

Integrating Mental Health Services Into Perinatal Care: Challenges and Opportunities

Garumma T Feyissa ¹, Enrique R Pouget ¹, Sena B Kitila ², Yonas Biratu Terfa ², Tracy Wong ¹

¹Department of Health and Nutrition Sciences, Brooklyn College, City University of New York, Brooklyn, NY, 11210, USA; ²School of Nursing, Institute of Health, Jimma University, Jimma, Ethiopia

Correspondence: Garumma T Feyissa, Department of Health and Nutrition Sciences, Brooklyn College, City University of New York, Brooklyn, New York, 11210, USA, Email garumma.feyissa@brooklyn.cuny.edu

Introduction: In most low-income countries, including Ethiopia, mental healthcare has not been fully integrated into perinatal services. As a prerequisite for the integration, this project aimed to understand the facilitators and barriers to integrating mental health services into perinatal care.

Methods: This exploratory qualitative research used in-depth interviews with 25 purposely selected participants representing diverse stakeholders (perinatal women, health service coordinators and providers, and community health workers and community volunteers). The transcribed interviews were coded and analyzed using Atlas ti Software.

Results: The study found the following major impediments to providing and receiving perinatal mental health services: a) the lack of sense of ownership and accountability, b) constraints related to institutional resources and infrastructure; c) inequitable access to healthcare; d) the absence of supportive policy framework with focus on perinatal mental health; e) cultural beliefs and community perceptions; f) limited support from stakeholders; g) limited practice of compassionate and respectful care; and h) poor service planning and coordination. The opportunities for the integration of mental healthcare into perinatal services are a) the presence of maternal and child health (MCH) and mental health professionals, b) a conducive structure linking hospitals to the community and c) a convenient institutional infrastructure, d) higher level government support. Strategies suggested for the integration are awareness creation, capacity building, development of guidelines and checklists, and stakeholder engagement.

Conclusion: The current Ethiopian primary healthcare system offers a conducive structure for the integration of mental healthcare into perinatal services. The existing bottlenecks against the service integration can be tackled by training health professionals, community sensitization, and advocacy and generating evidence that leads to the development of evidence-based implementation tools and health service delivery models tailored to local needs. The strategies outlined in this study may be used to design perinatal mental health services at multiple levels.

Plain Language Summary:

Why was this study conducted?

- This study explored barriers and facilitators to integrate mental health into maternal and child health services.

What did this study find?

- The absence of providers trained on perinatal mental health, absence of implementation tools, and limited focus on perinatal mental health deter the integration of mental health into MCH services.
- Cultural perceptions also deter seeking service for mental health problems during perinatal period.
- The existing primary healthcare structure of Ethiopia offers a favorable condition to integrate mental health into maternal and child health services.

What do these results mean?

- The integration of mental health into MCH services requires community sensitization, engagement of stakeholders and training of providers at different levels. The service integration also requires the development of implementation guidelines and tools.
- The strategies outlined in this study might be used to design perinatal mental health services at multiple levels with the Ethiopian Healthcare System.

Keywords: mental health, perinatal mental health, Ethiopia, service integration, maternal and child health

Introduction

In sub-Saharan African countries including Ethiopia, mental health disorders and substance use during the perinatal period are critical public health concerns; for instance, in Ethiopia more than one-fifth of women encounter postpartum depression.^{1,2} and more than one fourth of women develop depression during the perinatal period.^{3,4} While there are variations in the prevalence of perinatal depression across study sites, unplanned pregnancy, age between 15 and 24 years, marital problems, experiencing infant death, low social support, and history of substance use are associated with higher odds of perinatal depression.⁵ Perinatal depression, in turn, is associated with a higher risk of preterm birth, low birth weight, and other adverse birth outcomes.^{6,7}

In Ethiopia, traditional misconceptions about mental health problems and the experiences of stigma related to the diagnosis of mental health disorders during the perinatal period negatively affect both health seeking behavior and the quality and accessibility of perinatal mental health services.⁸ It is also not uncommon to attribute perinatal illnesses to supernatural causes and seek non-medical healthcare instead of getting modern medical care.^{9,10}

Furthermore, factors such as limited access to integrated service, low literacy, low health seeking behavior and stigmatizing attitudes in the community exacerbate the negative impact of perinatal mental health problems in Ethiopia.¹¹ According to the current model of primary healthcare, there is no routine assessment and management for perinatal depression in the Maternal and Child Healthcare (MCH) clinics of Ethiopia. Perinatal mental health services, such as screening for perinatal depression, are not integrated into the primary health care system as part of the perinatal services creating confusion both among providers and service recipients when services are indicated.^{12,13}

In our earlier project, we assessed compliance with antenatal psychosocial assessment, which involves identification of pregnant women with higher risk for perinatal depression. Our baseline assessment found a zero level of compliance with the recommended practice to psychosocial assessment during antenatal period. In our project, we found that none of the maternal healthcare providers were trained in women-centered communication skills and psychosocial assessment. Some of the minimally recommended practices include asking history of mental health illness, and screening perinatal depression.¹⁴ However, through intervention, we found a promising result showing higher level of compliance with evidence-based antenatal psychosocial assessment.¹⁴ Through this work, we have learnt that the implementation of perinatal mental health assessment is feasible. It also underscores the importance of generating further evidence on the assessment of factors related to the integration of mental health services into perinatal care.

The World Health Organization recommends that perinatal mental health services should be integrated into maternal and child health services.¹⁵ The integration of perinatal mental health services into maternal and child health services will contribute to increased health seeking behavior and will improve the primary healthcare system's proactive practices for early case detection and management of mental health problems during perinatal period. This will, in turn, reduce adverse outcomes associated with perinatal depression^{6,7} and will potentially improve breast feeding practices¹⁶ and child growth outcomes.¹⁷

Perinatal mental health services require the expertise of at least two disciplines: maternal health professionals and mental health professionals. In addition, mental health services and perinatal services are often delivered in two or more separate units and hence it requires either the colocation of specialist professionals¹⁸ or task sharing among professional¹⁹ or both. While there are clear practical guidelines for the management of perinatal mental health conditions in developed countries,^{20,21} there is no clear guideline in most sub-Saharan African countries, including Ethiopia. Globally, different models have been used to integrate mental health into perinatal care. Some of these models include intensive hospital day programs, community and outpatient clinics, collaborative care frameworks and stepped-care model.²² The collaborative care model includes screening for perinatal mental health illness at primary care setting followed by linkage to perinatal mental health specialists, as needed. In the stepped care model, mild perinatal mental health illnesses are managed using psychosocial and community-based interventions; moderately severe cases are managed by psychotherapy and pharmacotherapy; and severe forms of perinatal mental illnesses are managed by

specialized psychiatric interventions.¹⁸ Stepped care approach has been found to be feasible in some sub-Saharan African countries, such as South Africa.²³

However, there is no single model which is ideal for all contexts. Within each model, different implementation approaches may be adapted to suit local circumstances. Before choosing, adopting or adapting a specific model of integration, it is essential to generate in-depth information on contextual factors influencing the success of the integration. Even once a specific model of care is chosen, in-depth information on facilitators and barriers is needed to design tailored strategies for integration. Such evidence is generally scarce in Ethiopia, especially at the study context. While there are no such studies in the study context, and in Oromia Regional State of Ethiopia, existing studies from other regional states did not explore factors related to the overall integration of mental health into perinatal care. For example, a study conducted in Northern Ethiopia¹² explored barriers related to a specific topic (perinatal depression). The study found barriers such as health administrator's low literacy, lack of community awareness and lack of government capacity of as barriers to the treatment of perinatal depression. Another study from South Central Ethiopia,²⁴ found that women and health care providers link depression during pregnancy with social adversities. On the other hand, in-depth information on barriers, opportunities and strategies for the integration of mental health into perinatal care is still lacking. To address this gap, this project sought to explore barriers and facilitators related to the integration of mental health services into perinatal care from the perspective of diverse stakeholders. Such depth information will play a pivotal role in clarifying direction towards successful integration of mental health into perinatal care.

Methods and Materials

Study Design and Setting

This exploratory qualitative research followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guideline while preparing the report.²⁵ We conducted the exploratory qualitative research in four health facilities in Jimma Zone, Ethiopia. Jimma, the capital of Jimma Zone is located at 220.2 miles distance from the capital city of Ethiopia, Addis Ababa. The Ethiopian Healthcare system has three tier system: primary level healthcare, the secondary level healthcare and the tertiary level healthcare. At the bottom of the tier system is the primary level healthcare (primary healthcare unit) which is composed of health posts, health centers, and a primary hospital. The secondary healthcare is composed of general hospitals and the tertiary level care is composed of specialized hospitals.^{26,27} Specialized hospitals have mental healthcare units provided by mental specialists. Primary healthcare units are still on the process of introducing mental health services. Recently, as part of the national effort to introduce mental health at primary healthcare level,²⁸ health professionals were trained on mental health gap action program (mhGAP).

The study site (Jimma Zone) has 21 districts and two town administrations (Jimma City and Agaro town). The zone has one tertiary hospital, three general hospitals and five primary hospitals, 122 health centers, and 512 health posts. In Jimma Zone, health posts, health centers and primary hospitals provide antenatal care. Mental health service has not yet been integrated into maternal and child healthcare. The psychiatry clinic of the Jimma Medical Center has been the only psychiatry clinic in the southwest part of the country providing comprehensive mental health services including admission services.

Participant Selection

This project conducted face-to-face interviews with twenty-five participants. Participants were selected purposely based on their potential to provide rich information on the topic. In order to represent diverse opinions, we approached health workers, health service coordinators and managers, community health volunteers and women who have given birth in the last 12 months. We recruited perinatal women from four health facilities, namely, Higher-One Health Center, Shenen Gibe General Hospital, Jimma Medical Center, and Seka Primary Hospital. From the same health facilities and catchment areas of the facilities, we interviewed health professionals, health service coordinators and community health workers. In addition, we interviewed focal personnel from the Jimma Zonal Health Department and Jimma Town Health Office. The data collection was stopped after meaning saturation was reached. A total of twenty-five interviews were conducted. [Table 1](#) shows the details of the participant characteristics.

Table 1 Summary of Characteristics of Participants, Jimma, Ethiopia

Characteristics of Participants		Number (%)
Age in years	Mean (SD): 30.36 (4.34), Range=25 to 42 years	
Sex	Female	14(56)
	Male	11(44)
Educational level	No formal education	1(4)
	Primary School (1–8 grade)	2(8)
	Secondary school (9–12 Grade)	2(8)
	Diploma	3(12)
	BSc	10(40)
	MSc/Specialty	7(28)
Profession	Public health	2(8)
	Nurses	5(20)
	Midwives	3(12)
	Mental health	4(16)
	IESO	1(4)
	Obstetrics and gynecologist	2(8)
	Health extension worker (HEW)	2(8)
	Voluntary health worker	2(8)
Work experience (in years for health care providers), mean (SD):9.5(3) years, Range: 4 to 17 years		
Position/role of the participant	Head of the department	2(8)
	Vice head of health center	1(4)
	MCH Coordinator /focal	5(20)
	MCH service providers	3(12)
	Mental health service provider	3(12)
	Quality officer	1(4)
	Planning and monitoring	1(4)
	HEWcoordinator	1(4)
	HEW	2(8)
	Voluntary health worker	2(8)
	Clients / MCH service recipients	4(16)
	Total	25

Abbreviations: IESO, Integrated emergency surgical and obstetrics and gynecology; MCH, Maternal and Child Health; HEW, Health Extension Worker.

Data Collection Tools

The interview guide for in-depth interviews of women captured challenges related to seeking and accessing mental health services, and the community's perception and reaction to the encounter of women with mental illness during the perinatal

period. The in-depth interview guide for the interviews of health workers constituted their encounters with any perinatal population with mental illnesses and substance use, how the healthcare system handles the case, the referral system in place, and what challenges health workers from each unit (especially the Psychiatry and MCH units) face in managing mental health problems during the perinatal period. The research also explored the perspectives of focal persons at the zonal health department to understand their perspectives about integrating mental health services into other maternal and child health services.

The interview guide was translated into the local language (Afaan Oromoo) and back translated it into English by another researcher to confirm semantic equivalence. We pilot tested the interviews in another health facility (Dedo General Hospital). We used the results from the pilot test to refine the interview guides.

Data Collection and Analysis

The principal investigator (the first author) provided refresher training for the field research team on data collection, transcription and analysis. Two of the authors (the third and the fourth author) collected data. The data collectors had a minimum of master's degree and had experience and advanced training in qualitative research methods on maternal healthcare. Both researchers are fluent in English and the local language (Afaan Oromoo), and they are full time faculty at Jimma University, and they are known by the participants as researchers and faculty at the university. The researchers introduced the purpose and procedures of the study to the participants and obtained oral consents before starting the interviews. The interviews were conducted at private office spaces and took a duration of time ranging from 19 minutes to one hour. The researchers digitally recorded the interviews. In addition, the researchers took notes during the interviews.

The interviews were transcribed verbatim and coded using Atlas ti Software. The research team conducted data collection and analysis simultaneously. The research team conducted weekly peer debriefing sessions. The principal investigator moderated these debriefing sessions. During these sessions, the codes independently created by the two researchers were compared and the team members, including the two coders, discussed emerging codes and themes. All coding discrepancies and disagreements were addressed during these discussions. Based on the discussions of emerging patterns of data, the research team would design plans to further understand the meanings of each emerging data pattern by using additional probes in the subsequent interviews.

In the first round of interviews (the first eight interviews), the project used open coding. Similar codes were grouped into categories and the subsequent data were assembled under these codes and categories (subthemes). Then, a second and third round of coding were conducted, during which a thematic method of coding was used. During the second and third round, in addition to assembling data under the themes already identified, the research team also explored if new aspects or meanings of the codes and themes would appear from the subsequent interviews. The data collection was stopped when the research team unanimously agreed that the data collected has adequately explained the codes and that no new meanings or dimensions of the codes are emerging (after meaning saturation was reached).²⁹ Finally, we turned the themes, subthemes and child themes into final report.

Results

In total, the research included a total of twenty-five participants of whom 14 (56%) were females. The mean age of study participants is 30.36 (± 4.34). The participants included service recipients, service coordinators, healthcare managers, and health service providers and community health workers, including community health volunteers (Table 1).

Study Findings

The findings are structured under three major themes that are further categorized into subthemes and child themes (Table 2).

The Status of Perinatal Mental Health Services

The availability of available perinatal mental health services varies by health facility. According to the study participants, the main perinatal mental health services offered at the study sites that are staffed by mental healthcare professionals are

Table 2 Major Findings

Parent Themes	Subthemes	Child Themes
The status of perinatal mental health (PMH) services	Suboptimal or absent PMH services	Absence of formal screening and management of perinatal mental health problems at MCH clinics
		Unsatisfactory mental health promotion and illness prevention activities
		Limited continuity of care
		Absence of inpatient service
		Poor coordination and referral
Barriers to seek or provide perinatal mental health services:	Lack of sense of ownership and accountability	Lack of sense of ownership among the management
		Lack of accountability among MCH professionals to provide care for patients with mental health disorders
	Barriers related to institutional resources and infrastructure	Absence conducive rooms
		Absence of implementation tools
		Absence of staff trained to provide PMH services
		Absence of formal structure that facilitates discussion of perinatal mental health illnesses
	Inequitable access to healthcare	Poverty
		Transportation related barriers
		Difficulty to afford medications
	Absence of supportive policy framework	Absence of training curriculum on PMH
		Absence of training arrangement for health professionals including community health workers on PMH
		Absence of formal structure for screening, management, referral and communication
	Cultural beliefs and community perceptions	Women confined to home during perinatal period
		Perceived causes of mental health problems affecting health seeking behavior
		Lower perception of harm caused by substances
		Stigma and discrimination
	Limited stakeholder support	Limited support from NGOs
	"I did not come here for enjoyment": Limited practice of compassionate and respectful care	Disrespecting service recipients
	Poor service planning and coordination	Poor referrals
		Poor coordination
		Absence of coordinating structure for PMH services

(Continued)

Table 2 (Continued).

Parent Themes	Subthemes	Child Themes
Strategies and opportunities for integration	Opportunities for integration	The presence of MCH health professionals and psychiatry nurses
		A convenient structure linking hospitals to the community
		A conducive infrastructure
		Higher level government support
	Strategies for integration	Awareness creation, capacity building and optimizing resources.
		Development of guidelines and checklists
		Integrated care
		Leadership and stakeholder engagement
	Integration steps	Evidence generation
		Development of tailored intervention and deliverable plan
		Establishing goals and ownership of the program
		Implement home visitation as part of perinatal mental health service.
		Creating strong collaboration and stakeholder engagement.

Abbreviations: PMH, Perinatal mental health; MCH, Maternal and child health services; NGOs, Non-governmental organizations.

awareness creation activities, need-based counseling and advice and referral. In addition, participants mentioned activities such as reaching out to clients and families who cannot visit health facilities to collect their medications. Nevertheless, some participants acknowledged the absence of services, preventive and promotive services related to perinatal mental health problems. They acknowledged that screening is either absent or not based on standard checklists and formats. None of the study participants reported specific tools being used to screen for perinatal mental health problems.

The maternal and child healthcare (MCH) providers do not provide any mental health related services directly; instead, they consult mental health professionals or refer the patients to the psychiatry department or other locations where mental health services are available. In addition, the specific mental health services reported to be available are simple counseling services related to planning for procedures and not related to the screening or management of perinatal mental health disorders. A mental health expert relates,

For clients visiting our unit, we provide all the necessary services. When women come alone, I often advise them to bring their husbands for the next visit. We also educate husbands about the predisposing factors and how they can support their partners. Although we do not have a formal written referral system, we keep a referral linkage. If healthcare providers encounter mothers with mental health problems, they consult us, and we offer them psychotherapy. In more serious cases, we may prescribe a low dose of medication and continue with the follow-up care. However, we lack proactive screening systems. We believe that healing is in God's hands, and fortunately, many mothers experience significant improvement.

Mental health topics are included as part of general health education at waiting areas of outpatient departments even though they are not as frequent as desired. Nevertheless, primary healthcare facilities are missing opportunities to identify and manage cases of perinatal mental health problems because not only MCH providers but also mental health professionals working at primary healthcare facilities do not conduct these proactive screening activities. Instead, the

mental health professionals at primary care facilities respond to requests for consultation on cases of perinatal mental health problems. In addition, participants have exposed that there are gaps in the practice of tracking the status of the patients affecting the continuity of care.

From the perspective of service recipients, there is a common understanding that mental health services are confined to the limited few health facilities that have mental health specialty units. A service recipient relates,

On the other hand, I think it would be nice if the government, on their part, decentralize this service to the level of local health centers and hospitals, because there are very few mental hospitals in Ethiopia. I know they are Jimma University Medical Center and Amanuel Hospital. It is very difficult for people from remote rural areas to come from there and be treated in cities like Jimma and Addis Ababa; they cannot even afford it economically, and you cannot take public transport for someone with mental illness. Therefore, you cannot afford to take a car in contract form and travel long distances. Therefore, such things prevent people from getting adequate medical treatment, but if there is a mental clinic nearby, people can use it easily.

Barriers to Seek or Provide Perinatal Mental Health Services

According to the participants, the main barriers to provide or seek perinatal mental health services are a) the absence of sense of ownership and accountability for the service, b) resource constraints and the absence of convenient infrastructure, c) inequitable access to care, d) absence of a supportive policy framework focused on perinatal mental health, e) cultural beliefs and community perceptions, f) limited stakeholder support, g) lack of compassionate and respectful care, and h) weak referral and communication system.

Lack of Sense of Ownership and Accountability

Study participants reported that because of the limited training and awareness, the top management has a limited sense of ownership for mental health services. Study participants described their concerns about limited sense of ownership not only among health facility management, but also management at district and zonal levels. In addition, the lack of responsibility for patients with mental health problems and the limited readiness for task sharing among other health professionals resulted in overburdening the existing few mental health professionals. A mental health expert relates,

There is also lack of awareness and concern about this department (Mental health) from top leadership. For instance, there is no training related to mental health. I am not referring to the personal benefits I would gain from the training if there was any training but referring to the effect of the training on service provision. As I mentioned earlier, I am working as a service provider, care coordinator, focal person, and head of the unit. What I want to share is that, sometimes when I go to the OPD, our care providers say, “This is your patient”, but the patient is not only mine, but common to all of us. If I am here, I will try my best; otherwise, it will continue like this.

The lack of institutional support affects overall mental health care. Institutional support may be in the form of resource allocation, planning, and service delivery. Study participants blamed leadership for not arranging a favorable system for tracking patients. They recommended that the top leadership should give priority for mental health. A mental health expert says,

When the MCH unit healthcare providers identify mothers with mental health problems, such as postpartum blues, depression, or psychosis, they consult me and if women visit our unit (Psychiatry unit), I provide counseling, health education, and treatment based on their status; otherwise, I do not do that. We do not have opportunities for follow-up; we only learn about their status from their families. Sorry, I will take you back to the point that if there were more attention from leadership, it would be helpful for us ... we can consider how to reach this people and bring them to the health facility.

Institutional Resource and Infrastructure Constraints

Institutional resource and infrastructure constraints were mentioned as barriers to the provision of perinatal mental health services. The resource constraints listed by study participants are a) the shortage of trained staff, b) the absence of convenient infrastructure and c) the shortage of guidelines, supplies, and medications.

The shortage of MCH healthcare providers trained on mental healthcare is an issue even in the primary care settings. An MCH focal person relates, “Certainly, there is a staffing shortage, no midwife was trained on mental health service provision, but there is an independent psychiatry OPD”. The same challenge (lack of training) is common at the community level. While community health workers are potential resources for identifying and managing perinatal mental health problems, the lack of training and incentives hinders them from providing the necessary services.

Another factor outlined as an obstacle to providing perinatal mental health service was the inadequacy of infrastructure at facility level, specifically the absence of a separate mental health unit and absence of any rehabilitation center nearby. A health facility manager relates, “From my experience, and as an expert who has worked for a longer time in MCH clinic, the reasons for the absence of perinatal mental health services is related to the lack of a dedicated unit at our facility and the lack of trained human power.”

The absence of formally recognized structure of information exchange were also identified as obstacles to providing perinatal mental health service. A participant relates,

There is no formal structure to discuss the patients’ cases even if cases need teamwork. ..., there are no systems to rehabilitate mothers with substance use disorders who are addicted. There is no rehabilitation center that gives deep counseling for addicted clients. The good thing is that there are no potent substances rather than the less potent substances like khat in this area. The possibility of screening and sending them to the mental health department is low.

Another gap reported by the participants is the absence of guidelines, checklists and protocols for the screening and management of perinatal mental health problems. During the data collection, none of the health institutions had any checklist, guideline or protocol for screening and management of perinatal mental health problems. An MCH focal person relates,

Counseling services are available, but the absence of guidelines and screening tools poses a significant challenge. Although a comprehensive assessment may not always be possible, having these resources would facilitate effective counseling and service delivery. Their absence hinders our ability to provide adequate support. ...that is right, even though we advise them not to chew, some patients are seen chewing khat even while they are in this facility. Sometimes, we see this while they are with us, for instance when they come back with laboratory results. In that situation, we would repeat it repeatedly until they grasp it. Particularly, in the Jimma area, khat is acceptable or seen as even food.

Inequitable Access to Healthcare

Study participants cited socioeconomic inequities as factors deterring accessibility to perinatal mental health services. These disparities are related to the lack of medications and limited affordability related to poverty and the limitations of access to transportation. A Voluntary Health Worker relates,

However, the challenge we face is the lack of available medication for mental health issues. Even when the medication is available, it is often unaffordable for them. We have taken two or three people for treatment, but the availability of medication is still a significant challenge. I believe that improving the arrangements for them would lead to better outcomes after they receive treatment.

Absence of Supportive Policy Framework, Formal Structure, and Relevant Experiences

Study participants described their concerns related to inadequacy of the attention given to perinatal mental health services. According to the participants, one example showing that perinatal mental health has been overlooked is the absence of perinatal mental health components from the training of MCH professionals. The absence of a supportive policy environment and relevant experiences is also a challenge for the integration of mental healthcare into perinatal services. An MCH coordinator relates,

Yeah, the HEWs [Health Extension Workers] refer (send) too many clients to health facilities, including mothers with mental health issues. However, the screening and referral of mental health cases by HEWs are not supported by policy and programs. For example, we have policies to educate about family planning, but we lack organized structures to screen, refer, and teach about mental health.

Mental health is part of the noncommunicable diseases package of the health extension program. However, health extension workers are not provided with adequate training on the implementation of mental health services. A health extension worker says,

Currently, there are no established systems specifically for mental health, as it is often included under chronic diseases. The decision to refer them to a hospital or health center is based on individual circumstances.

Even though some participants recommended drawing lessons from the integration of mental health into the antiretroviral therapy (ART) clinic, some participants described their concerns about their readiness to integrate mental health into perinatal care, especially mentioning that they do not have any experience of implementing similar programs.

Cultural Beliefs and Community Perceptions

Many people associate mental health problems with curses from a creator or demonic attack and hence the experience of mental health problems often results in actual or perceived stigmatization. In addition, the community thinks that a mother who goes outdoors (even to health facilities) shortly after giving birth may be vulnerable to an attack by supernatural bodies. Therefore, they often avoid seeking healthcare from modern healthcare facilities and hence seek care from traditional or religious sources. A mental health professional relates,

There are different barriers to seeking mental healthcare during pregnancy and post-natal period among which cultural beliefs are the primary reasons. Among the different hindering factors are misconceptions, the lack of awareness about mental health, and not considering mental health problems as a medical problem and labeling of the mental health issues as demon-related activities. For instance, sometimes clients refuse medical treatment and go for home remedies, believing that mental health problems are related to demons, which they refer it as ‘Jinniitu tuqe.’ [literally translated as demon attacked the person]. They often turn to traditional medicines. Sometimes letting them go and allowing them to learn from the complications of their problems is good, I mean, when they are not ready to accept your advice and prefer to go, let them go; they will learn from their complications.

Interestingly, since the care given at health facilities is not satisfactory, clients seek religious treatment even after visiting health facilities. A service recipient further described the religious practices related to mental health.

As far as I know, if a mother is sick with a mental illness or something else, they say take her to the pharmacy [Health facility]. But once you take her to the health facility, if it doesn’t change, you take her to the church. For example, they take them to the Holy Water (it’s called Tsebela in the local language), the Protestants take them to the church and pray for them, and so do the Muslims according to their religion. I once went to a holy water place (Tsebela) and saw a woman who was mentally ill after giving birth. So, I think for my part that both medical and religious treatment is important.

Related to the perceived causes of mental health problems, the clients often face stigma. The fear of stigma and discrimination affects their health seeking behavior. An MCH focal person relates:

I raised this issue earlier: people do not seek these services due to the community’s perception of mental health problems. If they come for help, they often feel stigmatized. However, very rarely, they seek consultation. For instance, last week, a woman with six children came directly to the mental health unit to consult me about her concerns. In addition, seeking care for problems related to substance use is not common.

When it comes to substances such as khat use, deep-rooted social beliefs and practices affect the community member’s response to advice related to the use of these substances. This is especially an issue for substances, such as khat that are socially acceptable in communities such as Jimma. Even though addictive substances such as khat are socially acceptable for the general population, substance misuse and addiction during pregnancy is not socially acceptable, making it difficult for those women who are victims of substance misuse to seek support as they become pregnant because of the fear of social disapproval. A service recipient relates,

Most people find it offensive when a pregnant woman drinks alcohol, particularly because pregnancy can lead to high blood pressure, and alcohol can worsen this condition. Despite society’s disapproval, individuals struggling with addiction often do

not stop using substances during pregnancy. Instead, they continue to engage in behaviors that are visibly problematic, such as drinking and using substances.

Limited Stakeholder Support

Another challenge related to maternal mental health is the lack of adequate support from stakeholders. While general maternal health is supported by nongovernmental and governmental organizations, there is limited attention given to perinatal mental health. A mental health professional relates, “While there are many stakeholders working on MCH, there are only a few that focus on mental health. Recently, some training initiatives were launched to address issues related to displaced people and post-conflict mental health problems, to provide training for these people.”

“I Did Not Come Here for Enjoyment”: Limited Practice of Compassionate and Respectful Care

Service recipients shared their experiences as a perinatal client. They criticized healthcare workers for their failure to provide compassionate and respectful care. This problem usually worsens as it intersects with already existing socio-economic disparities. A maternal healthcare recipient describes her own experience,

I gave birth here; nothing happened to me. But excuse me, do I want to talk about what happens in this compound? No one can get proper treatment without the power and money. Sorry, but I'm so sorry. Because I have nothing for myself, and I have no one to help me. So, they [health professionals working at the facility] do not understand you. I had no money, no one to help me, but they did not understand that. They even treat you like a dog. However, I went through it not because of their support but according to God's will, and now everything is over. They tell me to go and buy medicine and do this, and I tell them that I have no one else, and they tell me to do this repeatedly. Thanks to God, but I went through it according to God's will, not based on their support... Yes, they discredit you, thus they do not serve anyone properly. However, it was not supposed to be anything like that. I did not come here for enjoyment, but because I was in a tricky situation. It is so difficult to discuss how they make you look bad. I assume there will not be any nurses today because of a weekend getaway. It is so difficult to discuss how they make you look bad. They treat you differently, which should not have happened. Since it is their job, I believe they ought to do it correctly.

Poor Service Planning and Coordination

Study participants mentioned the absence of well-coordinated and well-planned services and referral for perinatal mental health problems as obstacles to providing perinatal mental health services. Mental health services are not currently recognized as part of perinatal services and there is no coordinating structure for perinatal mental health services. Hence, for a mother to be assessed, or treated for mental health problems, the MCH units work with psychiatry units of the same facility or another facility. However, there is a problem with the coordination of these referrals. When it comes to the referral and linkage of perinatal mental health cases, usually multiple layers of communication and referrals are involved. The MCH care providers first consult the obstetrics and gynecology specialists within the same facility or from another facility, who will in turn consult mental health specialists.

Acknowledging the absence of both in-patient services and well-organized referral system for perinatal mental health problems, study participants emphasized the need for the establishment of a strong linkage system and the opportunity to use the current mentoring and feedback system that is already in place within general MCH services. In fact, there is potential for the coordination of the services and improving the linkage to the grassroots community level as there is currently such coordination amongst health extension workers, health center and primary hospitals for general MCH services. This general MCH service coordination may be modified to incorporate perinatal mental healthcare.

Even though mental health specialists state that they often receive referrals of non-perinatal mental health cases, they reported that referrals of cases of mental health problems from MCH clinics are not as expected. This is partly because of the misdiagnosis and the lack of guidelines and checklist for perinatal mental health problems at primary healthcare settings. However, referrals are crucial because limiting perinatal services to cases that come by self-referral will reduce the accessibility of the services to the needy clients.

The absence of a proper follow-up system is also an obstacle to the continuity and success of perinatal mental health care. The study participants believe that the integration of mental health into perinatal care by training MCH providers and having a dedicated room for the provision of perinatal mental health services will minimize this problem. An MCH focal person relates,

Providers may refer patients if their needs exceed their scope of practice; otherwise, they treat and discharge them. A key weakness is the lack of follow-up for those who miss appointments, especially given high service volumes. This should be addressed by integrating mental health assessments into regular services, ensuring all professionals recognize potential issues. Establishing a dedicated counseling room and providing targeted training for MCH staff would enhance care. Additionally, identifying mothers at risk for postpartum psychosis is crucial, as factors like recent loss or health issues can significantly affect their mental well-being.

Opportunities and Strategies for Integration

Opportunities for Integration

Some of the factors mentioned as opportunities for the integration of mental health into perinatal care are a) the presence of MCH health professionals and psychiatry nurses in some facilities), b) convenient structure linking hospitals to the community (such as the presence of mental health and MCH units and the presence of integration between primary hospitals, health centers, health posts and community health workers) and c) a conducive infrastructure (such as the presence of dedicated rooms in at least some facilities), and d) higher level government support.

Study participants mentioned the presence of integrated primary healthcare service structure that links hospitals to health centers and grassroot community structure as an opportunity to integrate mental health services into perinatal care. An MCH coordinator relates,

As an opportunity, we have set up systems which integrate primary health care with hospitals. So, if we want to incorporate this service [maternal mental health], it is easy to integrate these services into other services, it does not need to set up a new system. So, it may seem difficult to start, but we must have strategy and approaches to work on awareness creation in the community. To do this, we have stakeholders like Health Developmental Armies (HDA) and voluntary health workers in the community.

Another favorable situation for the integration is the presence of a system that encourages multidisciplinary and collaborative work among health professionals which is supported by the Ministry of Health. One such initiative is system bottleneck focused reform (SBFR). A participant relates,

If they are resolute enough, senior staff is facilitating this coordination activity. Last time, a new system called system bottleneck focused reform (SBFR) was initiated, which encourages a multidisciplinary approach and assigns responsible senior healthcare professionals at different units for consultation. The schedule is prepared for the senior staff, and care providers who will be consulted to manage the cases. In addition to this, there is also involvement of multidisciplinary staff during case discussions.

Another opportunity for the integration is the existence of a community-based structure composed of health extension workers and community volunteers. Health extension workers and voluntary health workers (VHWs) play a critical role in bridging between the community and the primary healthcare system. Health extension workers oversee community health at a grassroots level. Even though they are not paid for their services, voluntary health workers play substantial roles in delivering services at the community level by supporting health extension workers. VHWs are selected in part because of the extent to which the community trusts them; hence their services may potentially be impactful at community level as they can mobilize the community to use perinatal health services.

Study participants reported that voluntary health workers are potential untapped resources for screening and identification of individuals with different health problems. They may refer individuals with mental health problems to HEWs contributing towards improved accessibility to health services. Another role of VHWs is creating awareness through health education. Even though voluntary health workers work on broad health issues, they often encounter individuals with mental health problems and supporting them is one of their roles.

Strategies for Integration

The following methods were suggested as strategies for the integration of mental health services into perinatal care: a) awareness creation, capacity building and optimizing resources; b) development of guidelines and checklists; c) integrated care; and d) leadership and stakeholder engagement.

Awareness Creation, Capacity Building and Optimizing Resources

Participants highlighted the importance of investing in human capital through targeted training and awareness creation. They argued that without such efforts, healthcare providers may mistakenly believe that their current practices are adequate. To achieve this integration, they suggested training MCH providers, bringing the mental health department closer to MCH, and improving and formalizing referral linkage. However, they cautioned against placing mental health specialists within MCH units or vice versa. They explained that professionals from these fields often have distinct service delivery approaches, and placing mental health professionals in MCH clinics may not be effective. For other participants, in addition to training manpower, having dedicated rooms, materials and equipment and having strong referral linkages, and service utilization was emphasized as prerequisites for the mental health service provision.

Participants stressed the importance of awareness creation for the community, service coordinators and providers, especially to reduce misconceptions and stigma associated with mental health problems as these have effects on health seeking behavior. In addition, study participants recommended a prevention-focused education to reduce engagement in harmful activities. A mental healthcare expert relates,

Sometimes, our care providers and the community often share the same misconceptions about mental health. I prefer not to label individuals as ‘insane’ or ‘crazy,’ as these terms perpetuate stigma, even affecting the mental health department itself. In our local language, using the term ‘MARAATAA’ [translated as insane] to describe someone with mental health issues implies they are irrational, which deters people from seeking help. I believe that addressing these misconceptions will enhance mental health service use. Creating awareness among care providers is typically easier than implementing other health initiatives, as it requires less material but demands time and patience.

A service recipient emphasized the role of awareness creation activity to prioritize health facilities as a prioritized source of support.

In my opinion, if awareness-raising activities are conducted at the community level, this problem will be solved because the community would not take a person suffering from mental illness and substance use addiction to church or traditional medicine if they get enough awareness. Even if it was taken to church, priority should have been given to the hospital, so I think it would be nice to raise awareness of the community.

Development of Guidelines, Checklists, and Implementation Tools

Another action point suggested by the participants was creating an integrated unit with standard guidelines, screening, and implementation tools. An MCH focal person relates,

I believe it would be highly beneficial for all of us to receive mental health training. This would enable us to offer mothers the appropriate counseling and support they need. However, in my opinion, the integration would not be enhanced solely by training and having qualified health professionals. Instead, an integrated unit, standard guidelines, and screening tools could significantly improve maternal health services in this area.

Integrated Care

Acknowledging the absence of a structured governance system for perinatal mental health services, participants described the potential of stepped care model for the management of perinatal mental health problems. They emphasized the importance of building the capacity of MCH healthcare providers to identify and manage mild to moderate cases of mental health problems. An MCH Healthcare Provider relates,

Once the professional is trained and the unit is aware of this, the unit takes the ownership of the service and refers complicated cases to the mental health department. For that reason, if the professional in MCH unit is knowledgeable, they can provide the

initial care or treatment for the mental illness and the various addictions. After giving the initial care, if the management of the case is beyond their capacity, they will transfer it to the mental health department. Therefore, we need to capacitate the professionals working in MCH unit. If medications are available in the unit, the patient can receive them along with counselling. Thus, the patient will get the necessary follow-up services for mental illness and those who do not require follow-up will receive advice or counselling. Those needing medications will be provided with medications, and those requiring further treatment will be referred to the mental health department. Therefore, I think this arrangement might be suitable for the future.

In addition to suggesting the importance of training for MCH care providers, participants also suggested the importance of a dedicated room for screening and management of perinatal mental health problems. A healthcare provider relates, “When the client comes, I think it would be preferable to have a room for mental health screening alongside the pregnancy follow-up. It is of paramount importance to provide either counselling or medication to a mother, as needed.”

Leadership and Stakeholder Engagement

Study participants emphasized the involvement of internal and external stakeholders as one of the strategies to integrate mental health into perinatal care. Some of the stakeholders listed by the participants are MCH and mental health professionals, community leaders, community health workers and governmental and non-governmental organizations and business and faith-based organizations. Additionally, the active participation of leaders and policymakers was emphasized especially for optimizing resources required to provide perinatal mental health service. Study participants highlighted the limited attention given by the leadership to mental health services. Some of these gaps which the participants thought could be managed by the leadership are having a dedicated room for mental health provision which is located at a reasonable distance (not too far) from other units including MCH units. In addition, participants recommended a standard room for mental health examinations. A mental healthcare expert relates,

We often say that there is no health without mental health, but this issue requires policy attention. For instance, if policymakers accept and integrate mental health into MCH services like they have with ART, then care providers would have the responsibility to implement it. However, mental health still did not receive the necessary attention. We have no standard rooms for mental health service delivery. For instance, the room should have a two-way door, and currently the distance of the mental health unit is not only far from MCH but also it is far from the other units which needs rearrangement.

Mental health experts also complain about their limited involvement in planning and having their sayings related to mental health specific services. A mental healthcare expert relates,

For instance, in the last four years, nobody from leadership has asked me about what is important for this unit, I don't understand why. Even though we are two mental health care providers assigned here, one of us has totally left healthcare service provision and was assigned to a management role, we do not have any connection. I arrive and leave on time, yet issues related to MCH, the Emergency department, and other areas are frequently discussed in management, while mental health is not.

Steps for Integration

Study participants outlined the following steps essential to integrate mental health care into perinatal services: a) evidence generation, b) development of tailored interventions and deliverable plan of action, c) setting up goals and ownership of the program through transparent and open dialogue, d) implementing home visitation as a part of perinatal mental health services, e) creating strong collaboration and stakeholder engagement.

Evidence Generation

Study participants mentioned evidence generation as critical and the first step in the integration of mental health into perinatal care. Some types of evidence suggested by study participants are assessment of contributing factors, development of interventions and assessment of the needs, which helps with budgeting and planning. An MCH focal person relates,

Our doors are open to any partners who wish to collaborate on this issue. The first step is to conduct a study to generate evidence. The second step involves identifying the contributing factors to mental health problems. After identifying these

factors, developing targeted interventions based on the gathered evidence. It is important to note that perceptions within the community can vary. Some individuals believe that mental health issues are primarily caused by economic problems, while others attribute them to substance abuse. By understanding these differing perspectives, we can tailor our interventions more effectively to address the specific needs of the community. To tell you the reality currently, we do not have any relevant experience on how to integrate unless the program is established from scratch through evidence generation.

A HEW relates, “The initial step should be conducting assessment to identify what problems are in the community. The second step is to plan for budget and identify who will participate and identifying stakeholders. The partner should also consider what will be done at health post or health center.”

Developing Tailored Intervention and Deliverable Plan

The second step in the integration process, as suggested by the participants, is developing tailored intervention and deliverable plans. An MCH focal person relates,

After identifying these factors, targeted interventions will be developed based on the gathered evidence. It is important to note that perceptions within the community can vary. Some individuals believe that mental health issues are primarily caused by economic problems, while others attribute them to substance abuse. By understanding these differing perspectives, we can tailor our interventions more effectively to address the specific needs of the community.

Study participants also recommended that the plan should be based on a detailed assessment and resource mapping. An MCH focal person relates, “As I mentioned earlier, my recommendation is that an assessment should be conducted first. The second step is to discuss the resources available and how to use them, while setting a deliverable plan.”

A HEW relates, “.....The second step is to plan for budget and identify who will participate and identifying stakeholders. The partner should also consider what will be done at health post or health center.”

Transparency and Project Ownership

The third step outlined by the participants is setting up goals and ownership of the initiative through transparent and open discussion. Participants stressed transparency and sense of ownership as mandatory components of the integration. While one participant initially mentioned this in the third step, all participants agreed with this. In addition, one participant stressed the importance of continuous discussion. An MCH focal person relates, “From my experience, many partners come to this town, but there is often no open discussion about what they intend to do. Therefore, they need to be transparent about the aims of the project.”

An MCH coordinator further confirms the importance of transparency as follows,

The project should work in line with its aims; however, there are times when the project’s aims may contradict reality. Therefore, it should be flexible and take into account the situation on the ground. The project should also announce its plans before beginning the work. Communication with stakeholders is essential, and the project must engage stakeholders through discussions with them if any obstacles arise.

Home Visit as a Part of Perinatal Mental Health Services

As a fourth step, participants recommended the implementation of home visits to provide perinatal mental health service. A voluntary health worker relates,

I think it’s easier to do home visits. If they go to a hospital, it can be incredibly stressful for them. Mixing those who are severely ill with those who are only slightly unwell can make the situation even more challenging. It would be beneficial to conduct home visits during your vacations and try to keep these individuals together if possible.

Another participant elaborates on the opportunities that home visitation offers, such as to establish relationships with the clients and to get a better understanding of the resources and support system they have in the community. A voluntary Health Worker relates,

We can go house-to-house to visit these individuals, and it might be possible to arrange meetings with their families, in the field, to discuss their situations and get to know each other. Additionally, they know important resources that could help them because they are suffering, and they can share their concerns with the supporters. Thus, we can inform them that they can contact the support team whenever they need help.

Even though the presence of strong grassroots community structure was mentioned as an opportunity for the integration of mental health into perinatal care, low commitment of some VHWs and HEWs, unsuitable working conditions, and limited training, and the lack of incentive packages for VHWs hinder the effectiveness of services delivered at community level. Study participants stressed the importance of providing incentives for community health workers. A voluntary health worker relates, “Even a small reward can make a person feel valued and happy. Not everyone may feel as I do, so it is crucial to support these unemployed young people in finding work.”

Strong Collaboration and Stakeholder Engagement

The fifth step, as outlined by study participants, is to create strong collaboration and stakeholder engagement. Active involvement of stakeholders is critical to pool resources. A Voluntary Health worker relates,

As is well known, when we engage in health-related work, we call health extension workers if a situation is beyond our control. However, we often feel nervous when something urgent occurs, as sometimes people cannot even take the sick person to the hospital. But when we work together with the HEWs, we can solve the problem right there. I do not know of any other approach.

Another VHW further elaborates mentioning stakeholders who should be involved,

It would be nice if entrepreneurs, clergy, and higher authorities could come together, because everyone’s knowledge is different, and I think that’s beneficial. For example, one entrepreneur can own multiple companies. When a person is healed and comes to his senses, he can employ that person in a role he prefers, such as a guard or cleaner, so that this individual does not suffer. Stress causes mental illness, and improvements will occur if they can find a way to take care of themselves and provide for their children. It would be helpful if they had someone to look after. I believe that this person is valuable because he can bring solutions.

A health extension worker emphasized the importance of sustainability for the proposed program. The HEW relates, “If the program is initiated as community mobilization and stops in between, it may result in the drop out of service. So, sustainability is especially important.”

An MCH focal person describes his agreement as follows,

Yes, this means that the project should be planned collaboratively. If the stakeholders present a finalized document without involving everyone in the planning process, the project may not be participatory and may fail to meet its targets. Therefore, it is essential to start from the grassroots level and ensure a collaborative approach throughout the project development.

Discussion

This project sought to explore challenges and opportunities related to the integration of mental health services into perinatal care. As expected, we found that perinatal mental health service is either absent or suboptimal at MCH clinics. In addition, none of the essential components of integrated perinatal mental healthcare are included as part of perinatal care. According to Carter and colleagues,²² essential components of integrated perinatal mental healthcare are a) screening, assessment, and triage; b) integrated care delivery; c) patient-centred care; d) a biopsychosocial approach to treatment; e) clinicians trained on perinatal mental healthcare; f) health promotion and illness prevention; and g) transition and discharge planning.

Barriers to Seek or Provide Perinatal Mental Health Services

The barriers to the integration of mental health into perinatal care emanate both from the healthcare system side (such as absence of supportive policy framework, limited institutional resources, and limited practice of compassionate and

respectful care) and the community (cultural beliefs and community perceptions). These findings are echoed by previous studies conducted in Northern Ethiopia¹² and South Central Ethiopia,²⁴ which identified barriers to the management of perinatal depression.

Opportunities and Strategies for Perinatal Mental Health Service Integration

Opportunities

This study found some factors that facilitate the integration of mental health into perinatal care. The first factor mentioned as an opportunity was the presence of MCH and mental health professionals at primary care levels. However, the absence of an MCH provider trained on perinatal mental health was mentioned as an obstacle. The second opportunity for the integration is the current Ethiopian primary healthcare structure. The primary healthcare structure has community health workers, including the health development army at the bottom, health extension workers who provide services both at health posts and community outreaches, health centers and primary hospitals. Health extension workers and community health workers have direct access to the community not only through health post visits, but also via the house-to-house activities.³⁰ Health extension workers refer cases to health centers and primary hospitals. While this structure is currently being used for the provision of general perinatal services, perinatal mental health components can be integrated into that by training health professionals and community health workers at each level.

Third, the presence of convenient infrastructure such as the presence of separate mental health units was seen as an opportunity. Even though there has been long negligence of mental health at the primary healthcare level, as a result of recent focus given by the government, some primary hospitals now have mental health professionals and some of them have dedicated mental healthcare units which function as outpatient facilities. Furthermore, recently, the government has focused on noncommunicable chronic diseases, mental health and substance use, and has made dramatic reforms by introducing mental health at primary healthcare level.²⁸ Hence, this may be favorable for a collaborative activity in managing perinatal mental health problems.

Strategies

Considering both challenges and opportunities, study participants outlined the following strategies for the integration of mental health services into perinatal care: a) awareness creation and capacity building and optimizing resources; b) development of guidelines and implementation tools; c) integrated care; d) leadership and stakeholder engagement.

Awareness Creation, Capacity Building and Optimizing Resources

Study participants stressed that community misconceptions, cultural beliefs and limited skills and knowledge among providers are negatively affecting perinatal mental health service utilization and provision. And hence, they recommended awareness creation activities for the wider community and capacity building training for health professionals and community health workers.

As reported in previous studies,^{31,32} cultural beliefs, misconceptions and limited health literacy are obstacles to seeking perinatal mental health services. In the current study, we found that cultural beliefs about the causes of mental illnesses and beliefs that discourage women from any outdoor activities during perinatal period prevents them from seeking perinatal mental healthcare. This finding is echoed by a previous study which also reported that women are restricted from social activities during late pregnancy to avoid judgement from the society.²⁴ In addition, stigma associated with mental illnesses and perceived causes of mental illnesses deter patients from seeking mental healthcare. The findings of studies from South Central and Northwest Ethiopia concur with this finding.^{11,33} This is a common challenge in many low-and-middle income countries (LMICs) that results in underdiagnosis³⁴ and makes it challenging to expect demand for the service and plan for mental healthcare services in primary care settings.¹³ This underscores the importance of community sensitization to debunk misconceptions and beliefs related to perinatal mental health in the community.

When it comes to MCH staff, in addition to the lack of skills related to perinatal mental health, some perceive that it is not their responsibility to provide mental health screening or treatment. Staff territorialism has been known to be an

obstacle to a care that needs multidisciplinary efforts.³⁵ On the other hand, there has been a nationwide initiative as part of the system bottleneck focused reform (SBFR) that encourages a multidisciplinary team. This multidisciplinary team structure has a coordinator and regular meetings making it convenient to have regular discussions on multidisciplinary issues such as perinatal mental health. This will potentially tackle barriers related to the fragmentation of services.

While collocation of MCH providers and mental health providers has been used as one strategy for collaborative care models for the provision of perinatal mental health in other contexts,²² its feasibility in low-income settings is still not clear. In the current study, participants recommended having a mental healthcare unit closer to MCH unit. At the same time, they also recommended training MCH providers instead of placing mental healthcare providers in MCH units. This agrees with a previous study conducted in South Central Ethiopia²⁴ which reported that antenatal care providers are best positioned to deliver perinatal mental health interventions. Relatedly, based on emerging evidence from LMICs, the integration of mental health care into primary care setting has focused on the training of non-mental health professionals.³⁶ This approach (task sharing) of service delivery has been presented as a preferred model of collaborative care in low-and middle-income countries.²² For instance, the approach was feasible in South Africa.³⁷ This implies that the task sharing approach of the perinatal mental health service provision may be an applicable model for the integration of mental healthcare into MCH services in resource limited settings. Therefore, MCH providers may be trained using the cascade approach of training, which may be effective to scale up the training of MCH providers to deliver perinatal mental health services in resource limited settings. This approach has been found to be effective in Nigeria.¹⁹ However, MCH providers may not be able to manage severe mental health conditions. Hence, based on stepped care approach, conditions with mild to moderate severity may be managed at MCH clinics whereas severe cases can be referred to mental health specialists.^{15,22} Furthermore, study participants recommended prioritizing mothers who are at risk of developing mental health problems or who have preexisting mental health problems for mental health assessment and management by mental health specialists. Another potential long-term solution is integrating perinatal mental health into not only in-service training, but also into preservice training.

Development of Guidelines and Implementation Tools

Another area of interest that needs attention is working to close the gaps in the availability guidelines, checklists, and implementation tools. While there are recent developments, especially in the development of primary healthcare guidelines,³⁸ much work is needed in terms of specific clinical guidelines related to perinatal mental health. According to study participants, there are no clearly endorsed guidelines that are accessible to healthcare providers at point of care to screen and manage perinatal mental health problems. Even though studies suggested the importance of using some screening tools and some researchers have validated some of them to local context,^{39,40} none of these tools are currently integrated as part of routine screening of perinatal population for possible mental health problems. In addition, there is a need for the development of, or cultural adaptation of, psychosocial intervention tools and manuals.¹³

Leadership and Stakeholder Engagement

Overall, in Ethiopia, there is high level government support for mental health. This is evidenced through documents such as the national mental health strategy.⁴¹ Nevertheless, study participants described their frustration for not having enough stakeholders and leadership support for perinatal mental health. Consistent with these, previous Ethiopian research has recommended for the prioritization of mental health by the government.³³ Since our study was limited to zonal, district, facility and community level, it is expected to observe this gap as the implementation requires long process. For successful scale up of mental health integration at primary healthcare settings, strengthening the leadership at all levels is critical.⁴²

In addition, study participants have described their frustration on the absence of local training programs. Hence, it is essential for the national leadership commitment to be translated to local level along with strong training and supervision and support for research.

While researchers are exploring strategies to design a scalable intervention, the implementation is still stalling. Fekadu and colleagues outlined a framework for the provision of integrated mental health care at primary healthcare level. This framework will potentially tackle barriers at community level, health facility level and district administration

level.⁴³ The template outlined by Fekadu and colleagues generally addresses the barriers related to integration at a general primary care setting. Even though there are some actions specific to the perinatal population, the template may also help to address some barriers outlined in this study. In addition, the perinatal population requires proactive screening for mental health problems and substance use not only because of their potential impact on the entire family, but also because of the potential irreversible damage. Hence a proactive screening and management approach should be designed both at facility and community levels requiring active roles and detailed training for community level actors.

Therefore, it is important to mobilize resources through the engagement of community organizations, faith-based organizations, governmental and non-governmental organizations.

Steps to Integrate Mental Health Service Into Perinatal Care

Study participants outlined the following actions as essential steps to integrate mental health care into perinatal services:

a) evidence generation, b) development of tailored interventions and deliverable plan of action, c) setting up goals and ownership of the program through transparent and open dialogue, d) implementing home visitation as a part of perinatal mental health services, and e) creating strong collaboration and stakeholder engagement.

Evidence Generation

Study participants are concerned about the lack of evidence on contextually relevant interventions. As it has already been acknowledged in the national mental health strategy, the scarcity of evidence related to intervention development and evaluation, and health service delivery models have led to delays in the implementation of the perinatal mental health program at primary care setting.⁴¹ While there are some progresses in some LMICs, the effort to generate evidence that are contextually feasible, applicable, meaningful, and effective are still missing in many sub-Saharan African countries, including Ethiopia.

To be implemented as a stepped care approach, perinatal mental health services are based on psychosocial and psychological interventions that should be adapted locally. Hence, as recommended by study participants, pilot studies, cultural validation studies and exploratory studies are needed to develop, adapt and test interventions and implementation tools. Furthermore, need assessment is needed to make best use of resources and to plan and budget for tailored interventions. The national mental health strategy of Ethiopia also calls for urgent evidence related to intervention development and evaluation, and health service delivery models.⁴¹

Development of Tailored Interventions and Deliverable Plans of Action

As the participants unanimously reported, the absence of clear structure and ownership, and poor coordination hinders case detection, management, and referral. Hence, as recommended by study participants, at each level within the primary healthcare system, plans of action should be developed. Intervention development is especially important as most cases of perinatal mental health problems at MCH clinics will be potentially managed by psychosocial or psychological interventions.^{44,45}

Setting Goals and Ownership of the Program Through Transparent and Open Dialogue

Study participants recommended the importance of setting goals and accountability, thinking that currently the lack of sense of ownership and accountability is missing both from the leadership and healthcare providers' side. Especially, study participants stressed the importance of participatory planning that involves zonal, district and health facility managers and coordinators and community representatives.

Implementing Home Visitation as a Part of Perinatal Mental Health Services

Study participants strongly recommended not only the importance of community sensitization and harnessing the roles of community health workers to support institution-based services, but also the importance of home-based perinatal mental health services. This is especially important as there are many traditional rituals that tend to keep women at home during

perinatal period. Home visitation also allows the opportunity to provide holistic management of perinatal mental health problems. In addition to increasing accessibility to care, it is an opportunity to access patients with their family and significant others creating a favorable situation to debunk misperceptions and stigmatization related to perinatal mental illness. This is also convenient to provide care for the entire perinatal population (mothers, babies and the father) and the entire family. Therefore, in addition to health extension workers, the health development army and other voluntary health workers may be provided with manualized training and incentives to provide home-based perinatal screening and management.

Creating Strong Collaboration and Stakeholder Engagement

As part of the evolution of global health system integration, healthcare integration has moved from traditional institution-focused approach to community-focused strategy.⁴⁶ This has been echoed in the current study. As outlined above, the recommended service integration is not the traditional service integration that is limited to facility level collaboration. Rather, the integration of perinatal mental healthcare involves multiple health facilities (hospitals, health centers, health posts), community health workers (both voluntary and salaried), community leaders and religious leaders. In addition, it requires dedicated support from both governmental and non-governmental organizations. Strong partnership and collaboration are needed. Therefore, the integration of perinatal mental healthcare, especially in LMICs requires a community-focused strategy.⁴⁶ Strong coordination between hospitals, health centers, health posts and community health workers aid not only in early identification and management, but also for mental health promotion and mental illness prevention.

Overall, the community structure is favorable for a holistic approach to service provision. However, the integration of mental health into perinatal care is in its premature stage in most LMICs.³⁶ Even in those settings where it has been tested, the services mostly focused on single interventions, which call for further action. The current study showed that even though there is a willingness to support perinatal mental health services, there is limited commitment and action from stakeholders. In addition, concrete actions such as development of guidelines, checklists, and proper infrastructure require further work. While other healthcare initiatives have been scaled up in an abbreviated period of time, for perinatal mental health services, it requires further work, such as training MCH care providers, evidence generation, development and adaptation and testing of guidelines, and implementation tools. Therefore, resource and stakeholder mobilization are required.

This study generated evidence that may be used as an input to integrate perinatal mental health care into perinatal care. The strength of the study is that it presented the perspectives of diverse stakeholders including clients, healthcare providers, facility managers and health service coordinators and community health workers. The evidence may help to inform the development of strategy for the provision of perinatal mental health services at multiple levels (primary hospital, health center, health post and community levels) within the primary healthcare system of Ethiopia. On the other hand, this study is limited in that it did not conduct detailed inventory of available resources and skills. A resource inventory and need assessment is needed to make best use of resources and to plan and budget for tailored interventions.

Conclusions

This study explored the perspectives of health service providers, health service coordinators and managers, community health workers, community volunteers and health service recipients on the integration of mental health into perinatal care. The perspectives of all these stakeholders confirms that currently perinatal mental health detection and management is either suboptimal or absent in the Ethiopian primary healthcare setting. While there is clear political commitment, the implementation is challenged by the absence of clear guidelines and checklists, trained healthcare providers, lower health seeking behavior related to cultural beliefs and customs, and the long tradition of lower focus given to perinatal mental health services by different stakeholders. In addition, the scarcity of evidence related to intervention development and evaluation, and health service delivery models is a factor that contributed to the stagnation of the integration of mental health into perinatal care.

By elaborating both challenges and opportunities from the perspective of diverse stakeholders at different levels, this study also summarized steps to integrate mental health services into perinatal care. Even though there is no standard

model of integration that suits all contexts and circumstances, task sharing and stepped care model of perinatal mental healthcare may be implementable in low-income settings, including Ethiopia. While there are challenges to integrate mental health services into perinatal care, the current Ethiopian primary healthcare system offers a conducive structure for the integration. Some of the current challenges can be tackled by training health professionals, community sensitization, and advocacy. In addition, further efforts are needed to generate evidence that leads to the development of evidence-based implementation tools and health service delivery models tailored to local needs. By using the current Ethiopian health system structure as an opportunity, the strategies outlined in this study may be used to design perinatal mental health services at multiple levels (general hospitals, primary hospitals, health centers, health posts and the community settings). Overall, the study outlined practical steps in the light of existing challenges and opportunities to integrate mental health into perinatal care.

Abbreviations`

ART, Antiretroviral therapy CHW, Health workers; COREQ, Consolidated criteria for reporting qualitative research; HEW, Health Extension Workers; IESO, Integrated emergency surgical and obstetrics and gynecology; LMICs, low- and middle-income countries MCH, Maternal and Child Healthcare; mhGAP, mental health gap action program; OPD, Outpatient department; PMH, Perinatal mental health; SBFR, system bottleneck-focused reform; VHW, Voluntary Health Worker; WHO, World Health Organization.

Ethical Approval and Consent to Participate

This study complies with the Declaration of Helsinki. We received ethical permission for this study from the University Integrated Institutional Review Boards (UI-IRB) of the City University of New York (Ref. No: 2024-0297) and the institutional review board of Jimma University Institute of Health (Ref. No: JUIH/IRB/020/24).

Research Involving Human Participants

Yes.

Informed Consent

All study participants have given verbal consent before the interviews. Participants were informed that no personal identifiers would be used in the final report. We used the verbal consent script template of the City University of New York. The verbal consent script was approved by the University Integrated Institutional Review Boards (UI-IRB) of the City University of New York and institutional review board of Jimma University Institute of Health.

Acknowledgments

We are grateful to study participants for sacrificing their time.

Author Contributions

GTF formulated the research idea, formulated the protocol, acquired funding, supervised the overall project, conducted data analysis, and prepared the manuscript. All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Funding

This project obtained funding from the enhanced research award by the Professional Staff Congress of the City University of New York (PSC CUNY Award number 677480055) and the Tow creative grant from the Tow Foundation of Brooklyn College. We are also thankful to the study participants for their time.

Disclosure

The authors declare no competing interests in this work.

References

1. Tolossa T, Fetensa G, Yilma MT, et al. Postpartum depression and associated factors among postpartum women in Ethiopia: a systematic review and meta-analysis, 2020. *Public Health Reviews*. 2020;41(1):1–20. doi:10.1186/s40985-020-00136-3
2. Kitil GW, Hussen MA, Chibsa SE, Chereka AA. Exploring paternal postpartum depression and contributing factors in Ethiopia: a systematic review and meta-analysis. *BMC Psychiatry*. 2024;24(1):754. doi:10.1186/s12888-024-06206-z
3. Mersha AG, Abebe SA, Sori LM, Abegaz TM. Prevalence and associated factors of perinatal depression in Ethiopia: a systematic review and meta-analysis. *Depress Res Treat*. 2018;2018(1):1813834. doi:10.1155/2018/1813834
4. Rtbe G, Andualem F, Nakie G, et al. Perinatal depression and associated factors in Ethiopia: a systematic review and meta-analysis. *BMC Psychiatry*. 2024;24(1):822. doi:10.1186/s12888-024-06246-5
5. Duko B, Wolde D, Alemayehu Y. The epidemiology of postnatal depression in Ethiopia: a systematic review and meta-analysis. *Reproductive Health*. 2020;17(1):180. doi:10.1186/s12978-020-01035-1
6. Dadi AF, Akalu TY, Wolde HF, Baraki AG. Effect of perinatal depression on birth and infant health outcomes: a systematic review and meta-analysis of observational studies from Africa. *Arch Public Health*. 2022;80(1):1–11. doi:10.1186/s13690-022-00792-8
7. Eastwood J, Ogbo FA, Hendry A, Noble J, Page A, Group EYR. The impact of antenatal depression on perinatal outcomes in Australian women. *PLoS One*. 2017;12(1):e0169907. doi:10.1371/journal.pone.0169907
8. Monaghan S, Akale MA, Demeke B, Darmstadt GL. Prevalence and stigma of postpartum common mental disorders in the Gurage region of Ethiopia: a mixed-methods observational cohort study. *Frontiers in Psychology*. 2021;12:626797. doi:10.3389/fpsyg.2021.626797
9. Tareke KG, Lemu YK, Feyissa GT. Exploration of facilitators of and barriers to the community-based service utilization for newborn possible serious bacterial infection management in Debre Libanos District, Ethiopia: descriptive qualitative study. *BMC Pediatric*. 2020;20(1):1–14. doi:10.1186/s12887-020-02211-9
10. Abute Idris Z, Tolu Feyissa G, Tesfaye Elilo L, Selamu Jifar M, Mecha A. Healthcare-seeking behavior and associated factors for newborn danger signs among mothers who gave birth in the last 12 months in Anlemo District. *Advances in Public Health*. 2022;2022:1–11. doi:10.1155/2022/7592832
11. Daehn D, Rudolf S, Pawils S, Renneberg B. Perinatal mental health literacy: knowledge, attitudes, and help-seeking among perinatal women and the public - a systematic review. *BMC Pregnancy Childbirth*. 2022;22(1):574. doi:10.1186/s12884-022-04865-y
12. Dadi AF, Miller ER, Azale T, Mwanri L. “We do not know how to screen and provide treatment”: a qualitative study of barriers and enablers of implementing perinatal depression health services in Ethiopia. *Inter J Mental Health Syst*. 2021;15(1):41. doi:10.1186/s13033-021-00466-y
13. Baron EC, Hanlon C, Mall S, et al. Maternal mental health in primary care in five low- and middle-income countries: a situational analysis. *BMC Health Serv Res*. 2016;16(1):53. doi:10.1186/s12913-016-1291-z
14. Tessema M, Birhanu D, Mizana BA, et al. Compliance to antenatal psychosocial assessment practice among midwives: a best practice implementation project. *JBIM Evid Implement*. 2022;20(1):44–52. doi:10.1097/XEB.0000000000000299
15. World-Health-Organization. Guide for integration of perinatal mental health in maternal and child health services. 2022.;
16. Stansert Katzen L, Tomlinson M, Christodoulou J, et al. Home visits by community health workers in rural South Africa have a limited, but important impact on maternal and child health in the first two years of life. *BMC Health Serv Res*. 2020;20(1):1–10. doi:10.1186/s12913-020-05436-7
17. Tol W, Greene M, Lasater M, et al. Impact of maternal mental health interventions on child-related outcomes in low-and middle-income countries: a systematic review and meta-analysis. *Epidemiol Psychiatr Sci*. 2020;29:e174.
18. Moses-Kolko EL, Li R, Gopalan P, Poerschke R, Schlesinger AB. Impact of colocated behavioral health on OB-GYN clinicians’ rate of perinatal behavioral health diagnosis and psychotropic prescription. *General Hospital Psych*. 2023;84:18–24. doi:10.1016/j.genhosppsych.2023.05.004
19. Oladeji BD, Ayinde OO, Bello T, et al. Cascade training for scaling up care for perinatal depression in primary care in Nigeria. *Inte J Mental Health Syst*. 2023;17(1):41. doi:10.1186/s13033-023-00607-5
20. MS M, Kay Roussos–Ross MD. Treatment and management of mental health conditions during pregnancy and postpartum: acog clinical practice guideline no. 5. *Obstetrics Gynecol*. 2023;141(6):1262–1288. doi:10.1097/aog.0000000000005202
21. Vigod SN, Frey BN, Clark CT, et al. Canadian network for mood and anxiety treatments 2024 clinical practice guideline for the management of perinatal mood, anxiety, and related disorders: guide de pratique 2024 du Canadian network for mood and anxiety treatments pour le traitement des troubles de l’humeur, des troubles anxieux et des troubles connexes périnataux. *Can J Psych*. 2025;70(6):429–489. doi:10.1177/07067437241303031
22. Carter M, Russolillo A, Ou C, et al. Models and key elements of integrated perinatal mental health care: a scoping review. *PLOS Mental Health*. 2025;2(3):e0000164. doi:10.1371/journal.pmen.0000164
23. Honikman S, Van Heyningen T, Field S, Baron E, Tomlinson M. Stepped care for maternal mental health: a case study of the perinatal mental health project in South Africa. *PLoS Med*. 2012;9(5):e1001222. doi:10.1371/journal.pmed.1001222
24. Bitew T, Keynejad R, Honikman S, et al. Stakeholder perspectives on antenatal depression and the potential for psychological intervention in rural Ethiopia: a qualitative study. *BMC Pregnancy Childbirth*. 2020;20(1):1–11. doi:10.1186/s12884-020-03069-6
25. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357. doi:10.1093/intqhc/mzm042
26. Bogale F, Ararso D, Woldie E, et al. Situational analysis of health technology assessment in Ethiopia. 2022.
27. FMOH E. Health Sector Transformation Plan (HSTP): 2015/16– 2019/20. *Addis Ababa*. 2015.
28. Tadesse Gebremedhin L, Giorgis TW, Gerba H. Policies, delivery models, and lessons learned from integrating mental health and substance abuse services into primary health care in Ethiopia. *FASEB BioAdvances*. 2021;3(9):694–701. doi:10.1096/fba.2020-00145
29. Hennink M, Kaiser BN. Sample sizes for saturation in qualitative research: a systematic review of empirical tests. *Soc Sci Med*. 2022;292:114523. doi:10.1016/j.socscimed.2021.114523

30. Tafesse N, Gesessew A, Kidane E. Urban health extension program model housing and household visits improved the utilization of health services in Urban Ethiopia: a community-based cross-sectional study. *BMC Health Serv Res.* 2019;19(1):31. doi:10.1186/s12913-019-3868-9
31. Webb R, Uddin N, Ford E, et al. Barriers and facilitators to implementing perinatal mental health care in health and social care settings: a systematic review. *Lancet Psychiatry.* 2021;8(6):521–534. doi:10.1016/s2215-0366(20)30467-3
32. Oladeji BD, Ayinde OO, Bello T, et al. Addressing the challenges of integrating care for perinatal depression in primary care in Nigeria. *Soc Psych Psychiatric Epidemiol.* 2024;59(10):1671–1684. doi:10.1007/s00127-024-02611-7
33. Mekonen T, Chan GC, Belete T, et al. Mental health service utilization in a low resource setting: a qualitative study on perspectives of health professionals in Northwest Ethiopia. *PLoS One.* 2022;17(11):e0278106. doi:10.1371/journal.pone.0278106
34. Lasater ME, Beebe M, Gresh A, Blomberg K, Warren N. Addressing the unmet need for maternal mental health services in low-and middle-income countries: integrating mental health into maternal health care. *J Midwifery Women's Health.* 2017;62(6):657. doi:10.1111/jmwh.12679
35. Searby A, Burr D, Carolin R, Hutchinson A. Barriers and facilitators to mental health service integration: a scoping review. *Inter J Mental Health Nurs.* 2025;34(1):e13449. doi:10.1111/inm.13449
36. Prom MC, Denduluri A, Philpotts LL, et al. A systematic review of interventions that integrate perinatal mental health care into routine maternal care in low-and middle-income countries. *Frontiers in Psychiatry.* 2022;13:859341. doi:10.3389/fpsy.2022.859341
37. Spedding MF, Stein DJ, Naledi T, Myers B, Cuijpers P, Sorsdahl KR. A task-sharing intervention for prepartum common mental disorders: feasibility, acceptability and responses in a South African sample. *African J Primary Health Care Family Med.* 2020;12(1):1–9. doi:10.4102/phcfm.v12i1.2378
38. Kibret AG, Belete WM, Hanlon C, et al. Ethiopian primary healthcare clinical guidelines 5 years on—processes and lessons learnt from scaling up a primary healthcare initiative. *BMJ Global Health.* 2024;9(Suppl 3):e013817. doi:10.1136/bmjgh-2023-013817
39. Woldetensay YK, Belachew T, Tesfaye M, et al. Validation of the patient health questionnaire (PHQ-9) as a screening tool for depression in pregnant women: afaan Oromo version. *PLoS One.* 2018;13(2):e0191782. doi:10.1371/journal.pone.0191782
40. Tesfaye M, Hanlon C, Wondimagegn D, Alem A. Detecting postnatal common mental disorders in Addis Ababa, Ethiopia: validation of the Edinburgh postnatal depression scale and Kessler scales. *J Affective Disorders.* 2010;122(1–2):102–108. doi:10.1016/j.jad.2009.06.020
41. National Mental Health Strategy. 2012/13–2015/16 (federal ministry of health Addis Ababa). 2012.
42. Hanlon C, Eshetu T, Alemayehu D, et al. Health system governance to support scale up of mental health care in Ethiopia: a qualitative study. *Inter J Mental Health Syst.* 2017;11(1):1–16. doi:10.1186/s13033-017-0144-4
43. Fekadu A, Hanlon C, Medhin G, et al. Development of a scalable mental healthcare plan for a rural district in Ethiopia. *Br J Psychiatry.* 2016;208(s56):s4–s12. doi:10.1192/bjp.bp.114.153676
44. Motrico E, Bina R, Kassianos AP, et al. Effectiveness of interventions to prevent perinatal depression: an umbrella review of systematic reviews and meta-analysis. *General Hospital Psych.* 2023;82:47–61. doi:10.1016/j.genhosppsy.2023.03.007
45. Li X, Laplante DP, Paquin V, Lafortune S, Elgbeili G, King S. Effectiveness of cognitive behavioral therapy for perinatal maternal depression, anxiety and stress: a systematic review and meta-analysis of randomized controlled trials. *Clinic Psychol Rev.* 2022;92:102129. doi:10.1016/j.cpr.2022.102129
46. Evans JM, Baker RG, Berta W, Jan B The Evolution of Integrated Health Care Strategies. In: Friedman L, Goes J Savage G, editors. Annual Review of Health Care Management: Revisiting The Evolution of Health Systems Organization. Emerald Group Publishing Limited; 2013. doi:10.1108/S1474-8231

Journal of Multidisciplinary Healthcare

Publish your work in this journal

The Journal of Multidisciplinary Healthcare is an international, peer-reviewed open-access journal that aims to represent and publish research in healthcare areas delivered by practitioners of different disciplines. This includes studies and reviews conducted by multidisciplinary teams as well as research which evaluates the results or conduct of such teams or healthcare processes in general. The journal covers a very wide range of areas and welcomes submissions from practitioners at all levels, from all over the world. The manuscript management system is completely online and includes a very quick and fair peer-review system. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/journal-of-multidisciplinary-healthcare-journal>

Dovepress
Taylor & Francis Group