

MATERNAL MENTAL HEALTH REPORT

IMPROVING ACCESS TO MENTAL HEALTHCARE
IN LOW- AND MIDDLE-INCOME COUNTRIES

INTRODUCTION

PRIME is an eight-year, DFID-funded Research Programme Consortium (RPC), which aims to generate high quality research evidence on the implementation and scaling up of treatment programmes for priority mental disorders in primary healthcare contexts in low resource settings. PRIME has developed, implemented, evaluated and scaled up integrated mental healthcare plans (MHCPs).

A situation analysis of maternal mental health was conducted across all five PRIME countries¹.

There was a wide range of community and facility-based prevalences of perinatal depression across the countries (3–50 %).

In South Africa, India and Ethiopia, maternal mental health was included in mental health policies and a mental health care plan was in the process of being implemented in South Africa.

There were no dedicated maternal mental health services, but referrals to specialised care in psychiatric units or general hospitals were possible.

No information was available on maternal mental health care coverage.

Challenges to care included:

- limited evidence on feasible detection and treatment strategies for maternal mental disorders
- lack of mental health specialists in the public health sector
- lack of prescribing guidelines for pregnant and breastfeeding women
- stigmatising attitudes among primary health care staff and the community.

From the outset, maternal mental health was identified as a focus area for PRIME. This report presents the maternal mental health contributions in each of the PRIME countries.

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OUR WORK IN ETHIOPIA

Formative work on perinatal depression was conducted in the rural district of Sodo. Depressive symptoms were reported by 29% of pregnant women in a community sample of 1 311 women.

Depressive symptoms in pregnancy were associated with increased risk of non-scheduled antenatal care visits and increased risk of presentations for pregnancy-related emergencies². Women with depressive symptoms were more likely to have complications in pregnancy, labour and the postnatal period³. They were also more likely to have an emergency institutional delivery⁴.

Postnatal depressive symptoms were seen in 12% of women in a sample of over 3 000 women living in the community⁵.

Indicators of social and reproductive adversity were the most important factors associated with postnatal depression, especially perinatal complications, poverty, poor marital relationship and exposure to stressful life events⁶. Intimate partner violence in pregnancy was associated with both new onset postnatal depression and persistence of depression in pregnancy into the postnatal period.

A large treatment gap was apparent, with fewer than 1 in 20 women with depressive symptoms having contact with mental health care, and only 1 in 10 in contact with general health services⁵. More than half of women (60%) said the depressive symptoms were due to social problems.

Over two thirds of the women thought that their depressive symptoms needed an intervention. The most frequent coping strategy was prayer or finding comfort in spiritual beliefs⁷. Equal numbers of women supported an intervention through health care as those who supported traditional or religious interventions. There was very low detection of pregnancy by primary health care workers, even after mental health training.



OUR WORK IN ETHIOPIA (CONTINUED)

Participatory Theory of Change workshops were conducted in Addis Ababa and Sodo to identify the pathway to improving perinatal mental health.

The need for a brief psychosocial intervention was identified, with a preference for a problem-solving approach.

The PRIME Ethiopia team identified two key challenges. These are low detection of maternal depression by primary care workers and lack of a feasible and acceptable brief psychosocial interventions for perinatal depression.

Qualitative interviews have been carried out with facility-based health workers, community-based health workers and perinatal women to explore acceptable and feasible ways for a psychosocial intervention to be delivered within the Ethiopian health system.

The findings of the qualitative work will be used to adapt an existing brief 3-session problem-solving intervention which has been shown to be effective in South Africa.

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3. Bitew, T., Hanlon, C., Kebede, E., Honikman, S. and Fekadu, A., 2017. Antenatal depressive symptoms and perinatal complications: a prospective study in rural Ethiopia. *BMC psychiatry*, 17(1), p.301.

4. Bitew, T., Hanlon, C., Kebede, E., Honikman, S., Onah, M.N. and Fekadu, A., 2017. Antenatal depressive symptoms and utilisation of delivery and postnatal care: a prospective study in rural Ethiopia. *BMC pregnancy and childbirth*, 17(1), p.206.

5. Azale, T., Fekadu, A. and Hanlon, C., 2016. Treatment gap and help-seeking for postpartum depression in a rural African setting. *BMC psychiatry*, 16(1), p.196.

6. Azale, T., Fekadu, A. and Hanlon, C., 2018. Postpartum depressive symptoms in the context of high social adversity and reproductive health threats: a population-based study. *International journal of mental health systems*, 12(1), p.42.

7. Azale, T., Fekadu, A., Medhin, G. and Hanlon, C., 2018. Coping strategies of women with postpartum depression symptoms in rural Ethiopia: a cross-sectional community study. *BMC psychiatry*, 18(1), p.41.

* [“A woman pictured with her children, recovering from malnutrition at a health clinic in southern Ethiopia”](#) by [DFID - UK Department for International Development](#) is licensed under [CC BY 2.0](#).



Picture: DFID*

OUR WORK IN INDIA

Formative work demonstrated no maternal mental health services within a weak mental health care platform in Sehore District, Madhya Pradesh. In the PRIME-India Mental Health Care Plan, maternal mental health was included under the packages of care for depression.

PRIME-funded case managers (tertiary-trained graduates with public health experience) received a 6-day training in the PRIME intervention as well as a one-day training on maternal mental health.

This cadre would identify depressed mothers in at routine maternity care visits using the mhGAP master chart and the Patient Health Questionnaire (PHQ-9). In the implementation phase, 231 cases were enrolled. The intervention offered is the Health Activity Programme (HAP)⁸ which has been developed and evaluated in Program for Effective Mental Health Interventions in Under-resourced Health Systems (PREMIUM) project⁹.

This is based on Cognitive Behaviour Therapy with additional strategies relevant to the Indian context. In the HAP scale-up phase of PRIME, all 9 facilities incorporate maternal mental health services using existing nurses to take over the detection and intervention work.

PRIME validated a Hindi version of the Edinburgh Postnatal Depression Scale (EPDS) for this purpose^{10,11,12}. Due to competing demands on the nurses time, enrolment of cases has been very limited. Logistical barriers to enrolment and follow-up include a lack of resources for mothers to attend the facilities frequently enough to receive the intervention.

Quality improvement measures have been instituted to improve identification rates and intervention coverage. This may include the deployment of a lay health counsellor to provide home visits. A report of this work will be submitted to the Ministry of Health for inclusion of maternal mental health in the existing mental health care programme in entire state of Madhya Pradesh.

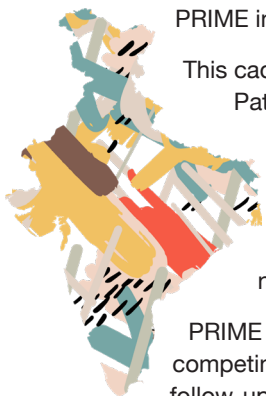
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OUR WORK IN NEPAL

Studies show that around 4.9-12% of women in the perinatal period in Nepal suffer from perinatal depression, yet identification and treatment are extremely rare^{13,14,15}.

A Community Informant Detection Tool (CIDT) and community sensitisation manual were originally developed for depression and other priority mental health disorders¹⁶.

These were systematically adapted to promote identification (case detection) and access to care for both antenatal and postnatal depression¹⁷.

A 5-day training was organized with 38 nurses and midwives in 20 PRIME health facilities.

The training content was focused on assessment of perinatal depression through the administration of a locally-validated version of the EPDS¹⁸ and treatment based on the HAP¹⁹ adapted for maternal depression.

These adaptations included using the EPDS as a screener instead of the PHQ-9, integrating a self-care component across several components, using maternal mental health vignettes and including family engagement.

To evaluate the impact of the approach, 6 months retrospective data was collected on maternal depression cases prior to starting the approach of pro-active case detection and screening, which will be compared to data from 6 months post training.

The retrospective data shows that fewer than 7 cases of maternal depression were identified at these health facilities of whom only 4



OUR WORK IN NEPAL (CONTINUED)



Nurses and midwives who received training in Nepal.

had received psychosocial counselling services and 3 were referred for tertiary care.

The end-line data collection shows that around 1500 cases have been screened of which 72 met threshold for depression in EPDS (i.e. >13) and 107 have been engaged in maternal depression specific HAP.

Where women indicated suicidal ideation, yet were below the EPDS cut-point, these were also referred for intervention.

A qualitative study is planned with the service providers to understand their experience and to assess feasibility and acceptability of maternal depression detection and treatment at the antenatal and postnatal clinics.

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OUR WORK IN SOUTH AFRICA

Various studies in South Africa indicated diagnostic prevalence rates of 16-47%^{20,21}. Formative findings in the Dr Kenneth Kaunda District in North West Province, indicated an absence of routine mental health screening assessments for perinatal patients.

Specialist mental health services were available via the sub-district psychologist and two part time psychiatrists as well as tertiary care at district hospitals and a specialist in patient facility. A case study²² was nested within PRIME-SA, at a 24 hour urban community health centre. A collaborative care plan for maternal depression was developed with the district Department of Health and piloted in an intervention cohort study.

Primary care nurses consulting women attending antenatal and postnatal services were trained to identify women with depressive symptoms using a short (2 item) maternal depression screening tool and clinical assessment using the Adult Primary Care (APC) guideline²³.

Pregnant and postnatal women who had mild/moderate depressive symptoms were referred to an existing 8-session manualized counselling intervention addressing common triggers of depressive symptoms, based on cognitive behavioural approaches.

The sessions were provided by a facility-based lay counsellor. Women with moderate to severe depressive symptoms were referred to both the counsellor and clinic doctor. Thirty one women screened and diagnosed with depression were recruited.

Preliminary findings suggest improvement in terms of reduction of depressive symptoms and improvement in functional disability as well as acceptability of the intervention by both service users and service providers.

Parallel to the case study, other perinatal patients who were not recruited into the study were also screened and assessed for depression by the nurse and referred for the same 8-session counselling intervention counselling as part of routine care. This is continuing at the facility although the research has ended.

The PRIME South Africa team has identified various key challenges with



OUR WORK IN SOUTH AFRICA (CONTINUED)

regards to screening for and addressing perinatal common mental disorders. These challenges include the absence of routine screening, the absence of indicators to assess these disorders in the BANC consultation checklist, the absence of targets to screen for these disorders and the absence of health system indicators to report according to.

The Mental health Integration (MhINT) programme/scale up based on the PRIME intervention is taking place currently in KwaZulu Natal province. Services for depression are directed towards all primary care patients including those attending for chronic care and maternal care.

The objective is to integrate depression care into PHC and to include maternal mental health care as a routine function of PHC using a standardised screening tool, clinician assessment and counselling programme.



“

I NEED SOMEONE THAT I CAN TALK
TO, ESPECIALLY SOMEONE
WHO DOESN'T KNOW ME AND THAT I
DO NOT KNOW; SOMEONE
WHO IS NOT JUDGMENTAL”.

- PERSON LIVING WITH POSTNATAL
DEPRESSION

”

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OUR WORK IN UGANDA

In Uganda, the prevalence of postpartum depression has been estimated to be 6.1 % among patients attending primary care clinics²⁴. No routine maternal mental health services are provided in the health system.

Formative maternal mental health work in PRIME involved qualitative interviews with perinatal women and health workers and managers. Participants perceived that there was an important unmet need for perinatal mental health care but there were substantial knowledge gaps about mental health and high levels of stigma.

Poverty and inability to afford transport to services, poor partner support and stigma were thought to constitute barriers for perinatal women accessing care. Both community- and facility-based health care providers were willing to provide care for mothers with mental health problems if equipped to do so by adequate training²⁵.



An intervention was designed based on problem-solving therapy. In the primary level health centre, pregnant mothers were screened for depression using the PHQ-9.

Mothers that screened positive were referred to midwives for diagnostic confirmation. For those diagnosed with severe depression and suicidal ideation, midwives offered immediate problem-solving therapy.

Follow-up sessions were scheduled and an average of 4 problem-solving therapy sessions were provided for these women. These women were also offered antidepressants (amitriptyline) for 4-6 months.

Follow-up visits for mothers on treatment were scheduled every 2 weeks. At each follow-up visit, a re-assessment was done and mothers were given the opportunity to discuss any side-effects caused by the medication.

However only a few completed the treatment regime. This may be attributed to medication stock outs at health facilities and mothers' logistical barriers to attending the facilities.

All mothers diagnosed with depression were offered the opportunity to be part of the group problem-solving therapy sessions. These were run on a monthly basis at 5 health facilities by midwives using problem solving therapy (PST).

As almost 80% of women in the group sessions were victims of gender based violence, coping skills and content on intimate partner

OUR WORK IN UGANDA (CONTINUED)

violence (IPV) were specifically incorporated in to the group work.

Women were also referred to NGOs addressing IPV. A majority of the mothers showed significant improvement in their PHQ9 scores by the 3rd/4th session with personal testimonies supporting these findings. Overall, mothers were very appreciative of the group therapy and often referred their friends.

Midwives identified that their heavy workload was as a key challenge to integration of mental health care. However, key elements of success included the basic and refresher trainings of at least 2-4 midwives in each health facility as well as monthly supportive supervision provided by specialists.



Namulondo Ruth - mother living with depression in Uganda.

“ I DO HAVE DEPRESSION, AM OFTEN
IN A LOW MOOD AND ALWAYS SAD.
[...] MARITAL CONFLICT IS THE
MAJOR CAUSE OF MY DEPRESSION.
MY HUSBAND AND I AREN'T IN GOOD
TERMS -NAMULONDO ”

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KEY LESSONS

- There is a high prevalence of common perinatal mental disorders in PRIME countries.
- Lack of support, experience of violence and poverty are key factors associated with these disorders.
- There is a large treatment gap for these disorders but a perceived need for care from mothers and those in the health system.
- Detection of disorders is low and may be related to the detection method chosen, staff attitudes and lack of disclosure by women.
- It is appropriate to refer women to care who do not meet screening score thresholds yet disclose ideas of self-harm.
- There are challenges linked to using existing maternity staff for management that may be linked to perceived work burden, perceived need for remuneration for additional tasks and lack of confidence in the required skills.
- These challenges may partly be addressed by providing adequate training and regular clinical supervision.
- Mental health Interventions tested for the general population may be effectively adapted for use in the perinatal population and may include a range of elements including individual and or group sessions, medication and activation of social support.
- Access to uptake of the intervention is restricted when women live long distances from health facilities, have competing demands on their time or do not perceive the benefits of attending facilities for mental health care.
- When there is careful engagement with Ministry of Health stakeholders in Maternal and Child Health and in Mental Healthcare, scale of maternal mental health services is feasible.



ABOUT DEPRESSION IN PREGNANT WOMEN AND NEW MOTHERS

What is the perinatal period?

The perinatal period refers to the time from pregnancy to the end of the first year after birth.

What is perinatal depression?

Depression is characterised by low mood, loss of interest and enjoyment, as well as reduced energy for at least two to four weeks. Other common symptoms include extreme tiredness, irritability, disturbed sleep, body aches and pains.

What are the consequences of perinatal depression?

For the child, consequences may include negative brain development, increased risk of infection, delayed growth, and long-term behavioural and emotional problems. For the mother, consequences may include increased risk of infection, disability, victimisation, violence, reduced productivity, and increased risk of poverty. In severe cases, depression can lead to suicide.

How is perinatal depression diagnosed?

A trained health care worker can distinguish between the symptoms of perinatal depression and the effects of pregnancy,

or another health condition.

How is perinatal depression treated?

A trained health care worker will know the appropriate form of treatment. Treatment options include supportive counseling, talking therapies, linking the woman to supportive social networks, assisting with problems linked to poverty and in some cases, antidepressant medication.

Source: [Perinatal Mental Health Project](#) (a PRIME partner)

GUIDE TO PRIME TOOLS

BELOW YOU'LL FIND LINKS TO THE VARIOUS
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A decorative background featuring a series of horizontal lines. On the left side, there is a grey triangle pointing right. On the right side, there is a red triangle pointing left, partially overlapping a grey triangle pointing right. The overall design is minimalist and modern.

The Programme for Improving Mental Healthcare (PRIME) is a consortium of research institutions and ministries of health in five countries in Asia and Africa (Ethiopia, India, Nepal, South Africa & Uganda), with partners in the UK and the World Health Organization (WHO). PRIME is supported by the UK government's Department for International Development (DFID), and is an eight-year programme which was launched in May 2011.

Our partners include the World Health Organization, the Centre for Global Mental Health (incorporating London School of Hygiene & Tropical Medicine and King's Health Partners, UK), the Ministries of Health and research institutions in Ethiopia (Addis Ababa University), India (Sangath), Nepal (TPO Nepal), South Africa (University of Cape Town, University of Kwazulu-Natal) and Uganda (Makerere University) to make a direct contribution to reducing the 'treatment gap' not only in the five PRIME countries, but also in other low resource settings.

LEADERSHIP



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