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Review Article

A lead for integration of perinatal mental health in maternal and child health services

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ABSTRACT

Life altering moments like pregnancy, birth, and early parenthood can be stressful for women and their partners. As a result, women may undergo a period of poor mental health or witness a worsening of previous mental health or witness a worsening of previous mental health condition. Almost 1 in 5 women will experience a mental health condition during pregnancy or in the year after birth. Among women with perinatal mental health condition, 20% will experience suicidal thoughts or undertake acts of self-harm. Ignoring mental health not only risks women's overall health and wellbeing, but also impacts infant's physical and emotional development. This article is based on a comprehensive literature search conducted on 22 February 2023, in the Medline and Cochrane databases, utilizing the medical topic headings (MeSH) and a combination of all available related terms, according to the database. To prevent missing any possible research, a manual search for publications was conducted through Google Scholar, using the reference lists of the previously listed in papers as a starting point. I looked for valuable information in papers that discussed information about the classification, pathophysiology and principles of therapy of shock. There are no restrictions on date, language, participants, age, or type of publication.

Keywords: Perinatal mental health, Maternal and child health, Perinatal depression, Anxiety disorders, Post-traumatic stress disorder

INTRODUCTION

Many women experience changes in their mental health during the perinatal period. Poor mental health can negatively affect women's health and wellbeing of their babies and families. Equally, poor health or difficult circumstances in the lives of women, their babies and families can negatively impact women's mental health. Maternal and child health (MCH) services during the perinatal period a unique opportunity for service providers to connect with women and provide support.[1]

Most women require low-intensity mental health support that can be provides in MCH services. For example, they may be given information about the management of stress and use of support from friends and family. Some women may experience mental health difficulties over a longer period, and they will require additional support either in MCH services or by specialized mental health care providers through referral, when possible.[2]

Women with perinatal depression and anxiety disorders, occurring during pregnancy and 1st year after the delivery, are at risk of obstetric complication and poor infants' outcomes. This includes low birth weight, pre-eclampsia, pre-term delivery, inadequate perinatal care, poor nutrition, increased substance abuse, suicide, disruption of maternal-infant bonding and attachments and in severe cases, infanticides. Offspring are at further risk of behavioural emotional, cognitive, language and motor and

development challenges with current evidence spanning from infancy through adolescence.[2]

It is estimated that up to 1 in 4 women are affected by clinically significant perinatal mood and anxiety disorders and many more experiences less severe symptoms of poor mental health. If not addressed, these symptoms and disorders may cause lasting harm to mothers, babies a family.[2]

There are several papers, books and guide were written for programme managers, health service administrators and policy makers responsible for planning and managing services for women and infants during the perinatal period who wish to integrate mental health care into MCH services or strengthen existing service provision. They include clinical managers and health services administrators at hospitals, districts and primary health facilities and in non-governmental organizations (NGOs) and community -based organization that provides MCH services, it will also be a useful resource for health care providers and allied health professionals.[3]

It has several sections to understand the perinatal mental health in MCH services: perinatal mental health (what is it and why it is important), provision of care, integration of programs, provision of care for specific needs, and monitoring and evaluation (ways to ensure that PMH services are effective).

Everyone has the right to good mental health and appropriate treatment. All women should benefit from health care that is respectful and free from abuse. Mental health is often understood as a spectrum, ranging from good mental health to day-to-day struggles and more severe mental health and psychosocial conditions.[3]

Frequency of perinatal mental health conditions

Pregnancy, birth and early parenthood may be stressful because they may change women's identity, physical health and economic situation. Perinatal anxiety and depression in the perinatal period are common, affecting an estimated 1 in 10 women in high-income countries) and one in five in low- and middle-income countries (LMICs), indicating the importance of support for PMH globally.

Women who already have mental health problems may find that their symptoms worsen during the perinatal period. Others may experience poor mental health for the first time during this period.[4]

Consequences

Worsening of a woman's mental health during the perinatal period may affect her well-being and that of her infant and family. Poor mental health is associated with higher risks of obstetric complications (e.g., pre-eclampsia, haemorrhage, premature delivery and stillbirth) and suicide. In addition, women may be less likely to attend antenatal and postnatal appointments. A woman's untreated mental health condition may lead to a poor birth outcome, such as low infant weight, and greater risks for physical illnesses and emotional and behavioural difficulties in childhood. Infants may also be at increased risk of difficulty in feeding and in bonding with their parents.[4]

Common symptoms

Poor mental health during the perinatal period may present in many ways. The symptoms may be general: feeling sad, crying easily or more than usual, finding no pleasure in experiences or activities that were once enjoyed lacking energy or motivation, worrying or "thinking too much", sleeping more or less eating more or less reduced concentration, difficulty in making decisions feelings of guilt or hopelessness feeling worthless, thinking that something bad is about to happen or that the future is hopeless thoughts of self-harm or suicide, and non-specific body aches and pains and other physical symptoms feeling troubled by memories or dreams about bad experiences.

Distinguishing everyday worries from clinically significant mental health conditions may be difficult, particularly during the perinatal period. A woman should be asked about how severe the symptoms are, how long they have been present and the extent to which they affect her ability to function in her daily life.[5]

Social determinants and other risk factors

Some women may be at greater risk of poor mental health during perinatal period because of external circumstances or other conditions. Services should be aware of such circumstances are explored in detail that a woman needs more intensive mental health interventions. Such circumstances are explored in detail in the WHO publications social determinants of mental health guide and maternal mental health and child health and development in low-and middle- income countries report.[5]

Examples of protective factors against poor perinatal mental health: strong social support Presence of caring family, friends and community, educational opportunities possibility of attending and completing schooling Opportunities for generating income ability to pay for essentials, opportunities for generating income ability to pay for essentials, and high-quality MCH services empathetic, competent health- care providers who treat women with respect and dignity.[3]

Availability of care

Routine screening and general psychosocial support from MCH providers are appropriate for all women in the perinatal period, ensuring that they feel able to discuss and manage their mental health struggles. More intensive or specialized treatment is appropriate for women with

longer-term, more severe mental illnesses. This is called the "stepped-care approach".[4]

Provision of care

Supportive environments

Supportive environments include reducing stigmatization of mental health conditions, and ensuring respectful care.

Promotion and prevention

Promotion and prevention include psychoeducation stress management, social support (including greater support by partners and family members), promoting functioning life skills, and recognizing mental health conditions.

Step 1: Promotion of good mental health

Provide respectful, non-stigmatizing care, promote PMH interventions for all women, and identify women experiencing mental health symptoms and women at greater risk of mental health conditions (e.g., adolescents, sex workers, women living with HIV, women experiencing violence).

Step 2: Preventive interventions for vulnerable women

Provide brief, evidence-based interventions in MCH services for women identified as having symptoms that do not meet the threshold for a mild mental health condition.

Step 3: Treatment of mental health conditions with mild symptoms

Provide brief, evidence-based psychosocial interventions in MCH services for women identified as having mild symptoms; and refer women whose symptoms do not improve to specialist care.

Step 4: Treatment of mental health conditions with moderate- to-serious symptoms

Treat serious mental health conditions by referral.

Promotion and prevention

Both promotion and prevention of mental health conditions can reduce physical and psychological distress and maintain human and financial resources for individuals, families, the health system and beyond.

Promotion of mental health includes supporting people in developing their personal skills or coping strategies and strengthening those they already have (e.g., protective factors). Promotion also includes creating environments to support mental well-being. These include social policies and strategies for creating employment, prevention and reduction of violence, supporting the education of women and girls and anti-discrimination initiatives. MCH providers can deliver mental health promotion and prevention interventions as a part of waiting-room talks, community outreach and perinatal and child health campaigns.[3]

Stress management

High levels of stress or constantly living in stressful conditions can affect physical and mental health. People naturally develop ways to deal with stress; however, some people may not realize when these strategies are helpful (e.g., speaking with a trusted friend, spending a quiet time in nature or in meditation or prayer, creative activities, exercise) and when they are unhelpful (e.g., using alcohol or drugs).

Using screening tools

Mental health screening involves asking women a series of standardised questions to identify whether they are likely to be experiencing a mental health condition. Screening can be administered by a trained community health worker, midwife, auxiliary nurse or other MCH service provider. Women who are literate can complete a screening tool herself. Any screening tool used should be adapted to the local context and culture and reflect the realities of women in the perinatal period. Screening should be done only when a mental health care pathway exists to assist women who may have a mental health condition.

Identifying risk factors for poor PMH

Social determinants and other factors are linked to increased risks for poor mental health. It may be useful to include questions to identify experience of violence, substance use, poverty, poor social support and other risk factors during consultations with women.

Treatment

The aim of psychological interventions without pharmacological treatment is to reduce or manage a person's mental health condition. There is growing evidence of a positive impact of psychological interventions for women attending MCH services.

All women with a suspected or diagnosed mental health condition should receive psychoeducation, information on ways to reduce stress and strengthen social support and encouragement to take part in daily activities that will support their mental well-being.

Conditions with mild symptoms

Brief psychological interventions for women in the perinatal period with suspected common mental health conditions such as depression or anxiety can be provided by trained MCH service providers. WHO has published manuals on use of the following evidence-based

interventions: thinking healthy (perinatal depression), problem management plus (PM+) (depression, anxiety and stress), group interpersonal therapy (depression), and self-help plus (SP+) (stress).

Conditions with moderate-to-severe symptoms

Severe mental health conditions include psychosis, bipolar disorder, suicidality and severe depression and are characterized by disordered thinking and behaviour. Women with moderate-to-severe mental health conditions have several symptoms of mental ill health that significantly affect their ability to engage in daily activities (including care of their infant), most of the time, on most days, for at least 2 weeks.

These conditions usually require more intensive interventions that are delivered or supervised by mental health specialists. Evidence-based interventions that may be provided if the resources are available are listed.

Integration of programmes

Steps for integrating PMH into maternal and child health services

Engage those important to funding, delivery and uptake, understand what mental health support is required and what is currently available, decide what support to provide, prepare a budget, assess progress towards service targets, adapt targets according to facility performance and outcomes, identify gaps in mental health provision, share progress and lessons with service providers, women and funders, plan, ensure that all women receive mental health support adapted to their need (a stepped-care approach), and provide all women with support that promotes good mental health.

Providing care for special needs

Some women are more vulnerable to mental health conditions during the perinatal period. Service providers should be aware of their needs, how to support them in MCH services and where to refer them for additional care. Women who have additional needs during pregnancy are likely to experience greater stigmatization and may struggle to engage with services for various reasons.

Substance use

Alcohol and drug use during the perinatal period can compromise the health and social lives of women and their infants. Women may use substances to deal with symptoms of mental ill health or difficult life circumstances. Substance use can affect their ability to function as a parent, decrease the likelihood of their accessing services and increase their risk of experiencing gender-based violence (GBV). As substance use during pregnancy is highly stigmatized, women are unlikely to disclose their use to service providers.

Self-harm or thoughts of suicide

Suicide is a leading cause of death among women. Depression is a major risk for suicide, and up to 20% of women with PMH conditions experience suicidal thoughts or self-harm. The risk is higher among adolescents. Thoughts and behaviour related to suicide include thoughts about suicide, planning suicide, and taking action to end one's life.

Suicidal thoughts do not always lead to plans to end one's life, although most suicides follow some warning signs. Some people have suicidal thoughts or behaviour without a previous mental health condition.[18]

Disability and physical illness

Women with a physical illness or disability may experience particular challenges and concerns about pregnancy, birth and parenting, which can cause greater stress and affect their mental health. Such women are also at a higher risk of stigmatization because of their health condition, which may worsen during the perinatal period. Health-care providers should ensure that services are accessible and inclusive for all women. These women must be able to make informed choices during their MCH care and feel that they have a say in their care.[8]

HIV/AIDS

Many women living with HIV learn of their status for the first time during pregnancy. The stress of living with HIV, including stigmatization and financial concerns, makes women vulnerable to depression and anxiety.

Adolescent pregnancy

Adolescents (aged 10–19) who become pregnant may face challenges such as stigmatization and difficulty in completing school and finding employment while caring for their children. They are particularly vulnerable to physical or sexual abuse. Pregnant adolescents are at greater risk of mental health conditions, particularly depression, than adolescents who are not pregnant and pregnant adults.

Domestic and gender-based violence

Domestic and gender-based violence (GBV) during pregnancy puts women, infants and others in the household in danger. The perinatal period may trigger violence and exacerbate existing abuse because of changes or strains that pregnancy or a new infant can create for a family. Violence increases the risks for miscarriage, infection, premature birth and injury or death of the baby.

Poverty

Women living in poverty lack the financial resources to maintain basic living standards such as ensuring food and

housing. Poverty increases the risk of mental health conditions, and mental health conditions may increase the risk of poverty.

Pandemics

Pandemics such as COVID-19 place stress on women in the perinatal period and their families, with a large increased risk for maternal depression and anxiety. The risk for GBV and intimate partner violence is also increased. As service providers may be redeployed during a pandemic, fewer face-to-face contacts may be possible.

As families spend more time in close contact, the risk of relationship stress is increased, which may cause anxiety and lead to abuse.

Family finances may deteriorate. Abusive partners may restrict access to money, health services and social support.

Women experience increased social isolation and restrictions on movement, which can lead to loneliness. This may be increased by controlling, abusive partners.

There may be less access to health-care services for women, such as abuse hotlines, shelters and crisis centres.[17]

Social isolation

Women with supportive partners, families and social networks are better able to cope with the stresses of parenthood. Feeling socially isolated may worsen women's mental health if they feel unable to cope with stresses in their lives. Women may feel isolated even when they live close to many other people. Women with mental health conditions during the perinatal period may also experience social isolation due to stigmatization of their condition. Some women may choose to isolate themselves if they fear judgement or feel discriminated against.[18]

Figure 1: Monitoring and evaluation.

Monitoring includes regular, planned collection of information to assess the integration of mental health care in maternal and child health services.

Evaluation is the review of information at certain times to assess the impact of mental health services.

M&E should include ways for women and MCH staff to provide confidential feedback on care.

Information about the provision of care can be collected in many ways, including surveys, interviews, feedback forms, and focus groups.

Some service providers may design and conduct a study to evaluate the service or part of the service. Health facilities or programmes may be able to attract researchers from NGOs or educational institutions to conduct external evaluations of the services, which may be quantitative or qualitative. An objective view from an external party of how the service is running can be helpful.[18]

Ensure that you engage stakeholders, so that everyone can agree on the indicators and how data will be collected and used. Plan joint meetings (every 6–12 months) to present and review data with the core planning team, MCH service providers and other stakeholders to strengthen collaboration and partnerships. Smaller, monthly meetings to review monitoring processes and data can be held in MCH services.[19]

LITERATURE SEARCH

This descriptive study explores perinatal mental health in MCH services. Literature search were conducted to identify paper on perinatal mental health in MCH services. Secondary sources have been used to collect the data, which includes: the study of books, journals, articles, published research papers, thesis and dissertations. The following key words were used; perinatal mental health, maternal and child health, perinatal depression, anxiety disorders, post-traumatic stress disorder.

DISCUSSION

In this study, we tried to cover all the available important literature related to perinatal mental health in MCH services. As we have studied in mhGAP operations manual. Geneva: World Health Organization; 2018, many women experience changes in their mental health during the perinatal period. Poor mental health can negatively affect women's health and wellbeing of their babies and families. Equally, poor health or difficult circumstances in the lives of women, their babies and families can negatively impact women's mental health. Maternal and child health services during the perinatal period a unique opportunity for service providers to connect with women and provide support.[7,8] Hence, it is vital to study about perinatal mental health.

A systematic review showed that of the 18% of women reporting depressed mood during pregnancy, 13% met the DSM-IV diagnostic criteria for a major depressive episode.[9,10] In a Japanese study, women (n=290) were assessed both antenatally and postnatally for the presence of DSM-III-R psychiatric disorders. About 12% of the women at pregnancy and postpartum, respectively, met the criteria for one of the following psychiatric disorders: major depressive disorder, manic episode, generalized anxiety disorder, social phobia, specific phobia and obsessive-compulsive disorder.[9]

A host of salient risk factors for antenatal psychological distress have been identified in the literature. Rich-Edwards et al in a US population study (n=1662) found that the strongest predictor for antenatal depressive symptoms was a past history of depression.[10] These findings were corroborated by studies from Canada and Brazil. Another cross-sectional analysis on a US sample (n=1522) found that domestic violence, drug use and medical problems was associated with a 3–4-fold increase in the odds of reporting stress during pregnancy.[11] A study from Japan found that 15 of the 279 respondents (5.4%) who reported domestic violence during pregnancy experienced significant sleep disturbances, anxiety and depression.[12]

The WHO postnatal care model places the woman-newborn dyad at the centre of care supported by quality care, family support and continued support from health services. Evidence from a qualitative evidence synthesis exploring what matters to women during the postnatal period shows that the postnatal period is generally a time of intense joy and happiness, while also characterised by marked changes in self-identity, the redefinition of relationships and opportunities for personal growth, as women adjust to parenthood as individuals within their own cultural context.

Positive postnatal experience

To enable the provision of the essential postnatal care package, the foundation of the model is the recommendation for at least four postnatal care contacts. First, ongoing care and monitoring in the first 24 hours after birth is essential, as part of continuous care in the health facility or home.

A minimum 24-hour length of stay following a facility-based vaginal birth is recommended to allow sufficient time to complete comprehensive maternal and new-born assessments, and to provide orientations for the transition of the woman and the baby to care in the home).

The second contact occurs between 48 and 72 hours after birth; the third between days 7 and 14, and the fourth during week six after birth. Postnatal care contacts can occur at home or in outpatient services.

Where feasible, the contact during the first week is recommended to occur at home, to allow the health worker to provide support in the home environment. The model recognises that additional contacts may be required depending on individual circumstances.

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