MENTAL HEALTH, THE ESSENTIAL MISSING PIECE IN STRATEGIES TO IMPROVE MATERNAL MORTALITY AND MORBIDITY

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SAFE MOTHERHOOD AND MAKING PREGNANCY SAFER INITIATIVES

- Reproductive choice
- Nutritional status
- Co-incidental infectious diseases
- Information needs
- Access to services
- Training and skill of health workers
• Non-psychotic depressive, anxiety, adjustment and somatoform disorders, which compromise day-to-day functioning;

• ‘Perinatal common mental disorders’

PREVALENCE OF PERINATAL COMMON MENTAL DISORDERS AMONG WOMEN IN HIGH-INCOME COUNTRIES

- Self-report measures yield symptom scores rather than diagnoses;
- Variation in sampling, measures, cut-off scores, period of ascertainment and whether point or interval prevalence ascertained;
- Limited precision and comparability;

**Pregnancy**
- Depression: 7.4% (T1), 12.8% (T2), 12.0% (T3) (Bennett et al, 2004)
- Anxiety: 10.4% - 16.2% (Matthey et al, 2003)

**Postpartum:**
- Depression: 6.8% (Woolhouse et al, 2012) to 20.7% (Webster et al, 2001)
- Anxiety: ≈ 10% in the first six months postpartum (Fisher et al, 2010)

Perinatal depression among women in high-income countries:
- ± 10% of pregnant women
- ± 13% of mothers of infants (Hendrick, 1998; O’Hara and Swain, 1996)
Women who live in low- and lower-middle income countries experience traditional ritualized care after birth including:

• Mandated periods of rest;
• Honoured status;
• Increased practical support and freedom from household and income-generating work;
• Social seclusion;
• Gift giving and prescribed foods
• These protect mental health and therefore;
• They do not experience perinatal mental disorders.

Stern and Kruckman, 1983; Howard, 1993
Most published since 2000:

- 13 studies about antenatal CMD from 9 countries;
- No evidence from 103 / 112 (92%) LALMI countries;
- 34 studies about postnatal CMD from 17 countries;
- No evidence from 95 / 112 (85%) LALMI countries;
- Diverse methods and endpoints;
- Mental health problems in pregnant women and mothers of newborns detectable in all studies;
- Study settings contribute to selection biases;

## Prevalence of Perinatal Common Mental Disorders Among Women in Resource-Constrained Countries

<table>
<thead>
<tr>
<th></th>
<th>Total N (number of studies)</th>
<th>Range of prevalence</th>
<th>Weighted mean prevalence</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy CMD (all studies)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary hospitals</td>
<td>2190 (5)</td>
<td>5.2-14.4</td>
<td>10.3</td>
<td>10.1-10.4</td>
</tr>
<tr>
<td>Provincial or district health services</td>
<td>1526 (5)</td>
<td>8.3-32.9</td>
<td>17.8</td>
<td>17.4-18.3</td>
</tr>
<tr>
<td>Community</td>
<td>2058 (3)</td>
<td>12.0-33.0</td>
<td>19.7</td>
<td>19.2-20.1</td>
</tr>
<tr>
<td><strong>Postnatal CMD (all studies)</strong></td>
<td>11,581 (34)</td>
<td>4.9-59.4</td>
<td>19.8</td>
<td>19.2-20.6</td>
</tr>
<tr>
<td>Tertiary hospitals</td>
<td>3600 (11)</td>
<td>9.1-27.2</td>
<td>13.6</td>
<td>13.5-13.8</td>
</tr>
<tr>
<td>Tertiary hospital and community clinic(s)</td>
<td>2876 (7)</td>
<td>4.9-32.9</td>
<td>18.9</td>
<td>18.7-19.3</td>
</tr>
<tr>
<td>Provincial or district health services</td>
<td>3999 (12)</td>
<td>6.1-35.5</td>
<td>20.4</td>
<td>20.1-20.8</td>
</tr>
<tr>
<td>Community</td>
<td>1106 (4)</td>
<td>28.0-59.4</td>
<td>39.4</td>
<td>38.6-40.3</td>
</tr>
</tbody>
</table>
RISK FACTORS FOR PERINATAL CMD AMONG WOMEN IN RESOURCE-CONSTRAINED COUNTRIES

- **Reproductive health** (OR range: 1.6–8.8): unwanted or unintended pregnancy; previous stillbirth; coincidental illness; premature birth; caesarean birth
- **Socioeconomic disadvantage** (OR range: 2.1–13.2): adolescent; religious or ethnic minority group; rural rather than an urban area; hunger in previous month, unable to pay for essential health care; low-income; holding a ‘poor card’;
- **Quality of relationship with the intimate partner** (OR range: 2.0–9.4): unsupportive, rejecting the pregnancy; polygamy; alcoholism;
- **Quality of family relationships** (OR range 2.1–4.4): critical mother-in-law, geographic separation from own mother;
- **Family violence** (OR range 2.11–6.75): criticism, coercion, intimate partner violence, worse if the baby is a girl than a boy;
- **Past history of mental health problems** (OR range 5.1–5.6)
PROTECTIVE FACTORS FOR PERINATAL CMD AMONG WOMEN IN RESOURCE-CONSTRAINED COUNTRIES

- **Education** (RR 0.5; p=0.03);
- **Employment** (OR: 0.64; 95% CI: 0.4–1.0) including income security while away from the workforce to care for an infant;
- Provision of **structured direct care** by a trusted person, preferably a woman’s own mother (OR: 0.4; 95% CI: 0.3–0.6);
- **Confiding affectionate relationship** with the intimate partner (OR: 0.52; 95% CI: 0.3–0.9).

MENTAL HEALTH AND MATERNAL MORTALITY

- Suicide rates are underestimated because maternal mortality data is restricted to the first 42 days after childbirth
- British Centre for Maternal and Child Enquiries (2006 – 2008) 0.57 deaths by suicide per 100,000 maternities; but
- increased to 1.27 per 100,000 if increased to first six postpartum months (Cantwell et al, 2011)
MENTAL HEALTH AND MATERNAL MORTALITY

Limited data from low and middle income countries;

• In Haryana, India, 20% of 219 deaths among 9894 women who had given birth in rural areas, in 1992, were due to suicide or accidental burns. 
  (Lal et al, 1995)

• At Maputo Central Hospital, Mozambique, 9 of 27 (33%) postpartum deaths (1991–1995) not attributable to pregnancy or coincidental illness were by suicide, 7 of these in women aged less than 25 years. 
  (Granja et al, 2002)
MENTAL HEALTH AND MATERNAL MORTALITY

• In Viet Nam, verbal autopsies of all maternal deaths in seven provinces (2000 – 2001) found that overall 8%, but in some provinces 16.5% were by suicide, with problematic ‘community behaviours towards women’ a contributing factor. (WHO WPRO 2005)

• In Nepal, the Department of Health Services examined maternal deaths 1998 – 2008 in 8 districts and found that while there was an overall reduction in deaths from 539 to 229 per 100,000 live births, suicide was the leading cause, accounting for 16%. (Karki, 2011)

• Recent systematic review: wide regional variation in suicide and injuries as causes of pregnancy-related deaths, requires definitional clarity (Fuhr et al, Lancet Psychiatry, 2014)
Iodine status in late pregnancy and psychosocial determinants of iodized salt use in rural northern Viet Nam

Jane Fisher, Thach Tran, Beverley Biggs, Tuan Tran, Terry Dwyer, Gerard Casey, Dang Hai Tho & Basil Hetzel

Objective To establish iodine status among pregnant women in rural northern Viet Nam and explore psychosocial predictors of the use of iodized salt in their households.

Methods This prospective study included pregnant women registered in health stations in randomly-selected communes in Ha Nam province. At recruitment (< 20 weeks of gestation), sociodemographic factors, reproductive health, intimate partner relationship, family violence, symptoms of common mental disorders and use of micronutrient supplements were assessed. During a second assessment (> 28 weeks of gestation) a urine specimen was collected to measure urinary iodine concentration (UIC) and iodized salt use was assessed. Predictors were explored through univariable analyses and multivariable linear and logistic regression.

Findings The 413 pregnant women who provided data for this study had a median UIC of 70 μg/l; nearly 83% had a UIC lower than the 150 μg/l recommended by the World Health Organization; only 73.6% reported using iodized salt in any form in their households. Iodized salt use was lower among nulliparous women (odds ratio, OR: 0.56; 95% confidence interval, CI: 0.32–0.96); less educated women (OR: 0.34; 95% CI: 0.16–0.71); factory workers or small-scale traders (OR: 0.52; 95% CI: 0.31–0.86), government workers (OR: 0.35; 95% CI: 0.13–0.89) and women with common mental disorders at recruitment (OR: 0.61; 95% CI: 0.38–0.98).

Conclusion The decline in the use of iodized salt in Viet Nam since the National Iodine Deficiency Disorders Control Programme was suspended in 2005 has placed pregnant women and their infants in rural areas at risk of iodine deficiency disorders.
HOW PREGNANCY CMD MIGHT INFLUENCE EARLY CHILDHOOD DEVELOPMENT

Through three possible mechanisms:

• less likely to use pregnancy health care;
• co-occurrence with worse physical health, poor nutrition, substance abuse;
• increasing stress-related hormones including cortisol;

These may affect foetal development, birth outcomes, and have lasting effects on early childhood development.
Birth outcomes:

- Increased rate of premature birth (RR=2.3, Rondo et al 2003)
- Increased risk of low birth weight (<2,500 grams) (RR=1.9, Rahman et al 2007);

Early childhood development:

- Increased risks for underweight, stunting (Rahman et al 2004);
- Poorer cognitive development (Bergman et al 2010, Tran et al, 2013),
- Poorer motor development (Tran et al, 2014)
- Behavioural and emotional problems in pre-school children (O'Connor et al 2002).

Most lacked consideration of macro and micronutrient deficiencies
HOW POSTPARTUM CMD CAN INFLUENCE EARLY CHILDHOOD DEVELOPMENT

• Day-to-day interactions between primary caregivers and babies influence the infant’s neurological, cognitive, emotional and social development;
• Effective care involves a mutually rewarding and affectionate relationship with the infant;
• Caregiver sensitivity and responsiveness involve observing infant cues, interpreting what these indicate, and acting consistently, contingently and effectively in response;
• Higher maternal sensitivity is associated with more secure infant to parent emotional attachment;
• Higher maternal responsivity is associated with higher infant cognitive ability and lower rates of behaviour problems in preschool children.

In resource-constrained settings maternal postnatal depression has been linked directly to:

- higher rates of stunting in infants and toddlers,
- higher rates of diarrhoeal diseases, infectious illness and hospital admission,
- lower completion of recommended schedules of immunization, and
- poorer cognitive and social-emotional development among infants.

SUMMARY AND CONCLUSIONS

• Perinatal common mental disorders are prevalent among women in resource-constrained settings;
• Reflect exposure to violence and socioeconomic disadvantage;
• Few have access to any form of social or mental health care;
• Women with PCMD are less likely when all other factors are controlled to be participating fully in health care and health promoting practices;
SUMMARY AND CONCLUSIONS

Co-occur with:

- Macro- and micronutrient deficiencies;

Are associated with:

- Lack of sensitive and responsive care for their infants;
- Lack of cognitive stimulation
SUMMARY AND CONCLUSIONS

Infants of women with CMD are at risk for:

• Poorer growth;
• Worse health;
• Compromised cognitive, social-emotional and motor development.
ADDRESSING MATERNAL MENTAL HEALTH IN RESOURCE-CONSTRAINED SETTINGS

• Mental health problems can be identified in women in resource-constrained settings;
• Women and infants are in touch with health services and integrated interventions are most likely to be acceptable and accessible;
• Care for the woman in her life context so that she can care for her very young children;
• Community development to promote awareness of these relationships and local solutions;