TTC Evidence Brief:

Evidence for Maternal Mental Health within World Vision Core Health Model Timed and Targeted Counselling (ttC)

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Introduction

Maternal psychosocial concerns, including depression, anxiety and Intimate Partner Violence (IPV) serve as significant risk factors, negatively influencing children's health and development outcomes (WHO, 2012; UNICEF, 2012). Community Health Workers (CHWs) commonly encounter caregivers experiencing such risk factors and thus must be responsibly equipped to respond to distress. Research has found that CHW can be trained in simple psychosocial interventions found to be effective in reducing symptoms of maternal depression and anxiety, in addition to distress related to IPV (WHO, 2013a and b; Lancet Perinatal mental health series, 2014). In turn, such interventions play a role in enhancing children's health and development (UNICEF, 2012).

Perinatal mental health

Depression is the third leading contributor to the global disease burden and the leading cause of disability, affecting more than 121 million people globally (WHO, 2012). WHO estimates that 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries these numbers are even higher, with up to 19.8% of women experiencing post natal depression after child birth, and in many places the cultural norms or expectations of women can be a barrier to the seeking of care and support when it is needed. Anxiety disorders too are common in the perinatal period and such disorders are often comorbid with depressive symptoms. The Lancet (2014) reports that up to 13% of women in developing countries experience an anxiety disorder in the perinatal period. Poverty, migration, exposure to violence, including domestic, sexual and gender-based violence, emergency and conflict situations, natural disasters, and low social support increase the risks for these specific disorders pre and post pregnancy (WHO, 2015). Such figures are disturbing given the implications for mother and baby; stress hormones are raised during periods of depression and anxiety, which has physical effects on the pregnant women predisposing her to high blood pressure, preeclampsia and a difficult delivery while the baby in utero experiences an increased chance of being born low birth weight and experiencing stunting (WHO, 2008). Such infants become apathetic or irritable and less able to gain their mother's attention in a positive way, creating a cycle leading to child neglect and underachievement in all areas of development (UNICEF, 2012). Furthermore, mothers with depressive symptoms are less engaged with their children and reduce their responsiveness to meeting their children's needs (Nahar, 2012). Mothers with depressive symptoms, including anxiety can be intrusive, forceful or withdrawn in their interactions. This

can result in children experiencing language and cognitive problems, insecure attachments, social interactive difficulties, and behavioural problems, leading to long term mental health issues, including increasing their own risk for developing mental illness (Center on the Developing Child at Harvard University, 2009).

In the past 15-20 years, research conducted in developing countries has shown that combining maternal & child health programs with support for positive parenting and psychosocial support for caregivers is likely to have long terms benefits on children's health & development and maternal mental health outcomes (UNICEF, 2012). Research in Pakistan revealed that community health workers could be trained to deliver a simple psychosocial intervention including techniques of active listening, collaboration with the family and guided problem solving. Results found that infants in the intervention group experienced less episodes of diarrhoea, were more likely to be immunized and both parents spent more time playing with their child. Furthermore, rates of depression more than halved amongst the intervention group as compared with those receiving routine care. In addition, women receiving the intervention had better overall social functioning, with effects being sustained after 1 year (Rahman *et al*., 2008). The Lancet review on perinatal mental health found that training CHW to deliver psychosocial interventions during routine care, with a focus on parenting, maternal and child health, psycho-education, social support, or supportive listening adapted to the circumstances of the women, can improve the mental health of women during the perinatal period in lower to middle income countries (Lancet, 2014).

Furthermore, according to WHO (WHO, 2013a), research conducted in China, Jamaica, Pakistan, South Africa and Uganda suggests that depression in mothers can be affordably treated in developing countries using a variety of interventions, such as social support, group therapy or home visits, which can be delivered by lay community workers. Community health workers caring for pregnant women can be taught to recognize signs of psychosocial distress and employ supportive listening techniques, provide education about stress reduction techniques as well as provide referral to specialist support if required (WHO, 2008). In Uganda (Morris *et al*., 2012), mothers involved in a playgroup established within a supplementary feeding centre for severely acute malnourished children, reported significant increases in positive mood, as compared with the control group where children received only nutritional interventions. This study demonstrates that the additive effects of appropriate child nutrition and psychosocial support interventions yield maximum benefits for mothers and infants, with reports that such approaches also advance mothers' capacity to become more involved with their children and show greater responsiveness to their children's needs.

Gender-based violence

An extensive review of sexual and reproductive health training materials and curricula for CHW was conducted by the World Health Organisation in 2013 (Tran *et al.,* 2014). Various gaps in the content were identified, including the integration of gender-based violence issues and how to address them. Studies estimate that between 13% and 61% of women have reported experiencing intimate partner violence (IPV) at least once in their lifetime, and 1% to 28% of women report they were physically abused during pregnancy by an intimate partner (WHO, 2013b). Of further concern, the risk of intimate partner violence increases during the pregnancy and post-partum period. This may be particularly

concerning for more vulnerable mothers such as adolescent girls who are up to seven times more likely to experience IPV from their spouses (UNICEF, 2014).

When considered together with perinatal mental health issues, the extent of women experiencing serious or acute psychosocial difficulties during and after pregnancy reflects an endemic problem, for which an integrated approach is warranted. CHWs and Care Group volunteers, who are the principle cadres implementing ttC across the World Vision partnership, are working with women and families on a day to day basis. They hold a position of trust with those individuals and may be the first to become aware of a serious issue within a family. Arguably, serious cases of IPV and other forms of violence do require specialist care, and may not have a high and sustained impact in the resolution and management of such problems. However, CHWs, given their high level of exposure, must have a basic set of supportive response skills which will enable them to respond appropriately when such crises arrive. In a recent consultation with World Vision Kenya, a MoH representative commented *"They (CHWs) deal with these kinds of issues every day of their work, it's just that at the moment, they don't know how to respond"*. WHO (2013b). Such comments highlight the importance of frontline health workers having skill based approaches integrated within their training, including supportive non-judgemental listening, providing practical care that responds to concerns, helping women access information about resources, including legal services and assisting them to increase safety for herself and her children, where needed.

Therefore, in direct response to WHO's recommendations, WV has included a mental health & psychosocial component within ttC 2nd Edition. Whilst this cannot be taken as specialised psychosocial intervention, it is designed to provide basic awareness and guidance on how to appropriately respond to situations that CHWs may encounter. This includes training for ttC home visitors in how to recognise signs and symptoms of psychosocial distress and IPV, and building capacity to respond using Psychological First Aid; a humane, supportive response to an individual who is in distress and may need support (see Table 1). This also includes training on promoting positive coping strategies such as stress reduction techniques, exercise, sleep and social support, all of which have proven benefits in reducing symptoms of depression and anxiety. In addition they will receive guidance on referring caregivers who may need specialised support. Further to this, CHWs will receive training on age appropriate stimulation activities to encourage caregivers to sensitively engage with their child to ensure adequate brain development and bonding takes place, also having positive impacts on maternal and paternal mental health outcomes (for more details regarding the ECD inclusions in ttC 2nd edition (TTC 2nd edition: ECD evidence brief).

Table 1. The psychological first aid approach

Psychological First Aid (Source: WHO, 2011)

According to Sphere (2011) and IASC (2007), PFA describes a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes:

- Providing practical care & support, which does not intrude;
- assessing needs and concerns;
- helping people to address basic needs;
- listening to people but not pressuring them to talk;
- comforting people and helping them to feel calm;
- helping people connect to information, service & social support;

- protecting people from further harm.

As discussed, evidence suggests that improving home visitor capacity to respond to distress, including maternal depression, anxiety and IPV, can have positive impacts on the emotional state of caregivers. Such improvements in caregiver mental health will in turn influence children's immediate and future health and development outcomes.

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