EPP022

Adapting the Thinking Healthy Programme for Perinatal Depression: A Culturally Tailored Approach in Three Central African Countries

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Introduction: In humanitarian settings, populations face extreme adversity, and women in the perinatal period are particularly vulnerable, often at heightened risk of depression. This impacts not only their mental health but also their ability to care for themselves and their newborns, presenting a serious challenge for maternal and infant well-being.
Objectives: This project aimed to reduce the risk of perinatal depression while strengthening infant care practices and parenting skills, ensuring that mothers, despite living in distressing and hostile environments, can be in the best possible state of mind to care for their babies.
Methods: As part of Action contre la Faim's psychosocial support projects, we adapted the WHO's "Thinking Healthy" (TH) protocol specifically for low- and middle-income countries (LAMIC), focusing on cultural sensitivity and the unique challenges of the intervention areas. The standard manual was condensed into three sessions, with additional cultural adaptations and the inclusion of two projective sessions (protolanguage approach) to allow women more freedom to express their specific challenges. The protocol was delivered to groups of up to eight women, separated based on whether they were pregnant or breastfeeding to better target their unique needs. Due to logistical and security constraints, the TH protocol required further adaptation to fit each context's specific limitations.
Results: Over the past three years, the adapted TH protocol has been implemented in three countries across Central Africa, including both humanitarian crisis zones and more stable developmental settings. The programme reached approximately 5,000 preganant women, mothers, and their babies. It was delivered not only in healthcare centres but also directly in communities and internally displaced person (IDP) camps, providing wider access. Results demonstrated significant reductions in psychological distress and depressive symptoms, with improved mother-infant interactions. The programme also helped train healthcare workers, including midwives, enhancing local capacity for long-term support. Quantitative and qualitative results, along with details of cultural adaptations, will be presented.
Conclusions: The adaptation of the Thinking Healthy protocol for low-resource, high-stress environments proved to be an effective and scalable approach for addressing perinatal depression. By tailoring the intervention to fit the cultural and logistical realities of Central Africa, we were able to provide meaningful support to thousands of families. The programme not only reduced depressive symptoms but also fostered stronger maternal-infant bonds and built local healthcare capacity. This model can serve as a reference for implementing mental health interventions in similar contexts globally.

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EPP023

Implementing a peer-led psychological self-support program in resource-limited contexts: a pilot in Eastern Cameroon

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Introduction: In Eastern Cameroon, the psychological needs of both Central African refugees and host communities are significant. Following psychological group interventions over a two-month period, many participants expressed a desire to continue the support process. To meet this need, a self-support protocol was implemented to encourage participants to maintain and strengthen their emotional and social bonds.
Objectives: The aim of this intervention was to enable participants to continue engaging in psychological support autonomously, enhancing their well-being, resilience, and coping mechanisms. The program sought to provide tools for ongoing emotional regulation and peer support, addressing the psychosocial challenges identified during the initial psychological care.
Methods: A flexible, peer-led protocol was developed and implemented after group psychological sessions. Participants were invited to form their own self-support groups, with a recommended size of up to 10 members, meeting weekly for approximately 90 minutes. The structure was intentionally loose to promote autonomy, creativity, and peer leadership. Two initial sessions were facilitated by psychosocial supervisors, while subsequent meetings were primarily observed to assess group evolution. Key dimensions such as emotional well-being, resilience, and social cohesion were measured pre- and post-intervention.
Results: The qualitaive analysis revealed increased cohesion and social connection between group members, especially between refugees and host communities. Participants reported feeling empowered and valued the emotional stability gained through the exercises introduced during the program. However, the evaluation also highlighted challenges, such as maintaining motivation without ongoing supervision and the need for economic opportunities to sustain long-term engagement.
Conclusions: This self-support protocol demonstrated the feasibility and positive impact of peer-led psychological care in contexts with limited resources. The program reinforced emotional resilience, social cohesion, and mutual support, but future iterations should consider integrating economic empowerment initiatives and more structured follow-up to ensure sustained participation.

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EPP025

Challenges and Solutions for Psychiatry's Approach to Indigenous People

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