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# MATERNAL MENTAL HEALTH IN THE CONTEXT OF COMMUNITY-BASED HOME VISITING IN A RE-ENGINEERED PRIMARY HEALTH CARE SYSTEM: A CASE STUDY OF THE PHILANI MENTOR MOTHERS PROGRAMME

Empowerment of Women and Girls

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## MATERNAL MENTAL HEALTH IN THE CONTEXT OF COMMUNITY-BASED HOME VISITING IN A RE-ENGINEERED PRIMARY HEALTH CARE SYSTEM: A CASE STUDY OF THE PHILANI MENTOR MOTHERS PROGRAMME

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# Executive summary

This document constitutes a briefing summary of the case study of a maternal mental health intervention in South Africa, the Philani Mentor Mothers Programme. The case study has been compiled by Professor Mark Tomlinson at Stellenbosch University as a contribution to the Empowerment of Women and Girls theme of the Accountable Grant at the Institute of Development Studies. In particular, it relates to the sub-theme that focuses on the health of women and girls in rapidly urbanising settings in South Africa and Kenya. The case study in this sub-theme discusses the particular health conditions that have been identified to affect women and girls in low-income urban settings, with a focus on identifying key 'good practice' and cutting edge interventions.

Community health workers (CHWs) are increasingly being identified as a potential vehicle for strengthening community-based care, especially for maternal, newborn and child health. It is estimated that globally there are currently more than 40 million CHWs (Lewin *et al.* 2010), and there have been recent calls for one million CHWs in sub-Saharan Africa by 2015 (Singh and Sachs 2013). Most research evaluating the impact of CHW programmes has been limited to small and short-term interventions in heavily resourced research settings (Haines *et al.* 2007). Larger scale CHW programmes have been hindered by barriers to effective scale-up. Among other things, large-scale programmes are frequently undermined by high attrition and low activity levels of CHWs, which are less likely in smaller scale initiatives where supervision is often more intense and consistent (Walt *et al.* 1989).

In global health, the extent to which the gap can be bridged between small-scale efficacy studies and effective interventions at scale will depend on a number of factors:

- Holistic programmes that target the broader health concerns of women, families and children such as mental health interventions, particularly in light of the fact that mental and behavioural disorders account for 22.7 per cent of all years lived with disability (Vos *et al.* 2012);
- While the use of CHWs has achieved many successes (Baqui *et al.* 2008; Rahman 2008), the system has also been characterised by a lack of consistent supervision and linkages to the health system (Walley *et al.* 2008; Haines *et al.* 2007).
- An enabling policy environment that facilitates the successful completion of tasks across the maternal and child health continuum of care.

In this paper Professor Tomlinson argues that unless we begin to examine the 'how' rather than the 'what' of interventions or, as McCoy and colleagues (2010) describe, moving from knowledge of what works to systems that deliver, we will not be able to improve holistic population health in low-middle income countries (LMIC). This summary describes the context of global health, mental health in South Africa, and a case study of a generalist health intervention (with a maternal mental health component) by a South African non-governmental organisation (NGO), Philani, within the current fluid South African health system. It analyses what the Philani experience has to offer in terms of lessons to surmount the significant obstacles to holistic and equitable health care delivery that exist in South Africa and elsewhere.

## Context of global health

Despite the enormous strides made in improving global health in the last 20–30 years, the progress is too slow for many countries to reach their agreed targets. Approximately 8.5 million children under five die each year, almost all of which take place in poor countries – about half of these deaths occur in Africa (Bhutta *et al.* 2010). Almost two-thirds of child

deaths could be diverted through the timely delivery (at scale) of the interventions we know to be effective in saving children's lives. A continuum of care provides a useful way of considering care across the life cycle (Kerber *et al.* 2007).

Gwatkin (2001) has shown how even interventions that are considered to be 'pro-poor' such as immunisation and oral rehydration therapy have better coverage amongst less disadvantaged groups. Reasons for this include greater distances to services and poor quality of services with shortages of supplies and drugs. The net effect is that while countries may on average achieve many of their Millennium Development Goals (MDGs), targets will not be achieved for children in the poorest quintiles within these countries.

The critical lack of human resources for implementation of health care in many LMIC impedes the potential scale-up of treatment and provision of care (Kakuma *et al.* 2011). In sub-Saharan Africa 36 of the 57 countries face health worker shortages (WHO 2006a). Other factors include brain drain and the migration of professionals, poor morale and lack of appropriate incentives (Zachariah *et al.* 2009). Task shifting—the delegation of health care tasks to existing or new cadres with either less training or narrowly tailored training has been a suggested response (Zachariah *et al.* 2009). At this level tasks can be delegated outside of the formal health system to train lay community members, such as CHWs with increasing evidence in support of this (Araya *et al.* 2003; Lehmann 2009; Patel *et al.* 2011; van Ginneken *et al.* 2011).

In the most recent Global Burden of Disease analyses mental and behavioural disorders were the largest contributors to global years lived with disability (YLD), accounting for 22.7 per cent of all YLD (Vos *et al.* 2012). Mental illness has thus far not achieved commensurate visibility or funding, particularly in LMIC (WHO 2011). Mental health is neglected in the national policies of many LMIC (Rahman 2005), with as many as 42 per cent of African countries not even having a mental health policy and only two-thirds having a mental health plan (WHO 2011). The vast majority of people with a mental disorder in LMIC do not receive basic mental health care. This 'treatment gap' is 50 per cent across all countries globally but reaches a staggering 89 per cent for some disorders in many LMIC (Lora *et al.* 2012).

## **Maternal depression**

For girls and women aged 14–44, anxiety and depression are the third leading cause of disease burden, while in LMIC approximately 16 per cent of women suffer from common mental disorders during pregnancy and 20 per cent postnatally (Fisher *et al.* 2012). In South Africa, up to 47 per cent of women have been diagnosed with major depression across the perinatal period (Rochat *et al.* 2011; Cooper *et al.* 1999; Hartley *et al.* 2011); the rate of postnatal depression was found to be 34.7 per cent two months after the birth of the child (Cooper *et al.* 1999); and almost 40 per cent of pregnant women screened positive on the Edinburgh Postnatal Depression Scale (EPDS) for depressed mood (Hartley *et al.* 2011).

In a high HIV prevalence region of KwaZulu Natal almost 50 per cent of women were diagnosed with antenatal depression (Rochat *et al.* 2011), a prevalence four times higher than in rich countries (Bennett *et al.* 2004). There is also growing evidence that antenatal depression is a strong predictor of maternal depression in the postnatal period (Lancaster *et al.* 2010). There is currently no routine screening or treatment for maternal mental disorders in South Africa (Honikman *et al.* 2012) at the primary health level.

A large body of research evidence has implicated maternal depression in disturbances in the early mother–infant relationship and in compromised child development (Patel *et al.* 2011). Key aspects of infant development, such as growth, are compromised in the context of the parental poverty and mental health problems that prevail in LMIC (Walker *et al.* 2011; Grantham-McGregor *et al.* 2007). In LMIC, where circumstances such as overcrowding, food

insecurity and poor sanitation are commonplace, sub-optimal care from the mother may have detrimental effects on the health of her child (Rahman 2005).

Child undernutrition is a major concern in LMIC and maternal depression has been implicated in poor infant and child growth (Rahman *et al.* 2007; Stewart 2007). A number of mechanisms such as poor self-care skills, poor illness detection and poor care-seeking behaviour have been implicated in the link between depression and physical morbidity (Rahman 2005). Inadequate antenatal care has also been shown to be characteristic of depressed women (Pagel *et al.* 1990). Depression in the postpartum period is particularly important in that the emerging processes of self and mutual regulation and social capacities make infants particularly vulnerable to early disruptions to interactions with their caregivers (Murray and Andrews 2000; Tomlinson *et al.* 2005).

Concerns for women's psychological wellbeing extend across the life cycle and cannot be confined to reproductive functioning (Astbury 2001). Risks for adverse mental health outcomes in women and girls include factors such as poverty and socioeconomic disadvantage, exposure to violence, stressful life experiences and inadequate support in addition to the risk factors associated with reproductive health. These factors, separately and together, work to reduce the degree of autonomy, control and decision-making possible for women and girls (Astbury 2001; Kehler 2001; Patel *et al.* 2007). In addition, in LMIC the economic and social realities of poverty and poor governance may be more constraining on individual behaviour than in richer countries (Tomlinson *et al.* 2010).

Women and girls have particular mental health needs that may vary from those of men, with gender playing an important role in defining susceptibility and exposure to various mental health risks, access to resources and treatment (Astbury 2001). Females are also at greater risk of experiencing gender-based violence such as interpersonal violence (IPV) and sexual assault, and the vast majority of partner abuse is perpetrated by men against their female partners (Heise *et al.* 2002). Women in abusive relationships report fear of violence as a barrier to contraceptive use (Heise *et al.* 2002; Williams *et al.* 2008) and are more likely to report negotiation challenges associated with male-controlled contraception (e.g. condoms) than women without such experiences (Heise *et al.* 2002). Access to individual level interventions to improve maternal mental health is essential.

## **Health in South Africa**

South Africa's apartheid history legitimised disparity, the unjust distribution of resources, inferior education and unequal access to health. This had, and continues to have a profound impact on health, the development of health services and the formulation of health policies to redress the disparities. South Africa faces a quadruple burden of disease, concurrently challenged by HIV/AIDS and tuberculosis (TB), high rates of maternal and child morbidity, a growing burden of non-communicable diseases (NCDs), especially mental illness, as well as high rates of injury and violence (Norman *et al.* 2007). Policies to create an enabling environment are essential but can only be realised in the medium to long term. This includes implementation of child-focused legislation, availability of adequate financing and monitoring systems and inter-sectoral coordination across government departments. Currently, there is political will and leadership which is essential to creating an enabling environment. A critical question, however, is the extent to which the actual environment is in a position to deliver on the vision.

In May 2010, the newly appointed Minister of Health, Dr Aaron Motsoaledi, visited Brazil to learn from its Family Health Programme (Paim *et al.* 2011). The current South African primary health care package was drawn up in 2002. Arising out of the visit to Brazil, the Department of Health embarked on a re-engineering of the primary health care package. The aim of the re-engineering process is to bring adequate service provision to those

communities in need and reorganise resource distribution for both health promotion and disease prevention in light of the current human resource crisis.

A central pillar of the re-engineering is the mobilisation of health systems to provide a continuum of care that follows from community to clinic, to district hospital to more specialised services. Unlike the current approach that focuses on curative, individually orientated health care, the re-engineered approach aims to reach out to families and communities through health promotion and prevention activities, and will be implemented by a multidisciplinary team. The aim is a service that is organised both vertically and horizontally.

The second prong of the Department of Health's strategy is the implementation of a system of national health insurance (NHI) that will be phased in over the next 13 years. This framework serves to overcome the unequal distribution of resources between the private and public sector (Mayosi *et al.* 2012). In principle, the re-engineered primary health care system and the NHI scheme have the potential to revitalise and reshape the delivery of equitable health care in South Africa.

## **Philani Maternal, Child Health and Nutrition Project**

The Philani Maternal, Child Health and Nutrition Project was established in 1979 by Dr Ingrid le Roux in the 'informal' settlements on the outskirts of Cape Town as an intervention to prevent malnutrition, rehabilitate underweight children and promote good health. This programme has as one of its core components the idea that communities are best placed to solve their own problems and that community participation in health care decisions (in line with the Alma Ata Declaration of 1978) is essential. Both the home-visiting intervention model and the selection of CHWs have been used to inform the recruitment and intervention strategy of Philani.

During a 4–6 week assessment and training period, mentor mothers are trained in skills relating to HIV/AIDS, maternal mental health, nutrition, basic health, early stimulation and play, knowledge about community resources and services, and information on grants, and referral routes and mechanisms. Following training, successful applicants are employed and conduct approximately six home visits per day, building supportive and trusting relationships and discussing family and parenting-related issues during each 15–60-minute visit. Ongoing supervision and input from coordinators and local clinic nursing staff ensures the programme's success.

In 2008, a cluster randomised controlled trial (RCT) was conducted and had significant benefits for mothers and infants over the first 18 months of life, based on a composite index of wellbeing composed of 32 measures. The benefits were in the areas of children's health and cognitive intelligence, maternal adherence to health care, and HIV prevention strategies (le Roux *et al.* 2013). The findings also provide evidence that while there might be benefits for child development in the context of perinatal depression, the primary preventive nature of community-based platforms such as Philani may not impact on moderate or severe depression.

The CHW system in the province has been characterised by extremely high levels of CHW attrition, with more than two-thirds of provincial CHWs having been employed for a year or less. There is a need for improved working conditions including increased remuneration, ease of mobility for CHWs and addressing the emotional strain that CHWs deal with on a daily basis. Intensive recruitment, ongoing high-quality supervision (individual and group based) and ongoing capacity development through on-the-job training, can also contribute to reducing attrition.

## Conclusion

The finding on depression in the Philani RCT raises important questions regarding generalist versus specialist CHWs. While there may be benefits for the infants and children of women with depression it appears that unless mental illness is directly targeted and treated, the benefits for women's mental health may be marginal (Cooper *et al.* 2009). However, specialist interventions for maternal depression are likely to be too expensive for many LMIC and, therefore, evidence is needed for how specifically targeted interventions for moderate to severe depression can be integrated into primary health care and other delivery platforms. What is needed now and in the post-2015 arena is a more explicit acknowledgement and focus on the tension between urgent action and building slowly. In the face of high HIV burden in South Africa, acting urgently is understandable given that policymakers need rapid demonstrable outputs from their interventions. There is however no quick fix for health systems strengthening, or building effective human resources. The Philani approach epitomises the ability to engage with the tension rather than being seduced into the 'quick technological fix' or the temptation to reduce the quality of recruitment, training and supervision in order to 'extend reach'. The Philani approach is one that focuses on quality (not on volume) and according to one respondent being staffed by enthusiastic, dynamic and motivated people 'is the difference between a good and a bad system'. Women are at the centre of the Philani approach, and Philani's core value (perhaps) is that behaviour change occurs in the context of a supportive relationship.