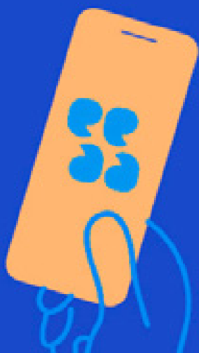
unicef for every child

EVALUATION

Pode Falar

Um lugar para acolher a **fala**.
Onde cada fala é **única** e **importa**.



REPORT 3

Impact Feasibility Assessment of UNICEF Mental Health and Psychosocial Support interventions

Impact Evaluation Design, Demonstration Case

Pode Falar (Speak Up) – Brazil

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01

Motivation and intervention description

Stage 3 of the Mental Health and Psychosocial Support (MHPSS) Impact Feasibility Assessment (IFA) proposes evaluation designs to serve as demonstration cases, showcasing how interventions implemented at various levels can be evaluated rigorously.

Specifically, the selected interventions for Stage 3 include one community-level intervention, one school-level intervention, and two individual-level interventions, of which one is a digital intervention. By offering these illustrative examples, the goal is to provide guidance for future impact evaluations in different countries with similar interventions. This demonstration case does not necessarily imply that an impact evaluation is being initiated; this will depend on continuity of the programme, will and opportunity.

The selected Pode Falar (Speak Up) intervention in Brazil is an individual-level digital solution. Research and data from Brazil have highlighted the need for strengthening and supporting MHPSS programming in Brazil, especially since the onset of the COVID-19 pandemic. The "ConVid" Adolescents survey, conducted by Oswaldo Cruz Foundation (Fiocruz) between June and September 2020, sampled 9,740 adolescents aged 12-17 years and reported the following key findings: 32 per cent of participants reported feeling sad most of the time or always during the pandemic, and the percentage of sadness reported by girls was 2.1 times higher compared to boys. Similarly, 49 per cent of participants reported irritation, nervousness, and moodiness most or all the time during the pandemic, with girls reporting these symptoms 1.7 times more often. These results alert to the importance of innovative strategies to address the specific demands of this phase of the life cycle, especially considering that people in the second decade of life represent approximately 15 per cent of the Brazilian population.[1]

In addition to the survey reported above, a U-Report poll carried out by UNICEF Brazil in September 2020 asked adolescents and young people: "During the period of the pandemic, have you felt the need to ask for help in relation to your physical and mental well-being?". Out of 2,102 respondents, 72 per cent said yes, they felt the need to seek help. When asked to whom they asked for help, 41 per cent said they had not asked anyone for help, 36 per cent looked to friends, and 13 per cent looked to references online, by phone, or professionals in public services.

The expansion of access to information and communication technology (ICT), the internet and social media, has seen the emergence of new resources to promote communication, socialization, and continuity of learning processes, as well as MHPSS interventions aimed at adolescents during the pandemic. Given this scenario, the understanding of the need to create a specific care tool for this age group was strengthened.

Moreover, given the rise in suicide and self-injury rates among adolescents and young people in Brazil (up +128 per cent between 2000 and 2009 among adolescents aged 15-19 years)[2]; the consequences

1 Brazilian Institute of Geography and Statistics – IBGE, 2020

2 The number of deaths by suicide per 100,000 individuals among 15-19 years young people in 2019 in Brazil is 6.3, and the percentage increase of deaths by suicide per 100,000 individuals among 15-19 years young people over time (from 2009 to 2019 is 128%). Source: https://ourworldindata.org/grapher/suicide-rates-among-young-people

of the COVID-19 pandemic, which includes social isolation, loss of loved ones, excessive use of screens to continue learning and communicating with their peers; in addition to the worry and insecurity of returning to face-to-face classes, UNICEF Brazil has invested in a strategy to promote adolescents and young people's mental health and well-being. One of the initiatives under the overall MHPSS strategy is the "*Speak Up*" or "*Pode Falar*" intervention, which started as an online platform for mental health and is becoming a network of institutions (mainly universities) to assist adolescents, produce knowledge and advocate for mental health intersectoral public policies.

The "Pode Falar" innovation project in Brazil has been running since February 2021, catering to the mental health needs of approximately 60,000 adolescents and young people (aged 13-24 years). It is a free online channel, functioning on swing shifts every day, except Sundays and holidays from 8:00 a.m. to 10:00 p.m. Using a chatbot it connects this age group to mental health content, to the possibility of reading and/or leaving testimonials, and to human attendants trained specifically to provide a safe and anonymous space to listen to users, that enter the service using WhatsApp, Telegram, Instagram or the website. It does not collect any cookies, and the only information retained from users is their age, gender, race, state of residence and if they have any disability.

The project has created materials and trained a group of professionals on how to provide mental health assistance to adolescents and young people from vulnerable settings in low-income communities from big cities and rural communities from the Amazon and the Semiarid regions, with a focus on girls; lesbian, gay, bisexual, and transgender populations; migrants; and indigenous and Afro-Brazilians. The platform was designed to be accessible through simple mobile phones with low quality and low connectivity. The platform uses the chatbot technology which is programmed with an Artificial Intelligence (AI) component tailored to issues of MHPSS that youth might be dealing with. UNICEF's support to Pode Falar includes developing a dashboard to monitor access and the most pressing demands from each profile. Moreover, UNICEF will support monitoring social media, and the capacity and number of available professionals that have been trained on adolescents and young people's mental health care. The innovation includes the implementation of an interactive digital platform/chatbot that can be easily accessed by adolescents and a mental health support approach focused on non-judgmental listening that could be adopted by professionals from diverse areas working directly with adolescents, contributing to prevent more serious issues.

The main donor for the project is AstraZeneca and the key partners for the project are the following:

- **Public National and Regional Councils:** Conselho Estadual dos Direitos da Criança e do Adolescente de Rondônia (CEDECA-RO), Conselho Nacional do Ministério Público, Programa Vidas Preservadas - Ministério Público do Estado do Ceará,
- **Public University:** Núcleo do Cuidado Humano da Universidade Federal Rural de Pernambuco, which coordinates a network of 18 universities.
- **Non-govermental organizations (NGOs) and Associations:** CVV-Centro de Valorização da Vida, ASEC - Associação pela Saúde Emocional de Crianças, Núcleo de Aprendizagem Syntese, Instituto Vita Alere de Prevenção e Posvenção do Suicídio, Safernet

The Pode Falar intervention was selected as a promising evaluation to develop an impact evaluation plan based on a systematic progress in Stage 2 of the Impact Feasibility Assessment including assessment of both country- and programme-level factors (see Box 1). In addition to the standardized criteria, this intervention is promising for evaluation for several reasons.

60,000 adolescents and young people

participated to "Pode Falar" innovation project

Box 1

How was the Pode Falar intervention in Brazil selected?

The Pode Falar intervention was selected for Stage 3 of the Impact Feasibility Assessment via a standardized process consisting of: 1) an analysis of **country context** and 2) an **intervention mapping** of MHPSS programming supported by UNICEF in the 21 selected countries interviewed during Stage 2 of the MHPSS IFA.

Key considerations in the analysis of country context were aspects like the political interest and will from partners in generating evidence, prioritization of knowledge gaps, national data and evaluation capacity, as well as the state and burden of mental health in the country.

Key considerations in the intervention mapping include scale and scalability of programming, plans for future expansion, existence of previous impact evaluations, type of programming and humanitarian setting context.

The results of the assessment for Brazil were as follows:

1. **Country context:** Brazil scored "high" in terms of country context, with strong political will and operational facilities for data collection. In addition, the total burden of mental health in Brazil is high, operationalized in terms of suicide rates, especially the relative change in suicide rates among adolescents aged 15-19 years between 2000-2019 (the suicide rate in 2019 of 6.3 deaths by suicide per 100,000 individuals among those aged 15-19 years marks a +128 per cent increase in suicide rates compared to the year 2000).
2. **Intervention mapping:** The Pode Falar intervention was considered a priority in Brazil, as it met all assessment criteria, including those around scale, future expansion, key thematic topics for high knowledge gain, digital application and no existing impact evaluation.

The Pode Falar intervention is one of four interventions short-listed as a priority for Stage 3 (alongside Benin, Nepal, and Papua New Guinea) for which impact evaluation plans are being developed.

For more information, see: Intervention mapping and analysis of country context for the Impact Feasibility Assessment of UNICEF Mental Health and Psychosocial Support interventions, Stage 2 (2024).

02

Impact pathways and key outcomes

The platform for Pode Falar was planned and developed to function as a hub, connecting adolescents and young people with materials on mental health and services in different regions of Brazil. Pode Falar was designed for and with teenagers and young people aged 13-24 years who wish to engage in a virtual dialogue, anonymously and free of charge.

The contact between the adolescent/youth can take place through WhatsApp (which is extremely popular in Brazil) or through the website developed exclusively for the project (www.podefalar.org.br).

Once connected to Pode Falar channel, the adolescent/youth initiates a dialogue with a robot named Ariel, using AI, in a friendly and colloquial language. The user responds to questions indicating: their well-being, age, gender, state of residence, or whether the user has a disability. After identifying the need (or not) of listening to a human interlocutor, AI suggests one of the **three main components**:

1. "Quero me cuidar" (I want to take care of myself), where there is a repertoire of materials on mental health for adolescents and young people (videos, podcasts, guides and manuals on self-care).
2. "Quero me inspirar" (I want to be inspired), in which the adolescent has access to testimonials from their peers on how to overcome difficult situations and can also contribute with their own testimony, which is filtered and edited before publication.
3. "Quero Falar" (I want to speak), where users have access to a human helper from UNICEF partner organizations, according to a schedule in which they are available (on average from 8.00 am to 10.00 pm from Monday to Friday).

The initial question on adolescent well-being serves as a risk assessment that indicates if the user is feeling ok to be offered materials on mental health and access to testimonials or if the user is unwell to be directly referred to a human helper. If no Pode Falar helper is available, the system refers user to the Centro de Valorização da Vida" (CVV) service (National Suicide Prevention Lifeline), which works 24/7. Even feeling well, the adolescent/young person can also ask to be referred to a human helper. Moreover, anytime when chatting with the robot, if the user writes key words representing well-being red flags, such as depression, cutting, suicide, self-harm, anxiety, killing, among other words, the system immediately refers the user to a human helper or, if not available, to the CVV service.

The main objectives of the Pode Falar platform are:

- Produce and make available reliable and permanently updated content on mental health and well-being with and for adolescents and young people.
- Promote the exchange of information on how to overcome demanding situations among adolescents and young people through anonymous testimonies, edited before they become public.
- Offer a safe space for welcoming listening, without religious or political bias and without judgment, carried out by a trained multidisciplinary team.

- Foster the participation of adolescents and young people in promoting their own well-being and mental health.
- Strengthen support networks for adolescents and young people on issues that affect their mental health.
- Provide guidance on possible referrals of adolescents and young people, when necessary, to mental health care services and protection networks in region where they live.
- Contribute to the strengthening of intersectoral public policies for comprehensive care for the mental health of adolescents and young people through partnerships and coordinated evidence-based policy advocacy actions.

Pode Falar is a programme that uses an approach that allows referrals between the four layers of the MHPSS pyramid of care as described in the figure below. With the Pode Falar platform being the entry point, the adolescent/young person interacting with the chat-bot and need to receive more focused and specialized support can be referred to the helplines and from the helpline service providers to the existing specialized mental health care.

The key targeted outcomes of the intervention are:

- Final outcome: Reduction in overall mental distress, measured by a scale of psychosocial functioning
- Intermediate outcomes:
  - Increased access to support,
  - Increased capacity for self-care and positive habits uptake, and
  - Increased awareness of mental health.

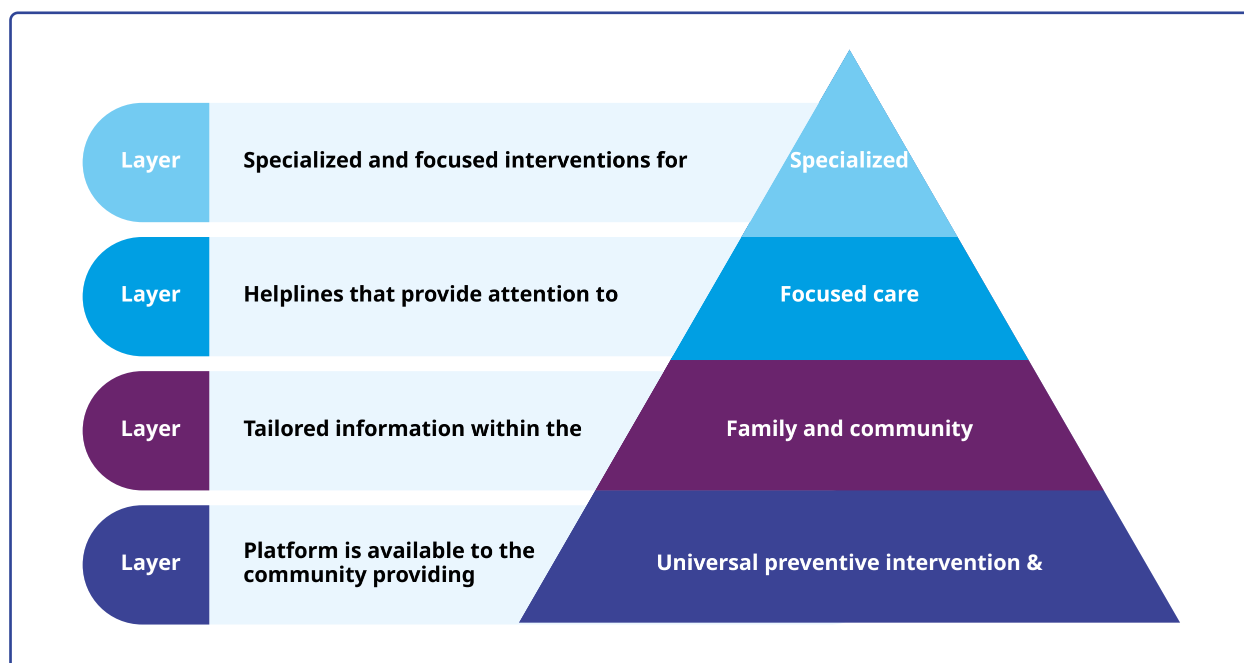
The outputs will be MHPSS providers with increased capacity to provide support, children and adolescents referred to MHPSS services, and people reached with quality and verified MHPSS information. These will be achieved through the following pathways:

Pathway 1: Increased access to and knowledge of mental health materials and resources, including self-help books, peer networks, and awareness of symptoms.

Pathway 2: Increased access to support and care, including peer support networks online, a 'helper' who provides guided psychosocial care, and referral to professionals for severe symptoms

Pathway 3: Increased capacity and skills to recognize mental health symptoms and seek help and support during periods of distress

Figure 1. Pode Falar programme representation in the four layers of the Intervention MHPSS Pyramid



03 Evaluation questions

The main evaluation question asked during the quantitative impact evaluation is:

> - Does Pode Falar lead to a decrease in mental health distress of adolescents and young people?

In addition to this main evaluation questions, it will be important to determine the effect of the intervention on the intermediate outcomes:

> - Does Pode Falar lead to an increase in adolescents' awareness of mental health?
> - Does Pode Falar lead to an improvement in access to mental health support?
> - Does Pode Falar lead to an improvement in adolescents' self-care behaviours and positive habits uptake?

In addition to answering the above questions, it will be important to investigate the "for whom does it work?" question by separately estimating effects for girls and boys and across adolescent and young people age groups (*subgroup analysis*).

Furthermore, qualitative data can be collected to further understand how the intervention works and investigate questions regarding its implementation and relevance to the needs of the targeted population, and the user experience of the users. Example research questions are as follows:

> - How is the user experience of adolescents with Pode Falar? How is the acceptability and engagement of users? What can be improved? (*UX*)
> - Is the platform easily accessible to the targeted population, including hard-to-reach groups? (*accessibility and reach*)
> - What are the factors influencing the achievement/non-achievement of the intervention outcomes? Are there internal (e.g., content) and external (e.g., country context) factors contributing to the effectiveness of intervention? How? (*Effectiveness*)
> - Would there be a more efficient way to manage the platform? (*Efficiency*)
> - How do the separate components contribute to the improvement in the intermediate outcomes? (*Understanding impacts*)
> - Is the programme suitable to the needs and characteristics of the targeted population? Are there emerging topics/issues to be addressed? (*Relevance*)

More detailed questions should be developed/revised in collaboration with the programmatic team and other stakeholders, following the further detailing of the Theory of Change (ToC) and finalization of evaluation design.

04

Evaluation design

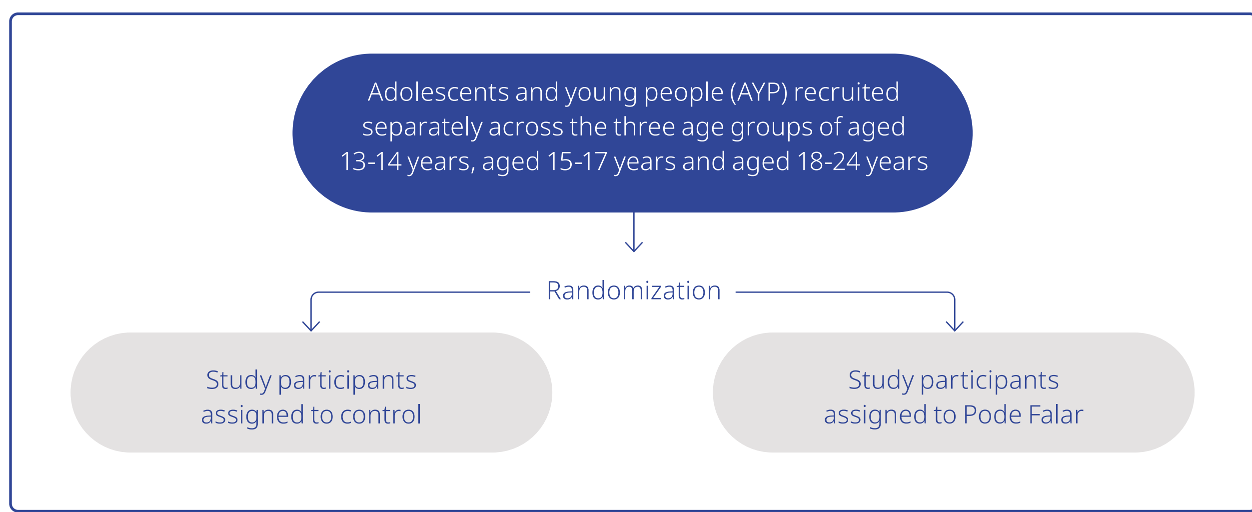
The suggested evaluation primarily aims to establish the causal effects, by testing whether the online platform component of Pode Falar *causes* any changes in the targeted outcomes.

Two initial options for conducting a high-quality impact evaluation for the intervention are suggested., which should be further discussed with the country office, especially to ensure how an impact evaluation can be integrated into the existing platform with as little disruption as possible.

A digital randomized control trial (RCT)

A first viable option is to conduct a digital (online) RCT at the individual participant level. In this design, participants will be recruited online (e.g., through social media ads and provision of participation compensation) and then randomly assigned into treatment and control groups. This design will ideally need approximately 150 control group participants and 150 treatment (i.e., Pode Falar) participants from each age group (e.g., aged 13-14 years, aged 15-17 years, aged 18-24 years), leading to a total sample size of 900 study participants. However, note that as the study will require longitudinal data collection from the participants, attrition is expected; therefore, the sample size at recruitment should be significantly inflated to accommodate the potential attrition over time and the uptake.

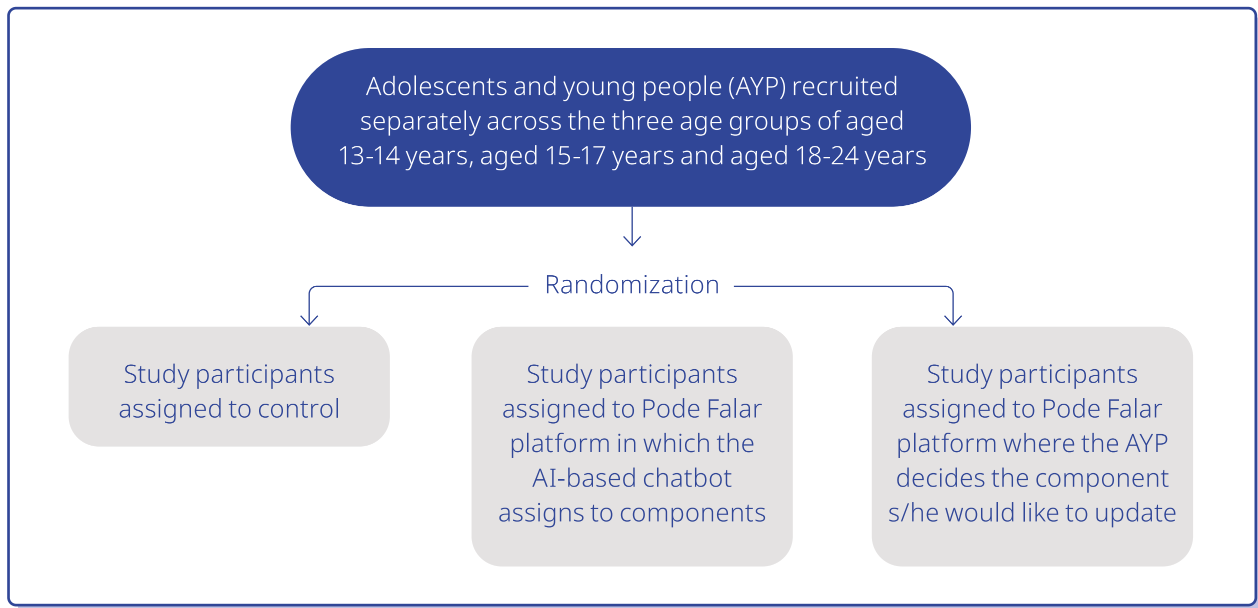
Figure 1. A digital randomized control trial (RCT) at the individual participant level



A digital multi-armed randomized control trial (RCT)

The second option is to conduct a digital (online) RCT at the individual participant level, which involves three study arms. In this design, participants will be recruited online again (e.g., through social media advertisements and provision of participation compensation) and then randomly assigned into treatment version A, treatment version B, and control groups. Treatment version A is Pode Falar platform in which the platform's AI-based chatbot identifies the needs and assigns participants into one of the components that it sees as relevant. Whereas treatment version B is Pode Falar platform in which the platform's AI-based chatbot only provides the list of three platform components and the participant chooses the components s/he would like to attend. The aim of this experimental study is to further test whether the AI-based chatbot strategy works well in deciding the referral to the appropriate/needed module.

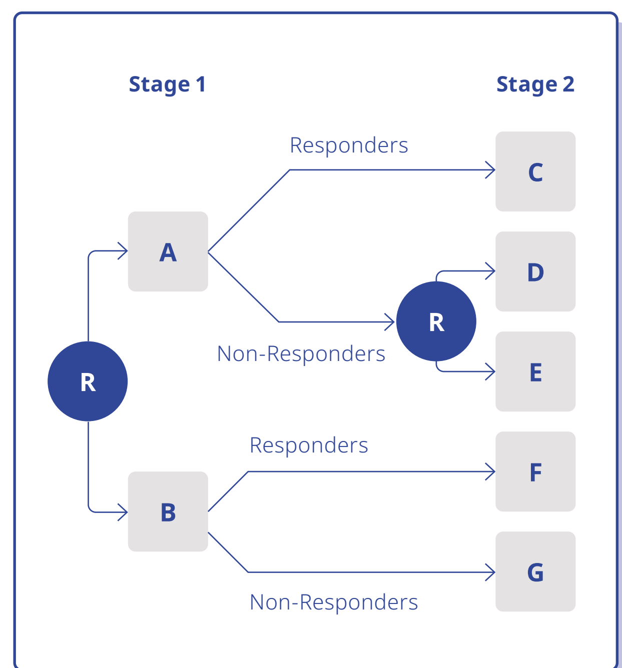
Figure 2. A multi-armed digital randomized control trial (RCT) at the individual participant level



Additional design possibilities:

For such a digital solution, additional design possibilities can include Sequential, Multiple Assignment, Randomized Trials (SMART). In a SMART trial, the aim is to achieve a multi-stage dynamic intervention protocol comprising predefined decision rules guiding the intervention sequence that is adaptive to the participant's responses to the intervention. In a SMART trial, in Stage 1 of the experiment, participants are randomly assigned to different treatment conditions (e.g., helper versus reading materials. The experiment is then followed with a Stage 2 randomization based on the response (i.e., achieving improved outcomes or not) of individual participants. Based on their response to the first stage intervention, participants are assigned to a different treatment condition. It should be noted that a SMART trial requires higher sample sizes.

Figure 3. Illustration of SMART design



05 Key outcome indicators

The targeted outcome variables are adolescents and young people's (AYP) mental health distress, awareness of mental health, access to mental health support, self-care behaviours and positive habits uptake. These will be measured at the individual participant level.

For each of these outcomes, age appropriate, valid and reliable measures should be included. As the study requires data collection from different AYP age groups, if researchers would like to use same measures for all age groups, measurement invariance across different age groups (i.e., whether the same construct is measured equally in different age groups) should be considered when selecting these tools and tested for during data analyses. Since the key indicators align with the evaluation questions, target sample, and will be tailored to the unique evaluation plan, they will undergo additional refinement in a subsequent phase of the evaluation plan.

Furthermore, it is important to measure the uptake of treatment participants (i.e., the level of engagement/ time spent with the platform component at individual participant level), that will enable to make additional estimations, such as the intervention effect estimate for AYP who were more exposed to the platform component (i.e., the treatment-on-the-treated effect).

06 Timeline

Quantitative baseline data collection would ideally start in early 2025, with follow-up surveys (conducted with the same participants at baseline) during time periods that are yet to be determined (e.g., likely an immediate post-test, and a short-term follow-up at three months, considering the online nature of recruitment). Qualitative data collection would occur during the follow-up during the same period. The full timeline for the study would be approximately between January 2025 to August 2025.

07

Data collection methods

The primary data collection method for this study will be online surveys and interviews, which will include both quantitative and qualitative methods. Quantitative data will be collected longitudinally at three main points in time from AYP. Adolescents will be surveyed before the intervention begins and followed longitudinally over time.

Qualitative methods to be used include semi-structured key informant interviews (KIIs) with program implementers and other stakeholders; and in-depth interviews (IDIs) with study participants. Furthermore, secondary data on the platform usage will be obtained and used in the impact evaluation analyses.

08

Analysis methods

Statistical methods should be employed to determine if there are differences between the treatment and comparison groups. The most common statistical analysis used with a randomized design is regression analysis. The subgroup analyses (e.g., to estimate whether there are differential effects for girls and boys) will be employed through building interactions into the regression models. Even though randomization is assumed to achieve balanced (i.e., similar) treatment and control groups at baseline, further analyses will be conducted to test potential baseline imbalance across groups at baseline; if groups are detected to be significantly different at certain characteristics at baseline, those characteristics will be controlled during the final analyses (i.e., through adding them as covariates into the regression model).

Qualitative data will be analyzed following an evaluation matrix, in which all evaluation questions are matched with the appropriate data source and data collection method. Regarding the evaluation questions on understanding how impact occurs, qualitative methods such as contribution analysis can be used.

09

Estimated resources for data collection

Ideally, a professional firm would conduct the study and collect evaluation data. Costs associated with data collection usually cover the development of a study protocol, ethical review, creation of survey instruments (including translations), pre-testing, data collection costs (e.g., recruitment ads in social media, gift cards for participants), data cleaning, and translation/transcription for qualitative data. Estimates are as follows:

- **Quantitative data:** For a digital RCT with 900 study participants the data collection costs including a US$5 recruitment ad cost and US$5 participant online gift card will sum up to a US$9,000 per wave. However, note that as the study will require longitudinal data collection from the participants, attrition is expected; therefore, the sample size at recruitment should be significantly inflated (e.g., doubled up) to accommodate the potential attrition over time and low uptake), leading to an approximately doubled cost. Furthermore, a technical company may need to be recruited to facilitate the online recruitment, randomization, and data collection.
- **Qualitative data:** For data collection including KIIs with key stakeholders and IDIs with users = US$30,000 for one data collection wave.

The estimated cost for a three-wave quantitative and one-wave qualitative data collection is around **US$120,000**. It is important to note that these costs are approximate. Adjustments in costs, either up or down, may be necessary based on the number of survey waves or study arms. The scope of each data collection could also be modified according to priorities or budgets, including additional components or questions. It is crucial to highlight that these costs exclude labour time for international or national principal Investigators, as well as expenses for analysis, dissemination, or publication of study findings.

Intervention website, documents and materials links

Pode Falar website:
https://www.podefalar.org.br/

Blog on Pode Falar on UNICEF website:
https://www.unicef.org/brazil/comunicados-de-imprensa/pode-falar-completa-um-ano-de-existencia-como-canal-de-ajuda-em-saude-mental

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