

Available online at www.sciencedirect.com

ScienceDirect

www.elsevier.com/locate/semperi

Maternal mental health: The missing “m” in the global maternal and child health agenda

Najia Atif, MSc^a, Karina Lovell, PhD^b, and Atif Rahman, PhD^{c,*}

^aHuman Development Research Foundation, Islamabad, Pakistan

^bUniversity of Manchester, Manchester, UK

^cInstitute of Psychology, Health & Society, University of Liverpool, UK

ARTICLE INFO

Keywords:

Maternal mental health

Perinatal depression

Postnatal depression

Public mental health

Low- and middle-income countries

ABSTRACT

While the physical health of women and children is emphasized, the mental aspects of their health are often ignored by maternal and child health programs, especially in low- and middle-income countries. We review the evidence of the magnitude, impact, and interventions for common maternal mental health problems with a focus on depression, the condition with the greatest public health impact. The mean prevalence of maternal depression ranges between 15.6% in the prenatal and 19.8% in the postnatal period. It is associated with preterm birth, low birth weight, and poor infant growth and cognitive development. There is emerging evidence for the effectiveness of interventions, especially those that can be delivered by non-specialists, including community health workers, in low-income settings. Strategies for integrating maternal mental health in the maternal and child health agenda are suggested.

© 2015 Elsevier Inc. All rights reserved.

Introduction

The World Health Organization (WHO) defines maternal mental health as “a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community.”¹ Globally, in women of childbearing age, depression accounts for the largest proportion of the burden associated with mental or neurological disorders.^{2,3} In addition to the economic and human costs of maternal depression, children of mothers who are depressed are at risk for poor health, developmental, and behavioral problems,⁴ thereby contributing to inter-generational disadvantage that accumulates throughout the life span. Addressing mental health could play an important

role in addressing the maternal and child health (MCH) agenda. However, mental health care remains conspicuous by its absence in large-scale global MCH programs.

For more than a decade, the mental health community has recommended integration of mental health programmes into primary care.⁵ Despite the WHO recommendations and the mounting evidence indicating high prevalence of maternal mental health and its adverse impact on both mother and her infant, the maternal mental health agenda has not been incorporated into the primary health care system in most low- and middle-income countries (LMIC). The barriers to the provision of primary maternal mental health care in LMIC include the lack of human and financial resources⁶ and quite often the double burden of communicable and non-communicable diseases, which relegate mental health to

*Corresponding author at: Child Mental Health Unit, Alder Hey Children's NHS Foundation Trust, Mulberry House, Eaton Road, Liverpool L12 2AP, UK.

E-mail address: Atif.Rahman@liverpool.ac.uk (A. Rahman).

the margins of health care.⁷ Consequently the treatment gap for mental illness in LMICs is large, accounting for 76–85% patients with mental health problems not receiving intervention.⁸

Integrating maternal mental health into primary care MCH programmes has the potential to address the treatment gap through early detection, prevention, and treatment of maternal mental health problems such as depression.⁹ Such integration requires intersectoral collaboration and health system-wide approaches, focusing on prevention and treatment across the life course and employing evidence-based interventions.¹⁰ Studies conducted in LMIC show that psychosocial, educational, and supportive interventions are effective in improving maternal mental health, even when delivered through non-mental health specialists rather than specialists.¹¹ Such non-specialist workers can play an integral role to provide primary mental health service to those who need it the most.

As maternal depression is by far the mental disorder with the highest public health impact,^{4,12,13} we will focus on this condition. This article aims to review the prevalence and risk factors for maternal depression, its impact on the mother and the infant, evidence of effective use of non-specialists in the delivery of interventions for maternal depression, and recommendations for strategies to integrate maternal mental health into public health. The focus of the review is LMICs, where the vast majority of the women with mental health problems such as depression reside, and where the burden from untreated depression is the greatest.

Prevalence of maternal depression in LMIC

Common mental health problems such as perinatal anxiety and depression are more prevalent in women from LMICs as compared to high-income countries (HIC). The weighted mean prevalence of these conditions was found to be 15.6% during the prenatal period and 19.8% during the postnatal period,¹⁴ which is higher than the rates reported in HICs, ranging from 6.5% to 12.9% during the perinatal period.¹⁵

A systematic review by Fisher et al.,¹⁴ included evidence available from nine countries on prenatal and 17 countries on postnatal depression. Most of the studies recruited participants from health care facilities such as primary care clinics, antenatal clinics, and maternity hospitals. The prevalence of prenatal depression recorded from these settings was 20.5% in Thailand,¹⁶ 21.5% in Vietnam,¹⁷ and 41.6% in Nigeria.¹⁸ Postnatal depression prevalence was 23% in India,¹⁹ 48% in Nigeria,²⁰ and 22.4% in Indonesia.²¹ Prevalence rates in community-based samples were even higher—33% in Bangladesh,²² 25% in Pakistan,²³ and 59.5% in Ethiopia.²⁴ It is important to note that the samples recruited from the community-based studies are more representative of country populations because many such settings have limited access to perinatal health facilities. Relatively low prevalence of postnatal depression was reported in Brazil (15.9%),²⁵ China (15.5%),²⁶ Mongolia (9.1%),²⁷ and Uganda (6.1%).²⁸

The pooled prevalence of perinatal depression ranges from 5.2% to 32.9% during pregnancy and 4.9–59.4%, after child birth.¹⁴ These studies varied in their settings, sample sizes,

assessment tools, cutoff point used, timing of assessment, the quality of data collection and reporting, along with differences in cultural and socio-economic variables in the countries. In order to achieve reliable results globally, there is a need to establish standard cutoff scores, assessment tools, and timing of assessment.²⁹

Risk factors for maternal depression in LMIC

Several contributing factors related to maternal depression have been identified in women in LMIC. These contributory factors can broadly be classified as poor socio-economic conditions, interpersonal problems, and adverse life events. Women from LMIC are more likely to be exposed to poverty,^{26,30} lack of a permanent job,³¹ low literacy,^{25,32} lack of social support,^{14,31,30} and lack of empowerment³³ compared to women in HICs. Likewise, evidence has also indicated a strong association with interpersonal relationship problems including poor marital relationship,²³ domestic violence,^{33,34} perceived unsupportive partner,¹⁸ lack of intimate relationship,³¹ low spouse involvement in the perinatal period,²⁶ abusive partner,³⁵ and relationship problems with in-laws.^{36,30,22,37} Stressful life events such as health complications during and after pregnancy, having a previous history of stillbirth,^{18,22,33} unplanned or unwelcome pregnancy,^{31,28} financial difficulties, separation or divorce,¹⁸ and bereavement²² have been identified as risk factors for perinatal depression. In some cultures, gender preference of an offspring is also found associated with perinatal depression. In Pakistan, a mother with two daughters was found to be at a higher risk of perinatal depression,²³ which is consistent with other cultures where there is a preference for male offspring such as India and Nigeria.^{19,28,30,36,38} Fisher et al.,¹⁴ in their systematic review covering 17 LMIC, quantified these key risks: socio-economic disadvantage [odds ratio (OR) range: 2.1–13.2]; unintended pregnancy (1.6–8.8); being younger (2.1–5.4); being unmarried (3.4–5.8); lacking intimate partner empathy and support (2.0–9.4); having hostile in-laws (2.1–4.4); experiencing intimate partner violence (2.11–6.75); having insufficient emotional and practical support (2.8–6.1); in some settings, giving birth to a female (1.8–2.6); and having a history of mental health problems (5.1–5.6). Protective factors were: having more education (relative risk = 0.5; $p = 0.03$); having a permanent job [OR = 0.64; 95% confidence interval (CI): 0.4–1.0]; being of the ethnic majority (OR = 0.2; 95% CI: 0.1–0.8), and having a kind, trustworthy intimate partner (OR = 0.52; 95% CI: 0.3–0.9).

Impact of maternal depression on mothers

Untreated maternal depression increases the risk of maternal morbidity and mortality.³ A global estimate of the maternal mortality ratio from suicide is 400 per 100,000 live births.³⁹ The risk is significantly higher in LMIC region (1 in 2800) as compared to HIC (1 in 61). During the postpartum period, 20% of deaths are because of successful suicidal attempt.⁴⁰

Maternal depression during pregnancy increases the risk of obstetric complications^{41,42} such as preterm birth⁴³ and

Download English Version:

<https://daneshyari.com/en/article/6155785>

Download Persian Version:

<https://daneshyari.com/article/6155785>

[Daneshyari.com](https://daneshyari.com)