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Editorial

Perinatal Mental Health

Pregnancy is a time of happiness and feeling of satisfaction in women's lives, with the welcoming of a new child in the family. However, pregnancy can also be a stressful and anxiety-provoking life event. Evidence shows that there is an increase in psychiatric morbidity, particularly depression and anxiety, which most of the women experience during this period[1]. Peripartum depression (antepartum and postpartum depression) refers to depression occurring during pregnancy or after childbirth. It is a consequential, but treatable mental illness. According to the standard diagnostic and statistical manual of mental disorders (DSM-5), postpartum depression (PPD) is one type of depressive disorder that occurs during pregnancy or within 4 weeks after childbirth[2]. According to the International Classification of Diseases 10 (ICD-10), PPD is characterized by a period of depressed mood during pregnancy or the puerperium that accompanied by symptoms which include sadness, anxiety, loss of interest or pleasure in daily activities, constant fatigue, poor concentration, disturbed sleep or appetite, feelings of guilt/low self-worth, social withdrawal, excessive crying and recurrent thoughts of suicide[3].

United Nations sustainable development summit, 2015, commits governments to develop national responses. These include, by 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and wellbeing (target 3.4); and strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol (target 3.5)[4].

A systematic review of 28 developed countries reported that the prevalence of PPD is about 6-13%[5]. An independent systematic review on low- and middle-income countries found the prevalence of maternal (antepartum and postpartum) common mental disorder (MCMD) was approximately 15-25%[6,7].

In Bangladesh, studies on the magnitude of peripartum depression remain scanty. Few studies conducted in different parts of the country showed that the magnitude of peripartum depression ranges from 22% to 39.4%[8-11]. Despite a potentially higher burden among mothers in LMIC, PPD is often understudied and given little importance in this region.

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 [12,13]. In addition, women may be less likely to attend antenatal and postnatal appointments[14]. 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[12,15]. Infants may also be at increased risk of difficulty in feeding and in bonding with their parents[14].

There are three forms of peri partum mental problems: Baby-Blues (85% of pregnant women experience it); usually there is no need for formal treatment. Family and social support and assurance are sufficient. In postpartum depression (6.5%-20%) there is need for specific formal treatment[16]. In Postpartum / Puerperal Psychosis (most severe form, 1-2 /1000 childbirths) symptoms can often begin within the day of delivery; mean time to onset within 2-3 weeks after delivery but almost always within 6-8 weeks of delivery. Common symptoms of mental disorder are: negative thoughts about baby, not able to take care own baby, thoughts about harm to baby or intent to harm, hallucination (mostly auditory), suicidal behavior, physically abusive to family members, delusion (mostly paranoid), grandiosity, over expenditure[16].

Some women may be at greater risk of poor mental health during the perinatal period because of external circumstances or other health conditions. These are: adolescent pregnancy, low educational opportunity, difficult birth experience, physical health condition, unwanted pregnancy, poverty, little or no social support, fertility difficulties, gender discrimination, natural disasters, substance use, poor nutrition and gender-based violence and other conflicts[17]. Post traumatic stress disorder related to pregnancy, delivery and childcare is also important.

Certain factors may help people to protect and promote mental health in the perinatal period. These

are strong social support (presence of earning family); educational opportunities; opportunities for generating income, positive child birth experience and high quality MCH services[17]. Management includes de-stigmatization, respectful care, promoting protective factors, psychoeducation to mother and family members, stress management, strengthening social support, promotion of functioning and life skills, recognizing mental health condition & risk reduction. Specific management, using pharmacological (Medicine & ECT) & non-pharmacological (counseling) treatment are important[16].

Although mental health conditions are common, most women do not receive the care they need[17]. 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[17].

In Bangladesh, maternal, newborn, adolescent and non-communicable disease directorates of Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) and other relevant authorities and stakeholders are trying to make adequate and user-friendly provision of care of mental health conditions during pregnancy and after childbirth. Obstetrical Gynaecological Society of Bangladesh (OGSB) and Family Health International (FHI-360) along with specialists in psychiatry conducted situation analysis through literature review[16]. A number of focus group discussions with various level of decision makers and service providers and case studies were undertaken[16]. A validated (PHQ-9) screening tool, algorithm for management and level of integration, roles of different service providers, cut-off point for referral, referral path way have been suggested[16]. Govt. of Bangladesh has developed a tele-medicine service to provide care by experts to the periphery from a central level; and has been implemented in selected health facilities and are being scaled up.

Mental health is an integral part and an important composite of all health care services including maternal health. All of us must be aware about the facts stated here and act accordingly as a team; and play our respective roles to support this important, but neglected area of health care services. Its inclusion in national strategies of mental and maternal health, with due importance, is crucial. All concerned at every level of health care services should be instrumental to integrate perinatal mental health in all possible preventive & treatment provisions. Maternal health services including antenatal and postnatal care must immediately initiate all necessary activities to integrate mental health (e.g. development of guideline and training manual, training of all categories of service providers, creation of service provision and referral linkage, supply of medicine, counseling services). Above all, family, society, educational and health institutes should nurture a culture of positive mental health for all.

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