



## Interventions for perinatal depression in low and middle-income countries: A systematic review



Amy Gajaria<sup>a,c</sup>, Arun V. Ravindran<sup>a,b,\*</sup>

<sup>a</sup> University of Toronto, Department of Psychiatry, Canada

<sup>b</sup> Campbell Family Mental Health Research Centre, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

<sup>c</sup> Division of Child and Youth Psychiatry, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

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### ABSTRACT

**Background:** Perinatal depression has been associated with infant low birth weight and with multiple health indicators affecting childhood morbidity and mortality. The condition is twice as prevalent in low and middle-income countries (LMICs) compared to high-income countries but poorly studied.

**Aim:** To conduct a review of published literature on interventions for perinatal depression in LMICs.

**Methods:** A search of the literature was performed for articles published up to October 2017. The key inclusion criteria were peer-reviewed studies focusing on interventions for perinatal depression during pregnancy and/or up to one-year postpartum.

**Results:** 1088 citations were retrieved, of which 18 studies with representation from countries in Africa, Asia, North America (Mexico) and South America were included. The majority of interventions were conducted in lower-income settings. Most were psychosocial in nature and often provided by lay health workers and in the community. Interventions integrated as part of general health programs and employing psychotherapeutic approaches were more effective and were also preferred. Only one study incorporated the use of psychiatric medications.

**Conclusion:** Despite the limited publications, there is reasonable evidence for the benefit of psychological interventions in perinatal depression in LMICs. More research is needed to verify and extend these results and, in particular, to evaluate the benefit of adjunctive medications when treating moderate to severe depression and whether interventions can increase social supports.

### 1. Introduction

In recent years, there has been greater recognition of mental illness as a global public health problem. For example, unipolar depression is the third leading contributor to disability-adjusted life years (DALYs) worldwide when all countries are included, regardless of income level, with greater incidence in women than in men (World Health Organization, 2008a). Research has increasingly focused not only on the study of mental illness in low- and middle-income countries (LMICs), but also on the interaction between poverty indicators, such as infectious disease and childhood mortality, and mental illness (Prince et al., 2007).

Perinatal depression is defined in the DSM 5 as a Major Depressive Episode occurring in the antenatal or postpartum period (American Psychiatric Association, 2013). In high-income countries (HICs), depression during pregnancy is estimated to be 17–18%, which decreases

to 13–15% in the postpartum period; (O'Hara and Swain, 1996; Josefsson et al., 2001); this rate is almost doubled for both antenatal and postpartum depression in LMICs – with one study of women in South Asia noting a prevalence of 25% in the antenatal period and a prevalence of 28% in the postnatal period and other studies noting a prevalence as high as 40% in some settings (Rahman et al., 2003, 2007; WHO, 2008b). In addition, women in LMICs with perinatal depression are more likely to experience a more adverse course of illness when compared to those in HICs (World Health Organization, 2008b). Reports from HICs note that perinatal depression leads to decreased social support, increased risk for subsequent depressive episodes, impairments in infant mood and behaviour, higher frequency of premature delivery as well as greater likelihood of insecure attachment and decreased rates of breastfeeding (Murray and Cooper, 1996; Henderson et al., 2003; Halligan et al., 2007; Jacob et al., 2007; American College of Obstetricians and Gynecologists, 2008; Conroy et al., 2012; Robinson,

\* Corresponding author at: University of Toronto, 250 College Street, Toronto, ON M5T 1R8, Canada.

E-mail address: [arun.ravindran@camh.ca](mailto:arun.ravindran@camh.ca) (A.V. Ravindran).

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2012; Gelaye et al., 2016; Eastwood et al., 2017). It has been suggested that the long-term cognitive and behavioural effects of untreated depression in utero is likely even more severe for children in LMICs compared to those living in HICs (Walker et al., 2007).

Studies note that infants born to mothers with perinatal depression in LMICs are likely at a higher risk for low birth-weight as well as infant stunting through the first year of life, irrespective of birth weight; this finding seems particularly relevant in South Asian countries but not necessarily in all LMICs (Patel and Prince, 2006; Rahman et al., 2007, 2004; Parsons et al., 2012). In addition, perinatal depression was associated with a greater frequency of infant diarrheal diseases per year, as well as lower likelihood of help seeking for childhood illnesses (Rahman et al., 2004; Prince et al., 2007). Low birth-weight, diarrheal diseases, premature birth, and limited or absent breast-feeding are all well-documented markers for child and infant morbidity and mortality, suggesting that improved interventions for perinatal depression would impact preferably on both maternal health and child well-being and survival.

However, despite the significant contribution of mental illness to global disease burden, mental health funding in LMICs remains limited. LMICs often struggle with managing the dual burden of communicable and non-communicable diseases, devoting less than 1% of their health budget to mental health (Saxena et al., 2007). Human resources are equally sparse, with insufficient numbers of psychiatrists, psychologists, social workers, and mental health nurses available to meet the demand (Kakuma et al., 2011). Access to psychotropic medications and mental health services within primary care settings are also limited (McBain et al., 2012).

It is well accepted that interventions used to treat mental illness in HICs may not always be applicable to the unique needs of LMICs. Stakeholders in LMICs often express frustration at programs developed in affluent countries being implemented when such programs are not culturally appropriate or tailored to the specific needs of a given community and are often not sustainable (Rahman, 2007). In addition, there exists a body of literature critiquing the application of mental health concepts developed in Western countries to less developed regions of the world (Whitley, 2015).

This review focuses on depressive disorders in the perinatal period rather than all mental health conditions during this time, as the majority of studies in LMICs have focused on perinatal depression (Rahman et al., 2013). In recent years, two excellent reports have been published on this topic (Clarke et al., 2013; Rahman et al., 2013). The first (Clarke et al., 2013) focuses on psychological therapies provided by non-specialist clinicians. The second (Rahman et al., 2013), a systematic review and meta-analysis, critically evaluates the benefit of psychosocial and psychological interventions. This report updates findings from previous reviews on perinatal mental disorders. It also further expands on the literature from previous reports and includes case studies and qualitative data.

Since there have been few randomized control trials of interventions since Rahman et al.'s (2013) publication, a decision was made to include qualitative investigations and case reports in the review as it was felt that this would provide patient perspectives in this emerging area of research.

## 2. Methods

An electronic search of the literature was performed following PRISMA, 2009 guidelines (PRISMA, 2009). Articles published up to and including October 2017 were considered for inclusion in the review. Databases (Medline, CINAHL, PsycInfo, EMBASE, Healthstar, AMED, Social Work abstracts) were searched using the following search strategy: [Depression OR “Depression, postpartum”, OR “Depressive Disorder” AND pregnancy, OR Depression AND mothers, OR “mother-child relations” OR “antenatal depression”] AND [“poverty areas” OR “developing countries” OR poverty] AND [intervention OR

therapeutics]. With the exception of the terms “antenatal depression” and “intervention,” all terms were MeSH headings. Following the initial electronic search, reference lists of included papers were searched manually and a Google Scholar search with similar search terms was performed to ensure no relevant papers were excluded.

The key inclusion criteria was that the studies were completed in low or middle-income countries with a focus on evaluating interventions and that they were peer-reviewed and published in English language. “Interventions” were defined as any therapeutic tool designed to address symptoms of depression in the perinatal period; this was interpreted broadly to include studies evaluating psychosocial, psychotherapeutic, and psychopharmaceutical treatment approaches. In addition, case studies that described novel program or clinical approaches and qualitative studies were included. Studies that recruited women during pregnancy or up to one-year postpartum and had either a primary or secondary focus on depressive symptoms or Major Depressive Disorder were considered for review. The one-year limitation was consistent with general research and clinical practice (Miller, 2002; Robertson et al., 2004; Gavin et al., 2005). Decisions regarding classification of countries as low or middle-income were based on the World Bank Country Classification from the 2018 fiscal year (World Bank, 2017).

Due to the sparse number of published RCTs, studies were not excluded based on the stringent requirements for study design or for methodological rigour. As well, peer reviewed reports of case series, dissertations, and open trials were included; however, letters, conference proceedings, editorials, or non-peer reviewed articles were excluded. Study quality was commented on descriptively but not ranked due to the various methodologies of studies included for review.

Decisions regarding inclusion or exclusion were made by one reviewer with difficult or controversial decisions marked and resolved through discussion with a second reviewer.

## 3. Results

After removing duplicate results, 1088 unique citations were retrieved (Fig. 1). After reviewing abstracts and full-text papers, 18 studies were included. Of the 18 included studies, three were reported by the same group with overlapping samples (Rahman, 2007; Rahman et al., 2008, 2012) leaving a total of 16 unique populations. These studies covered countries in Africa, (Cooper et al., 2002, 2009; Futterman et al., 2010; Honikman et al., 2012; Kathree et al., 2014; Rotheram-Borus et al., 2015; Nyatstanza et al., 2016) Asia, (Tezel and Gozum, 2006; Rahman, 2007; Rahman et al., 2008, 2012; Tripathy et al., 2010; Gao et al., 2012; Mao et al., 2012), Mexico, (Lara et al., 2010) and South America (Rojas et al., 2007; de Alencar et al., 2009). Though Chile is now considered a high-income country based on 2014 World Bank data (United Nations, 2011), it was included in the results as it was classified as a middle-income country at the time of study publication (United Nations, 2011).

No studies focused on low-income countries. Two samples were retrieved from lower middle-income countries (Rahman, 2007; Rahman et al., 2008, 2012; Tripathy et al., 2010), and nine studied marginalized populations from upper middle-income countries (Cooper et al., 2002, 2009; Rojas et al., 2007; de Alencar et al., 2009; Futterman et al., 2010; Lara et al., 2010; Kathree et al., 2014; Rotheram-Borus et al., 2015).

The included studies varied in several ways, including study design, type of intervention, and populations studied. Some studies focused exclusively on maternal measures of depression and used a variety of measures, most commonly the Structured Clinical Interview for DSM IV (SCID) and the Edinburgh Postnatal Depression Scale (EPDS) (Table 1). Other studies provided both measures of maternal depression while also looking at markers of child and infant health, generally by measures of birth weight or mortality rate.

The types of interventions employed varied widely, but had significant overlap. They can be broadly grouped into those (a) focusing

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