THE CHALLENGES OF PERINATAL DEPRESSION

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Perinatal depression can be defined as depression occurring any time from conception, including during pregnancy and into the first postpartum year. Rates of perinatal depression in high income countries (HIC) are reported at about 13% of all perinatal women, but there is a significantly higher rate of perinatal depression in low and middle income countries (LMICs), ranging from approximately 15 to 20% . Studies conducted in LMICs report higher prevalence rates as socially and economically disadvantaged women are more vulnerable to perinatal depression.[1,2] Maternal depression has serious consequences, resulting in significant morbidity and even mortality for both mothers and infants.

PARTICULARLY IN LMICs, MOTHERS FACE PHYSICAL AND LOGISTICAL CHALLENGES, INCLUDING CARING FOR AN INFANT IN CONTEXTS OF POOR SANITATION, OVERCROWDING, FOOD INSECURITY, AND POOR SOCIAL SUPPORT. THESE DIFFICULTIES ARE COMPOUNDED FOR WOMEN WITH DEPRESSION, IN WHOM THE SYMPTOMS – INCLUDING ANHEDONIA, IMPAIRED COGNITION, LOW MOOD AND ENERGY LEVELS – IMPACT ON THEIR ABILITY TO CARE FOR THEIR INFANTS' PHYSICAL AND EMOTIONAL NEEDS.[3]

The daily demands of early infant care are more difficult to negotiate when functioning is suboptimal as a result of depression.[4] As a result, infants and children of depressed mothers have poorer physical, cognitive and emotional outcomes. In these settings, poor maternal mental health during the antenatal period is a risk factor for low birth weight and preterm delivery.[5,6] Postnatally, malnutrition, poor infant growth, and increased frequency of infant diarrheal illness are prevalent, which may be related to the early cessation of breastfeeding in depressed mothers living in poverty.[7] This can lead to an increase in child mortality.[8] The emotional development of infants is compromised because of a disturbed mother-infant relationship, where mothers are less sensitive towards their infants and infants are less responsive towards mothers.[9] This in turn leads to poorer quality attachment, resulting in behavioural and psychological difficulties that can last into adolescence and adulthood.[10] Compromised cognitive functioning and delayed development also affect infants and children of depressed mothers, impacting on their scholastic achievement.[11] In the context of chronic social and economic adversity, as experienced by poor women in both high and low to middle income countries, poor quality parenting as a result of maternal depression is especially harmful.[10] These adverse outcomes further perpetuate social and economic inequality.

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Poverty and low-socioeconomic status affect more women numerically and as a proportion of a given population in low and middle income countries as compared to women in high income countries, making them vulnerable to depression. This is very clear in South Africa, where approximately 40% of women living in relative poverty will experience perinatal depression – three times the rate documented in high income countries.[12-14] Historically significant racial and wealth disparities

in South Africa existed as a result of Apartheid, but these have yet to be redressed. The country still faces many social, political and economic challenges and is one of the most economically unequal countries in the world, with a Gini co-efficient of 0.7.

THE TOP 10% OF THE POPULATION CONTRIBUTE (AND BENEFIT FROM) 58% OF THE INCOME AND THE BOTTOM 10% ONLY 0.5%. THIS IS RELEVANT AS ECONOMIC AND SOCIAL FACTORS CONTRIBUTE TO HEALTH EQUITY AND THE GENERAL HEALTH OF A SOCIETY. THIS IS SIGNIFICANT AS SOCIAL INJUSTICE IMPACTS NEGATIVELY ON HEALTH AND HEALTH EQUALITY.[15] THE HIGH RATES OF PERINATAL DEPRESSION MAY BE RELATED TO THE COMPOUNDING NATURE OF MULTIPLE ECONOMIC, SOCIAL AND PSYCHOSOCIAL STRESSORS.

These including poverty and unemployment, intimate partner violence, lack of partner support, unplanned pregnancy, and the high prevalence of HIV in pregnant women (39-45%), including diagnosis of HIV infection in the course of antenatal care.[12,13,16-19] Similar associations have been found in other low and middle income countries.

A SYSTEMATIC REVIEW CONDUCTED IN 2012, INCLUDING VARIOUS COUNTRIES FROM BOTH ASIA AND AFRICA, FOUND THAT SOCIOECONOMIC DISADVANTAGE COMPRISING OF FOOD INSECURITY, FINANCIAL DIFFICULTIES, UNEMPLOYED PARTNER AND LOW INCOME WERE ASSOCIATED WITH PERINATAL DEPRESSION.

In addition, social disadvantage comprising of poor emotional support and lack of empathy from partners, having hostile in-laws and having insufficient practical and emotional support, contributed to the risk of perinatal depression.[1] From this, it is clear that maternal depression has multiple etiologies, and cannot be solely explained by women's biological and psychological vulnerability. Rather, social and environmental factors are important contributing factors and determinants of risk and sociocultural context impacts both prevalence and presentation of perinatal depression.[20,21]

Recently there has been an increased awareness that mental health is a vital part of public health in South Africa. About 16.5% of South Africans suffer from common mental disorders.[22] In responding to this, most provincial health services support the integration of mental health in primary health care, run by primary health care nurses who have undergraduate training in mental health. These nurses are able to continue prescriptions while primary health care doctors initiate prescriptions with drugs available on the essential medicines list.

Mental illness cannot be viewed in isolation, however, as many social, political and economic factors, including those elucidated above, play a role in epidemiology of the illness. In South Africa, the country's high rate of mental health disorders, including perinatal depression, is exacerbated by high levels of violence, social and economic exclusion and racial discrimination, as existed under colonialism and apartheid, and as a result of apartheid's continued legacy.

ONE OF THE KEY OBJECTIVES OF SOUTH AFRICA'S MENTAL HEALTH CARE ACT 2002 (NO. 17 OF 2002) IS TO INTEGRATE THE PROVISION OF MENTAL HEALTH CARE SERVICES INTO THE GENERAL HEALTH SERVICES ENVIRONMENT.[23] THIS IS FURTHER SUPPORTED BY THE SUBSEQUENT NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020,[24] IN WHICH MATERNAL MENTAL HEALTH IS INCORPORATED INTO THE GENERAL MENTAL HEALTH ENVIRONMENT, INCLUDING THROUGH THE TREATMENT OF PERINATAL DEPRESSION AND ANXIETY AT ANTENATAL AND POSTNATAL CLINICS.

The policy states:

- *Specified micro and community level mental health promotion and prevention intervention packages will be included in the core services provided, across a range of sectors, to address the particular psychosocial challenges and vulnerabilities associated with different lifespan developmental stages. These will include:* ***Motherhood:*** *treatment programmes for maternal mental health as part of the routine antenatal and postnatal care package; and programmes to reduce alcohol and substance use during and after pregnancy.* ***Infancy and Early childhood:*** *programmes to increase maternal sensitivity and infant-mother attachment.*

- *Introduce routine indicated assessment and management of common mental disorders in priority programmes at PHC level, among others, antenatal mothers and postnatal care.*

In addition, the South African National Development Plan 2030 (2012)[25] makes specific reference to early childhood development by emphasizing the importance of the first 1000 days of life, describing how pregnant women need access to both emotional and material support, and explaining

that empowered mothers lay a solid foundation for healthy children. However, despite these policies, the establishment and provision of integrated mental health services into antenatal and postnatal clinics is non-existent in most areas. The Maternal Care Guidelines are also lacking in achieving these goals as they have no reference to screening, assessing or documenting current mental state nor recommendations regarding stepped referral for mental health care.

SOUTH AFRICA HAS AN UNACCEPTABLY HIGH MATERNAL MORTALITY RATE OF 269 PER 100 000 LIVE BIRTHS; OF THESE 60% ARE AVOIDABLE IF EARLY ANTENATAL CARE IS SOUGHT.[26] ANTENATAL CARE IS FREE IN SOUTH AFRICA'S PUBLIC HEALTH SYSTEM AND 91% OF ALL PREGNANT WOMEN ATTEND AN ANTENATAL CLINIC AT LEAST ONCE DURING THEIR PREGNANCY.[26] ANTENATAL CARE IS AN OPPORTUNITY TO PROVIDE VITAL HEALTH INFORMATION TO WOMEN ON LIFESTYLE RISKS AND TO OFFER SOCIAL SUPPORT AND COUNSELING.

Health promotion and screening can prevent the severe adverse effects of depression, including loss of quality of life and the risk of suicide and neonaticide in extreme cases. Given this, antenatal care may provide a good opportunity for health workers to intervene and offer screening and treatment for antenatal depression. This would be in line with the move to incorporate mental health services into primary health care. Preliminary evidence from a public obstetric facility in Cape Town suggests that it is feasible and acceptable to incorporate mental health screening and depression assessment, with referral, into antenatal clinics using a task-sharing approach. In another qualitative study conducted in Johannesburg, women found the screening process itself, to be helpful in building awareness and effecting behaviour change.[27]

HEALTH EQUITY SHOULD BE OUR AIM IN SOUTH AFRICA IN AN ATTEMPT TO ADDRESS HISTORICAL INEQUALITY. THIS CAN BE IMPROVED BY IMPLEMENTING UNIVERSAL SCREENING ON A NATIONAL LEVEL FOR COMMON MENTAL DISORDERS IN PERINATAL WOMEN. THE WHOOLEY CASE FINDING QUESTIONS ARE TWO CASE-FINDING QUESTIONS THAT REQUIRE ONLY A YES OR NO RESPONSE. THEY CAN IDENTIFY ANXIETY AND DEPRESSION WITH REASONABLE ACCURACY.

They are short and do not require literacy, or scoring and interpretation like pencil and paper tests, and so are more time-effective. They have been validated in urban women attending a high-risk antenatal clinic in Johannesburg.[28] These two questions address symptoms of depression that are necessary but not sufficient to make a diagnosis of depression: "During the past month, have you often been bothered by feeling down, depressed or hopeless?" and "During the past month, have you often been bothered by little interest or pleasure in doing things?"

A BRIEF AND VALIDATED SCREENING TOOL THAT CAN IDENTIFY DEPRESSION AND ANXIETY IN SOUTH AFRICAN PERINATAL WOMEN WOULD BE A VALUABLE ADDITION TO UPDATE THE ADULT PRIMARY CARE GUIDELINE AND FOR INCLUSION IN THE MATERNAL CARE GUIDELINES AND AMENDMENTS TO THE MATERNITY CASE RECORD (ANTENATAL CLINIC CARD).

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