get an opportunity to work with peer volunteers in your village?

Probes: What was the nature of that work? What was your experience of working with them?

Q: How were they perceived by you and your colleagues?

Probes: Colleagues include your supervisors, the primary care doctor, other lady health workers and paramedic staff. As colleagues, subordinates, non-professionals, threat to their jobs, nuisance...? What are the likely reasons for their perceptions/attitudes?

Q: What steps are needed to be taken to enhance/maintain their status within the health system?

Probes: Giving them permanent position? Salary? More incentives?
Q: What are your views of peer volunteers as delivery agents of the intervention?

Probes: What barriers/facilitators did they experience as delivery agents of the programme? How could those barriers be overcome to make their work more effective? Who else could have done this job better and why?

Q: Did their work have any impact on the mothers and their families?

Probes: How did their work benefit/not benefit them?

Q: Did their work have any impact on their personal selves?

Probes: What impact did their work have on their own mental and physical health?

Q: Did their work have any impact on your work?

Probes: How did their work benefit/not benefit you? How could their role be modified to be of more use to you?

Q: How were peer volunteers being perceived by mothers, their family members and community in general?

Probes: What were the likely reasons for their perceptions?

Q: How were peer volunteers being treated by mothers, their family members and community?

Probes: What were the likely reasons for their behaviour towards them? Did their behaviour and attitudes have any impact on peer volunteers’ work? What?

Q: What was peer volunteers attitude towards mothers, their family members and community?

Probes: Did their attitude alter the perceptions of their target population? How? Which personal characteristics of peer volunteers helped or hindered the work?
Appendix 13: Topic guide for PHC staff – Urdu version
حول خرید کالای کمکی که برای همکاران گرفته می‌شود که لازم برای کمک به همکاران ویژه‌شده است. چگونه کار می‌کنید؟

حول خرید را که کسب می‌کنیم چه می‌کنیم؟ کلیه کارکنان از آن خبر پیدا کرده‌اند؟

احترام به همکاران هست که در محل کار می‌کنند؟

حول خرید را که کسب می‌کنیم چه می‌کنیم؟ کلیه کارکنان از آن خبر پیدا کرده‌اند?

حول خرید را که کسب می‌کنیم چه می‌کنیم؟ کلیه کارکنان از آن خبر پیدا کرده‌اند?
Appendix 14: Topic guide for significant family member

Topic Guide for Significant Family Members

Introduction and background information: Hello my name is Najia. I am part of the Thinking Healthy Programme-Peer Delivered research team. I am a PhD student at the University of Manchester, UK, and work with the Human Development Research Foundation in Rawalpindi.

As you know, our research team have been working in your area for the last 12 years in relation to mother and child health. Recently we have been delivering an intervention called ‘Sayhathmund sooch programme’ (Thinking Healthy Programme-Peer Delivered) through peer volunteers (peer volunteer). Peer volunteers are locally based women who are trained to deliver THPP. They visit mothers at home who are experiencing zahne dabao (depression) and help them to overcome it. They have also been running groups with Lady Health Workers in your village.

I am interested in knowing your views about peer volunteers. The information you give will greatly help us to make recommendations for improving the programme, so that other mothers can be helped through it. However I can assure you that your identity will be kept confidential. I may use some quotes from the discussion but they will all be anonymised. Could I please remind you that this discussion will be audio-recorded. The discussion will not take more than one and a half hour, please let me know if anyone need a break during the interview.

Do you have any questions?

Can I start the interview now?

Q: Do women in general experience any psychosocial problems in their day to day lives?

Probes: Do these problems have any impact on them generally and during perinatal period? How is distress generally viewed by mothers and their families during perinatal period?

Q: What help is available to mothers experiencing perinatal depression?

Probes: Is the health care available and accessible? What alternative methods of care are used by mothers during perinatal period?
Q: Did peer volunteers involvement with your wives/daughters-in-law contributed to their perinatal care? If so how?

Probes: Tell me what were your expectations from your peer volunteer and how far they were met? Which aspects of their work were most effective/ineffective? What mode of peer volunteer’s contact do you prefer for your family member-individual, group or mixed sessions? Reasons? What else they could have been done to make their role beneficial?

Q: What was yours and your family’s attitude towards them?

Probes: What in your opinion are the likely reasons behind their doing this work? What personal characteristics of peer volunteers favoured/did not favour their engagement with families? Would your attitude be different if she would not have been working with the health system? Is there anyone else who could have done this job better?

Q: How was peer volunteers’ attitude towards you and your family?

Probes: What could be the likely reasons for their behaviour/attitude? How could it be improved?

Q: Would you allow your family member to become a peer volunteer?

Probes: What reasons will motivate you to allow/not allow your family member to take on the role of peer volunteer?

Is there anything else about the peer volunteers that you think is important to tell me?

Is there anything you want to ask me? Thank you for this very useful information.
Appendix 15: Topic guide for significant family member – Urdu Version
آپ کہاں سے گھر لوگوں کے لئے کیا تعمیر فورمیٹ کا؟

ان کے سبب کیا بھی کوئی طالب علم ہے؟ ان کو کیا کا مطالعہ کیا؟

کیا اپنے سالگرہ کا مزاحمہ کہا جا سکتا ہے؟ اگر نہیں، ہر کسی میں کچھ اہم ہے۔

کیا معاشرے میں کہاں سے جنگل سے کمیسیون ہے؟ اگر نہیں، خاص طور پر پہلی معاشرے میں کہا جا رہا ہے۔

کیا اپنی کتابوں کا کچھ کپڑے کہا جا سکتا ہے۔ اگر نہیں، پہلے کتابوں میں کچھ اہم ہے۔
Appendix 16: University of Manchester Ethics Committee approval

Mrs Najia Atif  
PhD Student  
School of Nursing, Midwifery and Social Work  
University of Manchester  

Najia.atif@postgrad.manchester.ac.uk  

ref: ethics/13202  

2 December 2013  

Dear Mrs Atif  

Research Ethics Committee 1  

The acceptability of peer volunteers as delivery agents of a psychosocial intervention of perinatal depression in Pakistan: a qualitative study (ref 13202)  

I write to confirm that the amendments to the ethics application form and the participant information sheet, and the provision of a letter from the gatekeeper giving consent for your to access the peer workers, satisfy the concerns of the Committee and that the above project therefore has ethical approval.  

The general conditions remain as stated in the letter of 27th November 2013.  

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by December 2014, whichever is earlier. When completing this form, please reference your project as:  

The acceptability of peer volunteers as delivery agents of a psychosocial intervention of perinatal depression in Pakistan: a qualitative study (ref 13202)  

Yours sincerely,  

Katy Boyle  
Secretary to University Research Ethics Committee
Appendix 17: Local ethics committee approval

Institution/Organization name: Human Development Research Foundation (HDRF)

Country of institution/organization: Pakistan

Project title: The acceptability of peer volunteers as delivery agents of a psychosocial intervention for perinatal depression in Pakistan: a qualitative study

Principal investigator(s): Najia Asif and Shumail Sikander

The committee of IRB-HDRF has considered the trial and is satisfied to approve this study to be conducted in Pakistan.

Dr. Abid Malik
Chairman IRB, HDRF  15/11/13
## THEMATIC CHART 1: The factors affecting the mothers’ wellbeing during perinatal period

<table>
<thead>
<tr>
<th>Respondents</th>
<th>1.1: Main concerns during pregnancy</th>
<th>1.2: Ongoing marital and interpersonal problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>02M</strong></td>
<td></td>
<td>The mother said that before she got married she used to be <em>light hearted</em> and <em>jolly</em>. However following her marriage her circumstances had changed her greatly (pg. 5). Unlike her father, her husband had conservative thinking (pg. 6). She has been trying to change him for the last two years and has almost given up hope. It would perhaps take a long time before he would change and by that time the children would have been influenced adversely by him. The home environment had to be appropriate from the start and they were been brought up in a house where they were witnessing arguments (pg. 17). The mother found it strange that when she was mistreated by her husband, her in-laws treated her well and when he treated her well, her in-laws treated her meanly (pg. 26).</td>
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<tr>
<td>Age: 25</td>
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<tr>
<td>No of children: 1</td>
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<tr>
<td>Year of schooling: 14</td>
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<tr>
<td><strong>03M</strong></td>
<td>The mother got worried and used to feel anxious all the time, been told by the doctor that her child</td>
<td>The daughter-in-law was feeling constrained because of the restrictions by her family. She stated that like a tree which cannot grow under the shade, she was being overshadowed by the restrictions of her in-laws. Her husband was strict and did not let her do things she wanted to do. She could not go even to her mother’s house without his permission. The father-in-law did not allow her daughter-in-law to take a job offered to her.</td>
</tr>
<tr>
<td>Age: 31</td>
<td></td>
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</tr>
</tbody>
</table>
| No of children: 4 | Year of schooling: 5 | would be delivered through the c-section (pg. 1&5). She felt fearful of the operation, thinking that she might die because of it. Consequently she was avoiding going for check-ups (pg. 1) and talking to others. She was regretting getting pregnant (pg. 5).

The mother wanted to have a baby girl ever since the birth of her first child and used to pray for it. She said to her husband that he would not be spared if it would be boy again (pg. 5-6).

<table>
<thead>
<tr>
<th>04M</th>
<th>Age: 27</th>
<th>No of children: 1</th>
<th>Year of schooling: 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>06M</td>
<td>Age: 24</td>
<td>No of children: 2</td>
<td>Year of schooling: 10</td>
</tr>
<tr>
<td>08M</td>
<td>Age: 35</td>
<td>No of children: 9</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>04M</th>
<th>Age: 27</th>
<th>No of children: 1</th>
<th>Year of schooling: 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>06M</td>
<td>Age: 24</td>
<td>No of children: 2</td>
<td>Year of schooling: 10</td>
</tr>
<tr>
<td>08M</td>
<td>Age: 35</td>
<td>No of children: 9</td>
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</tbody>
</table>

The mother got married in her extended family and initially found it difficult to adjust with them. Her husband went abroad for work 18 days after their marriage. It made the mother tense feeling she had no one to share her problems and concerns with (pg. 13).

The mother who previously had a daughter was tense during her pregnancy as she wanted to have a baby boy (pg. 5).

While she was pregnant the mother went to the hospital and saw some women experiencing labour pains. This made the mother fearful of going through labour (pg. 6).

While she was pregnant the mother was told by others that she looked weak. This made the mother concerned about her wellbeing (pg. 5) and made her fear for her life (pg. 4). She had other...
<table>
<thead>
<tr>
<th>Age</th>
<th>No of children</th>
<th>Year of schooling</th>
<th>Problem</th>
<th>Other Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>6</td>
<td>0</td>
<td>She conceived this child after a several year gap from her previous pregnancy and was conscious of what people would say about it – as they tend to blame the mothers if she gets pregnant after a certain age when she already had children (pg. 3).</td>
<td>The mother belonged to the Pathan clan who generally do not allow their women to work outside home (pg. 9). The mother cursed her mother for marrying her off at a very young age, after her first menstrual cycle – to a man much older than her. She had her first child within the first year. She had four daughters and two sons (pg. 8).</td>
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<td>38</td>
<td>6</td>
<td>0</td>
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<tr>
<td>29</td>
<td>3</td>
<td>5</td>
<td>While she was pregnant the mother used to constantly worry about dying during labour or something bad happening to her (pg. 4).</td>
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<tr>
<td>28</td>
<td>2</td>
<td>14</td>
<td>The mother had previous miscarriages, which had made her fearful for her life during this pregnancy. She was also worried about whether her child would be born healthy (pg. 7-8).</td>
<td>The mother found it difficult to share her problems with her in-laws, fearing that her mother-in-law would perceive her as being overly sensitive, especially when mother-in-law claimed to have given birth to her children without experiencing any distress (pg. 10), her younger sister-in-law was too young to understand her problems and she was not close enough to her other sister-in-law, to be able to share her personal issues (pg. 12). The mother wanted to be an ideal wife for her husband and did not want to cause any tension to him or to make him think any less of her (pg. 11). The mother was always preoccupied about her house work and was keeping a</td>
</tr>
<tr>
<td>Age</td>
<td>No of children</td>
<td>Year of schooling</td>
<td>While she was pregnant the mother was told by the doctor that her baby was very weak and she might have to undergo an operation, which she might not be able to survive (pg. 4).</td>
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<tr>
<td>12M</td>
<td>2</td>
<td>5</td>
<td>The mother did not have any friends in the village (pg. 13) and did not feel like socialising with others. She preferred to sit on her own (pg. 3) and used to think that she was not liked by anyone. The mother-in-law used to object to her for isolating herself from others, not sharing her thoughts and not asking for anything. She scolded the mother when she did not tell her family that she had a fever (pg. 9-10) The mother could not make any decisions without seeking the consent of her family (pg. 13)</td>
<td></td>
</tr>
<tr>
<td>13M</td>
<td>3</td>
<td>8</td>
<td>The mother did not socialise with others, as the father-in-law did not like visitors or his family members visiting others. He believed that others would think that they had come to waste their time (pg.20)</td>
<td></td>
</tr>
<tr>
<td>16M</td>
<td>1</td>
<td>14</td>
<td>The father used to get upset, if she was being told off by her mother-in-law or if there was some other problem in her house (pg. 21). Most of the time the mother kept her issues to herself, fearing that if they were taken wrongly, it might upset someone or someone might get worried about her (pg. 9-10).</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Year of schooling</td>
<td>No of children</td>
<td>Situation</td>
<td>Comments</td>
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<tr>
<td>17M</td>
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<td>1</td>
<td>The father-in-law did not allow the mother to visit her maternal home during her last trimester and once her Chilla period would be over, she could visit them only during the day (pg. 18).</td>
<td>The mother was not allowed to leave home without seeking permission or being accompanied. The family did not let her go to the shops (pg. 21). They believed that it was inappropriate for a woman to be walking around. The mother visits family and friends only on special occasions (pg. 22).</td>
</tr>
<tr>
<td>18M</td>
<td></td>
<td>2</td>
<td>While the mother was pregnant, she had spotting and was put on medication. Consequently she got worried about the effects of medication on her unborn child. In order to avoid hearing people’s gossip and their comments/suggestions about her situation, she withdrew from others and started spending most of her time on her own, experiencing worrying thoughts about the wellbeing of her baby (pg. 2-3).</td>
<td>The mother-in-law held a grudge against her daughter-in-law and used to say mean things to her, resulting in arguments between them (pg. 5-6). The mother had to lose contact with her closet friend because of the ongoing family feud between their in-laws (pg. 10). The mother found it difficult to share her thoughts and feeling, fearing that others might laugh at her (pg. 3).</td>
</tr>
<tr>
<td>20M</td>
<td></td>
<td>5</td>
<td>While the mother was pregnant she was feeling tense and was concerned about the wellbeing of her unborn child. Previously she had two children, who were born disabled and passed away. She was missing them and was worried about her other children and the one who was going to be born. The mother had indigestion which stopped her from eating well and this made her get weak (pg. 1-2).</td>
<td>When the mother-in-law had an argument with the mother, she was not supported by her husband. He wanted his wife to put up with his elderly mother’s ill treatment and not answer back. However the mother felt that after she had lost her children, she had become less patient and at times answered her back (pg. 13). The mother believed that Pathans are different; they do not allow their women to work because they have dignity and pride unlike those who allow their women to work (pg. 17).</td>
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<tr>
<td>21M</td>
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<tr>
<td>No of children:1</td>
<td>Year of schooling: 5</td>
<td>The mother wanted to have a son to provide the family with an heir (pg. 10).</td>
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<tr>
<td><strong>25M</strong></td>
<td>Age:25</td>
<td>The mother was not sure if the delivery would be at home or in the hospital and was experiencing uncertainties about her and her child’s wellbeing (pg. 2).</td>
<td></td>
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</tr>
<tr>
<td>No of children:2</td>
<td>Year of schooling:5</td>
<td>The mother did not share her problems with her mother-in-law and sister-in-law fearing that she might upset them (pg. 11).</td>
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<tr>
<td><strong>26M</strong></td>
<td>Age:30</td>
<td>The mother got pregnant after a 10 year gap from her previous child. She got upset when she was informed by the doctor about the likely complications and that the baby would be delivered through the c-section (pg. 7-8).</td>
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<tr>
<td>No of children:6</td>
<td>Year of schooling: 0</td>
<td>The mother-in-law was very strict with her daughter-in-law, who gets angry over minor issues and had the habit of scolding her daughter-in-law (pg. 2).</td>
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<tr>
<td><strong>29M</strong></td>
<td>Age:35</td>
<td>The mother was worried because she was told by her mother-in-law, when she was pregnant that she wanted to have a grandson (pg. 2).</td>
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<tr>
<td>No of children:4</td>
<td>Year of schooling:10</td>
<td>The mother-in-law did not want the mother to go out of the house to visit neighbours therefore she was confined to the home. The mother-in-law got upset even if the mother went with her husband.</td>
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<tr>
<td><strong>30M</strong></td>
<td>Age:25</td>
<td>The mother-in-law was very strict with her daughter-in-law, who gets angry over minor issues and had the habit of scolding her daughter-in-law (pg. 2).</td>
<td></td>
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<tr>
<td>No of children:4</td>
<td>Year of schooling:10</td>
<td>The mother-in-law did not want the mother to go out of the house to visit neighbours therefore she was confined to the home. The mother-in-law got upset even if the mother went with her husband.</td>
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</tbody>
</table>
The mother only stayed for three days after the birth of her baby and had to come back because of her domestic responsibilities (pg. 9-10). The mother had only visited her sister, who moved in the same village after getting married, only three or four times - as the mother-in-law did not allow her. Neither did she like the mother’s relatives coming to her house, as she believed that they only come to eat food (pg. 14).

<table>
<thead>
<tr>
<th>Age</th>
<th>No of Children</th>
<th>Year of Schooling</th>
</tr>
</thead>
<tbody>
<tr>
<td>32M</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>34M</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>

Women, who have strict husbands and mothers-in-law, do not disclose their problems as it might end up in arguments in their house. They stay quiet and don’t complain, fearing that they might be asked to leave home, having no place to go they suffer in silence.

The mother got married at the age of 15, while she was still studying in school. The family accepted the proposal because he was extended family and had no one at home to cook for him. The mother experienced problems getting married and had children at a very young age. She was not aware of contraception methods and had her first daughter after one and half year following her marriage (pg. 24).
<table>
<thead>
<tr>
<th>Respondents</th>
<th>2.1: Being local and other personal characteristics</th>
<th>2.2: Mother’s family endorsement</th>
<th>2.3: The peer volunteer’s linkages with the local health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>02M</td>
<td>The PV’s behaviour was perceived <strong>good</strong> which reciprocate mother’s <strong>good behaviour</strong> towards her. (pg.12). The PV was perceived <strong>good natured</strong> (pg.15). Matters could be <strong>discussed more easily</strong> with a PV who is not locally based (pg. 8), with someone local one is always fearing that information might be disclosed (pg. 7). No one from the mother’s family would have objected to a PV who is not locally based. (pg. 28)</td>
<td>The family approved the PV’s involvement (pg. 28)</td>
<td>The PV was introduced by the Lady Health Worker (LHW) which enhanced her credibility. (pg. 30)</td>
</tr>
<tr>
<td>Age: 25</td>
<td>No of children: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 14</td>
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</tr>
<tr>
<td>03M</td>
<td>The mother felt that the PV has <strong>tried really hard</strong> to make her <strong>feel better</strong> and has tried lifting her spirits by being jolly (pg.6). She enjoyed the PV’s visit and found the information given to her useful (pg.4). The mother found the PV’s attitude towards her good, but felt no improvement in her mood (pg.5) The mother felt that a local (belonging to rural area) PV is most appropriate for this work. As it will allow her to be fully aware of the mother’s cultural norms and traditions. This would be alien to a PV from a city (pg. 6-7). Mother felt that a PV doesn’t necessarily need to be from the same village as the mother. (pg. 7)</td>
<td>The husband approved the PV’s involvement (pg.8)</td>
<td></td>
</tr>
<tr>
<td>Age: 31</td>
<td>No of children: 4</td>
<td></td>
<td></td>
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<tr>
<td>Year of schooling: 5</td>
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<tr>
<td>Name</td>
<td>Age</td>
<td>No of children</td>
<td>Year of schooling</td>
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<td>04M</td>
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<td>8</td>
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<td>06M</td>
<td>24</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>08M</td>
<td>35</td>
<td></td>
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<tr>
<td>No of children:9</td>
<td>The mother found the PV’s involvement <em>inspiring</em> and motivational. (pg. 20)</td>
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</tr>
<tr>
<td>Year of schooling: 0</td>
<td>A PV should be between the <em>age of 35 and 40</em> and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17)</td>
<td></td>
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<tr>
<td></td>
<td>A local PV is better, as it can take a while to <em>trust an outsider</em> and one can feel hesitant to openly talk to her. (pg. 15)</td>
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</tr>
</tbody>
</table>

| 09M | The PV was perceived as a good listener, with whom the mother felt comfortable disclosing what was in *her heart and mind* (pg. 1). The mother appreciated the PV’s behaviour, her attention and the way she was asked questions and then responded back. (pg. 3) |
| Age:38 | |
| No of children:6 | A PV should be a mother, as it will allow a mother to *openly discuss* matters with her. Moreover she should be of same age as a mother; otherwise it will be *embarrassing* (if a PV is older than a mother) and *inappropriate* (if a PV is younger than a mother) to talk to her. A PV should be *kind* and her *character* should be *unblemished*. Lastly a PV should be a *Muslim* as it will be difficult to develop rapport with some who *doesn’t say her prayers* and is a *non-believer*. (pg. 10) |
| Year of schooling: 0 | The family found the information given by the PV useful. (pg. 6) |

| 10M | The mother felt better by finding the opportunity to talk to her PV and it helped her to take her *mind off her worries* and helped her feel better (pg. 8). The mother appreciated the PV delivering information in a *friendly* manner (pg. 3) and felt reassured of *confidentiality* (pg. 17). She appreciated the PV’s input in making her feel *less tense*. (pg. 21) |
| Age:29 | The husband had no objection to the PV’s visits. (pg. 13) |
| No of children:3 | The PV being introduced to the mother, by her LHW and having the intervention explained, helped |
| Year of schooling:5 | |

| 08M | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 07M | The family found the information given by the PV useful. (pg. 6) |
| Age:30 | |
| No of children:4 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 06M | The family found the information given by the PV useful. (pg. 6) |
| Age:31 | |
| No of children:5 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 05M | The family found the information given by the PV useful. (pg. 6) |
| Age:32 | |
| No of children:6 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 04M | The family found the information given by the PV useful. (pg. 6) |
| Age:33 | |
| No of children:7 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 03M | The family found the information given by the PV useful. (pg. 6) |
| Age:34 | |
| No of children:8 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 02M | The family found the information given by the PV useful. (pg. 6) |
| Age:35 | |
| No of children:9 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |

| 01M | The family found the information given by the PV useful. (pg. 6) |
| Age:36 | |
| No of children:10 | The mother found the PV’s involvement inspiring and motivational. (pg. 20) |
| Year of schooling: 0 | A PV should be between the *age of 35 and 40* and should have an experience of motherhood. This will allow her to explain things better to the mothers. (pg. 16-17) |
|                 | A local PV is better, as it can take a while to *trust an outsider* and one can feel hesitant to openly talk to her. (pg. 15) |
A PV should be educated, wise and should have the knowledge about mother and child health, in order for her to provide useful information to the mothers. Not anyone from the street. A PV should be around the same age as the mother, she is working with (pg. 18) and should have an experience of motherhood; otherwise she will not be able to carry out her peer volunteering role appropriately (pg. 19)

A PV from the same village as the mother can conveniently make home visits and will already be acquainted to the mother. (pg. 16)

11M
Age: 28
No of children: 2
Year of schooling: 14

The mother felt comfortable talking to the PV. (pg. 17). With time she felt more comfortable disclosing information without any hesitation as her trust built up. (pg. 29-30). She found sessions with her PV informative and responded freely to her questions. She appreciated when her PV shared her personal experiences and seek her advice. (pg. 17)

A PV should be of friendly nature, in order for her to establish rapport with a mother (pg. 40), should be between the ages of 41-45, as people are more respectful towards adults and will make no objections to their home-visits. Someone younger could experience resistance. Moreover a PV should have a motherhood experience to do this job better. (pg. 33)

A PV from a different village will earn more respect because of not been known to the family. (pg. 31)

the mother feels comfortable to work with her PV. (pg. 10-11)
| 12M | The mother appreciated the PV’s willingness to work with her and felt reassured by her input. (pg. 11) The mother felt comforted and cared for; by the way she was asked and advised by her PV. (pg. 5). She was pleased by the time spent with the PV in privacy to disclose her personal problems. (pg. 12) and felt better sharing her problems with the PV (pg. 11). She appreciated her PV’s input in making her understand things and decided to take care of her health (pg. 10).

A PV should be *wise, experienced* and preferably a mother. She should be between the *ages of 20-23*. (pg.14-15)

A PV from the same village will be trusted more because of her acquaintance. However the mother will miss the opportunity to meet new people. (pg. 14) |
| The mother-in-law enjoyed the PV’s company (pg. 12) |
| **Age:** 26  
**No of children:** 2  
**Year of schooling:** 5 |

| 13M | The mother enjoyed discussing matters in privacy with her PV (pg. 9).

A PV should be *experienced, knowledgeable and* should have *good mannerism*. Age is not relevant however being a mother should be a desirable criterion. (pg. 14)

A PV from a city or a different village will not be trusted because of perceived threat to personal safety. A PV belonging to the same village as the mother will be favoured. (pg. 7) |
| **Age:** 25  
**No of children:** 3  
**Year of schooling:** 8 |

<p>| The PV belonged to the same village as the mother and therefore could have introduced herself to the family without needing the LHW’s assistance. (pg. 7) |
| 16M | The PV visiting mother at home made her feel valued. (pg. 9) A PV should be <em>educated with good habits/attitudes</em> and preferably of <em>older age</em> group. (pg. 15) A PV belonging to the same village will be preferred because firstly she will be aquatinted to the mother and secondly she will be more <em>approachable</em>. (pg. 11 &amp; 16) | The PV involved the mother-in-law during her sessions with the mother (pg. 14) |
| 17M | The mother found the PV a <em>source of happiness</em> for her and liked her <em>mannerisms</em> and her style of communication. (pg. 17). The happiness which the mother was experiencing was noticed and communicated by to her by the PV. (pg. 16). The PV encouraged the mother to share her problems without feeling <em>embarrassed</em>, to which she agreed. (pg. 20) | The husband approved the PV’s involvement (pg. 15) |
| 18M | An experience of motherhood should be an essential criterion for a PV, as <em>only a mother can understand another mother</em> (pg. 7). A PV should be <em>same age</em>, as a mother, in order for her to develop rapport with her. However a younger PV will also be acceptable and treated well. Moreover a PV should be able to give <em>quality time</em> and <em>good advice</em> to a mother. (pg. 7) A PV does not necessarily have to be belonging to the mother’s village. (pg. 1 &amp; 8) | The husband approved the PV’s involvement and the approval of other family matters was not significant to the mother. (pg. 6) |
| 20M | The mother appreciated the PV’s input (pg. 3) and she was perceived as a likeable person (pg. 4) with whom the mother can talk to and feel better (pg. 14-15) | |</p>
<table>
<thead>
<tr>
<th>No of children: 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of schooling: 0</td>
</tr>
<tr>
<td>A PV not being married and not of similar age to a mother could cause barrier in establishing rapport. (pg. 5)</td>
</tr>
<tr>
<td>Regardless of where she is from, a PV will gain the mother and her family’s respect as a guest. (pg. 4)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>21M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 23</td>
</tr>
<tr>
<td>No of children: 1</td>
</tr>
<tr>
<td>Year of schooling: 5</td>
</tr>
<tr>
<td>A PV should be understanding, mature and intelligent (pg. 7-8)</td>
</tr>
<tr>
<td>A local PV will be preferred because she will have the good understanding of a mother’s circumstances. However a mother might feel anxious about her information been disclosed by the PV belonging to same village as the mother. (pg. 8)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>25M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 25</td>
</tr>
<tr>
<td>No of children: 2</td>
</tr>
<tr>
<td>Year of schooling: 5</td>
</tr>
<tr>
<td>The PV was perceived as having a good temperament (pg. 4)</td>
</tr>
<tr>
<td>The mother-in-law regarded the PV as an educated person who imparts good information (pg. 12) and appreciated her communication skills (pg. 4). The family appreciated the information given by the PV (pg. 8)</td>
</tr>
</tbody>
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<thead>
<tr>
<th>26M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 30</td>
</tr>
<tr>
<td>No of children: 6</td>
</tr>
<tr>
<td>Year of schooling: 0</td>
</tr>
<tr>
<td>The mother found the PV good natured, enjoyed talking to her and appreciated how things were explained to her (pg. 8-9). The mother used to wait eagerly for her PV’s visits (pg. 14) and trusted her with disclosing her personal problems. She was encouraged to do so by her good listening skills. (pg. 11-12) and positive input (pg. 10)</td>
</tr>
<tr>
<td>The husband appreciated the PV’s involvement in improving his wife’s mental well-being (pg. 6) and was happy that his wife is sharing her issues with her PV. (pg. 12). The family was gladly listening and taking on board the PV’s instructions. (pg. 8)</td>
</tr>
</tbody>
</table>

A PV from a different village will be preferred. (pg. 14).
<table>
<thead>
<tr>
<th>Age</th>
<th>No of children</th>
<th>Year of schooling</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29M</td>
<td>35</td>
<td>4</td>
<td>The mother enjoyed the PV’s company and appreciated her nature and style of talking. With time she became close to her PV (pg.6) and happily disclosed her problems to her (pg.5-6). The mother acknowledged the PV reassurance. (pg.8) A PV should be good natured, well-mannered and educated (pg.17-18). She should not be critical or argumentative (pg.16). A local PV will be able to communicate in local language to the mother, whereas a PV from a city will be more knowledgeable, learn things quickly and will explain skilfully. A local PV might struggle to be trained. (pg. 18-19)</td>
</tr>
<tr>
<td>30M</td>
<td>25</td>
<td>4</td>
<td>The PV was perceived as having good communication skills (pg.4). The mother’s initial shyness was overcome and later she enjoyed her company and liked talking and listening to her. (pg.3) A PV belonging to the same village will be preferred because she will be more acceptable to the mother’s family (pg. 12) The PV tried to encourage family members to join the sessions. At times mother-in-law used to briefly join the sessions (pg. 6), she held a soft corner in her heart for the PV because she belonged to the same village as her. (pg.12)</td>
</tr>
<tr>
<td>32M</td>
<td>25</td>
<td>2</td>
<td>The PV being a mother herself was helpful. It helped mother to off-load herself and helped the PV to understand and resolve her problems (pg.8). The mother enjoyed the PV’s company and wanted to share her problems and seek advice (pg.5 &amp; 11) The family appreciated the PV’s involvement (pg. 10)</td>
</tr>
</tbody>
</table>

The mother found her PV good natured and enjoyed talking to her. (pg. 3-4)
A PV should be *soft spoken*, calm and patient to others, not someone who gets angry easily as *anger can make you lose control* (pg. 23)

A PV will be respected and treated like a family member, regardless of belonging to the mother’s village or not. (pg. 13)

<table>
<thead>
<tr>
<th>34M</th>
<th>Age: 21</th>
<th>No of children: 1</th>
<th>Year of schooling: 12</th>
</tr>
</thead>
</table>

The PV being a mother was helpful in *empathising* with the mother (pg. 9) and was perceived as a family friend (pg. 12). The mother found her good natured and *understanding*, with whom she felt comfortable talking to. The mother appreciated the effort with she was making to visit her and held *sisterly* feeling for her. (pg. 7)

A local PV will be tuned to assess the family’s mood and the *dynamics* between them. She could further assess how much time mother can spare to receive session. A PV from a city will struggle to relate to the mother because of the cultural differences between the two regions. (pg. 10)

A local PV will take into considerations all the family dynamics before suggesting anything to mother. (pg. 12)

The PV invited the family members to join the session. The mother-in-law attended all sessions and happily gave permission to her daughter-in-law to attend group sessions to learn about child’s health (pg. 17). The father-in-law concerned about her granddaughter’s health, consulted the PV about mother’s diet, in order for her to produce more nourishing milk. (pg. 9)

The PV was introduced to the mother by the LHW, who was supportive of her - it was appreciated. (pg. 13)

The mother had a trusting relationship with her LHW, therefore when the PV was introduced by the LHW it helped her gain mother’s trust. (pg. 18)
**THEMATIC CHART 3: Approval of the intervention**

<table>
<thead>
<tr>
<th>Respondents</th>
<th>3.1: User friendly and intuitive</th>
<th>3.2: Perceived positive impact</th>
</tr>
</thead>
</table>
| **02M**     | The home-based individual sessions were appreciated by the mother. They gave her the opportunity to get to know her PV and discuss matters of her heart in privacy. (pg. 10)  
The group sessions gave the opportunity to meet other women and learn collectively. (pg. 9 & 10)  
The pictures in the books were most effective in delivering the intervention to the mothers, especially those who were not able to read. (pg. 3) | The mother found the intervention most helpful in improving her health and her relationship with others. It had helped her to change her thought patterns, which she felt were the most effective way, to deal with her problems.  
The mother started paying more attention to her diet through recognising its importance for her infant and for herself (pg. 2). She changed her attitude towards others by being patient and good to them (pg. 20)  
The mother recognised the importance of giving her infant quality time and expressing her love through holding, feeding, talking, playing and singing poems to the infant, making him go to sleep. The mother felt that doing this would make his infant recognise her voice. (pg. 2) |
| Age: 25  
No of children: 1  
Year of schooling: 14 |                                                                                               |                                                                                             |
| **03M**     | The mother found the story narrated during the group session informative (pg. 8)  
The PV used pictures to motivate the mother to take care of her diet and to stop worrying. (pg. 2) |                                                                                             |
| Age: 31  
No of children: 4  
Year of schooling: 5 |                                                                                               |                                                                                             |
| **04M**     | The mother appreciated the information delivered to her, at her doorstep and used to take a break from her housework to receive session from her PV. (pg. 8). | The mother felt better after sharing her concerns with her PV, as she gave her good advice and helped her to think well. She started appreciating her relationships (pg. 13) and taking care of herself (pg. 4) such as drinking milk and having fruit and taking some rest in-between daily chores |
| Age: 27  
No of children: 1 |                                                                                               |                                                                                             |
<table>
<thead>
<tr>
<th>Year of schooling: 8</th>
<th>The PV used the pictures in the manual to explain to the mother how her behavior is impacting her mood and circumstances (pg. 3). The PV gave useful information to the mother (pg. 5), about what is beneficial for her and her infant’s health (pg. 3), how important it is for her to take care of herself to be able to take care of her daughter (pg. 7b), about her relationships with her in-laws, neighbours, - almost about everything. (pg. 3)</th>
<th>(pg. 5). Overall the mother felt that her health improved (pg. 13) as she felt less tense and irritable and more happy (pg. 4). The mother had also started socialising more which she found helpful (pg. 7b) The pictures in the manual reminded the mother to be affectionate towards her daughter and to interact with her rather than feeling angry (pg. 3-4).</th>
</tr>
</thead>
<tbody>
<tr>
<td>06M Age: 24 No of children: 2 Year of schooling: 10</td>
<td>The mother preferred the group sessions as they gave her the opportunity to know other’s experiences and problems (pg. 28). The mother didn’t experience any barriers in attending the group sessions. (pg. 28) The pictures helped the mother to understand her problems from different perspectives and to explore their likely solutions with the help of her PV. (pg. 5 &amp; 6) The mother learned and took on board her PV’s advice to have a balanced diet, take care of her infant’s health and go for her check-up (pg. 6), the PV further made her understand that her health is going to have an impact on her infant’s health (pg. 4). The PV gave information to the mother about doing exercise and having a good night’s sleep. (pg. 19)</td>
<td>The mother felt better after her PV raised her awareness (pg. 4) and made her understand the link between mother and infant health. Consequently she started taking care of her health and eating well in order for her infant to get more nutrients through her milk (pg. 7-8) The mother recognised that if she would eat well then her milk would not be enough for her infant (pg. 8)</td>
</tr>
<tr>
<td>08M Age: 35 No of children: 9 Year of schooling: 0</td>
<td>The mother appreciated the delivery of the intervention through both individual and group sessions. (pg. 9). The mother appreciated the time and effort which the PV had put towards home visits. This helped her to trust her PV (pg. 7) and to take her suggestions on board (pg. 2)</td>
<td>The mother felt that the intervention has helped her to change her thoughts. She has taken on board the information given by her PV and has started paying attention to herself - having her breakfast, snack and a glass of milk (pg. 2), and not being preoccupied with the housework all the time (pg. 1)</td>
</tr>
</tbody>
</table>
The mood depicted in the pictures had an impact on the mother’s mood (pg. 15). The mother, not being able to read, asked her son to read the workbook to her (pg. 22).

The mother was informed about having a balanced diet (pg. 1), the importance of interacting with her infant (pg. 14), the link between her wellbeing and her infant’s wellbeing (pg. 13) and the importance of meeting others, to distract her worrying thoughts and for feeling better (pg. 18).

The mother would pick her crying infant up and sing hymns and read holy verses to calm him down (pg. 9-10).

09M
Age: 38
No of children: 6
Year of schooling: 0

The mother priorities receiving her home-based session over her domestic chores (pg. 6). The mother appreciated the time and effort which her PV had put into visiting her at home. (pg. 3). The group was held at the mother’s house as she was not allowed to leave home without being accompanied by men in their family. (pg. 7-8)

The mother liked the story narrated in the group (pg 8-9).

The mother was advised to take care of her health, eat fruit, take rest between work and talk to her infant - as this will make her feel good (pg. 4).

The mother felt better after disclosing her problems to the PV and being listened to. (pg. 1)

The mother followed her PV’s suggestion to interact playfully with her infant (pg. 6).

10M
Age: 29
No of children: 3
Year of schooling: 5

The mother was pleased to have her PV’s company, when alone at home, and she felt better sharing her concerns with her PV (pg. 8). The mother preferred home-based individual sessions over group sessions because she received her PV’s undivided attention. (pg. 9-10). However the mother found the information given during the group session also useful. (pg. 9)

The mother felt an improvement in her mood after the PV helped her to identify her worrying thoughts and gave her useful information (pg. 4). The PV’s support helped the mother to get rid of her tension (pg. 8), consequently the mother started eating well (pg. 6).

The mother followed her PV’s suggestion to interact playfully with her infant (pg. 6).
The mother liked the pictures about mother and infant wellbeing and found the health charts useful. (pg.3)

The PV helped the mother to identify and overcome her worrying thoughts in order for her to take care of her child better (pg. 4), eat at shorter intervals to improve her health (pg. 6), have proper rest and sit and talk to others to get rid of her tension (pg. 21)

| 11M | Age:28  
No of children:2  
Year of schooling:14 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>The workbook helped the mother to understand her situation (pg. 6) and bring some change in her (pg. 37) through recognising her feelings and behaviour. (pg. 10)</td>
<td></td>
</tr>
</tbody>
</table>

The mother recognised and tried to control her compulsion of cleaning her house (pg. 14) learned to involve her parent-in-laws in her infant’s care and ask for help with the housework (pg. 15-16). The mother recognised not to put herself in undue pressures and to accept help from others graciously (pg. 16)

The mother used to prioritise her housework over giving attention to her infant, but has now realised the importance of attending to her infant’s need prior to her other responsibilities (pg. 14).

| 12M | Age:26  
No of children:2  
Year of schooling:5 |
|---|---|
| The mother appreciated receiving information about mother and infant wellbeing at her doorstep. (pg. 16).  
The PV used to monitor the mother’s mood through the mood chart (pg. 6).  
She informed the mother about mother and infant wellbeing, having a balanced diet and doing exercise (pg. 18). She suggested the mother to engage in healthy activities to make her feel better: massage, sing, talk to her infant |

The mother started looking after herself, after being instructed by her PV (pg.4). She felt considerable improvement in her mood and overcame her reluctance to meeting others. She felt motivated to welcome guests at her house and to visit her neighbours in order to keep herself busy (pg. 6-7).

There had been considerable change in mother’s behaviour towards her infant. She started paying more attention to him, holding him and massaging him (pg. 9). She also asked
<table>
<thead>
<tr>
<th>Age</th>
<th>No of children</th>
<th>Year of schooling</th>
<th>Information to mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>13M</td>
<td>25</td>
<td>3</td>
<td>While feeding, and interact playfully in order to develop a bond with her infant (pg. 8). Her husband to hold and take care of their baby, like the husband in the pictures was doing (pg. 18) and was involving her mother-in-law in his care (pg. 18).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The pictures and the story helped the mother to understand about her wellbeing and what is required to improve it. Moreover the information about exercises and looking after the infant was useful (pg. 4&amp;5). The mother was taking good care of her infant, being blessed by a son after a long wait. (pg. 5-6).</td>
</tr>
<tr>
<td>16M</td>
<td>25</td>
<td>1</td>
<td>The mother enjoyed and appreciated the information on mother and infant interaction. She felt that the information given to her was in line with the old practices, suggesting how to interact while feeding, showing affection and talking to the infant. (pg. 6). Furthermore the mother learned the importance for a infant to have interactions with the rest of the family (pg. 21-22). The mother felt better after the delivery of her infant (pg. 22). It helped the mother to raise her awareness and motivation to engage in helpful activities (pg. 7). The mother enjoyed learning and took on board the information about mother-infant interaction such as massaging the infant. She started paying more attention to his needs, talking and singing poems to her infant (pg. 6-7).</td>
</tr>
<tr>
<td>17M</td>
<td>25</td>
<td>1</td>
<td>Having not been able to read, the intervention material was read out to the mother by her PV (pg. 13). The PV highlighted the importance for a mother to take care of herself in order for her to stay well and take care of her infant (pg. 13). The PV also instructed the mother to play and talk to her infant (pg. 14) and have breakfast each morning (pg. 18). The PV advised the mother to ask for help. The mother followed the PV’s advice to have something to eat each time after feeding her infant and to take some rest during the housework to avoid getting tired. (pg. 12).</td>
</tr>
</tbody>
</table>
from her family members until she fully recovered from her operation (pg. 19).

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Children</th>
<th>Year of Schooling</th>
<th>Finding 1</th>
<th>Finding 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>18M</td>
<td>25</td>
<td>10</td>
<td>The mother could identify with the mother’s character in the story (pg. 3). The mother was touched with the unhappy pictures in the workbook and found the health charts helpful. (pg. 4 &amp; 5)</td>
<td>The mother felt improvement in her mood and managed to overcome her worrying thoughts after her baby was born. She happily talked to others and had regular meals three times a day (pg. 4). It helped the mother to improve her interactions with others and she started visiting her maternal home more often (pg. 2)</td>
</tr>
<tr>
<td>20M</td>
<td>45</td>
<td>0</td>
<td>The PV helped the mother to understand her situation through showing her the workbook (pg. 1) and explained key messages such as looking after her infant (pg. 2). The mother used to ask her husband to read out the intervention material to her. (pg. 10)</td>
<td>The mother felt happy looking at her healthy infant and massaging him every day (pg. 2-3).</td>
</tr>
<tr>
<td>21M</td>
<td>23</td>
<td>5</td>
<td>The mother found the workbook easy to understand the workbook (pg. 3)</td>
<td></td>
</tr>
<tr>
<td>25M</td>
<td>25</td>
<td>5</td>
<td>The PV advised the mother to take care of herself, eat well and stay happy. (pg. 3)</td>
<td>The mother felt considerable improvement in her mood after receiving the intervention (pg. 7)</td>
</tr>
<tr>
<td>Age</td>
<td>No of children</td>
<td>Year of schooling</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>26M</td>
<td>6</td>
<td>5</td>
<td>The mother preferred individual sessions over group sessions as they gave her an opportunity to discuss matters peacefully and privately. (pg. 13) The workbooks helped the mother to understand that other women are experiencing problems similar to her. (pg. 3) The PV advised the mother not to feel tension, stay happy, have some rest (pg. 4) and pay attention to the infant which will make her infant healthy (pg. 5) The mother felt improvement in her mood (pg. 3) and she started taking care of herself (pg. 5) The mother’s anger used to cause her to hit her children, however now that it has subsided she does not do it as often. (pg. 2) The mother recognized that putting undue pressure on her children was not necessary. (pg. 4)</td>
<td></td>
</tr>
<tr>
<td>29M</td>
<td>4</td>
<td>10</td>
<td>The PV helped the mother to understand the link between her health and her infant’s health and suggested to eat well and look after her infant (pg. 1-2). She advised the mother to have a good relationship with her parent-in-laws in order to have a peaceful environment at home (pg. 3) The mother felt improvement in her health after improving her diet (pg. 3)</td>
<td></td>
</tr>
<tr>
<td>30M</td>
<td>4</td>
<td>10</td>
<td>The mother confined at home appreciated her PV’s home visits. (pg.13) The pictures used by the PV were found helpful by the mother. They explained the link between low mood and not taking care of oneself. (pg. 8) The mother found the information given to her about eating healthy, taking care of infantren, resting properly and staying happy useful (pg. 6-7). The mother learned not to take her mother in law’s scolding to heart, and started taking care of her health (7-8). The mother was feeling better and was breast feeding her infant. Which she could not do with her previous child due to the weakness (pg. 7-8)</td>
<td></td>
</tr>
<tr>
<td>32M</td>
<td>4</td>
<td>10</td>
<td>The mother appreciated the opportunity to meet other women during group sessions. (pg. 13) The mother was taking better care of herself by taking a glass of milk or a piece of fruit during the day to overcome her</td>
<td></td>
</tr>
<tr>
<td>No of children: 2</td>
<td>The mother found the workbooks useful in gaining information about having a balanced diet (pg. 2) and about the link between mother and infant wellbeing (pg. 15). The PV suggested that the mother should take care of her diet while breast feeding (pg. 3), take care of her infant and meet with her neighbours (pg. 4). The PV advised the mother not to lose hope and find happiness through socialising with others (pg. 5). The mother appreciated the programme which has raised her awareness and constantly reminds her to take care of her diet and look after the infant, through the PV visiting her regularly (pg. 10).</td>
<td>weakness during pregnancy (pg. 3) and continued doing so following her infant’s birth (pg. 21)</td>
<td></td>
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<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age: 21</td>
<td>The mother preferred group sessions over individual sessions because it helped her to understand different perspectives, learn from each other and increase her understanding. (pg. 16) The PV used pictures in the books to help the mother understand her situation. (pg. 6)</td>
<td>The mother benefitted enormously receiving sessions from her PV (pg. 6) and following her advice. It helped the mother to overcome her tension (pg. 15) and she felt relaxed raising her first born and taking 10 mins breaks during the day without getting anxious (pg 1-2). She enjoyed sharing her concerns and discussing her queries with her PV (pg. 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 1</td>
<td>The mother following her PV’s advice started taking care of her diet and consequently produced enough milk for her infant (pg. 3). Her PV suggested to her to share her concerns with her family to stay well, following that the mother started asking for her family’s help in caring for the infant (pg. 4-5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 5</td>
<td>34M</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### THEMATIC CHART 4: Barriers in receiving the intervention

<table>
<thead>
<tr>
<th>Respondents</th>
<th>4.1: Factors impacting mothers’ lack of engagement with the PVs and the intervention</th>
<th>4.2: Resistance from family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>02M</strong></td>
<td>The mother felt reluctant discussing her problems with her PV, fearing that information might be leaked out resulting in bringing shame to her family and creating further issues for her (pg. 7-8). She would rather keep it quiet rather than losing her pride (pg. 7).</td>
<td>The mother-in-law at times objected to the PV coming to see the mother saying that she must have too much spare time in hand to be visiting us (pg. 28). Some families think if PV is not providing any material help then her visits are pointless (pg. 17)</td>
</tr>
<tr>
<td>Age: 25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>03M</strong></td>
<td>The mother found it difficult to rest because she has no help at home (pg. 3). Moreover the mother felt that underprivileged people should be financially helped, otherwise it is not possible for them to afford a balanced diet (pg. 3). The mother did not find the information relevant, as she was already eating well and found it repetitive listening to similar messages each time (pg. 3). She felt that it did not have much impact on her, and despite her PV’s effort her mood did not get better (pg. 5). Her PV’s visit used to take her mind briefly off her worries but once she left she started to experience worrying thoughts again (pg. 2)</td>
<td></td>
</tr>
<tr>
<td>Age: 31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>04M</strong></td>
<td>The mother being in her Chilla period could not leave home to attend the group, therefore the group session was held at her house. (pg. 2)</td>
<td></td>
</tr>
<tr>
<td>Age: 27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 1</td>
<td>Year of schooling: 8</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td><strong>06M</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age: 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The mother felt that people have different perspectives, in some families the mothers-in-law, do not let anyone talk to their daughters-in-law, fearing that they would complain about them. This is because they ill-treat them and were afraid that it would be disclosed to a third person. They would also not like it if someone would give useful information to their daughters-in-law such as having a better diet, especially when they were either not providing a good diet to their daughters-in-law or they could not afford to do so (pg. 12-13), this could also lead to arguments in the house. There was also the possibility that a mother-in-law initially allowed her daughter-in-law to have sessions but later objected (pg. 21).

<table>
<thead>
<tr>
<th>No of children: 9</th>
<th>Year of schooling: 0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>08M</strong></td>
<td></td>
</tr>
<tr>
<td>Age: 35</td>
<td></td>
</tr>
<tr>
<td>No of children: 9</td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 0</td>
<td></td>
</tr>
</tbody>
</table>

The mother living in a big family (9 children, four sister-in-laws who are blind and an old mother-in-law) struggled to manage with her daily chores (pg. 4) and found no time to look after herself (pg. 10). The mother failed to attend the group because of her 40 days confinement period called *Chilla* after infant birth. (pg. 12)

<table>
<thead>
<tr>
<th>No of children: 6</th>
<th>Year of schooling: 0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>09M</strong></td>
<td></td>
</tr>
<tr>
<td>Age: 38</td>
<td></td>
</tr>
<tr>
<td>No of children: 6</td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 0</td>
<td></td>
</tr>
</tbody>
</table>

The PV advised the mother to take rest which was not possible for the mother because of her busy work schedule from morning till evening, including looking after her house, her family and the livestock (pg. 5).

Generally men in the family are alright but women object to the mother leaving her housework to receive sessions from her PV (pg. 6).
The mother’s husband was ill (hepatitis C) and his business was struggling, this made her worry about their financial situation and about the future of their children, such as how would they afford to marry their daughters off and paying for their dowry (pg. 2)

<table>
<thead>
<tr>
<th>10M</th>
<th>The mother could not follow her PV’s suggestion of resting because of domestic responsibilities and eating well because of too many mouths to feed at home (pg. 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 29</td>
<td>The PV’s visit to see the mother was not appreciated by her in-laws (pg. 11). They felt that she was coming without any reason and wasting everyone’s time, including her own. They did not recognise the importance of getting information without being given any tangible benefits. They did not understand the importance of a talking intervention and felt that elders in their family could have given the information to the mother. The PV could only be of any benefit to them if she was bringing some incentives to them (pg. 12).</td>
</tr>
<tr>
<td>No of children: 3</td>
<td>The mother felt apprehensive disclosing her personal problems to her PV in case they would be disclosed to a second or third person. She felt it was difficult to trust anyone with sharing her problems (pg. 34-35). The mother worried that if her PV would disclose information to her relatives, it could be possible that her husband would find out eventually (pg. 36)</td>
</tr>
<tr>
<td>Year of schooling: 5</td>
<td>The mother felt that people are lacking in understanding even those who are educated. Mostly its women who talk behind the PV’s back saying that she would be no good. They didn’t recognise the importance of their work and that they were meant to help them (pg. 27)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11M</th>
<th>The mother asked the PV to stop coming to her because she cannot afford to take time out of her house-work. (pg. 18-19) and neither can she attend groups because it would interrupt her daily routine (pg. 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 28</td>
<td>The mother felt that people are lacking in understanding even those who are educated. Mostly its women who talk behind the PV’s back saying that she would be no good. They didn’t recognise the importance of their work and that they were meant to help them (pg. 27)</td>
</tr>
<tr>
<td>No of children: 2</td>
<td>The mother felt that people are lacking in understanding even those who are educated. Mostly its women who talk behind the PV’s back saying that she would be no good. They didn’t recognise the importance of their work and that they were meant to help them (pg. 27)</td>
</tr>
<tr>
<td>Year of schooling: 14</td>
<td>The mother felt that people are lacking in understanding even those who are educated. Mostly its women who talk behind the PV’s back saying that she would be no good. They didn’t recognise the importance of their work and that they were meant to help them (pg. 27)</td>
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</tr>
<tr>
<td><strong>12M</strong></td>
<td><strong>13M</strong></td>
</tr>
<tr>
<td><strong>Age:</strong> 26</td>
<td><strong>Age:</strong> 25</td>
</tr>
<tr>
<td><strong>Year of schooling:</strong> 5</td>
<td><strong>Year of schooling:</strong> 8</td>
</tr>
<tr>
<td>The mother felt that exercise was not necessary for her, as she was already quite physically active with her housework. (pg. 6)</td>
<td>The mother found it difficult to share her issues with her PV (pg. 8). The mother could not afford to leave her house-work to receive home-based individual sessions from the PV (pg. 9), therefore she stopped her from coming (pg. 2). Likewise she didn’t go to attend the group sessions even though they were held just two doors next to her house, as she was in her Chilla period and felt that her infant was too young to be taken out in cold weather, moreover her husband and father-in-law would not have allowed her to go. (pg. 12) The mother was financially struggling as her husband’s business not going well. Consequently she separated her kitchen from her sister’s kitchen, which she felt would be embarrassing if others found it out (pg. 8-9). The husband initially agreed knowing that the PV would give information on mother and child health but later asked the mother to stop receiving it (pg. 2). He felt that the mother is wasting her time and could have received the information through reading the books. He did not believe that the PV was giving all that time without being paid. He advised the mother not to read those books during Chilla period as it might affect her eye sight (pg. 5).</td>
</tr>
<tr>
<td>Age</td>
<td>No of children</td>
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<tr>
<td>------</td>
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</tr>
<tr>
<td>16M</td>
<td>25</td>
</tr>
<tr>
<td>17M</td>
<td>25</td>
</tr>
<tr>
<td>18M</td>
<td>25</td>
</tr>
<tr>
<td>20M</td>
<td>45</td>
</tr>
<tr>
<td>21M</td>
<td>23</td>
</tr>
<tr>
<td>Age</td>
<td>No of children</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>25M</td>
<td>2</td>
</tr>
<tr>
<td>25M</td>
<td>2</td>
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<tr>
<td>25M</td>
<td>6</td>
</tr>
<tr>
<td>26M</td>
<td>4</td>
</tr>
<tr>
<td>26M</td>
<td>4</td>
</tr>
<tr>
<td>29M</td>
<td>4</td>
</tr>
<tr>
<td>30M</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Permission to attend the group sessions (pg. 9). Some people believed that the PVs are making home visits because they don’t have anything to do at home and were coming to waste their time (pg. 12)</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>32M</strong></td>
<td>In a village, if a woman has depression she may be fearful of disclosing it or not allowed to disclose it to others by her family, because of their domestic issues (pg. 19)</td>
</tr>
<tr>
<td>Age: 25</td>
<td></td>
</tr>
<tr>
<td>No of children:2</td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 5</td>
<td></td>
</tr>
<tr>
<td><strong>34M</strong></td>
<td>The fact is that I did not tell anyone that I had depression because it would be perceived as an illness (pg. 19). Some women felt that they already knew what was being told to them by the PV. They received the sessions half-heartedly on the PV’s insistence (pg. 21)</td>
</tr>
<tr>
<td>Age: 21</td>
<td></td>
</tr>
<tr>
<td>No of children:1</td>
<td></td>
</tr>
<tr>
<td>Year of schooling: 12</td>
<td></td>
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</tbody>
</table>
Appendix 19: Thematic Charts for the peer volunteers

<table>
<thead>
<tr>
<th>Thematic Chart 1: Reasons to continue working as a peer volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td><strong>01PV</strong></td>
</tr>
<tr>
<td>Age: 29</td>
</tr>
<tr>
<td>Marital Status: Married</td>
</tr>
<tr>
<td>No of children: 1</td>
</tr>
<tr>
<td>Years of schooling: 14</td>
</tr>
<tr>
<td>The PV felt that her training had increase her knowledge of issues which women experience in her community and allowed her to find answers to their common problems (pg. 4). Furthermore volunteering had helped her gain work experience (pg. 3)</td>
</tr>
<tr>
<td><strong>05PV</strong></td>
</tr>
<tr>
<td>Age: 30</td>
</tr>
<tr>
<td>The PV decided to do this work hoping it would fulfil her desire</td>
</tr>
</tbody>
</table>
| Marital Status: Married | to work for the betterment of women in her community (pg. 1). She had faced similar problems and wanted women to gain from her experiences (pg. 3). She hoped to find the work rewarding and it gave her peace of mind. (pg. 25). During her work the PV gained satisfaction knowing that her work was benfitting and resulting in the mothers’ overall wellbeing.

The PV used to ignore her health and prioritise everyone’s need over hers, peer volunteering helped her value and look after herself (pg. 27) | to become a PV and on receiving their approval, she agreed to it. Her mother-in-law was cooperating and encouraged her to do so. (pg. 23-24) | sessions. A mother-in-law used to consider the PV as her own daughter and appreciated all the information, which had helped to improve the health of her daughter-in-law and grandson (pg. 12-13).

The people in the village were satisfied after the PV told them that she had a received training for the mother and child health related programme called Thinking Healthy Programme at Dhoke Budhail (Basic Health Unit) (pg. 13-14).

The PV was willing to help mothers who were experiencing mental distress (pg. 1). She was hopeful that this programme would improve their health and consequently their children would be born healthy and | The PV’s father happily gave her the permission to be a peer volunteer. (pg. 39) | Before she started the intervention, the PV asked permission from the mothers’ husbands and their in-laws, to which they all happily agreed (pg. 17). She invited them to join the sessions in order to help

Training enhanced the PV’s trustworthiness as she was perceived more knowledgeable by her target population. PV felt that they should further be trained on providing

| 07PV Age: 35 Marital Status: Divorced No of children: 1 | The people in the village were satisfied after the PV told them that she had a received training for the mother and child health related programme called Thinking Healthy Programme at Dhoke Budhail (Basic Health Unit) (pg. 13-14). | The PV was willing to help mothers who were experiencing mental distress (pg. 1). She was hopeful that this programme would improve their health and consequently their children would be born healthy and | The PV’s father happily gave her the permission to be a peer volunteer. (pg. 39) | Before she started the intervention, the PV asked permission from the mothers’ husbands and their in-laws, to which they all happily agreed (pg. 17). She invited them to join the sessions in order to help

Training enhanced the PV’s trustworthiness as she was perceived more knowledgeable by her target population. PV felt that they should further be trained on providing

Training enhanced the PV’s trustworthiness as she was perceived more knowledgeable by her target population. PV felt that they should further be trained on providing
| Years of schooling: 14 | clever and would become successful human beings (pg. 2). The PV felt it would also give her the opportunity to learn from it (pg. 1). PV wanted to apply for the LHW’s to be earning and contributing to house income and to make her daughter feel proud. Helping others helped the PV to overcome her sadness. Knowing mothers’ problems made her forget problems and put all her effort in trying to help them (pg. 41) | them overcome their doubts and suspensions (pg. 18). This helped her to gain their trust (pg. 54). They used to sit around the PV (pg. 18) and felt happy with her, some of them even showed their interest to be a PV (pg. 39). They pleasantly spoke to her and were glad for the time she was giving to them (pg. 13). They seemed contented with the information they were receiving on mother and child health related matters. (pg. 14). Nobody had any objections to the programme - they liked it and trusted the PV. They appreciated the learning which would benefit their next generation. They also passed on the information to their sisters and cousins (pg. 33). An aunt visiting the mother found the session very informative and wanted the PV to come to her village to give the information to the mothers there (pg. 28) | medical advice, because of the lack of health facilities in their area (pg. 12). Supervision provides the opportunity for experiential learning. More frequent supervision would be preferred to discuss matters regularly, which cannot be discussed anywhere else. |
| 14PV Age: 32 | The PV believed that it would be her greatest source of happiness The PV asked her husband’s A mother-in-law was supportive after being told about the link | The PV liked the trainers and did not experience any |
| Marital Status: | Married | to see someone getting better because of her (pg. 1). It would be counted as a good deed (pg. 2 & 33). The PV told the mother that she was doing this work voluntarily (pg. 17) as these days one does not get much opportunity to engage in humanitarian acts. The PV found the work fulfilling (pg. 32-33) |
| No of children: | 3 | permission because it would not have been possible for her to do this work without his consent. He recognized the importance of learning for the PV, as she was a mother herself and kindly gave her his permission. If he would have not, it would have been difficult for the PV to persuade him. Both the PV and her husband recognized peer volunteering as a good deed and therefore her husband happily agreed to it (pg. 2). However he only allowed her to work in their own village (pg. 8) |
| Years of schooling: | 10 | between mother and her child health and its impact on the rest of the family (pg. 16). The PV felt that she was greeted affectionately by the mothers’ families and were always spoken nicely to (pg. 19). The PVs when they visited the mothers they involved the mothers-in-law and sister-in-laws, this helped the PVs to gain their trust. In cases where a mother-in-law and daughter-in-law didn’t get along with each other, a mother-in-law still join the session because of her interest in her grandchild’s wellbeing -this common interest in the child helped them to overcome their differences (pg. 21). |
| | | problem in receiving training. She felt that the topics were explained comprehensively. However she did realise that women are at different level of understanding and some might take longer than others, therefore a longer training might be a better option. The PV felt that her clients knowing that she was trained would engage with her better (pg. 13) |
| | | Supervisory team was in touch with the PVs (pg. 14) |
PV’s sympathetic feelings towards her friend, who had maternal depression and was sent back to her parent’s house, motivated her to become a peer volunteer, moreover she was always interested in doing community work (pg. 1-2).

The PV’s training helped her to recognise the problems which women experience and how their thinking impacts their wellbeing. It also helped her to recognise and change her unhelpful thinking patterns (pg. 4)

PV recognised that she experienced postnatal depression, understood the reasons for her unhappiness and withdrawal during that period (pg. 17).

The PVs following their training felt that it had helped them to overcome their depression; (pg. 16).

Nobody in the PV’s family objected to her becoming a PV (pg. 38)

The PV used to invite the mothers-in-law and sister-in-laws to attend the sessions, to ensure their support for the mothers (pg. 13). The mother-in-law appreciated the PV. She stated the information she was imparting had brought things she used to do with her children and which were important for the mother’s wellbeing back to her memory. (pg. 18-19)

People were inquisitive about the programme (pg. 39) and once they had the information, they all thought well about it (pg. 40). The PV’s friend also wanted to participate in it knowing that it was for the betterment of other women (pg. 39). The people in the village were educated and considered it right for a woman working if she had a benefit on others (pg. 54).

This was PVs first experience of receiving the training and she appreciated the way things were explained to her. She learned a lot through it. It helped her realise the problems women experience and how their thinking impact their mood. She also recognised her own negative cognitions while she was pregnant (pg. 13)

PV felt that they learned a lot through training. Self-reflection following the training helped them to understand and deal with their own depression. Information was also shared with the family members (pg. 12)

Supervisors accompanying the PVs (for field supervision) helped the mothers realise that PVs’
| **22PV** | The PV decided to work believing when one gives happiness one finds happiness in return, therefore this work might help her overcome worrying thoughts. Moreover when she would care for others, others would care for her (pg. 7). The PV recognised that she would only be able to make a mother listen to her, motivate her and make her feel better if she was well herself. Therefore she tried to improve her physical and mental health and only started giving information to the mothers when she felt alright. (pg. 17-18). The PV managed to overcome her worrying thoughts, through learning gained during her work was being monitored and therefore they were taken more seriously. However more contact with the supervisors would have been appreciated. | The PV's mother’s permission in all aspects of life was very important to her (pg. 21) The PV’s mother agreed to it, knowing that other girls would also be peer volunteering and travel facilities would be provided to them (pg. 4). However it was kept as a secret from the PV’s elder brother who lived in a different city and did not allow her sister to work outside home (pg. 20) | The PV found the learning environment friendly and homely. She learned new things and appreciated the message of thinking positively and finding the happiness through looking after others. |
training (pg. 6) and by reminding herself of the goodness in everything. Through her volunteering work she found a purpose in her life which helped her to deal with her negative cognitions (pg. 9). She felt good delivering the intervention which had benefitted both her and the mothers. She found something to fill her spare time with which she used to often spend sitting idly and experiencing unhelpful thoughts (pg. 23).

| 28PV | The PV’s training helped the PV gain an understanding of depression and its contributing factors. It further helped her to recognise that she was experiencing depression. The training helped her to snap out of it and later help other women overcome it (pg. 3). The peer volunteering work helped her overcome depression (pg. 43)  
The PV decided to work because she had spare time and decided  |
|---|---|
| Age: 34  
Marital Status: Married  
No of children: 1  
Years of schooling: 14 | The mothers-in-law of all four mothers the PV was seeing were good to her and enjoyed her company. She used to visit them for 40 minutes each, however they all wanted her to stay for longer (pg. 7). If they could not join the session from the start they wanted the PV to stay for a bit longer to give them the information they missed- they enjoyed spending time with her (9-10). A mother-in-law, who knew the PV’s mother and her |
|  | Training helped the PV to understand depression which in turn helped her to overcome it (pg. 13) |
to use it for something good, which would help her gain knowledge (pg. 1). The peer volunteering did help her to learn through receiving training, reading manuals and meeting other people. It helped her to realise that other people are experiencing similar problems and hers are relatively less intense compared to theirs.

The PV believed that it was a righteous act to pass what one has learned onto others. Moreover engaging in acts of kindness would compensate for being sinful because of being too engrossed in worldly activities and not saying ones prayers (pg. 2). The PV felt that God would be pleased and reward her for doing the good deed of helping depressed mothers (pg. 24).

It had helped the PV to know and socialise with other women in her neighbourhood (pg. 2).

The circumstances in the PV’s house were facilitative of her being a PV and her husband believed that the work she was doing was good (pg. 3).

A mother-in-law was very pleased with the PV’s work and was supportive towards her. She said that her daughters-in-law had started taking care of her diet because of her. Even now when she met the PV in the fields, she invited her to come over to her house (pg. 12). A husband also held a good opinion of the PV and when she was visiting the mother, he treated her kindly (pg. 12).

A mother from her youth, liked her a lot and treated her really well (pg. 27). The PV did not experience any problems, nobody doubted her intentions and she was welcomed wherever she went (pg. 28).

33PV
Age: 40
Marital Status: Married
No of children: 4
Years of schooling: 10

Family from her youth, liked her a lot and treated her really well (pg. 27). The PV did not experience any problems, nobody doubted her intentions and she was welcomed wherever she went (pg. 28).
Delivering the intervention had a good impact on the PV’s health. She learned a lot reading the manuals which contain information about raising children. She had applied it on her children. Her daughters had read the manuals and it would be useful for them when they would be mothers, likewise women from her neighbourhood have benefitted reading it (pg. 22-23).

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Theme 2.1: Ability to relate to the mother</th>
<th>Theme 2.2: Being local</th>
<th>Theme 2.3: Linkage with the health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>01PV</td>
<td>The PV felt that when someone was given an opportunity to talk, it helped them share their problems (pg. 18). The PV recognised the importance of maintaining confidentiality in order to build relationships with the mothers (pg. 6) and to ensure the peaceful environment at their homes, which could get disrupted if the information would be disclosed to their family members (pg. 27-28). She felt that mothers trusted her with their</td>
<td>The PV belonging to the same village as the mothers increased her credibility. The mothers knew her from before so the PV didn’t need to start the relationship “from scratch” (pg. 23). Furthermore she knew her community really well which made her work easier (pg. 28). The mothers trusted the information she was giving, knowing that it was based on her experience and training (pg. 22). If she was working in a different village it could have taken the</td>
<td>The PV did not experience any problem when she introduced herself to the mothers as she used to assist the LHW in her work. However someone who not known to the mothers and their families had to be introduced through the LHWs in order for the mothers to</td>
</tr>
<tr>
<td>PV</td>
<td>Information knowing that it would not be disclosed (pg. 22-23).</td>
<td>Mothers some time before they started trusting the PV (pg. 23)</td>
<td>Know about her work (pg. 21-22)</td>
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<tr>
<td>05PV</td>
<td>The PV knowing that mothers had limited resources, used to encourage them to look at the diet chart and rest chart and come up with their own ideas to make their diet better. This made them find ways, which could be followed such as having half a glass of milk instead of a full glass to make their diet more balanced (pg. 13-14).</td>
<td>The PV recognised the importance of being friendly with the mothers and listening to them with empathy and attention, this would enable them to feel encouraged to talk to her otherwise her visits would be a waste (pg. 17-18). The PV enjoyed visiting the mothers and felt welcomed by them (pg. 12). She formed a friendly relationship with the mothers and they wanted her to make more frequent visits to their homes (pg. 6). The PV assured the mothers of confidentiality but never pressurised them to give information. With time the mothers started sharing their concerns with her. The PV listened to them with empathy and maintained their confidentiality.</td>
<td>There is a risk having a PV from the same village as there could be family conflict between the PV and the mother’s family, therefore she would not be comfortable visiting the mother (pg. 34). Moreover a PV from the same village can be taken for granted whereas a PV from a different village would be valued more and would be paid more attention (pg. 35). The PV felt linkage with the Health System was useful especially where a mother belonged to a different village from the PV. The lady health workers (LHWs) had links in the community and being introduced to the mother through the LHWs ensured the mothers’ participation and helped to gain their trust (pg. 31-32).</td>
</tr>
</tbody>
</table>
which helped the mothers to open up further with her (pg. 18)

The PV advised the mother, who could afford to have expensive diet, to make use of whatever was available at home such as pulses and vegetables, to make her diet more balanced (pg. 10).

| 07PV | The PV being a mother herself shared her personal experiences (pg. 40) her thoughts and practises with the mother and encouraged her to look after herself for her child’s sake (pg. 6). She also told her the things she hoped she would have done for her daughter (pg. 41). She told them that she used to ignore looking after herself but is now taking care of her and her daughter’s health (pg. 7). The mother took her advice on board, regarding it as a sincere advice from one mother to another (pg. 29).

The PV developed a friendly relationship with the mothers and felt that they like her because of the way she communicated with them. They used to ask her to stay longer at their homes (pg. 27). |
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<tbody>
<tr>
<td>Age: 35</td>
<td>It is important for a PV to be local; because she can speak potohari (local dialect) otherwise mothers struggle to understand her or might not be able to speak freely to her. A local PV would be able to explain things using the right words which would then encourage the mothers to express their inner feelings (pg. 47). Having a PV who belonged to the same village as the mother would have the added advantage of knowing her family and knowing that she had received her training and therefore she would be trusted more to work with the mothers (pg. 48). It would be difficult to find information about a PV who is not local (pg. 49).</td>
<td></td>
</tr>
<tr>
<td>Marital Status: Divorced</td>
<td>A PV should be a mother herself because as this would make her a complete woman, increasing her understanding of</td>
<td></td>
</tr>
<tr>
<td>No of children: 1</td>
<td>Upon introducing the PV to the mother, the LHW informed the mother, she will be delivering the thinking healthy programme and the mother can discuss any issues she is experiencing with her PV (pg. 13).</td>
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</tr>
<tr>
<td>Years of schooling: 14</td>
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</table>

Upon introducing the PV to the mother, the LHW informed the mother, she will be delivering the thinking healthy programme and the mother can discuss any issues she is experiencing with her PV (pg. 13).
The PV felt that once she would be able to ensure the mothers that their meetings would be confidential, she would be able to gain their trust. Once this was achieved the process would be effortless (pg. 52). The only time the mothers can talk in privacy was when they were on their own with the PVs (pg. 35).

The PV was friendly towards the mothers and her smile used to take their worries away (pg. 24)

The PV felt that initially the mothers were feeling a bit reluctant to share their problems, but they gradually started to trust her (pg. 11). She encouraged them by ensuring confidentiality and suggested that sharing their problems will make them feel better and she might be able to help them. (pg. 19-20)

Upon introducing herself to the mother and her family, the PV was welcomed only after mentioning her family background (pg. 4-5). It was easier for the PV to be working in her own village as they knew her family and trusted her, otherwise they might have objected to her coming to their homes (pg. 28-29). Even working in the neighbouring village would be alright (pg. 28) because a PV could tell them that she had received training, hoping that they would allow her to work with them (pg. 9).

A PV should be trustworthy, sincere, able to face challenging situations, courageous and patient (pg. 26). She should be married and should be mother of at least two children, in order to have good experience of raising children. A

<table>
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<tr>
<th>14PV</th>
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<tbody>
<tr>
<td>Age: 32</td>
</tr>
<tr>
<td>Marital Status: Married</td>
</tr>
<tr>
<td>No of children: 3</td>
</tr>
<tr>
<td>Years of schooling: 10</td>
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</table>

It was important for the mothers to be introduced to the PV from a reliable source, creating a good impression on them; otherwise they would doubt her and would find it difficult to trust her (pg. 3). The LHW went with the PV, introduced her to the mother and informed her about the training she had received (pg. 4). However a PV belonging to the same village as a mother will already be known to the mothers (pg. 3)
A middle aged woman would be a better PV because of having more life experiences and for being more assertive (pg. 26-27).

<table>
<thead>
<tr>
<th>PV</th>
<th>Description</th>
</tr>
</thead>
</table>
| 15PV | **Age:** 37  
**Marital Status:** Married  
**No of children:** 3  
**Years of schooling:** 10  

The mothers started sharing the problems with the PV, once she reassured them that the information shared with her would not be disclosed to anyone and therefore it would not create any issues for them. Furthermore she could only help them if they would share their problems with her. A mother shared her husband’s ill-treatment towards her with the PV (pg. 20).

The PV felt that it would have taken longer to develop a trusting relationship with the mothers and their families, without being introduced by the LHWs. They would have questioned their credibility. Being accompanied by the LHWs ensured them that they had been trained and linked with an organisation (pg. 6-7).

<table>
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<tr>
<th>Description</th>
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| The PV found it convenient working in her own village as she could easily check if the mother is available at home and could ask the mother what time is suitable for a session (pg. 22-23). At times, mothers go to their maternal homes for Chilla. If the mother was living in a different village it would be really difficult for the PV to check her availability (pg. 24). The PV belonging to the same village as the mother had the added advantage of mothers’ knowing her from before. However this might stop them from openly discussing their issues fearing that their information might be disclosed to others (pg. 52).

A PV should be able to give her time, make the mothers understand the information and maintain confidentiality. In villages if a person knows that her information had been disclosed she would never trust that person again (pg. 49-50). It would be better if a PV would be a mother herself. |
because only then she would be able to empathise with the mothers (pg. 51)

<table>
<thead>
<tr>
<th>PV</th>
<th>Age: 26</th>
<th>Marital Status: Divorced</th>
<th>No of children: 0</th>
<th>Years of schooling: 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PV belonged to the same village as the mothers, knew them from before and went on her own, to introduce herself in her new role (pg. 14)</td>
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<tr>
<td>The PV should preferably be married and in her thirties, because she would have more experience and would be more sensible. She should have received at least 10 years of schooling, to understand the intervention. Moreover she should have good character and be of good nature enabling her to work well with the mothers and their families. Only then would the families treat her kindly and take what she was telling them on board (pg. 16-17)</td>
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<table>
<thead>
<tr>
<th>PV</th>
<th>Age: 34</th>
<th>Marital Status: Married</th>
<th>No of children: 1</th>
<th>Years of schooling: 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a mother helped the PV to relate to the mothers (pg. 38). The PV shared her personal problems with the mother who was experiencing a similar issue (pg. 10), this helped the PV to be perceived as a friend and gain trust. The PV then offered her assistance to help her resolve her domestic issues (pg. 12). The PV used to listen to the mothers attentively and try to help them find different alternatives to</td>
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<tr>
<td>The PV felt that the mothers belonging to different villages trusted her more with disclosing their personal problems. They knew that she didn’t know anyone in their village and therefore would not discuss their issues. The mothers living in the same village as the PV would fear that the PV would disclose their personal information to her family members, which would then be passed</td>
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</table>

The PV felt that LHWs input was essential especially in those cases where the mother belonged to a different village than her PV. The LHW introducing the PV helped the mother to engage with her which otherwise would be impossible, as they would not be acquainted (pg. 15).
deal with them, even when they were not mentioned in the manual. The PV being a mother herself recognised the value of having children and communicated to the mothers to consider their children as a blessing who deserve attention. (pg. 35) The PV recognised that in order to help the mothers, she had to develop a friendship with them, for which she had to listen to them with empathy and attention. Otherwise she could never understand their problems and could never help them be resolved (pg. 33)

The PV believed that the two things which helped her to gain the mothers’ trust were her friendly nature and her ability to trust others. She trusted mothers with her information which encouraged them to trust her (pg. 29-30). They shared their personal matters knowing that she was listening attentively and would help them (pg. 33)

The PV advised those mothers who had limited resources to make use of things, available at homes, to make their diet more balanced (pg. 8). The PV also suggested to the mother-in-law to compel onto their families, causing further issues for them (pg. 13-14).

Further, it helped her to locate the mothers’ houses as they were living in a village different to hers (pg. 4-5). The PV felt that it would have been difficult without the LHW’s support, as mothers might have responded differently or would have taken longer to develop a relationship with her. Furthermore the LHW helped her to resolve any issues which came up (39-40)
her daughter-in-law to eat well, who was ignoring her diet (pg. 10)

In order to make sure that two mothers from the Pathan clan, who were not allowed to leave home without being accompanied by the men, held the group at their house. The PV felt that this would help them to know other women in their neighbourhood (pg. 24-25)

The PV being a mother had gone through all the perinatal stages and had a good understanding of how mothers feel; this enabled her to openly talk to them. She was in a better position to give advice to the mothers, on mother-child health issues (pg. 26). The PV felt that it would have a greater impact on the mothers if she could relate to them, explain things to them on the bases of her experience and treat them as equals, only then they would listen attentively to her and take things on board (pg. 11). For example the PV used to tell them the problems she had experienced when her children were young and how she had managed to overcome them, hoping that it might strike their cord (pg. 12).

The PV felt that the mothers would feel comfortable talking to someone local, as only a local person will have an in-depth understanding of their issues. They would feel reluctant to talk to someone who was not local. For example during the training the PV did not participate in discussions fearing that she might be misunderstood or say something wrong and be mocked. Likewise mothers would only talk openly to someone who is locally based (pg. 20). The PV felt that it would be convenient for her to work in her own village; however for the mothers it would be better if a PV belonged to the neighbouring village. This was because the mothers living in the same village as the PV would worry

The PVs were new to the area, whereas the LHWs were working there for the last 18-19 years; therefore it was important that they introduced the PVs. It was necessary for the LHWs to get involved or else the mothers’ may not have allowed the PVs to work with them. (pg. 41-42).

<table>
<thead>
<tr>
<th>33PV</th>
<th>The PV being a mother had gone through all the perinatal stages and had a good understanding of how mothers feel; this enabled her to openly talk to them. She was in a better position to give advice to the mothers, on mother-child health issues (pg. 26). The PV felt that it would have a greater impact on the mothers if she could relate to them, explain things to them on the bases of her experience and treat them as equals, only then they would listen attentively to her and take things on board (pg. 11). For example the PV used to tell them the problems she had experienced when her children were young and how she had managed to overcome them, hoping that it might strike their cord (pg. 12).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 40</td>
<td>The PV felt that the mothers would feel comfortable talking to someone local, as only a local person will have an in-depth understanding of their issues. They would feel reluctant to talk to someone who was not local. For example during the training the PV did not participate in discussions fearing that she might be misunderstood or say something wrong and be mocked. Likewise mothers would only talk openly to someone who is locally based (pg. 20). The PV felt that it would be convenient for her to work in her own village; however for the mothers it would be better if a PV belonged to the neighbouring village. This was because the mothers living in the same village as the PV would worry</td>
</tr>
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<td>Marital Status: Married</td>
<td>The PVs were new to the area, whereas the LHWs were working there for the last 18-19 years; therefore it was important that they introduced the PVs. It was necessary for the LHWs to get involved or else the mothers’ may not have allowed the PVs to work with them. (pg. 41-42).</td>
</tr>
<tr>
<td>No of children: 4</td>
<td></td>
</tr>
<tr>
<td>Years of schooling: 10</td>
<td></td>
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</table>


The PV gained the mothers’ trust through ensuring them that they had received the training, showed them the training material, showed pictures to mothers who were not educated and reassured them that it was for their benefit. This helped the mothers overcome their initial hesitation (pg. 27-28) about their information being disclosed and other people making fun of them (pg. 18).

Thematic Chart 3: Appropriateness of intervention

<table>
<thead>
<tr>
<th>Respondent</th>
<th>3.1: Simple to deliver and intuitive intervention</th>
<th>3.3: Positive feedback reported or observed from mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>01PV</td>
<td>The mothers were able to comprehend the information given to them through the pictures. They were asked by the PV to describe the pictures, which gave them the opportunity to talk about their issues (pg. 11-13). During the group session, after been told Rashida’s story, they responded well through the pictures (pg. 37). The health charts were user friendly and allowed the PV to assess their mood and inquire about their diet and rest (pg. 13)</td>
<td>The PV felt that there had been considerable improvement in all the mothers she was seeing (pg. 10). She used to ask them about their mood during each visit, daily routine, diet, going for check-ups and it seemed that they were putting into practise what was told - the improvement in their health said it all (pg. 18). The mothers reported that they started taking more a balanced diet (pg. 13)</td>
</tr>
<tr>
<td>05PV</td>
<td>The PV ran a group session which was attended by 10-12 women. It was held at the mother’s house, as she was The PV’s visits helped the mothers overcome their tension, and they started taking better care of</td>
<td></td>
</tr>
</tbody>
</table>

05PV
Age: 30
<table>
<thead>
<tr>
<th>Respondent</th>
<th>3.1: Simple to deliver and intuitive intervention</th>
<th>3.3: Positive feedback reported or observed from mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>05PV</td>
<td>The PV ran a group session which was attended by 10-12 women. It was held at the mother’s house, as she was</td>
<td>The PV’s visits helped the mothers overcome their tension, and they started taking better care of</td>
</tr>
</tbody>
</table>
Marital Status: Married
No of children: 3
Years of schooling: 10

in her Chilla period and was not willing to leave home to attend the group session (pg. 14-15).

The manuals were helpful and the pictures in them were effective in engaging the mothers to get information from them and deliver key messages (pg. 9). The mothers liked Rashida’s story (pg. 16) and found the manuals useful in learning about improving their health (pg. 14).

The mothers believed that they were the only ones experiencing such problems. The PV informed them, that one out of four women experience mental distress, it is not an illness and they would overcome it through resolving their issues (pg. 19) Before the PV informed her, the mother was unaware of the importance of looking after herself during her post-natal period. It was a necessity to ensure her good health and provide nourishing milk for her child. (pg. 4). She suggested the mothers have a balanced diet by making use of whatever was available at home, have seven hours sleep at night (pg. 16), take rest during the day’s work and have enough water - as it will help to improve both the mothers and children’s health (pg. 10).

The PV cautioned them that they would only be able to look after their children and families when they are healthy (pg. 26).

07PV
Age: 35

Both the PV and the mothers liked the group sessions. It was held at the LHWs and quite a few women attended the group session (pg. 15).

They themselves. Their in-laws also noticed a change in them (pg. 21-22). The mothers were more informed and were paying more attention to their diet, children and going for regular check-ups (pg. 4). There was an improvement in their social interaction with others, as a mother reported to her PV since she could not visit people she invited them to her house (pg. 11).

The mothers started paying more attention to their children and interacting playfully with them while breast feeding (pg. 26).
| **Marital Status:** Divorced  
**No of children:** 1  
**Years of schooling:** 14 | The pictures helped those mothers who were unable to read (pg. 20). When the mothers were shown pictures depicting a happy and an unhappy family they all said they wanted to be like a family who seemed happy (pg. 22).  
The PV advised the mothers to take care of their health, diet, rest and go for routine check-ups (pg. 7). They stressed that by paying attention to their health, they would be able to take better care of their families.  
Likewise taking care of their children’s hygiene would keep them safe from illnesses (pg. 27). The PV felt that mothers had recognised that taking care of their health would be beneficial for everyone in their families (pg. 8).  
12). The mothers told the PV they were ignoring their health but ever since she had started coming, they had learned a lot and had applied it in taking better care of their health (pg. 27).  
The PV felt that it had improved their relationship with their in-laws. A mother reported that her mother-in-law was taking better care of her during her post-natal period. She gave her special food to eat and brought her a warm glass of milk each night (pg. 53-54).  
Additionally in her previous postnatal periods she was asked to resume her domestic responsibilities just after 4 to 5 days but this time she had been given a longer period to rest. The mother-in-law asked her not to worry about the housework and take care of her child (pg. 54-55). |
|---|---|
| **14PV**  
**Age:** 32  
**Marital Status:** Married  
**No of children:** 3  
**Years of schooling:** 10 | The individual sessions allowed the PV to give information individually to mothers. The group session gave the mothers an opportunity to know that other women were going through similar problems, which was beneficial for them (pg. 14).  
The information given in the manuals was good and the pictures were useful for mothers who could not read. There wasn’t anything missing in the manuals (pg. 33).  
The workbook was clear and precise and the reference manual gave detailed information. The PV used to read it before delivering the session (pg. 34). The mothers liked Rashida’s story and could relate to it (pg. 13).  
The PV was satisfied that the mothers she was seeing had improved moods (pg. 9). She praised the mothers when they looked after themselves (pg. 10). The mother reported that she had started socialising more, which made the PV realise that she was getting better (pg. 20).  
Likewise the PV felt that the mother had improved her mood when she started practising the healthy activities and started talking to her openly (pg. 15). |
The PV informed the mother that it is common to experience symptoms such as anger bouts during pregnancy, it is not an illness and several women in the village were experiencing similar symptoms (pg. 24). The mother felt that even though the information given was not new, it stuck in their heads and motivated them to look after themselves (pg. 10).

<table>
<thead>
<tr>
<th><strong>15PV</strong></th>
<th>The families knew that the group sessions were aimed to improve women’s health and therefore no one objected to the mothers’ attending them. If a mother could not attend the group then her mother-in-law or sister-in-law attended the group and gained the information (pg. 35). However the mothers did not disclose their personal information in the group, fearing that others would gossip about it - which would bring shame and dishonour to their families. Such information was shared during home visits (pg. 36). The mothers understood the information through looking at the pictures, which explained everything and left an impact on them. The mother appreciated all the research and hard work that had gone in developing them. It helped her to understand what she had to do to get better (pg.29-30). For example the picture which showed a husband taking his wife for a check-up encouraged the wife to ask her husband to accompany her on hers. Likewise a picture showing a father holding his child made the mother ask her husband to do the same (pg. 32-33). The health charts were good at</th>
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</table>

The PV felt that three out of the four women she was seeing had reported an improvement in their mood (pg. 49). A mother was experiencing a low mood was feeling so much better now that it seemed unreal. Her mother-in-law was pleased with the help, she noticed a change in her daughter-in-law’s behaviour, as she became sociable (pg.14-15). The mother said that she never used to visit people because of the fear of being judged. She had now overcome her fear and was visiting neighbours which made them wonder what had brought this change about (pg. 59). An old lady the PV met on the street also mentioned the change in that mother’s behaviour (pg. 60-61). Another mother felt that it had helped her to overcome her tension and deal with her issues. She used to blame her family for mistreating her which she believed resulted in her miscarriages. Now she was taking better care of herself and rather than getting stressed about the housework was asking her mother-in-law to help her (pg. 10-11).
explaining what to do, reminding and encouraging the mothers (pg. 31). Rashida’s story had a greater impact, it gave them the insight and they felt motivated to change (pg. 12).

<table>
<thead>
<tr>
<th>22PV</th>
<th>The PV felt that the intervention was easy to understand and when she explained information to them in simple words they followed it without any difficulty (pg. 13). The PV had two mothers who could not read. She showed them the pictures and asked about them. For instance after showing the pictures illustrating a happy and an unhappy family, she encouraged the family to discuss what needs to be done to be like the happy family in the picture (pg. 12). The PV stressed the importance of prioritising looking after one’s self which the mothers tend to undermine being too engrossed in their housework (pg. 25).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 26 Marital Status: Divorced No of children: 0 Years of schooling: 10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28PV</th>
<th>The PV enjoyed running the group sessions over individual sessions as women got together to receive them (pg. 42). The mother used to read the reference manual a night before delivering the session and used to carry the workbook with her, which included all the key points. The pictures in the workbook were helpful in finding what was going through the mothers’ mind. The PV used to show pictures and asked the mothers about them, while describing the pictures they used to express their own thoughts (pg. 17-18).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 34 Marital Status: Married No of children: 1 Years of schooling: 14</td>
<td>The mothers didn’t have anyone to share their problems with at home therefore they felt relieved after they shared their problems with their PV. For instance a mother who was experiencing a low mood, showed considerable improvement in her mood after receiving a few sessions (pg. 20-21). There were some mothers who were not paying attention to their children. They were not massaging, thinking that their child might catch the flu. The PV advised the mother to massage her child everyday as this would make the child active. The mother followed her instructions and told her that her child was significantly more active than before (pg. 24) Likewise</td>
</tr>
</tbody>
</table>

| 311 | |
The PV advised the mother to think differently, as it would be helpful (pg. 11).

The mother who did not recognise the importance of interacting with a very young child was told by her PV to pamper and talk to her child as this would help to build their relationship and it would be good for his wellbeing. She helped the mother to recognise that expressing her love to her child would make him happy. The mother listened and followed her instruction (pg. 22).

<table>
<thead>
<tr>
<th>Respondent</th>
<th>4.1: Lack of engagement of some mothers</th>
<th>4.2: Stigma of mental illness</th>
<th>4.3: Resistance from mothers’ families</th>
</tr>
</thead>
<tbody>
<tr>
<td>01PV</td>
<td>The mother felt reluctant to share her personal information fearing that if it would be disclosed to their in-laws and that would lead to confrontations between them (pg. 5).</td>
<td>It was difficult to say directly to the mothers that they had depression as they would deny it (pg. 34) or would take it to heart. It was better to motivate</td>
<td>The circumstances in the mother’s house stopped her from taking the necessary actions to look after herself. For instance when asked to take a balanced diet, her sister-in-law told the PV that her daughter-in-law who had lost her appetite had started eating well again (pg. 6). The mother, who used to beat her children, showed considerable improvement in her behaviour after she took the PV’s advice on board (pg. 7). She used to experience tension, but gradually changed her behaviour and felt better (pg. 9).</td>
</tr>
<tr>
<td>No of children:</td>
<td>1</td>
<td>Years of schooling: 14</td>
<td>them to socialise, in order to make them feel better without mentioning that they had depression. (pg. 33).</td>
</tr>
<tr>
<td>----------------</td>
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<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>05PV</td>
<td></td>
<td></td>
<td>said that she was the one experiencing weakness and needed a better diet (pg. 15-16). The sister-in-law did not allow the mother to talk to her PV in privacy (pg. 19). The mother’s sister-in-law criticised the PV for coming empty handed especially when the mother had to go through a c-section and needed money (pg. 20). The PV felt that some might be talking behind her back (pg. 26-27) and complaining to their daughters-in-law about her, rather than saying anything directly (pg. 26-27).</td>
</tr>
<tr>
<td>Age: 30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of children:</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of schooling:</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The mother was disinterested in receiving the intervention and was not paying attention to her PV. The PV could not manage to engage her even after delivering a few sessions (pg. 5). At times when the PV went to visit her she was asleep (pg. 12). The mother seemed more interested in monetary gains and could not comprehend the importance of receiving <em>mother and child health</em> information. She failed to understand the importance of the PV’s visits without having been given anything (pg. 8). The mother was very money minded (pg. 9).</td>
<td>Even when she knew that the mothers were experiencing mental distress, the PV did not mention it while introducing the programme. She told them they would receive the intervention because the programme needed to be evaluated (pg. 20-21).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **07PV** | Age: 35  
Marital Status: Divorced  
No of children: 1  
Years of schooling: 14 | The PVs felt that if mothers were told that they had depression, it would adversely impact their mood. Some mothers and their families would feel embarrassed because they would blame their family circumstances for mother’s depression (pg. 6-7). | The families might doubt the PV’s intentions if they did know her from before (pg. 18). Two mothers in their Chila period did not get permission from their families to attend the group sessions (pg. 42) |
| --- | --- | --- | --- |
| **14PV** | Age: 32  
Marital Status: Married  
No of children: 3  
Years of schooling: 10 | The PV used to visit the mother at the agreed time but she used to make excuses saying that she was busy (pg. 18). At times the PV waited for over half an hour at her house to deliver a session to her (pg. 17). Two mothers refused to attend the group session, even though it was arranged closer to their homes and they were asked repeatedly (pg. 40). The PV even offered to accompany them there and back but they refused (pg. 12). A mother asked the PV not to come again as she was not willing to receive any further sessions. (pg. 6) The mother was more interested in knowing if the PV had been paid for her work or not (pg. 17). | The husband was not cooperative and wanted the PV to finish delivering her session soon (pg. 16). A mother could not come to attend the group as she did not get permission from her family (pg. 13) |
| **15PV** | Age: 37  
Marital Status: Married | In villages, generally people keep their personal information to themselves or disclose it to a very trusted friend. This is because they fear that people will gossip | The PV did not say to the mothers that they were experiencing mental distress, as it could lead to the mothers’ |
<p>|  |  |  | One of the mothers the PV was seeing gave birth to a premature baby. Consequently the family stopped her from seeing the mother. |</p>
<table>
<thead>
<tr>
<th>No of children: 3</th>
<th>About them bringing disgrace to their families (pg. 36). Initially the PV found it difficult to engage the interest of mothers who were of higher socioeconomic backgrounds and were more qualified than her (pg. 22). However later their attitudes changed after they realised she had received training (pg. 18)</th>
<th>Denial and disengagement with the programme (pg. 11). Rather she said that if a mother was experiencing tension it could impact her child’s health and therefore it was important for a mother to take care of herself (pg. 9-10)</th>
<th>In villages they fear that it would bring bad luck (pg. 7) to the child, who may become weak or unwell. Some families also believe that a woman should not go near a newly born after combing her hair, taking a bath or during her menstrual period (pg. 8). Another mother the PV was seeing had strict in-laws, once the father-in-law asked her to make tea while she was receiving her session (pg. 15-16). They used to worry that the PV might encourage her to get a job and in that case, who would do their housework? (pg. 16-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV Age: 26</td>
<td>The PV was not known to the mother and she was a bit hesitant to engage with her PV (pg. 24)</td>
<td>The mother wanted to receive the intervention but her family did not allow her. The mother stopped the PV from coming, saying it could result in an argument in her house. The husband doubted the PV’s intentions and asked her not to come as they did not need the information</td>
<td></td>
</tr>
</tbody>
</table>
she was giving them. The mother-in-law said that she had given birth to her children and did not experience any problems, so she did not expect her daughter-in-law to be experiencing any issues either (pg. 21-22). The mother’s family said that they had daughters and granddaughters at home so they did not trust anyone to come to their house (pg. 10). The mother advised the PV not to come as she might be humiliated by her family (pg. 22).

<table>
<thead>
<tr>
<th>28PV</th>
<th>Age: 34</th>
<th>Marital Status: Married</th>
<th>No of children: 1</th>
<th>Years of schooling: 14</th>
<th>The mother belonged to the Pathan family who were very strict. They did not allow her to attend the group, despite being told by the PV that she would accompany the mother there and back, they refused (pg. 41).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>33PV</th>
<th>Age: 40</th>
<th>Marital Status: Married</th>
<th>No of children: 4</th>
<th>Years of schooling: 10</th>
<th>The PV felt if the mothers were told that they had mental distress, they might get tensed. The PV therefore encouraged them to talk about their issues through sharing her experiences with them (pg. 29).</th>
</tr>
</thead>
</table>

The PV’s family had a feud with the mother’s family, so they did not allow the PV to come to deliver the sessions. They were thinking that she was coming to spy on them (pg. 5).
Appendix 20: Thematic framework Local Primary Health Care Staff

<table>
<thead>
<tr>
<th>Respondent</th>
<th>1.1: The lady Health Workers’ role in legitimisation and facilitation of the peer volunteers</th>
<th>1.2: The peer volunteers’ programme supplementing the LHWs’ programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>19LHW</td>
<td>The LHW was asked to identify women who could be potential PVs. Someone who had at least 10 years of schooling, was good in communication skills, clever and allowed to work. The LHW gave it good thought and recommended xx (pg. 3-4). The LHWs believed that she had made it easy for the PV by taking her in the field and introducing her to the mothers. The people in her catchment area trusted her with sharing their problems and she was perceived as their well-wisher. If she would not have been accompanied by her, she might not be acknowledged by the mothers (pg. 5). The LHW felt that PVs did not experience any problems in the field because they had faced all the problems when they started working and had paved the way for the PVs. The PVs were working in partnership with them and had their support; otherwise they could have experienced resistance (pg. 14). The LHWs had also offered their support in inviting the women and organising the groups (pg. 1).</td>
<td>The LHW liked the programme. They deliver the health related information, which was then reinforced by the PVs. This made the mothers recognise the significance of the matter, appreciated the help provided to them (pg. 9) and motivated them to act upon the suggestions given to them (pg. 15).</td>
</tr>
<tr>
<td>23LHW</td>
<td>The LHW wanted to recommend someone who had the right attitude, good communication skills and would be supportive (pg. 5). The woman the LHW was initially suggesting was clever and highly qualified. However the lady health supervisor did not second her recommendation because she thought she might not cooperate with</td>
<td>The LHW felt that they had benefitted from this programme. It had helped them to gain information, which they were not aware of before (pg. 33). Consequently they had become more vigilant to the symptoms of mental distress in women they worked with</td>
</tr>
</tbody>
</table>
the LHW. So they suggested xx because she was previously working with the LHW and had the right attitude. (pg. 4). The LHW felt that people could have questioned the PV’s credibility because in villages it can take some time before things are taken on board. Being introduced through the LHW, who was already known in her community, expedited the process (pg. 10). She introduced her and supported her in all possible ways (pg. 34) and cooperated with her like her own sister (pg. 33). Without her support she might have struggled to explain her role (pg. 11).

(pg. 17-18). They had learned a lot through it (pg. 15).

<p>| 24LHW | The LHW was asked to recommend someone who had at least 10 years of schooling, good communication skills, had spare time to work and was easy to get along with, so thankfully she recommended the PV who had done a good job (pg. 2-3). The LHW accompanied the PV to introduce her. If she would have gone on her own, she had to introduce herself through mentioning her family background and it would have taken her longer to make them understand her job role and gain their trust. It was quicker being introduced by the LHW (pg. 15). The LHW told the mothers that the PV was working on a similar agenda as her and she would be making the home visits to give health related information – this made them feel satisfied (pg. 14). The LHW further reassured the families by saying that the PV aimed to educate the mothers, to show respect to their in-laws, and to improve their health to take care of their families (pg. 32). The LHW felt that as long as the PV had either her or LHS she would not experience any problems (pg. 29). The LHW facilitated the PV in conducting the group sessions (pg. 16). |
| 27MO | The Medical Officer (MO) believed that it was important for the PVs to be linked with the primary care staff, as it provided them with the |</p>
<table>
<thead>
<tr>
<th>Job role</th>
<th>Work experience</th>
<th>Information</th>
<th>Thematic Chart 2: Acceptance of the peer volunteer and factors contributing to it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer</td>
<td>5 years</td>
<td>channel to reach out to people. The government backing helped the PVs to gain the trust of the people they were working with (pg. 14).</td>
<td></td>
</tr>
<tr>
<td>31LHS</td>
<td>Job role: Lady Health Supervisor</td>
<td>Work experience: 12 years The LHS was asked to help identify the potential PVs. She asked LHWs, knowing that they were the best to do this job. They knew everyone in their catchment areas from the youngest to the eldest, they could tell who would be interested in doing this job (pg. 1-2). The LHWs were working in the community for the last 10-15 years, everyone knew them. They accompanied the PVs to the mothers’ houses and introduced both the PV and the programme. This made the families perceive the PVs as one of them. Without this the PVs might had experienced some problems and it would have taken double the time to gain the families trust (pg. 7-8). It was also likely that someone would not let them come in, if they turned up on their own (pg. 46).</td>
<td>The LHW could use the programme’s information to make her work better. She needed to understand if a PV could help the pregnant mother, she could do the same. The mothers needed guidance which the LHWs could provide, not expensive medications (pg. 28).</td>
</tr>
<tr>
<td>19LHW</td>
<td>Job role: Lady Health Worker</td>
<td>Work experience: 8 years The PV was doing a good job (pg. 16). The mothers were in lot of pressure experiencing interpersonal problems and raising their children without any support. She helped the mothers to get out of the depression by talking kindly and relating to them through sharing her personal experiences (pg. 7).</td>
<td>2.1: Positive views about the peer volunteers 2.2: Locality and other necessary characteristics of a peer volunteer</td>
</tr>
<tr>
<td>23LHW</td>
<td>Everyone liked the PV; there wasn’t anyone who disliked her (pg. 16). The mothers living</td>
<td>Although the PV was working in a different village she did not experience any problems, because these villages were well connected</td>
<td></td>
</tr>
</tbody>
</table>
Job role: Lady Health Worker
Work experience: 8 years

in the LHW’s village also liked her (pg. 22). She was a bit quiet but her work was very good and she cooperated with the LHW (pg. 05).

and their residents knew each other. Moreover it was the LHW’s catchment area. If a PV was working outside her catchment area it could have created problems for her. It would be difficult to communicate with the people to make them understand the programme. In order to avoid any issues it would have been better to work where people knew either her or the LHW (pg. 13-14).

The LHW had been working for the last 8-9 years and knew all the women in her area. She had a good understanding of who could do this job well. Someone who should have at least 12 years of schooling, right aptitude, good manners and communication skills. Furthermore she should be able to motivate mothers and be married and middle aged, in order for her to have life experiences (pg. 7-8). Importantly she should be a mother to relate to other mothers; otherwise it would be a problem (pg. 8-9). She should be light-hearted and non-argumentative (pg. 6).

24LHW

Job role: Lady Health Worker
Work experience: 18 years

The PV was giving mothers ample time to listen to their problems. She was kind and supportive to them.

People tend to trust those they already knew. It would be better if a PV belonged to the same village as the mothers. In this case she just had to go once, with a LHW, to be introduced to the mothers, and she would gain their trust. If she was from a different village it would take her some time (pg. 7-8).

Most importantly a PV should be married, firstly because she would have similar life experiences as the mothers and secondly visiting mothers would be easier for her. It would be difficult for an unmarried girl in a rural setting to deliver such information (pg. 4-5). As a young PV would find it difficult to educate and motivate the mothers and they would not trust her or disclose their problems (pg. 5-6). Gaining the mothers’ trust is the most important thing and they would trust someone who is educated and married (pg. 4-5).

27MO

The PVs’ supervisors need not to be local; they should be supervised by someone from the city. However someone not locally based would not
| Job role: Medical Officer | be able to do the work of the PVs because her approach would be different. The grass root work could only be done by someone local and belonging to same village as the mother. This is because women living in the same village or neighbourhood visit each other and have very good understanding of the issues which other women in their neighbourhood are experiencing. They are fully aware of their financial situation and their interpersonal relationship problems, more than their LHW, vaccinator or physician. Therefore the local PV would be best to deliver the intervention. (pg. 13). The only repercussion in doing so, would be some mothers might hide their problems from the PV, fearing that they might get disclosed (pg. 24). The PV should have a good reputation and should be on good terms with the families in their village. There are some LHWs who do not have a good reputation, they engage in malpractice and are argumentative with others (pg. 16). It is important for a PV to be a mother herself, she would have gone through similar experiences and would be able to explain things better to the mothers. The mothers will trust her more and disclose their problems to her. Importantly she should be able to maintain confidentiality (pg. 23). |
| Work experience: 5 years | A woman can only talk “heart to heart” to another woman; also if they are from the same village, she will trust her more and talk freely with her. (pg. 5). If a PV was local, usually the mother knew if she would or would not be able to maintain confidentiality. Whereas she might feel hesitant talking a PV who was not known to her (pg. 10). The PV should have at least 10-12 years of schooling, should have the confidence to talk to others and should be able to maintain confidentiality (pg. 33). A PV should be married in order to relate to the |
| | This was the first time when such a programme was delivered in a rural setting. The PVs gladly participated and their families did not object to it (pg. 2). They did it responsibly and honestly, without considering it a burden. They were also gladly coming to attend the meeting at the BHU. They never demanded any money in return. (pg. 14-15). They were doing the best thing, which was |
helping others through guiding them and as a result were getting their blessing (pg. 4) mothers and explain things to them with confidence allowing the mothers to feel comfortable discussing their personal issues (pg. 33-34).

<table>
<thead>
<tr>
<th>Thematic Chart 3: Approval of the intervention</th>
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<tbody>
<tr>
<td><strong>Respondent</strong></td>
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<tr>
<td><strong>19LHW</strong> Job role: Lady Health Worker</td>
</tr>
<tr>
<td>Work experience: 8 years</td>
</tr>
<tr>
<td><strong>23LHW</strong> Job role: Lady Health Worker</td>
</tr>
<tr>
<td>Work experience: 8 years</td>
</tr>
<tr>
<td><strong>24LHW</strong> Job role: Lady Health Worker</td>
</tr>
<tr>
<td>Work experience: 18 years</td>
</tr>
<tr>
<td><strong>Job role</strong></td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Medical Officer</td>
</tr>
<tr>
<td>Lady Health Supervisor</td>
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<tr>
<th><strong>Thematic Chart 4: Challenges in delivery of intervention</strong></th>
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<tbody>
<tr>
<td><strong>Respondent</strong></td>
</tr>
<tr>
<td><strong>19LHW</strong></td>
</tr>
<tr>
<td><strong>Job role</strong>: Lady Health Worker</td>
</tr>
</tbody>
</table>

A mother might not be able to share all her interpersonal problems. However even sharing half of them with the PV, who was also a woman, would help her to overcome her depression (pg. 23). The mothers were experiencing lots of problems, the majority of them felt well as the PVs helped them to deal with their issues (pg. 2-3). The mother living in Bunda village was experiencing lots of tension and was very withdrawn. The LHW was told that after receiving the intervention, there was considerable change in her, she had become sociable (pg. 35-36). The PVs had done their work well. They had conducted the group sessions and mothers had attended and had followed their instructions (pg. 21).
only a talisman will cure the illness. This is common in pathans (pg. 21). At times the families had objected to the PV coming to give them just the information and nothing of material value. The LHW kept some basic medication brought from her own money to avoid such objections (pg. 19-20).

| 23LHW | Job role: Lady Health Worker  
Work experience: 8 years | The mother was not keen to receive the intervention, as she believed that she had no problem and could not understand the purpose of the PV visiting her. The PV continued to make visits but she was not paying any attention to her (pg. 22). Some families who disliked the LHWs’ visits got annoyed by the idea of another person intending to work with them (pg. 39). The LHWs did not tell the mothers that PVs were visiting them because they had mental distress. Instead she told them that because they worked all day, didn’t rest or socialise, they needed to take better care of themselves in order for them to feel good. In cases where mothers were mistreating their children, LHWs asked them to treat their children kindly (pg. 24). The LHWs avoided using the word “mental distress”, to the mothers, as it would have affected them adversely and would have made them get concerned about their mental health (pg. 25). It was better to say that the PVs had come to help them because they were worried (pg. 28). Likewise the mothers-in-law were told that the PVs had come to make their daughters-in-law happy (pg. 36). |

| 24LHW | Job role: Lady Health Worker  
Work experience: 18 years | Some families might have objected to the PV because of doubting her abilities. This is because either they had not seen her being trained or not understood the nature of her work (pg. 31). It was not appropriate to use the term mental distress, as the father-in-law and mother-in-law might have suspected their daughter-in-law was complaining to others about them. The LHW explained to them without referring to mental distress, that the PV would help to improve her wellbeing and her relationship with her in-laws. She had moved to their family and might be missing her parents; it would take her mind off it by talking to her (pg. 33). If the LHW would say that she |
Some women might have objected to it as they believed that talking interventions were not the solution to their financial problems (pg. 16). Likewise some mothers-in-law might have objected as they did not agree with the suggestions made by the PV to their daughters-in-law, about taking care of their diet and having a good rest during the pre- and postnatal period (pg. 18).

In rural communities people are lacking understanding of mental illnesses. If a person is asked to see a psychiatrist, they will strongly object to it by saying that they are not mad so why would they go to see a doctor, who treats crazy people. However those who are educated were referred to the psychiatrist by the physician, the rest were prescribed medication by him - knowing that they would not go to see the psychiatrist (pg. 6-7). In rural communities if a physician says to his patient that he/she has depression they will deny it by saying that they have high blood pressure. They are not familiar with the term anxiety at all and it will take some time before the stigma of depression will be overcome (pg. 8).

The mothers-in-law might have doubted the PV because of uncertainty about the PV’s role and the authenticity of her information. She might have feared that the PV would advise family planning to her daughter-in-law (pg. 20) or instigate hatred by suggesting she be disrespectful towards her. She might have doubted that the purpose of the PV’s visit was to explore their personal problems (pg. 28). A couple of PVs had experienced such problems and they were asked by the mothers not to come to their homes (pg. 20).

A PV should not use the word depression, or else the mother would believe that she had an illness which the PV had come to treat, this would make her feel worried. The PV should start building rapport with the mother by introducing herself, talking kindly to her and giving her information without referring to depression or stress - otherwise she could fail in her PV’s role (pg. 43). Using the word mental distress has several repercussions. It could result in mother’s family blaming themselves or people gossiping about them. The family could be held responsible for her condition by blaming her mother-in-law or her husband for mistreating her or being put under too much stress of doing household work and therefore finding no time for self-care (pg. 43-44).
Appendix 21: Thematic Charts for significant family members

<table>
<thead>
<tr>
<th>Respondents</th>
<th>2.1: Positive views about the peer volunteers</th>
<th>2.2: Being local and other necessary characteristics of the peer volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>01ML</td>
<td>The mother-in-law liked the PV coming to her house, knowing that it would benefit her grandchild (pg. 27 &amp; 28). The PV was welcomed by the mother-in-law and was offered a meal or a drink to show hospitality (pg. 33). The mother-in-law wished her well for taking good care of them (pg. 34). The mother-in-law was aware of the need for such people, who could provide good information therefore she appreciated the PV’s help (pg. 35-36). The mother-in-law regarded the PV as her daughter and felt good having her at home (pg. 36). Knowing the PV’s family background, the mother-in-law welcomed her and treated her like a family member (pg. 45). The mother-in-law knew the PV’s family and treated her like a daughter. Each time she visited, the mother-in-law asked her daughter-in-law to make tea for her (pg. 46). The mother-in-law found the PV trustworthy (pg. 48). The mother-in-law found the information about keeping a balanced diet, taking care of one’s health and looking after family and guests given by the PV to her daughter-in-law useful (pg. 28). The PV made the</td>
<td>It did not make any difference to the mother-in-law, if a PV belonged to the same village as hers or not (pg. 37). A PV, who was from a different village, was warmly welcomed like a family member and was offered either a meal or a tea each time she visited (pg. 37-38). The PV’s village was not much of a consideration for the mother-in-law (pg. 38). It was important for a PV to be mature in order for her to have a good understanding of the subject (pg. 49) and she needed to be good with her communication skills (pg. 42).</td>
</tr>
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<thead>
<tr>
<th><strong>02H</strong></th>
<th>The women appointed to work as the PVs were regarded appropriate by the husbands and they valued them (pg. 27). The husband felt that the PV had made his wife understand things really well and he wanted her to continue coming every two to three months to pass on information (pg. 52). The husband advised his wife to listen to her PV carefully and follow her suggestions and as it would be beneficial for her health (pg. 43). The PV did a good job in the husband’s neighbourhood and in the village (pg. 16-17)</th>
</tr>
</thead>
</table>

|  | The PV belonging to the same village as the mother gave the husband peace of mind. He did not object to her visiting their homes. However it would have been a problem if she would have been a stranger to their family (pg. 21). The PV, who belonged to the same neighbourhood as the husband, was raised as siblings. She was welcomed to work with his wife (pg. 27) The local women, were rightly recruited as PVs. The mothers knew them from before and when they told their husbands, they did not object to it, knowing that they were local and aiming to give health related information to their wives (pg. 17). Women who were not local think differently, sometimes women living in different villages think differently. A local PV could relate to the mothers’ problems and could explain and guide them better (pg. 22). Moreover to train someone who was not local, would require extra effort and time, in order to accustom them to the rural cultures and traditions (pg. 22). The PV would only be allowed to visit homes if she was particular about her modesty, her reputation was unblemished (pg. 26) and she was of good character (pg. 27). She should be middle-aged, not too elderly (pg. 28). It was important for her to |
be a mother, only then she could relate to the other mothers. An unmarried PV would never understand the issues related to mother and child health, because she had not gone through similar experiences, so she would never fully understand them (pg. 29). She should have received at least 10 years of schooling to explain things intelligently (pg. 30). Even if she was not educated she should have life experiences (pg. 31). At times, educated women belonging to the privileged families become arrogant, whereas a PV should be humble (pg. 31). It would be better if she belonged to a lower socioeconomic class, as someone from a higher socioeconomic class could make the mothers feel uncomfortable by her smugness (pg. 31-32). However more importantly she should be sensible and able to guide mothers well (pg. 35). She should be tolerant and forgiving (pg. 33).

Thematic Chart 2: Approval of the intervention

<table>
<thead>
<tr>
<th>Respondents</th>
<th>2.1: Perceived positive impact on mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>01ML</td>
<td>The mother-in-law noticed a difference in her daughter-in-law’s mood. She used to get irritated over minor issues, now she was less annoyed and more sociable with them (pg. 12). The mother-in-law overheard the PV asking the mother to sing lullaby to her child, consequently the mother started talking and singing to her child (pg. 13). The daughter-in-law told her mother-in-law that she had to have a glass of milk each day while she was breast feeding (pg. 15). The daughter-in-law was taking better care of her diet and asked her mother-in-law to take her for the check-up (pg. 18)</td>
</tr>
<tr>
<td>02H</td>
<td>After noticing the change in her wife, the husband felt reassured of the PV’s help in improving her wife and her child’s health (pg. 43). The PV’s visits were helpful as it helped the wife to get better (pg. 16-17). The husband felt a difference in her wife’s diet and health following the PV’s visits (pg. 18). The wife told her husband that she felt good listening to the PV and looking at the pictures in the manual. It had helped her to overcome her tension and to control her anger. She used to hit her children but has stopped doing it now (pg. 19). The PV used to make regular visits to the mother’s house, consequently her behaviour changed. She was managing her anger and treating her children lovingly, another husband had also noticed her wife’s anger bouts more in control (pg. 20)</td>
</tr>
<tr>
<td>Thematic Chart 3.0: Barriers in receiving the intervention</td>
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<tr>
<td>----------------------------------------------------------</td>
<td></td>
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<tr>
<td><strong>Respondents</strong></td>
<td><strong>3.1: Resistance from mother’s family</strong></td>
</tr>
</tbody>
</table>
| 01ML | There is a difference between urban and rural life. In cities people keep themselves to themselves, whereas in villages they poke their noses into each other’s business and gossip about it. Therefore these families’ try to keep their issues under the carpet. Consequently the daughters-in-law keep suffering in silence without disclosing their problems as they won’t be tolerated by their in-laws (pg. 22).

The mother-in-law felt that in-laws mistreating their daughters-in-law would feel reluctant about others coming and talking to them (pg. 23) or would not give them permission to attend the group sessions (pg. 33). This was because they were guilty of mistreatment and wanted to hide matters. They felt worried that their personal information would be disclosed and they would face the embarrassment. However those who had nothing to hide had no problem with someone working with their daughters-in-law. For instance the mother-in-law let the PV and the mother talk in privacy, while she took care of the baby (pg. 24). The in-laws who objected to the PV’s visit would not say anything to her face but would talk behind her back (pg. 25). | Sometimes the families are financially struggling and appreciate more than just the information given to them (pg. 19). The mother-in-law felt that she had the experience of raising her children and could guide her daughter-in-law. Therefore they would have valued some financial help, along with the information provided, to buy fruits and medications for the mother (pg. 15). |
| 02H | Generally speaking people living in urban areas are more educated compared to people living in rural areas, and are more receptive. On the other hand rural people are more resistant to change. There is a (local) proverb, if a dog’s tail is kept in a pipe line even for hundred years it will still be curved (leopard never changes its spots). However once they understand they are alright (pg. 22-23). | The husband felt that just providing the information was not enough, the PV should bring some vitamins to please the mother. The PV came every month with the intention to give the mother an opportunity to talk about her problems, but in order for her to overcome her weakness she needed medications (pg. 44). It would make the |
Some people would object to the PV coming to their homes because they were not sure of the purpose of her visit. They might doubt her intentions, thinking that she had come to pry on their personal affairs. However those who understood would be alright with it (pg. 42). Women who observe the veil would find it difficult to attend the group sessions. Some husbands would not let their wives go, others would be alright if they were held in the neighbourhood but would not let them go if they were held further away from their homes (pg. 39). The mothers-in-law might also get irritated because she had to do her daughter-in-law’s work when she would go to attend the group sessions (pg. 40).

mother happy if she was provided with something useful and if she wanted she could discuss her problems with the PV for catharsis (pg. 45). The husband suggested to provide items which would be beneficial for the mothers (pg. 46)
Appendix 22: Protocol for the systematic review

Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review

Primary objective: To assess the effectiveness of peer-delivered interventions on mental health outcomes.

Inclusion/exclusion criteria of studies:

<table>
<thead>
<tr>
<th></th>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study design</strong></td>
<td>RCTs and any controlled evaluation</td>
<td>All other study designs</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>General adult population</td>
<td>Interventions directed at: Children and adolescents. Upper cut-off point for population group = 18 years.</td>
</tr>
<tr>
<td>HIC and LAMIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Definition of a peer</strong></td>
<td>Peers are defined as, Non-professional health workers who have no formal health background, but who share a common mutually lived experience and some common characteristics (e.g. age/same generation, gender, ethnicity, place of residence) with the service users.</td>
<td>- All cadres of professional health workers who have or may not have specialist mental health background. -Other professionals with health roles, such as teachers and community level workers, social workers. - Other non-professionals who do not fulfil peer-inclusion criteria.</td>
</tr>
<tr>
<td><strong>Definition of mental illness</strong></td>
<td>Mental and behavioural disorders classified in ICD-10 (F-cat) or DSM-IV respectively, measured using a validated tool</td>
<td></td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>-Any peer-led mental health intervention in which the peer is delivering an intervention to service users who have a mental disorder (purpose of the intervention should be on treatment of mental disorders), with the aim of improving mental health outcomes among service users.</td>
<td>-Any peer-led mental health intervention in which the purpose of the intervention is on prevention of mental distress/mental disorders among service users who do not have a mental health disorder.</td>
</tr>
</tbody>
</table>
Interventions in which peers are employed to provide training and research (e.g. interviewing people) only.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Primary outcomes:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>-Change in mental health outcomes among service users (i.e. change in e.g. depression scores or change in proportion diagnosed with a mental disorder)</td>
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<tr>
<td></td>
<td><strong>Secondary outcomes:</strong></td>
</tr>
<tr>
<td></td>
<td>-Change in disability and functioning (e.g. improved coping skills, social functioning, self-esteem) in service users</td>
</tr>
<tr>
<td></td>
<td>-Change in mental health outcomes (i.e. reduction in e.g. depression scores or change in proportion diagnosed with a mental disorder) and change in disability and functioning in peers delivering the intervention.</td>
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<tr>
<td></td>
<td>-Health service utilisation such as emergency admissions and hospitalisation days.</td>
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<td></td>
<td>-Economic status outcomes, for e.g. return to work, employment status or reduced health care costs.</td>
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<tr>
<td></td>
<td>-Cost effectiveness.</td>
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<tr>
<td></td>
<td>Secondary outcomes will be recorded where available but only systematic reviews of studies with appropriate primary outcomes will be included.</td>
</tr>
</tbody>
</table>

| Control Group | Any comparison group including: treatment as usual and treatment delivered by a professional health worker. |

Review methods

- Double screening of search results, selection of studies, quality assessment and data extraction.
- Quality of reviews assessed using Cochrane risk of bias tool (double assessment).
- If possible, quantitative synthesis of results in a meta-analysis. If not, qualitative synthesis of results.
Sub-group analyses:

Depending on the included papers, the following sub-group analyses will be performed:

- By mental health condition (depression, schizophrenia etc.)
- By type of intervention (peer-delivered psychological therapies, self-help groups, one to one interventions, telephone-based peer interventions, etc.)

Suggested databases to search:


Provisional search terms:

| self-help groups/ | psychotic or mood or bipolar or affective or obsessive?compulsive or panic or stress or common mental) adj3 disorder*.ab,ti. |
| social support/ | ((substance or drug* or alcohol or opioid* or prescribed opioid* or cannab* or cocaine or hallucinog* or inhalant* or sedative* or ATS) adj3 (dependence or misuse or abus*)).ab,ti. |
| (mutual support group or support group or group support or psychosocial support or user group or psychosocial care).mp. | or/15-20 |
| peer adj3 (support? or group? or intervention?).mp. | 14 AND 21 |
| peer?.tw | adults/ |
| (peer adj3 (volunteer? or worker? counsel? or expert? or advisor? or consultant? or leader? or educator? or tutor? or instructor? or facilitator? or therap? or assistant? or caregiver? or caregiver? or attendant? or aide? or staff or helper?)).tw. | randomized controlled trial.pt |
| (lay led or lay run).tw. | controlled clinical trial.pt |
| lay person?.tw. | (randomised or randomized or randomly).tw |
| expert patient?.tw. | trial.ti,ab. |
| user led.tw. | groups.ti,ab. |
| peer led. tw | intervention*.ti,ab. |
| peer to peer.tw. | evaluat*.ti,ab. |
| non professional.mp. or non-professional.tw. | control*.ti,ab. |
| or 1-13 | effect?.ti,ab. |
| exp Mental disorders/ | impact.ti,ab. |
| exp Substance related disorders/ | (time series or time points).ti,ab. |
| (mental* adj3 (health or ill* or disorder* or disab*)).ab,ti. | ((pretest or pre test) and (posttest or post test)).ti,ab. |
| | (quasi experiment* or quasiexperiment*).ti,ab. |
| | Or/24-36 |
| | 22 AND 23 AND 39 |