



Perinatal Mental Health Project Impact and Outcomes

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1. Introduction

The Perinatal Mental Health Project (PMHP) goes to great length to audit the outputs and outcomes of its programmes.

This has enabled us to refine our work and expand our reach in a strategic and evidence-based way. Further, we have gained credibility with local statutory stakeholders as well as international partners and the research community, thus influencing maternal and child health beyond the confines of our immediate location in the Western Cape.

Our donor partners have recognised that their investments have been well managed with respect to our data-driven operations. This is evidenced by long-term agreements being formalised with the PMHP.

This document provides an overview of the influence of PMHP's four programmes. A preliminary cost-effectiveness analysis has been included. The wider impact of maternal mental health interventions on maternal and child health and development is outlined.

2. Mental health services impact

On a monthly basis, all data captured from each service site is entered in to a database, cleaned, analysed and reported to relevant stakeholders. Trends are noted and incorporated into routinised service supervision and management processes. Careful balance is sought between quantitative targets and qualitative impact.

2.1 Reach

The indicators below reflect PMHP's reach since inception in October 2002.

17,671	Pregnant women screened for mental illness at booking appointment
3,220	Pregnant women counselled on-site at maternity facility
8,367	Total number of sessions provided by PMHP counsellors
26,198	Total number of women reached through psycho-educational engagement, materials, parenting guides and support service information (does not include partners reached through parenting and fatherhood brochures).

2.2 Outcomes

2.2.1 Data collection

The PMHP has conducted routine follow-up assessments with clients since 2003. Since 2011, this process was accompanied by detailed data collection and analysis. Conducted by the client's counsellor at 6-12 weeks postpartum, this session is a structured assessment of women's postpartum-related outcomes and of how they perceive and cope with the problems with which they initially presented during pregnancy. The PMHP acknowledges that the method of assessment may be influenced by bias. However, postnatal assessments are closely monitored and analysed to avoid bias as much as possible. Assessing the feasibility and impact of the service intervention is required to advocate for scalability, and thus the PMHP is raising funds and prioritising an independent evaluation of service outcomes.

To date, 532 postnatal assessments have been recorded for Mowbray Maternity Hospital (MMH), and 289 for False Bay Hospital (FBH). Due to the recent launch of services at the Retreat MOU and Hanover Park MOU, the number of postnatal assessments is too few to be statistically significant at this time.

2.2.2 Prior to PMHP intervention

The table below represents the most prevalent presenting problems among PMHP clients. These are poor primary support (unsupportive primary relationships, including but not limited to a lack of practical, financial or emotional support being provided by partners or close family members), problems in their social environment (for example, poverty, gang violence, HIV-related stigma) and lifecycle transition (for example, transitions related to adolescence, motherhood, marriage, bereavement or changes in responsibility or caregiving roles).

Annual targets

- Screen 3,000 pregnant women and girls
- Provide counselling for 500 pregnant women and girls
- Provide postnatal follow-up (telephonic session) to all PMHP counselling clients.

Table 1: Commonest presenting problems

Presenting problems	Reported by a sample of 532 clients at MMH	Reported by a sample of 289 clients at FBH
<i>Primary support</i>	87%	70%
<i>Social environment</i>	50%	52%
<i>Lifecycle transition</i>	58%	40%

2.2.3 After PMHP intervention

At the postnatal assessment, the counsellors rate clients' current perceptions and coping with their initial problems. The rating includes 5 options on a scale from 'worse' to 'resolved'.

Description of interventions

Primary support problems - counsellors enable women to identify and strengthen existing resources and means of support, as well as negotiate difficult primary relationships, such as abusive interpersonal relationships.

Social environment problems – counsellors help women to identify emotional and logistical resources in order to can build resilience and engage with additional economic activities and opportunities.

Lifecycle transition – counsellors support women in the transition to motherhood or with issues related to motherhood, including problems related to unintended or teenage pregnancies.

Table 2: Proportions of improvement in presenting problems - ‘much improved’ or ‘resolved’

Presenting problems	Proportion of clients (n= 532) at MMH	Proportion of clients (n=289) at FBH
<i>Primary support</i>	66%	49%
<i>Social environment</i>	49%	33%
<i>Lifecycle transition</i>	87%	74%

Studied together with counsellors’ notes and routine supervision processes, the indicators above infer that the PMHP maternal mental health intervention:

- builds resilience among women living in poverty and difficult social circumstances
- empowers women to identify resources and means of support, and to negotiate difficult primary relationships such as abusive interpersonal relationships
- equips and supports women in the transition to motherhood, or with issues related to motherhood, and
- promotes positive birth experiences, successful bonding and caregiving capacity.

Existing evidence shows that the above factors are important in promoting optimal infant, child and maternal health outcomes. The PMHP assessment data on bonding, noted in the table below, expands on the above findings.

Table 3: Birth and parenting outcomes

Positive postnatal outcomes	Proportion of clients (n=532) at MMH	Proportion of clients (n=289) at FBH
<i>Positive experience of birth</i>	66%	66%
<i>Bonding with the baby</i>	95%	96%
<i>Coping</i>	86%	84%

Complicated birth and attachment

A significant finding is that, despite negative birth experiences beyond the PMHP’s control, research shows a positive association between prenatal mental health interventions and improved coping and resilience among mothers experiencing complications during labour. Of the women who had negative to ‘mid’ birth experiences, at the time of follow-up assessment at 6 weeks postpartum, over 80% were able to cope with the situation, and over 90% reported positive and successful bonding experiences with their infants.

Mood

There is statistical evidence that after the intervention, women report crying less often than at screening, look forward to things more often than they did at screening, have thoughts of self-harm or suicide less often than they did at screening. Specifically,

- at MMH, of the 58 women reporting some or regular thoughts of harming themselves or ending their life at screening, 88% no longer reported these at the postnatal follow-up;
- at FBH, of the 84 women reporting some or regular thoughts of harming themselves or ending their life at screening, 93% no longer reported these at the postnatal follow-up.

Anxiety

It was statistically significant that after the intervention, women report being nervous, anxious or on edge less often than at their first counselling session.

Functioning

It was statistically significant that after the intervention, women report improved functioning in day-to-day activities and interpersonal relationships.

Perceptions of general life experience

Of the 85% of women who perceived their life experience as negative before counselling at MMH, 73% viewed it as positive after counselling. The same pattern applies at FBH, where 77% of clients expressing a negative view of their life experience before counselling had a positive view after counselling.

Impressions of the PMHP service

Between 96% and 97% of women counselled at MMH and FBH respectively report having a positive experience of PMHP's counselling service.

Feasibility

Clients attended an average of 2 to 4 counselling sessions in MMH and FBH. Less commonly, clients have had up to 13 sessions at MMH and 8 sessions at FBH. The data shows that brief interventions can have positive outcomes for women and their children. These interventions focus on containing clients' distress, empowering them and improving their assertiveness. This has a beneficial impact on mood and coping.

3. Health systems impact

The PMHP impact on health systems is assessed through the monitoring and evaluation work of the teaching and training programme, the research programme and the advocacy and policy development programme.

3.1 Teaching and training reach

The indicators below reflect PMHP's teaching and training reach since inception in October 2002*.

2,237	Health workers trained since the formal launch of the Teaching & Training Programme in 2008. Includes medical students, maternity nurses, midwives, allied health professionals and community health workers.
120,000	Estimated total number of women and children reached, per year, by the health workers trained by PMHP.

*For details, please see the attached Teaching and Training Reach cascade.

3.2 Teaching and training outcomes

Healthcare transformation as proposed by the Minister of Health's re-engineering plan is built on a policy framework that increases demands on nursing staff. As the primary interface between service users and health care, nursing staff are the first to respond to the complex health impacts of socio-economic challenges facing the majority of public health clients. Conventional training, however, does not necessarily equip nurses to manage causes and consequences of ill-health that are not purely bio-medical. Healthcare teaching and training focus on the technical aspects of care through didactic transfer of knowledge.

The PMHP experience shows that in addition to knowledge-building and skills development, to ensure *quality* care, training should focus on health worker wellness (see image). Nurses often experience a high level of occupational stressors. Therefore, the PMHP training intervention focuses on health workers' own emotional well-being. Evaluations show that this improves professional competence, morale, quality of care, and health outcomes for the client. Caring for the health worker re-establishes empathy for clients and diminishes compassion fatigue. It also addresses nurse abuse of clients, which has been a concern in maternity settings. Training also ensures that optimal referral pathways are in generated and maintained.



The PMHP Teaching and Training strategy improves general quality

Annual targets

- Teach 100 students in the health professions
- Train 250 maternity health workers (over 12 sessions) within the Peninsula Maternal and Neonatal Service as part of the Western Cape Department of Health's clinical education curriculum.
- Train 100 allied health professionals.
- Train 50 community-based health workers.
- Issue 10 CPD certificates (Continuing Professional Development) to health professionals.

Preliminary internal and independent outcomes assessments of feedback forms and key informant interviews have revealed positive outcomes for staff in the following key areas:

- Increased awareness of how staff mental distress may impact negatively on the care of mothers
- Improved insights into "difficult" or "rude" patient behaviour
- Improved understanding of psycho-social determinants of physical health problems
- Improved skills in providing empathic care
- Adoption of new communication skills – personally and professionally
- Awareness of the health systems challenges to implementing empathic care
- Enthusiasm about maternal mental health training and service development

4. Research

"The PMHP actively contributes to developing a coherent body of high quality, innovative research and systems development relevant to breaking the cycle of poverty and mental ill-health in South Africa, and other poor countries in the region. To this end, the PMHP contributes meaningfully to generating outcomes-oriented research and context-sensitive interventions in the marginalised field of maternal mental health."

Professor Alan J Flisher, founder of the Centre for Public Mental Health, UCT

The PMHP research programme includes:

- the generation of lessons from routine PMHP service monitoring and evaluation data
- the conducting of targeted research to refine components of the PMHP model, e.g. the screening tool development study
- the informing and supporting of research design and implementation in collaboration with regional mental health consortia and postgraduate research associates
- the dissemination of research findings through journal articles, conference presentations, academic platforms and research translation.

Yearly output targets are set for knowledge translation and sharing. The details of these may be found on the PMHP website at pmhp.za.org.

The Alan J Flisher Centre for Public Mental Health, UCT

The PMHP is part of the Alan J Flisher Centre for Public Mental Health and contributes substantively to developing research capacity, teaching, consulting and advocacy to promote mental health in Africa and other low-resource settings. Through the Centre, the PMHP accesses an international network of leaders and experts in the field of mental health, for example: World Health Organisation (WHO), London School of Economics, the Institute of Psychiatry at University College London and Sangath Centre in India.

Specific opportunities to promote the PMHP model for the integration of mental health into maternity care in low resource countries within this consortium include:

- 1. The Programme for Improving Mental Health Care (PRIME):** The PRIME study is funded by a 6-year DFID grant and is coordinated by CPMH. The overall purpose of PRIME is that world-class research on the implementation and scale-up of treatment programmes for mental disorders is adopted by policy makers and practitioners for the benefit of the poor, with particular focus on vulnerable women living with HIV. The study will be conducted in 5 countries: Ethiopia, Uganda, India, Nepal and South Africa.
- 2. The Africa Focus on Intervention Research for Mental Health (AFFIRM):** This collaborative research study, funded by the National Institute of Mental Health, aims to establish a hub for research and capacity development to improve the delivery of cost-effective interventions for mental disorders in sub-Saharan Africa. The study sites are in 6 countries: Ethiopia, Zimbabwe, Malawi, Ghana, Uganda and South Africa. The South African site will see the development of a randomised controlled trial of a community health worker-based intervention for maternal mental disorders.

A decade of stringent monitoring and evaluation protocols provides the PMHP with an important base for innovative and pragmatic research, informed by real-world service settings. On-going applied research is refining PMHP best practice models which are affordable and adaptable to low-resource settings. The Project is very close to finalising the validation of a context-specific maternal mental health screening tool for use by the Department of Health. The PMHP's research outputs are translated for a wide audience through its advocacy programme, reaching the Department of Health, educators, health workers, facility managers, and beneficiaries.

5. Advocacy

The PMHP aims to advance evidence-based policy development and implementation of maternal mental health services by: informing and supporting key public health stakeholders; raising PMHP's profile as a thought leader and resource (regionally and internationally); and empowering service users and civil society to contribute actively towards maternal mental health service delivery.

This is achieved through a range of modalities including; policy brief development, contribution to policy writing, multimedia engagement and consultation with key stakeholders in the governmental and civil society sectors. These outputs are recorded and evaluated against yearly targets. Details are available on the PMHP website www.pmhp.za.org.

5.1 South Africa

In 2012, the PMHP reached its 10-year milestone. The PMHP's lobbying, development of innovative models and tools, and relationship-building has enabled maternal mental health to become a key health priority on several complementary health agendas. Our positive working relationship with the Department of Health (DOH) is now well-established. Formal memoranda of understanding have been signed with several directorates. Maternal mental health interventions are recognised as broad, cross-cutting solutions to achieving key health and development priorities.

The Minister of Health is currently finalising the **Draft Mental Health Policy**, to which the PMHP contributed substantial content on maternal mental health, gender and HIV/AIDS – content areas on which the policy had previously been silent.

PMHP Director, Dr Simone Honikman, has made presentations to annual meeting of the **National Committee on Confidential Enquiries into Maternal Deaths**. As a result, the PMHP is contributing to the redrafting of **National Guidelines for Maternal Care**.

The PMHP model contributes directly to the **National Development Plan - Vision 2030**. **Appendix 1 outlines the relationships PMHP holds with national and provincial statutory bodies.**

5.2 International

The PMHP has developed several relationships with international organisations which has enabled the interchange of best-practise models and maternal mental health promotion more globally. The organisations include:

- World Health Organisation: the PMHP continues to consult to and provide technical expertise on materials development; partner in developing maternal mental health training manuals for a range of service providers, contribution to the Mental Health Gap Action Programme (mhGAP) Intervention Guide (2010);
- Member of the Movement for Global Mental Health
- Member of the Online Mental Health Community
- National Advocates for Pregnant Women (US): the PMHP presented to legal counsel at this New York-based organisation; PMHP's work informed an amicus brief submission
- Northern Territory Department of Health Mental Health Programme (Australia): shared resources and provided PMHP training materials to rural health programme

6. Cost effectiveness

The PMHP has reduced the cost of one-on-one counselling. The private medical insurance rate for 1 therapy session is R750. For the PMHP, to provide 1 woman with counselling and follow up care, as many times as she may need, it costs the **R185 per year**.

The current average is 3 sessions per woman, but the PMHP maintains an open door policy for all clients, and some women access the service for many more sessions. The service includes liaison work by the counsellor for specialist referrals and social support as well as postnatal follow-up care and evaluation. This calculation is based on the full cost of the PMHP Maternal Mental Health Service, including personnel and programme administration.

R6,275,250	Cost of mental health care for all sessions required by 3,220 women at standard private medical insurance rates.
R595,700	Cost of providing 3,220 women with mental health care for 1 year using the PMHP model (including as many one-on-one counselling sessions as needed).
R5,679,550	Savings in health expenditure.

7. Impact on Maternal and Child Health and Development

The crisis of maternal mental illness can be addressed: it is predictable, identifiable, treatable and in many cases, preventable. A significant body of evidence demonstrates the preventative, protective, and promotive benefits for mother, child, family and society of integrated maternal mental health services. These are summarised below.

For maternal & reproductive health

- Promotes optimal access to health and social services by vulnerable groups of women and girls, which improves functioning, capabilities and quality of life
- Prevents nurse abuse of clients in maternity settings and promote compassionate care in supportive maternity environments
- Addresses upstream causes of ill-health and burden of disease

For HIV prevention

- Prevents default and improves adherence to ARV and TB treatment regimens
- Promotes optimal PMTCT outcomes

To address poverty

Mental health care provides the necessary support to empower women to identify resources and personal capabilities. This can enhance their resilience to difficult life circumstances and support them to nurture their children optimally.

To address domestic violence

When women are listened to and validated in a safe and therapeutic environment they begin to restore their self-esteem and locus of control. Women may be empowered to identify what actions they can realistically take to change their circumstances.

For infant & child health

- Promotes successful and longer breastfeeding, which in turn prevents diarrhoeal episodes and improves mother-infant bonding
- Promotes completion of infant immunisations
- Reduced rates of infectious illness and hospital admissions
- Increases resilience, agency, and care-giving capacity of mothers living in poverty
- Improved infant, child and adolescent development
- A mother with positive self-esteem and an ability to work towards a better future will better be able to negotiate the hardships in her life and optimally nurture the development of her children

To strengthen the public health sector

- Addresses the gap in maternal mental health knowledge
- Reduces general health care costs through early detection, prevention or referral of mental health problems
- Addresses major stressors on the public health system, such as health worker burnout and human rights abuses in public obstetric facilities
- Builds capacity within the public sector to address maternal mental illness which
 - combats stigma, shifts attitudes and increases morale
 - empowers health workers to identify and manage maternal mental health problems and improves their ability to handle personal crises
 - maximises scarce resources
- These factors simultaneously contribute to improved quality of service delivery

For MDGs & development

- Improves outcomes related to MDG 4: reduce under-five mortality, MDG 5: improve maternal health and MDG 6: combat major diseases such as HIV/AIDS and TB
- Contributes to achieving DOH objectives as outlined in the Mental Health Care Act (2002), the Primary Health Care Re-engineering Plan and the National Development Plan - Vision 2030
- Reduces general health care costs through early detection and referral of mental health problems
- Research shows that investment in the antenatal period
 - increases rate of return of investment in human development and
 - requires less investment for interventions timed at later stages

Appendix: Relationship with statutory bodies

National Department of Health

1. Liaison and collaboration with national divisions:
 - Maternal and Child Health
 - Non-communicable diseases, Chronic Diseases and Mental Health
 - Prevention of Mother to Child Transmission of HIV
2. **National Committee on Confidential Enquiries into Maternal Deaths:** PMHP is contributing to the redrafting of National Guidelines for Maternal Care.
3. **Minister's Re-engineering of Primary Healthcare Plan:** PMHP invited to contribute to the development of the first Train-the-Trainer workshop as an initial component of this plan.
4. **National Mental Health Summit:** PMHP invited to participate.
5. **Nursing Update journal:** PMHP invited to write for National DOH publications (requested by Deputy Director of Child, Youth and Family Mental Health Adelaide Shiba)
6. **National Mental Health Policy:** PMHP contributed substantially towards content development on maternal mental health, gender and HIV components.
7. **Minister of Health's 2020 Health Plan for Mental Health**
8. **National Maternal Child and Women's Health Cluster:** PMHP contributed to Sexual and Reproductive Health and Rights policies and guideline documents.
9. **Research partnership:** Working with Director of Child, Youth and Family Mental Health, Ms Adelaide Shiba, in the development of strategy for a mental health screening tool for national use in busy maternity settings.

Provincial Department of Health

1. **Clinical Education:** PMHP training is part of the 2-monthly Perinatal Update educational programme in the Peninsula Maternal and Neonatal Service, monthly Obstetric Updates at the midwife obstetric units, as well as a range of mental health workshops and seminars to health staff (with national reach).
2. **Maternal Support Service:** PMHP consults to this project operating under the auspices of several health sub-directorates, and piloting at the Mitchells Plain Community Health Centre. Involvement includes service design, training and M&E.
3. **The Comprehensive Service Plan for the Implementation of Healthcare 2020:** PMHP contributed to development of provincial health strategy.
4. **Burden of Disease Project:** PMHP contributes to study exploring primary determinants of disease burden for the province.
5. **Early Childhood Development project:** PMHP conducted a situational analysis for the Department of Health in a sub-district proposed for service development.

6. **Western Cape Premier's Wellness Summit:** PMHP presented at the Summit; initiated development of the Provincial mental health working group; maternal mental health established as a key priority area.
7. **Task Team for 'Patient-Centred Maternity Care':** PMHP invited to join task team to develop and support code of conduct for reduction of patient abuse and increase in quality care.
8. **Postnatal Care Policy:** PMHP contribution toward development of mental health component of new provincial policy.
9. **Basic Antenatal Care Expansion Programme:** PMHP invited to contribute to design of service proposal and training of health workers.
10. **Board representation:** Dr Tracey Naledi, Director Health Impact Assessment, joined the PMHP Board of Advisors 2012.
11. **Met with Mayor Patricia De Lille:** PMHP request for a meeting with the Mayor of Cape Town received positively. Mayor tasked the Executive Director of City Health (Cape Town) to meet with PMHP Director to take strategic discussions further in 2013.

