Malawi Maternal Mental Health Manual

A Practical Guide for Healthcare Workers

1st Edition
January 2025

Foreword

The mental health of a woman in pregnancy and the postnatal period is key to her wellbeing and that of her child, family and the wider community.

Many women experience challenges to their mental health in the perinatal period including financial concerns, complications of childbirth, and gender-based violence. These distressing circumstances can lead to mental health conditions such as depression and anxiety. In addition, some women will experience severe mental illness including postpartum psychosis.

Effective evidence-based interventions exist for the detection, prevention and treatment of maternal mental health conditions. These are best delivered through integration of mental healthcare into reproductive and child health services, supported by mental health services with specialist expertise.

The Malawi Maternal Mental Health Manual has been developed to help healthcare providers in Malawi integrate mental healthcare into their routine clinical practice. The manual aligns with the World Health Organization call for the integration of mental health into maternal health care, and with the Government of Malawi's mental health policy of integrating mental health into primary care.

I commend the efforts of all those involved in the development of this manual and express my sincere gratitude for their dedication to improving healthcare of mothers in our country.

Finally, I encourage all healthcare workers to utilize this manual as a valuable tool in their commitment to promoting maternal health and well-being in our communities.

Honourable Khumbize Kandodo Chiponda, MP

MINISTER OF HEALTH

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Lead Editors: Dorothy Williams and Robert C. Stewart

Reviewers and contributors: Catherine Bamuya, Grace Chavula, Genesis Chorwe-Sungani, Simone Honikman, Mary Kachondemwale, Angella Mainjeni, Christina Mchoma, Madalitso Makhalira, Jullita Kenala Malava, Donncha Mullin, Mwawi Ng'oma, Innocent Nyanjagha, Ndumanene Devlin Silungwe, Michael Udedi, Gladys Vitsitsi. (Apologies to anyone who has been missed).

Illustrator: Ralph Mawera (working through Zaluso Arts).

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Publications from which material has been adapted for this guide:

- Maternal Mental Health: A Guide for Health and Social Workers (Field, Honikman & Woods, 2018)
- Where There is No Psychiatrist (Patel & Hanlon, 2018)
- WHO Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services (World Health Organisation, 2022)
- WHO mhGAP Intervention Guide Version 2.0 (World Health Organisation, 2016)
- The Malawi Quick Guide to Mental Health (Scotland-Malawi Mental Health Education Project; lead editors Mullin & Stewart, 2020)
- Malawi Standard Treatment Guidelines (MSTG; Malawi Ministry of Health, 2015)
- NICE Antenatal and Postnatal Mental Health: Clinical Management and Service Guidelines (The National Institute for Health and Care Excellence, 2014)
- WHO Recommendations on Maternal and Newborn Care for a Positive Postnatal Experience ((World Health Organisation, 2022)
- WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience (World Health Organisation, 2016)
- Symptom-based Integrated Approach to the Adult in Primary Care (The South African National Department of Health, 2019)
- Maternal Mental Health: A Handbook for Healthcare Workers 3rd Edition (Honikman & Field, 2013)

Dr Samson Mndolo

SECRETARY FOR HEALTH

1st Edition (Revised), May 2025

Introduction to the manual

The Malawi Maternal Mental Health Manual has been created to help maternity healthcare providers (e.g., nurse-midwives, maternity clinicians) in Malawi integrate mental healthcare into their routine clinical practice.

The manual describes common mental health conditions experienced by women in the perinatal period (pregnancy, childbirth and the first postnatal year). It offers practical guidance for staff working in busy healthcare environments with consideration of local and cultural contexts.

The manual emphasises mental health as a crucial element of safe and empowering maternity experiences.

With adequate training, supervision and access to referral pathways, maternity staff can:

1. Provide respectful and compassionate care to women attending maternity services, including those with mental health conditions.
2. Identify women who may have mental health conditions through use of routine history taking, mental wellbeing checks, and recognition of common presentations and stressors.
3. Act urgently in high-risk "red flag" presentations including delirium, aggression, high suicide risk, and the inability of a mother to care for herself or her baby.
4. Integrate aspects of mental health and psychosocial support (MHPSS) into routine practice including empathic listening, health talks and other forms of psychosocial care.
5. Know when and how to refer to the mental health team, and work jointly with them to support women with mental illness during pregnancy and after birth.
6. Support women following the loss of a baby, and in other distressing circumstances.
7. Take care of their own mental health and seek support if needed.

What does the manual contain?

This manual is split into seven parts:

Part 1, 'Introduction and Principles of Care' provides an overview of maternal mental health conditions and maternity healthcare workers' role in mental health care. It also includes information on combatting stigma, respectful maternity care and healthcare worker self-care.

Part 2, 'Core Knowledge and Skills' describes maternal mental health conditions in more detail and provides instruction on first-line mental health care, screening and referral.

Part 3, 'Red Flag Clinical Presentations' outlines strategies for care in urgent situations including those related to agitation and aggression, unusual behaviours, suicide, neglect of self and baby, and risk from intimate partner violence.

Part 4, 'Common Presentations and Management Through the Perinatal Period' describes the assessment, care and referral pathways for mental health conditions and social stressors. It also considers the needs of 'special' maternity populations such as women living with HIV and adolescent girls.

Part 5 'Helping Women Who Have Experienced Recent Loss and Trauma' acknowledges that the loss of a baby and birth trauma are some of the most devastating experiences for women. Caring for these mothers is a particular challenge for health staff; this section offers practical advice.

Part 6, 'Psychosocial Interventions' provides an opportunity for further learning on the delivery of psychosocial care, including guidance on psychoeducation, promoting mother-infant bonding, and how to deliver problem-solving counselling.

Part 7, 'Helping Fathers and Other Family Members' explains how family wellbeing should be inclusive of the father's mental health and offers advice for family members caring for a pregnant woman or mother with a mental health condition.

Appendices include a suggested script for a health talk and a patient information leaflet.

The clinical situations and recommended responses in this manual will vary depending on healthcare setting. Users of the manual should consider the availability of resources and referral pathways. The manual should always be used alongside clinical judgement.

Note: This manual often uses the terms 'pregnant woman' and 'mother' for ease of understanding but acknowledges that those who are pregnant, give birth and care for infants may occupy multiple other roles outside of these identities.

Some useful further resources

- Maternal Mental Health: A guide for health and social workers (Field, Honikman & Woods, 2018)
- Where There is No Psychiatrist (Patel & Hanlon, 2018)
- WHO Guide for Integration of Perinatal Mental Health in Maternal/Child Health Services (2022)
- WHO mhGAP Intervention Guide 2.0 (2016)
- The Malawi Quick Guide to Mental Health (SMMHEP; Editors Mullin & Stewart, 2020)
- Action on Postpartum Psychosis website - www.app-network.org

Table of contents

PART 1

Introduction and Principles of Care

- Overview of maternal mental health
- Role of maternity healthcare workers in maternal mental healthcare
- Respectful maternity care
- Reducing stigma and discrimination around maternal mental health
- Healthcare worker self-care

Overview of maternal mental health

Pregnancy, childbirth and the postpartum period bring huge changes in a woman's life. These changes may be physical, emotional, practical, financial, spiritual, cultural and in her relationships. It is normal for a woman to sometimes feel worried and uncertain during the perinatal period, even when all goes well.

Having support from a partner and/or family and friends is central to coping through this period. Good quality health services and respectful maternity care are also fundamental.

For some women, the perinatal period is a particularly difficult time due to adversities and social vulnerabilities. Such challenges make these women more likely to develop maternal mental health conditions that can affect not only the health and wellbeing of the woman but also her baby and wider family. Examples of these challenges include:

- A history of mental health problems
- Physical complications of pregnancy/childbirth
- HIV or other chronic health conditions
- Loss of a baby
- Intimate partner violence (IPV)
- Poverty and food insecurity

Maternal mental health conditions

Maternal mental health conditions can be broadly divided into three types:

1. **Distress, depression and anxiety**
   This is the largest category. It ranges from temporary distress to diagnosable depression and anxiety disorders.
2. **Psychosis and severe mood disorders**
   These severe conditions require special attention, in part because episodes can be triggered by childbirth.
3. **Mental health symptoms caused by obstetric or general medical conditions**
   These conditions should not be missed as they require urgent obstetric/medical treatment.

Other perinatal mental health challenges include **misuse of drugs and alcohol**. This is not common among women in Malawi at present but is likely to increase.

1. Distress, depression and anxiety

As described above, the perinatal period can bring many challenges to a woman's mental health. Often women can cope in these circumstances through emotional resilience and support from others.

However, if a woman is particularly vulnerable (e.g., she has a mental health history), the stress is overwhelming (e.g., loss of a baby) or chronic (e.g., IPV), and/or the woman lacks support, she may become distressed, depressed and anxious.

Distress may be temporary if the woman is able to access emotional and practical support. However, it can become persistent and disabling. Women may experience cycles of negative thoughts (depression) and worry (anxiety) that are difficult to break out of and that affect her ability to function.

In cases of traumatic delivery, the woman may go on to have intrusive memories about the event and experience a heightened emotional state. If persistent and disabling, this may be diagnosed as post-traumatic stress disorder (PTSD).

Distress in pregnant women and mothers may be shown through behaviours such as non-attendance at antenatal care, physical complaints, substance misuse, or even aggression.

Psychosocial interventions delivered within maternity care by trained staff can be effective treatments. However, for more severe or complex situations (e.g., suicide risk, probable PTSD) referral to a mental health team is required.

2. Psychosis and severe mood disorder

Some women are vulnerable to severe mental illness in the perinatal period. Although these conditions are relatively rare, they can have severe consequences if not identified and managed well.

Women may be identified at their antenatal clinic booking appointment as having a pre-existing diagnosis (e.g., previous postpartum psychosis, bipolar disorder, schizophrenia), or they may develop an acute episode for the first time in the postpartum period (postpartum psychosis).

Women with these conditions should always be referred to a mental health team for further assessment. They need treatment, monitoring and support through *collaboration* between maternity and mental health teams. Acute episodes often present with high-risk behaviours. These emergencies require urgent management/referral.

3. Mental health symptoms caused by obstetric or general medical conditions

Women presenting with mental health symptoms may sometimes have an underlying obstetric complication or general medical condition such as infection, haemorrhage, gestational diabetes, pre-eclampsia or medication overdose. Typical features include confusion (delirium) and signs/symptoms of the underlying cause (e.g., fever or raised blood pressure). These presentations require urgent investigation and management by the maternity/medical teams.

See Part 2 for further details on maternal mental health conditions.

The role of maternity healthcare workers in maternal mental healthcare

Maternity healthcare workers are in an ideal position to:

- Promote the mental health of all women attending maternity services.
- Identify women with mental health conditions needing further assessment, treatment and support.
- Deliver basic mental health and psychosocial support interventions.
- Make appropriate referrals.

To facilitate this, they need support from colleagues, access to mental health advice and referral pathways, and the support of health service management.

Maternity healthcare worker mental health and psychosocial support responsibilities

1. Provide respectful maternity care to all women including those with mental health conditions.
2. Show kindness and understanding to women experiencing distress, and, if possible, help them identify solutions to their problems, and/or effective ways of coping.
3. Identify (through screening or recognising clinical presentations) those women experiencing distress or who may have depression and/or an anxiety disorder. Provide basic psychosocial interventions, and referral if needed.
4. Identify (through screening or recognising clinical presentations) those women with psychosis or severe mood disorder. These women are at high risk of relapse in the perinatal period. Refer and work jointly with the mental health team to support these women throughout their pregnancy and delivery.
5. Provide initial assessment and management of urgent “red flag” situations such as aggression and agitation, unusual behaviours, suicidal thoughts and plans, neglect of self or the baby, and risk from intimate partner violence (IPV).
6. Look out for the signs and symptoms of delirium. Act urgently (and refer as needed) to assess, investigate and treat underlying obstetric complications/medical conditions.
7. Understand how traumatic events such as loss of a baby or delivery complications can affect a mother. Provide compassionate support and practical advice.
8. Recognise the stressful nature of working as a maternity healthcare worker and how this can affect how you provide care. Practice self-care and seek support where possible.

Support needed by maternity healthcare workers to fulfil their mental health role

Maternity healthcare provision in Malawi is not only a very busy job but also physically and emotionally demanding. Maternity healthcare workers may feel that taking on a role in maternal mental health is not possible given their other responsibilities.

However, there are many reasons why it is possible and beneficial for maternity healthcare workers to provide maternal mental health care:

- Maternity healthcare workers are already providing care for women with mental health problems – this manual just provides a structure to this work and guidance for doing it well.
- Early recognition and management of mental health problems prevents situations worsening and becoming more difficult to manage.
- Integration of mental health will improve the experiences of women and their perception of staff.
- For maternity healthcare workers to know that they are providing good quality holistic care is rewarding in itself and is a boost to job satisfaction.

Nevertheless, maternity healthcare workers need support to fulfil their mental health and psychosocial support roles. This support includes:

- Pre-service and in-service training.
- Access to guidance such as this manual.
- Support from colleagues within the obstetric team, e.g., a clinician should respond quickly whenever a maternity healthcare worker has concerns about possible delirium or escalating agitation.
- Access to easy referral to a mental health team, and channels of communication to allow ongoing collaboration and supervision.
- Support from administrative management to ensure that the mental health role is recognised in job descriptions, and resources made available (e.g., fuel for transfer in emergency situations).
- Support from government to adequately fund maternal and mental health services in Malawi.

Respectful maternity care

Respectful care is at the core of all maternal and mental health service delivery. *Respectful maternity care* is care organised and provided for all women that ensures freedom from harm and mistreatment.

Respectful care should also respect and enable women's rights to autonomy and informed choice (i.e., fully understanding the facts of a situation and being able to choose the course of action).

The provision of respectful maternity care is considered a universal human right that typically does not require additional resources.

Principles of respectful maternity care

Key principles of respectful maternal healthcare include the rights to:

1. **Freedom from harm and mistreatment -** care provided in the absence of abuse.
2. **Privacy and confidentiality -** ensuring care is discrete and kept private.
3. **Dignity and respect –** all women are of equal worth and should receive respectful and compassionate care.
4. **Autonomy -** the ability for a woman to be independent and make decisions without unnecessary external influence or control.
5. **Beliefs and preferences -** respecting the woman's way of thinking.
6. **Consent -** the right to information and the ability to make a choice, including refusal of care, based on this information.
7. **Accessible care -** timely healthcare that strives for the highest attainable level of health. No denial or abandonment of care.
8. **Equality -** equitable care provision and freedom from discrimination.

These principles should be upheld at all maternal healthcare interactions.

Vulnerable populations

All women are vulnerable to the harmful effects of disrespectful maternity care, but some groups are at a higher risk:

- Women with disabilities (physical or mental)
- Women living with HIV
- Women with low socioeconomic status
- Women from minority groups
- Unmarried women
- Adolescents
- Older women

Abuse and disrespect from healthcare providers can cause mental distress, discourage women from seeking healthcare due to fear, and dissuade women from facility-based delivery. This can put both a woman and her baby at risk.

Unfortunately, many women experience disrespectful, neglectful, and abusive maternity care. During childbirth, women are particularly at risk of disrespectful and abusive care due to their increased vulnerable state and the often highly intense and emotional situational environment.

How to practice respectful care during childbirth

Absence of physical abuse

- Not slapping, pinching or hitting the woman.

Confidential care

- Having privacy during assessment.
- Draping the woman.
- Providing the woman with her own bed.
- Using curtains or visual barriers to protect the woman during exams, procedures, and birth.
- Limiting access to assessment and examination rooms to only the staff attending to the woman.
- Keeping information and records about the woman's care private within the healthcare team unless consent has been obtained from her to share information with third parties.
- Not taking photos of the woman or sharing her personal care details on social media.

Dignified care

- Respectfully greet the woman.
- Not shouting, insulting or using demeaning words towards the woman.

Uplifting and empowering care

- Providing the woman with pain relief.
- Encouraging the woman to have fluid or foods.
- Encouraging and assisting the woman.
- Keeping the woman and newborn in the same room after delivery.
- Encouraging or allowing the woman to have a support person of her choice present.
- Allowing the woman to deliver in her preferred position assuming it is safe.

Consented care

- Explaining procedures to the woman or her support person before proceeding, including what the woman is supposed to do during delivery.
- Asking the woman or her support person if they have any questions or concerns.
- Explaining to the woman or her support person what will happen to the woman during labour.
- Giving an update on the progress and status of the labour.

Under **NO** circumstances should pregnant women or mothers be humiliated, harmed, detained or refused care or admission.

Reducing stigma and discrimination around maternal mental health

Women with maternal mental health conditions can often become the focus of stigmatising beliefs e.g., that they are weak, inferior or dangerous. Stigma is very damaging as it can lead to discriminatory actions such as not providing the same quality of maternity care to a woman with a mental illness.

Stigma and discrimination can make the experience of mental health conditions even more challenging for a woman in the perinatal period.

This can lead to internalised shame, isolation and a reluctance to seek support or help which can negatively affect both the woman and her baby.

Myths and misconceptions

Stigmatising myths and misconceptions about maternal mental health conditions include:

- A mother is weak for feeling depressed.
- A pregnant woman or mother is lying about her mental health experiences for attention.
- Maternal mental health conditions are caused by witchcraft.
- Maternal mental health conditions are the fault of the pregnant woman or mother.
- Women with mental health conditions should not have a baby.
- Maternal mental health conditions are rare.
- Maternal mental health conditions will just get better without help.

Healthcare providers should make a conscious effort to discredit myths and misconceptions such as these among both colleagues and patients.

Labelling

Sometimes women in distress may be labelled as "crazy", "mad", "difficult", "uncooperative" and "non-compliant" patients, especially during labour. Women may also be labelled based on their diagnosis (e.g., "psych" or "schizo") which can worsen stigma and undermine other aspects of the woman's identity.

Labels like these enable disrespectful treatment and can lead maternity healthcare providers to neglect the woman's underlying problems and/or needs.

Instead, maternity healthcare providers should understand that behaviours that may be labelled as "difficult"/"uncooperative"/"non-compliant" are often a sign of distress or underlying illness and not deliberately intended to cause problems or make the lives of staff more difficult.

> **Remember:** the most "uncooperative" or "difficult" women may be the most vulnerable and afraid.

Attitudes when you are providing maternal mental health care

Your attitude when speaking to a woman can determine whether a woman feels comfortable expressing her mental health care needs. Empathy, reassurance, warmth, and non-judgement should be conveyed throughout all interactions with no indications of stigma.

Empathy describes putting yourself in the woman's shoes and can be shown by saying phrases such as:

- "That sounds really difficult."
- "I am so sorry that has happened to you."

Reassurance helps to lessen doubts and fears. Reassuring phrases may be especially useful in situations where women are particularly vulnerable such as during childbirth. For example, "I am here to help you, not to do you any harm".

Speaking about mental health problems can be very scary for a pregnant woman or mother. A friendly smile and warm introduction can be enough to give the woman confidence to speak about her problems. If possible, try to ensure that you provide care to the woman at future appointments. This will help with continuity of care and will avoid making the woman repeat her personal experiences to multiple maternity healthcare workers.

Regardless of what the woman discloses or shares with you, it is not your place to make moral judgements even if what is shared goes against your values or beliefs (e.g., marital infidelity or use of substances).

Your role as a healthcare provider is to help and not to judge. Instead, recognise that the woman is looking to you for guidance and is placing her trust in you.

Healthcare worker self-care

The mental health and well-being of maternity healthcare workers are just as important as that of the women they care for. If maternity healthcare workers are not maintaining their own mental health, it will make it more difficult to provide mental health care to their patients.

Although it is a rewarding job, the physical, mental, and emotional burden of being a maternity healthcare worker can be very high. It is normal to feel stressed, drained, and exhausted at times.

Maternity healthcare workers may simultaneously be dealing with:

- Stressful work factors (e.g., high number of patients, inadequate resources, low morale)
- Interpersonal problems (e.g., financial stress, parenting own children, marriage difficulties)

Together these can make it easy to feel overwhelmed and to become frustrated and irritable towards patients and colleagues at work.

Though it can be easy to let personal stress impact on patient and colleague interactions, it is crucial to remain professional and maintain respect and compassion for others in the workplace.

Signs of stress in health workers

These include:

- Not sleeping well
- Worrying all the time
- Not wanting to be around people and withdrawing socially
- Feeling physically or mentally fatigued
- Physical health problems (e.g., headaches, gastro-intestinal problems)
- Fluctuating mood
- Shouting or being aggressive towards patients
- Alcohol or drug use

Self-care and managing stress

There are various strategies that can maintain healthcare worker self-care and prevent burnout.

1. Sharing and socialising
Talk to friends, family and colleagues about your work and any challenges you may have faced (remember to maintain patient confidentiality). Just speaking about it may help relieve some of the burden. Try to make time to socialise with people outside of work and do something positive and uplifting (e.g., visiting a religious space).

2. Ask for help
If you feel that you are not coping well on your own, reach out to a trusted colleague or a supervisor who may be able to provide supervision or point you in the direction of further support services and professional help.

3. Taking a break
Taking time out is essential for your mental health and can help stop things from becoming too overwhelming. 'Taking a break' might mean going for a walk, having some alone time, or doing something else that can help you relax in or after your workday.

4. Prioritising nutrition and sleep
Sometimes it's easy for us to forget the basics when we are physically and emotionally drained by work. Ensuring that you are getting enough sleep and eating regularly can improve your mood and positively impact your ability to cope with stress. Try not to skip meals and remember to drink enough water throughout the day.

5. Creative and fun activities
Participating in activities that you enjoy and find meaningful that are not related to work can help alleviate stress. Examples of these kinds of activities may be sewing, reading, or doing outdoor activities.

It may sometimes help to remind yourself that, although the job can be difficult and tiring, you are doing important and meaningful work.

PART 2

Core Knowledge and Skills

- Maternal mental health conditions
- First line maternal mental healthcare
- Maternal mental health screening and initial assessment
- Making referrals

Maternal mental health conditions

Maternal mental health conditions were introduced in Part 1. This chapter describes the conditions in more detail. Information about the assessment and management of presentations of these conditions are contained in later sections.

Maternal Mental Health conditions can be broadly divided into 3 categories:

1. Distress, depression and anxiety
2. Psychosis and severe mood disorders
3. Mental health symptoms caused by obstetric or general medical conditions

Other maternal mental health problems include misuse of drugs and alcohol.

Maternal mental health conditions affect not only the health and wellbeing of the woman but also her baby and wider family:

- Increased risk of maternal and infant mortality
- Suicide, baby abandonment, and, rarely, infanticide
- Lack of adherence to prenatal care, increasing the risk of untreated complications
- Delayed recognition or denial of pregnancy
- Increased risk of preterm delivery
- Poor infant nutrition, health and development
- Difficulty taking care of self and baby
- Difficulty breastfeeding
- Difficulty bonding with the baby
- An inability to work and earn income
- Damage to social and community relationships due to stigma and mistreatment

1. Distress, depression and anxiety

About a third (33%) of women will experience distress or depressive, anxious and related symptoms in the perinatal period. This third (33%) is broken down as follows:

- About 20% will be **distressed** but are generally able to carry out their daily tasks. They may have a few symptoms of depression and anxiety as described below, but these last no more than two weeks.
- About 10% will have symptoms that markedly interfere with their daily life. They can be given a formal diagnosis of **mild to moderate depression or anxiety disorder.** Symptoms of depression and anxiety often occur together.
- About 3% will have **moderate to severe depression** with risks such as suicidality or neglect.

Depression

In depressive disorder, the person experiences persistent and disabling low mood, loss of interest/pleasure, and other symptoms that last for at least 2 weeks (and often for much longer). Women are particularly vulnerable to depression in the postpartum period ("postnatal depression"), but it can also occur antenatally.

Signs and symptoms of depression

- Persistent sadness/tearfulness
- Loss of interest or pleasure (e.g., in caring for the baby)
- Loss of energy and poor concentration
- Loss of appetite
- Changes in sleep (e.g., being unable to sleep even when the baby is sleeping)
- Low self-esteem and feelings of guilt
- A sense of hopelessness about the future that may lead to thoughts or plans of suicide
- Lack of self-care, or struggling to meet baby's care needs
- Non-specific physical symptoms (e.g., headache, generalised body pain)

Vulnerability factors for depression

The following factors make women more likely to experience depression in the perinatal period:

General factors

- Experience of a previous episode of depression
- A family history of depression
- Experience of abuse or other trauma in early life
- Low income
- Lack of social support
- Intimate partner violence
- Being an adolescent
- Having a chronic disease
- Caring for a disabled child

Perinatal factors

- History of miscarriage or loss of a baby
- Unplanned pregnancy
- Pregnancy-related complications (e.g., nausea and pain)

'Baby blues'

It is common (50%) and considered normal for women to experience some low mood and tearfulness in the immediate 1-2 weeks following birth. This is known as the **'baby blues'**. During this period, women may feel emotions very intensely and experience mood swings.

These women need general support and reassurance. However, if they have symptoms lasting longer than 2 weeks, have thoughts of suicide, or unusual beliefs, they need further mental health assessment.

Anxiety

Pregnancy and the postnatal period can bring a lot of uncertainty and new challenges. These can exacerbate worry, unease, and other symptoms of anxiety.

Signs and symptoms of anxiety

Psychological

- Intense feelings of worry
- Restlessness
- Irritability

Physical

- Tiredness and sleep disturbance
- Heart racing and sweating
- Chest pains or difficulty breathing
- Stomach problems e.g., nausea or diarrhoea
- Headache, muscle aches and tension

If these symptoms are marked, long lasting and interfere with day-to-day living, this is referred to as an anxiety disorder.

Triggers and vulnerability factors for anxiety

Triggers for perinatal anxiety:

- Fear of childbirth (e.g., fear of vaginal and perineal trauma)
- Fear related to newborn wellbeing, including fear of the newborn being harmed in delivery or having a congenital abnormality
- Complications diagnosed during pregnancy
- Concern about being a good mother
- Unsuccessful breastfeeding initiation
- Negative healthcare worker attitudes
- Financial concerns
- Relationship concerns

Vulnerability factors include a personal or family history of anxiety or other mental health conditions, poor physical health, unplanned pregnancy, history of infertility, and being an adolescent.

Other distress reactions

Women may also show their distress through behaviours:

- Not attending or missing antenatal clinic appointments
- Unusual physical complaints (e.g., not being able to walk even though there is no underlying medical cause)
- Substance misuse
- Aggression

It is important to consider distress as a cause of behaviours that may seem “difficult”. However, always rule out a physical illness or mental disorder as a potential cause before managing it as a behavioural reaction to stress. Seek advice if you are unsure.

Reactions to severe traumatic events

The perinatal period brings the risk of severely traumatic events for a woman such as:

- Experiencing a traumatic birth injury
- Feeling that she is going to die in childbirth
- Having her infant die or be injured (or be at risk of this happening)

It is normal to have an intense emotional reaction immediately after a traumatic event. The woman may appear dazed, perplexed, intensely anxious, distressed, sweating, and tachycardic.

For most women, these acute experiences will resolve though they will still experience a normal process of grief and adjustment.

Some women, however, will go on to experience a persistent state of intense emotional disturbance known as post-traumatic stress disorder (PTSD).

Signs and symptoms of PTSD

- **Re-experiencing or reliving the trauma** often through flashbacks, nightmares and intrusive memories.
- **Avoidance** of situations or things that bring back memories of the trauma (e.g., avoiding hospitals or avoiding meeting other women with babies after a perinatal loss or traumatic birth).
- **Being constantly on high alert** (i.e., feeling very fearful or on edge) which may cause difficulty sleeping, panic attacks, irritability and difficulty concentrating.
- **Physical symptoms** including headaches, increased heart rate and blood pressure, dizziness, nausea, rapid breathing, muscle tension and diarrhoea or other gastrointestinal distress.
- **Functional impairment** such as being unable to carry out usual tasks or having trouble in relationships.

2. Psychosis and severe mood disorders

Psychosis and severe mood disorders are relatively rare (1%) but important mental health conditions that can affect women in the perinatal period.

It is very important to ask all women about a history of psychosis or severe mood disorder at her first antenatal clinic "booking" appointment (see pages 18-19).

Psychosis is a state in which the person experiences unusual thinking, perceptions and behaviour:

- Delusions – fixed, false beliefs not shared by others in the same culture (e.g., the mother may believe that the baby is evil and dangerous or that health workers are trying to hurt her)
- Hallucinations – seeing or hearing things that others cannot see or hear
- Disorganised speech and behaviour

Psychotic symptoms can occur in various conditions including schizophrenia and severe mood disorders (see below). They can also occur in drug-induced psychosis and delirium, so it is important to rule out a physical health cause if someone has these symptoms.

In severe mood disorders, depression may be very severe (see: signs and symptoms of depression on page 13), and/or there may be episodes of both depression and very high mood (mania). Symptoms of mania include:

- Not feeling the need to sleep
- Increase in energy
- Rapid speech
- Risky or impulsive behaviour that can have adverse consequences (e.g., reckless spending or sexual promiscuity/risk-taking)
- Elevated irritability and agitation
- Unreasonably inflated self-esteem
- Easily distracted
- Psychotic symptoms (e.g., hearing voices saying that one has special powers)

The condition in which a person has recurrent episodes of mania and depression is known as bipolar disorder.

Postpartum psychosis

Women may present with psychosis and/or severe mood changes in the early postpartum period. This is known as postpartum psychosis.

Postpartum psychosis occurs after 1-2 per 1000 deliveries, usually in the first 2 weeks, it can have a rapid onset and become severe very quickly. As such, it is a **mental health emergency.**

Most women who experience postpartum psychosis have no past history of mental illness. However, women who have had a previous episode of postpartum psychosis or who have bipolar disorder, are particularly vulnerable to having this condition.

Signs and symptoms of postpartum psychosis

- Disorganised speech and behaviour (e.g., aggression/agitation, incoherent speech, overactivity or underactivity/psychomotor retardation)
- Signs of self-neglect (e.g., refusing to eat, sleep, take medication or breastfeed)
- Hallucinations
- Delusions
- Confusion
- Severe depression
- Mania

Factors that make postpartum psychosis more likely include:

- Previous postpartum psychosis
- Bipolar disorder
- Family history of postpartum psychosis or bipolar disorder
- Discontinuation of medication for bipolar disorder during pregnancy
- Primiparity

Other presentations of psychosis and severe mood disorder in the perinatal period

Women with pre-existing psychosis or severe mood disorder (e.g., bipolar disorder, schizophrenia) who fall pregnant may have additional needs throughout the perinatal period. They are also at risk of relapse in antenatal period as well as postnatally. Relapse may be triggered by increases in stress and the changing or discontinuation of medications.

Schizophrenia is a particular form of psychotic disorder in which a person has recurrent episodes of acute psychosis but may also be affected by long-term symptoms that cause severe impairment. During acute episodes in schizophrenia a person may experience:

- Hallucinations, most commonly, hearing voices
- Delusions, such as the belief that other people want to hurt them, that their thoughts have been interfered with or broadcast for others to hear
- Disorganised speech and behaviour

Long-term symptoms include changes in overall personal behaviour such as social withdrawal, loss of interest and unusual behaviours. These may affect a mother's ability to provide safe consistent care to the newborn and will often require significant extra support from family and healthcare providers.

3. Mental health symptoms caused by obstetric or general medical conditions

People presenting with mental health symptoms may in fact have an underlying obstetric complication or general medical condition such as:

- Infection
- Haemorrhage
- Gestational diabetes
- Pre-eclampsia
- Medication overdose
- Alcohol withdrawal

The most common presentation of this is delirium. Delirium is a sudden state of confusion, usually lasting hours, or days. Delirium can occur at any time in the perinatal period but most commonly occurs during labour and postpartum recovery. **Delirium is a medical emergency.**

Being able to identify and manage delirium is a key skill that all healthcare providers working with pregnant women and mothers should have.

Failure to recognise delirium can lead to deaths that could have been prevented with the right identification and treatment.

Signs and symptoms of delirium

- Disorientation (e.g., the woman may not be sure where she is or what day it is)
- Drowsiness or agitation
- Trouble remembering things
- Trouble paying attention
- Trouble thinking or speaking clearly and quickly
- Seeing or hearing things that are not there (hallucinations)
- Signs of an underlying cause such as fever, bleeding, headache

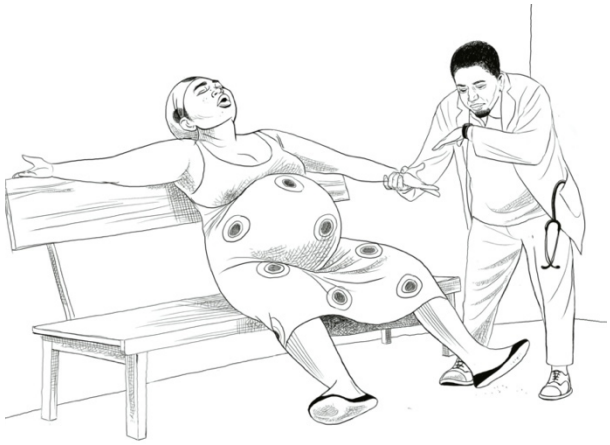
Factors that make delirium more likely

Some groups of women may be more at risk of delirium than others including:

- Women living with HIV/AIDS or other chronic conditions such as tuberculosis
- Women with malnutrition
- Women with unmanaged pain
- Women who misuse drugs or alcohol

Other presentations of underlying medical conditions

In addition to delirium, underlying medical conditions may present with symptoms that resemble other mental health conditions. For example, a woman with anaemia may present with low mood, or a woman with hyperthyroidism may present with anxiety and tremor. **Always be vigilant for physical causes of mental health symptoms.**



Substance misuse

Substance misuse refers to the harmful use of alcohol or drugs such as cannabis (chamba) and opiates (e.g., pethidine, morphine). Substance use in pregnant women is not common in Malawi at the moment but is likely to increase.

Alcohol use in pregnancy is known to cause harm to the unborn baby (foetal alcohol syndrome).

Women who misuse substances are often very vulnerable to abuse and at high risk of sexual exploitation.

Factors that make alcohol/substance misuse more likely

- Poor mental health; women may use alcohol or drugs to “self-medicate” or cope with unwanted thoughts and feelings
- History of substance misuse
- Unplanned/unwanted pregnancy
- Difficult life events (e.g., death of a close relative)
- Domestic violence
- Poverty-related stressors (e.g., poor finances, low-paying job, lack of food)

Women with severe substance misuse (substance use disorder) may:

- Present to health facilities with intoxication
- Have mood swings and/or show unusual levels of irritation, agitation or aggression
- Isolate themselves from other people
- Be unable to adhere to responsibilities (e.g., attending antenatal clinics, caring for the baby) due to intoxication or because they are spending a large amount of time and money trying to obtain alcohol or drugs

Women who are dependent on alcohol may have withdrawal symptoms (such as tremor and anxiety) when they cannot access alcohol (e.g., when they come to hospital to deliver). Severe alcohol withdrawal can cause delirium and seizures.

First-line maternal mental healthcare

First-line maternal mental healthcare describes the approach that maternity healthcare workers can use to provide initial assessment and support for women who are experiencing distress and/or may have a maternal mental health condition.

First-line maternal mental healthcare should form part of the usual care provided by maternity healthcare workers to women attending maternity services.

The 5 steps of first-line maternal mental healthcare are **SLEEP-R**:

1. Consider **S**afety
2. **L**isten actively and non-judgementally
3. **E**ncourage and **E**xplain
4. Make a **P**lan together
5. **R**efer if needed

These 5 steps are described in more detail below. They can be adapted to the different situations encountered by maternity healthcare workers in their day-to-day work.

Recognising women with mental healthcare needs

Women in distress and/or with other indicators of a mental health condition may be recognised in the antenatal clinic, delivery suite or postnatal ward as being:

- Tearful and despairing
- Quiet, withdrawn and disengaged
- On edge, jumpy and tense

Sometimes women may be recognised as having "red flag" presentations:

- Saying/doing things that others would consider unusual or strange
- Appearing confused
- Acting aggressively
- Neglecting self or baby
- Voicing thoughts of suicide

Alternatively, women may not appear distressed but are found to have a psychosocial problem or a possible mental health condition when asked about this as part of a mental wellbeing check.

This section sets out a general approach that you can take when speaking to and supporting a woman with a possible mental health condition. For further advice on the questions you can ask, and what to observe in order to briefly assess likely diagnosis, severity and risk please see later sections in the manual. As a maternity health worker, you are not expected to conduct a full mental health assessment. However, this information can be found in the *Malawi Quick Guide to Mental Health.*

The 5 steps of first-line mental healthcare

1. Consider safety

Although most women in distress will not be a risk to themselves or others, these "red flag" situations do occur and they must not be missed or ignored.

Sometimes, the risks are clear from the beginning of the contact with the woman, for example:

- She has attempted suicide
- She is acting aggressively
- She is confused and feverish

At other times, the risk only becomes clear during the process of providing first-line maternal mental healthcare. For example, the woman may describe:

- Suicidal thoughts and plans
- Unusual beliefs about her baby
- Life-threatening intimate partner violence

Therefore, it is important to always be aware of risks to the safety of the woman, her baby and others and, if you identify these risks, to act urgently.

See Part 3 on how to respond to red flag presentations.

2. Listen actively and non-judgementally

Let the person know that they can speak to you about anything they are going through. It is important to remain non-judgemental to allow people to feel comfortable disclosing any difficult experiences.

Active listening can help reassure the woman that you are genuinely listening and truly trying to understand what she is sharing with you.

Some aspects of active listening include:

- Not interrupting the woman
- Maintaining eye contact
- Keeping still and focused
- Making encouraging noises (e.g., 'mhm' and 'uhuh')
- Repeating back the main points from what the woman has been saying (e.g., "it sounds like you've been very sad since having your baby.")
- Summarise the main points from what the woman has been saying ("from everything you have just said it sounds like your main concern is that your marriage has been difficult ever since you found out about the pregnancy and you feel unsupported by your husband, is that correct?")

3. Encourage and explain

Even if there is not enough time to provide formal counselling, maternity healthcare workers can still offer encouragement and brief psychoeducation. You should:

- Reassure the woman that emotional reactions in the perinatal period are normal and provide words of encouragement.
- Provide the woman with information that may help her understand what she is experiencing. For example, explain that many mothers experience maternal mental health challenges and that these are not a sign of weakness.
- If appropriate, encourage the woman to use self-help strategies (e.g., eating properly, regular exercise, maintaining a daily routine, getting enough sleep and avoiding using alcohol or drugs to cope).
- Encourage the woman to seek support from friends, family, and the local community (e.g., her church).
- Make the woman aware of relevant sources of practical help and local support groups.
- If you are trained and have time at the appointment, provide more in-depth psychosocial intervention such as further psychosocial support or problem-solving therapy (see Part 6).

4. Make a plan together

Rather than just instructing the woman what to do, it is much better to agree *together* what the next steps are. This collaborative approach is empowering to the woman and more likely to lead to good outcomes. You should *agree* with her:

What is SHE going to do? For example:

- Tell a friend how she is feeling.
- Ask family to help with buying things for the delivery.
- Do an activity she used to enjoy before she was depressed, such as singing at church.

What are YOU (the healthcare worker) going to do? For example:

- **Follow up:** When are you going to see her next to monitor her progress? You might offer an early next antenatal care appointment.
- **Safety plan:** What should the woman do if she feels worse? You might advise her that she can come back to the clinic if needed.
- **Further intervention:** Are you able to offer more help such as further psychosocial support or problem-solving counselling (see Part 6)? Perhaps offer her an afternoon appointment when the clinic is less busy.
- **Referral:** Do you need to make a referral?

5. Refer if appropriate

Referral is required in urgent situations, if the woman has an existing mental illness, or if the woman is not improving.

Examples of referrals include:

Referral to obstetric/medical team

- Possible underlying obstetric/general medical condition (delirium)
- Aggression/agitation (for initial assessment)

Referral to mental health team

- Psychosis or severe mood disorder
- Suicidal thought and plans
- Neglect or harm of self and baby

Referral to Victim Support, a One Stop Centre or Social Services

- Woman at immediate risk of harm from intimate partner violence or other violence in the home

For further information of referrals see page 20.

You can remember the steps of First Line Maternal Mental Healthcare using the acronym **"SLEEP-R"**

1. Consider **S**afety
2. **L**isten actively and non-judgementally
3. **E**ncourage and **E**xplain
4. Make a **P**lan together
5. **R**efer if needed

Maternal mental health screening and wellbeing checks

Screening is a way of detecting those women who may have a mental health condition amongst all those attending antenatal care. Screening can help identify women with:

- Pre-existing severe mental illness
- Current depression/anxiety/suicidal ideas
- Challenges (stressors) that predispose to mental health problems, including intimate partner violence

Maternal mental health screening involves asking some standard brief questions to *every* woman attending her first antenatal (booking) clinic appointment.

There is no formal screening programme for maternal mental health in Malawi at present. However, it is already conducted in many other countries including South Africa.

The benefits of integrating mental health screening into maternity care:

- Prevention of mental illness if early symptoms and vulnerability factors are addressed.
- Early identification of emerging mental illness.
- Normalises mental health care and combats stigma.
- Does not require women to spend extra time and money on accessing specialist mental health assessment.

However, **screening should only be carried out if access to mental healthcare is available.** It is considered unethical to screen for mental illness when there is no capacity to provide care.

In Malawi, there is a mental health team in every district hospital to whom women with severe or high-risk conditions can be referred. Therefore, screening for a history of severe mental illness is justified.

However, currently most facilities do not have access to counsellors or trained maternity healthcare staff who can provide interventions for mild/moderate mental health conditions. It is therefore difficult to recommend universal screening for depression/anxiety/suicidal ideas in Malawi at present, though this may change in the future.

Over time, we hope that MOH, CHAM and NGOs offering maternity and mental health services will work together to ensure that, wherever maternity healthcare workers are offering maternity care, they have access to appropriate mental health training, supervision and referral pathways to make screening effective and ethical.

Current recommendations in Malawi

This manual recommends asking all women whether they have a history of severe mental illness, particularly if this occurred in the perinatal period.

We also recommend a **mental wellbeing check** for all women at booking and subsequent antenatal and postnatal clinic appointments. This can be as simple as asking each woman if she has any concerns about the pregnancy, and whether there are any problems at home causing worry or distress.

At present, we do not have the evidence to recommend specific screening for current depression/anxiety/suicidal ideas in Malawi.

However, if you suspect a woman is experiencing depression/anxiety/suicidal ideas and/or is experiencing challenges such as intimate partner violence, you should not ignore this.

Use the approach described in the First-line Mental Healthcare chapter, and the specific advice in Parts 3,4,5 of this manual.

See page 19 opposite for practical instructions.

Why screen for psychosis and severe mood disorder?

Women who have had an episode of postpartum psychosis are at high risk of having another episode after a subsequent delivery.

Women with a diagnosis of Bipolar Affective Disorder are also at high risk of postpartum psychosis, especially if they also have a sister or mother who has had postpartum psychosis.

People with a diagnosis of schizophrenia are also at risk of relapse or of having particular challenges in keeping well during the pregnancy and adjusting to motherhood. Some may need considerable support from family in caring for their new baby.

Women in Malawi may not have been given a precise mental health diagnosis, so it is best to treat all women with a diagnosis of “psychosis” as being at high risk of relapse and in need of additional support in perinatal period. The same applies to women who have not been given a diagnosis but who give a history that suggests a history of severe mental illness, particularly if the episode occurred after a previous delivery.

Identification of mental health conditions in maternity care – practical guidance

1. Screen for psychosis and severe mood disorders

At first antenatal appointment ("booking") ask ALL women:

- *Have you ever been diagnosed with a mental illness? (Munayamba mwapezekapo ndi matenda amumalingaliro?)* [Also check in her health passport.]

If YES then ask:

- *What is the name of the mental illness?*
- *Do you attend the mental health clinic? Are you taking any medication for your mental illness?*
- (If she has had previous pregnancies) *Did you have an episode of mental illness when you were pregnant or following delivery? What happened?*

If you identify that a woman:

- Has a diagnosis of previous postpartum psychosis, bipolar disorder, severe depression, schizophrenia, other psychosis
- AND/OR had symptoms of mental illness (e.g., severe mood changes, hallucinations, delusions, confusion) in the first few weeks after a previous delivery

Then:

- Refer to mental health team.
- Manage as high-risk pregnancy/postpartum (refer for maternity care at a tertiary facility if needed).
- Monitor closely at later visits (see pages 32-33 for further advice).

(If the woman has a history of another mental health problem (e.g., depression/anxiety), ask about current symptoms and challenges, refer if indicated and monitor closely at later visits.)

2. Identify and respond to Red Flag presentations

Assess/manage and refer as per the relevant sections in Part 3 of this manual:

- Agitation or aggression
- Unusual thoughts, experiences and behaviours
- Thoughts of suicide or intent to harm herself or her baby
- Neglect of herself or her baby
- At risk through intimate partner violence

3. Mental Wellbeing Checks

These checks can be carried out at any point in the perinatal period (e.g., at first and subsequent antenatal care appointments, before and following delivery, at postnatal appointments). If you are concerned that a woman may have a current mental health condition or social challenges:

- Use the *first-line maternal mental healthcare* approach to engage the woman and put her at her ease (see pages 16-17). Enquire about what is causing her distress. You might want to ask a general prompt question e.g., *Ndikuonangati simulibwino kwenikweni chilipo chomwe chikupangitsa izi?*
- Check for any obstetric or medical problems that might be contributing to her difficulties. These may need further examination, investigation, and referral.
- Go to the relevant page in Part 4 of this manual to assess further and manage:
  - A woman who is distressed, depressed or anxious
  - A woman with a history of loss and trauma
  - A woman with social or marital problems
  - A woman living with HIV
  - A woman who is using alcohol or drugs
  - A pregnant adolescent
- In addition to specific advice in these sections, use the first line mental healthcare approach to encourage, explain and make a plan together. Refer if needed (see page 20).

At subsequent Mental Wellbeing Checks:

- Ask again about any concerns she has about the pregnancy or problems at home.
- Enquire about any mental health or social problems identified previously.
- Reassess severity and refer if needed.

Making referrals

Understanding when and where to refer is an important aspect of the role of maternity healthcare workers in providing maternal mental healthcare. Referral is necessary in cases of high risk or where specialist intervention is needed.

In principle, if there is capacity and it is appropriate for a woman with a mental health condition to be managed within primary healthcare by a non-specialised healthcare worker, this should be done.

Integration of mental healthcare into routine maternity healthcare practice can relieve the referral burden on specialist services and specialist healthcare workers, as well as provide accessible care to pregnant women and mothers with mental illness. This is especially true for rural and lower-resourced settings where referrals may be particularly difficult as there may not be many nearby services with mental healthcare provision. Other factors such as transportation costs may prevent women in these areas from being able to access further support.

However, there will always be situations when referral is needed. See below for advice on how to make a good quality referral. Also, if you are not sure whether referral is appropriate, do not be afraid to contact the relevant team/facility/organisation in your area to ask for advice.

Get to know the services in your area

Getting to know the services in your area is crucial to making appropriate referrals. Services may be governmental (e.g., psychiatric services, social services, Victim Support) or non-governmental (e.g., community support groups or faith-based organisations).

Community-based organisations and support groups are a particularly useful source of non-medical social support for women with maternal mental illness or women who have had a difficult perinatal experience (e.g., women living with HIV, women who experienced the loss of a baby or birth trauma).

Making a referral

1. **Explain to the woman why you are making the referral**: express concern and outline specific symptoms or behaviours that are the basis of your referral.
2. **Choose the appropriate service to refer to:** consider not only which service will provide the most appropriate support but also what is the most feasible option for the pregnant woman/mother (consider things like cost of getting to the facility, childcare or other practical/emotional challenges that could stop her from going to her appointment).
3. **Write a referral note:** the note should briefly explain the background to the problem and any treatments that may have already tried.
4. **Monitor and follow-up on the referral:** during future appointments, try find out whether the woman attended the appointment. If she attended, ask her how it went. If she did not attend, you may ask why and try to discuss ways to overcome any barriers to attending.

Remember to remain non-judgemental and calm throughout conversations about referral even if the woman decides not to attend or does not agree with your referral.

When is referral necessary?

As mentioned, referral pathways will be different based on the location of the healthcare facility and the resources the facility has. However, **referral is always required: in urgent situations, if the woman has an existing severe mental illness, or if the woman is not improving.** Ideally, the woman would be referred to a face-to-face contact with the specialist. However, in areas where there is no easy access to specialist care, you can phone to seek advice. The *Malawi Standard Treatment Guidelines* also provide additional information on referrals.

Examples of referrals include:

Referral to obstetric/medical team

- Possible underlying obstetric/general medical condition (delirium)
- Aggression/agitation (Initial referral to obstetric/medical team to exclude physical cause. Mental Health team may be involved later if needed)

Referral to mental health team

- Psychosis or severe mood disorder
- Suicidal thoughts and plans
- Neglect or harm of self and baby
- Harmful use of alcohol/drugs

Referral to Victim Support, a One Stop Centre or Social Services

- Woman at immediate risk of harm from intimate partner violence or domestic violence

If the woman does not want help and/or referral, respect this decision unless this is a “red flag” situation in which the woman and/or her baby are at risk. In this case, you should speak to a senior colleague within maternity, or someone from mental health team for advice.

If it is not a high-risk situation, let the woman know that if she changes her mind in the future, she can come back to the healthcare facility.

PART 3

Red Flag Perinatal Presentations

- A woman who is agitated or aggressive
- A woman who has unusual thoughts, experiences and behaviours
- A woman with thoughts of suicide, self-harm, or harm to her baby
- A woman who is neglecting herself or her baby
- A woman at risk through intimate partner violence

A woman who is agitated or aggressive

Sometimes women can become aggressive or agitated when pregnant, during childbirth, or in the postnatal period.

Aggressive/agitated behaviour may include:

- Pacing or frequently changing body position
- Tense posture (e.g., clenching fists)
- Loud and aggressive speech
- Provocative or insulting behaviour
- Violent acts (e.g., hitting or throwing objects)
- Resistance or disruptive behaviour towards essential medical care (e.g., refusing to take medication or pulling out an IV drip)

Causes of aggression/agitation

- Delirium
- Postpartum psychosis or relapse of a pre-existing severe mental Illness
- Pain and fear
- Distress following loss of a baby or other upsetting event
- Daily stressors (e.g., social and relationship challenges)
- Alcohol and/or drug intoxication

Managing aggressive/agitated behaviour

The priorities in managing these situations are:

- To ensure safety of the woman, her baby, and others (e.g., healthcare providers, family members, other women receiving care)
- To alleviate suffering
- To identify and manage underlying causes

Steps in management

1. Prevention (if possible)
2. De-escalation
3. Restraint and sedation (if absolutely necessary)
4. Identification and management of underlying causes
5. Reassuring and explaining during and after the episode

1. Prevention

Practicing good quality, respectful care can reduce the likelihood of agitation and aggression occurring. Examples of preventative actions include:

- Clear and empathic communication
- Providing adequate pain relief
- Practicing good hygiene to reduce infections
- Planning ahead for the delivery/postpartum period in a woman at risk of psychosis

2. De-escalation

De-escalation is used to promote safety and avoid the need for restraint/sedation. De-escalation includes the following actions:

- Establish your own safety by calling for help from other staff members if you are alone.
- Remove any dangerous objects.
- Leave space between you and the patient at least two arm's length away and avoid being trapped in a corner.
- Explain the purpose/intention of what you are doing (e.g., "I am going to move the needles into the cupboard to avoid either of us getting hurt").
- Speak in an assertive, brief, and clear manner.
- Validate the woman's feelings – "I understand how you could feel that way", "other people in the same situation have felt as you are feeling"
- Take the woman to a quiet place if possible (but only if it is safe to do so).
- Offer choices based on her feelings and needs (e.g., if the agitation is related to having an invasive procedure you might offer a less invasive alternative).
- Negotiate options (e.g., use friendly gestures like offering a drink or food).
- Take threats seriously and take the necessary precautions.
- If the woman's behaviour is putting her newborn baby at risk, act urgently to make the situation safe. Ensure there are staff/guardians available to take the baby from the mother if needed.

These situations can be frightening, and you may feel angry with a woman who is being "difficult". However, remember that there is always an underlying reason for the behaviour.

Things not to do

- Shout or swear
- Argue or threaten (both verbally and in actions)
- Command the woman to "just calm down"
- Perform any sudden movements or approach the woman from behind
- Assault the woman
- Deny care as punishment

Any of these actions are likely to only make the situation worse.

3. Restraint and sedation

If attempts at de-escalation fail and the woman presents an ongoing danger to herself or others (including refusing essential treatment and putting baby at risk), consider restraint and sedation. This should only be considered if absolutely necessary.

Safe restraint

- Being restrained is a frightening experience.
- Throughout the restraint, you should talk to the woman in a kind and respectful manner.
- Explain what you are doing and why.
- Restraint will require assistance from other staff members (preferably including trained mental health staff if available).
- One person should hold each limb.
- Avoid pressure on the head, neck and chest.
- **Never** tie the woman with rope, cloths etc.
- **Never** restrain the woman face down (prone)
- Also, if a woman is in the second/third trimester **Do not** restrain her lying on her back (supine). This can cause dangerous compression of the main blood vessels. She should be restrained lying on her left side or sitting up.
- Restrain for the minimum period to ensure safety or complete the necessary procedures.
- Staff should stay with the woman throughout the restraint – do not leave her being held by family members/security staff only.
- Regularly monitor breathing, heart rate, and circulation in each limb.

Sedation

- Sedating medication should only be prescribed by a clinician or suitably qualified nurse. See Appendix 3 on page 58 of this manual. Also refer to *Malawi Standard Treatment Guidelines* or *Malawi Mental Health Quick Guide.*

Further management

- If the situation has stabilised and the woman can be managed safely in the maternity unit then continue care as usual with input from the mental health team if needed.
- If the woman still cannot be managed safely then you may need to call hospital security for help (if you have not already done so) and refer to the mental health team for additional advice.

4. Identify and treat the underlying cause

A key task is to identify whether the agitation/aggression could be caused by an underlying obstetric complication or general medical condition (delirium).

History

- Find out as much history as you can from the woman, her guardians, and her health passport e.g., pain, bleeding, known health conditions, accidents, ingestion of drugs/poison, etc.

Quick cognitive assessment

1. Is the woman disorientated? Ask her these questions:

- *What is the time of day, day of the week, date, season?*
- *Where are we now? Where do you live?*
- (If family member or friend present) *Do you recognize this person?*

2. Does she have altered level of consciousness (drowsiness)? This may fluctuate.

If YES to these questions, then delirium is likely.

Physical exam

Conduct as much physical examination as is possible including:

- Heart rate, blood pressure, respiratory rate
- Temperature
- Evidence of haemorrhage
- Abdominal exam
- Evidence of foetal distress

Investigations

- Blood sugar; other available tests

Management

- Provide immediate medical care (**ABC: A**irway, **B**reathing, **C**irculation),
- Refer urgently to the medical team,
- Seek senior advice whenever possible,
- Treat obstetric emergencies as your training/resources allow,

Remember that people who have a history of mental illness may present with delirium due to a general medical/obstetric condition. If the person has symptoms of delirium you must investigate for the cause. **Never just say that someone is a "known psychiatric case" and miss a diagnosis of delirium.**

5. Reassuring and explaining during and after the episode

Episodes that present with aggression are a frightening experience for the woman, whatever the cause. In addition, after recovery she may feel upset or embarrassed about what has happened.

During management of aggression, continue to reassure the woman and explain what is happening even if it appears that she would not understand.

Following recovery, if she wishes, explain to the woman about what happened, answer any concerns she has, and provide reassurance. Once the acute crisis has been resolved, the woman will still need care. Follow relevant advice in Part 5 depending on the cause of the acute episode.

A woman who has unusual thoughts, experiences and behaviours

Sometimes women will have thoughts, experiences and behaviours that are unusual, strange, or disorganised.

Examples of these include:

- Hearing or seeing things that others don't (hallucinations)
- Believing things that are not believed by others in the same culture (delusions) such as:
  - People are trying to harm her or her baby
  - She or and her baby have special powers
  - She has done something very bad and would be better off dead
- Speech that is muddled, very fast and loud, or very slow
- Very high mood and overactivity (mania)
- Very low mood and slowed up movements (severe depression)
- Rapidly changing mood and behaviours.
- Confusion
- Holding a strange or uncomfortable position for long period (catatonia)

Causes of unusual thoughts, experiences and behaviours

Unusual thoughts, experiences and behaviours may be the result of:

- Delirium
- Postpartum psychosis
- Relapse of pre-existing bipolar disorder or schizophrenia
- Severe depression
- Intoxication with alcohol or drugs
- A behavioural response to stress or trauma

Women who present with new onset unusual thoughts, experiences and behaviours require urgent assessment, initial management and referral.

How to talk to a woman who has unusual thoughts and experiences

It can be very scary and confusing for a woman who has unusual thoughts and experiences. It is important to minimise distress with calm and clear communication:

- Communicate in uncomplicated concise sentences.
- Be patient and repeat things if necessary.
- Avoid challenging or confronting the woman on her thoughts/experiences by saying that what she is experiencing is not real and is "all in her head". This may cause further distress, confusion and tension.
- Do not criticise or blame the woman.
- Communicate with a compassionate tone.

Extra effort should be made to avoid any stigma or discrimination. Though you might find the woman's behaviour strange, it is important to avoid labelling women as "crazy" or "mad" (wamisala) and instead remind yourself that this is a sick woman in need of care.

Assessment and management

You should:

- Treat the woman with respect and kindness.
- If necessary, manage agitation or aggression (pages 22-23) or self-harming behaviour (page 25).
- If the woman is with her baby, ensure that the baby is safe. Identify an appropriate caregiver (guardian). Ensure that the woman is not left alone with her baby.
- Find out as much information as you can about what led up to the woman presenting in this way. This can help you provide appropriate immediate management and communicate effectively when making the referral.
- Rule out delirium. See page 23 for advice on this.
- If it is not delirium, refer urgently to a mental health team or local psychiatric service for further management.
- Provide information to the woman and her family.
- Once the acute crisis has been resolved, the woman will still need maternity care. Meet this need in a respectful and kind manner.
- For ongoing mental health management, follow relevant advice in Part 4 or 5 depending on what was the cause of the acute episode. If appropriate, provide collaborative care together with the mental health team.

A woman with thoughts of suicide, self-harm or harm to her baby

A woman at risk of suicide may present having already harmed herself or attempted suicide, or she may report these thoughts at any time during the perinatal period.

Suicide is the intentional act of ending one's life. Methods of suicide include hanging, overdosing on medication, or ingesting poisons (e.g., pesticides). Self-harm is the intentional act of hurting oneself (e.g., cutting or burning) without intent to die.

Infanticide – although it is rare, some women who plan to die by suicide also decide to kill their children. They may be so depressed that they believe the children would be better off dead rather than to suffer in this world. When assessing a woman with suicidal thoughts, ask sensitively whether she has thoughts of harming her baby. If needed, take action to keep the baby safe.

Signs that someone may have suicidal intent

- Evidence of an act of self-harm or attempted suicide, or preparations to do so
- Expression of current thoughts, plans or acts of medically serious self-harm and/or suicide
- Expression of thoughts indicating that the baby would be better off without her
- Extreme hopelessness and despair
- Other signs of mental illness e.g., withdrawing from other people, eating or sleeping less

Some groups of perinatal women may be more at risk of suicide and self-harm including:

- Women with existing mental illness,
- Women with previous suicide attempts
- Women who have experienced violence
- Women engaged in substance misuse
- Adolescents
- Women with a family history of suicide

Assessment and Management

A woman who has attempted suicide or carried out a serious act of self-harm

Signs to look out for:

- Intoxication or signs of poisoning
- Extreme lethargy
- Bleeding from a self-inflicted wound
- Loss of consciousness
- No signs but she reports what she has done

Management

1. Manage the physical attempt first through medical stabilisation (**ABC: A**irway, **B**reathing and **C**irculation).
2. Make an urgent referral to a medical team.
3. If this is a mother, check that her baby and other children are safe.
4. Manage further as per risk level below.

Note: As suicide attempts are illegal in Malawi, great sensitivity is required when caring for a woman who may be at risk of suicide. Reassure the woman that you will only share information outside the healthcare team if it is in her best interests and if there is a serious risk to herself or others.

Assess suicide risk level

You can do an initial assessment of risk level by asking the woman:

- How often do the suicidal thoughts occur?
- Do you have a suicide plan?
- Do you intend to act on these plans now?
- Have you made preparations for your death?
- Do you have thoughts that your baby would be better off dead, or thoughts of harming them?

Remember that **asking about suicide does not encourage the woman to attempt suicide.** Often the woman will feel relief for voicing her thoughts.

High-risk indicators

- Persistent thoughts that life is not worth living
- High current suicide intent
- A well-formulated plan with high lethality
- Preparatory acts (e.g., buying poison or rope)
- Symptoms of depression, psychosis or excessive alcohol or drug use
- Social isolation or lack of support
- Any thoughts of harm to baby or other children
- Previous attempts

Management of high suicide risk

- Remove weapons and dangerous items including ligature points if possible.
- Do not leave the person alone; assign a staff member to stay with the person.
- Check that her baby/other children are safe
- Involve your supervisor.
- Urgent referral to a mental health team or local psychiatric service.

Lower risk indicators

- Fleeting thoughts of wanting to die
- No plan or immediate intent of suicide
- No other high-risk indicators

Management of lower suicide risk

- Provide psychoeducation.
- Encourage support from family/friends.
- Arrange early review and reassess suicide risk.
- Encourage the woman to come back or consult another health facility if the thoughts get worse.
- Refer to a mental health team or local psychiatric service if appropriate.

Discuss with your supervisor or a mental health professional if you are unsure about the level of risk.

A woman who is neglecting herself or her baby

Neglect includes a failure to provide oneself or others with adequate care, including food, water, shelter, clothing and medical care. It can also include emotional neglect.

Signs that a mother is neglecting herself

- Unkempt appearance
- Poor hygiene
- Regular illness, infection or injury
- Missed clinic appointments
- Anaemia
- Malnutrition

Signs that a mother is neglecting her baby

- Not interacting with the baby
- Not comforting the baby when distressed
- Not feeding the baby
- Missing baby check and vaccination appointments.
- The baby is very passive and withdrawn
- The baby is malnourished or repeatedly sick

The mother may also be showing signs of depression or other mental illness.

Causes

It can be difficult to understand why a woman may be neglecting herself or her baby, but this can happen for several reasons such as:

- Poverty
- Mental illness (e.g., depression, psychosis)
- General medical conditions/delirium
- Marital conflict
- Difficulty bonding with the baby
- Social isolation
- Substance misuse

Babies with intellectual or physical disability are particularly vulnerable to neglect.

When providing care to a woman who is neglecting herself or her baby, you should always remain non-judgemental and respectful. You should be empathetic as the woman is likely to struggling with illness or major social difficulties.

Management

Assess the mother and baby's immediate needs.

Encourage the mother to talk about the difficulties she is having taking care of herself and/or her baby. Assess her physical condition (and that of her baby) and look for signs of mental illness.

Manage immediate risk

If you are concerned that the baby is at immediate risk, take urgent steps to ensure safety. This may involve identifying an appropriate caregiver (guardian) who can take over support or care of the baby. Do not leave the baby alone with the mother whilst this support is being arranged.

Regarding immediate risk to the mother, identify and manage suicide risk and any acute medical conditions. Identify a supportive guardian if possible and don't leave the woman alone.

Once immediate risk is managed, follow the following guidance.

Provide support

Provide practical support where necessary, such as in cases of malnutrition in infants. Assess and treat as per Ministry of Health malnutrition protocols. Refer/admit if needed.

In cases where direct practical support may not be possible you can still:

- Reassure the woman that taking care of both herself and a baby can be very difficult.
- Encourage the woman to get enough sleep and maintain a daily routine.
- Encourage the woman to lean on social supports for emotional support and help with childcare.

Make the woman aware of any community support groups available.

Engage the family for help

Discuss with the woman's partner or family things they can do at home to help avoid neglect such as:

- Assisting with domestic responsibilities like cooking, cleaning and shopping.
- Assisting with childcare responsibilities (e.g., changing and feeding).
- Offering to take care of the child for some time in the day/night to give the mother an opportunity to rest and have time to herself.
- Accompanying the mother to medical appointments.

Encouraging the mother's relationship with the baby

If you identify that the mother is having difficulty bonding with her baby, see brief advice in Part 6.

Refer for assessment

If the mother has signs of a mental health condition that are impacting on her ability to care for herself and/or baby, refer to a mental health team for further assessment. Also refer for management of any physical conditions.
If she is pregnant, she will need close monitoring in antenatal clinic.

A woman at risk through intimate partner violence (IPV)

Intimate partner violence (IPV) is any behaviour by one partner to the other in an intimate relationship that causes physical, psychological, or sexual harm. Unfortunately, IPV is common in Malawi.

The stresses associated with pregnancy and the birth of a new child can put strain on the relationship and family and increase the occurrence of IPV.

Types of IPV

- **Physical** – acts of physical violence such as beating, kicking or slapping.
- **Sexual** – acts of sexual violence including rape and forms of sexual coercion.
- **Emotional** – psychological and emotional abuse including insults, belittling, humiliation, neglect, intimidation, threats of harm or threats to take away children.
- **Coercive control** – restricting access to financial resources, employment, education or medical care, monitoring a person's movements, isolating a person from friends/family.

During the antenatal period, IPV can have significant adverse consequences on a woman's mental health and affect her use of health services.

Note: Women may also experience violence from others in the home (e.g., parents, in-laws, siblings). Many of the principles in managing IPV also apply to other types of violence in the home.

Presentations of IPV

You may identify a woman experiencing IPV through:

1. History taking at first antenatal visit (mental wellbeing check, see pages 18-19).
2. Her reporting IPV at another perinatal contact.
3. Recognising signs/symptoms that may indicate IPV and asking sensitively about these.

It is not always obvious when a woman is experiencing violence or abuse. However, healthcare providers should look out for physical, psychological, and behavioural indicators of abuse:

Physical

- Frequent physical injury (e.g., cuts, bruising or broken bones) excused as accidents
- Sexually transmitted infections
- Vaginal discharge and/or bleeding
- HIV
- Miscarriages
- Unplanned pregnancies
- Unexplained chronic physical complaints such as nausea, headaches, pain
- Disturbed sleeping and/or eating patterns.
- Premature birth, injury or death of the baby

Psychological

- Fear and anxiety
- Feeling down or depressed
- Shame, humiliation, and low-self-esteem
- Feeling alone and/or emotional numbness
- Anger or aggression
- Personality changes
- Flashbacks and nightmares
- Being easily startled or frightened
- Difficulty concentrating
- Loss of hope for the future and suicidal thoughts

Behavioural

- Mention of their partner's possessiveness, jealousy or temper
- Missing appointments with no explanation
- Being easily upset and/or tearful
- Withdrawing and isolating self
- Dressing in clothes to cover injury or bruising
- Self-harm
- Substance misuse

Factors that make IPV more likely to occur

There is an increased likelihood of perinatal IPV if the partner:

- Has perpetrated IPV violence at other times
- Rejects the pregnancy
- Is generally unsupportive
- Misuses drugs or alcohol
- Is critical and coercive
- Has other partners

Adolescent girls are at a higher risk of experiencing IPV, as are women who have physical or intellectual disabilities.

Assessment

Women should **not** be asked about IPV in the presence of any partner, friend or family member.

Many women who experience IPV may not want to disclose out of fear for the safety of themselves or their baby. They may also feel shame and guilt and believe that the violence is their fault. Some women may also not realise the violence they are experiencing is not normal/acceptable.

When asking about IPV, reassure the woman that:

- Anything they disclose is confidential.
- IPV is sadly very common in pregnant women and mothers, so you ask about it routinely.
- IPV is not something that is the woman's fault, nor is it something she should have to endure.

If you suspect IPV you may ask the woman any of the following:

- How is your relationship with your husband?
- Is your husband supportive of you?
- Do you and your husband argue or fight? If so, how often and what about?
- Does your husband (or someone else at home) hurt or threaten you?
- Do you fear that you might be injured or even killed if you go home today?
- Is your husband violent or jealous of you?

If the person appears to be at immediate risk, act urgently.

Be aware that children are at risk in households where IPV is happening. When assessing risk and making a management plan, consider the safety and wellbeing of the baby and any older children in the family.

Management of IPV risk

1. Refer for assessment of any physical injuries or problems and signs of sexually transmitted infections.
2. Identify a 'safe place' for the woman – discuss with the woman where she and her baby/children can go to for safety if she feels too unsafe at home (e.g., a friend's house, family members, etc).
3. Identify a primary support person for the woman who she can go to when in need of support and who you can contact in cases of emergencies.
4. Offer psychological support.
5. Refer to the Social Welfare Department within the healthcare setting if there is one available.
6. Refer to Victim Support or a One Stop Centre if the woman would like that.
7. Make the woman aware of any locally available support services (legal, social and emotional) such as women's groups and other support groups.

A decision to leave the home

Remember, it is the woman's decision how she wants to handle the situation.

You should not actively encourage the woman to leave or report her partner as this could compromise her safety and make her and her baby more vulnerable to violence. She needs to be given information and support and to be allowed to make the decision that she is comfortable with.

If the woman says she does not want to leave her partner or the situation you should remain non-judgemental and support her regardless of what she chooses to do.

Managing cases of intimate partner violence can often be very sensitive. Discussing the case with senior colleagues and making clinical notes of your practice with the woman outside of her health passport can help avoid any potential questions and problems arising in the future regarding your delivery of care.

Discuss coping strategies

If you have time, you can try to find out about the woman's coping mechanisms and social support. Ask questions such as:

- "How do you cope with the violence that is being done to you?"
- "Have you told anyone else about it?"

You can then discuss some psychosocial care options such as stress management and the importance of social support. What to include in these discussions is outlined in Part 6.

Monitoring and follow-up

- Monitor the woman and her child for signs and symptoms of violence at future appointments.
- Ask the woman how she is feeling and coping at home.
- Monitor the woman for signs of poor mental health.

If it is evident that the violence is continuing you can express your concern to the woman and repeat the management guidance above.

PART 4

Common Presentations and Management in the Perinatal Period

- A woman who is distressed, depressed or anxious
- A woman with a history of psychosis or severe mood disorder
- A woman with a history of loss and trauma
- A woman with social or marital problems
- A woman living with HIV
- A woman who is using alcohol or drugs
- A pregnant adolescent

A woman who is distressed, depressed or anxious

Distress, depression and anxiety are the most common mental health conditions experienced by women in the perinatal period (see pages 12-13). You may identify a woman experiencing distress, depression or anxiety in the following ways:

1. A red flag presentation (e.g., suicidal ideas/acts).
2. You recognise in clinic or on the ward that she appears distressed or has other symptoms/behaviours that might indicate distress, depression or anxiety.
3. She reports symptoms of distress, depression or anxiety during a mental wellbeing check.

If you suspect distress, depression or anxiety you can ask some brief questions about core symptoms. Here are examples of questions you can use that are adapted from the PHQ9/GAD7 screening tools:

- *In the last 2 weeks have you often felt down, depressed or hopeless? (Mu masabata awiri apitawa, kodi mwakhala osasangalala, wokhumudwa, kapena opanda chiyembekezo mowilikiza?)*
- *In the last 2 weeks have you often felt nervous, anxious, or on edge? (Mu masabata awiri apitawa, kodi mwakhala ndi mantha, nkhawa, kapena kusowa mtendele mowilikiza?)*

A YES answer to either of these questions suggests need for further assessment. A longer screening questionnaire, the SRQ-20, is shown in Appendix 4 on page 59. If you have time, you can use this to ask about wider symptoms of depression/anxiety.

If you have identified a woman with *possible* distress, depression or anxiety, you can decide how best to help by considering these factors:

1. How severe are her symptoms?

- Does she have a lot of symptoms or just a few?
- Are they there all the time or just on some days?
- How long has she been feeling like this?
- How much do they interfere with her daily life?
- Are there any red flag symptoms e.g., suicidal thoughts, neglect, unusual beliefs/behaviours?

If she reports suicidal ideas, then assess her as per page 25. If she has tried to commit suicide before, has a plan to do so now, or has a history of severe mental illness, consider **urgent referral**.

2. What vulnerabilities and stressors does she have that might be contributing to her condition?
3. What things usually help her cope with problems?

Remember to check: could the symptoms be caused by a physical health condition (e.g., is she feeling tired because of anaemia?)

Levels of severity

Distress, depression and anxiety exist on a continuum of severity:

- Distress
- Depression/anxiety disorder - mild/moderate
- Depression/anxiety disorder - moderate/severe

Distress

A woman with distress has only a few of the symptoms of depression/anxiety, these last less than two weeks, and don't markedly interfere with day-to-day functioning. She may have specific challenges or concerns that she identifies as causing her distress.

Management

- Use first-line maternal mental healthcare.
- Review at subsequent appointments to see if things have improved.
- If distress is persistent or shows signs of getting worse, manage as for depression/ anxiety below.

Depression/anxiety disorder–mild/moderate

A woman with *depression/anxiety disorder–mild/moderate* experiences cycles of negative thoughts (depression) and/or worry (anxiety) that are difficult to break out of. She has symptoms lasting 2 weeks or more.

Her ability to carry out her day-to-day tasks is affected to some extent. However, she is not neglecting herself or her baby and has no unusual beliefs/behaviours.

She may have occasional thoughts that life is not worth living but no current intent to end her life or plans/preparations to do so.

Management

- Use first-line mental healthcare skills to engage with the woman.
- Refer to a psychosocial counsellor if available. If not available, consult with the mental health team for advice.
- If you or a colleague have been **trained**, consider offering treatment within the maternity service using psychosocial interventions /problem-solving therapy.
- Review at subsequent appointments to see if things have improved.
- If her depression/anxiety is persistent or shows signs of getting worse (including any red flag signs), expedite referral to the mental health team.

Depression/anxiety disorder–moderate/severe

A woman with *depression/anxiety disorder–moderate/severe* has intense and/or long-lasting symptoms. Her ability to carry out her day-to day tasks is affected to a major extent. She may be neglecting herself or her baby, and she may have unusual beliefs/behaviours. She may have suicidal thoughts with current intent to end her life and plans/preparations to do so.

Management

- Refer urgently to the mental health team.
- You can use first-line mental health care skills to engage with her and promote safety whilst you are waiting for her to be seen by the mental health team.
- See red flag management pages for further advice in managing suicide, neglect, unusual beliefs/behaviours, agitation (Part 3).

Monitoring and follow-up of a woman experiencing distress, depression or anxiety

Women with depression, anxiety or social issues identified at booking or later antenatal appointments should be carefully monitored throughout their pregnancy.

You should ask all women about their mental health or social problems at all antenatal care appointments. For example:

- "How are you coping with the pregnancy?"
- "How are things at home?"
- "How has your mental health been doing recently?"

Acknowledge that pregnancy and life with a newborn are difficult periods but that they are doing well.

Re-refer to counselling or a mental health team if depression/anxiety/social issues are impacting the woman's day-to-day function.

Psychoeducation for distress, depression and anxiety

As well as the general advice mentioned in the First Line Mental Healthcare section, here are some ideas for psychoeducation for women experiencing distress, depression and anxiety.

With the woman's permission, try to include a family member/support person in the delivery of psychoeducation to help them understand active ways to support the woman's recovery.

- Explain what depression/anxiety is, the possible causes, and symptoms the woman may experience.
- Correct any stigmatising beliefs.
- Reaffirm that depression in the perinatal period is very common and not a sign of weakness.
- Discuss relevant psychosocial issues that may place stress on a woman throughout pregnancy and early motherhood that can lead to low mood and depression e.g.,
    - Marital and family relationship strain
    - Employment and livelihood challenges
    - Poverty and food insecurity
    - Stigma and discrimination
- Discuss self-care.
- Explain the importance of getting enough rest/sleep, maintaining hygiene and eating well.
- Discuss coping strategies e.g.,
    - Spending time with a trusted friend or family member.
    - Prayer (if the person practices this)
    - Staying active
- Discuss the benefits of social support.

- If relevant, discuss the unhelpfulness of alcohol and drugs as a coping strategy. Though alcohol or drugs can dull or reduce negative thoughts and feelings in the short term, they can create more problems in the long-term.
- Talk through how pregnant women and mothers with low mood or depression can sometimes feel very socially isolated.
- Explain that social support can be *emotional* such as opening up to someone about problems and feelings or *practical* such as childcare assistance.
- Explain that social support can come from not just family and friends but also community members and organisations (e.g., faith-based organisations).
- Recommend relevant community support groups.
- Let the woman know that if she develops any thoughts about self-harm or suicide she should come back to the clinic or reach out to another healthcare professional.

A woman with a history of psychosis or severe mood disorder

You may identify a woman with psychosis or severe mood disorder at the following stages:

- At screening during her first antenatal clinic appointment.
- At another appointment or even during delivery if the woman has not attended antenatal care.
- From a red flag presentation.

She may have a pre-existing diagnosis (e.g., postpartum psychosis, bipolar disorder, schizophrenia), or may present for the first time in the perinatal period. See page 14.

Referral to mental health team

All pregnant women with a history of severe mental illness must be referred to a mental health team. If the woman is currently stable this can be a routine referral. If she appears to be acutely mentally unwell you should make an urgent referral (after you have excluded delirium as a possible cause).

Management

Care for women with psychosis or severe mood disorder should be a *collaboration* between maternity and mental health teams.

Some of the things that you can do as a maternity healthcare worker are:

- Treat the woman with respect and kindness. See page 9 for information on the importance of reducing stigma and discrimination.
- If necessary, give her extra time in appointments. Use first-line maternal mental healthcare skills.

- Ask how she is coping with the pregnancy, and whether she has any new concerns. Just because she has a diagnosis of mental illness, doesn't mean she won't have the usual concerns about pregnancy/childbirth as any other woman.
- Provide reassurance and encouragement.
- Provide general psychoeducation e.g., strategies to keep well during pregnancy and the postpartum period:
    - Getting enough regular sleep
    - Eating regularly and healthily
    - Support from family/friends
    - Keeping stress levels low by doing enjoyable activities
- Identify and manage physical health problems. These can occur as for any other woman. Always take physical complaints seriously.
- Watch out for signs of relapse such as unusual behaviour, sadness, anxiety and agitation. If there are any signs of relapse refer to a mental health nurse/clinician.
- Inform the woman that she should come back or reach out to a healthcare professional if she develops concerns about her mental health, including worsening symptoms or thoughts that she is going to hurt herself.
- If she is taking any psychiatric medication, encourage compliance.
- Some medications make physical health conditions more likely. For example, some antipsychotics may increase the likelihood of gestational diabetes. Refer on for further medical care and assessment if identified.

Making a delivery/postnatal care plan

Before delivery, work together with the woman, her family and the mental health team to develop a care plan for the delivery and postnatal period:

- If the woman lives far away, then she may need to come to the waiting home before her expected date of delivery.
- All staff involved in her care should be aware of her condition and the care plan.
- She should have a birth companion (guardian) to support her during childbirth and on the postnatal ward. This person should understand the signs of relapse and how he/she can call for help if needed.
- She should have a supply of her medication available (if applicable) and instructions on any "as needed" medication she can take if she experiences early signs of a relapse e.g., not being able to sleep.
- See below for further information about psychiatric medication in the perinatal period and what to include in the care plans for women on these medications.
- The woman and her family should be aware of the importance of the mother getting enough sleep and rest in the postnatal period. A family member should assist with caring for the infant to ensure that she gets sleep.

- The maternity healthcare worker, the woman and, if she would like, her chosen support person should come up with a plan for what she (and the family/support persons) should do if there are any signs of relapse. The priorities are to keep mother and baby safe, and to get them assessed at hospital as soon as possible.
- Review by a maternity healthcare worker before discharge should include asking about mental health. Ideally, the woman should also be reviewed by a member of a mental health team.
- Healthcare workers should routinely review the woman in the postnatal period even if she remains well.

Principles of use of psychiatric medication in the perinatal period

- Sodium valproate is used in the treatment of both bipolar disorder and epilepsy. It should **NEVER** be prescribed in pregnancy (or to any woman of childbearing age). It can cause congenital abnormalities and affect foetal brain development. If a woman attends antenatal care and reports that she is taking sodium valproate, refer her urgently to the local mental health and/or medical team for review of her medication.
- A woman with severe mental illness who is stable on medication should not usually be taken off medication just because she is pregnant or breastfeeding (although the medication may need to be changed e.g., if she is taking sodium valproate). Usually, the benefits of treatment outweigh any risk from medication passing to the foetus or breastfeeding infant. She should be referred to the mental health clinic for advice as part of collaborative care.
- Most psychiatric medications (except sodium valproate) can be prescribed with care in pregnancy and lactation. The general advice for prescribers is to keep to the lowest effective dose and to avoid multiple medications. Benzodiazepines should be avoided, except for occasional use.
- Some psychiatric medication can cause a withdrawal/adaptation syndrome in the infant immediately after delivery (jitteriness, breathing and feeding difficulties, and, rarely, seizures.) Women on these medications should deliver in a facility that has infant resuscitation equipment.
- Most women in Malawi breastfeed as formula milk is expensive and may be difficult to prepare safely. It is usually safe to breastfeed whilst taking psychiatric medication, but this may be different with a premature baby and with certain medications. A plan should be made with advice from the mental health team.
- For further information on prescribing in pregnancy and lactation, seek specialist advice.

A reminder about types of psychiatric medication

The main groups of medicines used to treat mental illness are shown here. As a maternity healthcare worker, you will meet women who are prescribed medications such as these.

- **Antipsychotics:** These reduce hallucinations, delusions and agitation in conditions with psychotic symptoms. Examples: chlorpromazine (CPZ), haloperidol, risperidone, fluphenazine (a long-acting "depot" that is given by injection).
- **Antidepressants:** Used to treat depression and anxiety disorders. Examples: fluoxetine, amitriptyline.
- **Anxiolytics:** Used to manage anxiety-related conditions. These medicines are addictive and should not be used for more than two weeks. Also used to manage alcohol withdrawal and control seizures. Examples: diazepam, lorazepam.
- **Mood stabilizers:** Used in the treatment of bipolar disorder. Examples: carbamazepine, sodium valproate.
- Other relevant medications include antiepileptic drugs (e.g., phenobarbitone) and anticholinergics used to manage side effects of antipsychotics (e.g., benzhexol).

A woman with a history of loss and trauma

The challenges of pregnancy and motherhood can be even more difficult for women with a history of loss or trauma. There is a risk of developing depression, anxiety, and in some cases post-traumatic stress disorder (PTSD). Women may also have trouble bonding with their baby.

Certain types of past trauma may particularly affect a woman in pregnancy including sexual assault, childhood abuse and traumatic birth experiences.

This section focusses on women who have experienced loss or trauma *in the past* and are now pregnant. For advice on supporting women *immediately* after loss of a baby, birth of a sick child, or birth trauma, see Part 5.

Reminders/triggers of past losses and traumas may be physical or emotional:

Physical - Ultrasounds, internal examinations, breast examinations and the birth itself may act as physical reminders of loss and trauma (e.g., sexual assault).

Emotional - Feeling a lack of control over one's body or life and reflecting on motherhood/raising a child are emotional triggers for past losses and traumas (e.g., childhood abuse).

Signs of past trauma in pregnancy

- Negative changes in mood and thoughts.
- Physical reactions such as sweating or tense muscles during examinations.
- Severe fear of childbirth or extreme worry for her and her baby's health and well-being.

Assessment and management

Past pregnancy loss or obstetric trauma should be recorded at the first antenatal care appointment. Avoid discussing the traumatic event in detail to avoid pushing the woman to relive the memory.

Women may also disclose other forms of past trauma but bear in mind that there will be many women with past trauma who do not disclose. This is why providing respectful and empathic maternity care to *all* women is crucial.

Management of women with past loss or trauma should aim to comfort, reassure and minimise distress.

For women with a history of miscarriage or stillbirth

- Reassure the woman that, if she had an early miscarriage before, there's still a good chance of having a successful pregnancy this time around.
- For women with past experiences of stillbirth, let them know that, although there is a higher chance of having a stillbirth as they've had one in the past, the healthcare team will be carefully monitoring them and the baby throughout the pregnancy and childbirth to afford them the best possible outcome.

For all women with past loss or trauma

- If possible, offer the woman a female practitioner if this would make her more comfortable or offer for a female colleague to be present during the examination.
- Explain the examination/procedure including where you are going to touch and why.
- Tell the woman she can tell you to slow down, pause or stop during any of the procedures if she becomes uncomfortable or distressed.
- Ask the woman if there's anything you can do to make her more comfortable.
- Offer the woman alternative, less invasive options if there is one available (e.g., using an external rather than internal ultrasound).
- Maximise privacy by limiting the number of care providers in the room.
- Minimising vaginal exposure during vaginal examinations.
- Encourage the woman to bring a support person with her to appointments if this would make her more comfortable.

Empowering communication

Feelings of powerlessness are associated with past trauma and can cause distress. Ways to practice empowering communication:

- Speak with the woman at eye level.
- Avoid blunt comments such as "relax!" that can come across as dominating.
- Explain the procedure and gently explain why relaxing might help, (e.g., If you try to relax your muscles, you may feel less pressure when I check your cervix. Let me know when it's okay to start").

Monitoring and follow-up

Ask the woman how she is coping with the pregnancy/baby. If the woman expresses or appears as sad, anxious or disengaged, assess for depression/anxiety and follow the relevant management guidance.

For women with symptoms of PTSD (e.g., intrusive and distressing thoughts, avoidance, feeling disconnected) or panic attacks, consider referral to a mental health team.

For a woman struggling to bond with her baby, see brief guidance in Part 6. Refer if needed.

A woman who is using alcohol or drugs

Alcohol or drug use can start in the perinatal period due to social challenges. (e.g., financial and marital strain) and mental health difficulties (e.g., anxiety and depression). Alcohol or drug use can also be longstanding and severe and include symptoms of *dependence*. Alcohol/drug dependence is characterised by:

- Frequent use of the substance.
- Increasing levels of use of the substance.
- Strong urges or cravings to use the substance.
- Finding it difficult to regulate the use of alcohol/drugs despite harmful consequences.

Always remember that women who are engaging with harmful alcohol or drug use in the perinatal period are usually struggling with current or past difficulties and are not "bad" people.

Assessment

All women should be asked about substance use at first antenatal care "booking" visit.

If you are concerned that a women may be using alcohol or drugs at further appointments, you should ask her about this sensitively, e.g., "Have you ever used any substance to help you feel better or relax?"

If the woman denies using alcohol or drugs, reassure her that if she ever does have concerns in the future, she can return for help.

Stigma

Remember that women may feel reluctant to be honest about their substance use due to stigma and fear of what may happen to themselves or their baby if they disclose. They may fear being reprimanded or being denied care by maternity healthcare workers. As such, you should take a kind and non-judgemental approach to asking questions about substance use to ensure the woman feels comfortable telling the truth.

Reassure the woman that everything discussed is confidential and will not be shared with others without her permission (unless there is immediate risk to her or dependent children). Respect whatever decision the women makes regarding seeking or not seeking support/treatment.

Management

For alcohol or drug withdrawal: Women should be referred immediately to a medical team if there are any symptoms of withdrawal (e.g., tremor, abdominal cramping, vomiting, insomnia, seizures, confusion).

If a woman presents as intoxicated:

- If the woman is aggressive/agitated see pages 22-23 for guidance on de-escalation.
- Ensure the woman is sitting in an upright position or lying in the recovery position to prevent her choking on her own vomit.

Psychoeducation

- Reassure her that people can and do get better
- Explain the adverse developmental risks to a foetus associated with alcohol/drug use.
- Remind the woman of safe sex practices.
- If relevant, discuss safer methods of using drugs (e.g., taking a pill rather than injecting).
- Remind the woman not to drive or cycle when intoxicated.
- Make the woman aware of treatment options available including counselling.
- Make the woman aware of community-based services and social support.
- With permission, involve the woman's partner or a family member. Make them aware of what to expect and how to help the woman with recovery (e.g., removing any alcohol from the house, spending more time together).

Referral

If the woman expresses a desire to stop using alcohol or drugs, or that alcohol or drug use is linked to poor mental health and the presence of mental health symptoms, consider a referral for counselling or to a mental health team/local psychiatric service.

Monitoring and follow-up

- If the woman has disclosed substance misuse but is not ready to stop using substances, respect her choice. Agree when to meet again to review how she and the baby are doing.
- Weekly review for those attempting to reduce or stop using alcohol or drugs.
- Review less frequently for those who have established abstinence.
- Each review should also include discussion on the welfare of the child.

A woman with social or marital problems

Having a child can come with several social stressors. These may relate to socioeconomic changes, relationship strain, or cultural expectations.

Social problems are risk factors for poor mental health in pregnancy and motherhood and are therefore important areas of consideration in antenatal and postnatal care.

Socioeconomic disadvantage

For those with low income, paying for basic necessities like essential health care or food may become even more difficult with pregnancy and the birth of a child.

Vulnerable women, such as those who are very young, those from marginalised social or ethnic groups, or those living in rural rather than urban areas, may be particularly at risk of socioeconomic disadvantage following pregnancy.

These socioeconomic challenges can cause stress and poor mental health that, in turn, can prevent women from being able to work and sustain their livelihoods. This can create a debilitating cycle.

What can you do?

It can feel frustrating for a woman (and her healthcare worker) that the health service cannot give direct food/financial support if that is the source of underlying stress. However, there are still helpful actions you can take. For example:

- Consider making the woman aware of various government social welfare agencies or NGO's that may be able to provide emergency support. This is particularly important if there are also other children affected.
- Deliver first-line maternal mental healthcare and/or provide the woman with advice on problem-solving, stress management, and activating social support (See Part 6).
- Consider a referral for mental health if there is evidence of moderate/severe depression, especially if neglect or risk of harm is present.

Marital and family relationships

Pregnancy and the birth of a baby can create new dynamics in marital and family relationships. This can sometimes lead to relationship strain and be a source of stress or pressure.

Marital relationships

Women who feel supported in their marital relationships are more likely to attend antenatal care, making this an important factor in the woman's and baby's well-being.

Learning how to navigate changes to finances, daily routines and emotional upheaval around having a child can all cause conflict in marital partnerships.

These challenges can affect the woman's mental health and bring up feelings of loneliness. This may be exacerbated by alcohol or drug use in the woman's partner.

In some cases, women may experience violence from their partner. Intimate partner violence includes physical, sexual and emotional violence as well as any form of coercive control.

Intimate partner violence is a threat to both the woman's and baby's physical and mental well-being. Any immediate risk of intimate partner violence requires urgent intervention. More information on intimate partner violence can be found on pages 27-28.

Family relationships

In some cases, women may feel they are unsupported by their family, that their family is critical/disapproving, or that they lack access to an affectionate and trusting relationship with their mother or other family members.

Some women may also experience violence from family members or other people within their household other than their partner. Any immediate risk of violence from anyone in the family requires urgent intervention.

What can you do?

- If it is suspected that the woman is experiencing violence. Urgent referral to Victim Support or a One Stop Centre is necessary (see pages 27-28).
- Listen to the woman. Being heard and having emotional support can be very important to the woman in this situation.
- Reassure the woman that conflict in relationships can be normal after a big life change but that if the situation is significantly affecting her mental health and she feels she can no longer cope she should come back to the healthcare facility for support where you can discuss the possibility of counselling.
- Encourage the woman to reach out to other friends or community members to share the emotional burden. She may also ask social supports for domestic assistance to alleviate pressures.
- Advise the woman to try spending some time outside of the house or by herself doing activities that she enjoys.
- You can also discuss stress management and relaxation as outlined in Part 6.

A woman living with HIV

Pregnant women and mothers living with HIV can often experience high amounts of stress and stigma that make them more vulnerable to mental health conditions such as anxiety and depression.

Mental health conditions may also make people more vulnerable to contracting HIV and have a negative effect on the progression of HIV/AIDS by affecting appointment attendance and adherence to treatment.

Common challenges

Challenges related to the present

- Some women may discover their HIV-positive status for the first time during pregnancy. This means they may be coming to terms with the diagnosis as well as the pregnancy.
- Women in this position who disclose their HIV status may also be accused by their partner of being unfaithful and "bringing" the disease into their relationship. In some cases, this can lead to intimate partner violence, and being thrown out or isolated by her partner and family.
- Because of this, many women will not disclose due to fear of violence/abandonment. This can make pregnancy a very isolating experience.
- Women will also need to adjust to taking antiretroviral treatment.

Challenges related to the future

- The woman may experience anxiety, fear, and guilt that her child may also be infected.
- The woman may worry that in the future, she, her partner and her child may become sick with AIDS.
- Feeding the baby may be an area of anxiety for the woman, especially if she has not disclosed her HIV status to their family or friends. Choosing to formula feed may make people suspicious that the woman has HIV/AIDS.

Management

- If the woman was recently diagnosed with HIV, ask if she would like any more information on the illness including ART.
- Reassure the woman that she should not feel shame for her diagnosis or pregnancy.
- Provide brief psychoeducation on the relationship between HIV and mental health (as above).
- Encourage the woman to engage with social supports including friends, family, and community organisations to reduce loneliness and isolation.
- If you have time/training, provide additional psychosocial guidance which can be found in Part 6.
- You may also consider a referral to an HIV diagnostic assistant for further support and counselling.
- Refer to local community support groups.

Positive healthcare interactions

Although you cannot control how women with HIV are treated outside of the healthcare facility, you can control the impact you have on the woman during her time at the healthcare facility.

Given the amount of stigma and discrimination this group of women may be experiencing, all care provided to pregnant women and mothers who are HIV positive should be respectful, empathic, and compassionate. Showing kindness and non-judgement can help pregnant women and mothers living with HIV feel more accepted. The healthcare environment should be seen as a safe space.

Monitoring and follow-up

- Ask the woman how she is coping with the pregnancy/baby.
- You should look out for indications of poor mental health and intimate partner violence in all pregnant and postpartum women living with HIV.
- If the woman appears to be disengaged/distressed/sad/anxious you should consider assessing for depression and anxiety (pages 30-31).
- Intimate partner violence is a red flag, if indicated refer to pages 27-28 for management guidance.
- If the woman is experiencing mental health problems that are impacting on her ability to function day-to-day, including an inability to care for herself or her baby, consider referral to a mental health team.

A pregnant adolescent

Adolescent girls (ages 10-18) who are pregnant may experience poor mental health. Stigma, shame and fear can all contribute to this. Conversely, adolescent girls with poor mental health are more likely to become pregnant due to a range of vulnerabilities. As such, adolescent pregnancy and mental health are closely related.

In pregnancy and after giving birth, adolescent girls may face several social challenges such as being unable to attend or finish school or find employment.

Adolescent girls may also have experienced previous trauma (e.g., abuse) highlighting the importance of sensitive, empathic and respectful care.

Reasons for adolescent pregnancies

- Early sexual activity for financial reasons due to poverty and lack of education or employment experiences.
- Child marriage or marrying at a young age.
- Contraception may not be easily accessible.
- Vulnerability to physical and sexual violence.

Risks associated with being pregnant in the adolescent period

- Vulnerability to abusive relationships.
- Increased likelihood of unsafe self-induced abortion.
- Higher chance of complications in pregnancy and labour such as obstructed labour, infections, and eclampsia.

Being pregnant in the adolescent period also creates various risks for the baby including:

- A higher chance of health problems in infants including preterm birth, low birth weight and severe neonatal conditions.
- Unmet needs of the baby. Poor mental health and lack of social support may mean the adolescent girl struggles to adequately care for her baby.

Pregnancy in the adolescent period may lead to:

- **Social withdrawal and isolation** – some girls may feel alone, ashamed, and afraid after finding out about the pregnancy, and want to keep it a secret.
- **Avoidance of maternity care** – stigma may act as a barrier to accessing maternity care services.

Importantly, not all adolescent girls will react or behave in the same way when finding out they are pregnant so each girl should be treated according to her own beliefs and needs.

Management

At the earliest opportunity, you should have an open discussion with the adolescent girl about her pregnancy. The discussion should address:

- Companionship for appointments – who will be accompanying her?
- Sexual and reproductive health.
- Contraception and HIV prevention.
- Infant and parenting support – does she have this in place?
- Reassure her that any complex thoughts and emotions she is having are normal.
- Discuss the possibility that people's reactions to the pregnancy may be negative but that she can still find people she trusts for support.
- Staying in school and remaining engaged with community and social activities.
- Healthy daily routine including eating regularly and getting enough sleep/rest.
- The adolescent girl may also have various concerns around her pregnancy such as:
    - Bodily changes
    - Family, friends' and community reactions
    - Having sex
    - Labour
    - Breastfeeding
    - How to take care of a baby

Allow her to ask questions and provide as much information as you can. She may feel more comfortable asking questions in private; if this is the case, ask her family member/support person to wait in a separate area.

Compassionate care

All care of pregnant adolescents should be non-judgemental and compassionate. Showing kindness and empathy can help create a comforting environment and help manage difficult behaviours that may be displayed in the healthcare setting. Reassure the adolescent of confidentiality and explain the circumstances around what you would be obliged to share with parents/guardians.

Adolescent girls are particularly vulnerable to rape and sexual assault so, even if there is not a clear history of this, be sensitive when providing care. Be aware of the risk of abuse/coercion by her partner or family (see pages 27-28 for advice on IPV).

Monitoring and follow-up

- Before the birth, make sure to discuss with the adolescent girl what to expect.
- Ask how she is coping with her pregnancy/new baby.
- Look out for indications of poor mental health and assess, manage and refer as needed.

PART 5

Helping Women Who Have Recently Experienced Loss or Trauma

- A woman who has recently miscarried or lost her baby
- A woman whose baby is premature, sick or has a congenital abnormality
- A woman who has had a traumatic delivery

A woman who has recently miscarried or lost her baby

Women may lose their baby through miscarriage, stillbirth or neonatal death. This experience is devastating and can be accompanied by feelings of guilt, shame and self-blame. For some women, grief can be just as intense after an early miscarriage as a stillbirth.

Although perinatal loss is often caused by uncontrollable biological processes some women will have their own understanding of the cause:

- **Traditional/spiritual:** they may attribute losses to various traditional or spiritual beliefs including marital affairs, witchcraft, and God's will.
- **Self-blame:** they may believe they caused the loss through something they think they did during pregnancy (e.g., not eating well enough).

Although some beliefs may provide a sense of *meaning* that can help women come to terms with what has happened, other beliefs can be detrimental to mental health. It is important to clearly explain why the death has occurred (if this is known) to help understanding and to reduce self-blame.

Grief following the loss of a baby is normal. However, some women may experience longer-term mental health difficulties. Certain factors may increase the likelihood of this happening:

- Existing mental illness or history of difficulty coping with distressing circumstances
- Experience of pregnancy loss in the past
- Been trying to conceive for a long time
- Minimal family and social support

Immediate care for stillbirths / neonatal deaths

1. Women should be given the option to see and/or hold their baby as soon as possible. Delaying contact with the baby can exacerbate any feelings of denial.
2. If possible, place the woman (and her guardian) in a separate room away from the postnatal ward. It can be very upsetting having to share a space with other women and their newborns after a loss.
3. Ask the woman what she'd like to happen to her baby's body.
4. Give the woman a health talk separate from the other women as listening to guidance on breastfeeding and taking care of a newborn may be very difficult.

What to say to a woman who has lost her baby

There are some things you may want to talk to the woman about following a perinatal death. Remember that some women may be in denial following the loss of a child. In such cases, it is important to be patient and be prepared to explain the situation as many times as necessary.

For all women who have experienced loss of a baby you should do the following:

- Provide a medical explanation to help the woman understand why the death occurred.
- Ask the woman if she has any questions. Do your best to answer these fully and unhurriedly.
- Explain that the death is not the woman's fault to help relieve self-blame and provide some words of comfort/encouragement.
- Explain that she may experience feelings of emptiness, sadness, anger, guilt, inadequacy and jealousy and that these are normal but to remember that this is not her fault.
- Encourage her to reach out for social support.
- Advise the woman to stick to her regular daily routine e.g., a regular time to wake and sleep.
- Advise to avoid using alcohol/drugs to cope.
- Remind the woman of her strengths.
- With the woman's permission, explain to her partner/support person and family members what has happened using a medical explanation and allow them to ask questions. Correct any stigmatising beliefs, such as the idea that the loss is the woman's fault.
- Discuss the possibility that the woman may develop flashbacks and nightmares and that should she experience either of these she should reach out to a healthcare professional.

Some things to note:

- **Language** – words such as *foetus* can come across as cold when discussing perinatal loss, instead try to use the term *baby* no matter at what stage of pregnancy the loss has occurred. Also avoid expressions like "you'll get pregnant again", "you will have more children", "at least it happened before the baby was born and not after" as these may only exacerbate the couple's sense of being misunderstood.
- **Empathy towards both the mother and father** – acknowledge that both of their feelings are valid and understandable.
- **Physical presence –** your physical presence in itself can be comforting; if possible, try to spend some time in the room with the mother.

Monitoring and follow-up

If she wishes, arrange to follow up the woman again but do so away from the postnatal clinic if possible. It may be very distressing for the woman to have to wait with other mothers who have their babies.

Consider psychosocial interventions. Make the woman aware of local support groups. If the woman appears depressed or has symptoms of PTSD (see pages 12-13, 30-31) refer to a mental health team. If she has suicidal thoughts/plans, refer urgently (see page 27).

A woman whose baby is premature, sick or has a congenital abnormality

Women who give birth to a baby who is premature, sick or has congenital abnormalities (e.g., hydrocephalus, cerebral palsy) may experience intense feelings of worry, stress, and disappointment.

Although giving birth to a baby who is premature, sick or has congenital abnormalities is, in most cases, the result of uncontrollable biological circumstances, some women will have traditional/spiritual explanations for what has happened, or they may blame themselves. Alternatively, some women may not have any idea what caused the baby's premature birth or ill-health.
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After the birth of a baby who is premature, sick or has congenital abnormalities, a woman may:

- Feel a mixture of different emotions including shock, sadness, anger, guilt, and helplessness, or not really know how she's feeling.
- Feel like a failure.
- Feel worried that the baby may not survive or, if they do survive, will not grow as expected.
- Feel anxiety around not knowing how to support and care for her baby, including worries about being alone with the baby and the baby becoming ill at home.
- Feel overwhelmed about the new challenges ahead including social, emotional, and financial.
- Find it hard to sleep.
- Be unable to focus on practical things.
- Feel a sense of disappointment, grief or loss towards the baby and life that they had anticipated and imagined.

Giving birth to a baby who is premature, sick or has congenital abnormalities may be accompanied by post-traumatic distress (see page 42) as the woman may have experienced emergency procedures, going into labour before expected, and being separated from her baby as soon as they're born.

It is normal for a woman with a baby who is premature, sick or has congenital abnormalities to be distressed. Some women may develop longer-term mental health difficulties. Factors that increase the likelihood of this happening are similar to those for women who lose a child (see page 40).

Management

These are some things you may want to talk to the woman (and her partner/family) about following the birth of a baby who is premature, sick or has congenital abnormalities:

- Provide a medical explanation of the baby's prematurity, ill health or congenital abnormality to help the parents understand how this has occurred.
- Ask parents if they have any questions and do your best to answer these questions fully and unhurriedly even if it means repeating the same information numerous times.
- Provide guidance on how to support and care for the baby at home. Reassure the woman that worrying about being alone with the baby is normal but that this will get easier with time.
- Explain that the prematurity/illness/abnormality is not the woman's fault to help relieve self-blame and provide some words of comfort/encouragement.
- For a woman who has given birth to a premature baby, reassure her that many premature babies develop as expected and have happy childhoods.
- Explain that in the next few months they may experience feelings of emptiness, anger, guilt, inadequacy, jealousy, disappointment, and grief and that these are normal but to remember that this is not their fault.
- Explain that in the next few months they may also feel overwhelmed and have difficulty focusing on basic tasks like organising meals, and that this is normal and to be patient with themselves.
- Emphasise that it is important for the woman to look after herself including maintaining hygiene and getting rest as some women may feel guilty for prioritising their own needs.
- Encourage them to reach out to social supports for emotional and practical help.
- Avoiding the use of alcohol and drugs to cope.

Monitoring and follow-up

- If she wishes, arrange a follow-up appointment. Consider psychosocial interventions (Part 6). Where possible, make the woman aware of local services including support groups.
- If the woman appears depressed or has symptoms of PTSD (see page 12-13, 30-31) refer to the mental health team. If she has suicidal thoughts/plans – refer urgently (see page 25).

A woman who has had a traumatic delivery

A difficult or complicated delivery can lead to a psychological birth trauma. Some women may go on to develop depression or Post Traumatic Stress Disorder (PTSD).

Psychological birth trauma after delivery is usually a consequence of obstetric complications, physical trauma and/or the woman's fear that she and/or her baby are unsafe and going to die. However, birth can also be experienced as traumatic in the absence of obstetric complications.

Psychological birth trauma may develop in cases of:

- Long and painful deliveries
- Unplanned interventions (e.g., emergency caesarean section)
- Disrespectful treatment during labour
- Perinatal loss
- Injuries or disabilities suffered by the woman or her baby during delivery

Psychological effects may be more likely in a woman who has experienced previous traumas (e.g., sexual abuse/assault and traumas with previous births) or those with pre-existing mental illness.

The adverse psychological effects of a traumatic birth can be wide-ranging. A woman may:

- Feel lonely and depressed following the traumatic birth as she may feel she is weaker than other women for not being able to forget or move on from her birth experience.
- Experience strain on marital and familial relationships due to feelings of isolation and other's lack of understanding towards what she is going through.
- Feel guilty that the events of the traumatic birth are somehow her fault.
- Have difficulty bonding with the baby as the baby is a constant reminder of the birth trauma she experienced.
- Be overly anxious about the safety of her baby, refusing to let other people hold the baby and being reluctant to let the baby out of her sight.
- The psychological distress may be worsened by distressing and painful physical symptoms caused by injuries during birth (e.g., incontinence, prolapse, pain, perineal tears that haven't healed, fistula).

Sometimes a woman who has experienced a traumatic delivery may develop depression or PTSD (see pages 12-13, 30-31).

Preventing psychological impacts of traumatic delivery

Prevention begins with efforts to reduce the likelihood of complicated deliveries through high quality maternity care. However, long and complicated deliveries may sometimes be unavoidable. Treating the women respectfully and sympathetically during labour can help ease their distress and likelihood of developing adverse psychological effects. As a healthcare provider, you can:

- Inform the woman on what is happening at every stage.
- Make sure to seek consent for all unplanned and emergency procedures.
- Listen to requests for pain relief.
- Listen to concerns or questions the woman has.
- Show sympathy when the woman is distressed.
- Not laugh or minimise the woman's experience by telling her to "stop causing problems" or "making a fuss".
- Provide the woman with as much privacy and dignity as possible.

What to say to a woman following a traumatic birth

- Traumatic births are not a sign of weakness.
- Feelings of guilt and shame are normal but to remember that this is not her fault.
- It is helpful to seek out social support.
- Avoid the use of alcohol and drugs to cope.
- Stick to her regular daily routine including maintaining a regular time to wake up and sleep
- Remind her about her strengths.
- Discuss the possibility that she may develop flashbacks, nightmares, and extreme anxiety, and that, should she experience any of these, she should come back to the healthcare facility or reach out to a healthcare professional.

Monitoring and follow-up

- If she wishes, arrange to follow up the woman again. Consider psychosocial interventions (Part 6).
- Where possible, make the woman aware of local support groups.

Mental health referral

- If the woman appears depressed or has symptoms of PTSD, refer to the mental health team.
- If she has suicidal thoughts/plans – refer urgently (see page 25).

PART 6

Psychosocial Interventions

- Psychosocial Care and Mental Health Promotion
  - Psychoeducation
  - Stress management and relaxation
  - Functioning in daily activities
  - Social support
  - Promoting bonding
  - Maternal mental health promotion
- Problem-solving counselling
- Managing cultural and traditional expectations

Psychosocial care and mental health promotion

Psychosocial care can be used as a first-line and standalone approach for women with distress or mild-moderate anxiety/depression or as a supplement to medication and specialist psychological treatment for women with severe mental health conditions.

In general, psychosocial support can be split into four areas:

- Psychoeducation
- Stress management and relaxation
- Functioning in daily activities
- Social support

In the postnatal period, it can also include:

- Helping the mother-infant bond

You do not need to deliver or cover all areas of psychosocial support as discussed below but can pick and choose based on:

- What is most appropriate for an individual woman's condition and concerns
- Her choice of intervention
- Whether you have been trained and are confident delivering an intervention
- Access to supervision from an experienced psychosocial counsellor or other mental healthcare professional

Psychoeducation

Explaining and sharing information on a mental health condition or concern is known as psychoeducation. Psychoeducation should be provided to both parents (and other family members) if possible.

The goal of psychoeducation is to increase knowledge and foster optimism. Psychoeducation should be carried out with the woman and her family or support person if appropriate.

When providing psychoeducation, you may choose to:

- Explain what the condition is, the associated symptoms and expected course and outcome.
- Correct any stigmatising or false beliefs (e.g., the mother is weak for feeling depressed).
- Discuss self-care and coping strategies (see 'stress management and relaxation', 'functioning in daily activities' and 'social support and promotion' below).
- Discuss treatment options/pathways (e.g., counselling or medication).
- Instruct on the importance of adhering to medication or other treatments.
- Explain any potential side effects of medication or other treatments.

Stress management and relaxation

Stress can be a major contributor to poor mental health. Stress management and relaxation are important areas to promote in pregnant women and mothers. Stress may manifest:

- **Physically** – headaches, difficulty sleeping, gastrointestinal problems, etc.
- **Emotionally** – feeling sad, angry, anxious, etc.
- **Behaviourally** – withdrawing socially, avoiding doing activities, becoming irritable, aggressive or violent, etc.

When discussing stress management and relaxation techniques it may be helpful to prompt the woman to draw on her knowledge of existing support structures and coping mechanisms. You can do this by asking:

- What has helped you in the past when you've felt this way?
- What do you currently do to help yourself feel better?
- Is there someone who can help you?
- Are there activities that you enjoyed doing in the past that you can do now?

Breathing and mindfulness techniques

Breathing and mindfulness techniques can be useful for women who feel stressed, overwhelmed and experience anxiety. Advise the woman that when she is feeling worried, overwhelmed, or anxious she can:

- Lay down or sit in a quiet place
- Close her eyes
- Concentrate on the rhythm of her breathing
- Then concentrate on taking slow, regular breathes, taking a deep breath in through the nose while counting to three and exhaling slowly through the mouth.

Spending even 10 minutes a day doing this exercise can help alleviate stress.

Activities

Other activities that a woman may find reduce stress include:

- Exercise
- Prayer
- Singing
- Doing something creative (e.g., sewing)
- Spending time with friends

Note: Some women may use alcohol or drugs to cope with stress. If this is the case, advise the woman that, although she may believe that in the short-term alcohol or drugs seem helpful, they can cause more problems and stress in the long term.

Functioning in daily activities

Sometimes when people are stressed or experiencing poor mental health, they may stop following their normal routine due to a lack of energy, motivation, or desire. This can worsen stress and mental health problems.

Promoting functioning in daily activities will often overlap with psychoeducation.

Encourage the person to maintain their routine and day-to-day activities. When promoting daily functioning with the woman, you should discuss both personal and social/occupational activities.

Personal

- Having a regular sleep and wake-up time
- Maintaining hygiene
- Eating regularly
- Exercising (if appropriate)
- Spending time outside of the home

Social and occupational

- Continuing in work or education
- Regularly engaging with friends, faith-based activities, or the community

Social support

A woman with poor mental health may isolate herself due to the symptoms she is experiencing and worries about stigma which can often lead to further mental distress and loneliness.

Social support can be very helpful for mental health challenges. Discuss with the woman that social support can come in many different forms including:

- **Emotional** – such as having open discussions with a trusted person about how you are feeling and what you are going through or experiencing kindness from others.
- **Practical** – such as having childcare support or being cooked for.

Reassure the woman that even though they may be feeling too tired or afraid to ask for social support, it is important to try if they want to improve their mental health.

Remind the woman that social support does not only have to come from a partner or family member but also can come from friends, community members, and community organisations (e.g., faith-based).

Promoting bonding

Before discussing some ways to promote bonding you might show the woman how her baby responds to her attention (e.g., when the mother moves or speaks/sings, the baby's eyes follow her) and explain that the baby can recognise who their mother is by voice and smell.

To promote bonding, you can:

- Encourage skin-to-skin contact
- Recommend maintaining as much eye contact as possible with the baby
- Suggest chatting/singing to the baby
- Advise spending as much time as possible carrying, holding and playing with the baby.

Remember to reassure the mother that not feeling an instant bond with her baby is normal and sometimes this can take time to develop.

Maternal Mental Health Promotion

Mental Health promotion aims to improve the mental wellbeing of women in the perinatal period. It can also play a role in the prevention of mental health conditions.

Health talks

Information about maternal mental health can be disseminated to women through a routine health talk in antenatal clinic. It is recommended that a mental health talk is included in the antenatal care of every woman in Malawi. Mental health should also be mentioned in postnatal health talks.

See Appendix 1 (pages 53-55) for a suggested Chichewa script for a maternal mental health talk.

Information Leaflets

For women experiencing mental health difficulties and social challenges, it can be helpful to have written information that they can read at home and share with their families if they wish.

See Appendix 2 (pages 56-57) for an information leaflet in Chichewa. This can be photocopied and given to women when appropriate.

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Problem-solving counselling

Problem-solving counselling is a short counselling approach used to help people identify how problems in their life are causing them to feel anxious, depressed or have other mental health difficulties, and strategies to help them cope with these problems.

The goal of problem-solving counselling is not to directly solve the person's problems (e.g., with financial support) but to equip the person with better problem-solving skills.

Problem-solving counselling is most beneficial for common mental health conditions such as distress, depression and anxiety.

How to deliver problem-solving counselling

Problem-solving counselling is usually delivered over a few (4-6) sessions that are 30 minutes to 1 hour long, but the healthcare provider can decide the number and length of sessions based on their and the woman's availability.

Problem-solving counselling can be broken down into six steps.

1. Explain about problem-solving counselling

- Explain that when a person faces problems in their life it can lead to a range of emotional and mental health symptoms that make it even more difficult to manage the problem.
- Problem-solving counselling tries to find the best ways that a person can deal with these problems.

2. Identify the problems

- Ask the woman what problems she has been experiencing in her life (e.g., financial, physical health, relationship, employment, and bereavement).
- To make the woman feel more comfortable sharing, you may suggest some personal problems that other women commonly experience to let them know you are not going to be shocked by what they choose to disclose.
- For example: *"It is common that when a woman is pregnant, any problems in her relationship with her spouse become worse. Has this happened to you?"* or "*When a woman is experiencing a difficult home life, she may use alcohol to help her manage some difficult feelings. Do you ever find yourself doing this?".*

3. Summarise the problems

- To show the woman that you have been listening and give structure to the problems, summarise the personal issues she has disclosed.

4. Prioritise the problems

- Ask the woman which problems are causing her the most distress and list them in order.

5. Select a problem

- When deciding which problem to focus on, it is advisable to try choosing a problem that is more manageable in the short-term.
- For example, it is better to first try to address a colleague problem at work or feeling socially isolated rather than tackling long-standing marital relationship issues.
- However, if you have the time and capacity, and it is safe to do so, you may consider tackling one of the larger more complex issues, by breaking it down into component parts.
- Ask the woman which problem she would like to prioritise, bearing in mind the above information.

6. Define solutions

- When defining a solution allow the woman to come up with her own solution even though you may be tempted to immediately advise her on what you think is best.
- For example, rather than telling the woman to reach out to a friend, instead ask *"how do you think would be best to go about dealing with this problem?".*
- Brainstorm various solutions with the woman, keeping practicality in mind.
- Consider the consequences of implementing these solutions. Together with the woman, evaluate the benefits and risks of each solution listed.

- Choose the solution and how to implement it.
- Set achievable targets that you can follow up on.
- To help the woman come up with a solution you may:
    - Identify key social supports.
    - Identify individual strengths in the woman that have helped her cope in the past.
    - Make the woman aware of various local and community support organisations.
    - Provide ideas if the woman is having trouble coming up with some on her own.

7. Review, encourage and support

- At the next appointment, check in with the woman on how the solution you agreed on is working.
- Consider addressing a separate problem if the woman has resolved or made significant progress on the first problem.
- If no progress has been made, reassure the woman that this is okay and encourage her to try again, rethinking the solution approach to something more achievable. You may also explore what prevented the woman from achieving her goal and make a plan to address this barrier.

Example of a problem-solving approach

1. Explain what problem-solving counselling is	• "When people experience problems in their life, whether marital, familial, financial, health or otherwise, it can make the person feel stressed, isolated, and worried which makes it even more difficult for the person to deal with those problems. I would like to discuss some of your problems so that we can think about ways you can try to address them".
2. Identify the problems	• Since the baby's arrival: ○ Not working ○ Lack of sleep ○ Not seeing friends as much ○ Arguing more with husband
3. Summarise the problems	• "You have told me your baby's arrival has changed a lot of things in your life. You are not working now, you're barely sleeping, and you see less of your friends, and it has affected your relationship with your husband".
4. Prioritise the problems	• Arguing with husband • Not seeing friends as much • Lack of sleep • Not working
5. Select a problem	• Not seeing friends as much.
6. Define solutions	• Agree for the woman to try maintaining a regular once-a-week catch-up with a trusted friend for at least 30 minutes.
7. Review, encourage and support	• The woman has not met her target at the next appointment. Reassure and encourage the woman. Discuss what barriers prevented her from meeting the target and change the solution to something more achievable. • "It is okay that you haven't yet achieved what you wanted to, these things are challenging and can take time. You said that one of the main barriers was that you have too many household duties to meet your friend. Why don't we try asking your family to help with some household duties over the next few weeks so that you can meet your friend for one 15 minute catch-up every two weeks and see if that's more manageable?".

Managing cultural and traditional expectations

All cultures have certain traditions, norms and expectations around pregnancy and having a baby. In Malawi, these may relate to:

- When to disclose the pregnancy
- When to seek antenatal care
- Who to seek care from (e.g., traditional birth attendants, traditional healers, village leaders)
- How a pregnant woman should behave
- How a spouse should behave
- What a pregnant woman should/should not eat
- Causes of miscarriage or newborn/infant loss
- Preferences of the gender of the baby

Cultural and traditional beliefs can be a source of comfort and promote a sense of being part of a supportive community. However, although these cultural and traditional norms/expectations are intended to protect the woman and her child, women may experience stress, stigma and feel pressure to conform to these beliefs even if it is not in their best interests or those of the infant.

These beliefs and expectations can also cause worry, fear and mistrust around antenatal care and deter women from disclosing or seeking help for their physical or mental health.

In some cases, these beliefs may actively put the woman and her baby at risk of harm, for example, if the traditional belief discourages attendance at a health facility, or compliance with advice about medications such as ART.

What can you do?

1. Reassure the woman that her and her baby's health is a priority to you and the healthcare facility.
1. Reassure the woman that all procedures are recommended by Ministry of Health and are considered safe.
2. Provide health education on antenatal care to correct any potentially harmful cultural beliefs that may put the woman and baby at risk.
3. When discussing cultural beliefs, it is important to try not to undermine the woman's subjective history about her pregnancy and health. Instead, try to understand her perspective and provide any clarifications using a sensitive and open approach.
4. Under no circumstances should the discussion make the woman feel ashamed or inferior for her beliefs. This will likely make the woman even less likely to seek or respond positively to antenatal care in the future.

Example 1

A woman expresses the belief that when a pregnant woman falls ill, they should first pray and seek care from religious leaders rather than healthcare facilities.

In a case like this, you may discuss with the woman that:

- Although prayer and religious practice are important sources of support during periods of ill health, it is advisable that women should use hospitals and other medical settings as the first point of call for medical advice and treatment during the antenatal period.
- Healthcare facilities have medical resources that will make it easier to determine the problem and course of treatment.
- Maternity healthcare workers are trained to provide safe medical care and to keep the health and wellbeing of women and their babies a priority at all times.

Example 2

A pregnant woman believes that she only needs to attend the antenatal clinic if she is ill or if something goes wrong.

In a case like this, you may discuss with the woman that:

- Generally, antenatal care tries to take a preventative rather than reactive approach to increase the chances of a positive outcome for both the mother and baby.
- Sometimes the pregnant woman may not even experience symptoms that indicate that she or her baby are having health problems which is why attending regular antenatal appointments is necessary.
- Maternity healthcare workers want to provide the best possible care to women at all stages of their pregnancy.

PART 7

Helping Fathers and Other Family Members

- Fathers' mental health
- Spouses/family members supporting a woman with a mental health condition

Fathers' mental health

Mental health in the perinatal period is not only about the mother but also the father. During the perinatal period, both the mother and father are going through big life changes and are likely to experience challenges related to these changes.

The mother and father's mental health are also closely related and directly impact on each other which means both are important to the family's overall well-being.

The father's mental health

Pregnancy and having a child are often a period of high stress and emotion for a new father. In the perinatal period, fathers may experience a range of mental health challenges which can lead to irritability, depression, anger, increased alcohol or substance use, anxiety, and post-traumatic stress.

Paternal well-being is important because it not only impacts negatively on the father himself but also on the mother's mental health and child outcomes. For example:

- Fathers who experience mental distress may find it difficult to bond with their baby. This is critical as fathers play an important role in promoting the health and early development of their children.
- Fathers who deal with their worries by using alcohol may end up worsening the family's financial situation and causing increased stress to the mother.

During the perinatal period, a father's mental health may be negatively impacted by:

- Changes in his relationship with his partner (e.g., less quality time to spend together, communication breakdown, increased arguments).
- Adjustments in lifestyle choices (e.g., having less time to spend with friends).
- Adjustments in home environment and routine (e.g., change in sleep schedules).
- Coping and managing the mother's pregnancy symptoms or complications.

Common challenges

The information in this section outlines some common challenges that fathers may face during the perinatal period and suggests strategies that healthcare providers can use to reduce mental distress.

Due to societal expectations about how men should behave (e.g., not crying when upset) and the stigma associated with mental health, men may be reluctant to disclose any experiences of poor mental health. They may worry about the reactions of their partners or healthcare providers.

Therefore, it is important to be sensitive and demonstrate understanding when discussing mental health and well-being with fathers.

***Challenge 1**: The gap between expectation and reality of becoming a parent can lead fathers to feel like they are failing.*

Strategies to reduce mental distress:

- Fathers should be provided with as much realistic information as possible on the transition to parenthood.
- Encourage fathers to speak to other fathers about their experiences of their partner's pregnancy and raising a child.

***Challenge 2 -** The focus in maternity healthcare is on the mother. Fathers often feel unsupported as they are frequently ignored and encouraged to "stay strong" and focus on supporting their partner.*

Strategies to reduce mental distress:

- Healthcare providers should ask the father how he is coping with the pregnancy and new baby at any opportunity and to acknowledge his presence at appointments.
- Any discussions around mental health and well-being with the parents should recognise that the father's mental health is also important.

***Challenge 3** - Relationship strain between parents.*

Strategies to reduce mental distress:

- Discuss with the parents the importance of getting enough sleep and setting aside quality time to spend with each other.
- Encourage open communication.

***Challenge 4** - Ideas around masculinity, fatherhood and mental health may lead to feelings of shame, and diminished confidence when fathers feel like they are not coping well with their new role.*

Strategies to reduce mental distress:

- Reassure fathers that it is normal to be experiencing mental health problems during this period.
- Reassure fathers that parenthood is not easy and that it is normal to feel like you are not in control and that you are doing things wrong.
- Encourage fathers to talk to their partner or a trusted friend about what they are going through.
- Encourage fathers to seek healthcare assistance if they are finding it difficult to function, are misusing substances or are having thoughts of suicide or self-harm.

Spouses/family members supporting a woman with a mental health condition

The spouse and family members will often be involved in the care of a pregnant woman or mother with a mental health condition. Therefore, it is important that they are knowledgeable and well-equipped to help support the woman who is experiencing mental distress, as well as to look after their own wellbeing at this difficult time.

If a woman is experiencing poor mental health and she has given permission for you to share this information with her partner/spouse or family, it is helpful to talk to them about:

- The mental health problem that the woman is experiencing and what to expect in terms of symptoms, mood, and behaviour.
- Things they can do to alleviate distress. For example, spend time taking care of the baby so the woman has more time to rest/sleep and to encourage her to talk about what she is thinking and feeling.
- That they mustn't put pressure on the woman to "get better". Instead, they can offer support and encouragement.
- Suicide and self-harm are medical emergencies and if they notice any indications of thoughts or actions around these, they should seek healthcare assistance for the woman as soon as possible.
- The importance of the father's mental health. It is normal for fathers to experience changes in their mental health and well-being during the perinatal period. For more guidance on the father's mental health, see page 51.

Mental health needs of those caring for a woman with a mental health condition

People who are caring for someone with a mental health condition may appear strong and unaffected by the situation, but, underneath, they may be struggling.

It may be helpful for the person to acknowledge how difficult this role can be and to have a chance to talk about their feelings.

You may choose to talk about the challenges around caring for someone who is struggling with their mental health and ways to reduce the stresses associated with these challenges, including:

- Reaffirming that caring for someone with a mental illness can be physically and emotionally draining.
- Normalising emotions that can come up when caring for someone with a mental illness such as:
  - Anxiety – about the woman's well-being and how to care for her.
  - Anger – at the woman for making life more difficult.
  - Sadness – at watching the woman struggle or suffer.
  - Guilt – around negative thoughts of the woman or situation.
  - Hopelessness – about the woman's future
  - Shame or embarrassment – at what friends, family, neighbours and community members might think or say about the woman's mental health condition.
- Talking through ways that the carer can better cope when caring for someone with a mental health condition (advice on stress management and relaxation can be found on page 44).
- Encouraging the carer to ask for practical support from friends and family (e.g., with childcare, preparing meals, shopping, etc).
- Discussing reducing feelings of loneliness and isolation by reaching out to social support systems such as friends, family, and community groups (e.g., faith-based) to talk about their experiences of caring for someone with mental illness.
- Encouraging the carer to make time to do enjoyable activities.
- Advising the carer to seek help from a healthcare professional if the stress is causing severe impact on their own mental health, e.g., they are having suicidal ideas or other symptoms of depression/anxiety.

Appendices

Appendix 1: Suggested script for a health talk (Chichewa)

KAGANIZIDWE KANGWIRO PA NTHAWI YA UCHEMBERE

Chiyambi: Namwino atchule dzina lake, udindo wake, dzina la chipatala komwe akugwira ntchito.

CHOLINGA CHA PHUNZIRO

Kupereka uthenga okhudzana ndi kaganizidwe kangwiro kuti Mayi azikhala ndi kuthekera kochepetsa kapena kuthetsa mchitidwe wodzisala kapenanso kusalidwa pankhani yokhudza matenda a kaganizidwe mnthawi ya Uchembere, polankhula momasuka pa zomwe iye akudutsamo popanda wina kumaseka kapenanso kumtonza mnjira ina iliyonse.

THANZI LA M'MALINGALIRO

Kodi thanzi la m'malingaliro nchiyani?

Mmene munthu amaganizira, amamverera mumtima mwake, ndi momwe amakhalira. Zimenezi zimampatsa munthu kuthekera kothana ndi zipsyinjo zobwera pamoyo wake, kugwira ntchito zothandiza pachitukuko cha pabanja lake ndi chitukuko cha mdera momwe iyeyo akukhala. Anthu omwe ali ndi thanzi la m'malingaliro amakhala okondwa, komanso ansangala polumikizana ndi anzawo, kuphatikizapo kumasuka pankhani zauzimu.

THANZI LA M'MALINGALIRO PA NTHAWI YA UCHEMBERE – ZIMATANTHAUZA CHIANI?

Kukhala ndi kamvekedwe kabwino ka mumtima pa nthawi ya Uchembere; kuzindikira kuthekera komwe mayi ali nako pakulimbana ndi zipsyinjo zobwera pamoyo wake mnjira zovomerezeka, ndi kugwira ntchito yothandizira kutukula banja lake komanso dera lomwe akukhalalo.

Dziwani kuti monga momwe thupi la munthu limadwalira, chomwechonso munthu amatha kudwala matenda a m'malingaliro.

Namwino afunse anthu omwe akumvetsera uthengawu:

Kodi matenda a m'malingaliro ndi chani? (akambirane ndi kupereka maganizo awo osiyana-siyana momasuka*)*

Namwino aunikire kuti:

Maganizo mwaperekawa akugwirizana ndi munthu yemwe akudwala "matenda a m'malingaliro" koma osati matenda a "misala" amene mwafotokozawo. Ku Malawi kuno anthu ambiri amalumikiza matenda a m'malingaliro ndi "misala"; ndipo kuti wodwala matenda a "misala" amayembekezeredwa kukhala omangolankhula-lankhula yekha, zolankhula zakezo zopanda mfundo, omangoyenda-yenda popanda cholinga chenicheni, omavula zovala komanso omavulaza anthu ndi kuononga katundu. Zindikirani kuti munthu yemwe mumamuyembekezera kuchita zinthu mwanena pamwambapo, ndi munthu amene:

- Akhoza kuchira atapatsidwa thandizo loyenera.
- Atha kubwereranso ku moyo wake wathunthu wakale, monga momwe ankakhalira ku malo komwe amakhalako.

Dziwaninso kuti matenda amapitilirira ngati munthuyo sakusamalidwa kapena kulandira thandizo loyenera.

Kenaka Namwino afotokoze tanthauzo lolondola la matenda a m'malingaliro:

- Matenda amene amakhudza kaganizidwe ka munthu, kamvekedwe kamumtima komanso m'mene amakhalira munthu zomwe.
- Zimabweretsa mavuto pamoyo wa munthu ndipo amagwira munthu m'modzi mwa anthu asanu ali onse pa nthawi ina yake pa moyo wa munthu.
- Pali matenda a m'malingaliro osiyanasiyana kupatula "misala", ndipo pano tifotokozeranapo ena mwa matenda amenewo.

Chidziwitso: Pali nthawi zina anthu ena amatha kusonyeza zizindikiro zofanana ndi matenda a mmalingaliro, zindikirani kuti zimenezo zimachitika chifukwa cha momwe akumverera mkati mwa mtima wawo kutsatira nyengo zomwe akudutsamo – mwa chitsanzo: namfedwa kapenanso munthu amene wagwidwa ndi mzimu kwambiri mnthawi ya mapemphero. Tisamale kwambiri kuti tisamtenge munthu oteroyo ngati wadwala matenda a m'malingaliro.

MATENDA A MU M'MALINGALIRO PA NTHAWI YA UBEREKI

Namwino afunse Azimayi ndi Azibambo za zomwe akudziwa zokhudza matenda a m'malingaliro pa nthawi ya Ubereki: zitsanzo za matenda, zomwe zimayambitsa ndi thandizo lomwe angalandire kapena kupereka kwa munthu oteroyo

Namwino afotokoze kuti:

Matenda a m'malingaliro pa nthawi ya Ubereki:

- Ali ngati matenda ena ali onse aku thupi omwe anthu amadwala ndipo amafunika chithandizo monga momwe zimachitikira ndi matenda a mtundu wina uli onse ndipo ndi ochizika.

Zindikirani kuti kuvutika ndi matenda a m'malingaliro sizipangitsa munthu kukhala "wa misala" kapena "Ozelezeka"; kotero tisamtchule Mayi amene ali ndi vutoli "wa misala/Ozelezeka", koma timtenge ngati mayi wina ali yense yemwe akudwala ndipo akufunika chithandizo monga momwe zimakhalira nthawi zonse. Kumtchula mayina chotero, ndiye kuti "tikumusala". Tikamtenga ngati munthu wina aliyense ofunika chithandizo, timthandizira kuti "asadzisale".

Gwero la matenda a m'malingaliro pa nthawi ya Ubereki

Nthawi ya Ubereki (pomwe mayi ali ndi pakati, nthawi yochira/yobadwa mwana ndiponso kuchokera nthawi yomwe mwana wabadwa mpaka pamene mwana ali ndi chaka chimodzi), pamakhala kusintha kwakukulu m'moyo wa mayi monga kusintha kwa mthupi kamvekedwe ka mumtima, zochita zake, nkhani ya za chuma ndi uzimu, chikhalidwe cha makolo komanso ubale wa mayiyo ndi anthu omuzungulira. Kusintha kumeneku kumatha kubweretsa vuto la mmalingaliro.

Nchachidziwikire kuti mayi amakhala ndi nkhawa ngakhale china chili chonse chitayenda bwino mu nyengo ya Ubereki. Kwa amayi ena, nthawiyi imakhala yovuta kwambiri chifukwa cha zokhoma/zipsyinjo zomwe amakumana nazo zomwe zimampangitsa kuyamba kukhala ndi vuto la matenda a m'malingaliro.

Matenda a m'malingaliro mu nyengo ya Ubereki amakhudza thanzi labwino la Mayi, la mwana ndi banja lonse.

Zitsanzo za matenda a m'malingaliro mnyengo ya Ubereki

Matenda odziwika kwambiri ndi matenda okhumudwa ndi matenda a nkhawa.

Kodi kukhumudwa nchiyani?

Sichachilendo munthu kukhala ndi chisoni kapena kukwiya kumene nthawi zina. Koma ngati mwakhumudwa kwa sabata, kapena pafupipafupi, kapenanso kukhumudwako kukukhudza moyo wanu wa tsiku ndi tsiku, zitha kutheka kuti muli ndi matenda okhumudwa.

Matenda okhumudwa sizitanthauza kuti munthu wakwiya, komanso sikusonyeza kuti ndiwe munthu ofooka/opepera, kapena wakhalidwe loyipa. Kukhumudwa ndi matenda, amene angathe kubweretsa mavuto aakulu pa moyo wamunthu komanso omwe amuzungulira.

Kodi matenda a nkhawa ndi chani?

Ndizabwinobwino kukhala ndi nkhawa, mantha kapena kudandaula pa zinthu zomwe zikubweretsa chiopsezo pa moyo wamuthu. Ndipo nkhawa yimatithandiza kuti tikonzekere zinthu zofunikira monga mayeso, kapena nthawi yoyankha mafunso pofunsira ntchito kapenanso kutithandiza kudzipulumutsa ku zinthu zoopsa.

Zindikirani kuti matenda a nkhawa ndi mantha ndi opezeka pakati pa anthu, ndipo anthu ochuluka amathana nawo popanda thandizo la ukadaulo ochokera ku chipatala. Koma onetsetsani kuti zizindikiro za matendawa zisatenge nthawi yaitali mukuzimvabe mthupi mwanu, chifukwa ngati nkhawa ndiyayikulu kapena mwakhala nayo nthawi yayitali, nkhawayo ingathe kubweretsa chiopsezo kumoyo wanu wathupi ndi kusokoneza zochita za tsiku ndi tsiku.

Zizindikiro za matenda okhumudwa komanso a nkhawa

- Kudzimva okwiya
- Kukhala odandaula/kukhala ndi malingaliro opyola muyezo (kupyola sabata ziwiri)
- Kusowa chiyembekezo kapena chikhulupiliro
- Kusowa chikhumbokhumbo chopanga zinthu zimene umazikonda
- Kusowa tulo, kapena kufuna kogona kwambiri mopyola muyeso (kusowa tulo ngakhale mwana akugona)
- Kusintha mchilakolako cha madyedwe - kudya kwambiri kapena pang'ono; mwinanso osafuna kudya kumene
- Kumva kutopa nthawi zonse
- Kusakhazikika
- Kukhala odzipatula
- Kumva mutu kupweteka, kumva kupweteka ndi kukokeka m'minofu
- Kumva kuthamanga mtima ndi kutuluka thukuta
- Maganizo ofuna kuzipha kapena kuzivulaza kumene

Zizindikiro zikapitirira kuoneka kupyola sabata ziwiri, ndipo zikusokoneza kachitidwe ka zinthu pa moyo wanu, bwerani msanga ku chipatala kuti mudzalandire thandizo loyenerera.

THANDIZO LA MATENDA OKHUMUDWA / NKHAWA

Makhalidwe a moyo wa tsiku ndi tsiku

Kusintha makhalidwe a moyo wa tsiku ndi tsiku ndi chinthu choyamba chomwe munthu ayenera kupanga potsatira zinthu izi:

- Kupanga masewero olimbitsa thupi (ngakhale kuyenda ndawala kwa mphindi 20 -30 tsiku lina lililonse), kudya zakudya zopatsa thanzi komanso kumagona ndi kudzuka pa nthawi yoyikika.
- Tsiku ndi tsiku munthu akhale ndi nthawi kumapanga zinthu zomwe zimakhazikitsa mtima pansi monga kumvetsera nyimbo/kuyimba nyimbo za kumtima kwake,

kupemphera, kulima, kupanga zaluso monga kujambula, kusoka/kuluka.

- Kulankhula poyera – fotokozerani mnzanu kapena wachibale amene mumamukhulupilira komanso kumpatsa ulemu za zomwe zikukupsyinjani, ndipo amatha kumvetsera mukamamuza zinthu.
- Sungani mbiri ya tsiku ndi tsiku mkabuku komwe mudzilembamo za m'mene mukumvera komanso kuona zimene zikumayambitsa nkhawa yomwe muli nayo.
- Konzani bwinobwino ndondomeko za tsiku lanu pokhazikitsa ntchito za tsiku ndi tsiku, ndipo muziyamikire nokha pa zomwe mwakwanilitsa kuchita pa tsikulo.
- Pewani kumwa mowa/kugwiritsa ntchito mankhwala ozunguza bongo ndicholinga choti mukhazikitse mtima pansi ngati mukumva kukhumudwa/ nkhawa. Izi zimapangitsa zizindikiro za matendawa kupita patsogolo ndi kudzetsa mavuto okhudzana ndi mankhwala amene mungalandire kuchipatala (ngati mwafika pa mlingo otero).

Malangizo kwa achibale, okondedwa komanso anthu amene amathandizira anthu odwala matendawa

- Mvetsereni mabvuto ake/nkhawa zake. Khalani odekha komanso omvetsetsa pamene akukutulirani nkhawa zake – musakhale pachangu, pewani kutenga mbali/kuweruza. Izi zingathandize kuthana ndi chomwe chayambitsa matendawo komanso kuwakumbutsa kuti alipo anthu amene amalabadira za moyo wawo.
- Munthu okhumudwa/wa nkhawa, amakhala osachedwa kupsya mtima ndipo amakhala ovuta kumthandiza. Mlezereni mtima pompatsa thandizo.
- Kumuuza munthu yemwe ali ndi matendawa kuti "angochokamo m'mavutowo", zimakulitsa vutolo.
- Onetsetsani kuti munthuyo asadzipatule ndi kusiya zinthu zomwe amapanga ndi anthu ena. Zimenezi sizothandiza.
- Mlimbikitseni amene akuvutika kuti atsatire zinthu zimene amapanga tsiku ndi tsiku. Mthandizeni kukhazikitsa mlingo wa ntchito za tsiku ndi tsiku. Myamikireni akakwanilitsa zinthu zomwe amafuna kupanga pa tsikulo.
- Mlimbikitseni kuti akalandire thandizo pogawana nkhawa zake ndi ogwira ntchito za Umoyo kudera kwanuko kusiyana ndi kuti athane nalo vutolo payekha.
- Musampangitse kuti azidzimvera chisoni chifukwa chomwa mankhwala kapena akamakumana ndi adokotala.

NDEMANGA

Nthawi zambiri, Mayi amathana ndi zipsyinjo/zokhoma kudzera mkuthekera komwe ali nako komanso pothandizidwa ndi anthu omwe amuzungulira.

Kudzisala kwa Mayi panyengo ya Ubereki/Uchembere kumachitika chifukwa chakuti Mayiyo amakhala ndi chikhulupiriro chakuti iyeyo ndi ofooka, ochepa mphamvu kapenanso kuti ndi oopsya. Izi sizoona ayi.

Titsindike pano kuti "kudzisala ndi kusalidwa" zikhoza kupangitsa anthu amene ali ndi matenda a m'malingaliro, "kudzisala komanso osamvetsetseka ndi anthu ena". Zimenezi zimachititsa kuti vuto lawo lipitirire mtsogolo ndipo anthuwo sagawana nkhawa ndi ena kuti apeze chithandizo chomwe angafune. Tiyeni tigwirane manja pothetsa zikhulupiriro zosayenera zokhudzana ndi matenda a m'malingaliro ku malo komwe timakhala komanso pa malo athu achipatala ano.

Tisawasale amene akuvutika ndi matenda a m'malingaliro. Ndi anthu ngati ife tomwe, chifukwa nawonso ali ndi mabanja, abwenzi komanso ntchito/mabizinesi.

Izi zidzathandizira kuchepetsa/kuthetsa mchitidwe "odzisala" ndi kuthandiza anzathu kuti achire ku matendawo ndi kuyambiranso kukhala moyo wawo wosangalala ndi wotukula miyoyo yawo ngati kale.

Appendix 2: Information leaflet (Chichewa)

UTHENGA OKHUDZA KAGANIZIDWE KANGWIRO PA NTHAWI YA UCHEMBERE

Mayi panthawi ya Uchembere

Pamakhala kusintha kwakukulu pa kamvekedwe ka mumtima mwa Mayi panthawi yoyembekezera komanso pa masabata oyambirira angapo kuchokera pomwe mwana wabadwa. Izi sizachilendo kwenikweni.

Mayi asatengedwe ngati ofooka chifukwa chakuti akumva kukhumudwa, nkhawa ndi kupsyinjika. Zomwe amadutsamo mnyengo ya Ubereki'yi ndi zomwe zimabweretsa kamvekedwe ka mumtima koteroko ndinso chikhalidwe chomwe amasonyeza. Musamtchule mayina monga kuti "wamisala/ ozelezeka". Mvetsetseni mayiyo pa nthawiyi.

Azimayi atha kuthana ndi kusintha koteroko kudzera mkuthekera komwe ali nako mkati mwawo komanso pothandizidwa ndi amuna awo kapena anthu omwe awazungulira amayiwo.

Zizindikiro zomwe Mayi angamve kapena kudutsamo panthawi ya Uchembere

- Kupweteka kwa mutu kapena thupi lonse koma osadziwika kuti pakupweteka penipeni ndi pati.
- Kutopa kosadziwika bwino gwelo lake
- Kusowa tulo, kapena kufuna kogona kwambiri mopyola muyeso kapenanso kugona pang'ono (kusowa tulo ngakhale mwana akugona)
- Kusintha mchilakolako cha madyedwe - kudya kwambiri kapena pang'ono
- Kumva kuthamanga mtima ndi kutuluka thukuta
- Kumva kupweteka mchifuwa ndi kulephera kupuma bwino
- Kudzimva ukali, kumva mantha, kusakhazikika,
- Kudziona olakwa
- Kusadzikhulupirira kapena kudziyang'anira pansi
- Kusowa chiyembekezo cha zinthu zamtsogolo
- Kudzipatula ndi kusachita zinthu zomwe munkakonda kuchita kale

Chitani izi kuti muthandizike ngati zizindikirozi mukuzimva munthawi yochepera masabata awiri ndipo sizikusokoneza kachitidwe ka ntchito zanu za tsiku ndi tsiku:

1. Vomerezani nyengo zomwe mukudutsamo pa nthawiyo, pozindikira kuti nyengozo zimabwera ndi kupitanso.

2. Chitani masewera olimbitsa thupi motere:

- Gonani pansi kapena khalani pansi mchipinda momwe mulibe phokoso komanso mopanda chisokonezo ndi kutseka maso anu.
- Pumani pang'ono-pang'ono; kenaka pumani monga mumachita nthawi zonse; kenaka kokerani mpweya mkati kudzera mphuno kwinaku mukuwerenga 1 mpaka 3; ndipo tulutsani mpweyawo pang'ono-pang'ono kudzera mkamwa.

Kuchita masewera olimbitsa thupi oterewa mwa mphindi khumi patsiku kumathandizira kuchepetsa mthino-thino wa mumtima.

3. Kenaka:

- Patulani nthawi yopemphera
- Pangani china chake chaluso monga kusoka/kujambula/kuluka
- Yendani kamtunda komverera ndi kukakhala mwachete

4. Tsatirani ndondomeko ya zomwe mumachita tsiku ndi tsiku monga:

- Kugona mokwanira ndi kudzuka pa nthawi yoyikika
- Kutsatira dongosolo la ukhondo wa tsiku ndi tsiku
- Kudya mwadongosolo, pa nthawi yake
- Osakhala modzipatula

Kupitiriza kugwira ntchito ngati muli pantchito, kupitiriza kuchita business yanu ngati ndinu wa business; kupitiriza kupita ku sukulu ngati muli pa sukulu.

Kutenga nawo mbali pa zochitika za ku Mpingo kapenanso za m'mudzi.

5. Gawanani ndi munthu amene mumakhulupirira za momwe mukumverera mkati mwanu ndi zomwe mukudutsamo. Zimenezi zikhoza kukuthandizirani kuzindikira kuti anthu ena akumva monga mukumverera inuyo.

6. Achibale akuthandizireni kulera ana anu/mwana wanu ndi kusamala pakhomo.
Chithandizo chithanso kuchokera kwa abwenzi anu, anthu okhala m'mudzi mwanu komanso ku magulu a ku Mpingo.

Musamwe mowa kapena kugwiritsa ntchito mankhwala ozunguza bongo ndicholinga choti mukhazikitse mtima pansi ngati muli ndi nkhawa. Zimenezi zimapangitsa zizindikiro za matendawa kupita patsogolo komanso kudzetsa mavuto ndi mankhwala amene mwalandira kuchipatala.
Ngati mukumva/mukuona kuti zizindikiro zomwe zatchulidwa mwambamo zikuchitika kopyola masabata awiri ndipo zikukhudza kachitidwe ka zinthu pa moyo wanu wa tsiku ndi tsiku; komanso mukumakhala ndi maganizo oyipa okhudza mwana wanu ndi inu nomwe, komanso mukuchitiridwa nkhanza za m'banja:

- Dziwitsani Amuna anu kapena achibale msanga ndi kuthamangira ku Chipatala kuti mukalandire chithandizo mwaukadaulo.

Malangizo kwa aku banja omwe akusamalira mayi amene ali ndi vuto la matenda a m'malingaliro pa nthawi ya uchembere

Ngati bambo wanyumba, komanso achibale, muli ndi udindo osamalira Mayi woyembekezera kapena amene wachira kumene.

Zizindikiro zomwe mungazione pa Mayi yemwe ali ndi vuto la matenda a m'malingaliro ndi zofanana ndi zomwe Mayi angamve kapena kudutsamo panthawi ya Uchembere (werengani pamwambapo).

Zomwe mungachite kuti muthandizire kuchepetsako chipsyinjo:

- Pewani kumtchula mayina Mayiyo monga kuti "munthu wamisala".
- Thandizirani kusamalira mwana wake/ana ake, ndi kugwira ntchito zina za pakhomopo, kuti Mayiyo akhale ndi nthawi yokwanira yopuma/yogona.
- Limbikitsani mwamuna wa Mayiyo kuti azimlankhula Mayiyo pa momwe akumvera mumtima mwake ndi zomwe akuganiza.
- Thandizirani pa zofunika pa kubadwa kwa mwana.
- Kumbutsani Mayi pa masiku oyenera kupita ku Sikelo asadachire kapenanso akachira.
- Limbikitsani Mayi kudya zakudya za magulu 6 zompatsa thanzi pamodzi ndi mwana akumuyembekezerayo ngakhalenso atabadwa kale.
- Musamkakamize Mayiyo kuti "achire msanga"
- Limbikitsani Mayi kuti adzikhala pakati pa achibale kuti adzigawana nkhawa zake ndi abalewo ndi abwenzi omwe amawakhulupirira
- Mayi azichita masewera olimbitsa thupi.

Ngati mungaone zizindikiro izi mwa Mayi:

- Kulephera kusamalira mwana ngakhale iye mwini; osapita ku Sikelo.
- Osamakwanitsa kugwira ntchito za pakhomo; kukhala ndi maganizo ofuna kudzivulaza.

Chitani zotsatirazi:

- Msamalireni Mayiyo mwachikondi ndi kuonetsetsa kuti moyo wake ndi wa mwana wake suli pa chiopsyezo.
- Pewani kumnyoza/kumnyogodola.
- Thamangirani naye ku chipatala kuti akalandire thandizo la ukadaulo kwa madotolo.

Malangizo Kwa Mayi yemwe wapititsa padera

- Zindikirani kuti simudalakwitse china chilli chonse kuti zinthu zikhale monga zakhaliramo, ndipo musazizenge milandu.
- Munachita mbali yanu monga mukadathera, koma kwinako sigawo lanu ndipo palibe chomwe mukadachita kuti zinthu zichitike mosiyana ndi momwe zachitikiramo
- Mutha kumamva mkati mwanu mkwiyo, kudzimva kuti ndinu olakwa, ndinu operewera komanso kumva nsanje. Mamvekedwe a mumtima oterewa ndi ovomerezeka, koma dziwani kuti sindinu amene mwalakwitsa china chake..
- Khalani omasuka kupeza chithandizo kuchokera kwa ena
- Londolozani zochita za pa moyo wanu za tsiku ndi tsiku monga kusunga nthawi yogonera ndi kudzuka.
- Pewani kumwa mowa kapena kugwiritsa ntchito mankhwala ozunguza bongo ndicholinga choti mukhazikitse mtima pansi ngati muli ndi nkhawa. Zimenezi zimapangitsa kuti zizindikiro za matendawa zipite patsogolo ndi kudzetsa mavuto ku mankhwala amene mwalandira kuchipatala.
- Ngati mukukhla ndi maloto kapena kumakumbukira zinthu zina zokhudza mwana opitayo, pitani msanga ku chipatala cha pafupi ndi kwanuko mukalandire thandizo mwa ukadaulo.

Kuti mumve zambiri zokhudzana ndi matenda a m'malingaliro panthawi ya Ubereki/Uchembere, chonde pitani ku chipatala chomwe muli nacho pafupi

Appendix 3: Medication in management of agitation/aggression in the perinatal period

If de-escalation (see pages 22-23) is not effective, and the woman continues to pose a risk to herself, to others or to her (unborn) baby, then sedating medication may be needed. Sedation should only be prescribed by a clinician or qualified nurse.

The main classes of medication that are used for sedation are benzodiazepines (e.g., diazepam, lorazepam) and antipsychotics (e.g. chlorpromazine, haloperidol).

Look out for acute side effects: benzodiazepines can cause respiratory depression (dangerous reduction in breathing rate); antipsychotics can cause acute dystonia (sudden onset muscle stiffness). Acute dystonia can be treated with oral/IM/IV benzhexol (artane) 5mg tds.

If the woman is pregnant, sedating medication may also affect the unborn baby. Benzodiazepines given late in pregnancy (or during delivery) can cause the baby to be born with respiratory depression and hypotonia (floppy baby syndrome). Antipsychotics may cause acute dystonia in the infant.

Monitor the baby's condition and, ideally, have infant resuscitation equipment available.

Steps in use of medication for management of agitation and aggression

(Adapted from the *Malawi Standard Treatment Guidelines)*

1. Oral medication: Offer oral medicine first.

Oral Antipsychotic options:

- Haloperidol 2.5 to 5 mg
  OR
- Chlorpromazine 100 mg
  OR
- Olanzapine 10 mg
  OR
- Risperidone 2 mg

Oral Benzodiazepine options:

- Lorazepam 1 to 2 mg
  OR
- Diazepam 10 mg (note: this is longer acting so may be more likely to cause floppy baby syndrome)

You may need to give an antipsychotic and a benzodiazepine if the patient is severely agitated.

Monitor respiratory rate, pulse, BP (and temperature) every 15-30 minutes. Repeat oral medication up to two more times at 30-minute intervals if still agitated.

2. Intramuscular Medication (IM): If oral medication is not effective or is refused then IM medication is the next step. You may need an antipsychotic plus one of the others listed below:

IM Antipsychotic options:

- Haloperidol 2.5 to 5 mg
  OR
- Chlorpromazine 25 to 100 mg

Other IM option:

- Promethazine 50 mg

IM Benzodiazepine option:

- Lorazepam 1 to 2 mg

Monitor respiratory rate, pulse, BP (and temperature) every 15-30 minutes. Wait for 30 mins. If disturbed behaviour persists, repeat the dose.

3. Intravenous Medication (IV): This should **ONLY** be given under senior supervision with resuscitation facilities available. Monitor respiratory rate **VERY** closely as it can cause the patient to stop breathing.

Use a large vein – **Diazepam** 10mg slow push over at least 5 minutes. Repeat after 10 min if insufficient effect (up to three times in extreme circumstances). Monitor respiratory rate, pulse, BP (and temperature) every 5-10 minutes.

Appendix 4: Self Reporting Questionnaire-20 (SRQ-20) Chichewa version

This screening measure can be used to identify possible depression/anxiety, and to monitor improvement or worsening over time. Answering "Eya" to 8 or more items AND/OR answering "Eya" to the question about suicidal thoughts (item 17) indicates need for further assessment and possible referral. (However, always use clinical judgement in determining need for assessment/referral; don't just rely on a screening measure score.)

Tsopano ndikufunsani mafunso okhudzana ndi momwe mumamvera mumtima ndi maganizo omwe mwakhala nawo m'sabata zinayi zomwe zapitazi. Muyankhe "eya" kapena "ayi" ku funso lirilonse. Ngati mukukaikira, yankhani mofanizira ndi momwe mwakhala mukumvera.

1	M'masabata anayi apitawa, kodi **mumamva kupweteka mutu pafupipafupi?**	Eya	Ayi
2	M'masabata anayi apitawa, kodi **simumakhala ndi chilakolako cha chakudya?**	Eya	Ayi
3	M'masabata anayi apitawa, kodi **mumavutika kugona usiku?**	Eya	Ayi
4	M'masabata anayi apitawa, kodi **manja anu amanjenjemera?**	Eya	Ayi
5	M'masabata anayi apitawa, kodi **mumakhala ndi nkhawa, mantha kapena madandaulo?**	Eya	Ayi
6	M'masabata anayi apitawa, kodi **simumachedwa kututumutsidwa?**	Eya	Ayi
7	M'masabata anayi apitawa, kodi **mumadzimbidwadzimbidwa?**	Eya	Ayi
8	M'masabata anayi apitawa, kodi **mumakhala ndi vuto kuganiza bwinobwino?**	Eya	Ayi
9	M'masabata anayi apitawa, kodi **mumakhala osasangalala kapena osakondwa?**	Eya	Ayi
10	M'masabata anayi apitawa, kodi **mumaliralira pafupipafupi ndipo koposera muyeso?**	Eya	Ayi
11	M'masabata anayi apitawa, kodi **mumaona ngati ndi chinthu chokuvutani kusangalatsidwa ndi zinthu zimene mumapanga tsiku ndi tsiku?**	Eya	Ayi
12	M'masabata anayi apitawa, kodi **mumakhala ndi vuto kupanga maganizo kapena kumanga mfundo?**	Eya	Ayi
13	M'masabata anayi apitawa, kodi **ntchito zanu za tsiku ndi tsiku sizimayenda bwino?**	Eya	Ayi
14	M'masabata anayi apitawa, kodi **mumalephera kupanga zinthu za phindu kapena zofunikira m'moyo wanu?**	Eya	Ayi
15	M'masabata anayi apitawa, kodi **munasiya kukhala ndi chidwi mu zinthu zosiyanasiyana?**	Eya	Ayi
16	M'masabata anayi apitawa, kodi **mumaziona ngati ndinu munthu wopanda ntchito kapena wosafunikira?**	Eya	Ayi
17	M'masabata anayi apitawa, kodi **maganizo odzipha anayamba akubwereranipo?**	Eya	Ayi
18	M'masabata anayi apitawa, kodi **mumamva kapena kukhala otopatopa nthawi zonse?**	Eya	Ayi
19	M'masabata anayi apitawa, kodi **mumakhala ndi vuto losamva bwino m'mimba?**	Eya	Ayi
20	M'masabata anayi apitawa, kodi **simumachedwa kutopa?**	Eya	Ayi

Appendix 5: References

See also *Contributors and acknowledgments* (page 2) for key resources used in creation of this manual.

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Malawi Maternal Mental Health Manual

The Malawi Maternal Mental Health Manual has been created to help healthcare providers (e.g., nurse-midwives, clinicians) in Malawi to integrate mental healthcare into their routine clinical practice. The manual describes common mental health conditions experienced by women in the perinatal period (pregnancy, childbirth and the first postnatal year). It offers practical guidance for staff working in busy healthcare environments with consideration of local and cultural contexts. The manual emphasises mental health as a crucial element of safe and empowering maternity experiences.

The manual is split into seven parts:

Part 1, 'Introduction and Principles of Care' provides an overview of maternal mental health conditions and maternity healthcare workers' role in mental health care.

Part 2, 'Core Knowledge and Skills', describes maternal mental health conditions in more detail and provides instruction on first-line mental health care, screening and referral.

Part 3, 'Red Flag Clinical Presentations' outlines strategies for care in urgent situations.

Part 4, 'Common Presentations and Management Through the Perinatal Period', describes the assessment, care and referral pathways for mental health conditions and social challenges.

Part 5 'Helping Women Who Have Experienced Recent Loss and Trauma', offers practical advice to healthcare workers to support women in these difficult circumstances.

Part 6, 'Psychosocial Interventions' provides an opportunity for further learning on the delivery of psychosocial care, problem-solving counselling, and mental health promotion. A script for a mental health talk and a patient information leaflet are included.

Part 7, 'Helping Fathers and Other Family Members", explains how family wellbeing should be inclusive of the father's mental health and offers advice for family members who are caring for a relative with a maternal mental health condition.

Organisations who contributed to the manual

UNITY AND FREEDOM

THE UNIVERSITY of EDINBURGH

KAMUZU UNIVERSITY OF HEALTH SCIENCES

MEIRU
Malawi Epidemiology and Intervention Research Unit

Saint John of God Hospitaller Services

AAMMH
African Alliance for Maternal Mental Health
Educate. Advocate. Act.

SMMHEP
Scotland-Malawi Mental Health Education Project
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