Maternal Mental Health in Africa

Conversations

A hybrid symposium: booklet

19 June 2024

St Antony's College
University of Oxford
&
online via Zoom

NUFFIELD DEPARTMENT WOMEN'S & REPRODUCTIVE HEALTH

UNIVERSITY OF OXFORD

University of Cape Town · iYunivesithi yaseKapa · Universiteit van Kaapstad ·

Africa Oxford Initiative

Perinatal Mental Health Project

Caring for Mothers. Caring for the future.

www.pmhp.za.org

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Summary

The Maternal Mental Health in Africa – Conversations symposium was held on 19 June 2024 at the University of Oxford.

This event was held at St Anthony's College Oxford, and online. It was hosted by the Nuffield Department of Women's and Reproductive Health, University of Oxford, as well as the Perinatal Mental Health Project, at the University of Cape Town.

Gracious co-hosts included the African Oxford Initiative, St Antony's College and African Studies Centre all at the University of Oxford, and partner organisations: the Global Alliance for Maternal Mental Health (GAMMH), the African Alliance for Maternal Mental Health (AAMMH) and Marcé Africa Maternal Mental Health Africa (MAMA).

We were thrilled to have so many join us for this day-long hybrid event - nearly 300 online registrants and about 40 in-person participants. We came together to engage in crucial conversations and shared groundbreaking research and practice relating to maternal mental health across the African continent.

Our symposium gathered voices and insights from over 20 African countries, highlighting the rich diversity and collective expertise present on the continent. With over 50 submitted abstracts to select from, it was a daunting task to choose the few that could feasibly fit into the one-day programme.

This booklet summarises the contributions of speakers at the symposium: it contains the abstracts of the presentations and short biographies of the speakers and convenors. Where available, we have added the slides of those who gave oral presentations.

The programme was organised around three key themes:

1. **Moving to Scale in Maternal Mental Health**: Exploring strategies and frameworks to expand effective maternal mental health interventions across diverse contexts.
2. **Working with Social Determinants in Maternal Mental Health:** Delving into the social factors that impact maternal mental health and discussing approaches to address these determinants.
3. **Sustaining Capacity in Maternal Mental Health:** Focusing on building and maintaining the necessary resources, skills, and systems to support maternal mental health initiatives over the long term.

In addition to the themed sessions, we offered a session highlighting key organisations that play a pivotal role in maternal mental health in Africa and globally. These organisations are vital resources for collaboration and support, and we encourage you to learn more about them and consider joining their efforts. More details are provided in this booklet.

Finally, a session on 'Ask the Experts' gave opportunity to engage directly with leading professionals in the field, ask questions, exchange and gain deeper insights into the topics discussed throughout the day.

The recording of the event, in separate sessions, can be found at this link

We are inspired and encouraged by the breadth and depth of work being carried out by colleagues in the field of maternal mental health. It is very exciting to witness the many collaborations that are emerging from the networking that took place on the day.

We extend our heartfelt gratitude to our speakers, contributors, administrative team, and participants for their dedication and enthusiasm.

We hope that the symposium will foster meaningful connections, spark new ideas, and strengthen our collaborative efforts.

Thank you for being part of this important journey. Together, we can create lasting change and support the mental health and well-being of mothers on the continent and elsewhere.

Warm regards,

Dr Nicole Votruba
Senior research fellow - Nuffield Department of Women's & Reproductive Health
Junior research fellow - Wolfson College
Honorary research fellow - George Institute for Global Health (UK), Imperial College London
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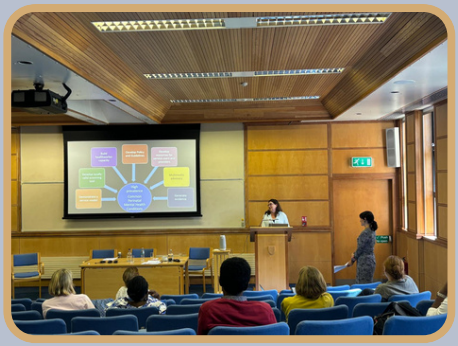
Alan J. Flisher Centre for Public Mental Health

Acknowledgements

We would like to extend special thanks to the following individuals and organisations who were instrumental in making the day a success:

- The Nuffield Department of Women's & Reproductive Health, particularly the Head of Department, Professor Krina Zondervan, who co-hosted with us; Lesa, Levett, Lesley Cockrem & Archie Buchanan for setup support., and to Mohammad Ali & Ashley Young for your invaluable logistical contributions on the day
- The PMHP team located at the Alan J Flisher Centre for Public Mental health based in Cape Town, South Africa specifically to our administrator Keesha James who played a pivotal role in the organisation of the symposium
- The African Oxford Initiative, David Kerr, Muhamed Hassan and Chimwemwe Manyozo for their invaluable technical and strategic support
- Professor William Beinart, alumnus of St Antony's College and Professor Miles Tendi, Director of the African Studies Centre who enabled us to use the beautiful facilities at the college
- Symposium convenors, Dr Tatiana Salisbury and Prof Carolyn Chisadza for so expertly facilitating sessions
- Symposium presenters for your invaluable contributions which were rich and inspiring
- Online and in-person participants who engaged and stimulated discussion throughout the day
- St Antony's College, Oxford for allowing us to use your venue, and especially, Pavlina Gatou, Priya Devi, Arun Prasath and the catering team.

with gratitude from Simone Honikman and Nicole Votruba



Symposium planning team

Assoc Prof Simone Honikman

Associate Professor Simone Honikman is a medical doctor with clinical experience in Paediatrics, Obstetrics & Gynaecology and Psychiatry. She has a Master's degree in Maternal and Child Health. She is the founding director of the 21-year old Perinatal Mental Health Project (www.pmhp.za.org) based at the Centre for Public Mental Health, University of Cape Town. Simone led the writing of the World Health Organisation WHO guide for integration of perinatal mental health in maternal and child health services, published in 2022.

She has received the international Ashoka Fellowship for Social Entrepreneurship and a fellowship through Africa Oxford Initiative. She has published 55 academic papers as well as book chapters, and editorials and a book. She runs a comprehensive mental health service integrated within a public midwife unit on the Cape Flats. Her maternal mental health research includes topics related to gender based violence, health economics, musical interventions and mobile training applications. She designs and conducts training for a wide range of healthcare and social service providers and is involved in developing films and other multimedia resources to support knowledge translation and capacity building. She consults to national and provincial health policy, guideline and programme processes within South Africa and supports others' research, advocacy and training work on the African continent and in other low-and-middle-income settings.

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Dr Nicole Votruba

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Dr Nicole Votruba is a senior research fellow at the Nuffield Department of Women's & Reproductive Health at the University of Oxford, and group lead of the Global Women's Mental health & Equity group. She is PI of the PRAMH study (MRC UK), a community-based perinatal mental health intervention, which is implemented in rural India in collaboration with the George Institute India. She is leading the process evaluation of the SMARThealth Pregnancy programme, and is co-lead of the multi-country Indigo Local study, developing a community anti-stigma campaign.

Nicole is a psychologist, holds a degree in political science and international law, is a junior research fellow at Wolfson College Oxford, and honorary research fellow at the George Institute for Global Health (UK), Imperial College. She is executive secretary of the charity Human Rights in Mental Health-FGIP. She completed her PhD at the IoPPN, King's College London, developing a framework for mental health science-policy priority setting in low- and middle-income countries (EVITA 2.0). She has worked on a number of global mental health research studies, as policy officer of the UK All-Party Parliamentary Group on Global Health, in the EU Parliament, and as coordinator of the FundaMentalSDG initiative for mental health in the UN Sustainable Development Goals. Her research interests are improving global women's mental health and equity, interventions to reduce stigma and discrimination, implementation science, and human rights for people with mental health conditions.

Symposium planning team

Dr Chimwemwe Manyozo

Dr. Chimwemwe John Paul Manyozo is a Chartered PR and Communications practitioner and researcher with extensive experience in Europe and Africa. His illustrious career includes significant roles at the University of Oxford, World University Services of Canada, UN Women, the British Council, Jesuit Refugee Services, and UNDP. In these roles, he has consistently led successful communication and development initiatives. As Lead Researcher at Mhub, Dr. Manyozo conducted a crucial study on the innovation and entrepreneurship ecosystem, contributing to the $350 million compact by the Millennium Challenge Corporation to the Government of Malawi. In his role as a Communications Consultant for UN Women, he enhanced the visibility of the €500 million UN and EU Spotlight Initiative in Malawi. At Oxford, he manages the internal and external communications for the Africa Oxford Initiative. Dr. Manyozo holds a PhD in Developmental and Educational Psychology from Central China Normal University, obtained as a Chinese Government Scholar. His Doctoral research focused on the mentoring experiences of refugee youth. He also earned an MA in Development Studies from the University of Sussex as a Chevening Scholar and a BA in Media for Development from the University of Malawi.

Dr David Kerr

Dr David Kerr is the Head of Programmes at the Africa Oxford Initiative (AfOx), University of Oxford. David is responsible for managing AfOx programs and supporting the development of partnerships with universities and research institutions in Africa. He is also a Research Associate at the University of Johannesburg and Honorary Research Fellow at the University of Bristol.

Keesha James

Keesha is the Administrative Assistant for the Perinatal Mental Health Project (PMHP).She has a strong academic background and a passion for promoting mental health, particularly within the context of higher education and women's well-being in South Africa. She holds a Bachelor of Science in Human Life Sciences and an Honours degree in Psychology from Stellenbosch University, and is currently pursuing her Master's degree with a focus on student mental health in the higher education environment.

Programme

9:00-9:30 **Arrival with tea and coffee**

9:30-9:45 **Welcome**

Nicole Votruba, NDWRH, University of Oxford &
David Kerr, Africa Oxford Initiative (AfOx), University of Oxford

9:45-11:25 **Moving to scale in maternal mental health**

Convenor: Simone Honikman, University of Cape Town, South Africa

- **Keynote by World Health Organization**, Neerja Chowdhary (WHO Geneva) Julius Muron (WHO Africa), Catherine Waweru (Ministry of Health, Kenya), Alicia Alicia Carbonell (WHO Mozambique), Erasmus Mndeme (Ministry of Health, Tanzania) **Improving outcomes for women and children: Integrating perinatal mental health into maternal and child health services** (V)
- Bibilola Oladeji (University of Ibadan, Nigeria) **Integrating mental health into routine perinatal service in primary care in Oyo State, Nigeria- moving from research to practice** (V)
- Anteneh Asefa (Institute of Tropical Medicine, Belgium) **Integrating perinatal mental health into maternal and child health services: perspectives from policy and implementation** (IP)
- Musa Krubally and Katie Rose Sanfilippo (City, University of London, UK) **Strategies for spreading and scaling complex perinatal mental health interventions in Low and Middle-Income Countries – A scoping review and thematic synthesis** (IP)

11:25-11:45 **Break**

Programme

11:45-13:15 Working with social determinants in maternal mental health

Convenor: Prof Carolyn Chisadza, University of Pretoria, South Africa

- Caroline W. Wainaina (African Population and Health Research APHR Center, Kenya, University Medical Center, Netherlands) and Estelle Sidze (APHR, Kenya) **Women's empowerment and maternal mental stress: exploratory study in Rural Kenya** (IP)
- Mona Bormet (MOMENTUM Country and Global Leadership, Kenya) **Engaging faith communities on maternal mental health** (V)
- Sarah Mlambo (Welwitchia Health Training Centre, Namibia) **Indigenous Knowledge Systems as a social determinant for the improvement of maternal mental health outcomes** (V)
- Josephine Akellot (Virjie University, Netherlands) **The evolution of a maternal mental health program for conflict-affected populations in Uganda** (V)
- Victoria Mutiso (Africa Mental Health Training and Research Foundation Kenya) **Intimate Partner Violence: A risk factor for Postnatal Depression in rural Kenya** (V)

13:15-13:30 Organisations to join

Introductions and invitations

- Alain Gregoire **Global Alliance for Maternal Mental Health** (V)
- Dalitso Ndaferankhande **African Alliance for Maternal Mental Health** (V)
- Lavinia Lumu **Marcé Africa Maternal Mental Health Africa** (V)

13:30-14:15 Informal lunch and networking

14:15-15:30 Sustaining capacity in maternal mental heath

Convenor: Tatiana Salisbury, King's College, London, UK

- Fernando Chissale (Centro Internacional para a Saúde Reprodutiva-Moçambique) **Involving Adolescents Girls and their Communities in the Development of a Perinatal Mental Health Intervention In Mozambique** (V)
- Kantoniony (Kanto) Rabemananjara (George Washington University, USA) **Perinatal Mental Health in Madagascar: Collaboration and Research Insights** (V)
- Saara Hatupopi (University of Namibia) **Development of guidelines to manage perinatal depression in Namibia** (V)
- Svetlana Karuskina-Drivdale (PATH Mozambique) **High feasibility, low effectiveness? Lesson from integration of perinatal depression management in routine maternal health services in Mozambique** (V)

15:30-15:45 Break

Programme

15:45-16:45 Perinatal mental health clinic - ask the experts

Convenor: Nicole Votruba, University of Oxford

Panel

- Linos Muvhu (Society for Pre and Post Natal Services, SPANS, Zimbabwe) **Developing and embedding a family therapist cadre into the health system in Zimbabwe** (V)
- Jullita Kenala Malava (Malawi Epidemiology and Intervention Research Unit, Malawi) **Perceived implementation challenges in Malawi for integration of common perinatal mental disorders screening and management into routine maternal and child health services among stakeholders in Northern Malawi: a mixed methods formative study** (V)
- Wendy Janssens (Vrije Universiteit, Netherlands) **Acceptability and feasibility of a group-based mental health intervention for pregnant women in Kenya** (V)
- Simone Honikman (University of Cape Town, South Africa) **The Perinatal Mental Health Project (PMHP): tackling the issue from many angles** (IP)
- Haliq Adam (Catholic Relief Services, Ghana) **Lessons Learned in the Implementation and Validation of the Integrated Mothers and Babies Course to Prevent Perinatal Depression in Sub-Saharan Africa** (V)

16:45-17:00 Closure

Simone Honikman and Nicole Votruba

Convenors

Theme 1: Moving to scale in maternal mental health

Assoc Prof Simon Honikman

See more on page 7

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Theme 2: Working with social determinants in maternal mental health

Prof Carolyn Chisadza

Prof. Carolyn Chisadza is an associate professor in Economics at the University of Pretoria in South Africa. She holds a BSc (Honours) in Economics from the University of Zimbabwe, and a BCom (Honours), MCom and Ph.D. in Economics from the University of Pretoria. Her research focusses on development issues related to inequality, conflict and quality of institutions (i.e. gender, ethnic, democratic and historical) within Africa. Her research papers have appeared in the top academic journals and peer reviewed edited books (https://sites.google.com/view/carolyn-chisadza/home). Carolyn has also collaborated with national and international organisations, such as The Lancet Commission on peaceful societies through health and gender equality (https://doi.org/10.1016/S0140-6736(20)30158-6). She is currently a research fellow at the University of Oxford under the AfOx initiative.

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Convenors

Theme 3: Sustaining capacity in maternal mental health

Dr Tatiana Taylor Salisbury

Dr Tatiana Taylor Salisbury is a Reader in Global Mental Health and Design at King's College London. She also acts as Deputy Director of the Centre for Global Mental Health, and Co-Director of the World Health Organization Collaborating Centre for Research and Training in Mental Health at King's. She is currently a UK Research and Innovation Future Leaders Fellow. Her fellowship blends human-centred design, systems thinking and implementation science to develop development of scalable and sustainable solutions to address adolescent perinatal mental health in Kenya and Mozambique. Tatiana's other interests include integrating mental health into physical health services, operationalising good quality mental health care, engaging communities in intervention development and service delivery through which she collaborates with UN agencies, national governments and NGOs.

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Perinatal mental health clinic - Ask the experts

Dr Nicole Votruba

See more on page 7

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Theme 1: Moving to scale in maternal mental health

World Health Organisation Keynote

Improving outcomes for women and children: Integrating perinatal mental health into maternal and child health services

Neerja Chowdhary, WHO Geneva

Dr Neerja Chowdhary is a technical officer in the Department of Mental Health, Brain Health and Substance Use in WHO headquarters (HQ). A psychiatrist by training, she works in the Brain Health team. Her role includes the development of normative tools and guidance to support integration of mental, neurological and substance use conditions. For example, resources linked to WHO's mhGAP programme aimed at building the capacity of nonspecialist health workers to provide quality mental health care. Neerja is the focal point for perinatal mental health and works closely with colleagues across WHO departments at HQ, regional and country offices to support country implementation of WHO guide for integration of perinatal mental health in maternal and child health services.

Catherine Wanjiku Waweru, Ministry of Health Kenya

Dr Catherine Wanjiku Waweru is a psychiatrist within the Division of Mental Health within the Ministry of Health in Kenya. She leads the unit of mental health standards and guidelines and is also secretary to the subcommittee for mental health standards and guidelines. One of her priority areas is integration of mental health into other health sectors such as maternal and child health.

Alicia Carbonell, WHO Mozambique Country Office

Dr Alicia Carbonell is a technical officer for Reproductive/Maternal, Neonatal, and Child Health at the WHO offices in Mozambique. She is a medical doctor with specialization in gynaecology and obstetrics with more than 20 years of experience in public health in maternal, neonatal, and child health programmes. Her professional experience has included supporting the MoH in strengthening priority health programs (maternal, new-born and child health, PMTCT) at various levels of the health system in Mozambique, teaching in Health Training Institutions, as well as supporting the development of strategic documents across the continent, including Equatorial Guinea, Guinea Bissau and Cape Verde.

Erasmus Mndeme, Ministry of Health Tanzania

Dr Erasmus Eliakimu Mndeme is a psychiatrist based within the Ministry of Health in Tanzania. Throughout his career, Dr Mndeme has held various clinical and teaching roles, including Clinical Coordinator and Clinical Head at Muhimbili National Hospital, as well as serving as the Director General of Mirembe Hospital. He has lectured at Dodoma Institute of Health and Allied Sciences and Muhimbili University of Health and Allied Sciences.

Julius Muron, WHO Regional Office for Africa

Dr Julius Muron is a psychiatrist and consultant with the WHO Special Initiative for Mental Health in the African Region. He has experience providing technical expertise during the recent Ebola outbreaks in West Africa and Uganda, preparedness planning in Rwanda and conflict in Northern Ethiopia. In addition to expanding community based mental health services, Julius has also contributed to the Uganda Mental Health Act of 2019. Through his work he has advanced the training of persons with lived experience to increase their participation in mental health service design and delivery.

Virtual presentation

Improving outcomes for women and children: Integrating perinatal mental health into maternal and child health services

Bibilola D. Oladeji, Olatunde Ayinde, Oye Gureje
Affiliations: Department of Psychiatry, College of Medicine, University of Ibadan and WHO Collaborating Centre for Research & Training in Mental Health, Neurosciences & Drug & Alcohol Abuse, Department of Psychiatry, College of Medicine, University of Ibadan

The gap between research and practice is well documented; with just about 50% of evidence-based practices implemented in real world settings. A major reason for the gap is the traditional linear research-to-implementation pathway where evidence is first generated by researchers before being transferred downstream to real-world intervention implementers. Recently, there have been calls for an approach that integrates research and implementation from the beginning. This presentation will draw on our experience with an implementation research project funded through the Innovating for Maternal and Child Health in Africa (IMCHA) initiative. The research project, titled Scaling-up Care for Perinatal Depression (SPECTRA), was designed to study the factors that may impede or facilitate the routine delivery of evidence-based intervention for perinatal depression by front-line health workers in Nigeria using the WHO mental health gap action implementation guide (mhGAP-IG).

The research design was based on the consideration that a more feasible and sustainable approach to expanding evidence-based maternal mental healthcare is to equip more senior and experienced primary care providers with the skills required to train and supervise their junior colleagues who routinely provide maternal and child health services to deliver care for perinatal depression with mental health specialists providing support.

A key innovation of the IMCHA studies was the involvement of policy makers at every stage of the research process. In the context of SPECTRA, the most relevant policy maker was the Executive Director of the State Primary Healthcare Development Board who had oversight function for the primary healthcare system in the state. This policy maker was embedded into the research team as a co-principal investigator (Co-PI) and, in that role, was a part of the design and conduct of the programme and participated in all investigator meetings.

The innovative project organization resulted in the development of a structure to facilitate the sustainable integration of mental health services in routine maternal primary healthcare in the state. The structure included the appointment of a senior primary healthcare worker as the first coordinator for mental health and the subsequent designation of focal health workers to oversee mental health service delivery at each local government area.

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Speaker: Dr Bibilola Oladeji

Dr Bibilola Oladeji (MBBS, MSc, FWACP) is a Senior Lecturer, College of Medicine, University of Ibadan, and a Consultant Psychiatrist to the University College Hospital, Ibadan and a former Head of the Department of Psychiatry. She has close to two decades of research and clinical experience in adult psychiatry and currently heads the general adult and maternal mental health unit. Her main research interests are in Psychiatric Epidemiology and Implementation Science with a special interest in integrating mental health services in primary healthcare including maternal and child healthcare and HIV clinical and support services. She has been involved with exploring the integration of mental health care with primary and maternal and child health care using a task sharing approach with funding from the Fogarty International Centre, National Institute of Mental Health, Grand Challenges Canada and the IDRC. In the context of her research and clinical work, she provides mentorship to psychiatry trainees and junior faculty and has trained hundreds of frontline non-specialist healthcare providers to identify and provide evidenced based care for common mental disorders in primary and secondary care.

Presentation in-person

Integrating perinatal mental health into maternal and child health services: perspectives from policy and implementation

Anteneh Asefa, Bruno Marchal, Samson Gebremedhin, Alexandre Delamou, Lenka Benova

Background: The burden of perinatal mental health conditions in Africa is substantial, with individual-level to societal impacts which can impede the achievement of the Sustainable Development Goals. While perinatal depression carries an important share of perinatal mental conditions, there is a significant unmet need for measures to address it.

Methods: Drawing on a mixed-methods research in Ethiopia and Guinea (longitudinal survey of 850 pregnant and postpartum women, 25 in-depth interviews with women who experienced perinatal depression, and 25 interviews with health system informants) and critical analyses of existing evidence, we report on complex health system bottlenecks to promoting perinatal mental health and propose policy and implementation considerations. Data were analysed using the theoretical framework of complex adaptive systems to identify key system hardware and software bottlenecks.

Results and discussion: In Ethiopia, Guinea, and other similar settings in Africa, perinatal mental health is barely integrated into maternal and child health services. This challenge is compounded by interconnected issues, including underinvestment in health systems, staff shortages and heavy reliance on task-shifted maternal (mental) health services, lack of training on perinatal mental health, lack of continuity of care, diverse sociocultural expectations of care, and societal factors, such as high levels of gender-based violence, and low awareness and stigmatisation of people with mental conditions. To overcome these system and societal bottlenecks, the design and implementation of perinatal mental health interventions should be (re)imagined based on the tenets of woman-centred approaches, by integrating perinatal mental health interventions into maternal health services at the macro-, meso-, and micro-levels of health systems. We propose this should be approached simultaneously from a bottom-up perspective by testing the effectiveness of context-appropriate models, and a top-down approach, by designing and implementing actionable policies and strategies and ensuring political and administrative commitment. At the meso-level, incorporating mental health modules in in-service training and mentorship of frontline health workers and leveraging resources to forge perinatal mental health interventions at the community level is vital to improve early prevention, detection, and early referral of perinatal mental health conditions. Given the very high levels of burnout among health workers in under-resourced health systems, caring for health workers and their mental health is also critical.

Conclusions: Despite the challenges, there are proven and cost-effective and system-oriented interventions which can avert the burden of poor perinatal mental health in Africa if supported by political support, context-adapted policies and strategies, intersectoral collaboration, community engagement, and ongoing research.

Speaker: Anteneh Asefa

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Anteneh is a health systems researcher with expertise and interest in global health, particularly implementation research aimed at ending preventable morbidity and mortality in low-resource settings. He completed his MPH at Addis Ababa University and his PhD at the Nossal Institute for Global Health, University of Melbourne. His PhD research involved implementation research to promote respectful maternity care in Ethiopia, using the theoretical framework of complex adaptive systems. Prior to joining the Institute of Tropical Medicine, Antwerp in 2021, Anteneh worked as a lecturer and research associate at the University of Melbourne and as an assistant professor at Hawassa University. Anteneh has been selected as a Fellow of the US Department of State's Mandela Washington Fellowship for Young African Leaders; the Emerging Voices for Global Health; the Harvard School of Public Health's Maternal Health Young Champions; the Population Reference Bureau's Policy Communication Fellows Program; and the World Health Summit's New Voices in Global Health Program. Currently, Anteneh is the PI of a project examining the link between disrespect and abuse during childbirth in health facilities and postpartum depression, and exploring health system capacity to improve respectful maternity care and maternal mental health services in urban settings in Ethiopia and Guinea.

Integrating perinatal mental health into maternal and child health services: perspectives from policy and implementation

Anteneh Asefa (PhD)
Department of Public Health
Institute of Tropical Medicine, Antwerp

Maternal Mental Health in Africa – Conversations
Oxford, United Kingdom
June 2024

In this presentation

- A brief overview of MISPOD Study
- Key findings
- Policy and implementation perspectives

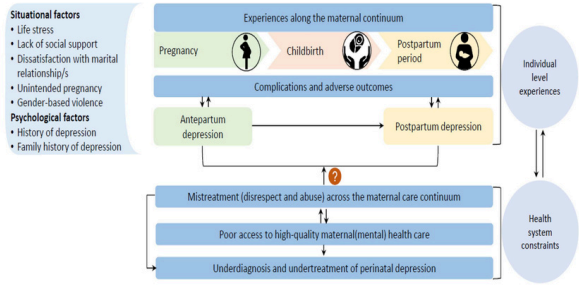
MISPOD Study

Research element	Study 1 (Quantitative)	Study 2 (Qualitative)
Research objective	To estimate the independent association between mistreatment of women during facility-based childbirth and postpartum depression in urban settings in Ethiopia and Guinea	To examine the integration of respectful maternity care and maternal mental health in maternal health services in urban Ethiopia and guinea
Research questions (RQ)	**1.1)** What is the prevalence of depression during pregnancy and the postpartum period among urban women in Ethiopia and Guinea? **(RQ 1.1)** **1.2)** What is the prevalence of mistreatment during facility-based childbirth among urban women in Ethiopia and Guinea? **(RQ 1.2)** **1.3)** What is the association between the mistreatment of women during facility-based childbirth and postpartum depression in Ethiopia and Guinea? **(RQ 1.3)**	**2.1)** To what extent is respectful maternity care integrated in maternal health services in urban Ethiopia and Guinea? **(RQ 2.1)** **2.2)** To what extent is maternal mental health integrated in maternal health services in urban Ethiopia and Guinea? **(RQ 2.2)** **2.3)** What challenges exist in the promotion of maternal mental health services in Ethiopia and Guinea? **(RQ 2.3)** **2.4)** What are the experiences of women in accessing care and support for postpartum depression in Ethiopia and Guinea? **[Optional]**
Methods	**1A.** Survey of women in their third trimester of pregnancy **1B.** Survey of postpartum women	**2A.** Literature and document review **2B.** In-depth interviews with key stakeholders across the health system **2C.** In-depth interviews with women who recovered from postpartum depression
Why is this important?	Understanding the prevalence of depression both during pregnancy and during the postpartum period allows to have a close estimate of how prenatal depression and mistreatment during childbirth act as risk factors for postpartum depression	Understanding the dynamics of respectful maternity care and maternal mental health provision is crucial to inform action aimed at • Designing interventions to improve positive pregnancy and childbirth experience, and thus, improving maternal mental health • Early identification and treatment of poor maternal mental health
Sequencing of studies*	PHASE I	PHASE II

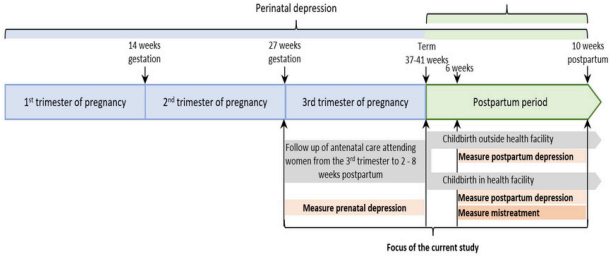
Preliminary analysis of data from PHASE I

Data analysis, integration of findings from PHASE I and PHASE II

Framework – MISPOD Study



Quantitative approaches



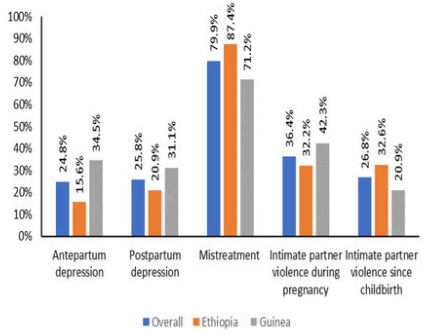
MISPOD - in numbers

Study component	Ethiopia	Guinea
Survey of Pregnant women	442	417
Follow up survey of women in the postpartum period	373	338
In-depth interviews with women in the postpartum period	25	25 – in progress
In-depth interview with health system informants	23	25 – in progress
Health facilities included	22	20
Research assistants involved (all female)	8	6

MISPOD – longitudinal survey

- Variables measured
  - Sociodemographic characteristics
  - Social support
  - Obstetric profiles and complications
  - Social support
  - Intimate partner violence – DHS questionnaire
  - Antepartum & postpartum depression – EDPS ≥ 11
  - Mistreatment during facility-based childbirth

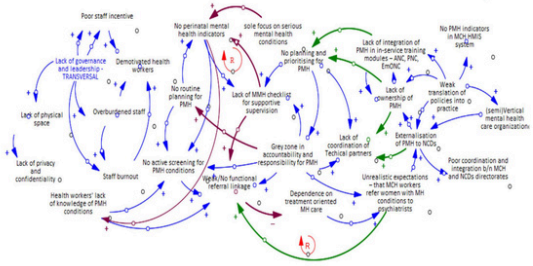
Key findings – surveys



Adjusted OR (Mistreatment vs Postpartum depression): **2.28**

Contributors to poor PMH integration – Ethiopia

Micro level – Health facilities | Meso level – Sub-city and city health departments | Macro-level Ministry of Health



"...Because of the living conditions and the salary we are paid is not enough, we carry a lot of burden in our lives and they [health workers] are trying to survive and that leads to a big change in their [health workers'] behaviour. That is the main reason for them to change their [health workers'] behaviour. It means that it is not just them [women] who are experiencing mental health challenges, it is us too.."

Head of MCH Unit, Health Facility X

The way forward

- Women-centred, respectful perinatal mental health systems
- Integration
  - Bottom-up and top-down approach to strengthening integration
  - Midwifery-led model
- More implementation research
  - To design, test, and scale-up context-appropriate and integrated PMH interventions

Acknowledgement

INSTITUTE OF TROPICAL MEDICINE ANTWERP

fwo Research Foundation Flanders Opening new horizons

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ADDIS ABABA UNIVERSITY

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Presentation in-person

Strategies for spreading and scaling complex perinatal mental health interventions in Low and Middle-Income Countries (LMICs) – A scoping review and thematic synthesis

Katie Rose Sanfilippo, Musa Krubally, Melina Michelen1, Gaotswake Patience Kovane, Ify Yusuf, Shannon McNab, Simone Honikman

Perinatal mental conditions are the most common complication of child¬bearing globally. Many different interventions have been developed and implemented to support perinatal mental health in low- and middle-income countries (LMICs), however most have not been sustained, scaled-up, or effectively spread. This may be due to a limit in available learnings from programs being implemented in a non-study environment and the problematic translation of interventions into scalable and sustainable programs .

We conducted a scoping review to explore strategies described in the literature for scaling up, spreading, and sustaining perinatal mental health interventions in LMICs. Scale is defined as the ambition or process of expanding the coverage of health interventions, but can also refer to increasing the financial, human, and capital resources required to expand coverage . Spread is defined as the process through which new working methods developed in one setting are adopted, perhaps with appropriate modifications, in other organisational contexts2. Sustainability is defined as the process through which new working methods, performance enhancements and continuous improvements are maintained for a period appropriate to a given context2.

Through systematically searching databases and grey literature, we identified 40 information sources (peer review articles, reviews, and reports) published from 2011 until November 2023. These included 12 sources specifically focused on Sub-Saharan Africa.

Using thematic synthesis, we identified 6 themes to describe different scaling, spreading and sustaining strategies: Diversify workforce, Integration, Tool and method development, Adaptation, Training, supervision and support and Stakeholder Engagement. Many of the information sources described more than one strategy and used them simultaneously. In this talk, we will describe the results of the scoping review but focus in on examples and learnings specifically for researchers and practitioners in Sub-Saharan Africa.

Speaker: Musa Krubally

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Musa Krubally is a Senior Clinical Research Nurse at Barts Health NHS Trust and the Chairperson of the charity Gambia Healthcare Matters UK, with over 15 years of combined experience in health research and adult nursing. He has received recognition from King Charles for his contributions to healthcare in the UK and from the Gambian High Commissioner and Vice President for his charity work in improving healthcare in The Gambia. Currently, Musa leads a registered charity organisation in the UK that supports the health and wellbeing of nurses, midwives, and other healthcare professionals working within the NHS while also contributing towards improving Gambia's healthcare system. He coordinates various pharma-sponsored clinical research trials at Barts Health NHS Trust.

Speaker: Dr Katie Rose Mahon Sanfilippo

Dr Katie Rose Mahon Sanfilippo is a Presidential Research Fellow at SHPS and a member of the Centre for Healthcare Innovation Research at City, University of London. Her current research is investigating how community and arts-based approaches and interventions can be scaled-up, spread and sustained more equitably in the UK and globally, with a focus on resource-constrained settings. She also works with various policymakers, charities, and health organisations to promote maternal mental health in the educational and health policy agendas. She is an affiliated lecturer in Cambridge within the music faculty and also has extensive experience working in the charity sector in the UK.

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Strategies for spreading and scaling complex perinatal mental health interventions in Low and Middle-Income Countries – A scoping review and thematic synthesis

Katie Rose Sanfilippo, **Musa Krubally**, Melina Michelen, Gaotswake Patience Kovane, Ify Yusuf, Shannon McNab, Simone Honikman

We are the Centre for Healthcare Innovation Research
joining the dots between innovation, policy and practice

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Research Questions

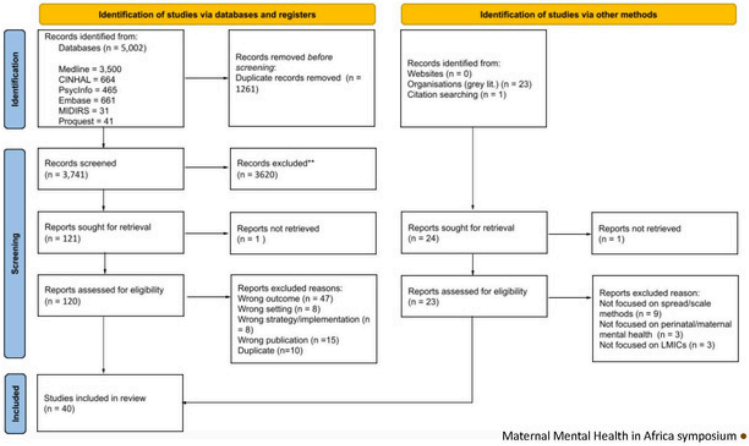
1. What is the scope, extent, and nature of the research/literature on scaling up, spreading, and sustaining complex perinatal mental health interventions in LMICs?
2. What approaches/strategies have been considered for scaling up, spreading, and sustaining complex perinatal mental health interventions in LMICs?
3. What are some of the gaps in our understanding of strategies and approaches to scaling up, spreading, and sustaining complex perinatal mental health interventions in LMICs?

Scale: the ambition or process of expanding the coverage of health interventions, but can also refer to increasing the financial, human, and capital resources required to expand coverage.

Spread: the process through which new working methods developed in one setting are adopted, perhaps with appropriate modifications, in other organisational contexts.

Sustainability: the process through which new working methods, performance enhancements and continuous improvements are maintained for a period appropriate to a given context.

Côté-Boileau et al., 2019



Scale Strategies

Diversify Workforce

- Peers
- Non-specialist providers (e.g., primary healthcare staff)
- Community health workers (CHWs)

Integration

- Primary care
- Maternal and child health
- Community models of care

Tool/method development

- Tech/digital solutions
- Implementation tools and methods

Spread Strategies

Adaptation

- Context
- Population
- Condition

Adaptation methods

- ADAPT
- NIHR context guidance
- MRC/NIHR complex intervention framework
- Theory of Change
- Bernal Framework for adaptation
- FDGs/interviews
- Co-deign
- expert panels,
- field testing
- PPI

Sustainability Strategies

Training, supervision and support

- Train the trainer (cascade model)
- Tech/digital soutlions

Stakeholder engagement

- People with lived experience
- Healthcare workers
- Community groups
- Policy makers

In summary

***Embedding innovation*—how innovations are successfully implemented at scale (Scarbrough & Yiannis, 2022).**

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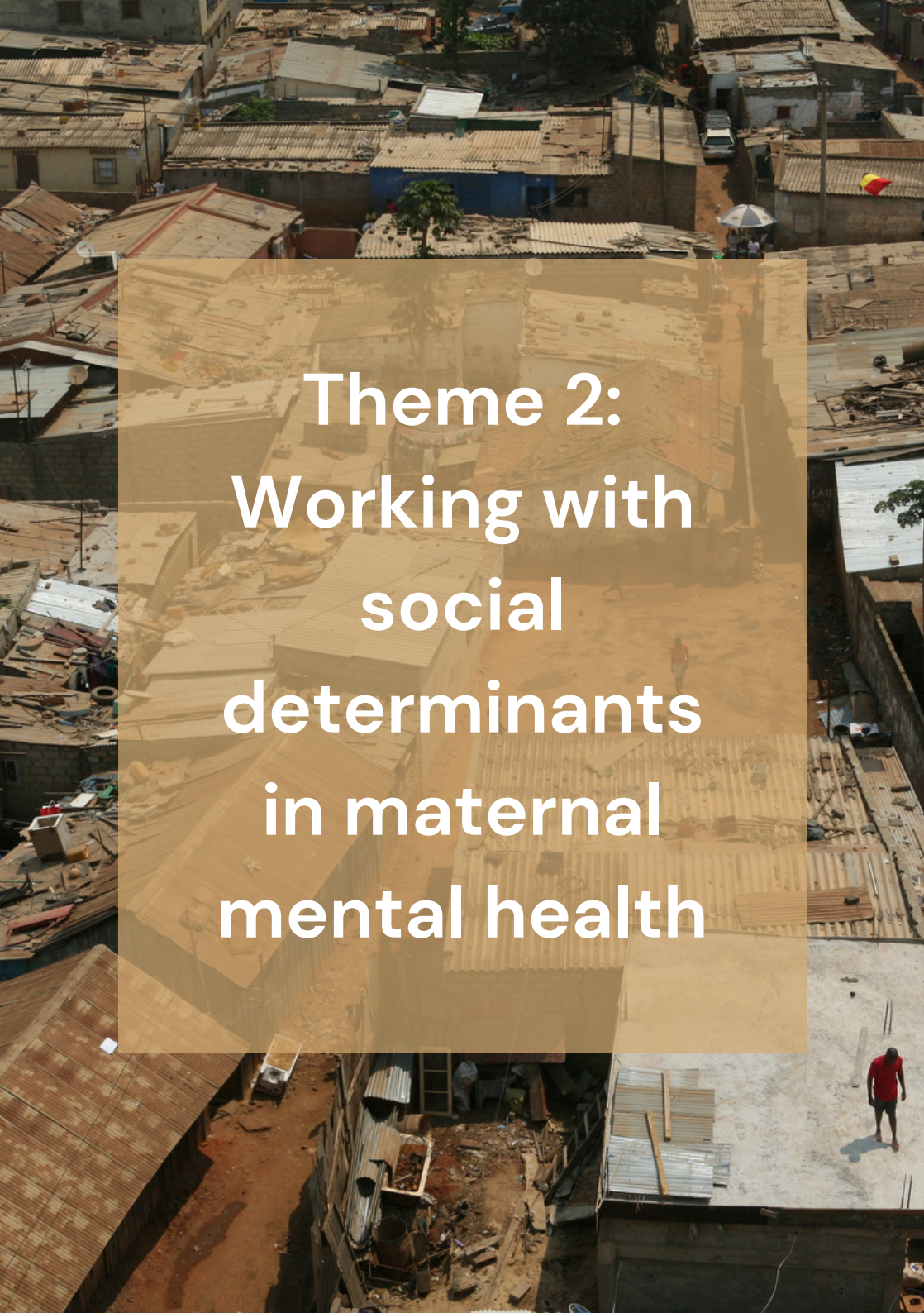

Theme 2: Working with social determinants in maternal mental health

Presentation in-person

Women's empowerment and maternal mental stress: exploratory study in Rural Kenya

Caroline W. Wainaina, Emmy Igonya., Manasi Kumar., Joyce Browne., John DeWit., Estelle Sidze, Wendy Janssens., Kitty Bloemenkamp

Background: Maternal mental health is a global public health concern, particularly in developing countries due to health and socio-economic inequalities. Mental well-being is crucial for women to handle daily stresses and contribute positively to their communities. Empowering women can improve their well-being and family health. This paper explores how women's economic empowerment in rural Kenyan communities affects their mental well-being, and discusses the challenges and lessons learned.

Methods: An ethnographic approach was employed consisting of a four-month participant observation of 20 women participants. Additionally, two focus group discussions were done separately with men and women from the community.

Results: We identified key themes related to women's empowerment and mental health. These included access to resources, gender roles, agency, community participation, and social support. Empowered women participated in decision-making processes. However, in this cultural context, women were not allowed to control or decide on resources, bringing to light family power dynamics. The cultural norms required us to seek the man's consent before interviewing the woman. Perinatal women were disadvantaged due to limited economic opportunities, making them vulnerable to food insecurity and family conflicts. Women faced different forms of violence (physical, verbal, and emotional) and cultural barriers when engaging in economic activities. Women faced significant stress especially when men couldn't provide enough support. These challenges posed a dilemma for the researcher(s) regarding their positionality
Some women were unreachable because of leaving home because of marital conflicts or women without phone access, making it hard to schedule appointments. The field researchers created a good rapport, enabling women to share their life stories openly.

To overcome economic challenges and lack of family support, women engaged in secret economic activities, individually or in groups such as Chamas, thus improving their autonomy and agency. Women overcame significant sociocultural barriers to achieve economic independence, ultimately reducing their mental stress. Women's empowerment efforts were, however, hampered by reduced financial support and increased risk of domestic violence, impacting their mental health. The project reimbursed them through the purchase of food items, and diapers for those who delivered during the project period. We were cognizant that our presence and reimbursements could influence our observations. The researcher reiterated the need for participants to be as natural as possible.

Conclusion: Women's empowerment can have positive and negative impacts on their well-being. To support women's well-being, mental health should be integrated into empowerment programs during the perinatal period. Men should be included in these programs and raise community awareness about socio-cultural influences.

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Speaker: Caroline Wainaina

Ms. Caroline Wainaina is an early career public health scientist she has a masters degree in public health from the University of Liverpool and is currently a PhD fellow at the University Medical Center in Utrecht, Netherlands. Caroline is passionate about engaging vulnerable individuals in poor and marginalised communities, researching social and health inequalities, and implementing interventions to improve maternal and child health outcomes. Her interests also include working with women to empower them to live healthier lives. Caroline is a Research Officer at the African Population and Health Research Center (APHRC). She manages the implementation of projects related to maternal and child health. With over 10 years of work experience, she has worked with various populations, including middle-income, urban poor, rural and migrant/pastoralist communities. Her expertise lies in public health research, focusing on maternal and young child health, non-communicable diseases (NCD) among low and middle-income populations, and maternal mental health among adolescent and vulnerable populations in different settings.

African Population and Health Research Center

Women empowerment and maternal mental stress

Exploratory study in rural Kenya

Caroline W. Wainaina., Emmy Igonya., Manasi Kumar., Joyce Browne., John De Wit.,Estelle Sidze., Wendy Janssens., Kitty Bloemenkamp.

Background of Project

DIGITAL FINANCIAL SERVICES, WOMEN EMPOWERMENT AND MATERNAL MENTAL WELLBEING. AN ETHNOGRAPHIC STUDY IN RURAL KENYA
Digital financial services, women empowerment and maternal mental wellbeing. An ethnographic study in rural Kenya - APHRC

Mental well-being is essential for a woman to handle daily life stresses and contribute positively to her community.

Initiatives that empower women can enhance their well-being and improve the health of their families.

Limited evidence shows how women's empowerment affects maternal depression in rural settings.

This study explored the perspective of women's empowerment in a rural Kenyan community and its effect on their mental well-being.

The method of data collection

Study design:
Ethnographic approach

20 Participants:
Pregnant women or with a child less than 1 year.

2 Focus group discussions
One with women and one with married men

Study setting:
Rural community,
Khwisero, Kakamega

What is the link between women empowerment and maternal mental stress?

Empowerment is seen as a process of change for women who were disempowered or denied the ability to make choices.

The ability to make choices is intricately tied to available resources, and the influence of poverty significantly restricts these choices.

Increased participation of women in community groups enhances social connectedness and improves their ability to cope with life's stresses.

Chama, a lifeline for women in the community

What is the link between women empowerment and maternal mental stress?

"I used to be in a saving group before I was pregnant. We used to give 200kshs monthly, and when it was my turn, I got Ksh 1200 (<10 USD), which I used to buy the cushions you are sitting on. I need to plan for my kitchen.
It is my responsibility to buy kitchen items for my house. I can't keep waiting for my husband, who doesn't care if I have cups."

— Participant observation, pregnant woman

Lessons and challenges in the process: What is the story?

The stressful situation

"Given a chance, I can never get married again. What I have seen is enough. Our child was chased away from school the other day because we have not paid for her exams (...). My husband is just relaxed at home doing nothing. I told my mother-in-law about the fees, and she told me I chose a stupid husband, so I should bear with that"

Participant 15, with a young child

The challenge: Unavailability of participants

"She is not around. This your person (referring to the respondent) I don't know what she really wants. I am fed up with her character. Today, she is in her marriage. Tomorrow, she is out. Right now, she left like a week ago she hasn't come back. They had a disagreement with her husband, and she left with the children"

Mother-in-law to the respondent speaking

Researcher Positionality

"I administer the mental health tool. She still says she has been thinking of harming herself. She says, "I sometimes think of how I came out of school when my parents had paid school fees, and I just cry. I think of the life I put myself to, and I feel it is useless to live. "There is a time he beat me up. Don't tell anyone". I promise her not to tell anyone but will only use the information for our data".

"She gives me the baby and walks out angrily. I can hear her talk to her mother-in-law while in the house...She comes back 10 minutes later with lots of anger".

"I tell her because she is doing things, just because I am present, I will not eat. I explain why it is important for them to remain in their natural lifestyle and not be influenced by my presence".

E	Goods bought	Ar
04/2022	Sugar 1kg	
	Pampers	
	Maize 2 tins	
04/2022	Maize 1 tins	
	Tilly cooking fat	
	Bar soap	
04/2022	Tilly cooking fat	
	Sugar 1kg	
	Maize 2 tins	
04/2022	Beans	
	Maize 1 tin	
	Sugar 1kg	
04/2022	Tilly cooking fat	
	Pampers	
	Sugar 1kg	
05/2022	Pampers	
	Tilly cooking fat	
	Sugar 1kg	
05/2022	Sugar 1kg	
	Tilly cooking fat	
	Bar soap	
05/2022	Cooking oil 1L	
	Bar soap	
05/2022	Sugar 1kg	
	Tilly cooking fat	
	Pampers	
05/2022	Sugar 1kg	
	Cooking oil 1L	
	TOTAL	

The Process: What Worked

Rapport-repeated visits/observations and informal conversations made participants comfortable to open up.

Household head consent- this was important for the male interviewer to conduct the observations.

Flexibility to accompany participants in their daily activities, engaging with the social environment around the women.

Conclusion: Perinatal women need to be cushioned to be able to cope with normal stresses of life

"You know in my condition currently (pregnancy) I am not able to work as I could have done while I was not pregnant. Right now, bending for a long time as I weed is not easy since I feel some part here (respondent pointing at the abdomen) when I bend for a long time.
But now I don't have a choice but to try and do farm work because there is no money at all".

Acknowledgement

UMC Utrecht
APHRC
African Population and Health Research Center
brac institute of governance & development
PharmAccess FOUNDATION
amref health africa

Virtual presentation

Engaging faith communities on maternal mental health

Authors: Mona Bormet, Deirdre Church, & Nkatha Njeru

Religious leaders, traditional and faith healers, pastors and imams, and other faith actors are often some of the most respected voices who naturally shape community attitudes, beliefs, and behaviors. For the sake of simplicity, "faith actors" is used in this abstract to encompass a wide range of formal religious leaders, lay members of a faith-based community, and traditional healers who offer care to community members. Historically, faith actors have been integral to the success of mental health efforts. They can facilitate open dialogue on mental well-being, provide theological dimensions of mental health, and promote positive mental health behaviors and services in their communities.

While faith communities and leadership have significant positive potential and influence, there have also been cases where faith actors have spread negative stereotypes and stigmatized those experiencing a mental disorder—claiming mental health conditions are caused by a curse, demonic possession, or wrongdoing. When not equipped with evidence-based information, faith actors can perpetuate these myths and misinformation and cause harm. To be successful, mental health initiatives need to partner with key influential stakeholders, such as faith actors, who are well-positioned to raise awareness, reduce misinformation and stigma, and decrease barriers for utilizing mental health services.

Recognizing that common perinatal mental health disorders are the leading complication of pregnancy and childbirth globally, MOMENTUM Country and Global Leadership presenters will share learnings from 16 key informant interviews (KIIs) with faith actors on their engagement in maternal mental health and results from a literature review on faith-based engagement in maternal mental health. They will also share a newly developed and released (May 2024) toolkit for engaging faith actors on maternal mental health. Faith communities are a crucial component of the social ecological model.

Presenters will facilitate discussion to understand if session attendees have had success or challenges when engaging faith communities on maternal mental health issues. What has worked? What hasn't? Have there been issues around stigma? Misinformation? Lack of resources to refer people to? How can we move forward using faith specific messages on maternal mental health?

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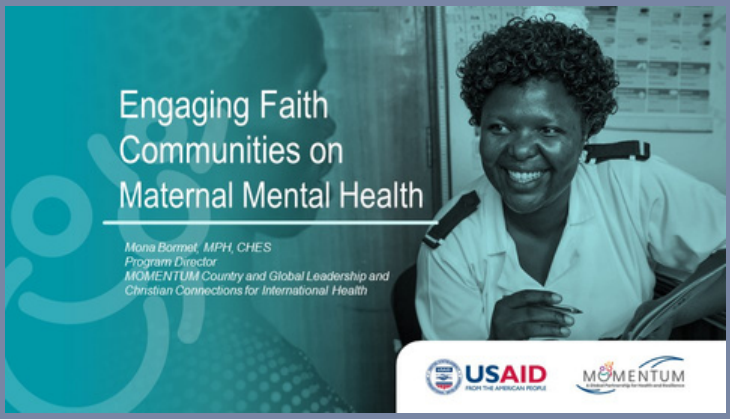
Speaker: Mona Bormet

Mona Bormet, MPH, CHES serves as Program Director for Christian Connections for International Health and the Program Director for the Faith Engagement Team of MOMENTUM Country and Global Leadership. Mona directs a global portfolio of initiatives that improve timely access to quality health services in communities and facilities, by working with faith-based partners and CCIH members around the world. Mona began working with CCIH as an individual member and volunteer, and since 2010 has been on staff, first focused on US advocacy efforts.

Previously, Mona served as Advocacy Program Specialist for the Asian & Pacific Islander American Health Forum. Mona has an MPH from the University of Minnesota School of Public Health and a BS from Illinois State University. She received the American Public Health Association International Health Section Mid-Career Award in 2023.



Discussion questions: Join at menti.com | use code 5889 1558

1. What has worked to engage faith communities on mental health/successes?
2. What is your #1 suggested resource on mental health to help faith communities?

Literature Review on faith-based engagement in maternal mental health

- Supportive religious communities provide invaluable psychosocial support for women who are struggling with mental health issues
- Harmful traditional practices sometimes masquerade as faith-related and/or are perpetuated by religious leaders and faith communities
- Stigma against mental health is highly pervasive
- Health systems that are insufficient, unavailable or harmful to women may encourage women to turn to traditional or nontraditional faith healers
- Faith-based health care seeks to take a holistic, more-than-medical-model approach to wellness, which includes a whole-person (including spiritual) response
- Faith leaders and FBOs: Have trust, extensive community outreach structures, values are for spiritual wellness (includes mental health). They need training and support.

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16 Key Informant Interviews

- FBOs have very few services designed specifically for mental health
- Can be helpful in:
  - Maternity wards, ANC or delivery
  - Community religious leaders referring women for care
  - Peer support groups for informal psychosocial support
  - Prayer and counseling
  - GBV services
  - Cascade training approaches
  - Trauma and psychological first aid trainings
  - Education and awareness campaigns
- Need:
  - Training on mental health
  - Outpatient and inpatient services
  - Partnership and linkages to improve service system collaboration
  - Anti-stigma awareness raising

> *Mental health issues are culturally embedded issues. The DSM and other rich-world clinical approaches do not mostly meet people where they are, so you see lots of women being put on the wrong meds.*
>
> *This does not help, and it is poor quality care.*
>
> *FBOs are well placed to contextualize care, rather than copy-paste diagnostic protocols. (If asked), the women themselves would say that they want more supportive communities, pastors, family members…that the social factors would be more open and helpful, with less stigma.*

> *Many women (e.g., with psychosis) get a wide range of support from Churches and Mosques ranging from fairly helpful, formal or informal to inappropriate, judgmental and sometimes quite abusive (eg, all-night prayer vigils) that blame the woman for her condition*

> *People often prefer to work with clerics and spiritualists because they are treated well by them, as contrasted with how poorly they are treated by the formal health system.*

> *Faith organizations are often the center of the community support system, it's where people turn when they need help, eg, the women's fellowship/group, some sort of financial system available for people in desperate straits, where people find informal networks of support.*
>
> *They are incredibly important in providing that baseline emotional support for women who are having problems.*
>
> *(It's) where people go first when they need emotional support. They go to church/mosque because that's the cultural understanding, of this being a spiritual issue. In the best cases, they can facilitate that by being thoughtful, caring in response to people's needs.*

MATERNAL MENTAL HEALTH:

A Toolkit for Engaging Faith Actors as Change Agents

MOMENTUM Country and Global Leadership

USAID | MOMENTUM

MMH

TABLE OF CONTENTS

Recognizing Mental Disorder Signs and Symptoms, like anxiety and depression

Signs and Symptoms of Maternal Anxiety	Signs and Symptoms of Maternal Depression
• Excessive worry, stress, and fear • Feeling unable to cope with daily life • Feeling alone and frightened • Difficulty focusing; mind racing through thoughts • Inability to prioritize tasks, moving from one to another • Racing heart, sweating palms, rapid breathing • Increased muscle aches or soreness • Difficulty sleeping	• Feeling sad, down, and/or crying extensively • Loss of interest in usual activities • Lack of interest in baby; not feeling bonded to baby • Feelings of guilt or worthlessness • Thoughts of death or harming self or baby • Low energy or increased fatigue • Loss of or increase in appetite or weight • Sleep problems • Trouble focusing, remembering things, or making decisions • Feeling restless or irritable

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7

Outcomes of Common Maternal Mental Disorders (Table 2)

• Less likely to attend antenatal care visits • Inadequate nutritional intake during pregnancy • More likely to experience complications during birth • More likely to have preterm birth and low-birthweight babies	• Increased risk of neonatal or infant death • Lower rates of exclusive breastfeeding • Increased risk of stunting and underweight • Poorer mother-child bonding and attachment
• Less likely to attend postpartum care • More likely to have difficulty breastfeeding • Poorer nurturing care practices • More likely to practice self-harm behaviors or die by suicide	• Poorer cognitive development • Less likely to be immunized • More likely to experience childhood illnesses

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8

Faith specific messages

ANNEX 3: CHRISTIAN-SPECIFIC TEACHINGS AND MESSAGES[72]

Christian sermons, devotionals, or informal messages can outline these key points with the following scripture references and supporting text:

- God cares for mental well-being and the suffering of his people.
- Mental health conditions are not a punishment from God or the result of sin.
- The Church should be a place of compassion and support for those who are suffering.

ANNEX 4: MUSLIM-SPECIFIC TEACHINGS AND MESSAGES[75, 76, 77]

Muslim khutbah, preaching, prayers, or informal messages can outline these key points with the following scripture references and supporting text:

- Supporting mental well-being is an important part of Islam.
- The Quran and Islamic teachings encourage supporting those who are suffering.
- Mental disorders are not a punishment from Allāh or the cause of wrongdoing.

ANNEX 5: HINDU-SPECIFIC TEACHINGS AND MESSAGES[78, 79, 80, 81]

Hindu teachings or informal messages can outline these key points with the following quotations and text references:

- Hindus care for mental well-being and the suffering of their people.
- Mental disorders are not a punishment or the cause of karma.
- Hindus should offer compassion and support for those who are suffering.

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Discussion questions:

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1. What has worked to engage faith communities on mental health/successes?
2. What is your #1 suggested resource on mental health to help faith communities?

THANK YOU

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Virtual presentation

Indigenous Knowledge Systems as a social determinant for the improvement of maternal mental health outcomes

Author: Sarah Mlambo

Maternal mental health remains of concern as one of the rising areas in maternal health that are leading to morbidity and mortality among women of the reproductive age group. Indigenous knowledge systems are the bridge between the health determinants and the social determinants. Identification of effective approaches to address mental health among women is of great concern as maternal mortalities remain high despite some progress in countries towards the Sustainable Development Goals and Vision 2030. Social determinants of health according to the World Health Organisation include five (5) domains namely: economic stability, quality education, quality healthcare, neighbourhood and built environment and social and community context.

The social dynamics of individuals tend to inspire researchers to look beyond the sector but rather the socialisation of individuals to enable community and social long-term solutions. To a greater extent, social determinants shape the health outcomes of individuals hence this paradigm underscores the need for researchers to look beyond sectoral borders in the quest to create synergies across health. Social support remains one of the biggest social determinants which also falls within the indigenous knowledge systems for women postpartum to reduce and improve maternal mental health. The 'masungiro' aspect stands out as a sustainable way of improving maternal mental health as the familiarity, family support and social structure intend to care for and support the pregnant woman towards and months after birth as well.

The African context identifies with indigenous knowledge systems that may be adapted and modified to address maternal mental health in a community that goes without saying has many sociocultural synergies that may improve maternal wellness. Urbanisation and globalisation have seen a dearth of the socio-cultural determinants that could curb maternal mental wellness. The vigilance of healthcare providers during antenatal care to screen women for risk of mental well-being and history of material and social resource availability for women among others also become an integral part of improving maternal mental health wellbeing.

Speaker: Dr Sarah Mlambo

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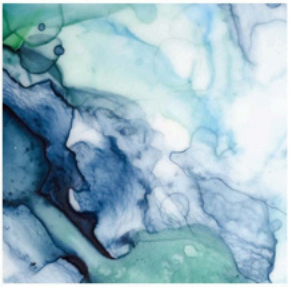
Dr Sarah Mlambo is a Midwifery lecturer at Welwitchia University in Namibia. Her experience in Nursing and midwifery spans over a decade in public and private sector settings in Namibia and Zimbabwe. She holds a PhD and MSc in Nursing, a Certificate in Project Management, and Diplomas in Midwifery, General Nursing and HIV/AIDS Management and Counselling. Dr Sarah Mlambo is an early career researcher with published work in midwifery – decision-making, childbirth choice facilitation and positive maternal mental health outcomes. She has shared her research outputs in different local, regional and international platforms including, the Independent Midwives Association of Namibia (IMANA), Sensitive Midwifery, GOLD Midwifery and International Confederation of Midwives (ICM). Her research interests include indigenous knowledge systems, midwifery, perinatal health, and shared decision-making. Dr Sarah Mlambo is a committee member on the National Maternal Stillbirth and Death Review Committee of Namibia and GOLD Midwifery Professional Advisory Committee Member. She is a proud mother of four wonderful children.



Indigenous knowledge systems as a social determinant for the improvement of maternal mental health

Presented at
Maternal Mental Health in Africa - Conversations
Hybrid symposium 19 June 2024

DR SARAH MLAMBO
WELWITCHIA UNIVERSITY

PROBLEM?

- Affects 1in 7 women
- 10% of pregnant women; and 13% of women who have just birthed have a mental disorder and the most common is depression
- Prevalence during pregnancy is estimated at between 4 & 20%

INDIGENOUS KNOWLEDGE SYSTEMS

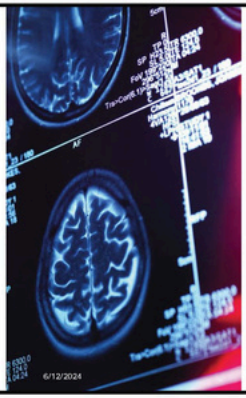
- Masungiro
- Masuwo
- Makorokoto

CHALLENGES

- Gobalisation/urbanisation
- Stigma and/or ignorance
- Mental health
- Perineal trauma

SUSTAINABILITY

- "Find where the rain began to beat us'' Chinua Achebe
- 360 Approach
- Endogenous approach
- Quality education and healthcare – inclusivity
- Economic stability – LMICs, minimal resources
- Social and family support



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Virtual presentation

Social determinants of mental health: the evolution of a maternal mental health program for conflict-affected populations in Uganda

Authors: Josephine Akellot, Samuel Wasereka, Nawaraj Upadhaya, Kohrt A. Brandon & Wietse A. Tol

Conflict-affected populations face multiple, interlocking social determinants of mental health. This presentation focuses on the evolution of a program that aimed to integrate mental health services into routine perinatal health care services provided through government health system in rural Uganda. The project went through several steps: First, initial formative research consisted of engagement with key stakeholders to identify priority maternal mental health concerns. Ethnographic methods including free listing and ranking (N=44), semi-structured interviews (N=16), Key informant interviews (N=33) and pile sorting were done in four sub-counties in Soroti District. We found that the common reasons for visiting health clinics were salient issues like malaria, general postnatal care, and 'husbands being absent'. However, the free listed mental health problems were adeka na aomisio (sickness of thoughts); ipum (epilepsy), and emalaria (malaria). In a second phase we initiated a stepped care model focused on treatment of maternal common mental disorder, sickness of thoughts, which overlapped with depression caused by "unsupportive husbands, intimate partner violence, chronic poverty, and physical illnesses" in Asuret, Gweri, Tubur and Arapai sub-counties in Soroti (Tol et al., 2028).

Over the 4 years period, we screened 22,139 women. Monitoring and evaluation activities identified reductions in maternal depression and improvement in functioning. However, many women were lost between steps, mainly because of restrictions placed on movement by male partners. Following consultation with men, in a third phase, we more closely involved male partners in care provision – and started implementing in more districts. We screened 6,503 women, enrolled 3,655 people in couples psycho-education and 334 women in interpersonal group therapy. In a final step, we started to screen for male alcohol use concerns and perpetration of intimate partner violence, and emphasizing social work approaches next to provision of mental health care. We are currently evaluating interventions for male alcohol use.

Further evolution of the program would benefit from multi-sectoral integration of community-based, couples-focused violence prevention and livelihoods efforts. This presentation, will highlight the real-world challenges between priorities for scaling up, while engaging with both complex structural and social determinants of mental health, as well as logistical concerns threatening sustainability and scaling.

Speaker: Josephine Akellot

Josephine, a clinical psychologist, is experienced in research, designing, training, supervising, and implementing MHPSS in low-resource settings. She has participated in implementation research to integrate social determinants in mental health and psychosocial service response and implementation. She has led community-based programming, adaptation, trained and supervised over 170 lay providers in the use of low-intensity interventions (e.g., Problem Management Plus (PM+), interpersonal therapy, and self-help plus) and in humanitarian settings. She coordinated the WHO-UNICEF EQUIP study and led the CHANGE Intervention for Alcohol Use Training and Supervision (EQUIP methodology) for Uganda and Ukraine. Currently. she is pursuing her PhD studies at Virjie University, Amsterdam.

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The evolution of a maternal mental health program for conflict-affected populations in Uganda

Josephine Akellot

PhD (Ext) student, Virjie University (VU) Amsterdam

Member MHPSS TWG; Head of Dept Pukka Psychometrics & Psychological services (PPPS), and Digestive & Liver Disease care Center (DILD)

6/19/2024

Outline

- Background
- Rationale
- Evolution steps
- Conversation point
- Acknowledgement

Background

- No comprehensive national prevalence studies on mental health nor social determinants and Mental health and/or perinatal depression
- 'Pockets' of perinatal depression, social determinant studies and stressing integration
  - ❖districts e.g.,
    - Iganga & Mayuge (Sarkar et al., 2018, http://dx.doi.org/10.3390/ijerph15061197) 'social nature of perceived Illness representation- socio-economic and cultural causal factors'- woman's fault
    - Lira (Arach et al., 2020, https://doi.org/10.1371/journal.pone.0240409), "Perinatal death triples the prevalence of postpartum depression among women…"
    - Kamuli (Nakku et al., 2021, https://doi.org/10.1186/s12884-021-04043-6)- impact of a' mental health intervention delivered by non-specialist health workers'-evidence based psychological intervention improve treatment outcomes
  - ❖disease-based e.g., HIV (Faherty et al., 2023, https://doi.org/10.1007/s10995-023-03741-1) multi-site cluster randomized controlled trial-" need to build capacity to implement the stepped-care protocol for non-responders and screen for social support and interpersonal violence"

Rationale

- Perinatal depression and/or social determinants are complex problem
- Conflict-affected populations face multiple, interlocking social determinants of mental health
- Integration through government health system in rural Uganda should be a routine perinatal service in primary health care
- Step by step integration and care approaches should be prioritized

Evolution steps: method

The steps

1. Formative research
2. Development of the stepped care treatment model
3. Inclusion of lessons learnt to improve care uptake and adherence
4. Integrated focus on social determinants of depression in care

Step 1: Informative research

Key stakeholder engagement (Ethnographic methods)

Aim: to identify priority maternal mental health concerns

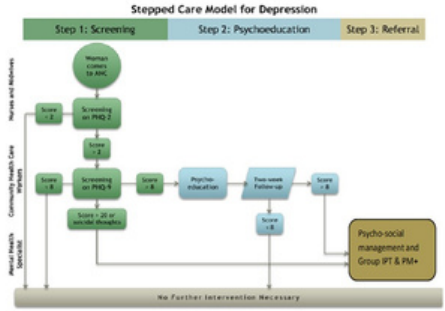
- free listing and ranking (N=44), semi-structured interviews (N=16),& Key informant interviews (N=33)
- Pile sorting was done in four sub-counties in Soroti District
- Validating the screeners

Results

- The free listed mental health problems were *adeka na aomisio* (sickness of thoughts); *ipum* (epilepsy), and *emalaria* (malaria)
- Reasons for visiting facilities: salient issues such as malaria, general postnatal care
- Social issue: Husbands being absent
- Validated PHQ-2 & PHQ-9 (Acholi & Ateso)

https://doi.org/10.1186/s12888-018-1626-x

Step 2: Stepped care model



Results:
4 years period:
22,139 women screened; 26% depressed; 79% & 89% depression symptoms reduction on Psychoeducation and IPT-G respectively; and 79% overall improvement in functioning

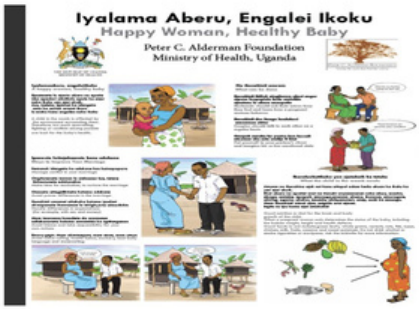
Challenges
lost to follow & care between steps, due to restrictions placed on movement by male partners (social issue)

Solution
Male involvement

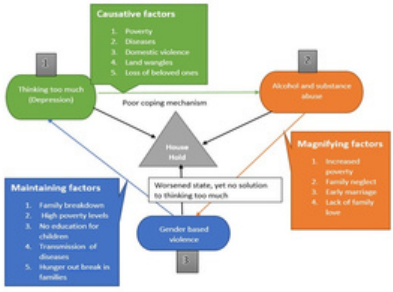
Step 3: Inclusion of lessons learnt to improve care uptake and adherence

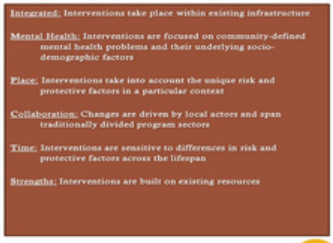
1. Task shifting mental health care service to lay providers
2. Capacity building in stepped care model steps (competency based training- EQUIP approach, https://equipcompetency.org/en-gb)
3. Clinical & competency based supervision of lay providers
4. Male involvement was key
   - ❖Low service uptake
   - ❖Poor adherence to appointments and care
   - ❖Alcohol and intimate partner violence

Male involvement approach



Step 4: **Integrated focus on social determinants of depression in care**



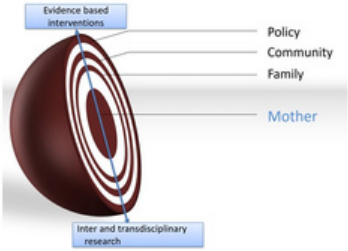


Conversation points

- Perinatal depression and Social determinants are a complex problem
- Could we change the research lens (ITDR)
- What lessons have we learnt, how have we used these in response
- What should be our focus ?? Effect

Cause — Effect Vs Cause — Cause — Effect ??

?? Design and method –how do we measure all the causes



Call to Action

- Collaborate and fund to scale

Acknowledgements

- HealthRight International (formerly PCAF) and field teams
- Dr. Wietse A. Tol, Global Mental Health, University of Copenhagen, Endowed Professor Global Mental Health & Social Justice, VU University Amsterdam & Adjunct Professor, Johns Hopkins University
- Dr Brandon A. Kohrt, Professor of Global Psychiatry, & Psychiatry and Behavioral Sciences, Global Health, and Anthropology, Director, Center for Global Mental Health Equity, Department of Psychiatry, George Washington University, 2120 L St NW, Suite #600, Washington, D.C
- Fondation d'Harcourt Ruth-BÖSIGER 6, 1201 Geneva - Switzerland

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Virtual presentation

Intimate Partner Violence: A risk factor for Postnatal Depression in rural Kenya

Author: Victoria Mutiso

Conflict-affected populations face multiple, interlocking social determinants of mental health. This presentation focuses on the evolution of a program that aimed to integrate mental health services into routine perinatal health care services provided through government health system in rural Uganda. The project went through several steps: First, initial formative research consisted of engagement with key stakeholders to identify priority maternal mental health concerns. Ethnographic methods including free listing and ranking (N=44), semi-structured interviews (N=16), Key informant interviews (N=33) and pile sorting were done in four sub-counties in Soroti District. We found that the common reasons for visiting health clinics were salient issues like malaria, general postnatal care, and 'husbands being absent'. However, the free listed mental health problems were adeka na aomisio (sickness of thoughts); ipum (epilepsy), and emalaria (malaria). In a second phase we initiated a stepped care model focused on treatment of maternal common mental disorder, sickness of thoughts, which overlapped with depression caused by "unsupportive husbands, intimate partner violence, chronic poverty, and physical illnesses" in Asuret, Gweri, Tubur and Arapai sub-counties in Soroti (Tol et al., 2028).

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Further evolution of the program would benefit from multi-sectoral integration of community-based, couples-focused violence prevention and livelihoods efforts. This presentation, will highlight the real-world challenges between priorities for scaling up, while engaging with both complex structural and social determinants of mental health, as well as logistical concerns threatening sustainability and scaling.

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Speaker: Victoria Mutiso

Victoria Mutiso, is a Clinical Psychologist and Senior researcher at Africa Institute of Mental and Brain Health (formerly, Africa Mental Health Research and Training Foundation (AMHRTF). Her research interest is on child and adolescent mental health, development and adaptation of culturally-appropriate interventions around promotion of mental well-being and prevention of/or delay of the onset of mental illness in young people as well as under-served and marginalized populations in Kenyan urban and rural settings. She has experience in navigating the Kenyan political and bureaucratic terrains and with this she successfully engaged with a Kenyan county government to integrate mental health services at primary healthcare level including maternal and child mental health services. She has been Principal and Co-Investigator in several mental health projects at AMHRTF and with other Kenyan and international collaborators on mental health and substance abuse which are the basis for policy and practice in Kenya. She has several publications on various aspects of public mental health in Kenya.

Intimate Partner Violence: A risk factor for Postnatal Depression

Presenter :

Victoria Mutiso, PhD
Africa Institute of Mental and Brain Health,
(*formerly*, Africa Mental Health Research and Training Foundation)
Nairobi, Kenya

"Maternal Mental Health in Africa Conversations" symposium|2024

OUTLINE

- Introduction
- Objectives
- Methods
- Results
- Conclusion
- Potential interventions

INTRODUCTION

- Postpartum depression (PPD):
  - defined as depression occurring within 12 months post-delivery,
  - is universal mental health problem affecting the optimal well-being and caregiving abilities of mothers.
- Research has shown a high prevalence of PPD in Africa,
- It is important to determine the contributing factors to this high prevalence considering the cultural diversity among African countries and within the same country.

OBJECTIVES

Objective 1

To determine the prevalence of PPD and that of the 4 domains of IPV, that is physical violence, sexual violence, emotional violence, and controlling behavior

Objective 2

To determine the co-occurrence of PPD and IPV

Objective 3

To determine the risk factors and associations between sociodemographic variables and PPDand IPV

METHOD

Sample size

Across-sectional study involving a cohort of 544 postpartum mothers, 6 weeks to 12 months post-delivery in rural Kenya

Analyses

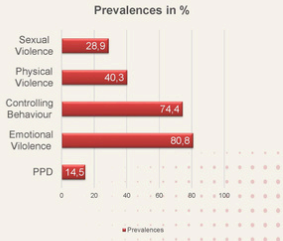
- Descriptive analyses
- Linear regression

Tools

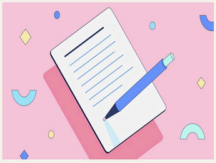
- Sociodemographic ad hoc questionnaire
- WHO Intimate Partner Violence questionnaire
- MINI Plus for DSM-IV/ICD10 depression.

RESULTS

- Physical violence was the most important predictor of PPDpost-delivery in our study.
- PPDwas associated with demographic characteristics such as low socioeconomic status, self-employed status, low education level
- PPDwas associated with physical and sexual violence during pregnancy, history of mood disorders and medical problems in the child.



CONCLUSION



- PPDand IPVwere highly prevalent in our population of postpartum mothers.
- Various sociodemographic indicators as well as sexual and physical violence were significantly associated with PPD.
- Quantifying the prevalence of PPDand identifying the different associated factors, including the understanding of the local sociocultural context, provide useful information to guide intervention.

POTENTIAL INTERVENTIONS

- Frontline healthcare workers– nurses, community health promoters to provide information on all aspects of good prenatal and postnatal health.
- Outreaches within the communities to create awareness and screening at both community (family) and facility level.
- Open discussions on any cultural barriers to disclosure or seeking of care, should be part of the services.
- Equip Traditional Birth Attendants (TBAs) with knowledge on PPD because they are widely consulted by prenatal and postnatal mothers.

Theme 3: Sustaining capacity in maternal mental health

Virtual presentation

Involving Adolescents Girls and their Communities in the Development of a Perinatal Mental Health Intervention In Mozambique

Author: Fernando João Júnior Chissale, Jaime Luís Mário, Maria Suzana Bata, Málica de Melo, & Tatiana Taylor Salisbury

Introduction: Mozambique is among the 6 countries in the world where 1 in 10 girls have children before the age of 15 or in adolescence, a phase of greater vulnerability to mental health problems, where 1 in 5 adolescents in the world suffers from mental disorders. The stress and strain associated with early pregnancy comes at a time when teenagers face social, economic and relationship changes that occur regularly during the phase. Although the prevention of teenage pregnancy is a priority in Mozambique, the challenges faced by girls during pregnancy and postpartum are rarely addressed. There is a lack of approaches to promoting good maternal mental health for adolescent girls. The INSPIRE project (Innovative Approaches to the Perinatal Well-Being of Adolescent Girls) is implemented in the province of Tete-Moatize, whose objective is to develop an intervention to support the well-being and mental health of adolescents and postpartum women from 15 to 19 years of age. A blended approach of human-centered design, systems thinking, and implementation science was employed to actively engage and partner with adolescents, their families, community influencers, and health care providers.

Objective: To describe the experience of engaging adolescents and other stakeholders in the development of a perinatal mental health intervention in Mozambique.

Methodology: Over twelve months, a range of activities (e.g. individual interviews, Photovoice, spiral walks, focus group discussions and workshops) were conducted with 24 perinatal adolescents and young women aged 15-24 years, and 10 service providers, 20 community influencers, 20 family members and 6 partners to understand the experiences and main challenges that adolescents face during the perinatal period and develop the intervention and delivery strategies.

Results: Stakeholders were eager to participate and most contributed to the project over the whole of the intervention development period. The biggest challenge to the co-design process was getting them to develop their own ideas for an intervention, as they were unused to taking on this form of ownership. This caused the workshops to take significantly longer than estimated in order to support and encourage participants. The most striking result of this approach was the satisfaction of the participants in knowing that their ideas were used to create a solution to their challenges. Several partner institutions expressed interest in adopting co-design approaches to address their own challenges.

Conclusion: In countries such as Mozambique, an approach in which all stakeholders participate equally is efficient as long as it is adapted to local realities and context. Co-design approaches encourage communities to take ownership of the initiatives because they feel part of the project. I also increases the potential sustainability of the resulting program.

Keywords: Mental health, adolescence, co-design

Speaker: Fernando Chissale

Fernando is a Master in Population and Development, working in research since 2015 and since 2021 as researcher and site coordinator of the INSPIRE (Inovative Approaches For The Wellbeing Of Adolescent) PROJECT at International Centre For Reproductive Health (ICRH) Mozambique.

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"Maternal Mental Health in Africa - Conversations Symposium"

19 June 2024

Nuffield Department of Women's and Reproductive Health, University of Oxford, and the Perinatal Mental Health Project, University of Cape Town

Theme: **INVOLVING ADOLESCENTS GIRLS AND THEIR COMMUNITIES IN THE DEVELOPMENT OF A PERINATAL MENTAL HEALTH INTERVENTION IN MOZAMBIQUE "**

Authors: Fernando João Júnior Chissale[1], Jaime Luís Mário[1], Maria Suzana Bata[1], Málica de Melo[1], Tatiana Taylor Salisbury[2]

1. International Centre for Reproductive Health- Mozambique
2. Kings College London- United Kingdom

ICRH*Moçambique*

CENTRO INTERNACIONAL PARA SAÚDE REPRODUTIVA

INSPIRE: Innovative approaches for adolescents perinatal wellbeing

Funded by: Kings College of London (KCL)
Implemented by: International Centre for Reproductive Health-Mozambique
From: September 2020 to August 2024
Site: Mozambique-Tete Province-Moatize District

ICRH*Moçambique*

CENTRO INTERNACIONAL PARA SAÚDE REPRODUTIVA

Why Mozambique?

Mozambique is among the 6 countries in the world where 1 in 10 girls have children before the age of 15 or in adolescence, a phase of greater vulnerability to mental health problems, where 1 in 5 adolescents in the world suffers from mental disorders. The stress and strain associated with early pregnancy comes at a time when teenagers face social, economic and relationship changes that occur regularly during the phase.

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Why mental health

Although the prevention of teenage pregnancy is a priority in Mozambique, the challenges faced by girls during pregnancy and postpartum are rarely addressed. There is a lack of approaches to promoting good maternal mental health for adolescent girls.



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About the project

To develop an intervention to support the well-being and mental health of adolescents and postpartum women from 15 to 19 years of age

Phase 1– Development of mental health intervention

(a) Field work- (Qualitative research with stakeholders) December 2021- Feb 2022

(b) Workshops- developing the intervention (with stakeholders) and research team March 2022- December 2022

Phase 2- Pilot testing of the intervention

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. The following groups were included in the research

Girls	Young Women (YM)	Partners	Family members	Community Influencers	Service providers
(A) attending participating health centres, or community-based group/service; (B) pregnant or gave birth in last 12 months; and (C) aged 15-19 years.	(A) living in study site; (B) was pregnant between the ages of 15 and 19 years; and (C) aged 20-24 years.	(A) partner referred by a girl or YM participating in the study; (B) lives within the study site; and (C) aged 18 years or older.	(A) family member referred by a girl or young woman participating in the study; (B) the girl or YM's parent or another responsible adult within her household; and (C) aged 18 years or older.	(A) aged 18 years or older; and (B) provide health or community services within the project setting or are responsible for the provision of these government services.	(A) aged 18 years or older; and (B) resident or working within the project site.

Grupo Alvo	Actividades realizadas				
	Sample	Interviews	FDG	Photovoice	Spiral Walks
Girls-Ad 15-19	20	20 Ad	12 Ad	4 Ad	4 Ad
Young Women 20-24	6		4	-	-
Families	20	-	2 H/M	-	-
Health Providers	10	10 Pr	-	-	-
Community Influencers	20	-	2 H/M	-	-
Total 74 participants					

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Workshops

Objective?

To develop an intervention that is:

1. Accessible for local deployment;
2. Attractive to stakeholders;
3. Aligned with the priority challenges of the country;
4. Easily integrated into existing local health systems;
5. And linked to evidence.

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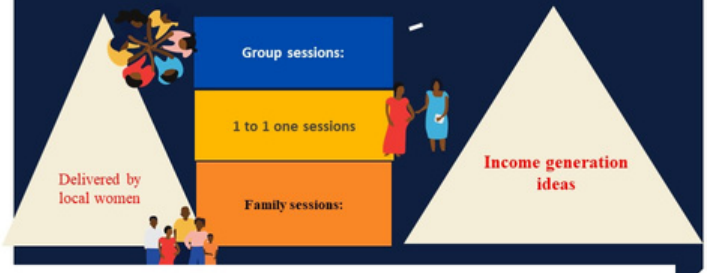
Objectivo:
Conceitualização da intervenção



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Challenges!

Broken barriers

1. One of the first and few projects putting together adolescents and other stakeholders.
2. The community influencers (leaders, service providers, professors, etc) are seen as the holders of knowledge.
3. The girls (the ones who faces the problem, with their parents and service providers) had their own ideas

This caused the workshops to take significantly longer than estimated in order to support and encourage participants

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Positive incomes

Within the group

The feeling of being important part of the solution (ownership)

1. Confidence of a successful implementation
2. Confidence of sustainability

Stakeholders were eager to participate and most contributed to the project over the whole of the intervention development period

Outside the group

Several partner institutions expressed interest in adopting co-design approaches to address their own challenges

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What we learned?

In countries such as Mozambique, an approach in which all stakeholders participate equally is efficient as long as it is adapted to local realities and context. Co-design approaches encourage communities to take ownership of the initiatives because they feel part of the project. I also increases the potential sustainability of the resulting program.

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Parceiros

CENTRE FOR GLOBAL MENTAL HEALTH

KING'S College LONDON

Royal College of Art
THE HELEN HAMLYN CENTRE FOR DESIGN

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CENTRO INTERNACIONAL PARA SAÚDE REPRODUTIVA

THE AGA KHAN UNIVERSITY

Financiamento: UKRI (UK Research & Innovation) Fellowship Grant
Período: Setembro, 2020-Agosto, 2024).

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Obrigado!

ICRH-M

Virtual presentation

Perinatal Mental Health in Madagascar: Collaboration and Research Insights

Authors: Kantoniony M. Rabemananjara, Lova Mael Rabemananjara, Olivier Rakotomalala & Huynh-Nhu Le

My current research is deeply rooted in my personal background. I was born in Madagascar and moved to the United States at the age of 13 with my family. Witnessing the harsh realities faced by families, particularly mothers, in Madagascar—ranging from stress-related poverty to intimate partner violence and inadequate access to healthcare—sparked my interest in perinatal mental health. As a doctoral candidate in clinical psychology, I have explored these issues in sub-Saharan Africa, with a current focus on my homeland, Madagascar.

Research in other parts of sub-Saharan Africa revealed the widespread prevalence of these perinatal mental health challenges, compounded by cultural variations and resource limitations. Madagascar's research on perinatal mental health is scarce, with only two studies conducted to date. Over the past 8 months, in partnership with a local university, I led a research team composed of 8 graduate research assistants, one research specialist, and a professor. We established partnerships with two large rural and urban community sites in Antananarivo and conducted a mixed methods study to investigate the state of perinatal mental health in Madagascar.

Preliminary findings from 186 perinatal women and 15 healthcare providers have revealed significant associations between social determinants such as financial stability, education, intimate partner violence, childhood trauma, and perinatal mental health issues. Insights from interviews with women and healthcare providers have highlighted specific needs, including the provision of psychosocial support in local clinics and the enhancement of educational opportunities and access for women.

My research journey into perinatal mental health among Malagasy women has sparked more questions than answers. How do we move beyond research, particularly during the interim between data analysis and intervention planning? Where do we start, given the interplay of factors (e.g., socio-economic status, gender-based violence, and access to care) influencing maternal mental health outcomes? How do we access resources from multiple levels to implement interventions on the ground? These are questions that we have been grappling with and hope to share some of our experiences to guide the future of research and practice in perinatal mental health in Madagascar.

krabema@gwmail.gwu.edu

Speaker: Kantoniony (Kanto) Rabemananjara

Originally from Madagascar, I completed my undergraduate studies at Georgetown University, majoring in psychology, and further pursued my MA in psychological sciences at the Catholic University of America. I'm now doctoral candidate in the PhD in Clinical Psychology at George Washington University. As a Fulbright Student Scholar, I am currently conducting my dissertation research on perinatal mental health and adversity back in my homeland in Madagascar. My research pertains to maternal and child mental health, and cultural adaptation of evidence-based interventions in the U.S. and in sub-Saharan Africa. As for my clinical interests, I am passionate about working with underserved children and families from diverse backgrounds as well as perinatal individuals.

PERINATAL MENTAL HEALTH IN MADAGASCAR: COLLABORATION AND RESEARCH INSIGHTS

By: Kantoniony Rabemananjara, M.A.

06/19/2024

Richard Walk Dissertation Fellowship

Perinatal Mental Health in Madagascar

1. **Prenatal anxiety:** 42% (Bakohariliva et al., 2019)
2. **Postpartum depression:** 10-14% (Andriamanjato et al., 2022)

Exploratory Mixed Methods Study

Funding from Fulbright USA and Richard Walk Dissertation Fellowship

1. What are the individual, social, and cultural risk and protective factors associated with CPMDs among Malagasy perinatal women?

2. What are Malagasy women's views and experiences of CPMDs?

Procedures (in partnership with local university)

Early 2022: Reaching out to community members and university partner

Fall 2022: Apply for funding with the help of local university and community members (letter of support)

2022-2023: Secured funding. Consultation with local researcher/staff and training for RAs

2023-2024: Recruit at each respective rural/urban site with the help of church leaders, CHVs, and healthcare providers

2024: Dissemination and sustainability efforts

Community Based Participatory Research

4

Preliminary Findings

Perinatal Depression rates: 56.9%
Rural: M = 10.88, SD = 5.30
Urban: M = 8.03, SD = 5.21

Lessons learned

- Community members (whether as advisors, informants, data collectors, researchers, and liaisons) are essential in maternal mental health research
- Cultural humility is key (as well as being open to learning about the intersection of mental health, womanhood, and motherhood in your specific context)
- Dissemination/Informational research sharing and Outreach efforts matter to communities
- Figure out creative ways to sustain partnerships and collaborations

"It takes a village"

Virtual presentation

Development of guidelines to manage perinatal depression in Namibia

Authors Saara Hatupopi, Mariatha Yazbek & Annatjie van der Wath

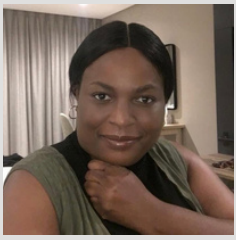
Background: Perinatal depression is a serious mental health disorder and public health concern, which can have disabling effects among women during the perinatal period. Perinatal depressive disorders contribute to between 5% and 20% of the disease burden of women during the perinatal period globally, and 11.9% of women suffering from perinatal depression are from low- and middle-income countries, including Namibia. Perinatal depression has been researched in high-income countries and guidelines developed. However, perinatal mental health guidelines are still lacking in more than 80% of low- and middle-income countries. The extent to which guidelines can target women during the perinatal period is still being explored in low- and middle-income countries. Namibia has no perinatal mental health guidelines, and mental health services are not always readily available.

Aim: The study aimed to develop guidelines to manage perinatal depression in Namibia.

Method: The researchers used a multi-method research design, the constructivist paradigm, and Kinser and Lyon's (2014) conceptual framework of stress vulnerability, depression, and health outcomes in the study. The study was conducted in three phases. Phase 1 explored and described the experiences and the needs of women with perinatal depression. Explored and described the healthcare providers' experiences of working with women with perinatal depression and its management. Phase 2 focused on a systematic literature review of guidelines used to manage perinatal depression globally. Phase 3 involved drafting, refining, and reaching a consensus on the guidelines to manage perinatal depression in Namibia.

Findings: The findings revealed the needs of women with perinatal depression, namely support needs and health care needs. Support needs included social needs and health care support. Healthcare needs included creating awareness about perinatal depression, sensitizing the community and family members, screening for perinatal depression, and a need for privacy, confidentiality, and follow-up visits. Women with perinatal depression established various coping strategies such as spiritual coping, prayer, distraction, self-reliance and resilience. The healthcare providers revealed that the following barriers prevented them from assessing and managing perinatal depression: difficulty recognizing signs and symptoms of perinatal depression, lack of guidelines and health service approach to maternal mental health, cultural influences, lack of community awareness, and a shortage of healthcare providers. The researcher selected the Centre of Perinatal Excellence (COPE) 2017 Effective Mental Health Care in the Perinatal Period: Australian Clinical Practice Guidelines for Adaptation to the Namibian Context. The researchers integrated the findings to develop guidelines to manage perinatal depression to benefit women with perinatal depression in Namibia. The eight developed guidelines to manage perinatal depression are: Prerequisites before screening for perinatal depression. Healthcare providers should screen for perinatal depression using a validated tool. Integrate screening for perinatal depression and assessment of psychosocial risk factors into perinatal care as part of integrative primary health care. Healthcare providers should ensure culturally appropriate screening for perinatal depression and assessment of psychosocial risk factors. Healthcare providers managing perinatal depression with psychosocial interventions. Healthcare providers should assess women with or at risk of suicide. Healthcare providers should establish clear referral pathways and ensure acceptability and feasibility of the integration of perinatal mental health into primary healthcare settings.

Conclusion: The guidelines are the first step in closing the gap in maternal mental health in Namibia. However, these guidelines have not yet been implemented in the primary settings in Namibia. Therefore,there is a need to implement, evaluate the effectiveness and sustainability of these guidelines. Their implementation might facilitate the integration of maternal mental health into primary healthcare settings. The implementation is also required as it will be the first step to train the healthcare providers at the primary health care settings on how to screen, detect and manage perinatal depression. This could help make perinatal depression a public health agenda in Namibia.



Speaker: Dr Saara Hatupopi

Saara holds, PhD in Nursing Science University of Pretoria, South Africa, MN Sc, University of the Western Cape, South Africa, Bachelor of Nursing Science (Advanced Practice) University of Namibia.
Developed guidelines to manage perinatal depression in Namibia during her doctoral study. She is co-author of a few peer reviewed articles in Maternal and Neonatal care in Namibia.

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TITLE: Development of guidelines to manage perinatal depression in Namibia :

- UNIVERSITY OF NAMIBIA
- FACULTY OF HEALTH SCIENCES AND VETERINARY MEDICINE
- SCHOOL OF NURSING AND PUBLIC HEALTH
- (MIDWIFERY DEPARTMENT
- SAARA HATUPOPI:

PERINATAL SERVICES AND PERINATAL ASSESSMENT IN NAMIBIA

- Namibia has no perinatal mental health guidelines and mental health services are not always readily available.
- Namibia has managed to achieve 95% perinatal care coverage, which is above the ratified target (MoHSS, 2017).
- The high enrolment in perinatal care in many parts of the country offers a good opportunity to introduce guidelines to manage perinatal depression.

AIM OF THE STUDY

- **Aim:** The study aimed to develop guidelines to manage perinatal depression in Namibia.
- The study was conducted in three phases.

PERINATAL DEPRESSION IN WINDHOEK/ NAMIBIA

The Edinburgh Postnatal Depression Scale (EPDS)

- Participants: 50 pregnant women and 50 postnatal mothers aged 18 years.
- Of the 100 participants screened, 38 screened positive for depression; 34 of the women scored 10 and above on the EPDS, four indicated suicidal thoughts.
- The researcher interviewed 21 women with perinatal depressive symptoms .
- Of the participants, 14 had antenatal depression and seven had postnatal depression.

Needs of women with perinatal depressive symptoms

1.**Support needs include:**

- Social needs
- Health care support

2. Healthcare needs include:

- Creating awareness about perinatal depression,
- Sensitizing the community and family members
- Screening for perinatal depression
- A need for privacy, confidentiality, and follow-up visits

Barriers preventing healthcare providers assessing and managing perinatal depression

- Difficulty recognizing signs and symptoms of perinatal depression.
- Lack of guidelines and health service approach to maternal mental health.
- Cultural influences
- Lack of community awareness
- A shortage of healthcare providers.

Barriers preventing healthcare providers assessing and managing perinatal depression

- Difficulty recognizing signs and symptoms of perinatal depression.
- Lack of guidelines and health service approach to maternal mental health.
- Cultural influences
- Lack of community awareness
- A shortage of healthcare providers.

GUIDELINES DEVELOPMENT

- The Centre of Perinatal Excellence (COPE) 2017 *Effective mental health care in the perinatal period: Australian clinical practice guidelines* for adaptation to the Namibian context.
- The researcher based the guidelines on the findings of Phases 1 and 2.
- The guidelines were refined by a panel of experts in a nominal group technique.
- Based on the comments and recommendations of the expert panel, the researcher reformulated the guidelines to manage perinatal depression, and consensus was reached.

The eight developed guidelines to manage perinatal depression

- **Guideline one** : Prerequisites before screening for perinatal depression,
- **Guideline two**: Healthcare providers should screen for perinatal depression using a validated tool,
- **Guideline three**: Integrate screening for perinatal depression and assessment of psychosocial risk factors into perinatal care as part of integrative primary health care,
- **Guideline four**: Healthcare providers should ensure culturally appropriate screening for perinatal depression and assessment of psychosocial risk factors,
- **Guideline five**: Healthcare providers managing perinatal depression with psychosocial interventions.
- **Guideline six**: Healthcare providers should assess women with or at risk of suicide
- **Guideline seven**: Healthcare providers should establish clear referral pathways
- **Guideline eight**: Ensure acceptability and feasibility of the integration of perinatal mental health into primary healthcare settings.

Conclusion

- These developed guidelines have not yet been implemented in the primary settings in Namibia.
- Therefore, there is a need to implement, evaluate the effectiveness and sustainability of these guidelines.
- The implementation is required as it will be the first step to train the healthcare providers at the primary health care settings on how to screen, detect and manage perinatal depression.
- This could help make perinatal depression a public health agenda in Namibia.

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THANK YOU !

Virtual presentation

High feasibility, low effectiveness? Lesson from integration of perinatal depression management in routine maternal health services in Mozambique

Authors: Svetlana Karuskina-Drivdale & Carolina Ezequias Bila

In 2019 the Mozambican Ministry of Health has requested PATH's technical assistance to test screening for maternal depression in routine maternal health services. PATH has supported the Ministry to design a protocol for the management of maternal depression and to test it in eight health facilities of Maputo province. The protocol employed client observation and PHQ2 for screening, and adapted WHO's Thinking Healthy approach for initial counseling.

Two rounds of project evaluation demonstrated the success of the pilot in terms of feasibility of integrating management of maternal depression in routine antenatal and postnatal services. All the nurses found the intervention acceptable, feasible and within their mandate. According to service delivery data, 83% of clients were screened at antenatal care and 67% - at postnatal care. The providers pointed to the simplicity of the protocol as key factor in its use. The protocol was made to look like a typical card from Integrated Management of Childhood Illnesses. Additionally, Thinking Healthy counseling steps were simplified into visual cards portraying negative (black and white) and positive (color) scenarios on self-care, relationship with the child, and relationships with significant others. The feasibility was also facilitated by presence of mental health providers in most urban health facilities, who engaged into ongoing mentoring of MCH nurses. The simplicity of the protocol allowed the MOH to quickly roll out the intervention to pilot facilities in seven new provinces, and facilitated its integration into recently approved national postnatal care guidelines.

While over 70% of identified and referred cases of perinatal depression were confirmed by mental health providers, the detection rates were low, with nurses identifying symptomatic cases in between 1 and 3% of all screened clients (rates varied by touchpoint and by pilot phase). Perinatal depression is estimated to be around 20-30% in countries with high HIV burden, which includes Mozambique. Differences between collection of survey and routine service-generated data; generally low adherence to protocols in MCH services; and selection bias in clients who come to maternal services may be implicated in low detection.

Resources: https://www.path.org/our-impact/resources/ppd-pilot-assessment-mozambique/

Speaker: Svetlana Karuskina-Drivdale

Svetlana Karuskina-Drivdale is an Early Childhood Development (ECD) and Maternal Mental Health consultant at PATH. For the last ten years she has been supporting the integration of ECD and maternal mental health promotion into health services and key MOH guidelines in Mozambique, Kenya and Ethiopia. She has led several formative assessments to understand how health services are structured and delivered in real time, and has used the insights to design provider-friendly job aids, training modules and mentoring tools. She is passionate about learning from caregivers and providers. Svetlana holds a Doctorate in Human Development and Psychology from Harvard Graduate School of Education.

sdrivdal@path.org

Organisations

GLOBAL ALLIANCE FOR MATERNAL MENTAL HEALTH

Working together for better outcomes for mothers, babies and families

The Global Alliance for Maternal Mental Health (GAMMH) is a coalition of international organisations and national alliances from around the world committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year (the '*perinatal period*'). Our goal is to prevent the avoidable suffering experienced by women and their families, ensuring child development does not continue to be compromised by a global failure to provide appropriate support and services for mothers' *mental* health.

Worldwide, maternal depression is the most common serious health complication of maternity. This and other mental health problems in pregnancy and postnatally result in huge documented human and economic costs for this generation and the next – yet they are a neglected area of investment in services and research. If the United Nations Sustainable Development Goals are to be achieved by 2030, maternal mental health must be prioritised.

Our aim is to foster the translation of research in perinatal and maternal mental health into better care and outcomes for women and their families wherever they live. This acknowledges the extensive evidence that better mental health in the perinatal period can have a dramatic impact on outcomes for mothers, partners, children, families and society.

Objectives

- Increase international knowledge, awareness and action on maternal mental health, including its pivotal role in child development; the scale of the human and economic costs; and the evidence-based solutions
- Encourage and inform the development of national and regional maternal mental health alliances throughout the world
- Advocate for all countries to develop national policies on maternal mental health
- Inspire investment in evidence-based services and programmes, as well as further research into the causes, prevention, impact and treatment of perinatal mental illness where needed
- Ensure the voice of women with experience of maternal mental health problems is central to all the above

Members

International (more than one country) organisations, or national alliances of organisations that collectively use their influence and efforts to produce change on the ground for women and their families through:

- Promotion of shared goals and vision on maternal mental health
- Easier international collaborative work at all levels
- Ensuring greater impact together than the sum of individual organisational efforts
- Mutual learning and capacity to predict and respond to opportunities
- Using the membership of GAMMH to enhance their own influence

Contribution of members

- *It is not necessary to contribute financially. There is no joining fee*
- Member organisations agree to support the above vision and aim by participating in collaborative efforts to further GAMMH's objectives; the extent of this involvement is dependent on members' own capacity.

Charity Trustees:

We are seeking to appoint two new trustees to the board of GAMMH. We encourage applicants from a variety of backgrounds, particularly those with lived experience and from low and middle income countries. For more information

Further information: For more information, and to enquire about membership, trusteeship and other ways of contributing, please contact Barbara Jayson, GAMMH Secretary, info@gammh.org

Global Alliance for Maternal Mental Health (GAMMH)

Speaker: Dr Alain Gregoire

alain1gregoire@gmail.com

Dr Alain Gregoire initially began his postgraduate training in obstetrics, but on seeing that women with perinatal mental illness were the most ill yet least well cared for, he switched to train in Psychiatry at the Institute of Psychiatry and Maudsley Hospital in London. For the past 30 years he has been a Consultant Specialist Perinatal Psychiatrist, during which he has set up and led multiple specialist perinatal mental health services, and won UK Hospital Doctor of the year and Royal College of Psychiatrists Team of the Year awards. He was a member of the NICE Guideline Development Group for Antenatal and Postnatal Mental Health, and has contributed extensively to the development of policy, strategy, guidance and clinical services in the area of parental and infant mental health in the UK and internationally.

He was the founder and is President of the UK Maternal Mental Health Alliance, a coalition of over 125 national organisations committed to improving maternal mental health care and outcomes for mothers and their infants, and which has successfully campaigned for over £1.3billion of new government funding for perinatal mental health services, now delivering high quality and equitable care to thousands of women and babies across the UK. He has worked closely with several UK ministers in successive Governments, and has been invited to speak to parliamentary meetings and ministers in Belgium, Bhutan, France, Sweden, Spain, Zimbabwe, and the EU; he is an advisor to the Princess of Wales, who recently became MMHA patron. He founded the Global Alliance for Maternal Mental Health, which has similar aims worldwide, with over 25 international member organisations, and has informed the development of successful alliances in many other countries and world regions.

Alain has worked extensively in radio, television and film, including the multiple award winning BBC documentary ‘My Baby Psychosis and Me’, and is a presenter for the multiple award winning BBC TV programme ‘Trust Me I’m a Doctor’. He is trilingual inEnglish, French and Norwegian.

African Alliance for Maternal Mental Health (AAMMH)

AFRICAN ALLIANCE FOR MATERNAL MENTAL HEALTH

WHO WE ARE

AAMMH is an alliance of multisectoral organizations working together to improve the mental well-being of African mothers through education, advocacy, and action. We aim to raise awareness, reduce stigma, and advocate for improved MMH care.

OUR GOALS

- To educate the public on the significance, recognition, prevention, and treatment of MMH conditions.
- To advocate for the prioritization of MMH in the policies, budgets, and research agendas of key actors.
- To ensure that MMH is centrally integrated into reproductive and child health services.
- To support AAMMH members in establishing national alliances.

JOIN US

We welcome members from all fields related to AAMMH's aims including but not limited to Sexual and Reproductive Health and Rights, child and maternal health, and women's rights. Register your organization for free on
Visit www.aammh.org/how-to-join/

WHY MMH MATTERS

Studies show that:

- At least 1 in 5 women experience mental health problems in the perinatal period
- 70% of women hide or underplay the severity of their illness.
- Suicide is the leading cause of maternal death
- Multisectoral action and integration of MMH into reproductive and child health programs can improve outcomes.

SEE US IN ACTION

@matmentalhealth

@matmentalhealth

africanalliancemmh@gmail.com

SOME OF OUR PARTNERS

www.aammh.org

African Alliance for Maternal Mental Health (AAMMH)

Speaker: Dalitso Ndaferankhande

dndaferankhande@mlw.mw

Dalitso Ndaferankhande is a mental health researcher with the Malawi Liverpool Wellcome Trust Programme in Malawi. Dalitso has a Master of Science in Global Mental Health from the University of Glasgow and holds a Bachelor of Social Sciences from the University of Cape Town.

She is a 2024 recipient of the African Mental Health Research Initiative scholarship and is undertaking her PhD co-designing a perinatal bereavement intervention for low-income country settings. Dalitso has many years of experience designing and implementing development and research projects and has worked for international and national non-governmental organisations and institutions of higher learning and research in Malawi, promoting the well-being of women and the youth in gender-based violence, maternal health, women empowerment, and mental health.

She has also consulted with the World Health Organization on defining maternal and perinatal well-being. Dalitso co-led the formation of the African Alliance for Maternal Mental Health and led as its first director. Dalitso has won and led two competitive research and training grants addressing maternal and adolescent mental health in Malawi.

Marce Africa Maternal Mental Health Africa (M.A.M.A)

Marcé Africa
Maternal Mental Health
Africa (M.A.M.A)

The International Marcé Society for Perinatal Mental Health

The International Marcé Society for Perinatal Mental Health is an international, interdisciplinary organization dedicated to supporting research and assistance surrounding prenatal and postpartum mental health for mothers, fathers, perinatal individuals and their babies. The overall mission of the International Marcé Society is to sustain an international perinatal mental health community to promote research and high-quality clinical care around the world. The society aims to promote, facilitate, and communicate about research into all aspects of the mental health of women, men/partners, infants, and their families throughout pregnancy and the first two years after childbirth. This involves a broad range of research activities ranging from basic science through to health services and development of best practice care and prevention. The Society is multidisciplinary and encourages involvement from all disciplines including psychiatrists, psychologists, paediatricians, obstetricians, midwives, nurses, early childhood specialists.

The development of the Marcé Africa regional group is in line with existing regional groups in Europe, North and South America and would be part of the overall mission of establishing international multidisciplinary perinatal mental health care for all. The intentions of the MAMA Regional Group are to showcase local expertise and promote maternal mental health awareness, training and education of health professionals (i.e., psychologists, general practitioners, obstetricians/ gynaecologists, paediatricians, registrars and psychiatrists) throughout the continent. The focus is training and education by Africans for Africans.

Marce Africa Maternal Mental Health Africa (M.A.M.A)

Speaker: Dr Lavinia Lumu

lavinia.lumu@yahoo.com

Dr Lavinia Lumu completed the fellowship in psychiatry and obtained the FCPsych (SA) qualification from the Colleges of Medicine in South Africa and a Master of Medicine in Psychiatry (Witwatersrand).

Currently in private practice with a special interest in perinatal psychiatry and currently running a pro-bono maternal mental health clinic at the Rahima Moosa Mother and Child Hospital. An advocate for maternal mental health and supports the Grow Great - Flourish Foundation in maternal mental health training.

An honorary lecturer at the University of the Witwatersrand, Department of Psychiatry, Faculty of Health Sciences, and also the president-elect of the International Marce' Society Perinatal Mental Health.

Perinatal mental health clinic

–

“Ask the experts”

Panel members

Linos Muvhu

Linos Muvhu is a Keynote Speaker, a global advocate for perinatal, paternal and child mental health. My interest in perinatal mental health spans over 20 years. He founded Society for Pre and Post Natal Services (SPANS), International Conference on Maternal Mental Health in Africa (ICAMMHA) and Society for Pre and Post Natal Services Vocational Training Institute. He is the African Ambassador International Father's Mental Health Day (IFMHD). Linos Muvhu has written many abstracts, several stories, several publised papers and articles. Linos was awarded scholarships to attend The Marce Society Conferences, Population Support International conferences (PSI), International Confederation of Midwives (ICM), International Maternal Newborn Conference (IMNHC) and FIGO.

Developing and embedding a family therapist cadre into the health system in Zimbabwe

Author: Linos Muvhu

Background: A growing body of evidence reveals the global burden of common perinatal mental health conditions, with direct and indirect links between mental health and maternal and child morbidity and mortality. The huge economic and human costs attached to global failure to take action warrant the development of whole family-based approaches to perinatal mental healthcare. However, in low-income contexts such as Zimbabwe, there are extremely few trained mental health specialists (1 psychiatrist, 4 psychologists and 65 mental health nurses per 1,000,000 people).

Methods: Family therapists use open dialogue and collaboration to create an enabling environment where all family voices are heard and cultural expressions of mental health conditions can be identified early. Family therapists in primary care settings can visit families at home, organise follow-up, referrals and link families to multidisciplinary service providers. The Society for Pre and Post Natal Services (SPANS) leads the perinatal, paternal and child mental health (PPCMH) programme. Through PPCMH, SPANS works with Zimbabwe's Ministry of Health and Child Care (MoHCC) to train family therapists, strengthen health education, conduct research and organise the international conference on maternal mental health in Africa (ICAMMHA).

Results: In this presentation, Mr Muvhu will share experience from the planning, recruitment and implementation of PPCMH in the Zimbabwean context.

Conclusions: Mr Muvhu's talk will focus on lessons learned by SPANS from PPCMH and recommendations for task-shared mental health services across the breadth of low-resource settings.

Panel members

Julitta Kenala Malava

She is a research scientist currently working with Malawi Epidemiology and Intervention Research Unit (MEIRU). Jullita briefly worked with Malawi Ministry of Health as a nurse before joining University of North Carolina (UNC) Lilongwe Project as a research nurse in 2004. She later joined MEIRU in 2015 to lead a large cluster randomized trial; the Cooking and Pneumonia Study (CAPS). She is currently leading Generation Malawi birth cohort. Her passion is in maternal mental healthcare and implementation research. She coordinated the northern region sites of Sub-Sahara African Regional Partnership (SHARP) for mental health capacity building. SHARP Study integrated depression care into 10 non-communicable disease clinics in the three regions of Malawi. This was a sub-contracted research project between MEIRU and UNC Project. Through the SHARP Project, she won a small grant to conduct a pilot implementation study to explore implementation challenges for integrating common perinatal mental disorders screening and management into maternal and childcare services. Jullita co-authored multiple mental health papers from the main SHARP project, and she is working towards submitting a manuscript of this pilot project which is part of her presentation today.

Perceived implementation challenges in Malawi for integration of common perinatal mental disorders screening and management into routine maternal and child health services among stakeholders in Northern Malawi: a mixed methods formative study

Authors: Jullita Kenala Malava, Maganizo B. Chagomerana, Christopher F. Akiba, Mina C. Hosseinipour, Albert Dube, Robert C. Stewart, Amelia C. Crampin, Bradley N. Gaynes & Brian W. Pence

Evidence shows that integration of interventions for common perinatal mental disorders (CPMDs) into primary care in low- and middle-income countries is feasible and acceptable. However, Malawi has not implemented this integration. We aimed at assessing stakeholders' attitudes toward, and organizations' readiness for, integrating CPMD care into routine maternal and child health (MCH) settings, and exploring barriers and facilitators for integrating CPMDs into MCH care, in Northern Malawi.

We conducted a mixed methods study June=September 2019 among stakeholders at Chilumba Rural and Karonga District hospitals. Participants included service users and healthcare providers. A structured questionnaire, Organization Readiness for Implementing Change (ORIC) checklist, and the Evidence Based Practice Attitude Scale (EBPAS) were used to collect quantitative data. The ORIC has a five-level rating scale ranging from 1 (disagree) to 5 (agree). The EBPAS has a five-level response scale ranging from 0 (not at all) to 4 (very great extent). Six focus group discussions and 20 in-depth interviews were conducted. We analyzed quantitative data using descriptive statistics, while qualitative data were transcribed and analyzed using a thematic analysis approach. Fifty-six participants completed questionnaires, 50% from each hospital. The mean age of participants was 39 years (SD=8.5). Slightly above half (n=29/56, 51.8%) were females and 57%(30/56) were service users. Stakeholders perceived that the two hospitals were ready to implement the change and that providers had positive attitudes towards integrating CPMDs into MCH services. Facilitators were, having dedicated staff, supportive leadership, availability of mental health staff, and referral linkage to a psychiatric hospital. Barriers included not enough space, extra workload, inadequate resources, inadequate pre-service mental health training, and unavailability of policies and guidelines for CPMD care.

Suggested solutions to barriers included using the inpatient maternity ward to create space, adding more staff/giving allowances, and changing the nursing-clinical curricula to accommodate maternal mental health during preservice training and Ministry of health to make maternal mental health screening a policy. We conclude that these findings indicate openness to integrating CPMDs care into MCH services, but certain barriers (extra workload and limited space) must be addressed when developing implementation strategies to support this integration in Northern Malawi.

UNC PROJECT Lilongwe, Malawi

MEIRU
Malawi Epidemiology and Intervention Research Unit

Perceived challenges of integration of common perinatal mental disorders' screening and treatment into routine maternal and childcare services

Jullita Kenala-Malava
malavajkenala@gmail.com
MMH in Africa Symposium
19 June 2024

Background

- CPMDs: depression, anxiety and somatic distress [1]
- Integrating MMH into MCH services both feasible and acceptable[2-6]
- Malawi, a critical shortage of MH specialists
- Task sharing.[7]
- Malawi has implemented MH integrated services by task sharing
  - community-based care [8],
  - HIV care [9]
  - non-communicable diseases (NCD) clinics. [10]
- However, the integration of CPMDs' interventions into MCH care not implemented in Malawi
- Aimed at assessing providers attitude, facility's readiness and barriers, facilitators for implementing the integration of CPMD screening and management into MCH settings.

Methods:

- Mixed methods
- Chilumba Rural and Karonga District hospitals
- Service users and health care providers
- EBPAS, ORIC, interview guides
- Stata version 15
- Interviews done in a local language, transcribed and translated into English,
- Theme guided by CFIR

Results

- 56 participants June-September 2019
- The two hospitals were ready to implement the change
- Providers had positive attitudes towards integrating CPMDs into MCH services.
- **Barriers:** inadequate pre-service MH training, unavailability of policies and guidelines for CPMD care, not enough working space, extra workload, inadequate resources.
- **Solutions:** GPs curriculum, CPMDS policy by MOH, Government to add more staff/provide incentives to existing staff, maternity ward, essential mental health medications available
- **Facilitators:** Dedicated staff, supportive hospital leadership, perceived benefits, availability of mental health staff and having a referral linkage to a psychiatric hospital

Conclusions:

- The integrated services are important, welcomed and needed
- Providers have positive attitude, and the two health facilities would implement this integration
- The findings indicate openness to integration of CPMDs into MCH services, but certain barriers must, be addressed when developing implementation strategies to this integration in Northern Malawi.

Next steps ??? funding

- Adoption
- Fidelity
- sustainability

- Manuscript submission

Acknowledgements and References

study participants

Dr. Robert C. Stewart & Prof Brian W. Pence (supervisors and mentors)

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Panel members

Professor Wendy Janssens

Wendy Janssens is Full Professor in Development Economics at the Vrije Universiteit Amsterdam. She is Academic Board member of the Amsterdam Institute for Global Health and Development (AIGHD), and appointed Director of the Health Economics Research institute Amsterdam (HERA). Her work focuses on evaluating the drivers of behavior and impact of interventions in the areas of women's empowerment, sexual and reproductive health, mental health and access to healthcare. She has extensive experience in designing and coordinating large-scale, multi-disciplinary and mixed-methods research programmes across the globe in order to provide rigorous and locally grounded policy advice. The methods she employs range from large-scale randomized control trials (RCTs), granular high-frequency diaries data, and psychological measurement tools, to focus group discussions and experimental lab-in-the-field games. She has received numerous research grants and awards, amongst others to assess "The acceptability and feasibility of a group-based maternal mental health intervention in Kenya", to study the relationship between "Contraceptive use, HIV/AIDS and women's bargaining power in Mozambique" and the differential impact of "Targeting an edutainment intervention to men, women or both, to change social norms and child marriages in Pakistan". Her work has been published in top journals in economics, medicine, and demographic studies. Wendy's maternal mental health research is joint work with a team from PharmAccess Foundation (Kenya and Amsterdam), the Amsterdam Institute for Global Health and Development (AIGHD) and the African Population and Health Research Center (APHRC): Teresa de Sanctis, Sujan Katuwal, Emma Waiyaiya, Moses Otieno, Rowena Wairimu, Charlotte Dieteren, Wietse Tol, and Estelle Sidze.

Acceptability and feasibility of a group-based mental health intervention for pregnant women in Kenya

Authors: T. De Sanctis, S. Katuwal, E. Waiyaiya, M.Otieno, R.N. Wairimu, C.Dieteren, E. Sidze, & W. Janssens

Background: Despite a high prevalence of perinatal depression in low-and-middle-income countries, access to mental health support services for pregnant women is scarce. Without adequate care, poor maternal mental health (MMH) can persist for years; adversely affecting maternal, newborn, and child health outcomes. This study aimed to assess: 1) the needs and perceptions towards emotional and psychological support for pregnant women, and 2) the acceptability and feasibility of a contextualized, group-based MMH intervention in Kenya, delivered through Community Health Workers (CHWs).

Methodology: To investigate needs and perceptions, 10 Focus Group Discussions (FGDs) were organized with 73 participants (mothers, partners, CHWs and nurses), and analysed using a socio-ecological model for health behavior. The results were used to adapt the WHO Problem Management+ group-based mental health intervention, which was subsequently piloted in three clinics in Kisumu County. Pregnant women who enrolled for antenatal care (ANC) at one of the study sites were screened for depressive symptoms using the Patient Health Questionnaire (PHQ)-2; eligible women were invited to participate in the MMH pilot, and respond to the PHQ-9 and EPDS before and after the intervention. After the intervention, 8 FGDs were conducted with 54 participants (mothers, partners, CHWs, and nurses), and analysed using Sekhon's seven dimension framework to comprehensively assess the acceptability of the intervention.

Findings: All baseline respondents acknowledged the burden of MMH, but participant types diverged in their perspectives on the main challenges. Of the 401 screened women, 36% showed depressive symptoms; 72% of them attended at least one session. Most mothers felt the learned strategies helped them to manage stress. They recommended expanding the intervention to include their partners. Partners were mostly supportive, and observed their wives handled daily challenges more easily. CHWs felt empowered to help mothers navigate through MMH challenges, while indicating a desire for additional training. Nurses emphasized the importance of engaging them more effectively.

Conclusion: This study underscores the need for contextualized, scalable MMH interventions. The integration of low-cost, group-based mental health support into routine ANC services within the primary healthcare sector is feasible and deemed acceptable by pregnant women, their partners and health workers alike.

Keywords: Acceptability, maternal mental health, perinatal depression, group-based intervention, task-sharing, Kenya

Contextualizing a Maternal Mental Health Intervention for pregnant women in Western Kenya

Oxford 2024 – Prof. Dr. Wendy Janssens (Vrije Universiteit Amsterdam)
with T. De Sanctis, S. Katuwal, E. Waiyaiya, M.Otieno, R.N. Wairimu, C. Dieteren, W. Tol, E. Sidze

Maternal mental health (MMH) support for pregnant women

- **WHAT:**

  → Adjust and contextualize the **WHO group-based Problem Management+ (PM+) intervention**.

  → PM+ is based on **task-sharing** – proven effective in helping people with mood/anxiety challenges in low-resource settings, but not adjusted for pregnant women in Western Kenya yet.

- **WHO:**

  Pregnant women who enrolled in PharmAccess' **MomCare** program (Maternal, Neonatal and Child Health – MNCH)

Maternal mental health (MMH) support for pregnant women

- **HOW?**
  We followed a multistep approach:

1. **10 baseline FGDs** with mothers, their partners, CHWs, and nurses on "mental health challenges and support"
2. **Consultation sessions** with local psychological experts
3. **Adaptation of PM+** to the context of MNCH in rural Western Kenyan (curriculum, posters, simplified manual)
4. **Recruitment and training of local facilitators**
5. **Screening of new MomCare enrollees (n=401)**: 161 (40%) screened positive for mental health challenges
6. **Delivery of PM+ group sessions** to 78 (48%) of invited pregnant women
7. **8 endline FGDs with participant** mothers, their partners, CHW's, and nurses on "acceptability of intervention"
8. **Dissemination** among local and national stakeholders, policy briefs, academic papers/presentations


Strengthening social support

MMH | Endline qualitative learnings

VU Vrije Universiteit Amsterdam

PHARMACCESSGROUP

MOMCARE

GOAL: Assess acceptability and feasibility of the MMH intervention

8 FGDs with **mothers** (n=3), **fathers** (n=1), **CHWs** (n=1) and **nurses** (n=3) in three clinics: Kombewa, Masaba, and St Monica (n=51)

Key findings

- Participants valued **confidentiality, sharing, laughing together**
- **Stress management** relieved tensions in homes
- Involvement/support of **husbands** is crucial
- **Embedding** with existing (primary care) MNCH program helps
- Combine with information on **maternal and child health**
- **Continue sessions** after birth
- **Practical barriers** remained a challenge (communication, transport, childcare support, refreshments)
- **Nurses and CHWs** expressed desire for advanced **training**

De Sanctis, T. et al (2024), "Acceptability and feasibility of a group-based mental health intervention for pregnant women in Western Kenya".

Funded by Share-Net Netherlands and the Health Insurance Fund

THANK YOU FOR YOUR ATTENTION!

Panel members

Associate Professor Simone Honikman

See page 7 for Simone's bio

The Perinatal Mental Health Project: tackling the issue from many angles

Author: Simone Honikman

Background
In South Africa, one in three women will experience depression and or anxiety during pregnancy and the year after the birth. This public health crisis is largely driven by systemic socioeconomic drivers - many linked to the legacy of Apartheid. Together with a healthcare system under enormous strain, this requires a complex and comprehensive response.

The Perinatal Mental Health Project (PMHP) has been operating since 2002 and is located within the Alan J Flisher Centre for Public Mental Health at the University of Cape Town.

PMHP's multicomponent response

- The PMHP provides a **comprehensive maternal mental health service**, using a collaborative, stepped-care model. The service is integrated within a community-based, public, primary maternity care setting in Cape Town. This service serves as a demonstration site for others who wish to adapt and provide similar models of care. Continued refinement of service design elements has yielded improved efficiencies and outcomes. The service integrates interventions that address social determinants of mental health problems.
- The PMHP developed and validated a brief, binary, first stage **mental health screening** tool suitable for the local setting, by using both psychometric and cognitive testing methods. This tool assesses for symptoms of depression, anxiety and suicidality. It has been incorporated into the national Maternity Case Record, the standard clinical stationery used nationally, as well as several national guideline documents.
- The PMHP builds healthworker capacity through a **teaching and training programme** for under- and postgraduate health science students and in-service health workers, including community health workers and managers.. The training rest on the pillars of building of 1) mental health knowledge 2) primary mental healthcare and empathic engagement competencies and 3) self-care strategies. Several multimedia resources and novel interactive training modalities have been developed to support the scaling of this programme.
- Building and maintaining relationships with Department of Health officials allows for PMHP to respond to their call for support to draft mental health or maternal health **policies and guidelines**.
- **Social and traditional media** are harnessed as **advocacy tools** to increase mental health knowledge, reduce stigma and increase demand for maternal mental health services among the general public, service users as well as service planners and managers.
- The PMHP conducts, translates and disseminates **research to facilitate the uptake** of evidence-based practice by practitioners, policymakers and health officials working in resource constrained settings.


Perinatal
Mental Health
Project
Tackling the issue from
many angles
www.pmhp.za.org
Photo: PMHP

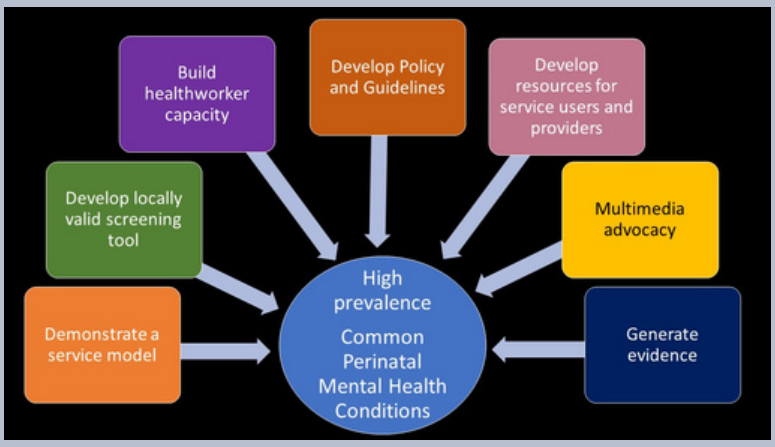

Build healthworker capacity
Develop Policy and Guidelines
Develop resources for service users and providers
Develop locally valid screening tool
Multimedia advocacy
High prevalence
Common Perinatal Mental Health Conditions
Demonstrate a service model
Generate evidence


Photo: Bev Meldrum

Mental Health Screen


health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Maternity Case Records

LEVEL OF CARE	
Antenatal clinic:	Delivery site:
Transport when in labour:	

MomConnect

Woman's name:

ID Number:

Institution file No.

Name of Birth Companion:

Contact number of Birth Companion:

CONTACT DETAIL of MANDATE

Name of person mandated to consent on behalf of woman when appropriate:

Contact telephone No of mandate:

Should I be unable to consent myself, I mandate the above in terms of the National Health Act to do so on my behalf

Signed: Date: Witness:

Revised June 2018


MENTAL HEALTH SCREEN

ONLY to be conducted if resources are available for referral, e.g. mental health nurse, social worker, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

"We would like to know about all the women who come here: how they are doing physically and emotionally. This helps us to understand the best sort of care we can offer. Please may I ask you three questions about how you are emotionally? Please answer 'yes' or 'no' to each question."

In the last 2 weeks, have you on some or most days felt unable to stop worrying or thinking too much?	☐ Yes [1]	☐ No [0]
In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	☐ Yes [1]	☐ No [0]
In the last 2 weeks, have you on some or most days had thoughts **and** plans to harm yourself or commit suicide?*	☐ Yes **Refer** [1]	☐ No [0]
TOTAL SCORE	☐ 1 ☐ 2 >>>>>>>>>>> refer ☐ 3 >>>>>>>>>>> refer	
Offered Counselling	☐ Yes	☐ No
Accepted counselling	☐ Yes	☐ No

*the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.


Photo: PMHP

BUT

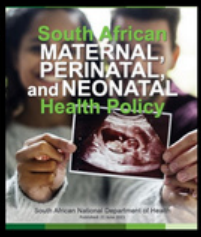
screening by staff remains low

AND

responses by women do not reflect high prevalence of common mental disorders

And then…
SA Policies and implementation work in last 3 years

Policies



Guidelines

- WHO Integration Guide
- SA Standard Treatment Guidelines
- SA Maternity Care Guidelines

etc.

Capacity Building resources

Perinatal Mental Health Project

Caring for mothers. Caring for the future.

Alan J. Flisher Centre for Public Mental Health

Maternal Support Service

At the Perinatal Mental Health Project (PMHP), we offer a comprehensive and collaborative stepped care mental health service on site at the Hanover Park Midwife Obstetric Unit (MOU).

1. All women who register at the MOU for antenatal care are provided with mental health Promotion, Prevention and Preparation (PPP) for the service.
2. Women are routinely screened by midwives at their first antenatal visit (mental health screening).
3. Health Promotion Officer obtains consent from mothers and onboards them to the PMHP service.
4. A PMHP counsellor conducts Engage, Assess, Triage (EAT).
5. The EAT session and counselling are provided on-site in the small PMHP building adjacent to the MOU.

1. PPP conducted in MOU waiting room
2. Mental health screening
3. Consent and onboarding
4. EAT session
5. PMHP service site at MOU

Stepped-care model

PPP
Waiting room talks and brochures for all women

Universal screening
Universal screening of all bookings by midwives; 3-item tool

Negative screen

***Target population including risk groups**

Positive Mental Health score of 2/3 or more

Onboarding by Health Promotion Officer
Consenting to the PMHP service. Rescreening if universal screen took place > 2 weeks ago. Screening of transfers from other sites.
Offered EAT session

Negative screen

Accept EAT (Engage, Assess, Triage)
PMHP counsellor conducts session

Decline EAT
Offer option to return for EAT at any stage

Decline counselling**

Tyla Prinsloo (Mental Health Counsellor) and Liesl Hermanus (Clinical Services Coordinator)

Counselling referrals

Low intensity intervention
Provide an extension of the EAT session when women require minor intervention but no ongoing counselling

***Moderate intensity intervention**
Offer on-site counselling and case management with Mental Health Counsellor

****High intensity intervention**
Offer on-site counselling and case management with Clinical Services Coordinator

Notes
*Teenagers, women with HIV, previous clients of PMHP service, women experiencing GBV
** Women who decline counselling: offer contact details of other support and option to return to book a counselling session
*** Counselled women: provided with further support through facilitated referrals to the community mental health team and/or various NGO's, depending on the needs of the client

Postnatal follow-up assessment (structured)
> 6 weeks post birth via telephone/in person

www.pmhp.za.org

Disclaimer: no images of PMHP clients used

Perinatal Mental Health Project

Caring for mothers. Caring for the future.

Thank you

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http://perinatalmentalhealth.wordpress.com/make-a-difference/

Alan J. Flisher Centre for Public Mental Health

Panel members

Haliq Adam

Haliq Adam, MPH is a Public Health Specialist with over 14 years' experience in the coordination of nutrition, HIV/AIDS, Maternal and Child Health Interventions. Haliq holds 2 masters degrees: One in Project Management from Kwame Nkrumah University and one in Public Health from the University of Ghana. Haliq is currently the project manager for the Rural Emergency Health Service and Transport for System development (REST4D) project, a 5-million-dollar grant in maternal and child health. He previously provided leadership for REST4D's predecessor project REST II under which Intgrated Mothers and Mothers Course was conducted.

Key co-author

Huynh-Nhu (Mimi) Le

Huynh-Nhu (Mimi) Le, PhD is a professor and clinical psychologist in the Department of Psychological and Brain Sciences at The George Washington University. Dr. Le's programmatic research spans both clinical psychology and public health fields and aims to develop, evaluate, and disseminate preventive interventions that are culturally and contextually adapted to meet the needs of pregnant and postpartum people at high risk for depression in the United States and internationally. She co-developed the 'Mothers and Babies Course' (MBC), a cognitive-behavioral group intervention designed to prevent perinatal depression in low-income women. This intervention was cited by the United States Preventive Task Force (USPTF; 2019) as an evidence-based intervention to prevent perinatal depression. For the past 8 years, she has served as a consultant collaborating with Catholic Relief Services to adapt the Mothers and Babies Course for rural women with young children integrating mental health prevention in early childhood development programs in different countries in sub Saharan Africa, including Kenya, Tanzania, Malawi, Zambia, and Ghana.

Special acknowledgment to Elena McEwan, Catholic Relief Services, USA; Sister Judith Mwango, Franciscan Missionaries of the Divine Motherhood, Zambia)

Lessons Learned in the Implementation and Validation of the Integrated Mothers and Babies Course to Prevent Perinatal Depression in Sub-Saharan Africa

Authors: Haliq Adam, & Huynh-Nhu (Mimi) Le

Perinatal depression is among the most common mental disorders affecting childbearing women in sub-Saharan Africa. In this presentation, we describe the history and partnership between an academic (George Washington University) and an international humanitarian organization (Catholic Relief Services/CRS) to adapt the Mothers and Babies Course (MBC), an evidence based cognitive behavioral preventive intervention developed in the United States, to the rural context in various countries in sub-Saharan Africa and implemented this innovation as part of an early childhood development (ECD) project. This partnership began in 2016, in which the MBC was adapted to fit the contexts of rural pregnant individuals and mothers of young children in Kenya and Tanzania, resulting in an Integrated Mothers and Babies Course (IMBC). Community Health Workers (CHWs) were trained to deliver these interventions with master trainers providing supervision in the field. Master trainers also received additional remote supervision from the intervention developer.

Since this time, the IMBC has been expanded to other countries in sub-Saharan Africa, including Ghana, Malawi, Zambia, Zimbabwe, and Rwanda. In each country, different strategies were used to: (a) justify the inclusion of preventive maternal mental health interventions; (b) gather support from different stakeholders (e.g., village elders, sisters congregations, ministries of health) for implementation; (c) identify and train master trainers and CHWs; (d) support supervision to maximize intervention fidelity; and (e) validate and evaluate the intervention. Several research trials have been conducted on the IMBC. However, these results have been mixed regarding the effectiveness of the IMBC, due to challenges in identifying “high risk” eligibility criteria, facilitator qualifications, competing social determinants of health demands that affect attendance (e.g., moving out of village for work), implementation, and intervention fidelity.

This presentation will include a discussion from the CRS team, including the senior technical advisor, project manager from Ghana, master trainer from Zambia, and intervention developer regarding how we addressed these challenges at the country level to optimize engagement, delivery, evaluation of outcomes and sustainability of this intervention in these countries.

Lessons Learned in the Validation of the Integrated Mothers and Babies Course to Prevent Perinatal Depression in Sub-Saharan Africa

Haliq Adam

Catholic Relief Services (CRS), Ghana

Huynh-Nhu (Mimi) Le, George Washington University

Elena McEwan, CRS Headquarters

Maternal Mental Health in Africa – Conversations

June 19, 2024

Mothers & Babies Course

Cultural Adaptation in Tanzania, Kenya, Ghana, Zimbabwe, Malawi, Zambia Rwanda and Myanmar.

Integrated MBC – RCT Kenya and Ghana

- Very high levels of participant satisfaction
- Low hope and moderate/severe hunger are significantly associated with poor maternal mental health.
- **Overall impact** –N*o difference* in maternal depression or child social-emotional development between iMBC/ECD and control groups in Ghana or Kenya
- **Sub-analyses** – Significant reduction in depressive symptoms among women with:
  - ✓ Higher attendance in iMBC/ECD
  - ✓ Moderate depression levels
  - ✓ Lower education status
  - ✓ Having more children (4+)
  - ✓ No experience of physical or sexual IPV

Baumgartner et al. 2021

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