

A Description

Perinatal Mental Health Project



*Caring for Mothers
Caring for the Future*

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral Drugs
CHC	Community Health Centre
DoH	Department of Health
HIV	Human Immunodeficiency Virus
H.P.	Hanover Park
MHaPP	Mental Health and Poverty Project
MMH	Mowbray Maternity Hospital
MOU	Midwife Obstetric Unit
M.P.	Mitchells Plain
NPO	Not-for-Profit Organisation
PGWC	Provincial Government of the Western Cape
PMHP	Perinatal Mental Health Project
PMNS	Peninsula Maternal and Neonatal Services
PMTCT	Prevention of Mother to Child Transmission of HIV
UCT	University of Cape Town
US\$	United States Dollars
WHO	World Health Organisation

1. Introduction

The negative cycle of mental ill-health and poverty is especially relevant for women and their infants during the perinatal period. During this time, women are rendered vulnerable to mental illness from social, economic and gender-based perspectives. Those with the most need for mental health support, have the least access. Overburdened maternal and mental health services have not begun to address this significant unmet need. There has been no attempt at a programmatic level, to integrate mental health care within maternal care services.

*The perinatal period, where women are accessing health services for their obstetric care, presents a unique opportunity to intervene in the natural and predictable course of mental distress. **Preventive work** involving screening and counselling may have far-reaching impact for women, their offspring and future generations.*

In response to a pandemic (**1 in 3 women**) (1) of mental illness among mothers in our communities, the PMHP began in September 2002 at Liesbeeck Midwife Obstetric Unit (MOU) attached to Mowbray Maternity Hospital (MMH) in Cape Town. A team of dedicated doctors, midwives and volunteer counsellors and psychiatrists, founded the screening, counselling and psychiatry service.

The PMHP aims to provide a holistic mental health service *at the same site* at which women receive obstetric care. The vision is to integrate mental health care within the primary level maternal care environment on a broader scale. The PMHP is actively involved in maternal mental health training and staff development for a range of different health workers. Further, dissemination of research and evaluation results of the Project will have impact on fundraising potential, policy development and wider rollout.

This document will describe the problem of perinatal mental health and the PMHP's vision, objectives, target groups and impact to date. The activities planned over the next three years will be described as well as the expected impact of the work.

2. Problem Statement: Perinatal Mental Health – an enormous unmet need for South Africa's poor women

Perinatal¹ mental health problems are epidemic in the low-income and informal settlements surrounding Cape Town. *One in three* women in informal settlements suffers from postnatal depression (1). This is nearly *three times higher* than the prevalence in developed countries (2).

Globally, 30% of primary care attenders suffer mental disorders, with depression, anxiety and substance abuse being the commonest types. Unipolar depressive disorders are the second highest cause of (Disability Adjusted Life Years) DALYs lost in young adults age 15-44 (HIV/AIDS is the highest cause) (3).

Psychiatric disorders leading to suicide contribute as a leading cause of maternal death in developed countries and accounts for 28% of maternal deaths (4).

In developing countries, suicide is among the most important causes of death in young women (5,6). Mental illness is currently not included in the maternal mortality calculations in South Africa.

Despite the high prevalence and far-reaching consequences of perinatal depression in impoverished communities, as well as the evidence for the effectiveness of simple treatments, the public health service is currently not addressing the mental health needs of women during and after pregnancy. This constitutes a lack of access to basic healthcare and acts to reinforce the inequities already faced by low-income women.

¹ The term "Perinatal" refers here to the period during pregnancy (antenatal), labour and up to one year after the birth (postnatal).

The costs of failing to address perinatal mental health issues may be felt over generations and in the general health sector as well as other areas such as education, crime and employment.

3. Vision

To develop and expand services, health systems research and health worker training from the existing PMHP in order to inform health policy and planning for a greater rollout of evidence-based mental health care for women in the perinatal period.

4. Objectives

The PMHP will continue to focus on its 4 key objectives; service delivery, research, training and informing policy development.

4.1 Service delivery

To provide an unmet health need for disadvantaged women in the perinatal period – enhancing access to those most vulnerable to mental illness

- To provide an integrated mental health screening, counselling and psychiatry service for pregnant and postpartum women within the maternal and child health public services.
- To expand the Project in a phased manner to more maternity units over a 3-year period
- To develop the Project in a dynamic and contextually sensitive way.
- To ensure quality control by responding to data from monitoring and evaluation and incorporating the evidence from research results.
- To strengthen community links and partnerships to enhance access, follow-up and sustainability

4.2 Research

To develop and improve on systems within the Project that enhance coverage, efficacy, effectiveness, cost-effectiveness, adherence, social capital development of staff and recipients

- To establish prevalence of various forms of perinatal distress
- To establish risk factors for perinatal distress
- To establish any associations between risk factors and particular distress patterns or health seeking behaviour
- To establish any associations between types of distress and health seeking behaviour
- To develop a culturally appropriate and valid screening tool for low resource midwife obstetric units
- To evaluate the impact of interventions within the Project on mothers and infants
- To audit the psychiatric component of the Project
- To ascertain any particular mental health needs of HIV positive women
- To ascertain any factors which enhance resilience to mental distress in women at risk
- To describe and evaluate alternative support resources for perinatal mental distress, e.g. traditional healers, groups, mentorship programmes etc.

4.3 Training

- To provide perinatal mental health training to;
 - i. Maternity and baby clinic staff
 - ii. Community health centre staff
 - iii. Counsellors linked to the Project
 - iv. Medical students
 - v. Community-based organisations and NGOs linked to the Project

- To continue, develop further and evaluate perinatal mental health training for maternity staff that
 - i. Enhances an understanding of their own vocational motivation
 - ii. Provides a self-exploration of their own experiences of mothering
 - iii. Raises an awareness and knowledge base of perinatal mental health issues
 - iv. Imparts practical resource-appropriate skills in screening, basic counselling and referral for mental health problems
 - v. Develops a model of best practise
- To distribute and promote the use of the “Perinatal Mental Health Handbook: a resource for health workers in maternal care” (3rd edition in press)

4.4 Policy development

- To strengthen and develop relationships with policy makers and health managers by incorporating them within project development and design
- To develop a body of evidence in order to inform health policy for integrating mental health within maternal services
- To consult policy makers on application of service design

5. Main target group

Pregnant and postnatal women accessing maternity public health services within the Peninsula Maternal and Neonatal Service (PMNS) in Cape Town.

6. Impact and achievements of PMHP to date

Since the Project’s inception in 2002, the following has been achieved;

6.1 Quantitative impact

- About 4800 pregnant women have received mental health screening from the midwives.
- About 740 women have received on site, free-of-charge counselling by the team of professional and trained counsellors (now numbering 7). See Appendix 1 for a personal testimony of one of the Project clients.
- About 95 women have received on-site psychiatric care by volunteer psychiatrists that attend weekly.
- A large database has been rigorously maintained. From this, several research papers are due to be submitted for publication in the next 6 months. See Appendix 2 for an outline of these papers.

6.2 Impact on maternal health staff

- The Project has been involved in training a range of health workers across the country (approximately 1000 health workers have received at least one session of training). Other organisations have adopted the training materials developed by the PMHP. Informal feedback from staff and other training organisations have been extremely positive. Long term positive changes in staff behaviour have been observed by facility managers. Trainees have consistently reported the training to be a personally transformative experience that has impacted upon their interaction with mothers in the workplace.
- A mental health training manual has been developed to compliment the workshops. The third edition is in press.

6.3 Qualitative impact

- Two qualitative evaluation studies have been conducted by psychology students (an Honours student and a Masters student). Both showed highly positive responses from both clients and staff.

6.4 Awards

- The PMHP received an award of commendation by the World Health Organisation and World Federation for Mental Health in 2004. This occurred after a paper on the Project was published in the WHO document, Mental Health Promotion: Case Studies from Countries in 2004.
- The PMHP received an award of achievement from the Impumelelo Innovations Awards Trust in 2005.
- The PMHP is currently short-listed for the Discovery Excellence Award for 2008.

7. Main activities and period of implementation

The activities of the PMHP are planned over three consecutive years. The first year is divided into 2 six-month periods. During the first six months, a fulltime screener/counsellor/administrator is employed for Liesbeeck MOU which will enable the Project head (S. Honikman) and co-ordinator (S. Field) to complete the writing up of research papers pending. During the second six months, the Project and the research work is extended to two further sites. Thus, three dedicated counsellors are employed as well as staff required for screening and administration. For each site, clinical supervision for the counsellors and psychiatrists' sessions are provided.

The second and third years involve expansion to two further sites in each year. Expansion in this manner will allow for comparative research questions regarding associations of perinatal mental illness with obstetric risk and geographic location. Each site expansion will include training and ongoing support of all maternal services staff.

Please see Appendix 3 for performance indicators and implementation timelines.

7.1 Year 1: 2008

Phase 1: Needs Assessment (1st 6 months)

- Maintain existing Project at Liesbeeck MOU
- Continue training of staff
- Analysis, write-up and dissemination of data collected from PMHP to date
 - Description of the PMHP
 - Psychiatry audit
 - Utilisation patterns
 - Development of short risk factor screen from existing PMHP data
 - Short evaluation study of PMHP

Phase 2: Development of Intervention (2nd 6 months)

- Maintain existing Project at Liesbeeck MOU
- Validation study of short risk factor screening (part 1)
- Service expansion to two further MOUs (allowing for comparisons between different communities and levels of maternity care)
 - Site-specific situation analysis
 - Develop community links
 - Develop links with Community Mental Health Team
 - Train MOU staff and Community Health Centre staff
 - Train screeners and counsellors
 - Set up systems for administration, Monitoring and Evaluation

7.2 Year 2: 2009 and Year 3: 2010

Phase 3 and 4: Evaluate the Intervention

- Service expansion to two further MOUs per year (see details as for phase 2)
- Study control site vs. intervention sites (prospective, longitudinal) to assess impact of service
- Validation of short risk factor screening (part 2)

8. Expected impact

The PMHP is expected to impact on maternal psychiatric morbidity and mortality, on infant and child physical, mental and developmental morbidity. It is anticipated that it will have an effect on overcoming poverty and social adversity. Evidence from the work accomplished through the Project should have an impact on policy development.

8.1 Reduction in psychiatric morbidity and mortality

The PMHP has the potential to achieve a *reduction in psychiatric morbidity and mortality* for mothers on a broad scale.

8.2 Reduction in physical, mental and developmental morbidity in infants and children

From evidence in the world literature, it is anticipated that this intervention may have the following outcomes;

- A reduction in rates of preterm labour
- A reduction in rates of growth-retarded fetuses and infants with failure to thrive
- Lower rates of mental health, conduct and developmental problems in the offspring of affected mothers.

8.3 Contribute to overcoming poverty and social adversity

Less easily measured outcomes of emotional support for pregnant and postpartum women include;

- A greater likelihood of being able to generate income
- A greater likelihood of being able to negotiate a place of safety for themselves and their children in situations of domestic violence
- A greater likelihood of being empowered to engage in safer sexual practices
- Better utilisation of available health services
- A lower chance of abuse of substances
- A lower chance of defaulting on preventive treatment schedules such as the Prevention of Mother To Child Transmission (PMTCT) protocol and Anti-Retrovirals (ARVs)
- Greater possibilities of being able to parent more effectively
- A lower chance that offspring of these women will be victims of child abuse

8.4 Impact on policies

The SA Mental Health Act (2002) explicitly states that mental health care should be routinely provided within the general health environment, at community level adopting a preventive approach. However, no formal policy exists to date regarding providing mental health care to pregnant and postpartum women. The research arising from the PMHP will thus provide crucial evidence to inform this policy development. This should enable replicability to other regions and it is anticipated that other low and middle income countries in the region may be informed by evidenced-based policy work.

9. Further information

Appendix 4 contains a list of donors to the Project, the management team and a list of networks with which the Project engages with actively. Financial statements from the 2006 / 2007 financial year as well as previous years and testimonials of endorsement are available on request.

10. Conclusion

The PMHP addresses a critical health need experienced by low-income women in Cape Town. In the MOU setting, it coheres perfectly with the basic tenets of the South African "Healthcare 2010" initiative, in that care is provided at *primary level*, is *community-based* and is *preventative* in nature.

Further, the PMHP's objectives and its strategic intent accord directly with the South African Mental Health Care Act of 2002. This Act recognises that health is a state of physical, mental and social well-being. It states that mental health services should be provided as part of health care at primary level, not only at specialist level. The Act states that access to mental health services should be *integrated into the general health services environment*. Although formal services

providing perinatal mental health have shown considerable success in many other parts of the world, no programme has been instituted in South Africa. This Project at Mowbray Maternity Hospital is the only known service of its kind in South Africa.

In general, women experiencing emotional distress during pregnancy have little access to mental health care support from either the community mental health team or maternity services. This is largely due to limitations in human resources and training. However, during pregnancy, women come into contact with medical professionals on a regular and frequent basis. This *provides a unique opportunity* to provide *prevention and intervention* for women with mental health problems who would not otherwise have access to, or seek, help. In the setting of regular antenatal visits, where screening for medical problems is routine, women can overcome a range of health-seeking obstacles, including stigma and may obtain help for mental health problems. This can occur in a known and non-threatening environment without women having to expend additional resources to obtain care.

When the mental health needs of women are met, they may be better empowered to exercise choice over all aspects of their lives. This would enable them to take greater control over crucial issues such as their sexual and reproductive health and economic and financial well-being. As several studies from around the world have shown, the knock-on effects of women's empowerment may directly be felt by the children within their care.

Appendix 1

Gloria Mbovu's story: "Speaking and Being Heard"



When I first became a mother, I didn't know about depression. Now I would like to let everyone know about this problem so that people can stand up and do something about it.

I was born, one of twins, in the Cape Town Tygerberg Hospital. My parents divorced when I was only two days old. Because my mother was alone she couldn't do what she was supposed to do as a mother and I grew up with her family.

There was really no one to talk to or to discipline us and I became pregnant at the age of 14. I have suffered depression since then.

Having a baby at such an early age was really hard. I had to leave school and was forced to work as a domestic worker, which I couldn't really do because I was so young. I just couldn't do it. So, I decided to go back to school when my baby was three years old. I passed my standard nine [penultimate year of high school], but didn't have enough money to register for my final year. I was forced again to go back to work as a domestic worker; which I am still doing to this day.

When I was twenty-one years old, I got married to my husband. He is not the father of my first child. When we had a child together, I again suffered very much from postnatal depression, although I did not know what it was called at the time. The clinic I went to in the township did not know anything about depression. So, I was unable to get help from them.

I was not at all happy to be pregnant with my last pregnancy. I was just very stressed and worried about telling my boss. I was very concerned about my job and all the things that I needed money for. Everything was very hectic for me and nothing that I was experiencing seemed to be good. I knew that I was becoming more and more depressed.

I attended Liesbeeck MOU for my antenatal care. There, I met with a counsellor as part of the Perinatal Mental Health Project. Finally, I was able to get help. It was very good to speak to her about how I was feeling and to just talk out about everything. That was what was killing me, having to keep all my feelings inside of me for a long time. I was so lonely and there were so many things that I needed someone to listen to. I needed to express my feelings and to be heard when I was saying something. I needed someone who could understand and who could listen when I was talking. Meeting with this counsellor gave me that chance to finally speak out, which helped so much. They also sent me to a psychiatrist to get medication for my depression. Now I am doing just fine and coping very well with motherhood

Dealing with antenatal and postnatal depression is a very difficult thing. When you are depressed there are so many things that are affecting you. You may not be able to tell exactly what it is that is making you feel so bad, but just that you can't get out from the fog you are in. Everything can feel like it is just falling apart. You may not know to take it seriously when you are first suffering from it, but it is very important to address it and to find a way out. There are so many women who are dying inside from this thing. They don't know how to deal with it or how to cope. Everything in their lives is turning upside down. And they need someone who will understand and not judge them.

If I could have my way, each and every one of the hospitals would have these kinds of counsellors, especially the government hospitals which are for everybody. That way everyone including all black women, who really don't know anything about this depression, could get help.

Appendix 2

Research papers pending in 2008/9

4.1 Programmatic description of the PMHP

- Context of setting up mental health services for pregnant women in resource-poor settings
- History and development of the Project
- Screening, counselling and psychiatry – description of work done
- Frequency of screening results of both tools used
- Comparison of screening results with age category and socio-economic status
- N=4000

4.2 Risk Factor Analysis and development of brief alternative screen

- Frequency distribution of all 11 risk factors of original screen
- Develop shorter alternative 5 risk factor tool with calculated sens, spec, PPV/NPV, LR +/-
- Establish internal reliability using cluster analysis
- N=1000

4.3 Psychiatry Audit – Case Series

- Description of all clients seen by a psychiatrist within the Project since it began
- Characteristics; demographics, screening scores, risk factors, psychiatric diagnosis, treatment, follow-up
- What are the challenges in providing specialist mental health care to perinatal women in need within a primary care setting?
- N=60

4.4 Utilisation patterns of the PMHP

- Flow diagram describing current utilisation patterns of the Project
- All women allocated to one of 5 categories describing their pattern of service usage for;
 - Counselling
 - Psychiatry
- Frequency distribution of all the categories for counselling and psychiatry
- Associations between the patient categories for counselling and psychiatry for;
 - Demographic factors
 - Screening scores
 - Individual risk factors
 - EPDS clusters – anxiety and depression
- N=1000 for counselling categories, N=4000 for psychiatry categories

4.5 Short evaluation study of PMHP

- Description of women who had accessed the PMHP and who gave birth at Mowbray Maternity between 1 June and 31 September 2007
- Postnatal screening comparison to antenatal screening
- Evaluation of perception of service delivery
- Association between antenatal scores, utilisation of counselling services and birth outcomes for;
 - Gestation at birth
 - Length of labour
 - Mode of delivery
 - Use of analgesia
 - Infant birth weight
- N=180

Appendix 3

Performance indicators and implementation timelines

		2008		2009		2010	
TRAINING SESSIONS	COUNSELLORS - ONGOING TRAINING & ENRICHMENT	4		4		4	
	NURSING / MEDICAL STAFF & STUDENTS – INTERACTIVE WORKSHOPS	6		6		6	
	N.G.O.S – INTERACTIVE WORKSHOPS	3		3		3	
		No. women	Coverage %	No. women	Coverage %	No. women	Coverage %
SCREENING²	LMOU & MMH ³	1557	100	2180	100	2289	100
	H.P. MOU	2242	100	4707	100	4942	100
	GUGS MOU	-	-	5849	100	6140	100
	RETREAT	-	-	4578	100	4807	100
	KHAYELITSHA	-	-	-	-	6084	100
	M.P. MOU	-	-	-	-	7221	100
COUNSELLING⁴	LMOU & MMH	273	379	381	362	400	345
	H.P. MOU	392	176	823	167	865	159
	GUGS MOU	-	-	1024	134	1075	128
	RETREAT	-	-	801	172	841	164
	KHAYELITSHA	-	-	-	-	1065	129
	M.P. MOU	-	-	-	-	1264	109
PSYCHIATRY⁵	LMOU & MMH	32	438	44	418	46	400
	H.P. MOU	45	200	94	195	99	185
	GUGS MOU	-	-	117	157	123	149
	RETREAT	-	-	92	200	96	191
	KHAYELITSHA	-	-	-	-	122	150
	M.P. MOU	-	-	-	-	144	127

² The number of women screened are based on the 2007 booking figures for each MOU which increase annually by 5 % (as indicated by the average increase in booking figures between 2006 and 2007). Coverage of 100% indicates that all women booking at the site will be offered screening. Screening is based on a 5-question screening tool, routinely incorporated into the booking procedure.

³ This is the figure for women booking at Liesbeeck MOU and at Mowbray Maternity Hospital in the Mowbray catchment area, it does not take into account women who are transferred in from other MOUs. It is assumed that they will, on the whole, receive counselling / psychiatry in their area of booking. However, those who are transferred to MMH, are more likely to be at risk for mental health problems.

⁴ Based on statistics from PMHS, 35% of women screened qualify for referral. However, half of those will decline or default appointments. Taking this into account, the number of women who will receive counselling has been calculated. A full-time counsellor will allow for each MOU to have 30 appointments per week x 46 weeks per year (taking into account annual vacation, sick leave and public holidays). Coverage in excess of 100% indicates that some women will be able to have more than one appointment with a counsellor.

Appendix 4

5.1 List of Donors

Wallace Global Fund (2006)
Impumelelo Innovations Awards Trust (2006)
Mary Slack and Daughters Trust (2007, 2008, 2009, 2010)

5.2 Management team

Prof. Dan Stein (Head, Dept. of Psychiatry and Mental Health, UCT)
Prof. Alan Flisher (Head, Mental Health and Poverty Project, Dept. of Psychiatry and Mental Health)
Prof. Sue Fawcus (Head, Dept. of Obstetrics and Gynaecology, Mowbray Maternity Hospital)
Dr Crick Lund (Co-ordinator, Mental Health and Poverty Project, UCT)
Dr Simone Honikman (Head, Perinatal Mental Health Project, UCT)
Ms Sally Field (Co-ordinator, Perinatal Mental Health Project, UCT)

The Mental Health and Poverty Project (MHaPP) is research project with international collaboration. They are conducting mental health policy and service research in South Africa, Ghana, Zambia and Uganda.

The Department of Health has been involved in the work thus far and has indicated its support. The following people have been involved in ongoing liaison and consultations:

Dr Krish Vallabhjee (Chief Director, Regional Hospitals, PGWC)
Dr Wezile Chitha (Medical Superintendent at Mowbray Maternity Hospital)
Dr Sue Hawkrige (Principal Specialist: Child and Adolescent Mental Health Services, PGWC)
Ms Carol Dean (Director, Mental Health Programmes, PGWC)

5.3 Network

Academic Institutions:

Child and Family Unit, Dept. Psychiatry and Mental Health, UCT
Dept. of Public Health and Family Medicine, UCT
Dept. of Obstetrics and Gynaecology, UCT

Public sector:

Cape Metro Community Mental Health Team
Psychiatry Outpatients Dept., Grootte Schuur Hospital
Education Department, Mowbray Maternity Hospital – Education and Training resource unit for nursing staff of the Peninsula Maternity and Neonatal Services

Non-governmental organizations:

Cape Town Drug Counselling Centre
Cape Mental Health
Cape Town Refugee Centre
FAMSA – counselling for families
Ikamva Labantu – development NGO incorporating range of projects e.g. health, income generation, early childhood development, geriatric support
Mosaic – provides help to abused women
Mothers' Programmes – information and support groups for HIV positive women
Parent Centre – provides information and support on parenting
Postnatal Depression Support Association of South Africa (PNDSA)
Quakers Services Cape
Sisters Incorporated – shelter for homeless and pregnant women, arrange adoptions
Siviwe / Ons Plek – shelter for homeless women under the age of 18
Ububele - Gauteng based NGO, involved in psychological support and training for carers of infants and mothers

⁵ Based on statistics from PMHS, 2% of women screened will see a psychiatrist. Psychiatry sessions allow for each MOU to have 4 appointments per week x 46 weeks per year (taking into account annual vacation, sick leave and public holidays). Coverage in excess of 100% indicates that some women will be able to have more than one appointment with a psychiatrist.

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