Maternal mental health: program and policy implications¹⁻³

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ABSTRACT
Despite increasing evidence of the seriousness of maternal depression, the number of individuals affected, and the impact of maternal depression on infant growth and development, maternal mental health has not become a component of the primary health care system in many parts of the world. The impact appears to be greatest in South Asia, possibly among low-income families. Some interventions, such as increases in social support or the education of mothers about responsive caregiving, appear to be effective in reducing maternal distress. However, we do not yet have recognized, effective, and scalable strategies to treat maternal depression or reduce the more common maternal distress. Efforts are needed to increase the availability of programs for maternal mental health and to develop simple interventions to reduce maternal distress that can be used by primary health care providers. Second, efforts are needed to develop policies that include maternal mental health. These efforts should build on research and on international conventions and statements, such as the recent United Nations Fund for Population Activities/World Health Organization recommendation for a comprehensive approach to preventing and treating maternal depression. Am J Clin Nutr 2009;89(suppl):963S–6S.

INTRODUCTION
Despite mounting evidence of the impact of maternal mental health on women and children, prevention and treatment have been slow to enter into maternal and child health programs. Rahman et al (1) point to the neglected “m” in MCH programs. Herrman and Swartz (2) found that the public health commitment to mental health has been minimal in many low- and middle-income countries. As Patel et al (3; p 1312) note, “with every new public health challenge, mental health is once more relegated to the background.” A series of articles on mental health in the September 2007 issue of The Lancet highlighted the critical lack of attention to mental health issues in the global health agenda (4–6). In an article on the importance of women to the development agenda, Gill et al (7) emphasized the importance of including maternal depression as a risk factor for this agenda.

Despite this outcry, prevention and treatment of maternal mental health continue to lag behind other health interventions. In this article, several key steps for advocacy and implications for programming are suggested. Second, international instruments that can facilitate greater progress are described. Third, it summarizes some of the current efforts to increase attention to maternal mental health are summarized.

Three conditions for moving an issue from advocacy to program implementation are 1) evidence that it is a problem that affects a broad range of the population, 2) evidence that it has serious consequences, and 3) that interventions are available that can make a difference at a reasonable cost.

STATE OF THE EVIDENCE FOR PROGRAM AND POLICY
Defining maternal mental health and identifying maternal depression
The World Health Organization (WHO) defines maternal mental health as “a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community” (2; p 1195). As Rahman et al (1) note, mental health is not the same as the absence of mental illness, but reflects a capacity to adapt and cope. The most common mental disorder, the “common cold” of the mental health field, is depression, and the evidence for a link with child outcomes is stronger than for other mental disorders.

Measurement of symptoms of maternal depression can be done with recognized questionnaires such as the WHO Self-Reporting Questionnaire (SRQ) (8) or the Center for Epidemiologic Studies–Depression instrument (9). In a normal population, there is a range of scores; a small percentage of women have severe or clinical depression, and a larger number are distressed (1).

Does the problem affect a large percentage of the population?
Numerous articles over the past 10 years have documented the extent of maternal depression, including postpartum depression, which ranges from 15% to 57% (10). Unipolar major depression was ranked fourth in the world league of disabling diseases in 1990 by the WHO. In developing countries, studies suggest rates of maternal depression of 15–28% in Africa and Asia (11), 50% in Bangladesh (12), 28–57% in Pakistan (13), and 35–47% in

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45% have a body mass index (in kg/m²) in northern India, 62% of women have never attended school, and maternal depression. For example, in the impoverished state of Bihar a country, and these differences will have implications for prevalence of HIV/AIDS (19–21). However, there can be substantial differences in the situations that women confront even within a country, and these differences will have implications for maternal depression. For example, in the impoverished state of Bihar in northern India, 62% of women have never attended school, and 45% have a body mass index (in kg/m²) < 18.5. Women tend to have little power; 55% of married women do not participate in household decisions and 59% have experienced spousal violence (22). On the other hand, in Kerala, where only 4% of women have not attended school and 12.5% have a body mass index < 18.5, the situation is very different. Only 27% of women do not participate in household decision making and 16% have experienced spousal violence (22). Depression is likely to be much higher in Bihar than in Kerala.

Are there serious consequences of maternal depression for children’s growth and development?

The previous articles in this volume have documented the association of maternal depression with poor infant growth and development. In India, Pakistan, and Bangladesh, associations have been found with lighter infant birth weight, poor infant growth, higher rates of diarrhea, shorter breastfeeding duration, and slower development, particularly when infants are perceived as difficult (23–28, 12). A recent study in Nigeria also found an impact of postnatal depression on infant growth (29). However, these effects may not be equally strong in all societies. Surkan et al (30) found that social support was a strong predictor of infant growth in northeastern Brazil, whereas maternal depression was not. In South Africa, Tomlinson et al (31) found associations between postpartum maternal depression and infant weight at 18 mo, but the association was explained by birth weight. Stewart (32) reviewed a number of mechanisms through which maternal depression could differentially affect child growth and development and concluded that the association is more likely to occur in mother-infant dyads living in conditions of socioeconomic deprivation. Evidence of an association of maternal depression with compromised outcomes for children seems to be reasonably strong.

Are there interventions that can make a difference at a reasonable cost?

This component is still a challenge. Treatment with medication is unlikely to be affordable or even recommended in many settings. However, there are a number of social support options that have been found to be effective that could be adopted. Improved social support, brief individual therapy, home visits, and even infant massage have been found to make a difference in developed and developing countries (33, 34). Similar methods have been used in developing countries (1). Improving mother-child interactions and mothers’ participation in interventions to improve children’s development show promise in reducing maternal depression and improving children’s growth and development (1, 35, 36). One intervention currently being tested is the Care for Child Development module of Integrated Management of Childhood Illness that helps primary care workers provide simple information and support to mothers to increase responsiveness and awareness of the child’s developmental level. Specific components of the module are designed to provide support to mothers.

Assessment of the evidence

Evidence of a widespread problem and for the negative effects of the problem for children’s growth and development has grown rapidly in the past decade. Additional work is urgently needed to expand the evidence on cost-effective and scalable preventive and treatment interventions for developing countries, including women’s empowerment. A barrier to further development is likely to be the lack of understanding of maternal depression and distress at many levels, the stigma associated with mental illness, and a broader lack of expertise in mental health issues in many countries.

RIGHTS-BASED AND MORAL ARGUMENTS AND INSTRUMENTS

An important argument for the prevention and treatment of maternal depression is based on the fulfillment of human rights (3, 7, 20, 37). Not only will policies and programs that reduce maternal depression improve women’s functioning and probably improve children’s growth, development, and behavior but they also protect women and children’s rights. Patel et al (3) argue that there must not be only a scientific but also a moral argument for mental health: “there can be no health without mental health.”

Definitions can make a difference. The much-quoted WHO definition of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, and the International Covenant on Economic, Social and Cultural Rights definition of health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (38) help support the inclusion of mental health into a health agenda.

Internationally ratified conventions, such as the Convention for the Rights of the Child, the Convention for the Elimination of All Forms of Discrimination against Women, and the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), adopted by the UN General Assembly in December of 2006, and international conferences and meetings that lay out plans of action, such as the International Conference on Population and Development in 1994, help to translate research into policy and programs.

Conventions are effective through moral rather than legal means. Countries that have ratified the convention should report their progress in fulfilling the goals of the convention to an impartial committee on a regular schedule (every 5 y for the Convention on the Rights of the Child). The committee provides morally, but not legally binding recommendations to improve countries’ adherence to conventions that they have ratified. The Convention on the Rights of the Child, the most widely ratified
convention of the United Nations, has several articles relevant to maternal depression. Article 2 states that children should not face discrimination on the basis of factors such as parents’ disability, which includes mental illness. Governments “shall render appropriate assistance to parents . . . in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities, and services for the care of children”. In Article 27, governments should recognize “the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development,” and governments are responsible for assisting parents and others in carrying out their duty to children.

In December 2006, after a decade of advocacy, the UN Convention on the Rights of Persons with Disabilities (CRPD) was signed at the UN. One of the disabilities included is “long-term mental impairment” (Article 1), which includes maternal depression. The CRPD requires governments to provide both medical and social support (20). Women are accorded particular protection in the CRPD. For example, Article 6 notes that “women and girls with disabilities are subject to multiple discrimination, and in this regard States Parties (governments) shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms” and adds “States Parties (governments) shall take all appropriate measures to ensure the full development, advancement and empowerment of women.” The CRPD also challenges stereotypes related to mental illness and argues for a wide variety of creative strategies, including self-help groups, occupational training, life-skills education, parenting skills, and use of local healing traditions (20).

Conventions define who is responsible for fulfilling rights. In these Conventions, Governments are held responsible (“duty bearers”) for ensuring that families have the livelihood and support needed to fulfill their responsibilities, but families are also responsible. The Conventions can provide powerful tools for nongovernmental organizations and other advocacy groups to pressure governments to address maternal depression and child well-being.

PROGRAM AND POLICY ADVOCACY FOR MATERNAL MENTAL HEALTH AND CHILD WELL-BEING

An international group of experts met with the UN Fund for Population Activities and WHO in June of 2007 to develop a joint statement on programming and policies for maternal mental health. The result of this consultation is a statement, agreed by both organizations, called “Maternal Mental Health and Child Health and Development in Resource Constrained Settings: Essentials for achieving the Millennium Development Goals (38). This statement notes that maternal mental health is fundamental to attaining 5 of the 8 Millennium Development Goals: improving maternal health, reducing child mortality, promoting gender equality and empowering women, achieving universal primary education, and eradicating extreme poverty and hunger. It calls on international agencies and governments to take immediate action to address maternal mental health as part of health services. The Statement reviews the evidence for the impact of maternal mental health on mothers and children, lists the risk factors for poor maternal mental health, and makes recommendations for action.

Specific recommendations include the following:

- Early detection with validated screening instruments and appropriate treatment through clearly defined protocols for health care providers, and in extreme cases, provision of low-cost psychotropic medication taking into account risks
- Psychoeducational interventions that combine information with psychological support
- Improvement in mother-child relations through enhancement of a mother’s sensitivity to infant developmental needs for stimulation, interaction, and comfort and improvement in maternal responsiveness
- Improvement in partner relationships through the promotion of gender equality, improved mother-father work sharing and parenting, and reductions in partner and family violence
- Culturally sensitive, solution-focused brief psychological therapies
- Improvement in social support for women
- Improvement in access to education and vocational training for girls and women

Key implementation strategies include building the evidence base, creating models for primary health care workers, developing a legal and policy framework, capacity building, estimating financial and human resource needs to provide these services, developing indicators, and establishing funding for research.

The Statement concludes with a call for governments, international organizations, and civil society to “take immediate action to address mental health in their endeavors to improve maternal and child health, survival and development. Political will, concerted action by global stakeholders and resources are needed now to integrate maternal mental health in strategies to achieve the Millennium Development Goals” (38; p 3).

Continued advocacy for the prevention and treatment of maternal depression and mental health of women in resource-poor settings is needed. Herrman and Swartz (2) recommend not only prevention and treatment at the individual level but also policies and practices such as taxation of alcohol, occupational justice, and gender equity to reduce maternal depression. Finally, as Patel et al observed, “mental health professionals in rich countries have an important role to play” (3; p 1314). They can advocate for mental health within their own health systems and tackle issues on the global mental health agenda. (Other articles in this supplement to the Journal include references 39–44.)

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REFERENCES