Chapter 27
Maternal Mental Health in South Africa and the Opportunity for Integration

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Maternal Morbidity and Mortality

Common perinatal mental disorders (CPMD), including depressive and anxiety disorders, are more prevalent in low- and middle-income countries (LMIC) than in high-income settings (Fisher et al. 2012). In South Africa, the prevalence of CPMD has been shown to be very high with 47% of diagnosed antenatal depression demonstrated in a rural setting (Rochat et al. 2013). In urban settings, rates from studies using diagnostic measures have been reported at 22% for antenatal depression (Van Heyningen et al. 2016), 37% for postnatal depression (Cooper et al. 1999) and 23% for antenatal anxiety (Van Heyningen et al. 2017). Risk factors for CPMD are well documented (Sawyer et al. 2010; Fisher et al. 2012) and in the South African setting include poverty, lack of emotional and practical support, domestic violence, HIV status and food insecurity (Rochat et al. 2006; Van Heyningen et al. 2016, 2017; Abrahams et al. 2018; Field et al. 2018).

South African health policy provides the framework for treatment and prevention of mental disorders at primary care level (Robertson et al. 2018). While there is good evidence that non-specialist primary health-care practitioners can be supported to implement mental health interventions effectively (Singla et al. 2017), these staff in South Africa have not yet been adequately trained to provide this support (Robertson et al. 2018). Maternal mental health services in most settings within South Africa (and other LMICs) are lacking, with few strategies in place to detect and manage CPMDs at primary health facilities (Baron et al. 2016).

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Despite high rates of maternal morbidity and mortality, South Africa has invested substantially in maternity care and seen a reduction in maternal deaths since 2009 (Moodley et al. 2018). The proportion of pregnant women receiving some antenatal care is 77.4%, with 66.6% of them booking for care before 20 weeks gestation. Of all births, 75.8% occur within a health facility, and 70.1% of these mothers receive a postnatal assessment within 6 days of delivery (Day et al. 2018). This provides an opportunity for the integration of mental health into maternal care.

The Perinatal Mental Health Project (PMHP), of the University of Cape Town, has supported the integration of mental health services into maternity care services in several locations within South Africa. Most communities served by these services face the complex intersecting adversities of poverty, food insecurity, gang violence, unemployment, alcohol and substance abuse, domestic violence and child abuse and neglect (Van Heyningen et al. 2016; Field et al. 2018).

The PMHP has developed an adaptable stepped-care, collaborative model for delivering mental health screening, counselling and case management (Honikman et al. 2012; Field et al. 2014). The services are free of charge and are usually delivered on-site, within the maternity care environment (clinic, hospital, non-governmental organisation).

The core components of the service model are described below, including the rationale behind certain design choices. We refer, in particular, to the experience of the site currently in operation at Hanover Park Midwife Obstetric Unit (MOU), Cape Town.

Preparing the Environment

Prior to initiating a mental health service within the maternity care environment, we established a small multidisciplinary team of staff, with experience working in public sector health and social services. We held several meetings with stakeholders at different levels of the maternity care system, from junior nursing staff, health promotion officers, administrative clerks, managers, senior clinicians and mothers themselves. Some meetings were conducted individually, and some took place in the form of group workshops. We aimed to ascertain existing mental health literacy among these staff, the staff motivation levels in general and their willingness to support the development of an integrated mental and physical service. We aimed to understand more deeply the common phenomenon of disrespectful maternity care in our setting (Jewkes et al. 1998; Kruger and Schoombee 2010) – its root causes and possible ways to address the problem.

A respectful and enquiring approach enabled us to learn early some key factors about the context in which we planned to launch our services. These included a concern by staff about taking on additional work in an already overburdened environment, the belief that mental health care should be placed in the realm of specialist providers only, a lack of confidence in primary care providers being able to detect and manage cases and the belief that mental health problems were rare and difficult to manage.

These finding enabled us to develop our approach in subsequent engagements with stakeholders. We were able to acknowledge concerns specifically and thereafter impart targeted evidence-based information about maternal mental health. We normalised for staff that mental health care and physical health care occur in parallel and gave rationale for how addressing mental health will have significant benefits for physical health on mothers and their infants. We dismantled the perceived complexity of providing integrated care, giving examples of how others in low resource settings have managed to do this. We suggested that this work may create greater professional fulfilment for staff than solely providing physical health care. Thus, we were able to generate excitement in the novelty and potential of the proposed service. With these stakeholders, we were able to codevelop service design ideas and to anticipate together the opportunities and challenges. We are able to identify those that would be able to champion and lead the service development together with the PMHP, going forward.

Capacity Building of Maternity Care Staff

The lessons we learned in preparing the environment enabled us to identify existing training platforms in which to embed our training and to develop the content of the training accordingly. In addition to simple knowledge transfer regarding maternal mental health, we discovered that staff of all cadres (nurses, midwives, medical officers and managers) needed to see demonstrated empathic engagement skills and, themselves, to spend adequate time practising these and critiquing their own skills. This critique would follow more easily if an informal style of training was adopted with frequent use of humour and the incorporation of 'ice-breakers' or games that involved a physical activity or creative processes. Further, we learned that staff needed to reflect in a safe and contained way on their own mental wellbeing and develop approaches for self-care: some activities together with their colleagues, and some on their own. We were able to integrate these elements into our trainings.

Over time, we were able to develop resources such as short films, text books, learning briefs and train-the-trainer modules for others involved in capacity building for providers working with mothers. These were extended to include social workers, undergraduate medical and nursing students, workers in the non-governmental organisation sector and others.

Detection Matters

The timing of the mental screening was a critical design consideration. In order to maximise screening coverage, screening procedures were integrated in to the routine medical history-taking procedures of the MOU staff, at the initial antenatal visit. Care was taken not to conduct the screening after the women learned of their

HIV testing result. Stationery and record keeping processes were refined to work seamlessly with existing maternity care process.

We learned that standardised screening instruments, even if locally validated within research settings, are not necessarily appropriate for busy, clinical settings. Unless tools have undergone cognitive testing, they may be culturally incongruent. Likert-type scoring systems and too many items reduce the technical feasibility and acceptability of the tools.

Through our research programme, we developed and validated an ultra-brief, binary (yes/no) symptom questionnaire for depression and anxiety symptoms as well as suicidality. We chose to combine this with a list of psychosocial risk factors for CPMDs. This coheres with the international recommendations on combining symptom screening with risk screening, e.g. experience of domestic violence, lack of partner or social support and prior mental health problem history (Meltzer-Brody et al. 2018). Referring for support based on risk factors enables the detection of women who may screen negative on the symptom tool and who may go on to develop symptoms of maternal distress in the future, thus enabling preventive work to be done. Risk screening allows for a more focussed and rationalised approach to referrals.

Referral Is a Thing

The *quality* of the referral to care is strongly related to whether women will take up this care. Women face several socio-economic and emotional barriers to accepting mental health care or formalised social support (Baron et al. 2015), and the methods used in making a referral need to take these into account, explicitly. Without due care taken in this process, treatment coverage will be low, and scarce resources may be wasted. Those staff making referrals are given training in the gentle and enquiring way referrals should be made. Staff explain in simple terms the rationale for the referral. Where possible, they provide options for referral sources and timing, and they discuss potential barriers and enablers of uptake. The maternity stationery includes a field where a record can be made of the referral being offered. At subsequent maternity visits, staff are thereby reminded to engage with the mothers about the referral – whether this was taken up, if it helped with the problem and whether another referral should be made. Importantly, signage and terminology pertaining the term "mental" is avoided. Rather, language used by staff and noted in the stationery draws on terms such 'distress', 'support' and 'care'.

Scheduling and Tracking of Counselling Appointments

Where possible, appointments with the PMHP counsellor are scheduled for the same day as the women's follow-up antenatal appointments. This maximises uptake of care and minimises inconvenience and costs for women facing several

socio-economic burdens. When women do not attend counselling appointments, a tracking system is instituted whereby the counsellor attempts to make contact through a maximum of two phone calls and then sends a letter to encourage the women to attend. This tracking system is monitored.

Brief Mental Health Counselling and Activating Social Support

The PMHP counsellor at Hanover Park MOU is professionally registered with a 4-year Bachelor of Psychology degree. Counsellors at other sites have a range of different qualifications, depending on the organisation. The counsellor conducts a detailed assessment and tailors the intervention according to the needs of the client. Where the counsellor has the expertise, this may include an eclectic mix of couple or family therapy, motivational interviewing, problem-solving therapy, psychoeducation and interpersonal and cognitive behavioural therapies. In settings where the counsellor does not have the expertise, supportive counselling is provided.

Even though counselling is available till one year after the birth, most women experience several logistical barriers to using the service postnatally. Thus, most of the PMHP intervention work occurs during pregnancy with a 6–10-week postnatal telephone assessment and follow-up counselling session provided for those women who received counselling antenatally. Counselled women attend for a mean number of three 50-minute sessions (see Fig. 27.1).

The flow diagram depicts service utilisation at the PMHP service site at Hanover Park MOU, since inception.

In addition to these sessions, the counsellor frequently spends significant time, activating social support, such as safe housing, police protection orders and liaising with social workers or non-governmental organisations, as required. We thus advocate for ‘mental health counselling’ to broaden its traditional scope to include social work and case management activities, in order to optimise impact for women with multiple needs and who face difficulties in accessing care.

A small minority of women with severe symptoms are eligible for and accept referral to psychiatric services.

Caring for the Counsellor

The emotional burden experienced by the counsellor in providing this work is substantial. In order to manage this and to ensure retention of loyal, skilled staff, we ensure weekly supervision processes – where possible alternating between group-based (with peers) and individually based sessions with a clinical psychologist. The supervisor and the counsellor together identify ongoing professional development opportunities, and counsellors are encouraged and supported by management to

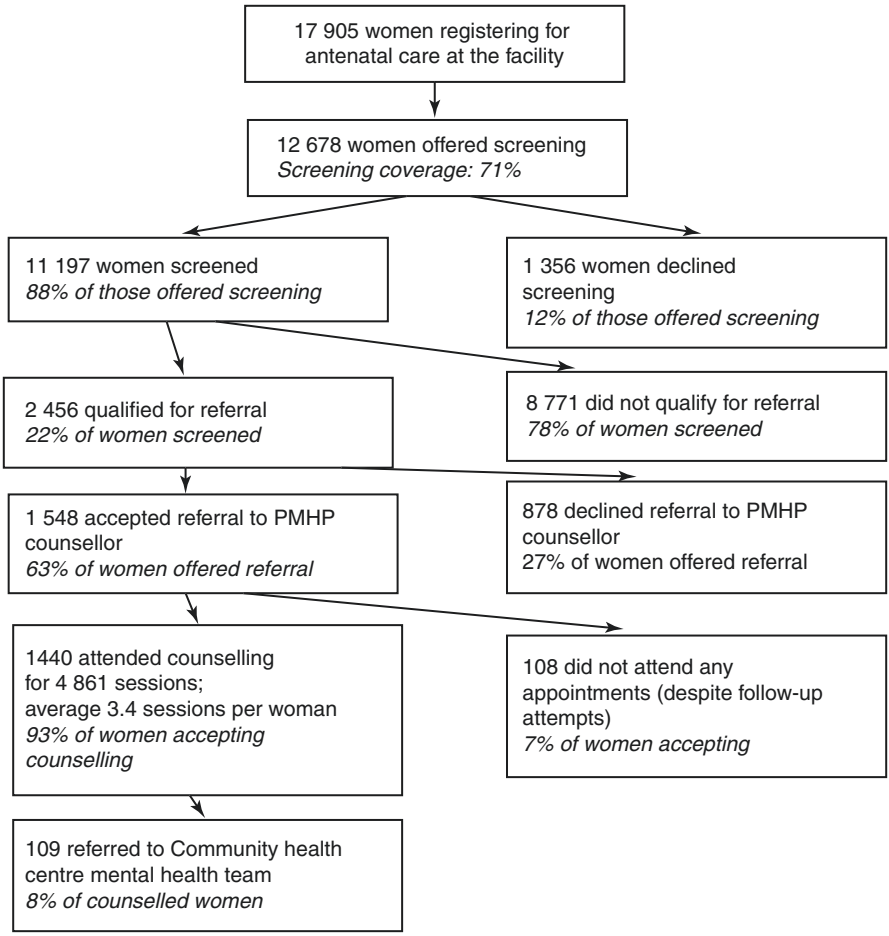

Fig. 27.1 Service utilisation September 2012–December 2018

attend a minimum number of these per year. Staff are offered regular mental health days where they can enjoy leisure activities in natural environments together.

Responsive and Regular Monitoring and Evaluation

Monitoring and evaluation systems are simple and routine. Several staff contribute to data collection, analysis and interpretation and to developing improvements based on the analysis. Key indicators include screening coverage, number of women receiving counselling, number of referred women lost to follow-up, number of sessions per woman and number of referrals made to external agencies. The data collected from the postnatal follow-up assessments enables an analysis of before-after

symptom score changes as well as determining the degree of resolution of presenting problems. Several researchers have conducted in-depth interviews with clients and staff to establish their attitudes and preferences with respect to the service. These data are regularly fed back to stakeholders, using different mechanisms, e.g. email, meetings, website and social media.

Linking the Service to Research, Resource Development and Advocacy Work

As mentioned previously, the PMHP experience of running integrated mental health services in maternity care environments generated the need for answers to scientific questions (e.g. can we develop a brief, psychometrically valid screening tool that has cultural and construct validity for use in our clinical settings?). The PMHP research project continues to work in an iterative way with the service site. The evidence generated is translated for a wide range of audiences and disseminated using traditional and social media platforms and through ongoing relationship building and collaborations with several sub-directorates of the Department of Health and Department of Social Development. Furthermore, the service has generated the need for the development of evidence-based resources like psychoeducational materials for clients as well as multimedia training materials, which are available as open access materials.

By drawing on nearly two decades of service delivery experience, we have thus been fortunate to be able to inform policy, guidelines and practice beyond the immediate reach of our clinical service sites.

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