Boston University

OpenBU **http://open.bu.edu**

Health Sciences BU Open Access Articles

2020-12

A right-to-health lens on perinatal mental health care in South Africa

This work was made openly accessible by BU Faculty. Please share how this access benefits you. Your story matters.

Version	Published version
Citation (published version):	S. Brown, G. MacNaughton, C. Sprague. 2020. "A Right-to-Health Lens on Perinatal Mental Health Care in South Africa.." Health Hum Rights, Volume 22, Issue 2, pp. 125 - 138. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7762903/

https://hdl.handle.net/2144/43493
Boston University

Boston University Libraries
OpenBU

HHR
Health and Human Rights Journal

A Right-to-Health Lens on Perinatal Mental Health Care in South Africa

SHELLEY BROWN, GILLIAN MACNAUGHTON, AND COURTENAY SPRAGUE

Abstract

South African women experience some of the highest rates of depression and anxiety globally. Despite South Africa's laudable human rights commitments to mental health in law, perinatal women are at high risk of common mental disorders due to socioeconomic factors, and they may lack access to mental health services. We used a right to mental health framework, paired with qualitative methods, to investigate barriers to accessing perinatal mental health care. Based on in-depth interviews with 14 key informants in South Africa, we found that (1) physical health was prioritized over mental health at the clinic level; (2) there were insufficient numbers of antenatal and mental health providers to ensure minimum essential levels of perinatal mental health services; (3) the implementation of human rights-based mental health policy has been inadequate; (4) the social determinants were absent from the clinic-level approach to mental health; and (5) a lack of context-specific provider training and support has undermined the quality of mental health promotion and care. We offer recommendations to address these barriers and improve approaches to perinatal mental health screening and care, guided by the following elements of the right to mental health: progressive realization; availability and accessibility; and acceptability and quality.

Shelley Brown, MPH, is a Clinical Assistant Professor in the Department of Health Sciences at Sargent College of Health and Rehabilitation Sciences at Boston University, Boston, USA, and a doctoral candidate in the Global Governance and Human Security Program at the McCormack Graduate School of Policy and Global Studies, University of Massachusetts Boston, USA.

Gillian MacNaughton, JD, MPA, DPhil, is an Associate Professor of Human Rights at the School for Global Inclusion and Social Development at the University of Massachusetts Boston, USA.

Courtenay Sprague, Ma, PhD, is an Associate Professor of Global Health in the Department of Conflict Resolution, Human Security and Global Governance at the McCormack Graduate School of Policy and Global Studies; the Department of Nursing, College of Nursing and Health Sciences, University of Massachusetts Boston, USA; and the Wits Reproductive Health and HIV Institute, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa.

Please address correspondence to Shelley Brown. Email: shelleyb@bu.edu.

Competing interests: None declared.

Copyright © 2020 Brown, MacNaughton, and Sprague. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

The Sustainable Development Goals (SDGs), adopted by the United Nations General Assembly in 2015, included the promotion of mental health on the global development agenda for the first time, signaling the rise of mental health as a policy priority for the global community.[1] Mental health remains a significant human rights concern that negatively affects a large number of women globally. Depression, for example, is a leading cause of disability worldwide; approximately 264 million people live with depression, and more women than men are affected.[2]

Common perinatal mental disorders, including depression and anxiety, during and after pregnancy affect an estimated 10%–13% of women in high-income countries and 15.6%–19.8% of women in low- and middle-income countries.[3] Prevalence estimates vary greatly across contexts, in part because they depend on how researchers define the perinatal period and whether they use screening or diagnostic data to estimate prevalence.[4] Mental illness, especially in perinatal women, affects women's capacity to work, interact with family, fulfill social and community roles, and achieve overall well-being, with detrimental effects for women and their families.[5] Poor mental health in pregnancy, if untreated, also undermines the health of infants, in part through higher risk of prematurity and low birth weight; and, exposure to maternal depression in utero can have lasting negative effects on the developing brain.[6] Postpartum depression has been linked to poorer emotional regulation in children through less responsive and attuned relationships between mother and child.[7] There is less attention in the literature to the impacts of maternal anxiety on the child, but research suggests that maternal depression, anxiety, and stress during pregnancy have potential long-term impacts on the baby and mother.[8]

Effectively addressing mental health requires a multisectoral approach that includes attention to the social determinants and lived experience of mental health. In his 2019 report, Danius Pūras, United Nations Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health (right to health), highlights the critical role of the social determinants of mental health—especially relationships and social connection—to realizing the right to mental health.[9] In addition, the World Health Organization launched QualityRights training and guidance in 2019, which promotes the active engagement of and support for civil society to build capacity among all stakeholders to improve mental health systems and services.[10] Both the Special Rapporteur's report and the QualityRights initiative emphasize that transforming mental health requires person-centered, human rights-based approaches within and outside the health care sector. For many people, quality mental health care is not available or accessible; and mental disorders, when left untreated, can have significant consequences for one's quality of life, physical health, and even risk of suicide.

South Africa is a highly relevant context for an investigation of perinatal mental health and human rights because South African women experience some of the world's highest rates of common perinatal mental disorders. Relative to women in high-income countries, they are almost three times as likely to experience mood and anxiety disorders during the perinatal period. The prevalence of women living with or at high risk of depression in South Africa is an estimated 21%–39%, and the prevalence of postnatal depression is an estimated 16%–32%.[11] And, according to one recent study, the prevalence of anxiety disorders among South African pregnant women is 23%.[12] Complex biological and social determinants position South African women uniquely for risks of adverse mental health during the perinatal period. The post-apartheid socioeconomic and cultural context, combined with 30% HIV prevalence in pregnant women, high prevalence of food insecurity, and an increasing non-communicable disease burden, increase the risk of poor mental health.[13] Importantly, the prevalence of intimate partner violence during pregnancy ranges from 15% to 38%. Research in South Africa shows an association between such violence and an increased risk of antenatal anxiety and depression; and an increase in the severity of intimate partner violence is associated with increased depression symptom severity for pregnant

and postpartum women.[14] These and other risk factors combine to substantially increase the risk of perinatal mental illness—especially in the absence of rights-based, holistic mental health promotion and access to mental health services.

The traditional, still dominant, model for understanding mental disorders is biomedical in orientation, viewing mental disorders as diseases of the brain and rooted in biology, which largely ignores the underlying social determinants of mental health.[15] There is growing evidence, however, to explain the ways in which social determinants shape mental health and how action to promote population mental health, using a rights-based approach at all stages of the life course, could significantly improve physical and mental health.[16] Audrey Chapman stresses the need for more attention to the social determinants of health when focusing on the right to health:

> If the human rights community wants to improve the health status and health outcomes throughout the society, as well as to protect the interests of vulnerable and disadvantaged groups, it will need to pay more attention to differences in social, economic, and political status and their underlying causes and mechanisms.[17]

South Africa has embraced a human rights approach to mental health in law and established a mental health policy framework, yet struggles to build a "culture of human rights."[18] Antenatal care attendance in South Africa is high, serving as an entry point to connect women to an array of supports within and outside the health sector, with a focus on comprehensively addressing mental health and well-being.[19] The National Department of Health periodically issues a manual that provides guidance on maternity care in South Africa; the most recent version provides for routine postnatal care, including postnatal visits at 3–6 days and 6 weeks postpartum to assess women's mood and general well-being.[20] Despite these advances, a complex set of mental health determinants persists, contributing to perinatal mental illness among South African women. To address perinatal mental health as a health and human rights concern, we identify the core obligations of the South African government concerning the right to mental health, with a focus on the perinatal period (Table 1). Guided by these core obligations, we then present findings concerning the obstacles to accessing perinatal mental health care based on in-depth interviews with 14 key informants with expertise in perinatal mental health in South Africa. To address the obstacles identified, we recommend a shift toward a more holistic, human rights-based approach that would better realize the right to mental health for perinatal women in South Africa. To that end, we present brief recommendations, communicated by key informants, to advance this shift (Table 2).

The right to mental health in South Africa

In 2015, South Africa ratified the International Covenant on Economic, Social and Cultural Rights, which enshrines the right to the highest attainable standard of physical and mental health. The covenant recognizes that in many countries it is not possible to fully realize the right to health for all immediately. Consequently, it provides for state parties to take steps, to the maximum of available resources, to progressively realize the right to health over time.[21] In 2000, the Committee on Economic, Social and Cultural Rights, responsible for monitoring implementation of the ICESCR, published General Comment 14 to elaborate the normative content of the right to health, thus guiding states on the implementation of their treaty obligations concerning the right to health.[22] General Comment 14 states that the right to health is an inclusive right to timely and appropriate health care and the underlying determinants of health.[23] It also specifies that "progressive realization" means that "States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12," and that each state must take "deliberate, concrete and targeted" steps to the maximum of available resources.[24] Further, the general comment provides that health care and the underlying determinants of health must

be available, accessible, acceptable, and of good quality.[25] Along with progressive realization and maximum available resources, these traits—commonly known as AAAQ—are the key elements of the right to health. Table 1 describes these elements.

South Africa's 1996 Constitution includes provisions on the right to health care services, which reflect the international right to health. Article 27(1) states, "Everyone has the right to have access to health care services," and article 27(2) provides, "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."[26] Additionally, South Africa adopted the Mental Health Care Act in 2002, which has a patient-centered and human rights orientation.[27] This law requires that any person needing mental health care services receive appropriate treatment or receive a referral to a health establishment that provides the appropriate mental health care.[28] Furthermore, South Africa's National Mental Health Policy Framework and Strategic Plan 2013–2020 promises, "The human rights of people living with mental illness will be promoted and protected through the active implementation of the Mental Health Care Act (2002)."[29] Full implementation of the plan was to be realized by 2020; however, delivering on this promise in practice has been hindered for many reasons, particularly a lack of funding.[30]

Integration of mental health into primary health care and antenatal care in South Africa

The prioritization of mental health globally has included the integration of mental health into primary health care and community-based settings, as outlined in the World Health Organization's *Comprehensive Mental Health Plan 2013–2020*.[31] Due to limited resources dedicated to mental health, South Africa largely relies on task-shifting (or task-sharing), whereby nonspecialist providers address mental health in primary care settings.[32] While task-shifting benefits include the reduction of stigma and disparities and more routine access to mental health services, a multicountry study highlighted the need for more mental health training for nonspecialist providers, in addition to resources, to mitigate the risks of overburdening nurses and other health professionals.[33] Another study conducted in 40 rural and urban maternal-child health clinics across four districts in South Africa

TABLE 1. Elements of the right to mental health

Element	Description
Progressive realization and maximum available resources	*Progressive realization* means that states must take deliberate, concrete, and targeted action, to the maximum of available resources, with a view to achieving the right to mental health.
	Maximum available resources means that states must prioritize revenue raising and the allocation of necessary resources toward fully realizing the right to mental health.
Availability and accessibility	*Availability* means that states must ensure the existence of sufficient health care services and the underlying determinants essential to mental health promotion. Health care must include integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care, and recovery. That includes mental health services integrated into primary and general health care, which support early identification and intervention and are designed to support a diverse community.
	Accessibility means that states must ensure that mental health services and the underlying determinants of mental health are accessible to all, with particular attention to nondiscrimination, economic accessibility (affordability), geographic accessibility, and physical accessibility. Accurate information on mental health must be made accessible to the public.
Acceptability and quality	*Acceptability* means that states must ensure that mental health services and the underlying determinants of mental health are acceptable to affected individuals and communities (including by being sensitive to cultural, gender, and life-cycle requirements) and designed to empower individuals to make informed decisions about their health and well-being.
	Quality means that states must ensure that goods and services provided to realize the right to mental health are of good quality. This requires the use of evidence-based practices to support prevention, promotion, treatment, and recovery. Effective collaboration between service providers and people using the services, as well as families and partners, ensure enhanced quality of care.

similarly revealed that a lack of provider training for mental health undermined the integration of mental health into primary care.[34] Long-term and locally delivered mental health training in South African primary care settings has shown promise to improve the quality of care in practice, but shorter-term training remains more typical, despite evidence demonstrating that it is less likely to translate into changes in clinical practice.[35]

In 2019, a study conducted in all nine provinces and at all levels of the South African public health system found that inpatient and outpatient mental health services represented only 4.6% of the total health budget, with inpatient care accounting for 86% of this budget.[36] The study also found insufficient numbers of mental health professionals, infrastructure, medication, and supplies, all constraining realization of the right to mental health guaranteed by law. Crucially, the National Mental Health Policy Framework and Strategic Plan does not explicitly require reporting on progress, which means that the true burden of mental illness and effectiveness of mental health care are unknown.

The literature has also documented the powerful role that nurses can play as agents of change in health care settings, while serving as health care providers to patients from similar communities.[37] Critical contextual factors associated with maternal health care delivery in South Africa, however, also include the mistreatment of patients by nurses.[38] Factors explaining this abuse are complex and can include nurses' own experiences of trauma and intimate partner violence.[39] South Africa's Perinatal Mental Health Project, which provides training designed to engender an ethos of care and compassion in maternity settings, has observed that "a complex mix of power and marginalization … plays out at the micro-level of nurse–patient relationships."[40] The provider-patient relationship in South Africa is crucial to understanding how to improve the quality of perinatal mental health care through a patient-centered and human rights-based approach.[41]

Despite the importance of incorporating the right to mental health into policies and practice in South African clinical settings, the literature examining mental health and human rights in practice is slender. In one study, based on 11 semi-structured interviews with health professionals and administrators, researchers in the Eastern Cape Province used the AAAQ framework to understand the integration of mental health into primary care and identified 11 barriers to realization of the right to health for people living with mental disabilities, including a dearth of staff training, a lack of organizational capacity, and an insufficient number of providers.[42]

Our research is located in this mental health and human rights opening. South Africa's National Mental Health Policy Framework and Strategic Plan 2013–2020, which guides mental health policy implementation for the provinces through 2020, is due to expire this year. This juncture therefore presents a timely window of opportunity to revisit the promise of the plan and to reevaluate policies governing clinical practice to promote mental health for perinatal women, particularly in antenatal care settings.

Approach and methods

We used a right to mental health framework to investigate barriers to accessing perinatal mental health care. Our study received ethical approval from the University of Massachusetts Boston's Institutional Review Board. Data collection included a document review and in-depth interviews with 14 key informants using a semi-structured guide. Our document review included international legal instruments, South Africa's Constitution, and laws and policies on mental health. This laid the groundwork for interviews. We developed the interview guide using the right to mental health framework outlined in Table 1. We obtained verbal informed consent from participants prior to conducting and recording interviews. The interviews were conducted via Skype and Zoom from September 2019 to March 2020 with key informants with expertise in perinatal women's health. The 14 key informants included three medical doctors; three

birth and postpartum doulas; two psychologists specializing in maternal health; two mental health academics; two nurse-midwives; a certified mental health counselor; and a government maternal health professional. Digital recordings were stored and encrypted in a password-protected location requiring authentication. Recordings were transcribed verbatim, and we coded and analyzed data based on preliminary themes emerging in accordance with selected elements of the right to mental health.[43] We used a code-recode strategy to capture the dominant themes and to arrive at our final set of analytical findings.

Findings and discussion

Below, we categorize the findings from key informant interviews across the interconnected elements of the right to health as (1) progressive realization and maximum available resources, (2) availability and accessibility, and (3) acceptability and quality. At the conclusion of each of these three subsections of findings, we discuss the contribution to knowledge and highlight key implications for policy and practice.

Progressive realization and maximum available resources

Three analytical themes emerged related to progressive realization and maximum available resources: first, clinicians view mental health care and screening as less important than physical health care and screening; second, the allocation of resources to mental health is inadequate to ensure minimum essential levels of mental health screening and care; and third, the implementation of mental health policies in clinical practice has been inadequate.

Most respondents remarked on the lack of equivalence between mental and physical health. Participant 3 questioned, "Why are we exceptionalizing physical health care above mental health care?" This lack of parity between mental and physical health was described as most pronounced in screening for mental health during antenatal care visits. Mental health screening is recommended but was viewed as separate and not as important as physical health screening. One participant explained:

> We've got high rates of rheumatic fever, diabetes, obesity, hypertension. There's going to be concentration on issues like that, and that mental health screen is probably going to be left behind for the last minute or so of the visit. (participant 4)

Notably, informants mentioned that mental health is relegated to a lower status, receiving fewer resources and attention because it is less tangible than physical health concerns. This hierarchy of importance is evident, according to several respondents, in the lack of resources devoted to promote mental health and address the rise in maternal suicides. One participant remarked:

> The number of deaths due to suicide are increasing. Because the other deaths overshadow the suicide deaths, we tend to concentrate more on other conditions such as HIV, hypertension and hemorrhage. I think the reason for this is resources and then also priorities. Although mental health is a priority, we've got other big issues as well. (participant 4)

A second challenge identified was the health system's lack of resources for the prevention of mental illness and the promotion of mental health. On this subject, one interviewee, who works closely with midwife obstetric units and district hospitals, referred to the World Health Organization's health system building blocks when discussing systems issues. She explained:

> [T]he other thing … that you must bring into the equation is the functioning of the system, where clinical governance is one, but the supplies and the documentation that needs to take place, and enough staffing. So it's the human resources, the drugs, the supplies, the physical environment and so on. Those all play a big role in how this woman that is arriving with a problem will be screened. (participant 10)

A third barrier identified by respondents was the weak implementation of the National Mental Health Policy and Strategic Framework despite the

strong human rights commitment in South Africa's mental health law. One key informant recounted:

> I do despair, and I get absolutely furious and angry. It's disgusting and shocking, and a human rights violation that we have a mental health policy in this country, which was signed off in 2013, which hasn't been implemented. There's all sorts of fabulous provisions, and it took millions … of rands to get various stakeholders to develop this policy and to ratify it and discuss it and have meetings and, as with many of the policies in South Africa, it looks fabulous on paper. (participant 3)

Related to policy implementation in clinical practice, interviewees noted that it is difficult to make substantial progress because habitual behaviors of health professionals are deeply embedded. Three respondents referred to a well-known study that found it can take, on average, 17 years to translate evidence-based findings into clinical practice and that it is understandable to expect progress to be slow.[44] As one respondent recalled:

> A lot of issues are culturally ingrained in South Africa, combined with poor facilities and lack of resources. How do you then accelerate progress and change? It is difficult and research has shown it takes 20 years to adopt new practices. (participant 7)

Translating policies into practice takes time and is understandably challenging. One key informant with extensive experience in policy implementation in district hospitals explained the need for champions of mental health in maternal health clinics to role model how mental health care policies should be implemented in practice.

Discussion: Knowledge contributions and implications. States must take deliberate, concrete, and targeted action, to the maximum of available resources, and must prioritize the allocation of resources toward full realization of the right to mental health. South Africa's National Mental Health Policy Framework and Strategic Plan 2013–2020 affirms that "the human rights of people living with mental illness will be promoted and protected, through the active implementation of the Mental Health Care Act" by 2014. We found, however, that this was not the case for perinatal mental health. The low allocation of resources to mental health overall, also found in previous studies, reduces the availability of staffing and supplies necessary for policy implementation.[45] Our findings substantiate that mental health lacks commensurate status relative to physical health in clinical practice in South Africa, despite recognition in law and policy that the right to health includes both physical and mental health. This lack of parity is apparent in the allocation of resources, including funding, supplies, and staffing, and in health provider decision-making in clinical practice, which is rooted in norms and deep-seated cultural practices. These norms and practices, according to respondents, result in physical health frequently taking precedence over mental health during antenatal visits.

The recommendations that emerged from the interviews included the need for increased mental health leadership at the district and subdistrict levels. Informants proposed that meaningful change be made by identifying leaders who are passionate about mental health care, willing to serve as role models, eager to champion efforts to promote perinatal mental health, and prepared to train others. This approach could be implemented within existing resources, while longer-term efforts should be focused on ensuring mental health parity with physical health, identifying additional resources for mental health promotion and mental health care, and developing a stronger system of accountability, including indicators and targets with specific deadlines and reporting on obligations.

Availability and accessibility

Two major themes related to the availability and accessibility of mental health care emerged from the data. First, there are insufficient numbers of antenatal health care providers in the public health system, which reduces opportunities to identify mental illness in women. Second, there are insufficient numbers of mental health care providers to whom women can be referred and an uneven distribution of providers across provinces, making

mental health care even less accessible to women in some provinces.

The absence of sufficient numbers of health care providers for women was apparent to respondents. Women in need of antenatal care often wait hours in long queues before seeing a nurse. Although women have access to health information through MomConnect, a mobile health app for pregnancy launched in collaboration with the National Department of Health, and access to a national counseling hotline called LifeLine, one respondent noted:

> [W]ith respect to actually being able to meet with a clinician, physically, that is much harder … We just don't have the coverage that we need. There's not enough people in the right places. (participant 6)

When women access providers for their first antenatal care visit, they should have a comprehensive examination and history taken. However, according to respondents, due to high patient volume, the high demand for services, and many required components of the visit, there are insufficient numbers of providers. Consequently, this places a burden on nurses providing care, who have to choose between providing the full protocol to only some patients, or reducing the care provided to see all patients. One respondent explained:

> [I]f it's one nurse and she has 30 or 50 new first visit ladies … announcing their pregnancy for the first time, and because of our HIV burden, the first visit should take you an hour. But now, there's one nurse, and there's 50 patients outside. But that's not the only burden, there's another 60 that's coming for their second and third visits. (participant 10)

Increased mental health screening during antenatal visits would, however, increase the need for referral resources. Almost every key informant mentioned the need for more referral resources to specialist providers and social support services, including in postnatal care, along with improved capacity building to deliver mental health services. As one respondent highlighted:

> [T]here is a lot more we can do in terms of mental health screening, upscaling our care and treatment and also then the referral system … There's a lot more that we should be doing in terms of maternal mental health and caring for these women. We're going to have to increase the resources out there, the other support services, social workers, psychiatric, psychological services, and that hasn't been done yet. If we're screening more, we're going to have to treat more and increase the other support services and structures. (participant 4)

Additionally, several respondents noted that it is important to support women by facilitating the connections to the referral resources rather than simply handing women a piece of paper with referral information. One informant advocated:

> It's not good enough for us to tell them, "I do actually know someone who [can help]. I'll give you her number, she can call you." We need to help make these connections for them. I think that's how we are going to get people the help they need after trauma. (participant 13)

Respondents indicated that if a woman did receive a referral, it would likely be to a junior medical officer or psychiatric nurse who would typically prescribe medication but not counseling, aligning with a narrow biomedical approach to mental illness.

Another impediment to accessing care through referrals was the variation across provinces. Patients in better-resourced provinces are more likely to gain access to care than those in provinces with less robust health systems. Respondents found such inequalities concerning:

> In South Africa, there's actually quite a big discrepancy in resources and health worker distribution among different provinces. For example, if you look at the Western Cape, there are quite well-resourced structures in place, and there's a system and a referral route where the patient will be able to go to. But if you go to a province such as the Eastern Cape, Mpumalanga or Limpopo, where the health system is not as well organized, women are going to fall through the cracks, even if they are screened, [they] may not get the treatment or care that is desired. (participant 4)

Discussion: Knowledge contribution and implications. Availability and accessibility mean that states must ensure that sufficient health services and the underlying determinants of mental health are accessible to all with attention to nondiscrimination, economic accessibility (affordability), geographic accessibility, and physical accessibility. Our study confirms existing research that insufficient numbers of providers in South Africa are a barrier to accessing mental health care.[46] Moreover, we found that the understaffing of nurses and their resultant heavy workload, especially (but not only) in antenatal care, resulted in insufficient time for nurses to focus on the mental health of women in their care. Similarly, respondents emphasized the urgent need for more specialist mental health providers, the development of stronger referral networks, and a focus on the support of nonspecialist providers who can promote mental health during antenatal care visits.

Screening for perinatal mood and anxiety disorders is being integrated into primary and antenatal care in South Africa through a locally validated and tested ultra-short screening tool, which provides an opportunity to identify those who might need referral for additional assessment or services.[47] However, according to respondents, if providers do not have functional referral networks, they might be less likely to screen. The decision not to screen due to poor referral networks discriminates against those in lower-resource locations with few options for referrals. It also distorts the evidence base, as without screening there is no record of the need for mental health services—data that could be used to advocate for further funding and additional providers. Additionally, we found that providing referrals to perinatal women may be insufficient to ensure that they connect to essential resources. Therefore, efforts should focus on building strong networks and directly linking women to further support.

Acceptability and quality

Two key themes emerged related to the acceptability and quality of mental health care. First, there is a need to address the social determinants of health underlying perinatal mental health, in addition to physical health. Second, training is needed in at least two key areas: integrating mental health into clinical practice and ensuring that the provider's mental health issues do not diminish the quality of care.

Several respondents urged a more holistic approach to engaging women in quality mental health promotion by attending to the social determinants of health. One common theme that emerged was that better integration of the social determinants into clinical practice was essential for improved mental health care. A mental health provider confirmed this need, stating:

> Addressing perinatal depression needs to include social determinants of health and well-being. Engaging social determinants of health needs to be integrated into [the] workload, and at a practice level, this needs to be prioritized. For example, if someone doesn't have housing, and they tell their provider, the provider needs something tangible to be able to refer the patient to. Social determinants of health is equally impactful, but providers do not know what to do. (participant 1)

A nurse educator shared similar thoughts on the necessity of integrating the social determinants of health both into workload and clinical practice. She also highlighted the importance of contextualizing what patients' lives are like and empowering nurses to think of ways they can support the whole person, with special attention to the role of the social determinants of health:

> A lot of people present with conditions where there [are] a lot of underlying social determinants … [S]ometimes it is a bit difficult to try and conceptualize what they can do as a nurse. You can't work in an environment where these issues are prominent and not acknowledge and recognize the influence of them. (participant 9)

However, respondents communicated a lack of emphasis on the interconnection among determinants such as gender-based violence, food insecurity, lack of basic resources, and mental health issues:

> Challenges which are enormous, like gender-based violence, and corruption, and food insecurity, and

> a lack of access to basic resources … Mental health is the Cinderella among … these big problems. I don't get a sense there is that appreciation of the vicious cycle of these colliding epidemics, nor the potential for the virtuous cycle. (participant 3)

Providing acceptable quality care includes attention to gender and life cycle requirements, and interviewees suggested working more holistically to provide better support systems for mental health in the perinatal period. One respondent suggested a possible solution: "If each doctor's office had someone to walk your journey with you, touch base with and ask those questions that you want to ask, mental health would improve" (participant 7).

Many informants emphasized the need to focus on the whole person in clinical settings and believed there was a need for more provider training on the importance of moving away from a disease-oriented focus on the most visible issues, such as high blood pressure, to a more holistic approach. One informant recounted:

> There is a need for some training that will make it meaningful for health professionals to link up and to understand that one works with a full person, not only with the mother's blood pressure and a baby that's growing inside her. And that she has a mind of her own that's maybe not doing very well. And how do you then make sure that this woman receives some extra care? Not only physical care, but mental health care. (participant 10)

Other respondents voiced concerns about a lack of training on how to address mental health in pregnancy and postpartum, especially in light of the extensive training and protocols that doctors and nurses receive to address obstetric emergencies. One informant explained:

> Our training is not specifically for mental health screening. We do detailed training for obstetric emergencies, and unfortunately, the mental health screen is not in that. It would be great if we can include the mental health screen as part of this. Provinces are rolling out training on how to explain the maternity case record and how it should be filled in and to give clarity on the changes. I think we're probably lacking in the training and we're not doing detailed and specific mental health screening. (participant 4)

Another barrier identified was the impact that the provider's mental health and potential burnout might have on the quality of mental health care provided to patients. Respondents pointed to health providers' often unresolved mental health needs as critical in how they carry out mental health care. One informant commented on the lack of attention paid to provider mental health and the impacts that this might have on patients: "Why should we worry about somebody else's mental health when nobody worries about ours?" (participant 5).

Providers' mental health was seen as a barrier to integrating evidence-based practices for mental health. As one key informant explained:

> I think a lot of the barriers I'm hearing about, … integrating this kind of evidence base into their thinking and decision-making, may well have to do with their own mental health issues. So when you come to them and you speak about mental health, it evokes a kind of defensive shutdown response … This happens at … coalface when you are speaking to midwives or nursing sisters who are providing services, but … it equally applies to high-level decision makers. (participant 3)

One respondent with 16 years of experience supporting women during pregnancy and childbirth in government hospitals described providers' mental health as a multilayered concern warranting further attention. Over the years, she witnessed many perinatal care providers using coercive tactics, which undermines the quality of care that women receive and can result in trauma for patients. She suggested that those who resort to such tactics have unresolved issues, which results in pain and self-protection and might manifest in their patient interactions.

Discussion: Knowledge contribution and implications. The acceptability of mental health services is a subjective assessment by individuals and communities concerning the extent to which services provided are culturally acceptable and sensitive to

gender and life stage. Quality mental health services require adequate supplies; providers with necessary skills and training; acceptable standards of care; and treating patients with respect before, during, and after the provision of care. Our study found that there is a lack of attention to the drivers underpinning patients' and providers' mental health. Respondents recommended a shift in practice to provide better support systems for women's mental health promotion across pregnancy, childbirth, and postpartum. General consensus converged on the need for a more holistic approach to engaging women in quality mental health promotion through attention to the social determinants of health. Additionally, this research highlights the importance of addressing the mental health needs of health providers both as rights-holders themselves and to mitigate the impacts that their mental health care needs have on the quality of care they provide to perinatal women. It is necessary to work toward an ethos of care to better support all women.

One recommendation actionable in the short-term was to identify patient-centered mental health supports during the perinatal period, including doulas, peer counseling, and support groups. Doulas focus more broadly on the well-being of women, while peer counselors draw on their own experiences of mental illness and recovery to provide support to individuals facing similar experiences. Both offer a relationship of care and social connection, which is a key underlying determinant of the right to mental health. Individuals in these roles work collaboratively with nurses, midwives, doctors, and mental health professionals.

Study limitations

The main strength of this study is its application of a right to mental health framework to empirical research conducted among perinatal mental health experts, which advances our understanding of real-world challenges to accessing perinatal mental health care and realizing human rights in practice in the South African social context. Further, the findings highlight significant opportunities to address existing gaps, with concrete guidance on ways to strengthen the implementation of mental health care and promotion in clinical settings. Study limitations encompass the following: (1) due in part, to the COVID-19 pandemic, we were able to conduct only a small number of interviews; (2) the majority of respondents were based in urban areas rather than less-resourced rural areas; (3) the views of other mental health professionals (such

Table 2. Key recommendations for advancing perinatal mental health

Progressive realization and maximum available resources	• Move toward a culture of parity for mental and physical health care • Increase resources for mental health • Establish champions of mental health in antenatal clinics who role model how mental health care policies are implemented in practice
Availability and accessibility	• Increase the number of mental health providers, develop stronger referral networks, and focus on training and supporting nonspecialist providers who can promote mental health during antenatal care visits • Ensure equitable access to referral resources across provinces • Integrate screening for perinatal mood and anxiety disorders into antenatal care through a locally validated and tested ultra-short screening tool • Provide mental health screening even in the absence of referral resources to build evidence of the need for further mental health services
Acceptability and quality	• Integrate opportunities for identification of and screening for social determinants of health in clinical practice • Work more holistically to provide better support systems for mental health throughout the perinatal period • Improve mental health education and training for all health professionals, including capacity-building to improve attitudes and practices to address mental health-related stigma and discrimination • Provide detailed guidance on engaging women in conversations about their mental health and delivering mental health screening as part of antenatal visits • Provide training and a system of support to address the mental health needs of health care providers, and to improve an ethos of care • Include mental health courses in nursing school and midwifery curricula, and provide opportunities for critical thinking and empowerment of nurses to address mental health

as psychiatrists, psychologists, and social workers involved in the routine implementation of mental health care) and perinatal women were not included in this study. Future research should capture the views of health providers implementing mental health care and, especially, the views of perinatal women receiving care to deepen the understanding of women's experiences and challenges to the realization of their right to mental health.

Conclusion

South Africa has taken significant strides to address women's perinatal mental health, including increasing the number of recommended antenatal visits and encouraging universal antenatal screening for common perinatal mental disorders. These are important steps for improving perinatal mental health in South Africa. Now is a crucial window of opportunity to revisit the National Mental Health Policy Framework and Strategic Plan 2013–2020, to provide stronger guidance on the implementation of policies and training for providers, and to increase the resources available for promoting perinatal mental health. The right to mental health can provide guidance to inform policy and practice, grounded in human rights-based approaches, to improve perinatal mental health promotion and mental health care in South Africa.

References

1. United Nations General Assembly, Resolution 70/1, UN Doc. A/RES/70/1 (2015), p. 16.

2. S. L. James, D. Abate, K. H. Abate, et al., "Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017," *Lancet* 392/10159 (2018), pp. 1789–1858.

3. World Health Organizatioon, *Maternal mental health*. Available at https://www.who.int/mental_health/maternal-child/maternal_mental_health/en; World Health Organization, "Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review," *Bulletin of the World Health Organization* 90 (2012), pp. 139–149G; T. van Heyningen, E. Baron, S. Field, et al., *Screening for common perinatal mental disorders in low-resource, primary care, antenatal settings in South Africa* (Center for Perinatal Mental Health Policy Brief, 2014).

4. T. van Heyningen, L. Myer, M. Onah, et al., "Antenatal depression and adversity in urban South Africa," *Journal of Affective Disorders* 203 (2016), pp. 121–129; M. W. O'Hara and K. L. Wisner, "Perinatal mental illness: Definition, description and aetiology," *Best Practice and Research: Clinical Obstetrics and Gynaecology* 28/1 (2014), pp. 3–12.

5. A. Rahman, P. J. Surkan, C. E. Cayetano, et al., "Grand challenges: Integrating maternal mental health into maternal and child health programmes," *PLoS Medicine* 10/5 (2013), p. e1001442.

6. J. Chan, A. Natekar, A. Einarson, et al., "Risks of untreated depression in pregnancy," *Canadian Family Physician Medecin de Famille Canadien* 60/3 (2014), pp. 242–243; S. Gentile, "Untreated depression during pregnancy: Short- and long-term effects in offspring; A systematic review," *Neuroscience* 342 (2017), pp. 154–166.

7. T. W. Wilson, "Does exposure to persistent maternal depression alter the developing brain's empathetic circuitry?," *Journal of the American Academy of Child and Adolescent Psychiatry* 56 (2017), pp. 8–9.

8. V. Glover, "Prenatal stress and its effects on the fetus and the child: Possible underlying biological mechanisms," in M. C. Antonelli (ed), *Perinatal programming of neurodevelopment* (New York: Springer, 2015), pp. 269–283; C. Dunkel Schetter and L. Tanner, "Anxiety, depression and stress in pregnancy: Implications for mothers, children, research, and practice," *Current Opinion in Psychiatry* 25 (2012), pp. 141–148.

9. D. Pūras., Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/HRC/41/34 (2019).

10. M. Funk and N. Drew Bold, "WHO's QualityRights initiative: Transforming services and promoting rights in mental health," *Health and Human Rights Journal* 22/1 (2020), pp. 69–75.

11. E. C. Garman, M. Schneider, and C. Lund, "Perinatal depressive symptoms among low-income South African women at risk of depression: Trajectories and predictors," *BMC Pregnancy and Childbirth* 19/1 (2019).

12. T. van Heyningen, S. Honikman, L. Myer, et al., "Prevalence and predictors of anxiety disorders amongst low-income pregnant women in urban South Africa: A cross-sectional study," *Archives of Women's Mental Health* 20/6 (2017), pp. 765–775.

13. H. Jack, R. G. Wagner, I. Petersen, et al., "Closing the mental health treatment gap in South Africa: A review of costs and cost-effectiveness," *Global Health Action* 7 (2014), p. 23431; S. Woldesenbet, T. Kufa, C. Lombard, et al., "Key findings of the 2017 South African Antenatal HIV Sentinel Survey (ANCHSS)" (2017). Available at http://www.nicd.ac.za/wp-content/uploads/2019/10/key-findings-of-the-2017-south-

african-antenatal-hiv-sentinel-survey-anchss_nicd-bulletin-vol17-iss2-october2019.pdf.

14. S. Field, M. Onah, T. van Heyningen, et al., "Domestic and intimate partner violence among pregnant women in a low resource setting in South Africa: A facility-based, mixed methods study," *BMC Women's Health* 18/1 (2018), p. 119; M. Mbokota and J. Moodley, "Domestic abuse: An antenatal survey at King Edward VIII Hospital, Durban," *South African Medical Journal* 93/6 (2003), pp. 455–457; A. Biaggi, S. Conroy, S. Pawlby, et al., "Identifying the women at risk of antenatal anxiety and depression: A systematic review," *Journal of Affective Disorders* 191 (2016), pp. 62–77; A. C. Tsai, M. Tomlinson, W. S. Comulada, et al., "Intimate partner violence and depression symptom severity among South African women during pregnancy and postpartum: Population-based prospective cohort study," *PLoS Medicine* 13/1 (2016), p. e1001943.

15. B. J. Deacon, "The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research," *Clinical Psychology Review* 33/7 (2013), pp. 846–861.

16. J. Allen, R. Balfour, R. Bell, et al., "Social determinants of mental health," *International Review of Psychiatry* 26/4 (2014), pp. 392–407.

17. A. R. Chapman, "The social determinants of health, health equity, and human rights," *Health and Human Rights Journal* 12/2 (2010), pp. 17–30.

18. L. London, N. Fick, K.H. Tram, and M. Stuttaford, "Filling the gap: A learning network for health and human rights in the Western Cape, South Africa," *Health and Human Rights Journal* 14/1 (2012), p. 100.

19. Pūras (see note 9).

20. National Department of Health, *Guide to maternity Care in South Africa* (Republic of South Africa, 2015).

21. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI) (1966), art. 2.

22. Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

23. Ibid., para. 11.

24. Ibid., paras. 30–31.

25. Ibid., para. 12.

26. Constitution of the Republic of South Africa (1996), art. 27.

27. Republic of South Africa, *Mental Health Care Act of 2002* (2002). Available at https://www.gov.za/sites/default/files/gcis_document/201409/a17-02.pdf.

28. Ibid.

29. Department of Health, *National mental health policy framework and strategic plan: 2013–2020* (Pretoria: National Department of Health, 2013). Available at http://www.safmh.org/documents/policies-and-legislations/mental%20health%20policy%20framework%202013-2020.pdf.

30. S. Docrat, C. Lund, and D. Chisholm, "Sustainable financing options for mental health care in South Africa: Findings from a situation analysis and key informant interviews," *International Journal of Mental Health Systems* 13 (2019).

31. World Health Organization, *Mental health action plan 2013–2020* (Geneva: World Health Organization, 2013).

32. L. Maconick, L. S. Jenkins, H. Fisher, et al., "Mental health in primary care: Integration through in-service training in a South African rural clinic," *African Journal of Primary Health Care and Family Medicine* 10/1 (2018), pp. e1–e7.

33. Ibid.; E. Mendenhall, M. J. De Silva, C. Hanlon, et al., "Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda," *Social Science and Medicine* 118 (2014), pp. 33–42.

34. K. L. Lovero, S. L. Lammie, A. van Zyl, et al., "Mixed-methods evaluation of mental healthcare integration into tuberculosis and maternal-child healthcare services of four South African districts," *BMC Health Services Research* 19/1 (2019).

35. L. Maconick, L. S. Jenkins, H. Fisher, et al., "Mental health in primary care: Integration through in-service training in a South African rural clinic," *African Journal of Primary Health Care and Family Medicine* 10/1 (2018), pp. e1–e7; G. Liu, H. Jack, A. Piette, et al., "Mental health training for health workers in Africa: A systematic review," *Lancet Psychiatry* 3/1 (2016), pp. 65–76.

36. S. Docrat, D. Besada, S. Cleary, et al., "Mental health system costs, resources and constraints in South Africa: A national survey," *Health Policy and Planning* 34/9 (2019), pp. 706–719.

37. C. Sprague, N. Woollett, J. Parpart, et al., "When nurses are also patients: Intimate partner violence and the health system as an enabler of women's health and agency in Johannesburg," *Global Public Health* 11/1–2 (2016), pp. 169–183.

38. R. Jewkes, N. Abrahams, and Z. Mvo, "Why do nurses abuse patients? Reflections from South African obstetric services," *Social Science and Medicine* 47/11 (1998), pp. 1781–1795; L. Kruger and C. Schoombee, "The other side of caring: Abuse in a South African maternity ward," *Journal of Reproductive and Infant Psychology* 28/1 (2010), pp. 84–101.

39. Jewkes et al. (see note 38).

40. S. Honikman, S. Field, and S. Cooper, "The Secret History method and the development of an ethos of care: Preparing the maternity environment for integrating mental health care in South Africa," *Transcultural Psychiatry* (2019), p. 175.

41. Ibid.; S. Honikman, S. Fawcus, and I. Meintjes, "Abuse in South African maternity settings is a disgrace: Potential solutions to the problem," *South African Medical Journal* 105/4 (2015), pp. 284–286.

42. I. Schierenbeck, P. Johansson, L. Andersson, et al.,

"Barriers to accessing and receiving mental health care in Eastern Cape, South Africa," *Health and Human Rights Journal* 15/2 (2013), pp. 110–123.

43. J. Ritchie, J. Lewis, C. McNaughton Nicholls, and R. Ormston, *Qualitative research practice: A guide for social science students and researchers* (SAGE Publishing, 2014).

44. E. A. Balas and S. A. Boren, "Managing clinical knowledge for health care improvement," *Yearbook of Medical Informatics* 1 (2000), pp. 65–70.

45. Docrat et al. (see note 36).

46. J. H. De Kock and B. J. Pillay, "A situation analysis of psychiatrists in South Africa's rural primary healthcare settings," *African Journal of Primary Health Care and Family Medicine* 9/1 (2017), pp. e1–e6; Schierenbeck et al. (see note 42).

47. A. McKenna, Z. Abrahams, C. Marsay et al., *Screening for common perinatal mental disorders in South Africa* (Perinatal Mental Health Project, 2017). Available at https://pmhp.za.org/wp-content/uploads/southafricanscreeningadvisory_pmhp.pdf.