Guide for integration of perinatal mental health in maternal and child health services

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Acronyms

CBT	cognitive behavioural therapy
GBV	gender-based violence
LHW	lady health worker
M&E	monitoring and evaluation
mhGAP	Mental Health Gap Action Programme
MCH	maternal and child health
NGO	non-governmental organization
PMH	perinatal mental health
WHO	World Health Organization

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Introduction

1. Introduction

Many women experience changes in their mental health during the perinatal period. Poor mental health can negatively affect women's health and the well-being of their babies and families. Equally, poor health or difficult circumstances in the lives of women, their babies and families can negatively impact women's mental health. Maternal and child health (MCH) services during the perinatal period provide a unique opportunity for service providers to connect with women and provide support.

In this guide, the perinatal period refers to the duration of pregnancy and the year after birth.

This guide was written to provide information about how staff in MCH services can provide mental health promotion, prevention, treatment and care. Supporting good mental health can improve health outcomes, and the quality of MCH services for all women can be improved by creating an environment where they feel safe to discuss any difficulties they are experiencing in a respectful and caring environment that is free from stigmatization. This may increase attendance and result in better engagement in care for women and their babies.

Most women require low-intensity mental health support that can be provided in MCH services. For example, they may be given information about the management of stress and use of support from friends and family. Some women may experience mental health difficulties over a longer period, and they will require additional support either in MCH services or by specialized mental health care providers through referral, when possible.

This guide will help to identify ways of supporting the women who use MCH services. The guide can be adapted to individual levels of resources, funding, and service providers, in addition to local culture, procedures and policies.

1.1 Who is this guide for?

The guide was written primarily for programme managers, health service administrators and policy-makers responsible for planning and managing services for women and infants during the perinatal period who wish to integrate mental health care into MCH services or strengthen existing service provision. They include clinical managers and health service administrators at hospitals, district and primary health facilities and in nongovernmental organizations (NGOs) and community-based organizations that provide MCH services. It will also be a useful resource for health-care providers and allied health professionals.

Mental health specialists receive specific training and are certified as psychologists, psychiatric nurses or psychiatrists.

1.2 Purpose

The guide is intended to be used to develop and sustain high-quality, integrated mental health services for women during the perinatal period. It brings together the best available evidence to support MCH providers in promoting good mental health, identifying symptoms of mental health problems and responding in a way that is adapted to their context. The guide lists the steps required to plan for integration of perinatal mental health (PMH) care and for assessing its impact. It does not include support or guidance on the provision of mental health interventions, which will be addressed in separate resources for specific contexts, such as training materials and job aids.

All the elements in this guide should be considered in planning for either an entire MCH service or an individual facility.

Integration takes time and a series of steps. Involvement of a range of stakeholders is essential. In some cases, resistance must be overcome.

1.3 Use of the guide

The guide has the following sections:

PERINATAL MENTAL HEALTH

What it is and why it is important

PROVISION OF CARE

Promotion, prevention and treatment of PMH conditions in MCH services

INTEGRATION OF PROGRAMMES

Planning effective integration of PMH care into MCH services

PROVISION OF CARE FOR SPECIFIC NEEDS

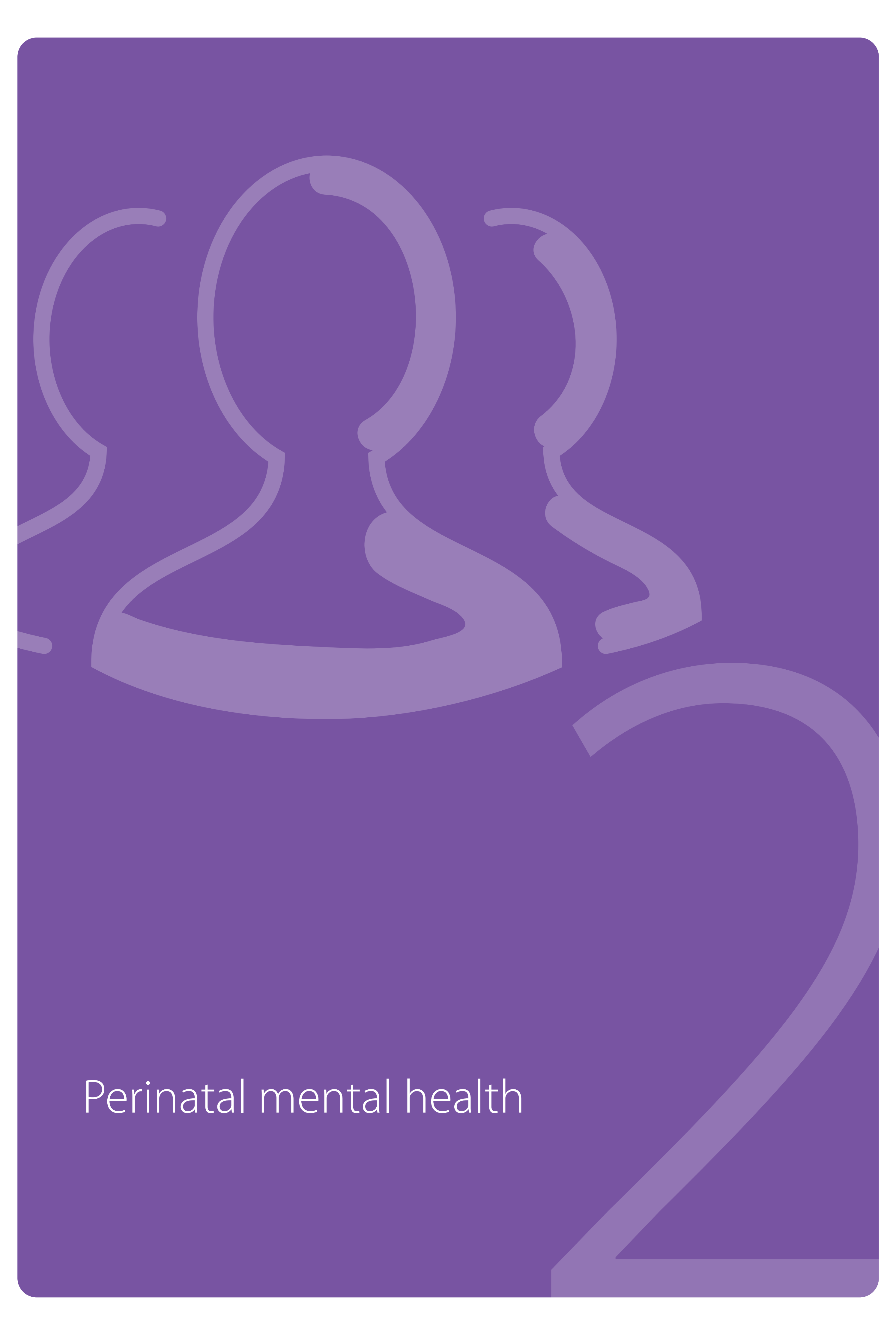
Provision of tailored, inclusive care to vulnerable groups

MONITORING AND EVALUATION

Ways to ensure that PMH services are effective

The guide was designed to expand on previously published guidance on integration of mental health care into health-care settings. Although it provides specific information for MCH services, it is designed to be used in conjunction with the World Health Organization (WHO) resources on promotion, prevention and treatment of mental health conditions:

Title and description	Reference no.
Mental Health Gap Action Programme (mhGAP) Community Toolkit: Interventions for mental health promotion and prevention	*1*
mhGAP Intervention Guide v2.0: A guide to support delivery of high-quality care for mental, neurological and substance use conditions by non-specialist health-care providers in resource-constrained settings. Includes recommendations for treatment of mental health conditions in the perinatal period	*2*
mhGAP Operations Manual: Provides specific information on supporting integration of mental and physical health services, with practical guidance and tools for planning, preparing, implementing, monitoring and evaluation	*3*
Recommendations on maternal and newborn care for a positive postnatal experience: A guide for improving postnatal care for women and newborns, which recommends screening and prevention interventions for common PMH conditions	*4*
Guideline on improving early childhood development: Includes a recommendation to integrate psychosocial interventions to support maternal mental health into early childhood health and development services	*5*
Guidance on community mental health services: A guide for strengthening community mental health care with a person-centred, human rights-based approach to mental health service provision	*6*


Perinatal mental health
2

2. Perinatal mental health

Many women experience changes in their mental health during pregnancy and during the year after the birth

1 in 5 women

will experience a mental health condition during pregnancy or in the year after the birth

Most women require only light mental health support

Common symptoms of poor mental health

- feeling sad
- no pleasure in experiences or activities that were once enjoyed
- lack of energy and motivation
- excessive worrying
- sleeping too much or too little
- eating too much or too little
- difficulty in concentrating
- difficulty in making decisions
- feelings of guilt and hopelessness
- feeling that something bad is going to happen
- non-specific body aches or pains
- feeling worthless

WHO has published manuals for the delivery of effective brief interventions by community health workers, midwives, nurses and doctors:

mhGAP Intervention Guide
(mental health conditions)

Thinking Healthy
(perinatal depression)

Problem management plus
(depression, anxiety and stress)

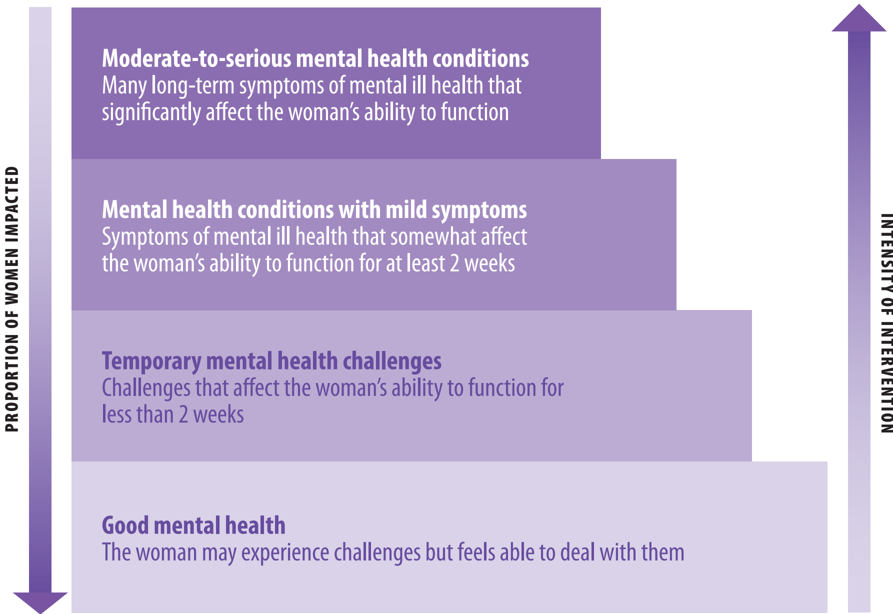
Group interpersonal therapy
(depression)

Self-Help Plus
(stress)

Maternal and child health services are in a unique position to support women in their mental health

Everyone has the right to good mental health and appropriate treatment. All women should benefit from health care that is respectful and free from abuse. Mental health is often understood as a spectrum, ranging from good mental health to day-to-day struggles and more severe mental health and psychosocial conditions (Fig. 1).

Fig. 1. Spectrum of mental health conditions and related requirements for care



2.1 Frequency of perinatal mental health conditions

Pregnancy, birth and early parenthood may be stressful because they may change women's identity, physical health and economic situation. Perinatal anxiety and depression in the perinatal period are common, affecting an estimated 1 in 10 women in high-income countries *(7, 8)* and one in five in low- and middle-income countries (LMICs), indicating the importance of support for PMH globally *(9, 10)*.

Women who already have mental health problems may find that their symptoms worsen during the perinatal period. Others may experience poor mental health for the first time during this period.

2.2 Consequences

Worsening of a woman's mental health during the perinatal period may affect her well-being and that of her infant and family. Poor mental health is associated with higher risks of obstetric complications (e.g., pre-eclampsia, haemorrhage, premature delivery and stillbirth) and suicide *(11, 12)*. In addition, women may be less likely to attend antenatal and postnatal appointments *(13)*. A woman's untreated mental health condition may lead to a poor birth outcome, such as low infant weight, and greater risks for physical illnesses and emotional and behavioural difficulties in childhood *(11, 14)*. Infants may also be at increased risk of difficulty in feeding and in bonding with their parents *(13)*.

2.3 Common symptoms

Poor mental health during the perinatal period may present in many ways. (See mhGAP Intervention guide *(2)*). The symptoms may be general:

- feeling sad, crying easily or more than usual
- finding no pleasure in experiences or activities that were once enjoyed
- lacking energy or motivation
- worrying or "thinking too much"

- sleeping more or less
- eating more or less
- reduced concentration
- difficulty in making decisions
- feelings of guilt or hopelessness
- feeling worthless
- thinking that something bad is about to happen or that the future is hopeless
- thoughts of self-harm or suicide
- non-specific body aches and pains and other physical symptoms
- feeling troubled by memories or dreams about bad experiences

Some symptoms may be more specific:
- unable to stop worrying about the baby
- feeling unable or unwilling to care for the baby
- negative thoughts about the baby

In severe cases, women may experience hallucinations or psychosis, suicidal thoughts or severe depression. Women with these symptoms require more intensive interventions from service providers.

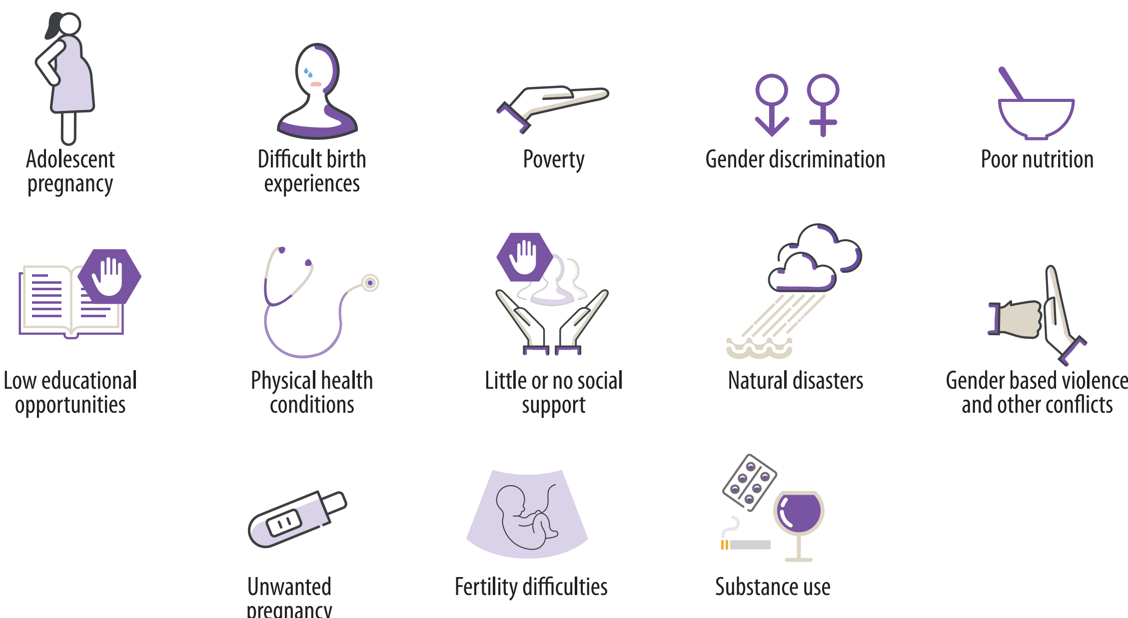
Distinguishing everyday worries from clinically significant mental health conditions may be difficult, particularly during the perinatal period. A woman should be asked about how severe the symptoms are, how long they have been present and the extent to which they affect her ability to function in her daily life.

The mental health support that many women need can be provided during a routine MCH consultation. For example, information can be given on managing stress and using the support of friends and family. Women who experience many difficulties over a long time will require additional support, either within MCH services or from a specialist in mental health care.

2.4 Social determinants and other risk factors

Some women may be at greater risk of poor mental health during the perinatal period because of external circumstances or other health conditions *(15)* (Fig. 2). Services should be aware of circumstances that indicate that a woman needs more intensive mental health interventions. Such circumstances are explored in detail in the WHO publications Social determinants of mental health guide *(16)* and Maternal mental health and child health and development in low- and middle-income countries report *(17)*.

Fig. 2. Examples of risk factors for poor perinatal mental health



2.5 Protective factors

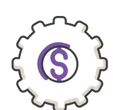
Mental health is not merely the absence of mental health conditions but a state of wellness in which individuals can realize their potential, cope with everyday stress and contribute to their community. Certain factors may help people to protect and promote mental health in the perinatal period (Fig. 3). See WHO Mental health: Strengthening our response *(18)* for more information.

The perinatal period is a time in a woman's life when she is likely to have increased contact with health services. It is therefore critical that those services provide mental health support to all women at a level that is appropriate to their needs.

Fig. 3. Examples of protective factors against poor perinatal mental health

Strong social support
Presence of caring family, friends and community

Educational opportunities
Possibility of attending and completing schooling



Opportunities for generating income
Ability to pay for essentials

Positive childbirth experiences
Feeling informed and able to make decisions

High-quality MCH services
Empathetic, competent health-care providers who treat women with respect and dignity

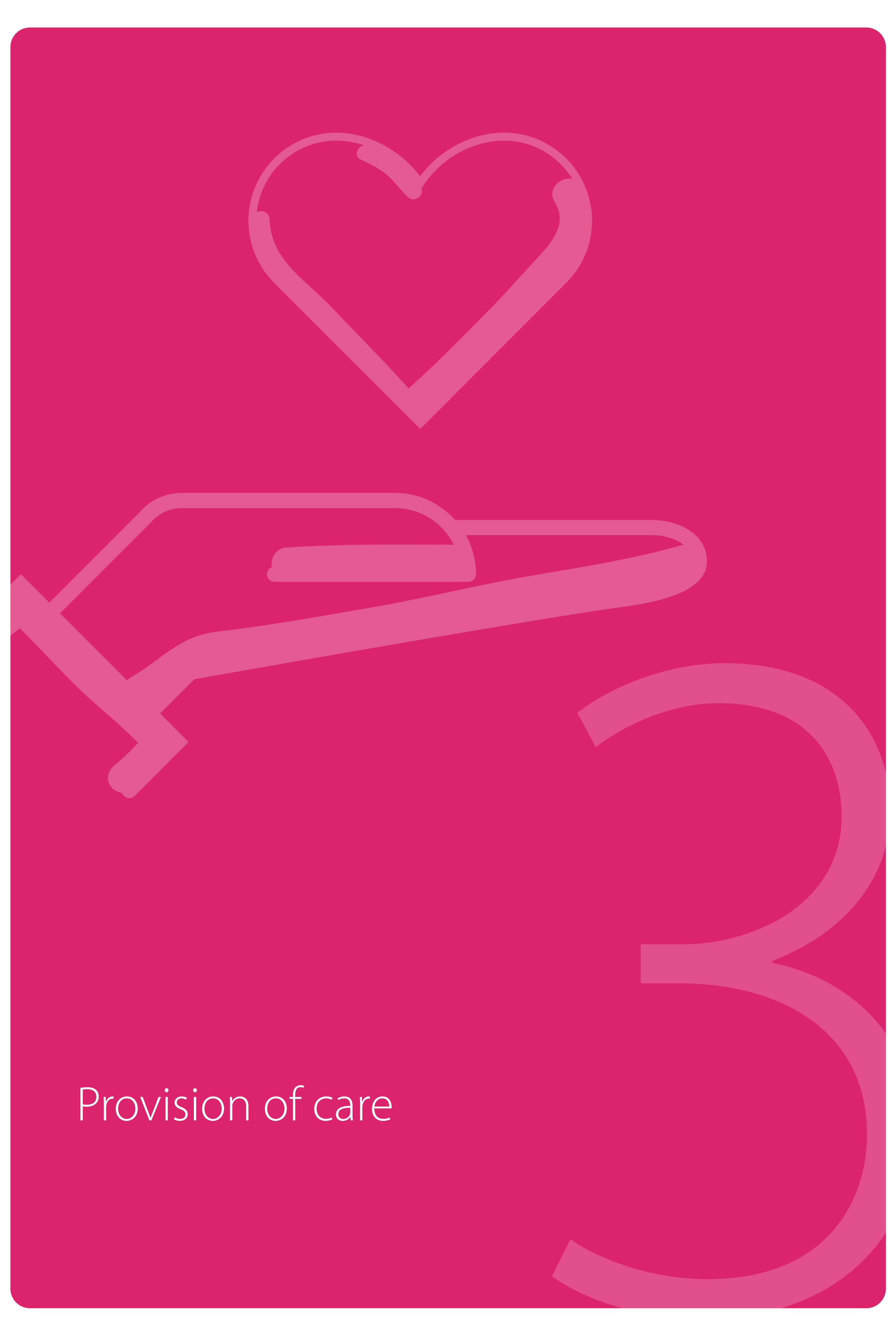
2.6 Availability of care

Although mental health conditions are common, most women do not receive the care they need *(14)*. Some reasons why women with mental health conditions are not identified and treated are lack of mental health specialists, particularly in LMICs, and little training in mental health of other health-care providers. When health-care providers in MCH services are trained to identify symptoms of mental health conditions and to deliver appropriate interventions during routine contacts during the perinatal period, they can address the treatment gap in PMH care and improve mental and physical health outcomes for women and their children.

Routine screening and general psychosocial support from MCH providers are appropriate for all women in the perinatal period, ensuring that they feel able to discuss and manage their mental health struggles. More intensive or specialized treatment is appropriate for women with longer-term, more severe mental illnesses. This is called the "stepped-care approach" (see Section 3).

Additional information is provided in several WHO publications:

Title and description	Reference no.
mhGAP Intervention Guide v2.0: A guide to support delivery of high-quality care for mental, neurological and substance use conditions by non-specialist health-care providers in resource-constrained settings. It includes recommendations for the treatment of mental health conditions in the perinatal period.	*2*
Social determinants of mental health: thematic paper	*16*
Maternal mental health and child health and development in low- and middle-income countries: meeting report	*17*
Mental health: strengthening our response: fact sheet	*18*



Provision of care

3. Provision of care

Supportive environments

- Reducing stigmatization of mental health conditions
- Ensuring respectful care

Promotion and prevention

- Psychoeducation
- Stress management
- Social support (including greater support by partners and family members)
- Promoting functioning
- Life skills
- Recognizing mental health conditions

Treatment of mental health conditions with mild symptoms in maternal and child health services

Treatment of mental health conditions with moderate-to-severe symptoms by referral to specialist care

Medication (provided, when possible, by trained service providers)

A stepped-care approach provides an efficient model for the provision of perinatal mental health in maternal and child health services

PROPORTION OF WOMEN IMPACTED

Moderate-to-serious mental health conditions
Many long-term symptoms of mental ill health that significantly affect the woman's ability to function

Mental health conditions with mild symptoms
Symptoms of mental ill health that somewhat affect the woman's ability to function for at least 2 weeks

Temporary mental health challenges
Challenges that affect the woman's ability to function for less than 2 weeks

Good mental health
The woman may experience challenges but feels able to deal with them

INTENSITY OF INTERVENTION

This section reviews evidence-based interventions that can be included in a package for integration of PMH into MCH services. A situation analysis will be useful for developing a feasible package of interventions that is based on the needs of women attending MCH services during the perinatal period. All interventions should be adapted to the context and culture of the setting in which they will be provided.

3.1 Stepped care

A stepped-care approach results in the most efficient use of MCH service providers and resources for the provision of mental health care (Fig. 4) *(19)*. This method of delivery ensures provision of less resource-intensive evidence-based interventions to the majority of people. Interventions that require increasing resources are provided to those with greater mental health care needs. The package of PMH care in a stepped-care approach includes interventions for mental health promotion and prevention of mental health conditions during the perinatal period, identification of mental health conditions and treatment. Treatment may be provided either in MCH services or elsewhere by referral.

Fig. 4. A stepped-care approach to perinatal mental health

Case study: Implementing stepped care for perinatal mental health *(20, 21)*

Title: Stepped care for perinatal depression in primary care

Setting: Chile (nationwide)

Description: In 2003, Chile introduced a national programme for the detection and treatment of depression into primary care facilities. Specific guidelines were issued for early detection and treatment of depression during pregnancy and the postnatal period. The model includes universal screening for depression by midwives and nurses. Referral to a general practitioner and/or psychologist to confirm a diagnosis or to a specialized unit if severe depression is indicated. Women with moderate-to-mild symptoms are seen in primary care in individual or group therapy, and psychotropic medication is provided as needed. Women who respond well to treatment are followed up for at least 6 months before being discharged from the programme. Interviews were conducted 5 years after the programme was started to assess its implementation.

Challenges: The socio-political context and the media have a major influence on public perceptions of mental health and should be leveraged to reduce stigmatization and promote discussion of perinatal mental health to maximize the benefit of the intervention.

Lessons learnt: In this programme, 89% of pregnant women who used public health facilities were screened for depression. Other LMICs can begin to incorporate mental health interventions into primary care services following the experience in Chile.

3.2 Supportive environments

The effectiveness of PMH care depends on creation of a safe, non-judgemental service in which women feels respected and listened to. In such an environment, women may be more open to talking about their mental health and using available services.

Stigmatization

Stigmatization is projection of negative stereotypes of people because of certain characteristics, which can lead to their rejection and poor treatment. People with mental health conditions are stigmatized in many cultures *(22)*. Women with PMH conditions may be perceived as bad or unfit parents. As a result of stigmatization, women may be unwilling to disclose their mental health problems or to access services *(23)*. Integration of PMH into MCH services and engagement on mental health at every contact with health services will help to normalize mental health conditions and reduce stigmatization.

Respectful care

Respectful maternity care ensures women's rights to privacy, dignity, autonomy, their beliefs and their preferences. It can be ensured by training and working with MCH service providers to identify, understand and address barriers to respectful care and identifying and celebrating good practices. Promotion of respect and dignity should be at the centre of mental health service provision. Respectful care promotes good mental health for all and does not require resources. Respectful care includes keeping women's details private from anyone not involved in her care and delivering all procedures with consent. During a consultation, people share personal information and trust providers to use the information to help them. Without trust, people are less likely to seek help when they need it.

Abuse and disrespect of women by health-care providers have been reported in maternity settings throughout the world. This can include *(24)*:

- physical abuse (e.g., hitting, slapping, shoving, punching)
- verbal abuse (e.g., shouting, swearing or name-calling)
- non-consensual care
- undignified care
- discrimination
- abandonment or neglect
- detention (e.g., keeping a woman in hospital until fees are paid)
- non-confidential care

Services are responsible for ensuring that such behaviour is not permitted and that mechanisms to bring perpetrators to account are in place. Women should be made aware of their right to respectful care and feel empowered to report maltreatment by service providers anonymously.

3.3 Promotion and prevention

Both promotion and prevention of mental health conditions can reduce physical and psychological distress and maintain human and financial resources for individuals, families, the health system and beyond *(25)*.

Promotion of mental health includes supporting people in developing their personal skills or coping strategies and strengthening those they already have (e.g., protective factors). Promotion also includes creating environments to support mental well-being. These include social policies and strategies for creating employment, prevention and reduction of violence, supporting the education of women and girls and anti-discrimination initiatives *(26)*. Promotion of mental health during the perinatal period can support women's activities as community members, caregivers and workers and help strengthen their resources (e.g., income, social connections, assets) and mental well-being.

Prevention builds awareness of the symptoms of mental health conditions and early warning signs to ensure early intervention. The aim is to stop the development or worsening of symptoms associated with mental health conditions *(27)*.

MCH services can play a vital role in both promotion and prevention of mental health for women during the perinatal period, as women have many contacts with these services. Promotion and prevention can also be delivered in the community by informal support services, which may be part of the care pathway. Most types of MCH service providers can be trained and supported to promote and prevent PMH conditions, including midwives, community health workers and peers. MCH providers can deliver mental health promotion and prevention interventions as a part of waiting-room talks, community outreach and perinatal and child health campaigns.

Psychoeducation

Psychoeducation involves sharing information about mental health conditions and ways to support mental well-being *(28)*. It empowers women to recognize symptoms and seek help if necessary. It also provides women with the skills to counter psychological harm, including healthy assertiveness, understanding their right to be treated respectfully in all spheres of their life and that gender-based restrictions are harmful. It includes addressing stigmatization, including the belief that women with mental health difficulties are "lazy" or "bad" parents or partners. Information is also shared about self-care and coping strategies, available treatment options, their benefits and possible side-effects.

If permission is granted by a woman, psychoeducation can and should include her partner and close family. Psychoeducation for family members should include information on supporting a woman during the perinatal period.

Stress management

High levels of stress or constantly living in stressful conditions can affect physical and mental health. People naturally develop ways to deal with stress; however, some people may not realize when these strategies are helpful (e.g., speaking with a trusted friend, spending a quiet time in nature or in meditation or prayer, creative activities, exercise) and when they are unhelpful (e.g., using alcohol or drugs). Mindfulness practice, relaxation and breathing exercises can be helpful. WHO has published manuals on two stress management interventions that are delivered by a provider (Problem Management Plus, PM+ *(29)*) or as guided self-help (Self-Help Plus, SH+ *(30)*).

In the perinatal period, stress management exercises can easily be integrated into support groups, parenting clubs or antenatal classes if these are available and facilitators are trained to deliver them. WHO's stress management publication, Doing what matters in times of stress *(31)*, which is part of the SH+ programme, can also be useful to women for stress management.

Strengthening social support

Social support may be emotional support (e.g., sharing one's problems or feelings, experiencing kindness and respect from others) or practical support from friends, family or community members (e.g., child care, providing meals).

Women experiencing mental health difficulties may find it difficult to use social support. They may feel too tired, unworthy or afraid that the support will not be useful or given. This may cause further isolation which can worsen their mental health. MCH service providers can play an important role in assisting women in identifying and connecting with people around them to whom they can turn for support. Antenatal or parenting classes can also function as peer support groups.

Including partners and families

Partners and other close family members involved in care-giving are also at risk of anxiety and depression in the perinatal period.

Positive mental health among partners and other caregivers can protect against the development of PMH conditions and negative effects on children (32). Preventing and treating mental health conditions may benefit the whole family.

Most MCH services focus on the health of women and infants. Often, partners and other caregivers feel that they have no right to support. It is important that services take an inclusive approach to the mental health of the whole family, when possible, and design PMH services for all caregivers, which may include screening, treatment and referral to support groups.

Promotion of functioning and life skills

Women with PMH conditions may struggle in their daily lives to care for themselves and their infants. Services can provide a number of activities to help women with these tasks, such as teaching or supporting the development of life skills (e.g., income-generating, parenting, problem-solving and communication skills, emotion management, assertiveness) and involvement in social activities (e.g., supporting other people in need, participating in community projects, faith-based activities, self-care).

Recognizing mental health conditions

The recognition or detection of mental health conditions is a vital aspect of PMH care. They may, however, be difficult to recognize. Women may be ashamed or hesitant to speak about their difficulties because of the stigmatization of mental health conditions. They may also feel that their symptoms are normal, attributable to a physical health condition or cannot be helped. MCH providers may lack confidence in asking women about mental health difficulties, be uncertain about what support is available or may be worried that it will take too much time and energy to deal with such difficulties. As part of usual care, MCH providers should ask about a woman's well-being, stressors in their lives and any depressive symptoms.

Using screening tools

Mental health screening involves asking women a series of standardised questions to identify whether they are likely to be experiencing a mental health condition. Screening can be administered by a trained community health worker, midwife, auxiliary nurse or other MCH service provider. Women who are literate can complete a screening tool herself. Any screening tool used should be adapted to the local context and culture and reflect the realities of women in the perinatal period. Screening should be done only when a mental health care pathway exists to assist women who may have a mental health condition.

The Patient Health Questionnaire, the Edinburgh Postnatal Depression Scale and Whooley questions are examples of screening tools (33, 34). Scoring cut-offs for probable mental health conditions may differ in different settings. When possible, select a tool or tools that have been developed, adapted, translated or tested in the local (or similar) setting.

A positive screening result is not a clinical diagnosis: it indicates a high chance that a woman is experiencing a mental health condition. When possible, women with a positive result should receive a diagnostic evaluation by a psychiatrist or other mental health specialist who has been trained in diagnosis (e.g., clinical psychologist, psychiatric nurse).

Identifying risk factors for poor PMH

Social determinants and other factors are linked to increased risks for poor mental health. It may be useful to include questions to identify experience of violence, substance use, poverty, poor social support and other risk factors during consultations with women.

Case study: Supporting mental health and help-seeking *(20, 35–37)*

Title: Facilitating detection of and help-seeking for mental health problems with the Community Informant Detection Tool

Setting: Chitwan, Nepal

Description: Insufficient awareness of mental health problems, services and stigmatization are important barriers to access by mental health service users. The Community Informant Detection Tool (CIDT) was developed in Nepal to improve detection and increase help-seeking by people who need mental health care. It was designed for depression, alcohol use disorder, epilepsy and psychosis. It is a paper-based case-finding tool consisting of locally relevant, real-life examples and illustrations. Local cultural expressions are used, and the images are of typical local scenes; it is thus easy to understand. Anyone recognized as having symptoms that match the stories or images and gives a positive response to at least one of the additional questions on impaired daily functioning and need for support in dealing with problems are encouraged to seek help from mental health services. The tool is used by female community health volunteers, who have no background in mental health but are community members who are trusted and respected and have received brief training. The volunteers accurately detected two thirds of people with mental health conditions, and use of the tool resulted in 47% more use of mental health services.

Challenges: The CIDT can be used as a low-cost alternative to screening. It should not be used as an alternative to clinical diagnosis and should be used only to create demand for mental health services. Regular supervision is recommended to address practical challenges, to empower community volunteers in detecting cases and to keep them motivated.

Lessons learnt: To improve detection of perinatal depression, other tools were designed with local community health workers and women with perinatal depression. The CIDT has been included by the Nepal Government in the mental health training package.

3.4 Treatment

The aim of psychological interventions without pharmacological treatment is to reduce or manage a person's mental health condition. There is growing evidence of a positive impact of psychological interventions for women attending MCH services *(38, 39)*. In the past, psychological interventions were provided only by mental health specialists in many sessions. Now, many other service providers, including general health-care providers, community health workers and even peer educators, are being trained to deliver these interventions (under the supervision of a mental health specialist) in a few sessions. The WHO mhGAP intervention guide *(2)* and related training and operation manuals provide detailed information on the delivery of mental health care in non-specialist settings.

Women with a suspected or diagnosed mental health condition should be supported according to the severity of their symptoms. This is often achieved through psychological interventions and/or medication. While women with moderate-to-severe symptoms should be referred for specialist care, where available, most women can be effectively supported by trained MCH staff.

All women with a suspected or diagnosed mental health condition should receive psychoeducation, information on ways to reduce stress and strengthen social support and encouragement to take part in daily activities that will support their mental well-being. Interventions targeting their specific mental health conditions should be provided within MCH services, where possible, or externally through referrals, as appropriate.

Conditions with mild symptoms

Brief psychological interventions for women in the perinatal period with suspected common mental health conditions such as depression or anxiety can be provided by trained MCH service providers. WHO has published manuals on use of the following evidence-based interventions:

- Thinking Healthy *(40)* (perinatal depression)
- Problem Management Plus (PM+) *(29)* (depression, anxiety and stress)
- Group Interpersonal Therapy *(41)* (depression)
- Self-Help Plus (SP+) *(30)* (stress)

Conditions with moderate-to-severe symptoms

Severe mental health conditions include psychosis, bipolar disorder, suicidality and severe depression and are characterized by disordered thinking and behaviour. Women with moderate-to-severe mental health conditions have several symptoms of mental ill health that significantly affect their ability to engage in daily activities (including care of their infant), most of the time, on most days, for at least 2 weeks.

These conditions usually require more intensive interventions that are delivered or supervised by mental health specialists. Evidence-based interventions that may be provided if the resources are available are listed in Table 1.

Table 1. Evidence-based interventions for treatment of mental health conditions

Intervention	Mental health condition	Description
Behavioural activation	Depression	Psychological treatment to improve mood by re-engaging in activities that are task-oriented and used to be enjoyed, despite the current low mood. It may be used as a stand-alone treatment and is also a component of cognitive behavioural therapy (CBT) (see below).
Relaxation training	Depression	Training in techniques such as breathing exercises to bring about a relaxation response.
Problem-solving treatment	Depression, self-harm, suicide	Psychological treatment that involves systematic problem-identification and problem-solving techniques in several sessions.
Interpersonal therapy	Depression	Psychological treatment by linking depressive symptoms and interpersonal problems, especially those involving grief, disputes, life changes and social isolation. Also known as "interpersonal psychotherapy".
Cognitive behavioural therapy (CBT)	Depression, substance use conditions, psychoses, trauma, self-harm, suicide	Psychological treatment comprising cognitive components (for thinking differently, for example, by identifying and challenging unrealistic negative thoughts) and behavioural components (doing things differently, for example, helping a person to do more rewarding activities). CBT for trauma usually includes exposure (in images or in person) and/or a direct challenge to unhelpful trauma-related thoughts and beliefs.

Table 1. *continued*

Intervention	Mental health condition	Description
Family counselling or therapy	Psychoses, substance use conditions	Counselling is usually given in more than six planned sessions over months. It should be delivered to individual families or groups of families and should include the person with a mental health condition, if feasible. It has supportive and educational or treatment functions. It often includes negotiated problem-solving or crisis management.
Eye movement desensitization and reprocessing	Post-traumatic stress disorder	This therapy is based on the idea that negative thoughts, feelings and behaviour are the result of unprocessed traumatic memories. Treatment involves standardized procedures to focus on associations of post-traumatic stress disorder while inducing bilateral stimulation in the form of repeated eye movements.
Contingency management therapy	Substance use conditions	A structured method of rewarding certain desired behaviour, such as attending treatment and avoiding harmful substance use. Rewards for desired behaviour are reduced over time as natural rewards become established.
Motivational enhancement therapy	Substance use conditions	Structured therapy (up to four sessions). The approach to motivating change is motivational interviewing, i.e., engaging people in a discussion about their substance use, including perceived benefits and harm, values, avoiding argument if there is resistance and encouraging people to decide on their goals themselves.
Parenting skills training	Depression, anxiety	A group of treatment programmes to change care-giving behaviour and strengthen confidence in using effective care-giving strategies. It involves teaching caregivers emotional communication, positive care giver–child interaction skills and positive reinforcement methods to improve the behaviour and functioning of children and adolescents.

Case study: Delivery of effective programmes in the community *(42)*

Title: Engaging health workers in integrating mental health into maternal and child health services: The "Thinking Healthy Programme"

Setting: Rawalpindi, Pakistan

Description: An intervention was designed to be delivered to women in Pakistan with depression during the perinatal period by trained community health workers, known as "lady health workers" (LHWs). The LHWs were consulted to identify their work patterns, and the Thinking Healthy Programme was developed on the basis of the principles of CBT to integrate a mental health intervention into their MCH workload without creating an additional burden. Four focus groups were conducted with 24 LHWs of various ages and experience, representing a cross-section of the LHW workforce in two sub-districts. Most of the health workers were mothers. The researchers addressed the issues involved in delivering a psychological intervention for perinatal depression in a rural setting. The experience of LHWs in providing health care to women in their areas was explored and particularly the difficulties they faced in accessing families, health beliefs and attributions, health-seeking behaviour and existing resources, such as social support. Using the same themes, face-to-face interviews were carried out with six primary care doctors, midwives and traditional birth attendants to determine how the LHW-led intervention would fit into the primary and traditional health care system without tension, conflict or issues of territoriality.

Challenges: As LHWs already have many responsibilities, additional training and tasks might be perceived as a burden. Interventions identified as related to mental health or therapy might be considered undesirable by women because of stigmatization of mental health. As a large proportion of the population is illiterate, the intervention must be relevant for different educational levels.

Lessons learnt: The intervention should be referred to as "training" and be provided by "trainers" to avoid stigmatization. The intervention should relieve the burden on LHWs by helping women to achieve their health goals independently. This would increase the attractiveness of the intervention to LHWs. The intervention should be culturally adapted for women in the setting.

Medication

Most women who experience mental health conditions can be helped with a combination of psychosocial support and psychological interventions. Prescription of psychotropic medicine may, however, be necessary for women with moderate-to-severe symptoms of mental illness, women who are not helped by psychological interventions (or if these are not available) and women with a diagnosis of bipolar disorder, schizophrenia or another form of psychosis.

The minimum psychotropic medicines that WHO suggests for a health system are listed in the WHO Model List of Essential Medicines. National lists of essential psychotropic medicines should also be reviewed to identify any additional medicines that may be available.

Additional information on the provision of mental health care is provided in several publications:

Topic	Organization (country)	Title and description	Reference no.
Promotion and prevention	WHO	Public mental well-being resources	*43*
Promotion and prevention	WHO	Helping adolescents thrive (HAT): Guidelines on promotive and preventive mental health interventions for adolescents	*44*
Promotion and prevention	Maternal Mental Health NOW (USA)	Emotional Wellness Self-Help Tool	*45*
Promotion and prevention	Perinatal Mental Health Project (South Africa)	Resources for parents and families in several languages	*46*
Promotion and prevention	WHO	Mental Health Gap Action Programme (mhGAP) Community Toolkit: mental health promotion and prevention interventions	*1*
Promotion and prevention	WHO	Recommendations on maternal and newborn care for a positive postnatal experience: A guide for improving postnatal care for women and newborns, which recommends screening and prevention interventions for common PMH conditions	*4*
Promotion and prevention; treatment	WHO	mhGAP Intervention Guide v2.0: First-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers	*2*
Promotion and prevention; treatment	WHO	Self-Help Plus (SH+): a guide for stress reduction	*30*
Promotion and prevention; treatment	WHO	Doing what matters in times of stress: An illustrated self-help guide for adults experiencing psychological distress	*31*
Treatment	WHO	Thinking Healthy: Intervention manual for perinatal depression	*40*
Treatment	WHO	Problem Management Plus (PM+): intervention manual for depression, anxiety and stress symptoms	*29, 47*
Treatment	WHO	Group Interpersonal Therapy (ITP) for Depression: intervention manual	*41*
Treatment	WHO	Guideline on improving early childhood development: Includes a recommendation to integrate psychosocial interventions to support maternal mental health into early childhood health and development services	*5*
Treatment	WHO	Model lists of essential medicines	*48*
Treatment	National Library of Medicine (USA)	Drugs and Lactation Database (LactMed): Information on medication while nursing an infant	*49*
Provider skills	WHO	Basic psychosocial skills: A guide for COVID-19 responders	*50*

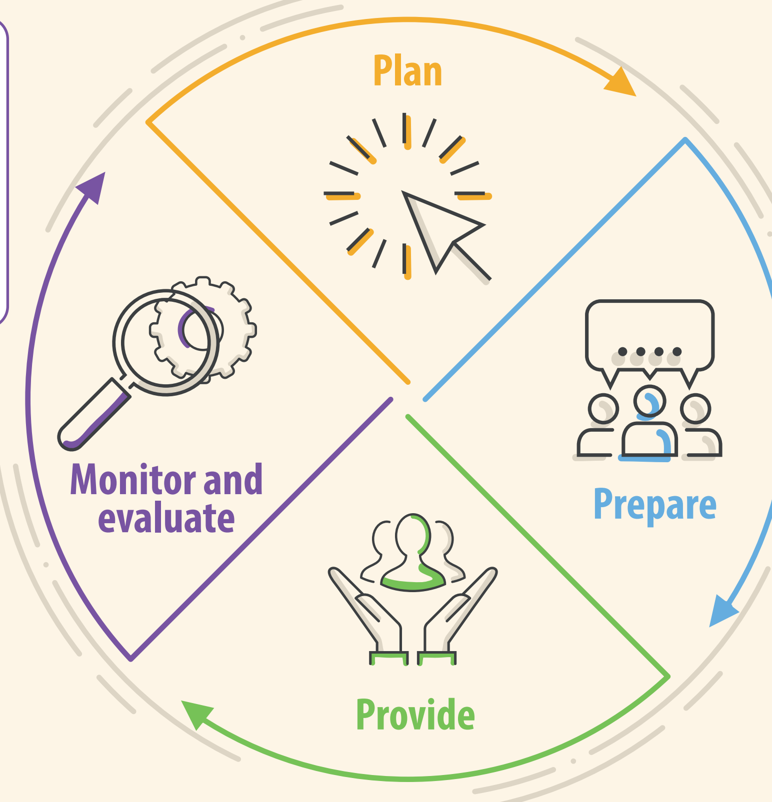
Integration of programmes

4. Integration of programmes

Steps for integrating PMH into maternal and child health services

- Engage those important to funding, delivery and uptake.
- Understand what mental health support is required and what is currently available.
- Decide what support to provide.
- Prepare a budget.

- Assess progress towards service targets.
- Adapt targets according to facility performance and outcomes.
- Identify gaps in mental health provision.
- Share progress and lessons with service providers, women and funders.

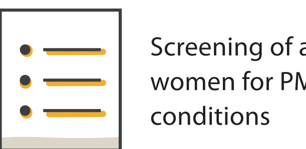


- Work with relevant health and community providers to develop a care pathway and referral strategies.
- Adapt support to the local context and culture.
- Promote respectful care.
- Identify service providers to deliver mental health support.
- Train service providers, and set up supervision structures.
- Address stigmatization of mental health conditions.

- Ensure that all women receive mental health support adapted to their need (a stepped-care approach).
- Provide all women with support that promotes good mental health.
- Support recognition of mental health problems by women, their families and service providers.
- Enable access to treatment for women with mental health conditions.

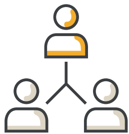
4.1 Planning

A plan to integrate mental health care during the perinatal period into MCH services should include:



Screening of all women for PMH conditions

Identification of women who would benefit from mental health support



Referrals to other services that can offer additional support

Community champions and mental health coordinators are crucial in steering programmes around challenges, learning from the challenges and driving forward the integration process.

Planning should reflect the local culture and context and be based on careful consideration of the needs of women during pregnancy and during the year after the birth, available services and budgets. In developing a plan, the following should be considered.

Forming a core working team

Identify leaders

First, the people who will lead planning and integration of mental health care into MCH services should be identified. The core working team will be responsible for overseeing integration of PMH care and should ensure that stakeholders are consulted throughout the process.

There may already be a core working team. If not, you should try to include the following:

Potential core working team members and additional stakeholders

- women who have experienced pregnancy and caregiving
- families
- women with experience of (perinatal) mental health conditions
- health service managers in government, the district and the facility
- health information and medical records staff
- financial managers
- MCH service providers (e.g., doctors, nurses, midwives, community health workers, social workers)
- mental health workers, trainers and supervisors
- community leaders
- traditional and faith practitioners
- representatives of NGOs, civil society and advocacy groups that support women and children
- academics and researchers
- international agencies
- donors

Set expectations

Teams should be given clear responsibilities and should show mutual respect and good communication. Annex 1 provides sample terms of reference for a working team to guide PMH service integration.

Conducting a situation analysis

Collect contextual data

Before developing a plan, it is important to collect and analyse information about the culture, context, existing policies, systems, resources, local needs and barriers to care and also the demand and need for PMH care and what exists already to meet the demand. Situation analyses are dynamic and continuous. They ensure that the interventions are tailored to the local context, are consistent with government guidelines, build on available resources and meet the identified needs. This kind of planning ensures community engagement and sustainability. Partnerships with universities and NGOs can be useful in conducting such resource-intensive research.

*A **situation analysis** provides information about what services and resources are currently available to support PMH, while a **needs assessment** provides an estimate of the level of services and resources necessary to ensure that mental health care is available to all the women who need it. This information can be used to identify gaps in PMH service provision.*

Speak with relevant stakeholders

The core working team should identify and engage stakeholders at the start of planning, and stakeholders should be consulted throughout planning, preparation, provision and evaluation of mental health services. They may contribute their expertise in mental health, local and national contexts and health care systems to guide the process and address issues.

The group of stakeholders will depend on the setting. They will be called upon to give input throughout integration, in group meetings or individual consultations, depending on the situation. Information about the current provision of PMH care and the local context can be collected from stakeholders during interviews, by direct observation, in focus group discussions and at informal meetings.

The core working team could distribute the tasks among themselves or collaborate with researchers for the situation analysis. It may be helpful to set timelines and a means for ensuring that tasks are completed.

An example of a mental health situation analysis is given on p. 76 of the mhGAP operations manual *(3)*.

Case study: Engaging stakeholders *(51)*

Title: Working with local stakeholders to design an intervention to support the mental health of adolescent mothers

Setting: Manhiça, Moatize and Cateme, Mozambique, and Rabai and Mariakani, Kenya

Description: Project Catalyst and Project INSPIRE were designed to identify the mental health challenges of adolescent girls during the perinatal period and to design an intervention to address them. The researchers identified various groups of pregnant adolescents and groups involved in working with them. Group and one-to-one interviews were conducted with adolescent mothers, their partners and families, community leaders, health-care providers and government representatives. Maternity and other health-care providers recruited staff and young mothers in a maternity facility. The young mothers were asked to bring their partners and families to focus groups and to name other people who had affected their experience as young mothers. School teachers and religious leaders were also consulted to identify the cultural context of the young mothers. In collaboration with these stakeholders, the team designed potential interventions to improve the mental health of adolescent mothers that were considered to be feasible and acceptable to the community.

Challenges: When bringing together girls, their partners, professionals, community leaders and other stakeholders, the power dynamics of sex, age and employment should be considered. Not all stakeholders are used to being asked for their opinions. While bringing stakeholders together can be a powerful means for making them see and think about problems from a different perspective, tensions among them may inhibit people from expressing themselves freely.

Lessons learnt: It is important to understand the relationships and power dynamics among stakeholder groups. Trust among them must be built over time. Spending time with young mothers and showing them that their experiences and ideas are important gave them confidence to speak more freely about their needs and priorities and potential solutions. All stakeholders must understand the process and how they are expected to contribute. The length of meetings should be decided carefully. Information should be provided to and requested from stakeholders in formats and language with which they are comfortable.

Conducting a needs assessment

The situation analysis provides the initial information necessary to prepare a budget for integration of mental health care into MCH services. Next, the mental health care needs and resources necessary to provide care should be reviewed. The following questions should be considered:

- **What is the need for PMH services?**
  This can be determined from data on the prevalence of maternal mental health conditions in the country or region. Choose the best available data. If local or national data are not available, epidemiological data from similar settings may be used and adjusted, where necessary, in discussion with local experts.
- **What is the expected annual number of women who will require PMH care in MCH services?**
  This can be determined by discussion with MCH service managers, researchers and other local experts. The number should include mental health promotion interventions for all women as well as treatment for those with mild and moderate mental health symptoms.

In order to understand the current situation, the following questions should be considered:

- ***What policies, plans, guidelines and standard operating procedures and indicators are related to mental health in MCH?*** *Do they make provision for psychosocial support for women? Do they make provision for treatment (including psychotropic medication) for mental health conditions?*
- ***What mental health services are currently being provided to women in the perinatal period?*** *What is the quality of the interventions? How many women are served? Are any groups of women unable to access these interventions (e.g., adolescents, women with disabilities, women living with HIV)? What service resources are currently available within MCH services?*
- ***How do cultural beliefs and practices affect the provision or use of mental health care?***
- ***What are women's needs and priorities for PMH care?***
- ***What are women's barriers to accessing mental health care in the perinatal period?***
- ***Are there obvious gaps or opportunities on which you can build?***
- ***What is the current budget for the provision of PMH care? What funding and resources are available for plans for integrating PMH care into MCH services?***
- ***Who is responsible for authorizing the budget?***

Developing a plan and a budget

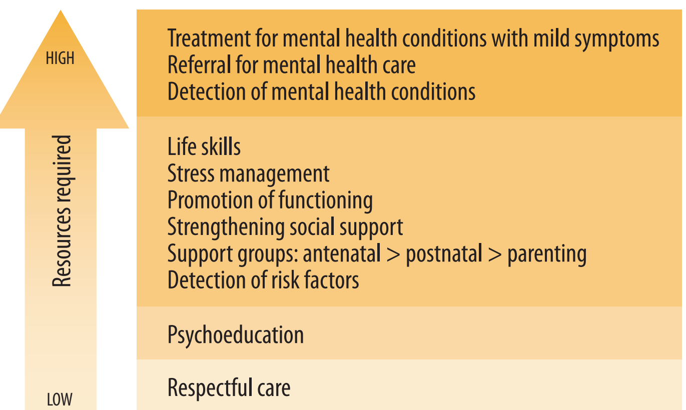
Once the targets are agreed upon, a plan and budget to achieve them can be developed by considering the following questions:

- **What services are to be provided?**
  Fig. 5 proposes interventions based on service type and available resources.
- **How feasible will it be for MCH service providers to add the desired interventions to their routine tasks?**
- **What resources are necessary to provide mental health care to women attending MCH services during the perinatal period?**
  The resources may include:
  - health-care service providers
  - time for training, supervision, support, attending staff meetings, intervention delivery for health-care service providers
  - private spaces for providing care
  - transport (for health-care service providers and women)
  - psychotropic medication
  - referral pathways

  The desired interventions will determine the types of service providers and resources required for delivery. If additional service providers or resources are not available, the interventions chosen may depend on the abilities and available time of those already employed and existing resources. Consider the use of volunteers or peer providers.

- **What resources are currently available in MCH services that could be used to provide the interventions? What are the costs associated with those resources?**
  A sample budget template is shown in Annex 2.
- **What is the estimated cost of any additional resources required?**
  The costs of existing resources and services may be used to determine this amount.
- **What budget is available for integration?**
  The mental health care that can be provided will be determined by the available budget and the interventions to be delivered.

Fig. 5. Perinatal mental health care interventions according to needs and resources



Setting targets

In discussions with local stakeholders, service gaps can be prioritized for short- (within 3 years) and medium-term (3–5 years) targets. The criteria that can be used to select priorities include: the estimated number of women experiencing mental health conditions, what stakeholders consider the most important conditions to be addressed, the severity of conditions, the potential impact of existing interventions to improve mental health outcomes and the cost of intervention. These can be tested during monitoring and evaluation of integration.

The targets should be aligned with local and national mental health and MCH plans, policies and targets.

The targets should be clear and achievable. They should include a goal, a time frame and the outcome to be measured. For example:

- *75% of midwives, nurses, doctors, and community health workers to be trained to detect PMH conditions within the first 6 months of implementation*
- *50% of women attending antenatal care to receive mental health education in the first year of implementation*

Additional information is provided in several publications:

Topic	Organization / author	Title and description	Reference no.
Needs assessment	United Nations High Commission for Refugees	A needs assessment toolbox	*52*
Ethical research	Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings	Recommendations for conducting ethical mental health and psychosocial research in emergency settings	*53*
Human resource planning	WHO	Global strategy on human resources for health: Workforce 2030	*54*
Stakeholder engagement	United Nations Children's Fund, WHO	Nurturing care handbook, focus on families and communities for practical guidance on stakeholder engagement	*55*
Multi-sectoral collaboration	Kuruvilla S, et al.	Business not as usual: how multisectoral collaboration can promote transformative change for health and sustainable development	*56*

4.2 Preparing for implementation

Once the core working team and stakeholders have established the PMH needs and collected the relevant data for planning integration of PMH into MCH services, they should prepare to deliver the service. Careful preparation will ensure that the strategies for delivery are suitable for the setting and that the MCH service providers are adequately trained and supported.

Adaptation for context and culture

The care already provided in MCH services and the beliefs, values, attitudes and behaviour of MCH service providers, women attending MCH services and their partners and family members are important considerations in integrating PMH care. The success of integration will depend on the willingness of these stakeholders to implement, take part in and support integration. A situation analysis will help to understand existing services and stakeholder perspectives; however, further collaboration with stakeholders is necessary to adapt the interventions and delivery strategies to the local context and cultures *(57)*.

Mental health and MCH policies and legislation may differ widely by country. Those relevant to mental health and human rights should be considered.

Local cultural practices affect how and when women can access MCH services. For example, in settings where women are expected to spend a specified time in their homes after childbirth, community health workers would ideally provide initial mental health support. Considerations such as who makes decisions in households and women's rights to personal safety, autonomy and economic empowerment also influence women's access to services. Stigmatization of mental health conditions may delay or prevent women from seeking help.

Workforce

Dedicated PMH service providers assure the continuity of care and case management, resulting in less loss to follow-up and better coordination of care. Many issues can affect the staffing and effectiveness of services, including recruitment, skills, training, capacity-building and the well-being of service providers and should be considered by health-care managers and planners.

Consider gender dynamics. Women in the perinatal period may prefer to receive care from female staff.

Recruitment

In many settings, it may be difficult to recruit skilled service providers to train, supervise and deliver PMH care, as few individuals may have knowledge and skills in mental health. Furthermore, limited additional funding for the integration of PMH may make it difficult to hire additional service providers. In these situations, task-sharing can be effective, in which specific tasks are delegated to increase the care *(58)*. For example, health promotion, psychoeducation and screening can be provided by trained peer workers or community health workers. In task-shifting, it is important to work closely with service providers to determine the feasibility and acceptability of any new responsibilities.

Task-sharing: *Extending the types of health providers who can deliver health services appropriately. Tasks are not taken from one cadre and given to another, but additional cadres are given the capacity to take on identified tasks.*

Task-shifting: *Tasks are redistributed from highly-qualified providers to health providers with less intensive training to make more efficient use of human resources.*

Training

The requirements for training are determined by:

- the PMH interventions chosen;
- the skills and competence of the selected providers;
- the availability of service providers to provide the different levels of stepped care; and
- whether MCH service providers have received any training in mental health before introduction of the PMH service.

This will ensure that training is relevant and appropriate, built on existing knowledge and skills. Training may be provided alone or as part of other MCH training. Training will help health workers not only in assessing and managing women's mental health conditions but also in increasing their overall skill in providing care.

Competence

Successful implementation requires the core working team and stakeholders to acknowledge the challenges of identifying, developing, and assessing core competencies of the selected providers *(59)*. In-service training should be competence-based and provide the required competence in terms of knowledge, skills and attitudes.

In addition to basic knowledge about PMH, training should include learning and practice appropriate to allocated tasks (e.g., detection of PMH conditions, psychosocial support, psychological interventions, prescribing, making referrals, monitoring), knowledge of other relevant services and MCH service provider attitudes towards mental health conditions. Ideally, PMH training should be part of pre-service education.

Effective training approaches allow trainees to feel comfortable in asking questions and discussing freely. Participatory learning, which combines lectures, case studies, group work, role-play and problem-solving, can make training enjoyable. Drawing on MCH service providers' experiences may improve the effectiveness of training. Standardized role plays may serve as an assessment tool to regularly evaluate competencies of the trained workforce *(60)*.

The content of the training should be adapted to the local context and culture and reflect local experience.

Cascade training

Training may be scaled up in a cascade training approach *(61)*, in which a mental health specialist (i.e., master trainer) trains health professionals, who then train community health workers or peer providers. In this approach, trainers must have the knowledge and skills to deliver training and to teach others how to train. Use or adaptation of training manuals linked to local and national policies, legislation and guidelines will help ensure quality.

Opportunities should be provided for continuous in-service learning after training. This can include case reviews from the MCH service, refresher training to address gaps in knowledge and skills, on-the-job mentoring, supervision and support.

Training resources

Reading materials, tools (e.g., protocols, standard operating procedures, posters, pocket cards) or online resources to support training may be used to supplement face-to-face training. This also ensures access to information long after training has been completed. Links to any national remote training platforms, such as telehealth, can be useful.

Case study: Cascade training in mental health for primary care workers *(62)*

Title: Experience of implementing "train the trainers"

Setting: Nigeria (participants from 8 Nigerian states)

Description: In Nigeria, community health workers who work at primary care centres typically receive training in physical health but not in mental health. Intensive 1-week training of trainers in mental health was prepared for 24 staff who train community health workers. The participants completed a questionnaire to assess their knowledge about and attitudes toward mental health issues before and after training. The training had five components: core concepts (mental health and consequences); core skills (mental health support skills); common neurological disorders; psychiatric disorders; and links between mental health and other health care provision. The sessions consisted of theory, discussion and role play.

Challenges: Certain socio-cultural beliefs, such as that people with a mental health disorder cannot recover, would require a long-term intervention to reduce stigmatization. Changes in knowledge were assessed immediately after training, but knowledge retention was not monitored over time.

Lessons learnt: The scores for mental health knowledge increased between pre-training (60.4%) and post-training (73.7%). Training also reduced some (but not all) negative attitudes to mental disorders.

Clinical supervision

Clinical supervision provides an opportunity for service providers to discuss challenging cases, ideas about doing things differently and any emotional stress they might have experienced in delivering PMH care. Clinical supervision to ensure the provision of high-quality mental health care comprises both mentoring and supportive supervision. Both support service providers and build capacity. Supervision should ideally be provided by a mental health specialist or trainer but can also be provided by peers or non-specialist service providers (e.g., obstetricians, gynaecologists, nurses, midwives and community health workers) with experience in mental health. Where there are few mental health specialists, a cascade model may be used for supervision. In this model, a qualified, experienced supervisor provides supervision to one or several less experienced supervisors, who, in turn, supervise service providers, either individually or in groups.

Mentoring supervision

Mentoring supervision involves a mentor, who is an MCH provider with a higher level of professional training (e.g., obstetrician, gynaecologist, psychiatrist, midwife), who supports a "mentee", who has a lower level of training (e.g., nurse, community health worker) in a clinical setting. The relationship enhances individual practice through:

- review of PMH cases and constructive feedback on improving practice;
- guided reflection on personal attitudes, beliefs and behaviour that may maintain stereotypes and stigmatization associated with mental health conditions; and
- support to prevent distress or exhaustion in the mentee and encourage self-care.

Supportive supervision

Supportive supervision involves a manager (i.e., supervisor) who is accountable for the care provided by a group of MCH providers (i.e., supervisees). The manager supports providers to improve their clinical practice continuously. Supervision should be conducted regularly, with open, two-way communication that is respectful and non-authoritarian. It may be used to improve providers' knowledge and skills, improve team work, conduct case management reviews and assess performance against team goals.

MCH provider self-care

MCH providers have stressful jobs, and their work often brings a heavy emotional burden. Self-care is an important part of maintaining a healthy work–life balance and increases resilience to work stressors. Being conscious of one's mental, physical and emotional well-being means taking time to care for oneself. Those who provide psychological therapy or counselling need to talk about and share their experiences in a safe space. They cannot continue to listen to and help other people if they are not cared for themselves. MCH providers may also have stressors in their own lives. They must address their own emotional health to ensure that they can care well for the women they serve.

Coordination of care

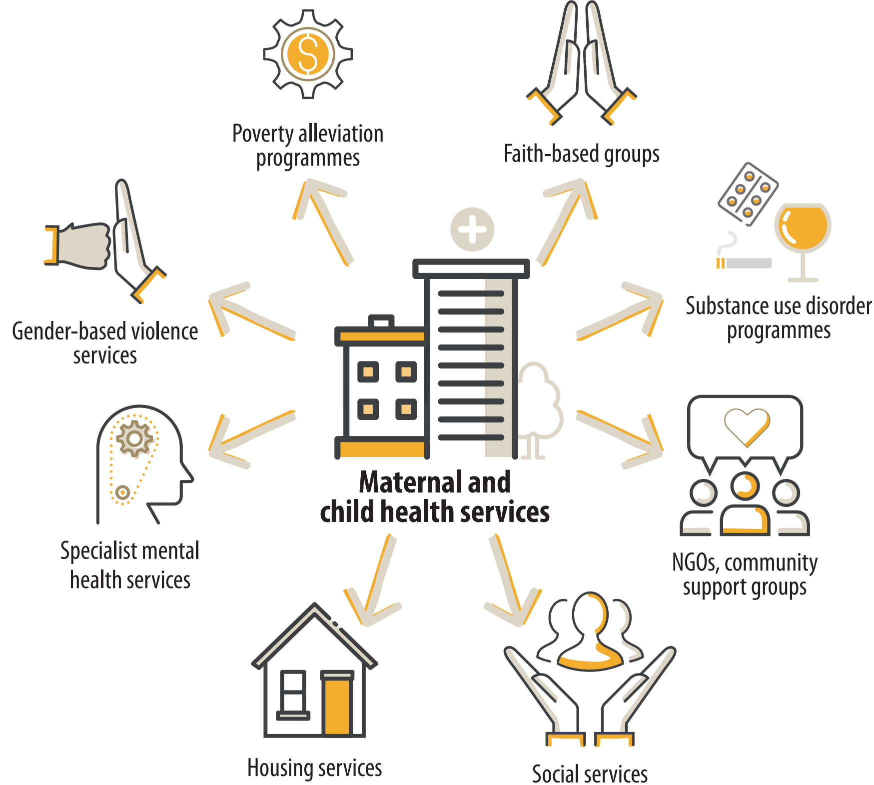
Provision of PMH care often requires links with other relevant services. For example, a woman who experiences depression during pregnancy may be supported by a midwife; however, she will continue to require care and support after the birth of her baby, which may be provided by a community health worker who also provides antenatal and newborn care. In certain settings, additional care from social, employment, community, legal and other mental health services, community-based organizations, faith-based organizations and traditional and faith healers may be available to provide further support.

Successful integration of PMH care into MCH services requires effective coordination to ensure that women receive the care they need at the appropriate time. This includes establishing clear pathways of care for women attending MCH services who require mental health care, case management and referral to higher-level mental health services and other relevant formal and informal services.

Care pathways

A clear step-by-step guide for care pathways should be developed to assist MCH service providers in decision-making. This would include criteria and guidance for making referrals to local higher-level mental health services, social support and community organizations (Fig. 6). These resources should have been identified in the situation analysis during planning.

Fig. 6. Examples of local providers for the coordination of care and support



When developing a care pathway, consider the following:

- Points of entry for women to access services. These may include primary care facilities, hospitals, maternity units and child health clinics. They may also include non-health organizations such as NGOs, women's and parents' groups and faith-based groups.
- A stepped-care approach to services based on mental health promotion and prevention for all women attending MCH services, brief treatment for those with mild symptoms and referral to more care for those with moderate-to-severe symptoms
- Roles of MCH service providers in providing mental health care (Table 2)
- Systems to monitor referral and back-referrals for case management
- A user-friendly directory of resources, which should be updated regularly and provide as much detail as possible, such as hours of opening and names and contact details of providers. The resources need not be formal organizations; community groups and associations, effective peer educators and other informal sources of support are all important resources.

Table 2. Examples of MCH provider roles in a care pathway

MCH providers	Role
Community health workers Trained peer workers Volunteers Social workers Health champions	• Facilitate or provide basic social support and raise awareness about mental health conditions • Recognize women experiencing mental health difficulties • Provide basic psychological interventions and/or psychoeducation to women and their families in the community • Refer women in the perinatal period with suspected mental health conditions to care in MCH facilities • Follow-up women in the community with identified mental health difficulties
Midwives Associate midwives Nurses Associate nurses Doctors	• Conduct mental health assessments • Prepare treatment plans in collaboration with women • Monitor and support adherence to treatment • Provide psychoeducation, basic counselling and psychological interventions in communities and facilities • Accept referrals from community health workers • Refer complex cases to specialized care • Train, supervise and support community health workers • Follow-up women with identified mental health difficulties who attend MCH facilities
Psychiatrists Psychiatric nurses Psychologists Other mental health specialists	• Coordinate PMH care in MCH services • Conduct diagnostic assessments • Provide treatment to women with moderate-to-severe mental health conditions • Train, supervise and support MCH staff

Intersectoral coordination of care and support can avoid duplication of services and ensure more comprehensive support for women in the perinatal period. It is important to engage with relevant local providers when setting up the service to foster shared ownership of and commitment to the care pathway. Later, regular interaction in formal meetings (to discuss implementation) and informal gatherings (to celebrate successes) can help to maintain collaborative relationships and clear communication channels. It may be helpful to set agreements or standard operating procedures with collaborating organizations to define roles, align pathways and identify roles and responsibilities.

If possible, mental health services should be offered at the same location as MCH services. It is often difficult for women to travel to several sites, and this may be a significant barrier for use of services.

Referral

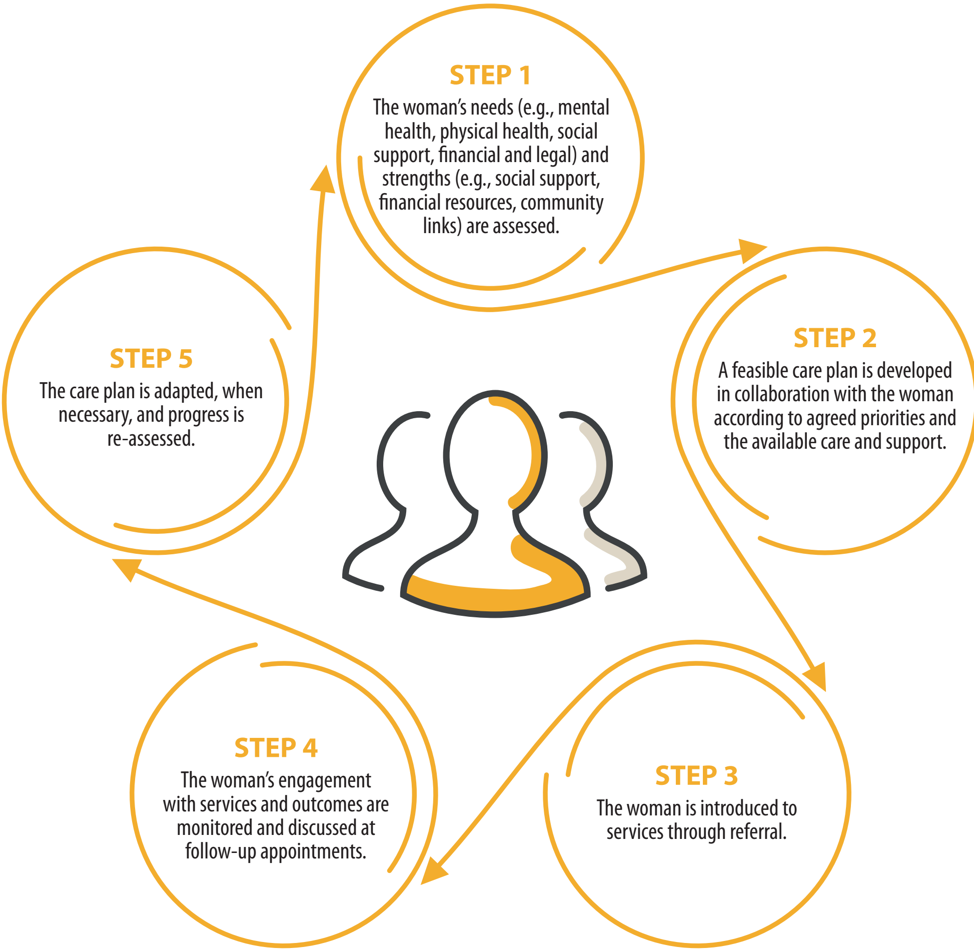
Referral is an essential part of PMH care. A referral system should be set up before identifying women with mental health conditions and should be linked to the care pathway. If this is not done, expectations for help may not be met, and women's trust may be broken, which will have a negative impact on their future use of services and their health outcomes.

An effective referral system provides links to all levels of the health system and mechanisms for referral to and from supporting services outside the health sector. Case managers and providers should receive training in the criteria for making a referral to specific services in the local pathway of care.

Case management

It is often difficult for women experiencing PMH conditions to make the best use of the available care and support. Case management consists of coordinating care and support on behalf of women attending MCH services (Fig. 7). In MCH services, cases may be managed by various service providers (e.g., midwife, associate clinician, associate nurse, nurse, non-specialist doctor, mental health specialist) if they have received the appropriate training. They should also have regular supervision and support.

Fig. 7. Case management



Additional information on workforce and coordination of care is provided in several publications:

Topic	Organization (country)	Title and description	Reference no.
Task-sharing	WHO	Task-sharing to improve access to family planning	*63*
Human resources	WHO	Guidelines for human resources planning in environmental and occupational health	*64*
Human resources	WHO	Global strategy on human resources for health: Workforce 2030	*65*
Human resources	WHO	Global policy recommendation. Increasing access to health workers in remote and rural areas through improved retention	*66, 67*
Integration	WHO	Global experience of community health workers for delivery of health-related Millennium Development Goals: A systematic review, country case studies and recommendations for integration into national health systems	*66*
Mental health operations manual	WHO	mhGAP operations manual	*3*
Provider competence	WHO	Ensuring quality in psychosocial support (EQUIP)	*68*
Training	WHO	mhGAP Training of trainers and supervisors Manual provides resources for mental health training.	*69*
Training	Perinatal Mental Health Project (South Africa)	Empathic engagement skills film Maternal mental health: a guide for health and social workers	*70, 71*
Training	WHO	mhGAP intervention guide for effective communication skills	*2*
Self-care	Perinatal Mental Health Project (South Africa)	Self-care leaflet for health-care providers	*72*
Self-care	WHO	Guideline on self-care interventions for health and well-being	*73*

Provision of care for specific needs

5. Providing care for special needs

Some women are more vulnerable to mental health conditions during the perinatal period. Service providers should be aware of their needs, how to support them in MCH services and where to refer them for additional care. Women who have additional needs during pregnancy are likely to experience greater stigmatization and may struggle to engage with services for various reasons. It is critical that PMH services are respectful and inclusive for all women. Situational analyses and needs assessments can be used to identify whether there is a high proportion of women in the context with specific needs and to design appropriate services for them with the available resources. Each section below gives a brief description of the characteristic, the associated additional needs and resources that could be used in different situations.

5.1 History of mental health problems

Women who become pregnant may have a history of or a current mental health condition, which may or may not have been diagnosed and treated. These women are at increased risk that their mental health symptoms will worsen during the perinatal period. It is important to identify women with a history of mental health problems because of the possible impact on both the women and their babies.

Additional considerations for service delivery

- Monitor mental health throughout the perinatal period, in particular immediately after the birth.
- Medication for a mental health condition during pregnancy and breastfeeding should be managed by a mental health specialist (when possible).
- MCH providers should understand the risks for the woman and her baby of starting, stopping or changing medication.
- If a woman has previously used mental health services, MCH care should be coordinated with those teams.
- Include supportive family members in caring for women, and make a plan in case mental health symptoms worsen.
- Adequate supplies of medicines for mental health conditions should be available in MCH services.

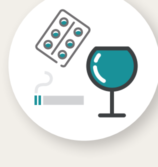
Additional information on service delivery is provided in several publications:

Resource type	Organization (country)	Title	Reference no.
Good practice guide	Royal College of Obstetricians and Gynaecologists (United Kingdom)	Management of women with mental health issues during pregnancy and the perinatal period	*74*
Fact sheets	Centre of Perinatal Excellence (Australia)	Perinatal mental health fact sheets for health professionals	*75*
Fact sheets	Centre of Perinatal Excellence (Australia)	Antenatal mental health fact sheets for women and families	*76*

5.2 Substance use

Alcohol and drug use during the perinatal period can compromise the health and social lives of women and their infants. Women may use substances to deal with symptoms of mental ill health or difficult life circumstances. Substance use can affect their ability to function as a parent, decrease the likelihood of their accessing services and increase their risk of experiencing gender-based violence (GBV). As substance use during pregnancy is highly stigmatized, women are unlikely to disclose their use to service providers.

Additional considerations for service delivery



- Provide non-judgemental information to women about the risks of substance use during pregnancy.
- Identify needs and triggers for substance use and the available support.
- Engage friends or family members (with the woman's permission) in providing support.
- Make a plan with the woman to address triggers for substance use.
- Refer women to substance and alcohol use support groups and services when appropriate and available.

Additional information on the identification and management of substance use and substance use disorders in pregnancy is provided below:

Resource type	Organization	Title	Reference no.
Good practice guide	WHO	Guidelines for the identification and management of substance use and substance use disorders in pregnancy	*77*

5.3 Self-harm or thoughts of suicide

Suicide is a leading cause of death among women. Depression is a major risk for suicide, and up to 20% of women with PMH conditions experience suicidal thoughts or self-harm *(34)*. The risk is higher among adolescents. Thoughts and behaviour related to suicide include thoughts about suicide, planning suicide, and taking action to end one's life.

Suicidal thoughts do not always lead to plans to end one's life, although most suicides follow some warning signs. Some people have suicidal thoughts or behaviour without a previous mental health condition.

Additional considerations for service delivery

- MCH service providers should routinely ask women about thoughts of self-harm and suicide:
  - whether they feel hopeless and/or have a negative view of their future,
  - whether they have a plan to harm themselves or
  - whether they have tried to harm themselves before, as women who previously self-harmed are at higher risk of suicide in the future.
- Refer women with suicidal plans and behaviour for urgent assessment by a medical doctor or mental health-care provider and counselling.

- Develop a clear plan for the woman's safety with the family, if possible.
- For actively suicidal women, inform all their health-care providers and people close to them. A woman should not be left on her own until the risk is minimized.

Additional information on suicide and self-harm in the perinatal period is provided in several publications listed below:

Resource type	Organization (country)	Title	Reference no.
Fact sheet	WHO	Suicide	*78*
Fact sheet	Perinatal Mental Health Project (South Africa)	Suicidal ideation during the perinatal period	*79*
Good practice guide	Centre of Perinatal Excellence (Australia)	Guide to assessing suicide risk	*80*

5.4 Disability and physical illness

Women with a physical illness or disability may experience particular challenges and concerns about pregnancy, birth and parenting, which can cause greater stress and affect their mental health. Such women are also at a higher risk of stigmatization because of their health condition, which may worsen during the perinatal period. Health-care providers should ensure that services are accessible and inclusive for all women. These women must be able to make informed choices during their MCH care and feel that they have a say in their care.

Additional considerations for service delivery

- Train service providers in the needs associated with physical illness and disability and how they affect care in MCH services.
- Make the health facility as accessible as possible (e.g., wheelchair access, infant cots or cribs that open on the side) and provide home care (if necessary) or care near the woman's home.
- Ensure that service providers are respectful and inclusive of all women when providing care.

Additional information on PMH and disability and physical illness in the perinatal period is provided in publications listed below:

Resource type	Organization	Title	Reference no.
Toolkit	United Nations	Toolkit on disability for Africa: inclusive health services for persons with disabilities	*81*
Fact sheet	WHO	Disability and health factsheet	*82*

5.5 HIV/AIDS

Many women living with HIV learn of their status for the first time during pregnancy. The stress of living with HIV, including stigmatization and financial concerns, makes women vulnerable to depression and anxiety. Mental health conditions can also have a negative impact on the progression of HIV/AIDS, because, if they are not treated, they may result in poorer adherence to HIV treatment, missing routine MCH appointments and an increased risk of HIV-related maternal death.

Additional considerations for service delivery

- Coordinate links and provide referrals to HIV service providers and support groups.
- Train service providers in supporting women living with HIV/AIDS.

Additional information on PMH and HIV/AIDS in the perinatal period is provided in publications listed below:

Resource type	Organization (country)	Title	Reference no.
Fact sheet	Perinatal Mental Health Project (South Africa)	HIV and maternal mental health conditions	*83*
Best practice guide	WHO	Mental health and HIV-AIDS	*84*

5.6 Adolescent pregnancy

Adolescents (aged 10–19) who become pregnant may face challenges such as stigmatization and difficulty in completing school and finding employment while caring for their children. They are particularly vulnerable to physical or sexual abuse. Pregnant adolescents are at greater risk of mental health conditions, particularly depression, than adolescents who are not pregnant and pregnant adults.

Additional considerations for service delivery

- Create an adolescent-friendly environment that ensures privacy and builds trust.
- Provide information on physical and mental health in appropriate language and format.
- Provide counselling for adolescents in distress.
- Try to identify a supportive adult who could accompany the adolescent to MCH services, during labour and birth and support the adolescent after her baby is born.

Additional information on PMH and adolescent pregnancy is provided below:

Resource type	Organization (country)	Title	Reference no.
Fact sheet	Perinatal Mental Health Project (South Africa)	Adolescent pregnancy and mental illness	*85*
Fact sheet	Perinatal Mental Health Project (South Africa)	Resource for pregnant teens	*86*

5.7 Unintended pregnancy and termination

Unexpected or unintentional pregnancy may have consequences for the mental health of both women and their children. Women who have no choice but to continue an unwanted pregnancy may experience poor mental health, while termination of a pregnancy should be handled sensitively but may also have negative mental health consequences for women.

Additional considerations for service delivery

- Provide readily accessible information about the legal options of a service user for an unplanned pregnancy.
- Ensure that health-care providers are trained to deliver care that is safe, respectful and non-discriminatory to women with an unintended pregnancy and those who terminate their pregnancy.
- Provide or refer women to counselling to explore their legal options and make their own decisions.
- Determine whether an abusive relationship or sexual trauma led to the unintended pregnancy. If this is the case, provide supportive counselling, and refer the woman for more intensive counselling, psychosocial support or legal services.

Additional information on PMH and unintended pregnancy and termination is provided below:

Resource type	Organization (country) / Author	Title	Reference no.
Literature review	Horvath S, Schreiber CA	Unintended pregnancy, induced abortion, and mental health	*87*
Database	WHO	Global abortion policies database	*88*

5.8 Infant loss

When women lose their infants through termination, miscarriage, stillbirth or neonatal death, they and their partners need emotional support. Women may have various emotional reactions to the loss of a pregnancy or baby, including experience shock, guilt, anger and sadness. Many women do not know how to tell their family members and friends and may require support in doing so.

Additional considerations for service delivery

- Provide training to service providers in supporting women after a pregnancy loss.
- Assess women's mental health status after a loss.
- Provide or refer for counselling, as necessary.
- In cases of stillbirth, women and their partners may be given one or more options:
  - having a keepsake of the baby
  - seeing a photograph of the baby
  - seeing the baby
  - holding the baby

Additional information on PMH and infant loss is provided in this publication:

Resource type	Author	Title	Reference no.
Good practice guide	Geller PA et al.	Psychological and medical aspects of pregnancy loss	*89*

5.9 Premature birth, infant ill-health

Carers of infants who are born prematurely or with poor health are usually stressed and worried. The infants may have to spend a long time in intensive care, which may limit bonding with their mothers and make breastfeeding more difficult.

Additional considerations for service delivery

- Provide clear information to women about the health of their babies and what to expect.
- Ensure that women can discuss their worries with service providers.
- Monitor women for symptoms of deterioration of their mental health.

Additional information on PMH and premature birth and infant ill-health is provided in publications listed below:

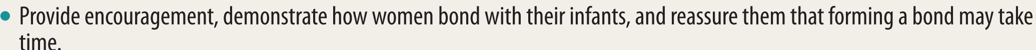
Resource type	Author	Title	Reference no.
Peer-reviewed paper	Anderson C, Cacola P	Implications of preterm birth for maternal mental health and infant development	*90*
Systematic review	Vigod SN, et al.	Prevalence and risk factors for postpartum depression among women with preterm and low-birth-weight infants	*91*
Prevalence study	Lambrenos K, et al.	The effect of a child's disability on mother's mental health	*92*

5.10 Difficulty in bonding

A close, intimate relationship or "bonding" between a woman and her infant is very important for the infant's emotional and physical development. Some women may find difficulty in forming an emotional attachment to their infants, because the pregnancy was unwanted or due to negative childhood experiences, domestic violence or mental health conditions. Women with severe mental health conditions may feel unable or unsure of how to tend to their infants. If women do not bond with their infant, this can impact their responsiveness to the infant's needs and whether they are able to breastfeed.

Additional considerations for service delivery

- Assess the relationships between women and their infants routinely as part of postnatal care to determine whether healthy bonding is occurring. Provide support when necessary.
- Determine whether infants are achieving normal developmental milestones. Delays may have physical causes but may also be related to poor bonding.



- Provide encouragement, demonstrate how women bond with their infants, and reassure them that forming a bond may take time.

- In cases of severe difficulty in bonding and the infant is at risk of neglect, refer the case to appropriate services.

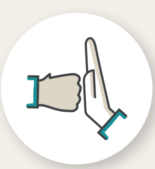
Additional information on PMH and parent-infant bonding and attachment is provided in publications listed below:

Resource type	Organization (country)	Title	Reference no.
Best practice guide	Centre of Perinatal Excellence (Australia)	Assessing mother–infant interaction and safety of the woman and infant. A guide for health professionals	*93*
Video	United Nations Children's Fund	The bond with your baby	*94*
Parental guidance	Raising Children Network (Australia)	Bonding and attachment: newborns	*95*

5.11 Domestic and gender-based violence

Domestic and gender-based violence (GBV) during pregnancy puts women, infants and others in the household in danger. The perinatal period may trigger violence and exacerbate existing abuse because of changes or strains that pregnancy or a new infant can create for a family. Violence increases the risks for miscarriage, infection, premature birth and injury or death of the baby. It can contribute directly to emotional and mental health problems in the woman, such as depression, anxiety and post-traumatic stress disorder, which can affect the development of the baby. Women who are experiencing domestic violence may feel vulnerable and alone but not want to report the abuse for a number of reasons. They may feel guilty or ashamed, believing that the abuse is their fault. They may be afraid that the abuse will worsen or that they might be killed if their abuser knows they have told anyone. They may not even realize that they are being abused or may feel that the abuse is normal. Domestic violence can also impact infants, through child abuse and neglect.

Additional considerations for service delivery



- Provide training for MCH service providers in GBV and providing caring, non-judgemental support to women.
- Refer women for assessment of injuries, possible sexually transmitted infections and any other physical problems.
- Provide information on the available support in the community for women experiencing abuse or neglect.
- Do not pressurize women to leave their abusers or to report the abuse, as this may put them in danger.
- Assist women who are willing and able to leave their abusers.
- Ensure continuous counselling in the service or on referral.
- Monitor infants for signs of abuse and neglect, and refer cases to child protection services.

Additional information on PMH and domestic and gender-based violence is provided in publications listed below:

Resource type	Organization (country)	Title	Reference no.
Fact sheet	WHO	Intimate partner violence during pregnancy information sheet	*96*
Fact sheet	Perinatal Mental Health Project (South Africa)	Sample leaflet for women experiencing violence	*97*

5.12 Poverty

Women living in poverty lack the financial resources to maintain basic living standards such as ensuring food and housing. They have fewer educational and employment opportunities, are exposed to unhealthy living environments and are less able to access high-quality health care. These stressful living conditions place them at higher risk of mental health conditions such as anxiety, depression and suicidal ideation and behaviour. There is a circular relation between mental health conditions and poverty: Poverty increases the risk of mental health conditions, and mental health conditions may increase the risk of poverty.

Additional considerations for service delivery

- Encourage women to create strong social networks to provide support during difficult times.
- Ensure that health services are accessible to women with little money. Care in the community may be used by those who cannot pay for transport to health facilities.
- Monitor infants for malnutrition.

- Create links with support groups, NGOs, housing services and income-generating activities, which can provide additional support for women living in poverty.

Additional information on PMH and poverty is provided in publications listed below:

Resource type	Organization (country)	Title	Reference no.
Fact sheet	WHO	World mental health report Transforming mental health for all	*98*
Fact sheet	Bettercare (South Africa)	Poverty and mental illness	*99*

5.13 Humanitarian settings

In emergencies, people may experience grief, acute stress reactions, harmful use of alcohol and drugs, depression, anxiety and post-traumatic stress disorder. Mental health may deteriorate due to:

- inability to meet basic needs; housing, food, medical care, safety;
- vulnerability to GBV, torture and rape;
- poverty and discrimination of marginalized groups;
- loss of loved ones and social support systems;
- lack of information about the humanitarian response, e.g., provision of food and how to obtain basic services;
- pre-existing mental health conditions.

Additional considerations for service delivery

- In humanitarian settings, fast, effective service is required in a rapidly changing, pressurized environment where resources may not be consistent.
- Mental health services should focus on the most urgent cases.
- At least one service provider trained in mental health provision should be on duty at all times.
- Train all service providers to create a supportive, non-stigmatizing environment for people with mental health conditions.
- Ensure that all service providers are aware of the available mental health referral pathways.
- Be aware of context-specific risk factors for mental health, such as GBV and family separation.

Additional information on PMH in humanitarian settings is provided in this publication:

Resource type	Organization	Title	Reference no.
Manual	WHO	mhGAP Humanitarian intervention guide	*100*

Case study: Delivering community-based mental health and psychosocial care in humanitarian settings

Title: Strengthening mobile health teams to provide integrated response to mental health and psychosocial problems and gender-based violence in Ukraine (N. Upadhaya and H. Skipalska, personal communication, June 3, 2022)

Setting: Ukraine

Description: Since 2015, HealthRight International has provided psychosocial support to the survivors of GBV, domestic violence and violence against children in the Donetsk and Luhansk region of eastern Ukraine through 13 mobile health teams funded by UNICEF. The teams served more than 70 000 survivors of violence.

With growing requirements for mental health and psychosocial support after the Russian invasion of Ukraine in February 2022, the number of teams was increased to 63 to provide services in other parts of Ukraine for other vulnerable groups, such as internally displaced persons and local communities. The teams provide services at railway and bus stations, checkpoints, transit points, border crossings and at centres for internally displaced persons and community protection centres, including child-friendly spaces. The psychosocial support mobile team consists of four specialists (a social worker, a psychologist, a nurse and a legal advisor) and a driver. The social worker distributes "family on the move" kits, conducts rapid assessments, helps in tracing families and reunification and provides referral information. The psychologist provides basic emotional support, gives tips about self-care and coping strategies and makes referrals to other services. The nurse provides immediate basic medical assistance and supports the nutrition of children and mothers with young babies. The legal advisor provides legal aid and counselling. The mobile health teams have provided psychological, social and legal services to 48 555 people.

Challenges: The limited number of team members has resulted in a high workload for mobile health teams. They are also exposed to danger by working in a conflict area and worry about their families' safety and security while providing mental health and psychosocial support services to affected populations.

Lessons learnt: Mobile mental health and psychosocial support teams in conflict-affected, insecure settings should also address the well-being of the providers. This will help protect them from "burn out", secondary traumatization and moral injury and encourage them to remain positive, productive and effective in providing mental health and psychosocial support services.

5.14 Pandemics

Pandemics such as COVID-19 place stress on women in the perinatal period and their families, with a large increased risk for maternal depression and anxiety. The risk for GBV and intimate partner violence is also increased. As service providers may be redeployed during a pandemic, fewer face-to-face contacts may be possible.

- As families spend more time in close contact, the risk of relationship stress is increased, which may cause anxiety and lead to abuse.
- Family finances may deteriorate. Abusive partners may restrict access to money, health services and social support.
- Women experience increased social isolation and restrictions on movement, which can lead to loneliness. This may be increased by controlling, abusive partners.
- There may be less access to health-care services for women, such as abuse hotlines, shelters and crisis centres.

Additional considerations for service delivery

- Ensure that women receive up-to-date information about changes to service delivery during a pandemic to reduce stress.
- Maintain face-to-face contacts with women when possible, in line with government guidance. For women at risk of mental health problems, more face-to-face contacts may be necessary.
- Remote service delivery may be more common. Ensure that service providers are adequately trained to detect risk during such remote contacts.
- The provision of care during pandemics will increase pressure on health systems and health service providers. Ensure that the well-being of service providers is monitored and that they can rest to prevent "burn out".

Additional information on PMH during pandemics is provided in publications listed below:

Resource type	Organization (country) / Author	Title and description	Reference no.
Systematic review	Mukherjee TI et al.	Reproductive justice in the time of COVID-19: a systematic review of the indirect impacts of COVId-19 on sexual and reproductive health	*101*
Report	Maternal Mental Health Alliance (United Kingdom)	Maternal mental health during a pandemic	*102*
Editorial	Roesch E et al.	Violence against women during covid-19 pandemic restrictions	*103*
Message	WHO	Mental health and psychosocial considerations during the COVID-19 outbreak	*104*

5.15 Social isolation

Women with supportive partners, families and social networks are better able to cope with the stresses of parenthood. Feeling socially isolated may worsen women's mental health if they feel unable to cope with stresses in their lives. Women may feel isolated even when they live close to many other people. Women with mental health conditions during the perinatal period may also experience social isolation due to stigmatization of their condition. Some women may choose to isolate themselves if they fear judgement or feel discriminated against.

Additional considerations for service delivery

- Ask women about their social support. Supportive partners and families can be invited to mental health appointments to support the recovery of the woman.
- If women indicate that they are socially isolated, suggest that they join peer support groups in the local community, where they can interact with other women in a similar situation. Group psychological therapy is a good way for women with mental health conditions and who experience social isolation to meet other women.
- Pandemics are likely to exacerbate social isolation. Ensure that services can stay in touch with women during such times.
- Women who are very isolated may not attend primary health centres. Community health workers may have to identify such women in the community and accompany them or refer them for care.
- Social isolation is more common in marginalized groups, such as refugees or sex workers. Be aware of groups in your setting that may face discrimination.

Additional information on PMH and social isolation is provided in publications listed below:

Resource type	Organization (country) / Author	Title and description	Reference no.
Fact sheet	Tulane University (USA)	Understanding the effects of social isolation on mental health	*105*
Research article	Taylor BL, et al.	Mums alone: Exploring the role of isolation and loneliness in women diagnosed with perinatal depression	*106*

Monitoring and evaluation

6. Monitoring and evaluation

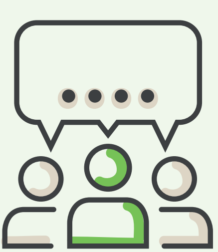
M&E
Monitoring and evaluation

Monitoring includes regular, planned collection of information to assess the integration of mental health care in maternal and child health services

Evaluation is the review of information at certain times to assess the impact of mental health services

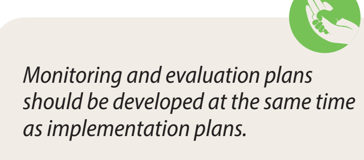
M&E should include ways for women and MCH staff to provide confidential feedback on care

M&E of mental health services should be integrated into a facility's existing M&E plan



Information about the provision of care can be collected in many ways, including surveys, interviews, feedback forms, and focus groups

Information on the provision of PMH care within MCH services will help the core working team to understand what is going well and what should be improved through continuous quality control. Monitoring consists of regular, planned collection of information to assess the progress of PMH integration into MCH services over time. Routine monitoring helps to ensure that challenges are identified early so that larger problems can be avoided. For evaluation, specific information is assessed at certain times to determine whether the intended results have been achieved.



Monitoring and evaluation plans should be developed at the same time as implementation plans.

Monitoring and evaluation (M&E) may focus on determining how well care is being delivered, its availability in the setting, the impact of the care on women's mental well-being and demand for and satisfaction with mental health care among women during the perinatal period. The desired impact, outcome or output is called an "indicator". Examples of indicators are provided in Annex 3.

M&E for mental health care should build on and be integrated into local MCH services. Mental health indicators should be included in the local services plan for M&E.

M&E should also include ways for women and MCH service providers to provide feedback on PMH care. The reports may be confidential, such as for reporting complaints, violations of rights or positive experiences of care (e.g., helpline, ombudsperson, feedback box). Routine service follow-up, such as exit interviews with women in the perinatal period, could be planned as part of the intervention.

Privacy, confidentiality and safety are key principles in data collection systems for monitoring and evaluation to protect women and MCH staff from stigmatization and discrimination.

Some service providers may design and conduct a study to evaluate the service or part of the service. Health facilities or programmes may be able to attract researchers from NGOs or educational institutions to conduct external evaluations of the services, which may be quantitative or qualitative. An objective view from an external party of how the service is running can be helpful.

Ensure that you engage stakeholders, so that everyone can agree on the indicators and how data will be collected and used. Plan joint meetings (every 6–12 months) to present and review data with the core planning team, MCH service providers and other stakeholders to strengthen collaboration and partnerships. Smaller, monthly meetings to review monitoring processes and data can be held in MCH services.

Considerations in developing an M&E plan for PMH:

- Integrate the plan into existing M&E processes.
- Identify the desired impact or outcome of the care provided with stakeholders (including women who might use the service).
- Ensure that the information collected will indicate whether the desired impact or outcome has been achieved.
- Ensure that the necessary information can be collected easily and reported accurately.
- Collect information by various methods (e.g., surveys, written responses, interviews, focus groups).
- Collect information from a variety of people (e.g., women who use the service and MCH service providers).
- Include confidential ways to collect feedback on the service from women and service providers.
- Clearly describe how the information collected will be analysed.
- Collaborate with researchers to design and implement the M&E plan.

Case study: Integrating monitoring and evaluation of perinatal mental health care

Title: Perinatal Mental Health Project *(107)*

Setting: Cape Town, South Africa

Description: The Perinatal Mental Health Project provides comprehensive stepped-care mental health services for pregnant women attending primary public health facilities. During the first antenatal visit, women are given a three-item mental health screening questionnaire by clinic staff or counsellors, and women who screen positive for depression, anxiety and/or suicidality are referred to a counsellor, who conducts a brief "engage, assess, triage" session with them to validate the questionnaire and to assess risk factors. M&E are included through routine follow-up assessments with counselled clients 6–12 weeks after they have given birth.

Data from each interaction, at each step in the service are recorded in an electronic database that includes the number of women who: register for antenatal care, are offered mental health screening, refuse or accept screening, qualify for "engage, assess, triage", accept or refuse "engage, assess, triage", qualify for counselling and accept or refuse counselling. Service data are collated, analysed and shared with service stakeholders every month in a brief report. To monitor counselling, records include the type of session (face-to-face or telephone) and whether a full or a brief session. The records include the kinds of interventions provided by the counsellor (such as psychoeducation, trauma, bereavement, family counselling, behavioural activation) and referral to other support services. At the postnatal follow-up assessment, changes in mood, general functioning, birth experience, bonding with the infant and feedback on the service are recorded.

Challenges: M&E take time and require training and supervision of all those involved. It is important to balance the requirement for data with staff capacity and time, which may be limited, and M&E systems have evolved over time to optimize this balance. Paper-based systems can be cumbersome and result in errors; however, electronic databases may be difficult for some staff to master. Both forms require proper security systems to protect the data. Staff may misinterpret the M&E process as one that is designed to detect their personal shortcomings.

Lessons learnt: The rationale for M&E should be explained carefully to staff to obtain their participation. The aim is to collect data to evaluate the service, improve service delivery and ensure transparency and accountability. M&E can be used to celebrate successes. It is particularly important for ensuring that resources are used effectively and to justify decisions to funders or programme managers. Careful decisions must be made on the demographic data to be collected, balancing client confidentiality with obtaining enough data for clinical decision-making. For example, women in some contexts may be uncomfortable in revealing their marital status, and this information may not be relevant to service delivery. Routine data collection and regular stakeholder feedback are important. Feedback should be presented in a format that is easily understood by various stakeholders. While quantitative data are useful for assessing trends and determining allocation of resources, qualitative data may provide a further depth of understanding. Client feedback, observation and narrative accounts from stakeholders can usefully supplement M&E processes and complete a holistic picture *(108, 109)*.

Additional information on M&E is provided in publications listed below:

Resource type	Organization	Title	Reference no.
Indicators	WHO	mhGAP operations manual	*3*
M&E toolkit	WHO	Health facility and community data toolkit	*110*
Health information systems	WHO	SCORE for health data technical package systems	*111*

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ANNEX 1
Sample terms of reference for a working team

1. Purpose

1.1 The working team leads the planning and implementation of integration of perinatal mental health (PMH) care into maternal and child health services. It oversees progress in planning and implementation milestones and deliverables. It acts as the decision-making body.

2. Terms of reference

2.1 To advocate for and champion integration of PMH into existing maternal and child services
2.2 To support development of action plans, policies and protocols to integrate PMH into maternal and child services
2.3 To support development of monitoring systems to collect data on PMH
2.4 To support resource mobilization for services and allocate human, financial and technical resources.
2.5 To develop a training plan to build capacity to respond to PMH
2.6 To facilitate multi-sectoral coordination and collaboration with other services and organizations
2.7 To report to senior management on the performance of the programme in addressing PMH

3. Membership

3.1 Chair: (Name)
3.2 Members: (Names)

4. Decisions

4.1 (Insert details of how decision will be made by the group)

5. Meetings

5.1 (Insert details of the frequency, location, hosts and dates of meetings)

6. Communications

6.1 (Insert details of the format and anticipated frequency of communication between meetings)

ANNEX 2
Sample template for a budget

Development of a budget requires estimates of the costs of providing services and identification of sources of funds to cover those costs.

The template below gives examples of the items that should be considered in budgeting (see Table A1.1).

Table A1.1. Sample template for a budget

Item	Quantity	Unit cost	Total cost
Workforce: Service management and administration (salaries; a percentage of time if they do not work only for the programme)			
Workforce: service provider salaries (percentage of time spent by non-dedicated staff)			
Workforce: training costs (initial)			
Workforce: training costs (refresher)			
Workforce: expert technical support			
Workforce: supervision and mentoring visits			
Workforce: recruitment costs (if new service providers are to be hired)			
Meetings with stakeholders (planning and coordination, including venue, stationery, refreshments, etc.)			
Space renovation (if necessary, to increase privacy or to add space)			
Computer hardware, software			
Internet, communications			
Clinical supplies and equipment			
Drugs and commodities			
Advocacy and outreach			
Producing, printing and dissemination of communication materials			
Resources to collect, analyse and disseminate results of monitoring and evaluation			
Insurance			

ANNEX 3
Examples of indicators for monitoring and evaluation

The monitoring and evaluation (M&E) plan should have indicators to measure progress towards achieving objectives. The table below provides examples of outputs, the indicators of achievement of the output and the source used to verify the indicator. Each service should select the indicators that are important or measurable in the local setting. Measurements may be quantitative (how many) and qualitative (how well).

Table A1.2. Examples of M&E plan

Output	Indicator	Source
Situational analysis	• Situational analysis conducted	• Situational analysis report
Standard operating procedure for maternal mental health service components	• No. of standard operating procedures developed and implemented	• Standard operating procedure
Enhanced provision of mental health care in MCH services	• No. of facilities and community programmes that provide mental health care • Proportion of clients with mental health conditions identified and treated	• Service use records from health information systems • Attendance registers
Mental health promotion and awareness raising	• No. of people reached by awareness-raising activities • No. of awareness-raising activities held • No. of psycho-educational materials distributed • Proportion of clients reached by awareness-raising activities • Client satisfaction with awareness-raising activities	• Community survey on change in knowledge and attitudes • Activity reports • Satisfaction survey, client feedback • Observation by supervisors
Screening and detection	• No. of clients who booked at the facility and followed the programme • No. of clients who were offered screening • No. of clients screened • Screening coverage (no. of clients screened / no. of clients attending) • Numbers and proportions of clients who: – refused screening – qualified for referral – refused referral – were referred to other services	• Facility data • Service screening log • Observation by supervisors of how well screening is being conducted
Social support	• No. of new clients attending social support service • No. of appointments booked • No. of appointments attended • No. of appointments rescheduled • No. of follow-up appointments missed • No. of clients referred to additional services • Proportion of clients who reported decreased symptoms and improved functioning because of the service • Client satisfaction with the social support provided	• Social support provider records • Satisfaction survey, client feedback • Supervisor's review of case management
Psychological intervention	• No. of new clients attending a psychological intervention • No. of appointments booked • No. of appointments attended (may be broken down by type of appointment: full, half, face-to-face; digital) • No. of appointments rescheduled • No. of follow-up appointments missed • No. of clients referred to additional services • Proportion of clients who reported decreased symptoms and improved functioning because of the service • Client satisfaction with the psychological intervention provided	• Counsellor's diary • Client evaluation records, data on repeat screening • Satisfaction survey, client feedback • Supervisor's review of case management

Table A1.2. *continued*

Output	Indicator	Source
Medication	• No. of new clients seen by prescriber • No. of appointments booked • No. of appointments attended • No. of appointments rescheduled • No. of follow-up appointments missed • Types of medication prescribed • No. or proportion of clients who adhered to medication at 3 months, 6 months and longer • No. of medications in stock • Client satisfaction with the medication provided	• Psychiatric and mental health service diaries • Medication supply records • Satisfaction survey, client feedback
Training	• No. of workshops and training opportunities held • No. of trainees who attended • No. of trainers and supervisors who attended training of trainers and of supervisors • Trainee feedback and satisfaction • No. of non-specialist trainees trained to meet competence standards	• Training logs • Training evaluation forms • Competence assessment forms and tasks
Provider supervision	• No. of supervisors trained • No. of supervision sessions held per month (frequency as per standard operating procedure)	• Supervision notes • Group supervision attendance forms
Coordination of care pathways	• No. of facilities, organizations and programmes with procedures for referring or receiving women with mental health conditions and psychosocial needs • No. of referrals and back-referrals made monthly	• Service utilization records • Facility referral records

Source: Programme reporting standards for sexual, reproductive, maternal, newborn, child and adolescent health. Geneva: World Health Organization; 2017 (WHO/MCA/17.11).

For more information

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