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ADDRESSING THE GROWING NCD BURDEN AMONG WOMEN AND CHILDREN

Integrating perinatal mental healthcare into maternal and perinatal services in low and middle income countries

Gergana Manolova and colleagues argue for a comprehensive approach to the challenge of treating perinatal mental health conditions in maternal, neonatal, and child health services

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Key messages

- One in five women experience a perinatal mental health condition, but historical neglect has resulted in limited investment in service provision and research in this area
- Integration of perinatal mental health care into maternal and child health services through task sharing is a widely accepted solution
- A number of factors hamper integration such as shortage and overload of health workers, lack of research on acceptability, feasibility and sustainability, and insufficient cultural adaptation of interventions
- A comprehensive stepped-care model for perinatal mental health care can make integration more achievable

Mental and maternal health are historically disregarded public health areas that have only recently received appropriate attention in the past 20-30 years.[1 2] In recognition of the detrimental effects of poor mental health, especially on women's lives and caregiving capabilities, perinatal mental health is now gradually being included in policy and clinical practice considerations for maternal, newborn, and child health around the world.

Pregnancy and the period of up to a year after birth, known as the perinatal period,[3] are times of heightened vulnerability for mental health conditions among women. Up to one in five women will experience a mental health condition in this time.[4 5] In low and .-middle income countries, the prevalence increases to more than one in three women.[6] Data indicate that one in 10 women globally experiences suicidal ideation and is at increased risk of suicide in the postpartum period.[7] Vulnerability to mental health conditions is higher in certain groups, such as female migrants, refugees and internally displaced people, women experiencing domestic or gender based violence, women living in poverty, and adolescent girls.[5 8 9]

Maternal and newborn care has largely centred on physical health, with a specific focus on newborn health outcomes.[1] But perinatal mental health conditions also pose risks to the mother-infant bonding process, preventing women from providing optimal care and stimulation to support their child's cognitive, psychosocial, and motor development.[10] Women with a perinatal mental health condition are more than twice as likely to give birth prematurely and 60% more likely to have babies with low birth weight, as shown by systematic review of middle income country studies published in 2020.[11] Research from low and middle income countries indicates that adverse outcomes for the child might be seen into childhood, increasing risks of cognitive, gross motor, socio-emotional and global development issues.[12]

Despite the convincing body of evidence of public health issues, there is still limited investment in service provision and research on perinatal mental health conditions. The investments made so far have not improved outcomes for women.[13]

Task sharing in perinatal mental healthcare

Low and middle income countries frequently face shortages of mental health professionals, with under 15 mental health workers per 100 000 population on average across low and middle income countries and less than 1 per 100 000 in low income countries. There is a severe discrepancy between the burden of mental health conditions and the availability of health workers.[14] There are not enough providers trained in maternal, newborn, and child health, which affects services' ability to identify mental health conditions, provide psychosocial interventions for their prevention and management, and make referrals.[15]

One approach to tackling the resource gap is task sharing, where non-specialist health practitioners are trained to deliver specific activities. This can be successfully used in perinatal mental healthcare.[16] Under this model, community health workers and maternal, newborn, and child health providers are trained and supervised by mental health specialists to deliver psychosocial interventions in primary and community care. The Mental Health Gap Action Programme , developed by the World Health Organization (WHO) for integration of mental healthcare into primary care, has been used for training of non-specialist health providers to increase access to perinatal mental healthcare in a variety of settings.[17]

Raviola and colleagues have described diverse implementation approaches to task sharing including balanced care, where an interlinked network of specialist workers share responsibility for care; collaborative care, which encourages self-management by the patient and using community resources; digital innovations to support screening, diagnosis, and treatment; and staged interventions,

which look beyond the binary of "case versus non-case."[16]

In the practical application of task sharing, it is important to consider the systemic effects on healthcare planning and increased workloads. Heavy workloads or lack of time have repeatedly been identified as barriers to the delivery of mental health services by maternal, newborn, and child healthcare providers.[15]

Providing an integrated service

Lack of evidence from research and implementation hamper policy adoption and practical integration of interventions for perinatal mental health into maternal, newborn, and child health services.[13]

Economic modelling studies in high income countries overwhelmingly support the economic effectiveness of integrated care models for perinatal mental health, which involve the provision of screening for perinatal mental health problems and low intensity treatments by midwives and health visitors in collaboration with primary mental health services.[18] Specific evidence from low and middle income countries, however, is missing and needs to be urgently generated across settings to examine the best solutions for integration and to identify policy needs.

Several steps can be taken to overcome the challenges of providing an integrated service. Universal assessment and basic support of all women in prenatal and postnatal care can help reduce women's avoidance of care services because of stigma. A recent review of evidence, summarising results from 3654 participants from Hong Kong, Sweden, and the United States reported that women undergoing screening for depression in communities or health settings were nearly four times as likely to seek treatment (odds ratio 3.74, 95% confidence interval 2.14 to 6.52, n=1082).[19] A supporting approach on its own was found to be therapeutic when conducting screening for perinatal depression in communities.[20]

Importantly, those carrying out screening for mental health conditions must be trained in active listening and empathic approaches and show openness to emotional issues and ability to validate women's feelings.

A stepped care approach can help overloaded maternal, newborn, and child health services with limited resources to deliver perinatal mental healthcare. In the stepped care model, most people receive less resource intensive evidence based interventions, while more complex cases are referred to specialist services when necessary.[21] Interventions that require more resources, such as longer term counselling and prescribing medication, are then provided to those with higher mental healthcare needs by healthcare workers with more training and responsibility. It is important to note that appropriate training and supervision by specialists are vital to the success of the stepped care model.[21] A multicomponent package of perinatal mental healthcare provided through a stepped care approach includes interventions for mental health promotion and prevention of mental health conditions during the perinatal period and identification of mental health conditions and treatment.

An example of a multicomponent intervention for perinatal mental health is the Thinking Healthy Programme, a psychosocial intervention to be applied by community health workers for women with depression, which considers separately the woman's wellbeing, her relationship with her newborn baby, and her relationships with others around her.[22] The Thinking Healthy Programme emphasises empathy, communication skills, and principles of cognitive behavioural therapy for psychosocial management. There is excellent evidence for this programme, and its success depends on eight important pillars ensuring the success of these programmes (fig 1). Ensuring consistent financing, effective policy making and legislation, and multi-stakeholder involvement is essential for such programmes to work effectively.

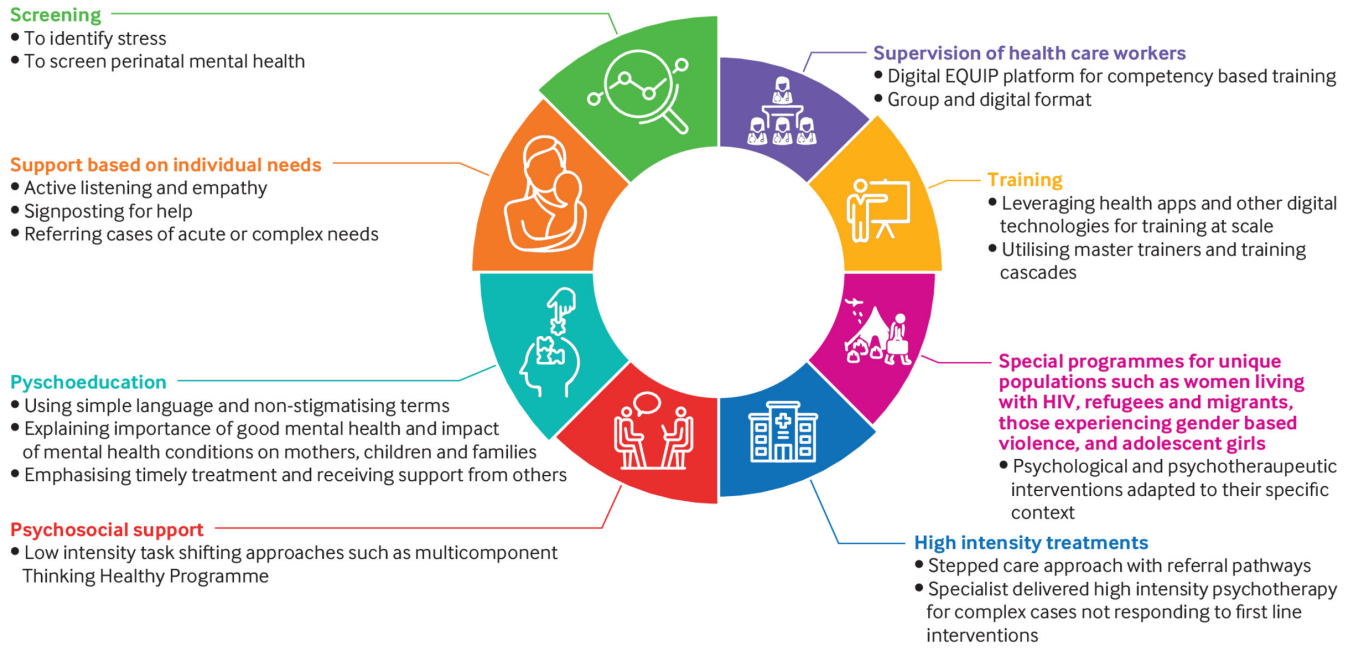

Fig 1 | Pillars for integration of perinatal mental health

The need for integration between perinatal mental health services and child health services was underscored in the WHO guideline on early childhood development, with the recommendation that psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.[23] A systematic review of 17 studies on maternal outcomes of anxiety and depression found significant improvement in symptoms from interventions such as psychoeducation, cognitive

behavioural therapy, interpersonal therapy, and others; effect sizes were also greater for multicomponent interventions.[23] The review also noted insufficient information on implementation, barriers and, resourcing, as well as a dearth of interventions based in the community.[23]

How can the neglect of perinatal health be tackled?

A focus on low and middle income countries

Existing evidence, particularly on barriers to integration, remains overwhelmingly based on studies conducted in high income countries. More research and better data from low and middle income countries are needed on various aspects of perinatal mental health conditions. Quantitative research is needed to learn more about the prevalence of perinatal mental health conditions across settings to design appropriate public health responses. Qualitative research should be used to understand specific risk pathways, investigate the feasibility and acceptability of interventions to health workers and women, and explore the ways in which psychosocial distress in the perinatal period manifests, depending on the cultural context.

Implementation research

There is a need to conduct implementation science research in low and middle income countries exploring innovative ways to tackle the burden of perinatal mental health conditions, evaluating existing services, and assessing sustainability of scale-up efforts. There are multiple factors that might reduce the effectiveness of interventions described in experimental trials when implemented in real world settings. Maselko and colleagues referred to "voltage drop" (the intervention loses some degree of its potency (or fidelity) when moving from efficacy to effectiveness in the real world) and "programme drift" (the intervention deviates from its manualised or implementation protocols)" in their study of a peer delivered intervention for maternal depression in Pakistan.[24] Dissemination of lessons learnt from adaptation and implementation efforts on how to use interventions and ensure maximum flexibility, while retaining fidelity of interventions, will help to strengthen and streamline delivery.

Acceptability for women and their families

Equally important to effectiveness, interventions should be attractive to women and their families, using screening methods and treatments that are culturally appropriate in the specific setting. The active involvement of potential end users is required to develop and adapt the methods and interventions, using co-creation and participatory design.[25] Sensitivity to the cultural aspects of a particular group is valuable whether interventions are taking place in a low or high income country.[25 26] Taylor Salisbury and colleagues successfully partnered with adolescent girls and young women and their families as well as other key stakeholders in Mozambique to co-design an intervention to support the perinatal mental health of girls and young women.[27] In the process, the young women and their families identified their priority challenges and discussed ways to tackle them, resulting in an outline intervention aimed to achieve greater acceptability, feasibility, and sustainability. Such an attentive approach to design, applied locally, would result in richly varied intervention modalities, including peer delivery, self-help groups, culturally specific activities, and more.[25 28]

There are still unanswered questions on how integrated services can be delivered. Research can also provide evidence on barriers and facilitators to scale up interventions in specific (low and middle income) settings, information about the culture, context, existing policies, systems, resources, local needs, and the demand for perinatal mental health care, as well as what exists already to meet the demand. This will ensure that the interventions are tailored to the local context, are consistent with government guidelines, build on available resources—institutional, cultural, and community—and meet the identified needs. This kind of planning ensures community engagement and sustainability. The WHO guide for integration of perinatal mental health in maternal and child health services provides information about what steps can be taken to plan for integration of perinatal mental health care and for assessing its effects.[29]

Conclusion

Adding mental health support, screening, and low intensity interventions, which are culturally appropriate and acceptable to specific settings, to a package of universal health coverage for maternal, neonatal, and child healthcare can reduce perinatal mental health morbidity and improve newborn and child health outcomes. There are many strategies to navigate the challenges of integration. The urgency of the unmet burden of perinatal mental health conditions demands that we put these strategies into action.

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