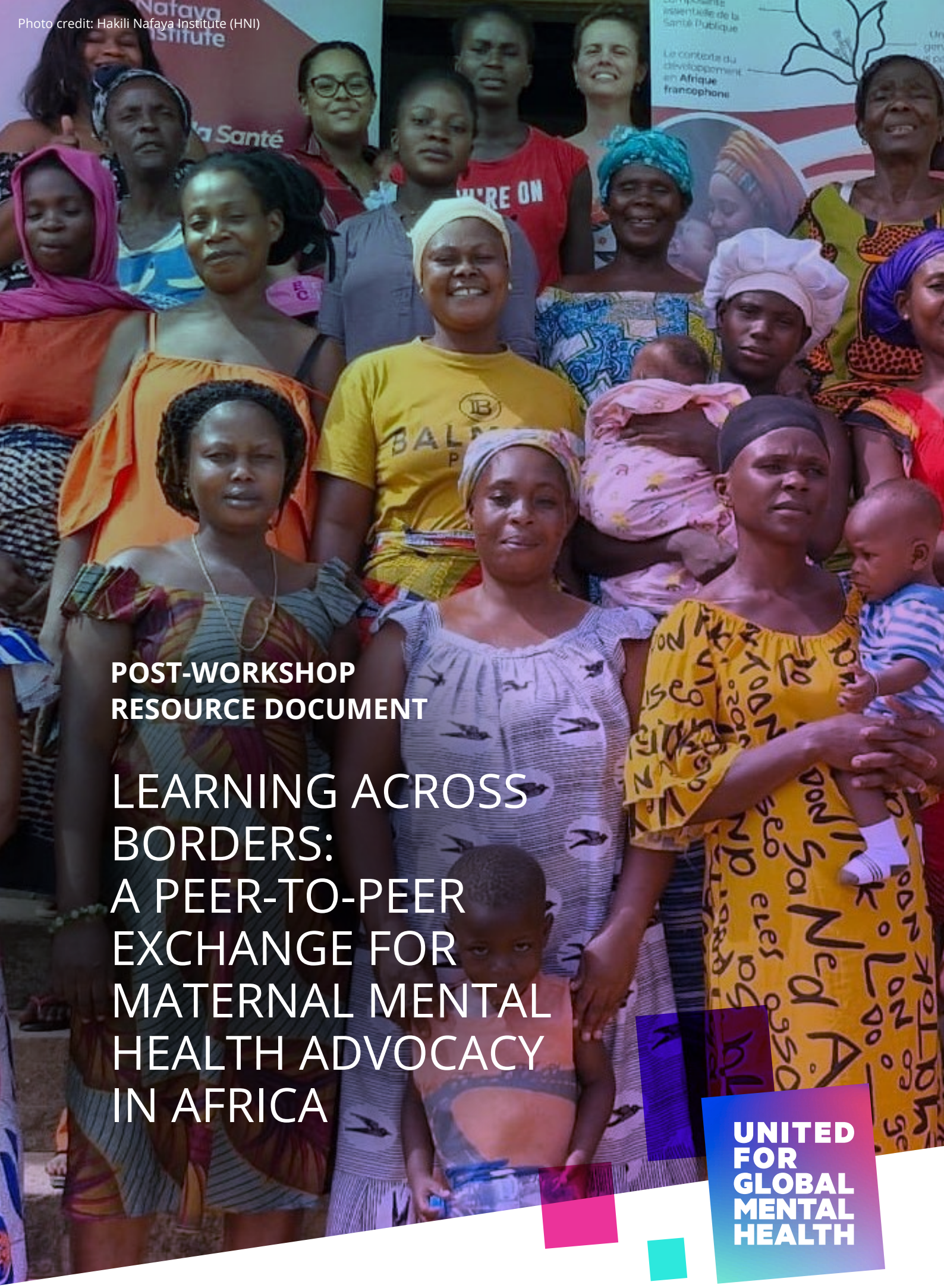


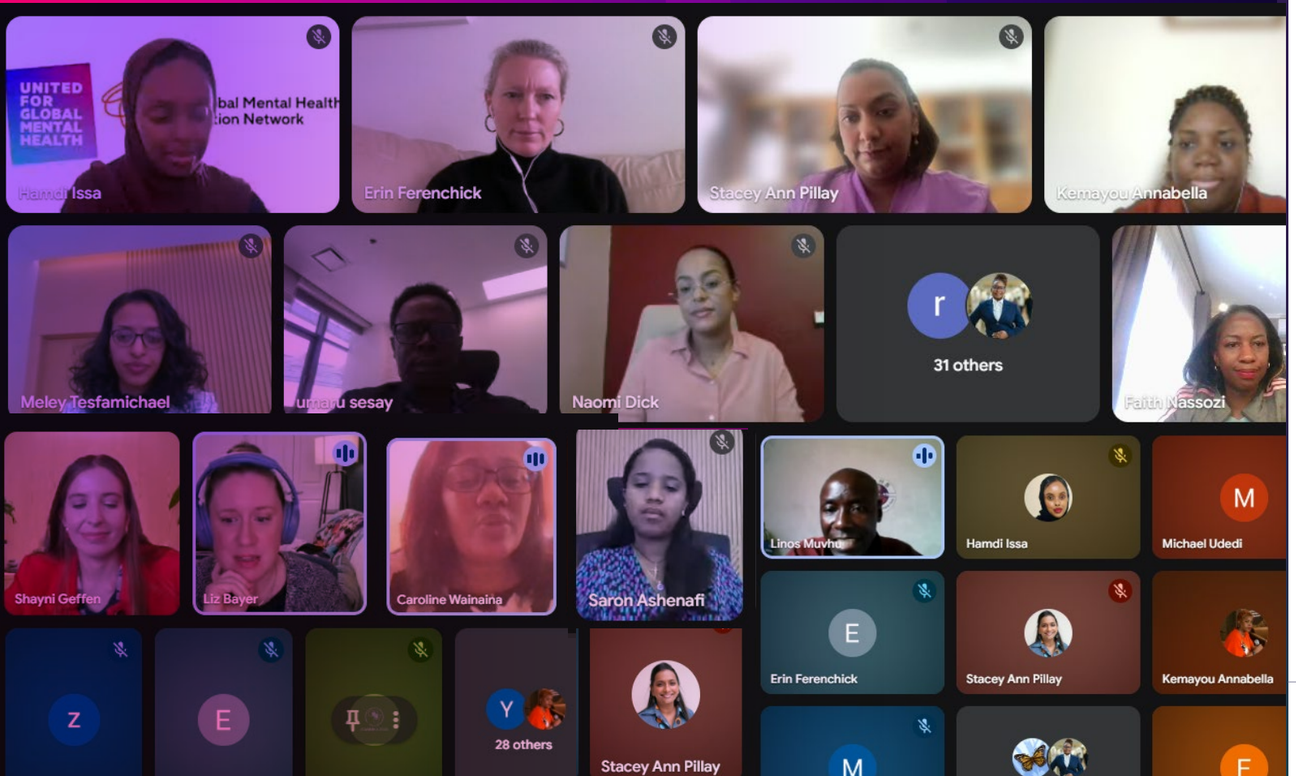
POST-WORKSHOP RESOURCE DOCUMENT

LEARNING ACROSS BORDERS: A PEER-TO-PEER EXCHANGE FOR MATERNAL MENTAL HEALTH ADVOCACY IN AFRICA

UNITED FOR GLOBAL MENTAL HEALTH

CONTENTS

Group photo taken during the Maternal Mental Health Workshop



INTRODUCTION

Globally, maternal mental health (MMH) conditions, which occur during pregnancy and postpartum, represent a significant public health challenge.

The perinatal period – from a child's conception up until one year after their birth – is often a physically and emotionally vulnerable time for mothers. While the physical risks associated with pregnancy and childbirth are well documented, the mental health and psychosocial challenges are often overlooked.

Depression and anxiety remain the most common mental health conditions experienced by pregnant and postpartum women.[1] Perinatal depression, anxiety and other MMH conditions affect up to 1 in 5 women globally. The prevalence is significantly higher in LMICs, where an estimated 15.6% of pregnant women and 19.8% of postpartum women are affected.[2]

Although accurate country-level data is limited, the risk is elevated across African countries, because many pregnancies and births occur amid high levels of poverty, disease (e.g. HIV), gender inequality and conflict. A systematic review of depression among women in Africa reported a prevalence of 11.3% during pregnancy and 18.3% after childbirth.[3]

Despite the well-established evidence base, MMH is rarely integrated into routine maternal and neonatal care, and remains a neglected dimension of maternal and child health in many LMICs, especially across Africa.

Maternal health care cannot remain fragmented – with physical and mental health care kept separate. It must be integrated and oriented toward people-centred care that holistically addresses both mental and physical health needs.

Beyond the biological and physiological factors that increase women's risk of developing mental health conditions during the perinatal period, a large proportion of women presenting with MMH conditions do not or are not able to access appropriate care.

There are multiple structural barriers to accessing high-quality maternal mental health care, including:

- **Lack of data**: Few countries collect perinatal mental health data.
- **Stigma**: Cultural and social stigma prevent women from seeking timely help.
- **Insufficient policy frameworks**: Most maternal and child-health policies do not address mental health.

1 Atif N, Lovell K, Rahman A. Maternal mental health: The missing 'm' in the global maternal and child health agenda. Seminars in Perinatology 2015;39:345–52. 10.1053/j.semperi.2015.06.007
2 WHO website, Maternal Mental Health https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health.
3 Sawyer A, Ayers S, Smith H. Pre-and postnatal psychological wellbeing in Africa: a systematic review. J Affect Disord 2010;123:17–29. 10.1016/j.jad.2009.06.027

- **Workforce constraints**: Shortage of mental health professionals and/or non-specialist mental health workers trained in maternal mental health care.
- **Limited access to appropriate care:** Mental health support is not integrated into routine maternal and child health services – from good mental health promotion and screening through to culturally appropriate interventions.

These barriers are significantly compounded by the pervasive **social and commercial determinants of mental health** and at a societal level, **persistent stigma** continues to influence how and when women access care.

The Africa Regional Maternal Mental Health Workshop

As a first step towards addressing the MMH challenges facing pregnant and postpartum women, civil society organisations (CSOs) and advocates from across the continent came together for the virtual **Africa Regional Maternal Mental Health Workshop on 4-5 November 2025**. They explored strategies and interventions for advancing maternal mental health as a public health priority.

This document builds on the outcomes of that workshop. It:

- provides an overview of the current MMH landscape
- showcases national partner initiatives (in Côte d'Ivoire, Ethiopia, Malawi, South Africa and Zimbabwe)
- highlights key challenges and opportunities for progress
- outlines important considerations for advocates when developing targeted advocacy action plans to influence national policies.

The document includes:

1. Key advocacy messages from our partners
2. Examples of countries' perinatal mental health interventions
3. Factors to consider when putting advocacy into practice

Photo credit: Perinatal Mental Health Project

KEY ADVOCACY MESSAGES FROM PARTNERS

CSO representatives and advocates made a series of statements during the workshop:

"Whilst the world has made progress in maternal healthcare – more is needed and disparities remain. Global statistics reveal **10% of pregnant women** and 13% of women who have just given birth experience a mental health condition, most commonly postpartum depression. Women living in LMICs are at even greater risk. With estimates increasing to **15.6% of pregnant women and 19.8% of women who have recently given birth**. This growing challenge is unfolding amid a **major global funding gap**, which threatens the sustainability of maternal mental health programmes for women."

Dr Hamdi Issa, United for Global Mental Health

"Perinatal mental health is a multisectoral issue requiring a platform for collaboration – forming alliances is more effective than working alone, as unified groups are more influential in producing policies and advocating for change."

Jacqueline Malombe, African Alliance for Maternal Mental Health

"Maternal mental health is one of the silent killers affecting mothers across the African continent."

Dr Michael Udedi, Africa CDC

"Together we have the opportunity to nurture a promising future where all women, regardless of their background, can access quality and affordable maternal mental health services without facing catastrophic health care costs. This vision can be realised by innovative policy design initiatives and the integration of mental health prevention and control programmes within existing maternal healthcare services."

Dr Michael Udedi, Africa CDC

"Despite ongoing health workforce shortages, we can still make meaningful progress by leveraging existing resources to bring perinatal mental health to the frontlines of care through simple yet effective approaches: **Integrate** mental health screening into routine maternal health services, particularly within antenatal care; **Enable** mental health professionals to conduct outreach and train primary healthcare workers; **Utilise** digital and innovative tools to support community health workers in appropriate identification and referral of common perinatal mental health conditions at the community level."

Dr Mercy Wanjala, AfroPHC

"On the front line, primary care doctors have shared that they have limited training in mental health despite the fact that they would like to be able to appropriately treat and refer cases of perinatal mental health conditions."

Dr Mercy Wanjala, AfroPHC

"We need to launch community campaigns to sensitise the public to maternal mental health, amplify the voices of service users, remove stigma, and remind people that mental health is real."

Zenab Barry, Zenab Barry Consulting

"We need to develop policies that support maternal mental health initiatives, that are relevant to the needs of communities, and co-produced with service users to ensure the impact is relevant."

Zenab Barry, Zenab Barry Consulting

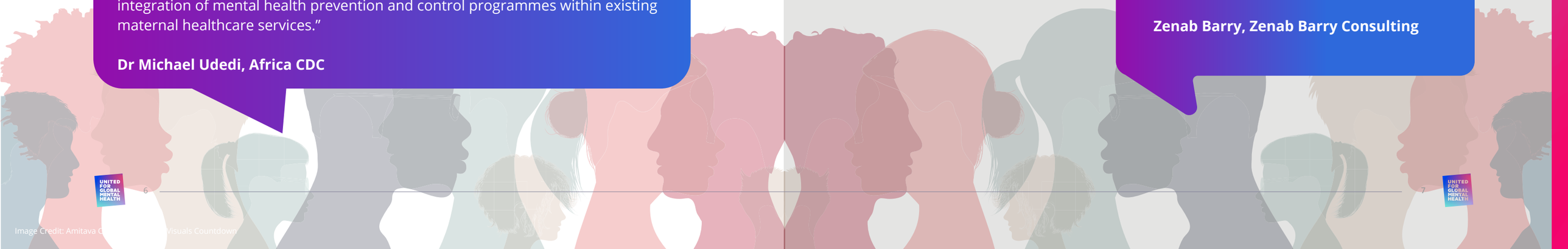


Image Credit: Amitava C… Visuals Countdown

MATERNAL MENTAL HEALTH INTERVENTIONS: NATIONAL PARTNER CASE STUDIES

CÔTE D'IVOIRE

Name of intervention:
Taki Women's Voices: Participatory Action Research on Perinatal Mental Health in Rural Côte d'Ivoire

Organisation
Hakili Nafaya Institute (HNI) – a research and advocacy organisation promoting women's mental health in Francophone Africa

Photo credit: Hakili Nafaya Institute (HNI)

Intervention design and implementation

The Taki initiative was conceived as **participatory action research**. It generated contextual evidence and provided a safe collective space for women to express themselves about their perinatal mental health. The intervention served as a moment of shared reflection and emotional release that fostered **connection, healing, and self-awareness** among participants. It allowed women of various age groups to **connect with one another**, to begin **putting words to their pain**, and to articulate emotions that had long remained unspoken.

The activity took place in the village of Taki, in Côte D'Ivoire's San Pedro region. As well as Hakili Nafaya Institute (HNI) staff, the multidisciplinary implementing team included:

- a **socio-anthropologist**, who contributed to the literature review and the design of the interview guides
- a **therapist**, who was present on site throughout the sessions to ensure emotional safety and post-discussion debriefing
- several **community mediators**, who played a crucial role in facilitating trust, translating into local languages, and ensuring cultural resonance.

The intervention included **two group discussions** followed by **individual interviews** exploring perceptions of mental health, perinatal grief and coping strategies. Discussions were conducted in a **culturally sensitive and non-judgmental way**, emphasising empathy and respect. The interviews were recorded and analysed thematically, focusing on local idioms of distress – such as the recurring metaphor of the heart and the intersection of gender norms, spiritual beliefs, and economic hardship – shaping women's mental health.

This intervention emerged from a clear **gap in perinatal mental health services** in rural Côte d'Ivoire, where emotional suffering during or after pregnancy remains largely invisible and interpreted through fatalistic or religious lenses. It aimed to make visible these unspoken burdens, while generating grounded evidence that could later inform **policy dialogue and advocacy for gender-sensitive, community-based approaches** to perinatal mental health.

Advocacy and influencing

The evidence gathered in Taki became the cornerstone of HNI's advocacy for perinatal mental health in Côte d'Ivoire. What began as a local research-action initiative evolved into a **national conversation on the mental health needs of women**, particularly those in rural areas. Using a **storytelling-based advocacy approach**, HNI transformed the narratives of women from Taki into policy messages illustrating how perinatal grief, gendered expectations, and social neglect silently erode women's wellbeing and family stability.

These findings were formally presented to the **Ministry of Women, Family and Children** during a high-level meeting where HNI highlighted the absence of psychosocial support in existing maternal-health frameworks. Policymakers were visibly moved and surprised by the depth of the testimonies, realising that what had long been considered 'private suffering' was a **public-health and gender-equity issue**. The dialogue led to a **formal partnership agreement** between the Ministry and HNI, through which the government committed to:

- support the national ***Hakili Nafaya 360*** **campaign**
- explore the integration of perinatal mental health into future national strategies on women's empowerment.

This engagement marked an important milestone: for the first time, perinatal mental health was discussed at ministerial level in Côte d'Ivoire. The collaboration also positioned HNI as a trusted civil-society partner capable of bridging community realities and institutional response. Through this process, advocacy became an **extension of the research** –transforming women's lived experiences into evidence-based influence and laying the groundwork for future policy reforms.

Factors that supported the intervention's successful delivery

Community mediation and female facilitation built trust, ensuring cultural safety and genuine connection.
The presence of a **therapist** provided emotional containment, while **community mediators** ensured understanding and inclusion.

Challenges during implementation

There is an **absence of mental health literacy**, both among participants and within the community at large. Many women had never been asked about their emotions before, and some initially found it difficult to separate physical pain from psychological distress.

- The **emotional intensity** of the discussions required careful facilitation, as several participants relived painful experiences of loss and needed time to process their feelings.
- **Rural isolation** presented logistical challenges including long travel distances and limited infrastructure.
- There was a need to work in **local languages** that often lack direct equivalents for psychological concepts.

In the end, these challenges became learning opportunities. They demonstrated that **evidence alone is not enough without trust**, that community engagement is the first condition for impact, and that addressing mental health in rural Africa requires both **scientific rigor and deep cultural empathy**. The lessons from Taki continue to guide HNI's efforts to build sustainable, government-backed approaches that give equal weight to the psychological and social dimensions of maternal health.

Recommendations and learnings

The Taki experience showed that:

- **Listening** can be a form of care.
- Creating **safe spaces** for dialogue lets women voice their pain, connect with others, and begin redefining what mental well-being means in their own cultural context.
- **Storytelling is a powerful advocacy tool** – transforming lived experience into evidence that can move policymakers.

This model can be adapted in other settings by:

- Preserving its core principles: **participation, cultural sensitivity** and **community ownership**.
- Training local mediators, integrating dialogue spaces into maternal-health programmes, and embedding women's voices in policy processes.

The lesson from Taki is clear: even in resource-limited contexts, **giving women a voice is already an intervention**.

A CALL TO ACTION FOR AFRICAN GOVERNMENTS

African governments must integrate perinatal mental health into national maternal and gender policies, while recognising lived experience as a source of expertise. Emotional wellbeing must be treated as an essential component of women's health, not a luxury. Investing in community-based, culturally grounded models like Taki can help bridge the gap between health systems and lived realities, giving every woman the right to be heard, supported and healed.

FOR MORE INFORMATION CONTACT:
Name: Dr Naomi Dick Kaba, Executive Director of Hakili Nafaya Institute
Organisation: Hakili Nafaya Institute
Email: info@hakilinafayainstitute.org

ETHIOPIA

Name of intervention:
Mothers Time

Organisation
Johns Hopkins Center for Communication Programs (Breakthrough ACTION)

Photo credit: Adobe Stock

Intervention design and implementation

The impact of mental health on family planning (FP) is complex, affecting reproductive health and family dynamics. Women with mental illness are particularly vulnerable to unplanned pregnancy, the mental strain of childbearing, and the psychological and financial hardships associated with unplanned pregnancies.

Breakthrough ACTION tested the feasibility, acceptability and preliminary effectiveness of using cognitive behavioural therapy (CBT) to address symptoms of anxiety and depression, as well as associated barriers to family planning, among postpartum mothers in Ethiopia. It developed a CBT-based tool called Mothers Time[4], which can be used by community health workers with a group of postpartum women experiencing mild to moderate symptoms of stress, depression or anxiety.

Through a series of structured sessions, Mothers Time uses CBT techniques to help mothers identify and reframe negative thoughts, build self-efficacy and develop problem-solving skills. These skills are directly applied to FP decision-making, enabling women to overcome doubts, clarify personal goals and navigate discussions with their partners about reproductive health. The tool also includes role-playing and guided

4 Mothers Time Tool: https://breakthroughactionandresearch.org/resource-library/mothers-time-tool-for-chws/

Photo credit: Adobe Stock

practice to help mothers communicate effectively about FP.
Mothers Time includes four sessions, each approximately 60–90 minutes long, delivered in small groups of six to eight women over a window period of a month. The intervention is designed for young, married mothers, specifically those who have given birth within the last year. The content focuses on a fictional young mother named Birhan, who is struggling with sad and anxious thoughts as she navigates life with a new baby, relationships and FP decision-making. Each story about Birhan is designed to provoke discussion on different types of anxious or depressive thoughts relevant to FP decisions. The intervention also includes pictorial worksheets to be completed in between group sessions.

Advocacy and influencing

The intervention engaged Ethiopia's Ministry of Health to ensure its buy-in and participation. The ministry was initially concerned about overburdening health workers with extra training on top of their already busy schedules, but a compromise was reached on the number of training days. The team made sure government concerns were addressed and data was shared from the initial pilot. The data was also used to advocate for additional training days ahead of the randomised control trial described below.

Factors that supported the intervention's successful delivery

The team iteratively refined Mothers Time before rolling it out to a larger group of postpartum mothers in Amhara region, Ethiopia. First, we implemented a feasibility and acceptability study to identify and address implementation challenges before testing the tool on a larger scale. We then used human-centred design activities to adapt materials. Rigorous training for community health workers ahead of the programme's implementation was also central to its successful delivery.

Challenges during implementation

Ongoing violence in Ethiopia, particularly in the Amhara region, caused unexpected challenges. A state of emergency was declared in Amhara, resulting in road closures, curfews and limited internet access.

Recommendations and learnings

To examine the efficacy of Mothers Time, we ran a randomised controlled trial in northwest Ethiopia. Compared to a control group, the women who used Mothers Time saw significantly greater reductions in symptoms of depression and anxiety – and much higher use of modern contraceptives.

Results suggest that more holistic family planning services that consider postpartum mental health can both reduce postpartum depression and anxiety, and support women in making their own reproductive choices. Recommendations and learnings include:

- Modified, group-based CBT, implemented through community health systems, can be an acceptable and effective way of addressing symptoms of anxiety and depression, as well as associated barriers to family planning, among postpartum mothers in Ethiopia.
- Simple solutions like CBT should be integrated within existing community-level family planning or maternal newborn and child health services to close mental health treatment gaps.
- More long-term coaching may be needed to make sure community health workers can implement the programme effectively.
- The programme should be refined so future versions provide long-term support without overburdening community health workers who implement the programme.
- Our study was limited to short term outcomes. Thus, more research is needed to understand the long-term, sustained benefits and scalability of this type of intervention in the region.

A CALL TO ACTION FOR AFRICAN GOVERNMENTS

Integrate training in mental health and postpartum reproductive health into existing training for community health workers supporting postpartum mothers and families.

FOR MORE INFORMATION CONTACT:
Name: Zoé Hendrickson, PhD, Principal Investigator
Organisation: University of Pittsburgh School of Public Health
Email: zoe.hendrickson@pitt.edu

Name: Lynn Van Lith
Organisation: Johns Hopkins Center for Communication Programs
Email: lynn.vanlith@jhu.edu

Name: Tesera Bitew, PhD
Organisation: Injibara University
Email: tesera_bitew@dmu.edu.et

Our team would like to acknowledge:

- colleagues at the Ethiopia Federal Ministry of Health (FMOH) for their contributions to the study design
- the team of mental health specialists at Injabara University for their technical expertise in adapting and implementing Mothers Time
- the Deep Dive Consulting research team for its coordination and implementation of data collection
- researchers from Breakthrough ACTION (Camber Collective and Johns Hopkins Center for Communication Programs) for their study design, management and analysis support.

We also extend our gratitude to the study participants, as well as Woreda Health Office officials and health workers in the Amhara region for their cooperation in delivering Mothers Time.

MALAWI

Name of intervention:
Routine Screening Protocol for Antenatal Depression (RSPADe)

KAMUZU UNIVERSITY OF HEALTH SCIENCES

Organisation
Kamuzu University of Health Sciences (KUHeS) in collaboration with the Malawi Ministry of Health –Blantyre District Health Office

Photo credit: Adobe Stock

Intervention design and implementation

Antenatal depression is a significant but largely hidden public health issue in Malawi, affecting the health and wellbeing of new mothers and their children, as well as early child development.

Before RSPADe, there was no standardised approach to identifying or managing depression during pregnancy in Malawi's public health system. Routine mental health screening was rare and not integrated into antenatal services, so many women went undiagnosed and untreated. RSPADe has changed that.

The programme serves pregnant women attending public antenatal clinics – many facing some of the key sources of psychological stress, such as poverty, intimate partner violence, and limited social support. It identifies and manages depressive symptoms to improve maternal and infant health outcomes.

It involves routinely screening all pregnant women for symptoms of depression during antenatal visits using the Three Item Screener and Self Reporting Questionnaire (SRQ) 20. This screening is primarily delivered by midwives trained in basic perinatal mental health care, with district mental health nurses and psychiatrists providing follow-up care. Women identified with possible depression are referred to mental health professionals at the facility where the screening occurs or to district-level services through established referral systems. Depending on the depression's severity, this could involve brief psychological support, counselling or psychiatric assessment.

The intervention is offered **during the antenatal period**, with plans to expand it to postnatal visits in the future.

Advocacy and influencing

Advocacy was central in gaining institutional and policy-level support for RSPADe. KUHeS researchers and clinicians presented evidence – including pilot data from two districts – to Malawi's Ministry of Health, showing the link between maternal mental ill-health and adverse birth outcomes. As a result, the ministry integrated screening for depression into its antenatal guidelines. Initially, policymakers expressed concern about workload increases for midwives expected to perform the screening and the lack of mental health professionals to handle referrals. In response, the programme team integrated screening tools into routine antenatal care and trained midwives to conduct initial assessments efficiently.
Key government champions for the programme included the Ministry of Health's Department of Reproductive Health, Mental Health Unit, and Nursing and Midwifery Directorate.

Factors that supported the intervention's successful delivery:

- **Collaboration** between KUHeS, the Ministry of Health, and district hospitals.
- On-site **mentorship and supportive supervision** for midwives.
- Use of a short, culturally adapted **Three Item Screener, SRQ 20 tool** in Chichewa (a local language).
- **Integration** of RSPADe into existing maternal health structures rather than creating parallel systems.
- Continuous community **sensitisation and translation** of screening tools helped reduce systemic barriers.

Challenges during implementation

- Lack of staff trained in perinatal mental health.
- High workload in antenatal clinics.
- Stigma associated with mental illness.
- Inconsistent referral systems in rural areas.
- A lack of transport making referrals difficult in rural areas.
- Cultural stigma and language barriers sometimes hindered the disclosure of emotional symptoms.

We will make the programme sustainable by integrating it into national antenatal care guidelines, training midwives, and calling on the government to adequately fund training and supervision.

Recommendations and learnings

- Integrating mental health screening into routine antenatal care is possible with proper training.
- Engaging government decision-makers early ensures long-term sustainability.
- Addressing stigma requires ongoing community education and supportive supervision for service providers.
- Data collection and feedback loops improve accountability and motivation among healthcare workers.

This model can be adapted to other settings by:

- Using locally validated screening tools.
- Training primary-level health workers in perinatal mental health.
- Embedding screening into existing maternal health programmes rather than creating new ones.

A CALL TO ACTION FOR AFRICAN GOVERNMENTS

Integrate routine perinatal mental health screening and care into national maternal health policies and ensure training for all frontline maternal health workers.
For more information contact:

FOR MORE INFORMATION CONTACT:
Name: Dr. Genesis Chorwe-Sungani
Organisation: Kamuzu University of Health Sciences (KUHeS)
Email: gchorwe@kuhes.ac.mw

Photo credit: Adobe Stock

SOUTH AFRICA

Name of intervention
The Maternal Support Service (MSS) of the Perinatal Mental Health Project (PMHP)

Perinatal Mental Health Project
Caring for Mothers. Caring for the Future.
www.pmhp.za.org

Organisation
Alan J Flisher Centre for Public Mental Health, University of Cape Town (UCT)

Photo credit: Perinatal Mental Health Project

INTERVENTION DESIGN AND IMPLEMENTATION

Common mental health conditions – namely depression, anxiety and post-traumatic stress disorder – are highly prevalent in South Africa. Between 16% to 50% of perinatal women experience depression, stress or anxiety, and at least10% are at risk of suicide.[5] Yet, over 90% of the uninsured population who require outpatient mental health care do not receive it.[6] Aside from the Maternal Support Service (MSS), there are no dedicated staff available to provide psychosocial support to perinatal women in healthcare institutions.

The Perinatal Mental Health Project (PMHP) aims to support the integration of mental health care into routine maternal health services. The Maternal Support Service (MSS) acts as a demonstration site and is located at a Midwife Obstetric Unit (MOU) in Hanover Park, South Africa. The intervention serves low-income pregnant and postpartum women in an area with high levels of unemployment, poverty, gender-based violence, gang violence and substance abuse.

5 Honikman, Simone, Sally Field, Siphumelele Sigwebela, Thanya April, Keesha James, Liesl Hermanus, and Tyla Prinsloo. 2024. "Making Maternal Mental Health Work: Lessons from a Collaborative, Stepped-Care Model in Primary Maternity Care." South African Health Review 27. doi:10.61473/001c.142330.
6 Docrat, Sumaiyah, Donela Besada, Susan Cleary, Emmanuelle Daviaud, and Crick Lund. "Mental Health System Costs, Resources and Constraints in South Africa: A National Survey." Health Policy and Planning 34, no. 9 (September 23, 2019): 706–19. https://doi.org/10.1093/heapol/czz085.

The intervention follows collaborative care principles supporting primary care providers to treat clients in collaboration with more specialist providers and with other services in the community. The MSS services are delivered on-site by one senior and one junior full-time registered counsellor, and are offered both antenatally and postnatally (from pregnancy to one year postpartum).

The MSS is a stepped-care model of service delivery and monitoring. The least resource-intensive services are delivered first, with clients progressing to more intensive or specialist services as required.

The intervention's first step is to carry out promotion, prevention, and service preparedness group sessions. These informal daily sessions improve women's mental health literacy, self-care skills and potential engagement with the service.

Then women are screened using PMHP's validated Maternal Distress Tool (MDT), and if scoring above a cut-point, are offered an Engagement, Assessment and Triage (EAT) session, if appropriate, to gauge level of need. After that, they have access to personalised on-site psychosocial support throughout pregnancy and up to one year postpartum. Women in vulnerable groups (e.g., adolescents, women experiencing violence, women with previous mental health issues, women with a recent HIV diagnosis and those staff are concerned about) are referred to an EAT session irrespective of their screening score. Those with low levels of need are engaged in a brief containment and psychoeducation session as an extension of the EAT session. Those with medium to high levels of need receive the intervention receive individual counselling and psychosocial support – in person, via telephone or via WhatsApp, according to their preference. Counsellors draw on a range of therapeutic approaches, including bereavement counselling, interpersonal therapy, cognitive behavioural therapy and psychoeducation. Women receive an average of 3-4 sessions each. Counsellors also refer women to services that address the social determinants of mental ill-health, such as domestic violence, food insecurity and social isolation. When required, counsellors collaborate with psychiatric services to ensure women receive a comprehensive assessment and medication.

In 2024, 568 MMS sessions were conducted antenatally and 348 sessions postnatally. They've been well received: in postnatal follow-up assessments of 69 women in 2024, 37% reported complete improvement, while 23% reported partial resolution.[7]

7 Honikman, Simone, Sally Field, Siphumelele Sigwebela, Thanya April, Keesha James, Liesl Hermanus, and Tyla Prinsloo. 2024. "Making Maternal Mental Health Work: Lessons from a Collaborative, Stepped-Care Model in Primary Maternity Care." South African Health Review 27. doi:10.61473/001c.142330.

Advocacy and influencing

PMHP has used the MSS at Hanover Park to showcase the most efficient and feasible approaches to providing perinatal mental health care. By disseminating these findings to government policymakers, the PMHP was invited to contribute to developing the South African health policy that includes perinatal mental healthcare. PMHP has been invited to contribute to the writing of new national mental health and maternal health guidelines. The organisation led the writing of three new chapters for the *2024 National Integrated Maternal and Perinatal Care Guidelines for South Africa*[8]:

- Respectful Maternity Care
- Maternal Mental Health
- Intimate Partner and Domestic Violence.

National training programmes for maternity care staff include PMHP materials. And the PMHP has led the drafting of the 2022 *WHO Guide for the Integration of Perinatal Mental Health into Maternal and Child Health Services*.

Initially, policymakers were reluctant to give maternal mental health the necessary attention because they believed:

- South Africa lacks the necessary staff and capacity
- physical health is more important than mental health in maternity care
- a focus on maternal mental health might come at the expense of life-saving obstetric care.

There was also very little appreciation of what common mental health conditions are, and how they can affect child health outcomes.

CHALLENGES DURING IMPLEMENTATION

- The cost of employing registered counsellors compared to community health workers
- The mismatch between the large number of perinatal women requiring support and the capacity of only two counsellors
- Socio-economic problems – e.g. gang violence around the site – which makes it more difficult for people to access services and increases levels of trauma in the community and among providers
- The significant amount of time required for case management with external services.
- A lack of adequate funding, threatening the project's sustainability.
- Stigma surrounding mental health conditions, making people less likely to engage with services.
- The lack of mobile phone ownership and high data costs, and a shortage of private space in clients' homes, making it more difficult for the service to offer virtual counselling.

8 National Department of Health, National Integrated Maternal and Perinatal Care Guidelines for South Africa (5th ed.,)National Department of Health, 2024, https://knowledgehub.health.gov.za/system/files/elibdownloads/2024-10/Integrated%20Maternal%20and%20Perinatal%20Care%20Guideline_23_10_2024_0.pdf

Factors that supported the intervention's successful delivery

- Close collaboration with maternity staff.
- Strong community liaison and strong NGO partnerships.
- Clinical supervision and psychological support for counsellors.
- Robust monitoring and evaluation to promote high-quality services.

The service is funded by grants from philanthropic organisations, donations, the Department of Social Development and the provincial Department of Health and Wellness. The latter provides on-site amenities and infrastructure. To promote sustainability, PMHP continues to advocate for stable funding and integration into the formal health system.

Recommendations and learnings

Integrating maternal mental healthcare within primary maternity care services is feasible and impactful when provided through collaborative care and using stepped-care design. Stepped-care design is particularly useful when resources are limited as it increases efficiency and allows service users to receive personalised care.
Staff wellbeing measures sustain quality and retention.

Adapting this model in other settings

Elements of this intervention have been adapted and taken up in other South African maternity services and community-based organisations. PMHP supports these services and organisations to adapt the model's processes and tools in other settings, to make them as contextually relevant and efficient as possible. The screening tool is used in national antenatal care, and PMHP provides open-access online resources, as well as training modules for the National Department of Health.

A CALL TO ACTION FOR AFRICAN GOVERNMENTS

Governments need to provide sufficient investment to enable the integration of perinatal mental health services into maternal and child health services. This integration should involve strengthening the health workforce and implementing stepped-care and collaborative approaches that address both the social determinants of maternal mental ill-health and psychological distress.

FOR MORE INFORMATION CONTACT:
Name: Associate Professor Simone Honikman
Organisation: Director of the Perinatal Mental Health Project (PMHP)
Email: simone.honikman@uct.ac.za

ZIMBABWE

Name of intervention:
Using Family Therapists to Address Perinatal Mental Health in Zimbabwe

Organisation:
Society for Pre and Post Natal Services (SPANS)

Photo credit: Society for Pre and Post Natal Services (SPANS)

Intervention design and implementation

In low- and middle-income countries (LMIC), there are considerable gaps in the early identification, screening, treatment and care of common perinatal mental conditions. Approximately 80% of cases remain unrecognised and untreated.

In countries such as Zimbabwe, there is a significant shortage of mental health care professionals to provide these services, so SPANS has trained family therapists in perinatal mental health care to close this gap. Through this 2-year diploma program, family therapists have played an essential role in addressing perinatal mental health issues in Zimbabwe – helping to improve wellbeing of mothers and children, and build more resilient communities.

During routine ante- and post-natal care, family therapists conduct mandatory screening for common mental health conditions, using validated screening tools. They offer expert guidance to mothers facing perinatal mental health challenges. They're also able to provide other forms of mental health support to the wider family – such as therapy sessions with couples.

Advocacy and influencing

Through our advocacy we were able to register SPANS as a private voluntary organisation, which facilitated a signed Memorandum of Understanding with the Ministry of Health and Child Care which meant we could provide professional courses for family therapists.

We convinced policymakers of the value of addressing perinatal mental health issues early and within a holistic family context. Some policymakers even saw the potential for integrating family therapy into existing social services, such as schools and community health centres.

The key government champions included:

- the Ministry of Health and Child Care
- the Ministry of Higher and Tertiary Education Innovation Science and Technology Development
- Health Professionals Authority Zimbabwe
- Allied Practitioners Council of Zimbabwe
- the Counselling & Psychotherapy Central Awarding Body (CPCAB)

Challenges encountered during implementation

- Lack of trained mental health professionals to deliver family therapy.
- Country-wide shortage of mental health care professionals at primary, secondary and tertiary care levels, hampering the rollout of services.
- The need to engage with multiple government departments and navigate highly bureaucratic procedures, which delayed coordination and slowed implementation.
- Lack of social support during registration.
- Absence of sustainable funding.
- Structural and systemic barriers including:
  - stigma surrounding mental health
  - inadequate infrastructure, including transport
  - language barriers.

Factors that supported the intervention's successful delivery

- Strategic advocacy and formal partnerships.
- Registering SPANS as a private voluntary organisation
- Establishing a memorandum of understanding (MoU) with the Ministry of Health and Child Care enabled family therapists to be formally recognised and employed by the government, ensuring institutional support.
- Collaborating with key institutions such as the Allied Practitioners Council of Zimbabwe and the CPCAB also ensured standardised training and professional accreditation.
- Unwavering passion, commitment and focus.

Funding for this intervention came through partnerships between SPANS, government ministries and recognised professional bodies. Sustainability will depend on the continued collaboration between SPANS and the Ministry of Health and Child Care through the signed MoU, which allows the government to employ trained family therapists as part of the public health workforce. Integrating family therapy into existing maternal and child health services will also promote long-term sustainability.

Recommendations and learnings

- **Coordinated, multi-sectoral collaboration** between multiple government departments and professional bodies was vital in formalising the training and recognition of family therapists.
- **Advocacy and policy engagement** helped in registering SPANS as a private voluntary organisation and in securing a MoU with the Ministry of Health and Child Care.
- **Build local capacity strengthens sustainability**: Training local family therapists and registering them under recognised professional bodies helped address the shortage of mental health professionals.
- **Address stigma and community awareness**: Integrate community education and awareness-raising into mental health programmes to promote acceptance and help-seeking behaviour.
- **Patience and persistence is needed**: Implementing new professional roles within existing government systems requires patience, thorough documentation, and ongoing follow-up to navigate institutional procedures.
- **Strong partnerships enhance credibility and government support**: Collaboration with established institutions such as the Health Professionals Authority and Allied Practitioners Council of Zimbabwe increased the intervention's credibility – helping secure official recognition and long-term government support.
- **Limited resources and infrastructure can slow implementation**, making early financial planning and advocacy for integration into national budgets necessary to ensure continuity once initial donor or project funding ends.
- **Consistency in participation**: Engagement from all family members is essential for successful outcomes – inconsistent attendance at therapy sessions can hinder progress.

This model can be adapted in other settings by:

Implementing a pilot programme to test the model on a small scale, gathering feedback and making necessary adjustments before a full rollout. Identify family therapists – who are already recognised in many countries' registers and provide them with the necessary training and support in delivering perinatal mental health care.

A CALL TO ACTION FOR AFRICAN GOVERNMENTS

African governments need to prioritise and invest in community-based mental health systems that integrate family therapy into primary healthcare and social services. They must recognise maternal mental health as an essential component of reproductive health and allocate dedicated funding for perinatal mental health services across all public health facilities.

FOR MORE INFORMATION CONTACT:
Name: Linos Muvhu
Organisation: SPANS
Email: lmuvhu@gmail.com

PUTTING ADVOCACY INTO PRACTICE: FACTORS TO CONSIDER

Advocacy in action

WHAT IS ADVOCACY?

- The process of **influencing** public policies, decisions, or behaviours to create social, political or systemic change related to a particular cause or issue.
- Advocacy takes many forms, but typically involves **raising awareness, mobilising support**, and **engaging** a variety of **stakeholders**.
- It can focus on influencing specific decision-makers or changing broader public attitudes.
- Advocacy can be carried out at any level of society – local, national, or international.

ADVOCACY FOR MENTAL HEALTH

It is how we build long-term, lasting structural change.

- **Building momentum**: gaining political backing, public financing and supportive policy frameworks.
- **Accelerating progress**: through grassroots advocacy, increased involvement of those with lived experience, and connecting local and global agendas.

HAVE A STRATEGY

- Have a very clear **goals** and **objectives** for your advocacy:
  Who needs to do **what** and **by when**?
- Focus on the person, not the office they hold.
- Identify your key messages and practice delivering your ask.
- Build allies and champions in government.
- Develop partnerships and coalitions - share the work, share the credit.
- Engage the public.
- Have a monitoring and evaluation plan.

TIPS FOR EFFECTIVE ADVOCACY

- **Be persistent and proactive** – follow up and set calendar reminders
- **Have one clear key ask** – keep it simple
- **The messenger matters** – who says it can be as important as what is said
- **Decision-makers are human too** – they read the news and respond to stories
- **Know your audience** – tailor your message to what matters to them
- **Share a story** – stories make issues real and relatable
- **Create feedback mechanisms** - set up systems to track responses and changes

Communications for advocacy

AUDIENCE ANALYSIS

Identify and understand your audience to communicate their interests, understanding, attitudes, beliefs, and habits:

- Identifying who you want to communicate to – your audience
- Who influences them: Peers, celebrities and/or political leaders
- What influences them: Types of media or engagement

Use these insights to inform your **communications strategy, timings and tactics**. Effectiveness and efficiency of communications is dependant on using trusted and high engagement platforms that reach your target audience

A STRONG, VISIBLE AND TRUSTED BRAND OPENS DOORS FOR ADVOCACY.

Advocacy organisations need both high credibility and high visibility.

- Maintain a consistent **'always on'** brand approach that clearly communicates who you are and what you stand for
- Produce **evergreen** content focused on your core values and the meaningful change you want to achieve
- Be present across multiple platforms: events, media and social channels, and through partnerships
- Create a brand people want to be associated with: **brand affinity = emotional connection**

FURTHER RESOURCES

1. Burgess, S., T. Bitew, A. Haile, J. Souffrant, D. Shattuck, L. M. Van Lith, … and Z. M. Hendrickson. "The Feasibility and Acceptability of Implementing Simplified Cognitive Behavioral Therapy Approaches to Support Postpartum Mental Health and Address Associated Social and Behavioral Barriers to Postpartum Family Planning in Amhara, Ethiopia: A Qualitative Study." BMC Women's Health 25, no. 1 (2025): 248. https://doi.org/10.1186/s12905-025-03744-w
2. Chorwe-Sungani, G., and J. Chipps."Validity and Utility of Instruments for Screening of Depression in Women Attending Antenatal Clinics in Blantyre District in Malawi." South African Family Practice 60, no. 4 (2018): 114–20. Accessed via https://www.ajol.info/index.php/safp/article/view/176865
3. Chorwe-Sungani, Genesis."Screening for Antenatal Depression by Midwives in Low Resource Settings in Primary Care Settings in Malawi." In Healthcare Access. IntechOpen, 2022. https://doi.org/10.5772/intechopen.97411
4. Chorwe-Sungani, G., M. Mwagomba, E. Chirwa, et al. "Acceptability and Feasibility of a Screening Protocol for Antenatal Depression (SPADe) in Blantyre District, Malawi." BMC Psychiatry 22 (2022): 544. https://doi.org/10.1186/s12888-022-04195-5
5. Docrat, Sumaiyah, Donela Besada, Susan Cleary, Emmanuelle Daviaud, and Crick Lund. "Mental Health System Costs, Resources and Constraints in South Africa: A National Survey." Health Policy and Planning 34, no. 9 (September 23, 2019): 706–19. https://doi.org/10.1093/heapol/czz085
6. Holmes, L., T. Bitew, A. Haile, L. M. Van Lith, S. Burgess, J. Vandermark, … and Z. M. Hendrickson."Mothers Time: A Cluster Randomized Controlled Trial of the Effects of a Community-Based Cognitive Behavioral Therapy Intervention on Postpartum Mental Health and Family Planning in Northwest Ethiopia." Studies in Family Planning 56, no. 1 (2025): 9–39. https://doi.org/10.1111/sifp.70000
7. Honikman, Simone, Siphumelele Sigwebela, Marguerite Schneider, and Sally Field. "Perinatal Depression and Anxiety in Resource-Constrained Settings: Interventions and Health Systems Strengthening." South African Health Review (2020). https://journals.co.za/doi/pdf/10.10520/ejc-healthr-v2020-n1-a11
8. Honikman, Simone, Sally Field, Siphumelele Sigwebela, Thanya April, Keesha James, Liesl Hermanus, and Tyla Prinsloo. "Making Maternal Mental Health Work: Lessons from a Collaborative, Stepped-Care Model in Primary Maternity Care." South African Health Review 27 (2024). https://doi.org/10.61473/001c.142330
9. Howard, L. M., E. Molyneaux, C.-L. Dennis, T. Rochat, A. Stein, and J. Milgrom. "Non-Psychotic Mental Disorders in the Perinatal Period." The Lancet 384, no. 9956 (2014): 1775–88.
10. Nweke, M., M. Ukwuoma, A. C. Adiuku-Brown, P. Ugwu, and E. Nseka."Characterization and Stratification of the Correlates of Postpartum Depression in Sub-Saharan Africa: A Systematic Review with Meta-analysis." Women's Health 18 (2022). https://doi.org/10.1177/17455057221118777
11. Perinatal Mental Health Project. No Maternal Health without Mental Health: Psychoeducation, Screening and Referral; Staff Self-Care.YouTube video, 2022. Accessed [22 November 2025]. https://www.youtube.com/watch?v=9TZo40F10rM&list=PLKet3CJ4HYIVloic01hhKbDNKX2MZlQyT
12. Perinatal Mental Health Project Empathic Engagement Skills: For Maternity Staff. YouTube video, 2018. Accessed [22 November 2025]. https://www.youtube.com/watch?v=w9260fFtgMo&list=PLKet3CJ4HYIUeNpxLBLooF-mHCzwJBNP5
13. SMART Advocacy. SMART Advocacy (build an advocacy strategy step-by-step using the workbook and resources). Accessed November 18, 2025. https://smartadvocacy.org.
14. StrongMinds. Advocacy Case Study: Mental Health in Uganda Schools Circular 20 Case Study. 2025. https://strongminds.org/wp-content/uploads/2025/09/Circular-20-Case-Study-A4.pdf
15. World Health Organization. Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services. Geneva: World Health Organization, 2022. https://www.who.int/publications/i/item/9789240057142

A Peer-to-Peer Exchange for Maternal Mental Health Advocacy in Africa

UNITED FOR GLOBAL MENTAL HEALTH

@UnitedGMH