Mental health, maternal health and sexual and reproductive health and rights

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> **Query:** 1) Please provide a brief overview of the evidence of the relationship between mental health, maternal health and SRHR, including evidence on relevant outcomes 2) What is the evidence of good practice in integrating mental health into maternal health and SRHR? What models have worked best? 3) Please provide a list of the key existing guidance on integrating mental health into maternal health and SRHR. Please provide a brief summary of the main messages and key entry points for integration.
> **Purpose:** To support the DFID SRHR team to integrate mental health into their work and to complement the existing Disability Inclusion Helpdesk query on "Family Planning and Disability Inclusion"
> **Enquirer:** Jessie Kirk, DFID Disability Inclusion Team

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1. Overview

DFID's strategy on disability inclusion recognises mental health as a "fundamental part of being human" (DFID, 2018), and momentum has slowly grown for the promotion of mental health, including prevention and care, and protection of the rights of those with lived experience. First formally recognised in the World Health Organisation's (WHO) inaugural Global Mental Health Action Plan 2013-2020 (2013), mental health has become a global health and development priority. International and high-level commitment has been reinforced through a variety of multisectoral efforts. These include introduction of relevant targets within the UN Sustainable Development Goals (SDG) (e.g. 3.4, 3.5, and 3.8) (Patel et al., 2018) and the Global Reference List of 100 Core Health Indicators (WHO, 2018), ratification of the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006; DFID, 2018), and development of leadership in knowledge generation and priority setting through collaborative bodies such as the Lancet Commission on Global Mental Health (Patel et al., 2018).

Mental health is also undergoing a reconceptualisation as the current global agenda around the SDGs aims to reframe priorities, looking beyond the historically narrow focus on mental disorder, to incorporate "a full spectrum from everyday well-being through to mental health conditions and long-term psychosocial disabilities (DFID, 2018). Emerging data is beginning to demonstrate the increasing contribution of mental health conditions and psychosocial disabilities to disability prevalence worldwide and secondly, that there is routinely poorer quality of care in mental health compared to physical health conditions (Patel et al., 2018). It is LMICs however facing a triple disadvantage as they bear the greatest burden of poor mental health outcomes, with the most limited evidence, and significant care gaps of up to 85% (WHO, 2017).

There are considerable evidence gaps in LMICs to highlight the relationship between mental health, maternal health and, sexual and reproductive health rights (SRHR). However, available evidence does show that women and girls are at a heightened risk to mental health and psychosocial issues as a result of societal and gendered norms, and these are compounded by maternal and SRH issues or events during a women's lifetime from adolescence to older age. Evidence also shows that there is also an association between perinatal mental health issues and negative outcomes for the child, which can result in intergenerational impacts. As a result, experts in the field argue that there is an urgent need to understand the relationship between women's mental health and associated gendered areas of risk including SRHR and maternal health, using a life course approach[1]. It is argued that this approach will ensure continuity of care that may help prevent long-term and more chronic mental health issues.

Relevant definitions:
• **Mental health:** Mental health can be defined as an asset or a resource that enables positive states of wellbeing and provides the capability for people to achieve their full potential. Consistent with the WHO definition of health, mental health does not simply imply an absence of illness. In addition, mental health is the unique outcome of the interaction of environmental, biological, and developmental factors across the life course (Patel et al., 2018). • **Maternal health**: Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period (WHO). • **Sexual and reproductive health**: Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity (Guttmacher-Lancet Commission).

Evidence to highlight best practice in integrating mental health into maternal or SRH programming in LMICs remains limited. Evidence of good practice is predominantly found in high-income countries (HICs) including the United States and United Kingdom. However, some of these models and examples provide useful learning and recommendations that can be considered for low- and middle-income contexts (LMICs) and these are included in section 5. Examples of promising practice from LMICs that are potential entry points to consider for future interventions and programmes include:

- Involving and training primary health care workers and non-specialist providers (e.g. nurses and midwifes) to provide mental health services, particularly during the perinatal period. This is proving to be effective in low resource settings there there are few mental health specialists.

- Providing universal screening and referrals for common perinatal mental disorders (CPMDs) and associated issues like GBV through primary care services using locally validated assessment tools.

- Supporting health workers to apply psychotherapeutic approaches, such as cognitive behaviour therapy (CBT), interpersonal therapy, or problem solving, for those living with mental health issues.

- Using mobile health (mHealth) technologies to increase engagement, reduce barriers and costs, increase adherence to treatment programmes, provide immediate psychological support, and facilitate self-monitoring and self-care.

- Tackling negative attitudes of health workers towards mental illness.

- Integrating mental health into school health and nutrition (SHN) programming as a key entry point for childhood/adolescence and for prevention of mental health issues (in later life).

- Taking a socio-ecological approach to target the drivers of poor mental health particularly at critical periods; for women this includes childhood and adolescence, menarche, motherhood, and menopause (although this has been done less in practice in LMICs).

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[1] Discussion with Alexis Palfreyman, April 2019.

Other entry points include: a) placing human rights, gender equality and inclusion at the centre of a comprehensive approach to mental health programming, particularly in relation to sexuality and sexual health; b) supporting health programmes, including those providing mental health services already, to be gender-sensitive and geared to addressing mental health problems in women and girls, such as maternal depression and the consequences of violence; c) taking a life course approach when designing interventions to tackle women's mental health; and d) using infant health as an entry point to engage with mothers and fathers about maternal and parental mental health to minimise stigma related to participation in mental health programmes, and to include the fathers in the treatment and recovery of the mother.

2. Methodology

This rapid research query has been conducted as systematically as possible within 3 days of research time. SRHR and maternal health are both broad areas and for this reason it has not been possible to cover all related aspects through this query - the authors have had to be selective.

The methodology is described below.

Search strategy: Studies were identified through a variety of search strategies:

- **Google and relevant electronic databases** (PubMed, Science Direct, and Google Scholar) for priority sources using a selection of key search terms.[2]

- **Review of key disability portals and resource centres**, such as the Lancet Commission on Global Mental Health, the Archives of Women's Mental Health, Leonard Cheshire Disability and Inclusive Development Centre, the Global Alliance for Maternal Mental Health, Mental Health Innovation Network, and PRIME.

- **Mental health-focused journals**, such as Lancet Psychiatry, BMC Psychiatry, International Journal of Public Health, and PLOS Med.

- **Contacted the DFID Disability Inclusive Development Programme consortium partners[3] and experts** for evidence recommendations (see Section 5 for experts who replied).

The review prioritised existing syntheses, evidence reviews, and systematic reviews where possible in order to draw on the fullest range of evidence possible.

Criteria for inclusion: To be eligible for inclusion in this rapid review of the literature, studies had to fulfil the following criteria:

- **Focus**: Evidence of relationship between mental health, maternal health and SRHR and programming that has integrated these different elements.

- **Time period**: 2008[4] – 2019.

- **Language**: English.

- **Publication status**: publicly available – in almost all cases published online.

- **Geographical focus**: Global, with a focus on low- and middle-income countries.

Overall, the evidence base on the relationship between mental health, maternal health and SRHR is limited, particularly in LMICs. Research on sexual and reproductive health (SRH) has

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[2] Key search terms included: perinatal / maternal mental health, SRH/SRHR, mental health, LMIC
[3] The Disability Inclusion Helpdesk is funded under the DID programme. The DID consortium partners are ADD International, BBC Media Action, BRAC, Institute of Development Studies (IDS), International Disability Alliance (IDA), Humanity & Inclusion, Leonard Cheshire Disability, Light for the World, Sense, Sightsavers and Social Development Direct.
[4] Note: The Disability Inclusion Helpdesk reviews evidence from 2008 onwards as this is the year that the Convention on the Rights of Persons with Disabilities and its Optional Protocol came into force.

predominantly been carried out on married women of childbearing age. Evidence on the reproductive health of single women, adolescent girls, and women past the age of child-bearing is harder to find.

The evidence base on good practice is also limited. The mental health and emotional needs of women has typically been seen outside the scope of maternal and SRH services, meaning that health care practices, treatments or services of mental health are rarely considered. This is often compounded by a perception that mental health is an unaffordable "luxury" for women in resource-poor settings. Longitudinal research on women's mental health following exposure to maternal mental health, and/or SRHR interventions is also negligible. Women's SRHR have been largely overlooked in mental health research globally, with a need for attention to issues such as female genital mutilation, girl-child marriage, sexual violence and trafficking, sex work, access to safe abortion, in/fertility, and critical periods of transition including menarche, motherhood and menopause. Although maternal mental health has received more investment than mental health's relationship with SRHR, evidence also remains limited. Evidence also shows a trend in LMICs has been to test the feasibility and acceptability of integrating mental health into primary maternal health provider roles (e.g. midwives and nurses) using screening assessments and tools. Other models found in HICs that are more preventative in nature and address the systemic issues that put women and girls at risk, have not yet been sufficiently adapted or tested in low-resource settings.

2. Brief overview of the evidence on the relationship between mental health, maternal health and SRHR, including evidence on relevant outcomes

This section presents the evidence found on the relationship between these different elements. There is more evidence to support the links between mental health and maternal health than there is for SRHR, although this is also very limited in LMICs.

The challenges to achieving improved mental health facing LMICs are compounded for girls and women, as the global health community has "largely omitted gender-specific analyses and actions" and in so doing has abdicated its responsibility "for achieving gender justice in [mental] health" (Horton, 2019, p.511). Across the life course, evidence shows that women experience more distress comparative to men (Denton, Prus and Walters, 2004). For example, girls and women are more likely than male counterparts to experience mental disorders[5] and self-directed violence (SDV), i.e. fatal and non-fatal thoughts and behaviours that may or may not be suicidal in nature (Crosby, Ortega and Melanson, 2011). Perinatal women, i.e. women who are pregnant through to one year postpartum and may include those experiencing spontaneous or induced abortion, also represent a subpopulation of concern as reductions in maternal deaths from obstetric causes have simultaneously revealed a growing contribution of deaths due to suicide (Romero and Pearlman, 2012). Maternal suicide, now classified as a direct cause of maternal mortality (WHO, 2012), is a leading contributor to deaths in pregnancy and the postnatal period across contexts including LMICs (Fuhr et al., 2014). Disability experienced because of poor mental health interacts with and compounds discrimination in other aspects of women's lives including (maternal) health, sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) (DFID, 2018).

There are gendered risk factors that put women at higher risk of depression, anxiety, migraine[6], and other debilitating mental health issues compared to men (Disease Control Priorities 3, 2018). Most mental health issues begin in women's late teens and twenties, but they occur across the lifespan– affecting several key stages of women's lives; in adolescence, their reproductive period and when they transition out of the reproductive period during the menopause. See the diagram taken from the

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[5] These are diagnosed mental health issues.
[6] Some studies have suggested a bidirectional relationship between the migraines and poor mental health with each increasing the risk for the onset of the other.

Partnership for Maternal, Newborn and Child Health Knowledge (Summary 31), showing risk factors at various stages in women's lives and their impact on both the mother's life and her child.

Women across LMICs are at an elevated risk of poor mental health due to their gender-determined devalued social status. Negative impacts of operating within rigidly patriarchal systems on women's SRHR have been documented such as reduced decision-making power over marriage, childbearing (family planning), and safe and consensual sex (Mattebol et al., 2016). Undermining and/or violating women's SRHR may also exacerbate existing or contribute to new forms of psychosocial distress. These social factors and norms are important contributors to poor mental health for women at different stages in their lives. For example:

- A systematic review of health studies in LMICs (Fisher et al., 2011) found CPMDs were more likely to occur if the mother was from socially and economically disadvantaged backgrounds, was an adolescent, if the pregnancy was unwanted, if the women experienced GBV or if the baby was a girl. Conversely, women are much less likely to experience problems if they have received an education, had access to SRH services including family planning, were employed and had childcare, and maintained a healthy relationship with an intimate partner, especially during the perinatal period when a woman is more dependent (Fisher et al., 2011).

Risk factors for maternal mental health at various stages in women's lives and their impact

LIFELONG
- Low social status
- Stressful life experiences
- Violence (domestic, sexual, gender-based)
- Genetic predisposition
- History of mental health problems
- Alcohol/ substance misuse
- Fragile circumstances (conflict, migration, natural disaster)
- Belonging to an ethnic minority

ADOLESCENCE
- Family/ peer problems
- Socioeconomic disadvantage

PRENATAL PERIOD
- Lack of social support from partner or in-laws
- Adolescent pregnancy
- Being unmarried
- Unwanted pregnancy

POSTNATAL PERIOD
- Infant characteristics, e.g. poor health, developmental problems etc.
- Having a girl child
- Abortion/ miscarriage/ stillbirth
- Lack of social support

Impact on mothers' lives and health

MATERNAL MENTAL HEALTH PROBLEMS
- CPMDs (including depressive and somatic disorders, anxiety and postnatal depression)
- Use of alcohol, tobacco and other harmful substances
- Psychosis
- Suicide

PHYSIOLOGICAL AND SOCIOECONOMIC PROBLEMS
- Predisposition to some medical conditions
- Poor quality of life
- Poor bonding with children
- Marriage disruption
- Less able to work and earn a living

Intergenerational impact on children

DURING INFANCY
- Poor bonding
- Poor feeding
- Poor health
- Delays in physical development
- Poor emotional development

DURING CHILDHOOD
- Less social and playful
- Limited attention span
- Emotional and behavioural problems
- Poor intellectual performance
- Poor educational performance

- Other studies show that mental illness rates can be around 3-5 times higher in women who are exposed to intimate partner violence (IPV) (Hind et al, 2014; Gelaye, B et al, 2016). Women's experience of IPV has long been associated with increased depression and suicide attempts, however recent evidence suggests that this relationship also works the other way, and women who are depressed experience higher levels of IPV (Devries KM et al., 2013).

- A WHO literature review finds significantly higher levels of depressive symptoms among women seeking treatment for infertility than in presumed fertile controls (WHO, 2009). Infertility in some countries can also bring immense shame and guilt (Rouchou B, 2013).

- A population-based study shows high prevalence of depressive disorder and higher frequency of psychiatric diagnosis when there are also pregnancy complications such as stillbirth, premature birth or miscarriage (Toffel E, 2013).

- Adolescence is also a period of intense change— both biologically and socially—where girls experience rapid physiological development, sexual maturation, and social changes. The mental strain is particularly acute for those questioning their own sexuality and gender identity (Russell, Stephen T., and Jessica N. Fish, 2016). A recent scoping study of evidence relating to knowledge and experiences of puberty and menstruation among females aged 10–14 years in LMICs (Coast
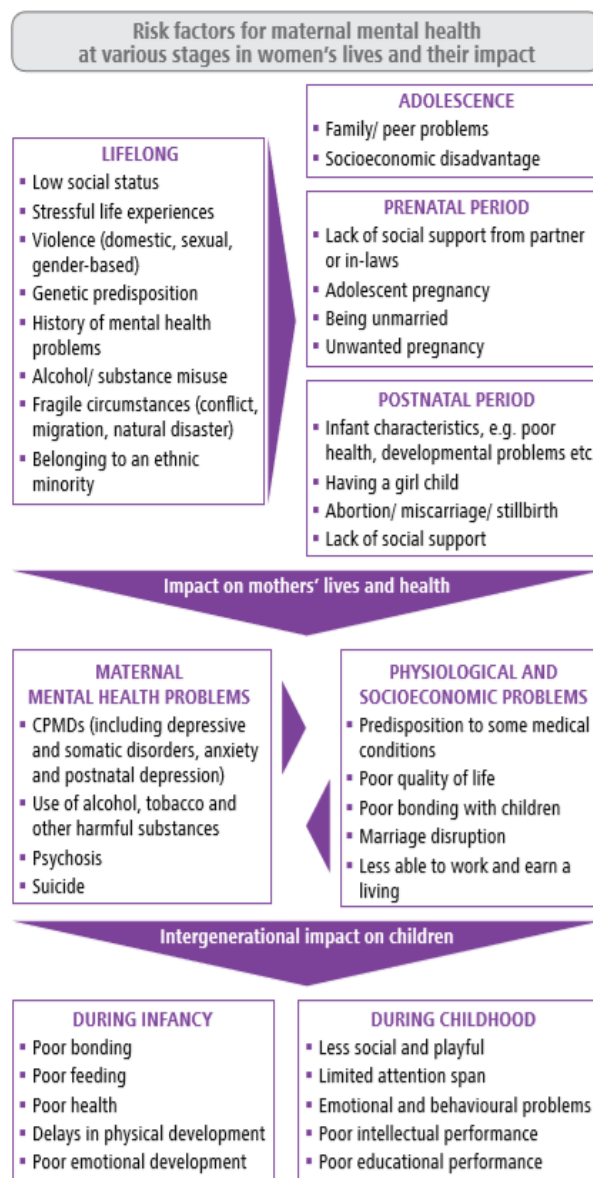
E et al., 2019) found menstruation is often a time of negative emotions. For example, "Kenyan girls perceived pubescent, menstruating girls to be increasingly vulnerable to marriage, sexual advances, and abuse" and in a study in Bangladesh "upon reaching menarche in Bangladesh, nearly two-thirds (64%) of girls reported feeling scared" (p.6). Negative emotions related to menstruation are also associated with issues of menstrual management, particularly around schooling (Coast E et al., 2019).

Evidence also shows that there are associations between perinatal mental health issues and negative outcomes for the child[7]. For example, a systematic review of studies in LMICs found associations between poor perinatal mental health and preterm delivery, low birth weight, impaired postnatal infant growth, suboptimal breastfeeding practices, and insecure infant-mother bonding (Gelaye, B, et al, 2016). This is also supported by other literature (Leigh, b and Milgrom, J, 2008; Fisher J et al., 2012; Black MM et al., 2007).

Poor mental health can also be associated with risky sexual behaviour and substance abuse through impaired judgement and decision-making which can have dramatic consequences on reproductive health including heightened vulnerability to unintended pregnancy, sexually transmitted infections including HIV and GBV (UNFPA, 2008). Young people are more likely to engage in these risky sexual behaviours, as well as substance abuse and violence owing to mental health difficulties (UNFPA, 2008). Attention to mental health is necessary to prevent these and other behaviours that lead to sexual and reproductive problems.

There are powerful negative stigmas surrounding poor mental health and psychosocial disabilities, presenting significant obstacles for women seeking care, including from maternal and SRH services. As a result, research also suggests that many women find it challenging to disclose their history to healthcare providers, especially during pregnancy and birth, some even avoiding formal service providers as a result due to fear of being judged or stigmatised (Mascayano, F. et al., 2015). Disease Control Priorities argues that stigma also affects service delivery at multiple levels— "lower prestige for professionals in the mental health community; inadequate resources allocated to prevention and treatment; and insufficient data on need for and coverage of evidence-based interventions for women" (DCP-3, 2018 p 2). Understanding structural barriers that contribute to stigma – at the individual, community and institutional, levels – is therefore a fundamental step to improving mental health services and polices. However, as shown in section 4, there is less evidence to show that this has been done in practice in LMICs.

4. Good practice in integrating mental health into maternal health and SRHR

*The query found that **most the evidence that exists in LMICs has tested the validity of integrating mental health into primary (maternal) health systems and structures. This is because LMICs are low resource settings where there are few mental health specialists.** This approach is also in line with WHO guidelines suggesting that this is the most viable way to close the treatment gap in LMICs. However, there are challenges; including limited recognition of mental health and other psycho-social issues by primary health care workers; a shortage of specialists trained in assessing and managing those with chronic mental health issues; and the scarcity of cross-culturally valid perinatal depression screening and diagnostic tools (Gelaye, B, 2016). Experts in the field also highlight the importance of taking a life course approach and tackling systemic issues that may cause poor mental health outcomes in women and girls in the first instance. This includes addressing the stigma surrounding mental health, as well as the gendered and societal norms that put women and girls at particular risk. The query found very little evidence to show that this has been done in LMICs to date.*

Task-sharing and the involvement and training of community health workers and other non-specialist providers (including nurses, health visitors and midwives) to deliver mental health services. This is the most commonly suggested approach showing promising results across LMICs, in low resource settings where there are few mental health specialists. This is in line with Disease Control Priorities (DCP) and the WHO's recommendation to use primary health workers to address the treatment gap for mental, neurological and substance use disorders in LMICs (WHO, 2008b) and to move away from a sole focus on psychiatric institutional care to recovery-oriented psychosocial care in community settings. In addition, there is some argument that by integrating mental health into existing health programmes, there is more likely to be an uptake of services and interventions by not explicitly targeting mental health and exposing those with poor mental health to further stigma and discrimination (Rahman et al., 2008.).

Integrating mental health into antenatal care: Case Study, The Perinatal Mental Health Project (PMHP) in South Africa (Rahman, A et al, 2013).

The PMHP developed a *stepped care intervention* for maternal mental health that was integrated into antenatal care. It provided interventions to break the cycle of maternal mental distress by recognising that mental health services should be provided as part of health care at the primary level, not only at the specialist level. Women were referred to on-site counsellors who also acted as case managers or to on-site psychiatrists or specialists for secondary care. Over a 3-year period, 90% of all women attending antenatal care in the maternity clinic were offered mental health screening with 95% uptake. Of those screened, 32% qualified, of which 47% received counselling through the programme.

Important lessons include: (a) maternity health workers may be trained to screen for and refer women with mental distress in low-resource primary care settings; (b) training programmes that address and support the mental health needs of health workers may help staff to manage their workload and prevent compassion fatigue and "burn out"; (c) on-site screening and counselling fosters the establishment of efficient referral mechanisms and access to mental health care often lacking in maternity settings in LMICs; (d) on-site, integrated mental health services can increase access for women who have scarce resources and competing health, family, and economic priorities; e) coordinating mental health visits with subsequent antenatal visits further facilitates access for women with insufficient resources.

There are many other examples of screening and treatment of mental illness by primary health care workers. An evaluation was recently undertaken to evaluate the impact of district mental healthcare as part of the Programme for Improving Mental Health Care (PRIME) in Nepal (Jordans, J.D et al, 2019). Results showed the percentage of persons in the community receiving treatment increased from 0% to 12% for depression, 0% to 8% for alcohol use disorder, 3% to 53% for psychosis, and 1% to 13% for epilepsy. After six months of training, health workers accurately detected 1 out of 4 patients with depression (1 out of 5 patients 2 years after training) and 3 out of 5 patients with alcohol use disorder (1 out of 8 patients 2 years after training) among patients presenting to primary care facilities (Jordans, J.D et al., 2019). Of the patients detected with depression and alcohol use disorder 95% received minimally adequate care (at 2 years after training this was 2 out of 3 for depression, and 3 out of 4 for alcohol use disorder). The evaluation highlighted that having health workers deliver community- and primary-healthcare-based mental health services is a promising strategy to increase the number of people with mental health problems benefiting from such care.

Applying psychotherapeutic approaches, such as cognitive behaviour therapy (CBT), interpersonal therapy, or problem solving, for depression, by health workers. An intervention called the 'Thinking Healthy Programme' in Pakistan, used CBT techniques of active listening, collaboration with the family, guided discovery and homework and applied these to health workers'

routine practice of maternal and child health education, with women with depression. A cluster-randomised control trial (Rahman et al., 2008) tested the efficacy of the intervention in two rural areas. Results showed a remarkable decrease in the percentage of women with depression over a 6- to 12-month period and improvement in infant health outcomes (PMCH 2014). The programme aimed to minimise stigma that would likely be associated with participating in an intervention explicitly for mental illness by using infant health as the entry point and integrating the intervention into an existing health programme.

Supporting health care workers to recognise mental illness using locally validated assessment tools. One example is the 'Friendship Bench' approach – a bench is placed within the clinic premises, where clients can speak with the health workers about their problems. Patients are also invited to take part in income generating activities. After six months, all participants are assessed using locally validated questionnaires for depression and anxiety; the Shona Symptom Questionnaire, the Patient Health Questionnaire, and the Generalised Anxiety Disorder scale.[8]The Friendship Bench started in Zimbabwe as a research project with funding from Grand Challenges Canada in early 2016 and after the intervention was evaluated through a cluster randomised controlled trial, it was approved for scale-up by the health authorities (it is now operating in 72 clinics in Zimbabwe). The trial found that 14% of patients in the treatment group experienced symptoms of depression after six months compared to 50% patients in the control group. After six months, nearly half (48%) of patients who received standard care still had symptoms of anxiety compared to 12% who participated in Friendship Bench, and 12% of patients who received standard care still had suicidal thoughts compared to 2% participating in Friendship Bench (Chibanda, D et al., 2015).

Using mobile health (mHealth) technologies to increase engagement, reduce barriers and costs, increase adherence to treatment programmes, provide immediate psychological support, and facilitate self-monitoring and self-care. In LMICs, where access to mental healthcare is poor, there is a need to develop cost-effective methods that can identify and support hard to reach vulnerable women without having them face stigma and other related barriers (Price et al., 2014). The rapid growth in mobile telecommunications and internet access enables access to an increased number of people with mental health problems and psychosocial disabilities and to bridge the mental health treatment gap (Patel et al, 2018). A randomised controlled trial of an mHealth self-care intervention by nurses for women living with HIV in rural India (Chandra, P.S et al., 2018) showed women were able to express and communicate effectively during the mobile phone intervention. Women shared worries about their own and their children's future, stigma, loneliness, financial difficulties and poor emotions such as sadness and guilt. Other literature supports using emerging technologies as **o**nline communities to promote mental wellbeing and enable people with mental health conditions to feel less alone and find support from others with shared experiences. Family members can also access important resources such as social support, recommended coping strategies, and self-help programmes delivered online or through mobile phone platforms, for example the WHO iSupport programme (Patel et al., 2018).[9] Digital technology can also support effective training and supervision of non-specialist health workers (engaged in the task-sharing approach discussed above) through digital learning and supervision platforms, by providing crucial decision support tools, or access to specialist consultation and support (ibid;). Digital technology has also been used to educate health care staff and the public overall, and to disseminate information about common mental disorders through anti-stigma campaigns (ibid;).

A task-sharing model requires tackling negative attitudes of primary health care workers towards mental illness. A qualitative study conducted in 2014 in Ethiopia, India, Nepal, South Africa

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[8] https://www.mhinnovation.net/innovations/friendship-bench?qt-content_innovation=4#qt-content_innovation
[9] https://www.who.int/mental_health/neurology/dementia/iSupport_flyer.pdf?ua=1

and Uganda found that if primary care workers have stigmatising attitudes towards people with mental illness, it can make them more reluctant to take on mental health care duties as part of an integrated approach (Mendenhall, E et al., 2014). This point is also supported in a recent qualitative study undertaken in Sri Lanka (Palfreyman, 2018), which highlights that because public health workers including midwives are members of the communities in which they work, they occupy powerful positions socially and in the health system. With training and systematic support, they can play a critical role in alleviating women's risk of self-directed violence resulting from psychosocial distress related to gender roles, particularly women's exposure to violence and poor SRHR. However, the author cautions that without tackling rigid social and cultural norms, midwives can also play a negative role, for example, denying or discouraging sexual and reproductive rights such as access to abortion and encouraging compliance with societal and gendered expectations which perpetuate the psychosocial distress for which women sought help. DCP3 also states that mainstreaming a rights-based perspective throughout the health system and ensuring health policies, plans, and laws are consistent with international human rights standards and conventions would help tackle some of the negative attitudes towards those with poor mental health (DCP3, 2018).

Integrating mental health into school health and nutrition (SHN) programming as a key entry point for childhood/adolescence and for prevention of mental health issues. SHN programming is widely implemented across LMICs for skills-based health education on HIV but increasingly for other issues. UNICEF Kazakhstan trialled this approach by integrating suicide prevention and mental health into their SHN programme. A recent summative evaluation (ITAD, 2018) found that the programme contributed to increasing awareness of mental health issues among adolescents (and their parents), decision makers, and health providers and "an overall decrease in suicidal ideation (36.1%), depression (56.1%), anxiety (80.6%) and stress (65%) amongst all students" (p. 7). Experts in the field have identified this as a positive model, if a gendered lens is applied, that can be further rolled out in other LMICs – "*this is a crucial age to normalise language around mental health*"[10]. A similar school-based approach has also been piloted in Liberia, Mozambique and the Democratic Republic of Congo (Sarr et al., 2017).

Other recommended, and less evidenced, approaches include using a convergent or socio-ecological model by recognising and addressing social, biological, environmental and cultural factors across the life course, for the promotion of mental health and the prevention of disorders. Patel et al (2018) argue these interventions should target social and environmental determinants that have a crucial influence on mental health at developmentally sensitive periods, particularly in childhood and adolescence. This is also articulated in the DCPs recommendations and supported by UNFPA (2008) which states that while family, partner and peer support are effective; community involvement also plays an important role-as does the social environment. This is important to effectively tackle and address mental health overall, and to not create a view that these as women's issues alone[11].

5. List of key guidance documents and entry points to integrating mental health into maternal health and SRHR programming

This section presents some guidance documents by key organisations such as the WHO, UNFPA, and UNICEF on how to better address and promote mental health more generally. Few guidance documents are available to help identify entry points for integrating mental health into maternal health and SRHR

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[10] Discussion with Alexis Palfreyman, April 2019.

[11] For example, antenatal models are crucial for screening of women with mental health issues or disorders, but they can also perpetuate a model that keeps men out and puts the full responsibility on the woman. The Mental Health Foundation uses the term 'parental mental health' for this reason.

programming, particularly in LMICs. Some of this guidance included in the table below relates to HICs; These guidelines can provide useful frameworks that can be adapted and applied elsewhere.[12]

Reference	Year published	Overview
Disease Control Priorities (DCP) 3	2018	The third edition of the DCP focuses on mental neurological, and substance use (MNS) disorders health in separate volume (Vol 4). to the volume on Reproductive, Maternal, Newborn and Child Health (Vol. 2). In the RMNCH volume, the focus is on preventing poor maternal mental health in order to tackle negative developmental outcomes for children and intergenerational transmission of ill health and poverty, rather than improving outcomes for the women. However, DCP3 identifies a number of interventions to address women's mental health needs that are both cost-effective and feasible in low-resource settings. • Prevention – although there is limited evidence on interventions to prevent or delay the onset of mental and neurological conditions, DCP argues that interventions targeting parenting skills and parent-child communication are highly recommended. DCP3 also recommends targeting children and adolescents with life skills training in schools to build social and emotional competencies that could help mitigate the development of mental illness. Community-based education campaigns for the prevention of gender-based violence should be considered due to the relationship between discrimination and violence and mental illness. Policies are also interventions. Legislation regulating access to means of suicide (such as pesticides) can effectively lower mortality rates due to self-harm. • Treatment – this includes psychosocial care coupled, where necessary, with generic formulations of essential medicines, and is often done at primary care facilities • Scale up as part of Universal Health Coverage (UHC) – DCP argues that 'years lost to disabilities' could be averted in lower-middle income-countries in 2030 by achieving full coverage. All this requires embedding health indicators for mental health within national health information and surveillance systems so that progress and achievements can be monitored and evaluated.

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[12] However, it is important to note that most available guidance, while valuable, is not designed with gender-sensitive strategies and gender-specific needs in mind.

Mental Health and Prevention: Taking local action for better health by the Mental Health Foundation	2016	This guidance document is a HIC contribution, however it lays out key actions to support a socio-ecological model approach (involving the whole community) to public mental health and to prevent the development of mental illness at key stages of the life course, and includes a focus on pregnancy, young people and older ages.
WHO Guideline: Recommendations on Digital Interventions for Health System Strengthening	2019	The key aim of this guideline is to present recommendations based on a critical evaluation of the evidence on emerging digital health interventions that are contributing to health system improvements, based on an assessment of the benefits, harms, acceptability, feasibility, resource use and equity considerations. The guideline is useful to consider when thinking through feasibility of using digital interventions in LMICs, for mental health interventions.
UNDP, UNFPA, UNICEF, WHO and WB: New Supplement for Self-care Interventions on SRHR	2019	The special supplement includes a collection of analyses, systematic reviews and opinion pieces, providing an evidence base for the development of global normative guidance. The supplement aims to support an individual's capacity and ability to make informed decisions and make use of available health resources to successfully managed a health condition. This approach can support many people in low-resource settings where access to professional medical care is minimal.
Global Challenges in Mental Health	NA	The principles underlining the priorities are to use a life-course approach, system-wide approaches to address suffering, and to understand the environmental context in which illness occurs and services are delivered. In summary, the recommendations include: • Enhancing collaboration between maternal and child health, and mental health programmes, researchers, and practitioners • Developing effective treatments for use by non-specialists, with minimal training • Addressing stigma related to mental illness that could impede the integration of mental health into broader health programmes and systems • Increasing capacity in LMICs by creating regional centres for mental health research, education, training, and practice that incorporate the views and needs of local people • Strengthening the mental health component in the training of all healthcare personnel • Redesigning health systems to integrate maternal depression with other chronic disease care, and create parity between mental and physical illness in terms of investment • Incorporating a mental health component into international (MNCH and SRHR) aid and development programmes

WHO's Mental Health Gap Action Programme (mhGAP)	2008 onwards	The programme includes a range of resources: • A locally applicable intervention guide and application to help support non-specialised healthcare providers to diagnose and treat a range of mental, health issues from their tablets or phones. • A training manual to build capacity among non-specialist health-care providers. Modules include essential care and practice, depression, epilepsy, psychoses, child and adolescent mental health, self-harm amongst others.
WHO Thinking Healthy: A Manual for Psychological Management of Perinatal Depression	2015	The manual, originally developed in Pakistan, outlines an approach to help community health workers reduce prenatal depression through CBT interventions using less resources compared to conventional psychological treatments. Examples of low-intensity psychological interventions include brief, basic, paraprofessional-delivered psychological treatments as well as self-help books and self-help e-mental health programmes.
The Friendship Bench: Training Manual	2015	The training manual explains common mental illnesses and how to administer and score the locally validated questionnaire. Required counselling skills are explained in detail, as is the Problem-Solving Therapy approach.
UNICEF: Operational Guidelines on Community Based Mental Health and Psychosocial Support (MHPSS) in Humanitarian Settings -Three-tiered Support for Children and Families	2018	The guidelines offer practical information and tools to implement a range of mental health and psychosocial support interventions to rapidly address the protection and psychosocial support needs of children and families, in parallel with tailored mental health interventions for those most in need. They are intended to help embed MHPSS programmes in communities.
WHO QualityRights Tool kit	2012	The tool kit provides countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities. It is based on the United Nations CRPD and is designed for use in both LMICs and HICs. The WHO states that a comprehensive assessment of facilities can help to identify problems in existing health care practices and to plan effective means to ensure that the services are of good quality, respectful of human rights, responsive to the users' requirements and promote the users' autonomy, dignity and right to self-determination.

Key entry points identified through the query are the following:

- Integrating mental health into primary mental and SRHR services and interventions by supporting and training non-specialist staff (e.g. midwifes and nurses).
- Engaging other key sectors concerned with mental health to improve services, notably the social care, non-governmental organizations, private sector, criminal justice, education, and indigenous medical sectors, as they all have complementary roles.
- Addressing stigma related to mental illness that could impede the integration of mental health into broader health programmes and systems.
- Placing human rights, gender equality and inclusion at the centre of a comprehensive approach to mental health programming, particularly in relation to sexuality and sexual health.

- Supporting health programmes, including those providing mental health services already, to be gender-sensitive and geared to addressing mental health problems in women and girls, such as maternal depression and the consequences of violence.
- Undertaking a lifecourse approach when designing interventions to tackle women's mental health. This is important to ensure that no one is left behind and that there is continuity of care, especially for women with chronic mental health issues.
- Using infant health as an entry point to engage with mothers and fathers about maternal and parental mental health to minimise stigma that would likely be associated with participating in an intervention explicitly for mental illness, and to include the fathers in the treatment and recovery of the mother.[13]
- Integrating mental health into school- based health programming (e.g. SHN, SRHR) to help destigmatise mental illness and to prevent mental health issues in later life.
- Using a convergent or socio-ecological model by recognising and addressing social, biological, environmental and cultural factors that put women at risk of poor mental health.
- Exploring the use of technologies to remove barriers facing some women in accessing health services and support (for SRHR, maternal and mental health)

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[13] This is also important to not put full responsibility of the infant's health on the mother.

5. References

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Mental health, maternal health and sexual and reproductive health and rights

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