

## **THE BURGEONING BURDEN OF PERINATAL MENTAL HEALTH IN LOWER MIDDLE-INCOME COUNTRIES**

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Perinatal mental health broadly refers to mental health during the six months before conception, through pregnancy, and up to a year after delivery.<sup>1</sup> Perinatal mental health problems (PMHPs) affect women all over the world and include conditions such as anxiety, depression, psychosis, tocophobia and obsessive-compulsive disorder amongst others. Teenagers and young women under 25 are at particularly high risk of having perinatal mental disorders. PMHPs can also affect men although in much lesser proportions.

Per recent global mental health literature, up to one in five women worldwide will experience a perinatal mental health condition but the prevalence increases to more than one in three for women in low and middle-income countries.<sup>2</sup> In particular, the prevalence of perinatal depression ranges between 7 per cent and 15 per cent in some high-income countries (HICs) while it increases to between 10 per cent to 39 per cent in low and middle-income countries (LMICs).<sup>3</sup>

PMHPs do not only contribute significantly to maternal morbidity and mortality but they also create potential long-term adverse impacts on the physical, emotional, and neurological development of newborns and children. For instance, a systematic review of middle-income countries showed that women with perinatal mental health conditions are 60% more likely to have

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babies with low birth weight and more than twice as likely to give birth prematurely.<sup>7</sup> In Pakistan, low birth weight, growth retardation, and delayed cognitive and motor development are outcomes that have been identified as associated with children of depressed mothers.

PMHPs may also put women at risk of additional mental health issues including eating disorders, substance-use-related issues, post-traumatic stress disorder, and personality disorders. Literature has shown a correlation between serious perinatal mental disorders and an increase in maternal deaths by suicide, a significant cause of maternal mortality in the past two decades with a higher burden in LMICs.<sup>8</sup>

Despite this higher burden of PMHPs in LMICs requiring greater investment, Perinatal Mental Health Services remains under resourced in LMICs. For instance, while the UK spends 8.1 per cent of its National Health Service budget on mental health, Bangladesh only spends about 0.5% of its health budget on mental health, thereby severely limiting service provision.<sup>5,6</sup>

Beyond financial resources, there are multiple barriers to service provision in LMICs extending from the individual level (e.g., stigma, poor awareness, poverty), to the interpersonal/community level (e.g., intimate partner violence, preference for male child, cultural barriers), to the institutional, or organisational level (e.g., resource inadequacies, service fragmentation) and the structural level (e.g., weak policies). A few of these barriers demand further expatiation.

Stigma and shame associated with PMHPs prevents women from accessing care due to entrenched notion

that mental health conditions are not serious conditions and should stay within the family when they occur. This is even more applicable in South Asian cultures which are collectivist in that social controls such as family, culture, religion, and community often dominate decision-making and strongly shape the attitudes that individuals hold. Another significant barrier involves the shortage of manpower. A severe discrepancy exists between the burden of mental health conditions and the availability of health workers in LMICs. There are less than 15 mental health workers per 100,000 population on average across low- and middle-income countries and less than 1 per 100,000 in low-income countries.<sup>9</sup>

In finding lasting solutions to service provision, several care models have been trialled. One is the ‘integrated care model’ which involves the provision of screening for perinatal mental health problems and low-intensity treatments by midwives and health visitors in collaboration with primary mental health services. Another is the ‘task-sharing’ model in which non-specialist health practitioners are trained to deliver specific interventions with support from interlinked specialists sharing responsibility for care; or collaborative care, which encourages self-management by the patient using community resources and digital innovations.

A further variation is the stepped care model that involves ‘task-shifting’ to non-specialist health practitioners who provide less resource-intensive evidence-based interventions while more complex cases are referred to specialist services. An example is the WHO’s Thinking Healthy Programme. This model was adopted in Pakistan where social peers were trained and used to deliver psychosocial intervention on maternal depression. A review of this intervention during the 3-year postnatal period showed reduced severity of maternal depression symptoms and high remission rates.<sup>10</sup> However, this multi-year, psychosocial intervention task-shifted via peers was also discovered to be susceptible to reductions in fidelity and dosage over time. It was posited that early intervention efforts might need to rely on multiple models, be of greater intensity, and potentially target higher-risk mothers.<sup>10</sup> Ultimately, what these findings reveal is that whatever model an LMIC country chooses to adopt would require longitudinal evaluations of efficacy and effectiveness to determine the best fit. It is also important that the model of care caters to users’ partners and families. Furthermore, consideration for and provision of perinatal mental health care for childbearing-age women within generic adult psychiatric care should be fostered. Overall, it is clear that perinatal mental health care is a key global health concern in LMICs that requires urgent attention. Stakeholders must address the complex

cultural, social, and structural determinants from the individual to the structural level. Established (and new) economically effective models need to be piloted in different settings and evaluated to determine needed modifications for effectiveness, efficacy, and sustainability. Of course, without adequate funding and thorough commitment from relevant stakeholders to manage this burgeoning burden, making a lasting change would remain an elusive ideal.

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