

Maternal mental health care: refining the components in a South African setting

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Introduction

In low- and middle-income countries (LMICs), competing health priorities, civil conflict, and a lack of political will mean that expenditure on mental health is a fraction of that needed to meet the mental health care needs of the population (Chisholm *et al.* 2007). For mothers, this treatment gap is most notable in regions where health agendas focus on maternal mortality indicators (Saxena *et al.* 2007).

The South African Stress and Health study indicates that in the general population, 9.8% of South Africans experience mood disorders, with a lifetime prevalence of 15.8% for anxiety disorders (Stein *et al.* 2008). However, research shows that, despite South African policy and legislation advocating for a community-based provision of mental health, mental health services are still not adequate (Lund *et al.* 2010). Untreated perinatal mental disorders can have significant impact on the well-being of the mothers, their children, and their community. The transgenerational effects have been well established, and are felt particularly in societies facing adversity (Talge *et al.* 2007, Hay *et al.* 2008).

This chapter briefly reviews the literature on common perinatal mental disorders, describes the activities of the Perinatal Mental Health Project (PMHP) based at the University of Cape Town (UCT), South Africa, and reports on lessons learnt regarding the integration of maternal mental health care within primary care settings.

Background to common perinatal mental disorders

A global perspective

Common perinatal mental disorders (CPMDs) refer to non-psychotic disorders, most commonly depression

or anxiety, which are experienced during pregnancy (antenatally) and/or within the first 12 months after delivery (postnatally) (Fisher *et al.* 2012).

Data from high-income countries show prevalence rates of 13% for antenatal depression (Hendrick *et al.* 1998) and 10% for postnatal depression (O'Hara & Swain 1996). A literature review from LMICs, however, reported that CPMDs are more common in LMICs, particularly amongst poorer women (Fisher *et al.* 2012), with a mean prevalence of 16% and 20% for antenatal and postnatal CPMDs respectively.

Interventions for pregnant women in sub-Saharan Africa have primarily focused on physical aspects of maternal and reproductive health, neglecting mental disorders (Skeen *et al.* 2010).

CPMDs in South Africa

In South Africa, research has shown high prevalence rates of depression amongst pregnant and postnatal women. In an informal settlement outside Cape Town, 39% of pregnant women screened positive for depression (Hartley *et al.* 2011) and 34.7% of postnatal women were diagnosed with depression (Cooper *et al.* 1999). In a rural area with high HIV prevalence, 47% of women were diagnosed with depression (Rochat *et al.* 2011).

Consequences of CPMDs

Adverse consequences of CPMDs reported in women during pregnancy include non-adherence to maternal care, self-medication with alcohol or drugs, disturbed sleep and appetite, and poor weight gain. Maternal depression in HIV-positive pregnant women can result in reluctance to access healthcare services, which affects adherence to antenatal interventions,

critical to the prevention of mother-to-child transmission of HIV (Rochat *et al.* 2006). CPMDs are also associated with higher rates of miscarriage, cesarean section delivery and preterm delivery, and low infant birth weight (Lusskin *et al.* 2007, Grote *et al.* 2010).

Untreated CPMDs can lead to multiple negative health outcomes for the fetus, infant, and child (Meintjes *et al.* 2010). CPMDs have been associated with poor fetal brain and neuro-development (Oates 2002), as well as alterations in the internal hormonal environment, all of which have implications for postnatal information processing (Bonari *et al.* 2004). CPMDs have also been associated with delay in the initiation of breastfeeding, which in turn is associated with infant mortality and increased diarrheal episodes, particularly in low-income settings (Rahman & Creed 2007).

Finally, CPMDs are associated with negative cognitive and emotional development outcomes in infants and children. These include increased crying and irritability, hyperactivity, unsocial behavior, attention-deficit/hyperactivity disorder, inconsolability, and lower language achievements (O'Connor *et al.* 2002, Murray *et al.* 2003, Patel *et al.* 2004).

Context of the Perinatal Mental Health Project (PMHP)

For women living in adversity, it is challenging to engage with mental health services when, in addition to facing competing priorities relating to poverty, violence, and childcare, they are confronted with the stigma of mental illness. However, in South Africa, despite limited resources, women tend to access health care during their pregnancies: over 99% of pregnant women have at least one antenatal care visit at a maternity facility, with a mean of 3.7 visits per client (Padarath & English 2011). Obstetric services in South Africa provide antenatal care at a primary level, and women with obstetric risk or complications are referred to secondary or tertiary-level care. The antenatal period thus presents a unique opportunity for intervention for women who are experiencing mental disorders.

The Perinatal Mental Health Project (PMHP) was founded in 2002 as a new mental health service for pregnant and postnatal women in Cape Town, South Africa. The PMHP provides integrated screening, counseling, and psychiatric services in four primary-level maternity facilities around Cape Town. For

the purpose of this chapter, only the clinical services of one of the facilities is described. Cape Town has a population of approximately 3.5 million, where 85% are literate, a quarter of the population is unemployed, and 12% of the general population access poverty grants (Provincial Government Western Cape 2010). The South African birth rate is reported to be 19.48/1000 population, with Cape Town reporting 68 180 births annually (Index Mundi 2011).

Aims of the PMHP

The aim of the PMHP is to develop a model of mental health services for pregnant and postnatal women that is integrated into primary obstetric services in low-resource settings.

Clinical services

Integrated stepped-care model

The PMHP's mental health service is based on a stepped-care model (Honikman *et al.* 2012), which has been shown to provide a useful framework for the integration of psychological treatment in primary settings (Araya *et al.* 2003, Patel *et al.* 2007). At the facility, screening for mental health among pregnant women is conducted by maternity nurses, who refer those identified with mental distress for counseling. Counselors can then refer clients to a psychiatrist if further intervention is needed. Clients can continue to receive counseling for up to one year postpartum.

Screening

With the women's consent, nurses or midwives offer women a mental health screening form, which consists of the Edinburgh Postnatal Depression Scale (EPDS: Cox *et al.* 1996) and the Risk Factor Assessment (RFA), designed by the PMHP (Meintjes *et al.* 2010). The RFA screens for the presence of 11 common risk factors for perinatal disorders (Josefsson *et al.* 2002, Husain *et al.* 2006, Lusskin *et al.* 2007, Robertson *et al.* 2007); these include lack of partner or family support, unintended pregnancy, and domestic violence.

The mental health screening is self-administered in private. It is available in three local languages – English, Afrikaans, and Xhosa – and in French, because there is a significant Francophone refugee population attending the facility. The screening form is scored by midwives, and if scores meet the cut-off

Table 19.1 Descriptors of women screened at PMHP in 2011 ($n = 1708$)

Mean age	26.6 years
Mean gestation	22.5 weeks
Mean gravidity	1.96
Mean parity	0.7
Mean EPDS score	8.5
Mean RFA score	1.5

EPDS, Edinburgh Postnatal Depression Scale; RFA, Risk Factor Assessment.

on either the EPDS or RFA (> 12 on EPDS and/or > 2 on RFA), women are offered referral for counseling. These cut-offs were chosen on the basis of international convention (Cox *et al.* 1996) and a pragmatic approach to service capacity.

Table 19.1 provides demographic and mental health screening data for women screened in 2011. In that year, the majority of women booked their first antenatal appointment in their second trimester. Most women were primiparous.

Counseling

Individual face-to-face counseling is provided by counselors. The counseling component has changed over time in terms of employment status, qualifications, and the number of hours available for counseling. Details indicating these differences over three time periods can be found in Table 19.4. Counselors were oriented to the PMHP and trained to use a client-centered approach to overcome the clients' distress and address problems presented at screening.

Brief structured psychosocial treatments, including cognitive behavior therapy, interpersonal therapy, and problem-solving approaches, have been recommended as evidence-based interventions for depression (Dua *et al.* 2011). The PMHP counseling techniques include elements of these, and others such as containment, psychoeducation, bereavement counseling, debriefing of traumatic incidents, and suicide and impulse risk management. A research protocol is being developed to standardize the counseling intervention provided by lay counselors, based on one of these evidence-based interventions. Table 19.2 indicates mean screening scores and categories of problems presented by clients counseled in 2011.

Table 19.2 Presenting problems for counseling clients of PMHP in 2011 ($n = 291$)

Clients' screening scores	
Mean EPDS score	13.8
Mean RFA score	2.9
Presenting problems	% of clients
Primary support problems	89
Social environment difficulties	51
Health/medical problems	31
Problems adjusting to life-cycle transition	65
Previous/present psychiatric condition	24
Presenting more than one problem	76

EPDS, Edinburgh Postnatal Depression Scale; RFA, Risk Factor Assessment.

Lack of primary support, which typically involves lack of partner or family support, was the most reported problem. Adjusting to life-cycle transition was also a commonly reported problem, and typically referred to clients who had unintended, unwanted, or adolescent pregnancies.

Though the total number of counseling sessions can be limited, with a mean of 2.8 sessions per client in 2011, additional support to counseled clients is provided by the counselors through liaison with external agencies, social services, or support organizations, as well as through additional counseling provided on the telephone. In 2011, more than 10% of counseled clients were referred to additional services, and 20% received one or more telephone counseling sessions, in addition to their face-to-face counseling sessions.

Psychiatric referral

As part of the stepped-care model, counselors can refer clients who require additional assessment and treatment to an on-site psychiatrist. The psychiatrist attends the clinic twice a month. Table 19.3 provides a summary of descriptors for clients who have been referred to the psychiatrist from 2003 to 2011.

The most common diagnostic category presented was major depressive disorder, followed by diagnoses of comorbid features of anxiety and post-traumatic stress disorder. Approximately 75% of clients were prescribed medication.

Table 19.3 PMHP clients referred to a psychiatrist, 2003–2011 ($n = 100$)

Descriptors of clients	
Mean age	27.4 years
Mean EPDS score	18.2
Mean RFA score	4.0
Presenting diagnostic categories	% of clients
Major depressive disorder	82
Comorbid features of anxiety	14
Generalized anxiety disorder	2
Post-traumatic stress disorder	12
Panic disorder	3
Adjustment disorder	1
Sleep disorder	2
Personality disorder	3
No diagnosis	6
Comorbid disorders	31
Medication prescribed	75

EPDS, Edinburgh Postnatal Depression Scale; RFA, Risk Factor Assessment.

Monitoring and supervision

PMHP's experience is that adequate emotional support and routine supervision for counseling staff is fundamental to ensuring a sustainable, high-quality maternal mental health service. The PMHP protocol requires all counselors to receive weekly individual supervision. In addition, the PMHP counseling team attends a clinical meeting every two weeks to debrief as a group, support each other, and receive guidance from the clinical services coordinator (CSC).

In addition, the project coordinator conducts comprehensive monthly monitoring and evaluation of screening and counseling activities, and consults with counseling and clinic staff to adapt aspects of the service and implement changes to improve service delivery.

Service user's perspective

The perspective of one service user was chosen to foreground the common experiences of clients using the PMHP's services. Her name has been changed for confidentiality purposes.

Zukiswa's score of 24 on the EPDS suggested that she was very distressed: she had not been able to get hold of her boyfriend since she found out she was pregnant, and had just learnt that she was HIV-positive. After screening, Zukiswa was referred to a PMHP counselor, who initially focused on containing her emotions through active listening, reflection, and empathy.

He won't take my calls. And his friends say he has gone to Jo'burg. I've been going through hell. I am so afraid my baby will get the virus. And what if I get sick? Who will support this child? I'm afraid to ask my mother because she never liked my boyfriend. (First session)

I don't know what is wrong with me. I'm bad. My memory is very poor. On Monday I lost money in the taxi. Yesterday, I lost my jacket. I don't know what I must do these days. Maybe this virus works in my mind, and I'm suffering. I'm always thinking about my future and my children. (Subsequent mobile text message)

With the counselor, Zukiswa worked on solutions to her problems. She identified the resources she had around her, and thought of ways to use these in the best way. Subsequently, her mood improved, and she no longer felt as depressed and anxious. Eventually Zukiswa felt ready to disclose her HIV status to her mother. This helped her to get more support and understanding at home, which gave her the strength to cope with her HIV status, her pregnancy, and her plans for the future.

I finished my job application today. I want to say thanks for everything you did for me. God bless you. You must continue to help other people, other people who are suffering, just like I was. (Mobile text message one month after final session)

Preliminary evaluation

Once the counseling intervention has been standardized, an evaluation study is planned to assess the impact of the intervention. A six- to ten-week postpartum telephone or face-to-face follow-up was introduced in 2010 as part of continuity of care, and has been used as an opportunity to evaluate mood status, bonding with the baby, and breastfeeding. A preliminary evaluation of the follow-up calls made in 2011 ($n = 276$) indicated the following:

- 90% of clients reported that their primary problems had improved, including 65% which had "much improved" or were "resolved completely."
- Social environment issues and primary support problems were the most difficult to resolve.

- More than 85% of clients with primary support issues indicated that these issues improved. A subset of 63% of these clients reported that those problems were “much improved” or “resolved completely.”
- 95% of mothers reported successful bonding with their baby.
- 71% of mothers reported to be coping at follow-up.
- 67% of mothers reported to have a positive mood at follow-up.
- 93% of women saw counseling sessions in a positive way.

In 2011, counselors were able to follow up 68% of counseled women postnatally, 97% of whom were followed up telephonically. This mode of follow-up is feasible in South Africa, where there is high mobile phone ownership, text messaging services are relatively cheap, and “please call me” messages can be sent free of charge (UNDP 2012). The same pattern is also true in other African countries (UNDP 2012).

Lessons learnt

Table 19.4 provides a summary of the PMHP organizational structure and service outputs over time:

Table 19.4 PMHP’s organizational changes over time

Organizational descriptors	2003	2008	2011
Management	Director	Director Coordinator University oversight	Director Coordinator University oversight
Service staff	3 sessional volunteer counselors (social workers, counseling psychologist)	Full-time employed counselor – clinical psychologist	Clinical services coordinator (clinical psychologist) Full-time counselors (trained lay counselor, registered counselor with undergraduate counseling degree)
Pathways to care	Screening for mental disorders and risk at second antenatal visit Counseling provided in antenatal clinic Counselors refer to psychiatrist at antenatal clinic as required	As for 2003	Screening for mental disorders and risk at first antenatal visit Counseling and psychiatry as for 2003
Service use indicators	2003	2008	2011
No. of women attending the antenatal clinic	1164	1728	2198
No. of women screened	588	1436	1708
Coverage (no. of women screened / no. of women attending antenatal clinic)	50.5%	83.0%	81.0%
% of women screened who qualify for counseling	31.6%	32.9%	30.0%
% of women who decline referral among those who qualify for counseling	33.8%	34.5%	33.8%
No. of new clients seen in counseling	112	252	291
Total no. of counseling appointments booked	242	843	1039
Total no. of counseling sessions held	149	563	822
Average no. of counseling sessions per client	1.3	2.2	2.8
% appointments defaulted	42.0%	25.5%	17.0%
% of referred women lost to follow-up	6.0%	16.5%	0.0%
No. of clients attending psychiatry	15	13	7

2003 represents the first full year of service delivery, 2008 is the year the PMHP shifted management and funding structures into UCT, and 2011 represents the most recent full year of data collection.

Over the years, the number of women attending the antenatal clinic nearly doubled, yet the PMHP managed to increase its screening coverage, from 50% in 2003 to 81% in 2011. The rate of women qualifying for referral remained constant, and so did the rate of women declining referral to counseling. Finally, while the number of new clients seen per year and the average number of sessions held per client increased steadily, the number of women defaulting or being lost to follow-up decreased.

Organization of services and staff

In the PMHP's experience, community-based obstetric units have high patient volumes and significant mental health needs. Because counselors routinely have to deal with suicide risk management, extreme poverty, domestic violence and abuse, problematic social environments, and primary support problems, the PMHP has had to be conscious of the possibility of counselor burnout.

The employment of a CSC in 2011 was found to be crucial in avoiding burnout and ensuring the sustainability and quality of maternal mental health care provided. The CSC provides regular supervision, debriefing, and ongoing support to the counselors, who in turn provide the main client interface work.

Instituting an appointment and follow-up system has assisted with the management of increasing client numbers, ensuring continuity of care and reducing rates of loss to follow-up. The latter is the result of a tracking system which involves counselors' attempting telephone contact three times to re-schedule missed appointments.

Screening

Maternity nursing staff have successfully managed to incorporate mental health screening into routine history-taking procedures and have reported high levels of acceptability of this integration. Furthermore, by labelling the screening as the "maternal support questionnaire," clients have found the mental health screening acceptable. This is evidenced by the low rate of clients declining to be screened (4%).

Counseling

Though the demands may vary across maternity facilities, a full-time counselor can be more flexible with appointments and ensure that these coincide with women's antenatal visits, further improving uptake of the services and decreasing the number of women declining the services or being lost to follow-up.

Short interventions, which focus on improving the women's social support environment and their resilience, can have beneficial effects on women's mood and functioning. This is the case even in circumstances where women can only attend two or three counseling sessions.

The women attending South African maternity facilities are likely to represent a variety of cultural backgrounds, and many may also be refugees. The PMHP's experience has shown that having a refugee as a counselor for refugee pregnant women is beneficial for this population. In addition to speaking the same language, a similarly located counselor can, for example, identify factors which may be masked to an "outsider," interpret cultural differences in expressions of distress, or understand how the local context may affect a displaced person.

Teaching and training

The aim of the training program is to prepare the service delivery environment to integrate maternal mental health care into routine practice. To reach this objective, the PMHP has three different strategies: increase awareness on CPMDs among health workers, attend to health workers' emotional well-being, and equip them with empathic engagement and basic counseling skills.

Rationale for training interventions

The PMHP has identified that nurses, as the initial – and often primary – interface between women and the primary health system, have the potential to exacerbate or alleviate mental distress among this vulnerable population.

However, nurses in South Africa's public health sector work in high-stress environments, because of insufficient staff, a lack of support from supervisors, long working hours, and task overload. The psychological phenomenon of "othering" as a form of "depersonalization" is routinely identified as a coping mechanism in this setting (Willets & Leff 2003,

Rothmann *et al.* 2006). This results in a significant number of cases of abuse and neglect of clients, particularly in maternity settings (Jewkes *et al.* 1998). For nurses and health workers to provide quality care and address women's mental distress in these settings, health workers' own emotional well-being and stresses must first be addressed (Rothmann *et al.* 2006, Pillay 2009).

Also, even among health workers, there is a poor understanding of the prevalence, etiology, and manifestations of mental illness, such as CPMDs. By raising awareness about CPMDs, the PMHP aims to shift attitudes and stigma around mental illness, so that health workers are more likely to accept and advocate for the need for maternal mental health services. This can facilitate the integration of screening, basic care, and management of mental health into maternal care, and the implementation of these services.

Emotional support for staff

PMHP's experience validates research findings reporting that nurses are overwhelmed, stressed, and traumatized, with little recourse to supportive services or debriefing opportunities. The CSC provides regular support and debriefing sessions with health workers to address their psychological needs. In addition, the training program has focused on designing training which allows health workers to develop insight into their own feelings and needs, whilst simultaneously gaining an awareness of and approach to the emotional state of the women in their care. One such method developed is called the "secret history."

The "secret history" training method

The PMHP's "secret history" training aims to shift attitudes and raise awareness among health workers about pregnant women's personal circumstances and how health workers' own personal problems can affect their interaction with other health staff and clients. The training, which lasts 2–3 hours, focuses on group role play, which immerses participants in the typical narratives of a pregnant mother and an overworked health worker, both experiencing social and emotional difficulties. Half of the group enacts the role of the health worker and the other half, the mother. Over time, new background information is revealed for each character and the facilitators enquire about what the participants are feeling and needing, as their assigned character. Participants are

encouraged to interact with one another in a naturalistic way. Halfway through the narrative, the participants swap roles. In the debriefing component of the training, interpersonal interactions and internal processes are examined in a participatory way.

Improving skills in empathic care and counseling

Training health workers in maternal mental health usually takes the form of workshops in counseling skills, didactic teaching on maternal mental health, and service development workshops. The PMHP teaches health practitioners who work in obstetric services, such as medical, nursing, midwifery, and postgraduate students. It provides in-service professional development for approximately 600 health workers per year and capacitates community-based practitioners working with vulnerable women.

It [the training] opened our eyes. Sometimes we are doing things to patients, unaware of what we are doing. As nurses, we can talk and act in a way without thinking, but when you are in the shoes of the patient, you realize what you are doing. (Midwife)

Manuals on basic counseling skills and maternal mental health for general health workers have been developed to supplement the training.

Lessons learnt

The PMHP's experience is that a maternal mental health service requires foundational work to prepare the environment. Training health workers requires a synthesis of capacity building in empathic care and mental health knowledge, and requires regular debriefing to address their psychological needs.

By addressing health workers' emotional well-being, the PMHP found that mental health was stigmatized among staff, and, despite being located in busy, low-resource facilities, health workers were more willing and able to take on screening and referral responsibilities, as well as to provide high-quality, empathic care. The uptake of training was further enhanced when participative methodologies were used to draw on and emphasize health workers' existing knowledge, intuitive wisdom, and skills. They reported that this gave them a sense of empowerment to address the psychological distress in their clients and in their own lives.

The PMHP has found it helpful to raise awareness among, and to collaborate with, complementary services at health facilities, such as HIV/AIDS peer counselors, social workers, or breastfeeding consultants. This provides more comprehensive care for mothers.

Research

The research program focuses on developing components of the PMHP's service model, as well as assessing its effectiveness and transferability to other low-resource settings. The PMHP is currently developing a short screening tool for CPMDs, and is engaged in developing and testing a standard counseling intervention. Future research plans are for an implementation study to assess PMHP's integration of services in other low-resource settings, and an amendment of the intervention accordingly, for scale-up.

Screening tool development study

The screening tool development study was initiated when health workers reported that the EPDS was too cumbersome to use and score for mental health screening in a busy clinical setting. The aim of the study was to develop and validate a brief screening tool for CPMDs, which would be more pragmatic and acceptable for use by health workers, thereby ensuring the sustainability and effectiveness of the screening services. The data for this study have been collected and are currently being analyzed.

Assessing the intervention's effectiveness

The PMHP has finalized a monitoring and evaluation framework which is implemented monthly across all clinical service sites. The framework facilitates the identification of clients' characteristics, risk profiles, and related care requirements, which can then be addressed effectively. It allows the PMHP to obtain thorough information to assess the PMHP service's impact and delivery.

However, developing a standard counseling intervention, which is consistent for all women receiving counseling, is necessary to assess whether PMHP's clinical services are effective or not. Feedback from clients and preliminary outcome analyses indicate that counseling is helpful in improving women's mood and functioning. However, prior to advocating

a model for scale-up, more rigorous effectiveness analyses must be undertaken.

Collaboration with national and international partners

Through collaboration with two global mental health research consortia, the PMHP has strengthened its capacity as a research partner and cross-country maternal mental health consultant. The focus of these research consortia is on strengthening mental health systems at primary care level, and developing capacity for scaling up mental health interventions in LMICs. PMHP's experience in service delivery has served to inform the design of these research protocols, which include a specific focus on CPMDs.

Lessons learnt

CPMDs remain under-recognized in low-resource settings, and the majority of those who need mental health care lack access to treatment (World Health Organization 2008). In South Africa, the limited availability of valid, feasible, and acceptable screening tools for maternal mental disorders, and increased demand from service providers, has generated demand for the development of a screening tool as a matter of priority. This is the first step towards the provision of universal maternal mental healthcare interventions at primary care level.

Regular monitoring and evaluation of screening, counseling, and follow-up procedures are important to be able to understand the patterns of service use, and identify existing barriers to accepting and attending mental health services. This is essential to be able to improve services and the effectiveness of counseling and referral mechanisms. The ongoing assessment of services is also valuable in accessing research grants and facilitating fundraising.

Advocacy

The PMHP's advocacy and communication program focuses on raising awareness among health officials, policy makers, and the public concerning the prevalence and impact of CPMDs, and on maternal mental health as a cross-cutting solution to several key health and development priorities. In addition, the advocacy program aims to increase demand for and utilization of services in communities, while simultaneously raising awareness and improving service delivery among

health providers. The program promotes research uptake and policy implementation by disseminating PMHP's lessons and evidence through several channels and to the relevant stakeholders to present a "powerful case for sustainable social change" (Servaes & Malikhao 2010).

Advocacy activities

The PMHP has developed a website, which describes the role and objectives of the project and provides a resource portal for maternal mental health (www.pmhp.za.org). In 2011, the website generated over 23 000 hits. Also, public opinion is targeted through mainstream and community newsprint media, television, and radio. The PMHP's social media platforms, launched in 2012, are generating a substantial body of informed followers.

Psychoeducational pamphlets on maternal mental health aimed at service user groups (mothers, adolescents, refugees, and fathers) have been distributed at service sites and are regularly updated. Seven information briefs have been developed for dissemination to stakeholders engaged in maternal and mental health, early childhood development, women's rights, and public health policy. These briefs clarify the relationship between maternal mental illness and HIV/AIDS, violence and abuse, child outcomes, and adolescent pregnancy. In addition, the PMHP has outlined the costs of maternal mental illness to society, as well as produced a special issue on the mental health needs of pregnant refugee women.

Policy briefs are designed to expedite research uptake, and the PMHP has produced three policy briefs on the benefits of integrating maternal mental health services into the public healthcare system. These have been disseminated to a wide audience, including the Department of Health, health managers and planners, policy developers, partner organizations, and stakeholders at various local and international fora.

The project has also contributed to the development of the Draft National Mental Health Policy, and has developed input on maternal mental health and HIV for the HIV/AIDS and STI Strategic Plan for South Africa 2012–2016.

Targeted campaigns

A short film, *Caring for Mothers*, was produced in 2009, and outlined a service user's experience of maternal distress. In 2010, the PMHP embarked on

a six-month "road show," screening the film to approximately 270 maternity staff and community-based carers across 12 sites in the Cape Town area.

Feedback from the film road show provided the opportunity for health workers to discuss with the PMHP team and reflect on their difficult circumstances. Health workers supported the PMHP's rationale for training, by explaining that they would be able to treat their patients better, and with better outcomes, if their own mental health issues were attended to.

If other staff can see this, maybe they can understand why patients seem rude. Maybe they are just scared. If we understand this, we can treat them better. (Midwife)

Lessons learnt

Advocacy must engage at the policy level, producing original research and an evidence-based model for service integration, but this alone will not affect change. An increase in awareness among health workers *and* potential service users is also required. Through the use of advocacy materials and communication campaigns, demand for maternal mental health services becomes more widespread as health workers understand the benefits of an integrated and holistic health service, and women are empowered to know their rights and demand the services they need.

Institutional stigma is, however, a major challenge to providing mental health services in the public sector. Thus, at an institutional level, among decision makers at policy and facilities level, stigma against mental illness prevents effective interventions from being implemented. This is another arena in which PMHP advocacy has been active, and here research uptake strategies have been key in securing engagement at this level.

Cost and sustainability of the PMHP

The cost of integrated maternal mental health services

In 2011, it was calculated that it cost the PMHP R185 (US\$22.50) to provide maternal mental health services to one woman for one year. This included as many counseling sessions as she needed, the counselor's liaison work with psychiatric services and social support agencies, and postnatal follow-up care. This can be compared to the average rate of private-sector

psychotherapy, which is R700 (US\$85.00) per hour for one individual counseling session alone (PsySSA 2012).

In low-resource settings, where women can face many barriers to accessing health care, providing integrated mental health care at the same time and same place as routine maternity and well-baby care can minimize travel costs or time away from employment or child-care responsibilities. Thus, these integrated interventions use existing services and resources and are likely to achieve better coverage, with minimal extra costs.

Longitudinal studies assessing the cost-effectiveness of the intervention, both at care and development levels of impact, are planned.

Sustainability

Though PMHP's mental health services were initiated with volunteers providing counseling, it became clear that, as uptake increased, a project coordinator and funding for basic costs, such as stationery and workshop materials, were necessary for the smooth running of the service. The PMHP's operations were formalized as it relocated into the University of Cape Town. This location provided PMHP with the infrastructure and means to access funding support from donor organizations.

Lessons learnt

The PMHP has identified three complementary pathways to support and sustain integrated maternal mental health care. This is vital in a health infrastructure with competing priorities and limited resources: (1) train for task shifting to equip the people who will be providing the service; (2) conduct ongoing research to develop and improve the healthcare package, and to inform the training and teaching programs; and (3) engage in advocacy, to convince health planners and policy makers that maternal mental health is not a competing priority, but a feasible solution that cuts across multiple sectors and serves key health priorities.

Key lessons learnt and replicability

Key lessons learnt

The overview of the four different programs at PMHP reflects how, over time and with regular feedback from counselors, service users, and health providers,

the programs have evolved and developed to improve the project's efficiency and reach. Table 19.5 summarizes the key lessons learnt over the 10 years.

Replicability to other settings: preparing the environment

PMHP's experience, developed through providing maternal mental health services in four different maternity facilities, is that preparing the environment is one of the key elements in developing such services. The public health environment is varied and diverse, with each health facility presenting challenges and opportunities specific to its context. The first step is then to undertake liaison work with facility staff, to get full support and buy-in at all levels within the hierarchy. Effective communication strategies and training programs aimed at service providers is required to ensure that they understand the need for the intervention. Rapport and respect is very important, especially in low-resource, busy clinical settings where health workers may already feel over-burdened.

Maternal mental health interventions require screening, which is ideally undertaken by maternity staff during routine antenatal care. Therefore, the second step in preparing the environment would be to equip health workers with the necessary skills to deliver the new intervention efficiently. The third step is to ensure that referral pathways are in place. Screening for mental illness alone is not sufficient and, for ethical reasons, adequate referral pathways and treatments must follow. Ideally, this would be a dedicated on-site mental health counselor. Where this is not possible, maternity staff may be supported in identifying and consolidating links with resources and organizations in their communities that offer support to pregnant women.

Adapting the clinical services to other environments

A situation analysis is essential to understand the economic and social demographics, as well as staffing profiles of a facility, as these may affect the organization and strategies of the screening, referral, and counseling services to be put in place.

For example, the types of questions raised in the situational analysis should establish where and how women access care during and after pregnancy (formal facility, traditional birth attendants, etc).

Table 19.5 Key lessons from 10 years of PMHP

Clinical services: service organization	<p>A clinical service coordinator, who provides supervision, debriefing, and ongoing support to counselors, ensures the sustainability of quality mental healthcare provision</p> <p>An appointment and follow-up system can improve service organization, continuity of care, and reduction in rates of women lost to follow-up</p>
Clinical services: screening	<p>A brief, valid screening tool is required for use in busy, low-resource settings</p> <p>Routine integrated screening destigmatizes mental health among health workers and pregnant women</p> <p>Discussing referrals with clients and their families optimizes service use and referral mechanisms</p>
Clinical services: on-site counseling	<p>On-site mental health services increase access for women who have scarce resources and competing health, family, and economic priorities</p> <p>The employment of full-time counselors (as opposed to sessional) is beneficial for meeting the mental health needs of mothers, and facilitates tracking and follow-up of clients</p> <p>Even a limited number of counseling sessions can help improve mood and functioning of distressed pregnant women</p> <p>A refugee counselor can gain a better understanding of pregnant refugees' situations and problems, and can improve the counselor–client relationship</p> <p>Telephone counseling is possible when women cannot attend face-to-face meetings for logistical or psychological reasons</p>
Training	<p>Training should focus on improving health workers' understanding of the need for the mental health intervention, so that they can become advocates for maternal mental health care</p> <p>Addressing the mental health needs of health workers helps them manage their workload, prevents burnout, and improves motivation and morale</p> <p>Training should equip health workers with skills to screen for mental distress and to provide basic counseling and empathic engagement to pregnant and postnatal women</p> <p>The support and buy-in from health workers, through training, ensures the sustainability of the task-sharing approach and of the integrated mental health model</p> <p>Improving maternal mental health knowledge and awareness among complementary services or other community-based organizations can facilitate referrals to other services and provide comprehensive care to women</p>
Research	<p>To integrate screening effectively and efficiently into low-resource primary care maternity settings, a new short screening tool for CPMDs must be developed</p> <p>Through regular monitoring and evaluation, patterns of service use and barriers to mental health service uptake can be identified</p> <p>Monitoring clinical services is important for understanding how to improve the effectiveness of counseling and referral mechanisms</p> <p>The effectiveness of integrated mental health services needs evaluation so that the model can be implemented in other low-resource settings</p>
Advocacy	<p>Awareness among decision makers at policy level alone will not affect change – awareness must also be improved among health providers and potential service users</p> <p>Stigma at the institutional level is a barrier to integrating maternal mental health services, and advocacy should focus on securing engagement at this level</p> <p>Advocacy materials and communication campaigns improve health workers' understanding of the benefits of maternal mental health services</p> <p>Advocacy materials and communication campaigns help empower women to know their rights and demand the service they need</p>
Cost and sustainability	<p>Teaching and training, research, advocacy, and communications programs are essential to support and sustain integrated maternal mental health care</p> <p>The integration of evaluation plans into service, teaching, and training programs is important for fundraising activities</p>

The situation analysis should also establish information about obstetric and postnatal care facilities (how many in the area, how many women attend, how many visits are attended, staffing, etc.), and about existing support services available to mothers. Information on mental illness, prevalence, presentation, attitudes to mental illness, and care provision must also be collected.

The high antenatal attendance in South Africa has led the PMHP to identify women's first antenatal visit as a suitable and effective way to initiate contact with and screen pregnant women for mental distress. In contexts where women do not attend health facilities regularly in the perinatal period, a situation analysis would allow the identification of the optimal environment to reach, screen, and provide mental health care to women.

The birth rate in South Africa is considerably lower than in other African countries (e.g., 42.99/1000 in Ethiopia, 47.49/1000 in Uganda). Where higher birth rates exist, a greater number of women may require screening and, ultimately, mental health care. In this case, changes in the organization of the services, such as raised referral cut-offs or different referral strategies, may have to be put in place.

The literacy rate is also particularly high in South Africa compared to other African countries (e.g., 43%

in Ethiopia, 70% in Uganda). Where the literacy rate is low, screening that is self-administered would not be feasible, and it may need to be administered by health workers instead. The screening tool development study may provide a tool that is effective and short enough for health workers to administer as part of their history taking.

Conclusion

The PMHP has been conducting training, research, and advocacy work in maternal mental health to improve the uptake and quality of integrated maternal mental health services in primary care settings. While awareness is growing among the community and health providers, advocacy and communication campaigns at policy level are still required if maternal mental health is to be accepted as a cross-cutting solution to several key health and development priorities. With 10 years of experience as a unique mental health service provider and an advocate for maternal mental health in South Africa, the PMHP envisions its future role as a facilitator for the Department of Health, strengthening and supporting the public health sector to develop good practice and scaleable maternal mental health service models for low-resource settings.

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