

A Shared Vision for Improving
Perinatal Mental Health in Low-
and Middle-Income Countries:
**A Theory of Change and
Prioritized Implementation
Research Questions**



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List of Abbreviations

ANC - Antenatal Care

CHWs - Community Health Workers

CPMDs - Common Perinatal Mental Disorders

GBV - Gender-Based Violence

HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

LMICs - Low- and Middle-Income Countries

NGOs - Non-Government Organizations

PMH - Perinatal Mental Health

PNC - Perinatal Care

RMNCAH - Reproductive, Maternal, Newborn, Child and Adolescent Health

ToC - Theory of Change

UNFPA - United Nations Population Fund

USAID - U.S. Agency for International Development

WHO - World Health Organization

Document Purpose and Audience

We envision that this global perinatal mental health (PMH) Theory of Change¹ (ToC) and supporting package of materials will offer a common framework that can guide global PMH thinking, investments, and programming to improve countries' progress towards widely accessible, high-quality provision of PMH care services. The co-creation of these guiding documents was a critical step in fostering a global community working collaboratively towards a shared vision of better PMH globally. The PMH ToC, grounded in a social ecological model, provides a framework for learning. It was developed with the belief that long-term attention to all levels of the social ecological model will create the changes and synergy needed to support sustainable improvements in health.

1. Perinatal mental health includes mental health during the perinatal period. The literature on perinatal mental health does not use a consistent definition for the perinatal period: the period generally commences with pregnancy, but may be defined as extending up to two years after delivery.

Executive Summary

Addressing women’s mental health needs during the vulnerable and transformational time of pregnancy, childbirth, and postpartum is a focus and commitment that is long overdue. To better understand the state of perinatal mental health (PMH) in low- and middle-income countries (LMICs), as well as interventions that address PMH, the U.S. Agency for International Development-funded MOMENTUM Country and Global Leadership project conducted a landscape analysis titled “The Silent Burden: Common Perinatal Mental Disorders in Low- and Middle-Income Countries” in 2021. The landscape analysis found that:

- **PMH conditions affect a woman’s physical health during the perinatal period as well as her long-term mental and physical health, functioning, and quality of life.**
- **PMH conditions also affect the physical, emotional, and neurological development of newborns and children and increase the risk of preterm birth, low-birth weight babies, and stunting.**
- **Risk factors for common perinatal mental disorders (CPMDs) include social determinants, such as economic or gender inequality, and individual pregnancy and childbirth experiences, such as stillbirth.**

- **Core components identified in successful PMH interventions at community level included stepped care (referring clients to higher levels of care if more advanced support is needed); detailed context assessments to ensure that interventions are truly tailored to the needs, realities, and preferences of specific populations and settings; task-sharing models; and talk therapy. At health-facility level, they included pre-service training on mental health, trained and supervised providers, referral and assessment processes, mental health support for providers, provision of respectful care, and linkages with gender-based violence services.**
- **Significant gaps remain in understanding how to address CPMDs sustainably and at scale in LMIC contexts.**

This landscape analysis, as well as a three-day technical consultation on PMH in LMICs held in September 2021, prompted a clear call for a common global vision and framework for PMH programming and a shared PMH research agenda.

To respond to this call, a human-centered design partner, Quicksand, facilitated a co-creation process to develop the PMH theory of change (ToC) and the prioritized list of implementation research questions shared in this document. These materials were developed over a series of virtual,

participatory co-creation workshops with experts from a diverse range of fields and backgrounds. The resulting PMH ToC includes a shared impact statement, outcomes, and illustrative interventions.

The PMH ToC is anchored in the social ecological model with the individual woman at the center and the added impact of her family, community, the service delivery ecosystem, and society at large as further levels of influence. This package also includes foundational elements, or “principles,” which underpin the ToC, and key considerations to bear in mind when applying the ToC to a given need or context.

A design sprint identified a set of prioritized implementation research questions to support alignment of PMH research agendas. This package offers a common framework to guide PMH thinking, investments, and programming that can be contextualized to varying priorities, stakeholders, and stages in addressing PMH. It supports a global “call to action” to accelerate improvements in programming for PMH around the world, so that all women might realize the mental and physical health that is their fundamental human right.

Introduction and Background

The pressing need to address perinatal mental health (PMH) globally has garnered increasing attention in recent years, particularly as the COVID-19 pandemic further worsened mental health outcomes for women during pregnancy, childbirth, and the postpartum period. To better understand the state of PMH in low- and middle-income countries (LMICs), as well as interventions implemented to address PMH needs, the U.S. Agency for International Development (USAID)-funded MOMENTUM Country and Global Leadership project conducted a landscape analysis titled The Silent Burden: Common Perinatal Mental Disorders in Low- and Middle-Income Countries in 2021. The landscape analysis followed a multi-tiered approach including a literature review on PMH in LMICs; key informant interviews and focus group discussions with 60 experts from the fields of mental health, reproductive, maternal, newborn, child, and adolescent health (RMNCAH); faith-based organizations; humanitarian work; nutrition; gender-based violence (GBV); advocacy; and implementation. A document analysis of relevant mental health policies from 19 countries². It explored issues such as the prevalence of common perinatal mental disorders (CPMDs), risk factors for CPMDs, and interventions to address identified mental

health issues and support women and families. It also highlighted some of the gaps—in both research as well as implementation—when trying to address the PMH needs of women globally.

Following the completion of the landscape analysis, in September 2021, MOMENTUM Country and Global Leadership, in collaboration with World Health Organization (WHO) and United Nations Population Fund (UNFPA), facilitated a three-day technical consultation on PMH in LMICs. This interactive virtual event was attended by more than 700 participants from over 70 countries and engaged a diverse group of stakeholders with unique and important perspectives to further explore the issues, challenges, and opportunities raised in the landscape analysis. Panelists, speakers, and participants focused on populations that particularly need to be reached by PMH programming, such as adolescents, families experiencing perinatal loss, and women living in humanitarian settings, and further explored the available evidence as well as some of the challenges in implementing programs for PMH with fidelity and at-scale.

The technical consultation led to a clear call for a common global vision and framework for PMH programming, as well as a shared PMH research agenda, behind which the mental health; the maternal, newborn, and child health; and the maternal mental health communities could coalesce. These collaborative conversations led to the engagement of a human-centered design partner, Quicksand, from May to July 2022 to support a co-creation process. This co-creation process resulted in the development of the PMH journey maps, the global PMH theory of change (ToC), and the prioritized list of implementation research questions shared in this document.

2. The initial search consisted of 16 countries where MOMENTUM is currently implementing health programming (Bangladesh, Cameroon, Cote d'Ivoire, Ghana, India, Indonesia, Kenya, Liberia, Malawi, Nepal, Nigeria, Rwanda, Tanzania, Togo, Uganda, and Vietnam). Later, Ethiopia, South Africa, and Pakistan were added, given work being done at the policy level in these countries.

The Co-Creation Process

Quicksand facilitated the co-creation process through three stages. The process was highly collaborative and leveraged the vast range of expertise, experiences, and stories that the participants brought with them. Experts were engaged from a diverse range of fields and backgrounds including women with lived experience, representatives from local and non-governmental organizations (NGOs), advocates, implementers, researchers, and representatives from global agencies including WHO and United Nations organizations, among others. **The process included the following three stages of engagement:**

1. ToC Co-Creation Workshops:

The team hosted four 1-hour online co-creation workshops, each focusing on one layer of the social ecological model: individual and interpersonal relationships, community, service delivery ecosystem, and policy landscape. Based on the landscape analysis and technical consultation discussions, the MOMENTUM team prepared initial impact, outcome, and intervention statements. The workshops were conceived as open conversations where participants were taken through the draft statements and were invited to share their stories and experiences to input into the document. The final PMH ToC reflects these rounds of feedback and co-creation.



A screenshot of the Miro board (an online interactive whiteboard) used during the Co-Creation Workshop activity

[Find image here](#)

2. Post-Design Readout Sessions:

After redesigning and incorporating the comments from the workshops, two readout sessions were conducted to present the outcomes of the process to the participants and to share the next steps in disseminating this work. The meeting ended with the participants sharing ideas on how we might take this work forward, what platforms and events can be leveraged to share it, and what projects might benefit from this work.

3. The Implementation Research Design Sprint:

The team hosted a 1.5-hour online design sprint where participants were invited to provide feedback on a prepared list of implementation research questions drawn from the landscape analysis, technical consultations, and internal conversations within MOMENTUM. Participants voted on the questions they considered to be top priorities. The criteria for a “priority” was that it 1) addressed the unmet needs of women and/or providers during the perinatal period, 2) addressed pertinent data and evidence gaps, and 3) revealed findings that would support effective scale-up of critical interventions for improved PMH. This design sprint resulted in the prioritized PMH implementation research questions.

Activity 1 - Finalizing the Questions

The package of co-created materials in this document includes 1) PMH journey maps—one based on a woman’s lived experience, and the second grounded in the lived experience of her health care provider, 2) a global PMH ToC, and 3) prioritized PMH implementation research questions. These materials can be referenced together or separately, depending on the contextual needs.

While adding these, discuss in your group why you think this question or reframing is important, and what experience of yours inspires this input.

Remember to add tags to your questions

Add new questions

Question	Reason for adding
11. What are effective methods for screening for CPMDs?	Implementation research is required especially in low and middle-income settings to answer questions related to who does the screening, for where, when and with which tools
2. What are the necessary inputs across the health system to sustainably integrate maternal mental health interventions into existing routine care at both the community and facility levels?	Considers the health system as a whole and the inputs needed across the entire health system for sustainability
3. How will we know that interventions or policy changes are having an effect on maternal mental health and for which women?	Establishing effectiveness is crucial for sustainability and investment
24. What are effective interventions for paternal mental health?	Few studies have looked into the prevalence of paternal mental health difficulties, its family and social determinants and its impact on mothers' mental health and on child health and development

Reframe existing questions

Question	Reason for reframing
10 A. What mechanisms lead to improvements in both maternal mental health and child health, growth and development?	Children's development is more than their physical health
10 A. What interventions lead to improvements in both maternal mental health and child health, growth and development?	Not clear what is meant by mechanisms. Should it say interventions?
14A. What training is needed to create a respectful, person centered environment for women and providers? (Health System)	This focuses the question on training -
3 A. How do interventions aimed at addressing structural barriers ? to health equity impact/improve perinatal mental health?	This is important, but I am not sure what the barriers are to

A screenshot of the Miro board (an online interactive whiteboard) during the design sprint activity

[Find image here](#)

Journey Maps

We believe that it is essential to focus on a woman's experience as the basis for the design of program interventions so that all approaches are grounded in that lived experience. To that end, the co-creation process began with the development of a journey map that captures the lived perinatal experiences of a woman, including her needs, the barriers she faces, and the assets/opportunities available to her throughout her journey through pregnancy, childbirth, and the postnatal period. Further, because the landscape analysis and the technical consultation uncovered critical conversations around the role of and importance of addressing health workers' mental health needs, we also co-created a journey map that centers on the experience of the woman's health care provider. This reminds us that health workers, often women and mothers or caregivers themselves,

face similar and distinct needs, barriers, and opportunities within the environments where they live and work. To develop these evidence-informed journey maps, Quicksand conducted an in-depth review of the landscape analysis, particularly the qualitative content, to draw out the voices and experiences of women and providers. The intention was not to create stand-alone products that would exist outside of the ToC package; the journey maps do not represent the comprehensive set of needs, barriers, and assets women and providers face. Rather, these illustrative journey maps offered an entry point for participants in the co-creation process, a way to humanize the evidence, ground the discussion in lived experience, and inspire the co-design of the ToC. Each ToC co-creation session started by revisiting, and refining, the woman's illustrative journey map.

GRAY BOXES INDICATE ASSETS OR OPPORTUNITIES

Journey Map of Women

PRE-PREGNANCY

PREGNANCY

CHILDBIRTH

POSTPARTUM

My Health Care Experience

I want the care I receive for my pregnancy and birth, and care for my baby, to be in line with my cultural values.

I have no information or resources to prepare for my pregnancy. I have many questions but if I ask a health worker, they may think they are silly.

I can use my smartphone to better prepare for pregnancy and to check what health services are available around me.

My provider assumed that I should be happy because I am having a baby. Honestly, I was very anxious knowing that I am pregnant.

I am being told to eat a balanced meal 3 times a day, but I don't know if my family and I will have enough food to eat the next day.

I often see the community health worker visit houses in my neighborhood. Maybe I should reach out to them for support.

My provider told me that pregnancy is not a disease. It's just a normal part of life.

Because I constantly feel fatigued, I find it very difficult to go for routine checkups.

I am not treated with respect at the facility.

My family is not able to afford the care I need, so we have to rely on our savings. Moreover, the facility is far away and doesn't have all the diagnostic services. Paying for care costs a full day of my husband's earnings.

I am sure there are others who have had / are having similar experiences like mine. How can we help each other?

It was midnight when contractions started and I was sent to another facility as providers were not available close to my home. I was very scared.

There were complications during my delivery. No one explained what was happening. I had to be taken to a bigger hospital in the middle of my labor. I didn't know if I would live.

I wanted to have a normal delivery but the doctors have been insisting that I need a C-section.

Today I heard the religious leader in my community speak about mental health, and I felt better about my own experience.

I always wanted to deliver at a hospital but during the second wave of COVID, everyone was scared to go to the hospital. I felt safer delivering at home.

Due to COVID protocols, there was no one with me at the facility, I felt lonely. Even my baby was not given to me immediately following the birth.

I was not given any guidance on how to take care of myself or my baby at the time of discharge from the hospital.

I wish that they had asked me about my mental health as well when I was in the facility.

My anxiety increases when I have to repeat my story to lots of different care providers.

It seems like the facilities around me are all 'general' facilities. I cannot find any place where I can go and speak to a provider about how I am feeling.

It will help if the doctors are able to refer me to other mental health specialists who can counsel and guide me.

I am scared that my provider will say I am "depressed" and everyone will think there is something wrong with me and I am not a good mother.

My Community Experience

I have uterine fibroids and I heard from my neighbours that it would be difficult to get pregnant. I am very stressed about whether I will be able to conceive.

We have 3 daughters and my husband and I love them. But my in-laws are getting lot of pressure from the extended family and neighbours to have a grandson. My husband is unable to explain our viewpoint to them - I hope the next child we have is a boy so that we don't have to plan a fifth child!

I don't have a mother-in-law and I have been getting advice from an elder in the village, but she has been out of town. I am pregnant for the first time and don't know who to ask for help other than her? I feel helpless and worried.

The village healer tells me different things from the health worker.

Ever since I've been pregnant, my friends, extended family, and neighbours have an opinion about what I should or shouldn't do. I feel I have no agency over my own wellbeing.

I want to go to a women's support group in the community but my family does not allow me to leave home during my pregnancy.

I have nowhere to go. My family doesn't support my pregnancy and I have been asked to leave school. I feel so ashamed and lonely.

As soon as the baby was born, everyone's focus has turned to the baby and I feel invisible.

The village dai is the most trustworthy person I have ever met. She delivered my child and I only reach out to her for any questions around my health and my baby's wellbeing.

My neighbours and friends look down on me if I mention that I am not doing well mentally. They think I am weak and that being a mother should be "natural."

I think my friends and neighbours sometimes make fun of me when I am unable to breastfeed my child as I have a disabled arm.

As soon as my child was 40 days old, I was expected to resume all household cleaning, and cooking, along with taking care of my three other children. This is common in my village but I don't feel happy about it.

My Interpersonal Experience

I am not able to connect with my partner, and make him understand my needs.

My husband and I have been trying to conceive for 3 years—my mother-in-law and mother advise me to visit a doctor—no one advises my husband to go to a doctor for a check-up. Is the issue always with a woman? I am afraid to ask this to anyone.

I came home from the doctor's clinic and informed my mother-in-law that I am going through a miscarriage. She asked me when I would get pregnant again and make her a grandmother. I know she loves me but I didn't feel good when she said that.

I experience domestic violence at home, and have no one to confide in.

Good partner and family support is essential for me to have a successful perinatal experience.

I am sometimes worried about my pregnancy as it is my first, but my husband has anger issues. I don't know how he will react if I share my thoughts with him.

I am not getting support from my partner and family, and am dependent on them to access care.

My in-laws are pushing me to have children. The last time I tried to have a conversation with them, they dismissed me.

Having employment helps me be more financially independent and take better decisions for myself.

I wish my partner had used protection because this pregnancy feels too early for me.

While pregnant, I am expected to keep up with my household and familial duties. This makes me feel tired.

My family and health worker tell me different things on what to eat or not. I am confused.

I know my husband is stressed due to his work. He comes home drunk. I don't want to ask him to take care of our other child or burden him by saying that I am stressed.

My family and health providers think I am lazy and trying to seek attention.

I can see that my baby is not like others—she is underweight, and not growing well.

My husband and I tested positive for HIV before our child was born. Now that our baby is here, I can already feel stigma from my family towards her. I feel scared—there's a whole life in front of her.

My Individual Experience

I do know what I should eat and the importance of doctor's checkups, but I am too scared to discuss this with my husband. We just got married some months back.

It would feel good if I am able to express my needs and make decisions myself.

I do not know what to expect and prepare for with my pregnancy; I wonder if what I am thinking and worrying about are normal?

I feel like I am too young to take care of another person. I wanted to finish my education and get a job. But I think this is shameful. What if I am not able to be a good mother?

I feel worn out constantly and experience bouts of hunger. We do not have enough food and nobody else seems to care.

I feel sick in the morning, and I am getting headaches.

When COVID-19 hit while I was pregnant, I was so worried! What impact will COVID have on me and the baby?

I am getting nervous about the delivery process. It seems painful. I hope the baby and I stay safe. I need more information but I am afraid to ask. Last time I asked, the doctor didn't give any attention to it.

Since my child was born, I have been feeling sad and it is affecting my ability to care for my child. Who do I talk to about this?

I can see very clearly that my state of mind is affecting my baby as I am not able to feed her properly and I just want to get away from her for a while.

My bad experience through family planning, pregnancy, childbirth, and caring for my baby have left me questioning whether I should have more children.

If I am not feeling mentally healthy, is it a sin? Have I been possessed by a spirit?

I do not feel like I have gained the strength through this experience to do better the next time. Will I ever be capable of being a good mother?

I Need

I need to be heard and supported.

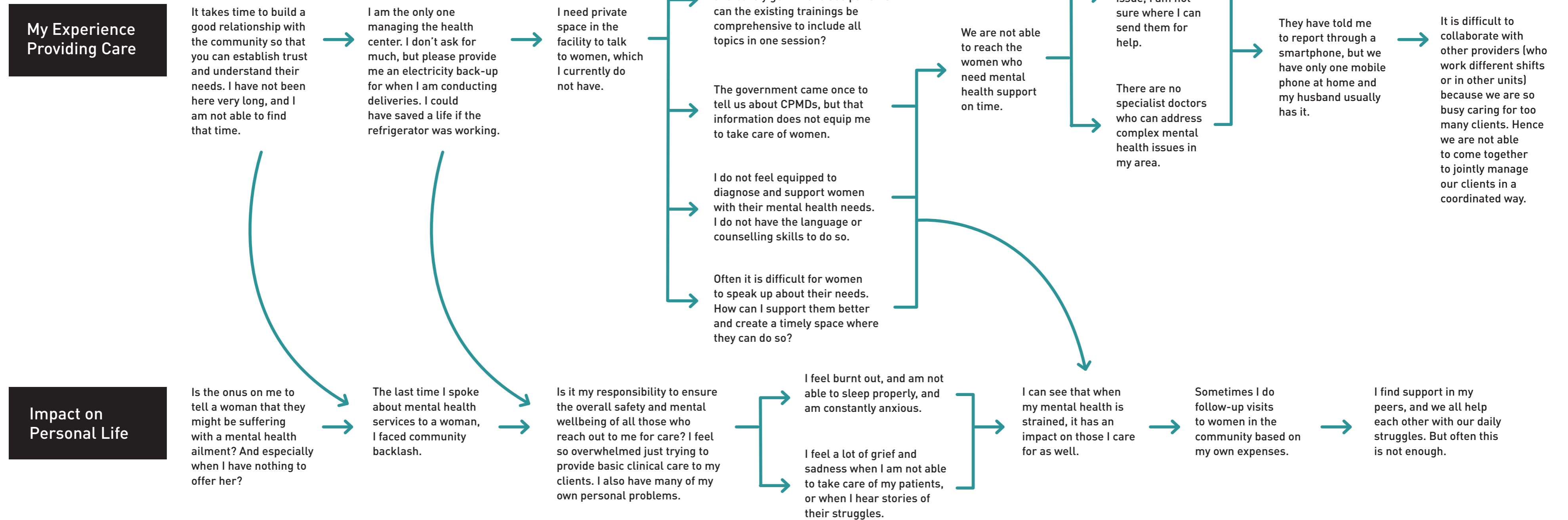
I need to be able to access timely, affordable care.

I need to be respected at the facilities.

I need to care for myself and not just my baby. If I am not well, my baby's health will also be impacted.

I need a space to be able to speak about my mental health needs and the stress and fatigue I feel without judgement.

Journey Map of Health Care Providers



I Need

I need support systems in place to take care of my own mental health.

I need training and mentorship from the health system to be able to take better care of my clients.

I need more peers and partners to work with—to be able to effectively task shift and scale programs.

I need someone to be taking care of social protection of the communities (including economic empowerment and poverty reduction).

I need programs that work towards PMH prevention, treatment, and recovery support.

I need to integrate mental health care into other maternal and child health interventions like nutrition, childcare, education.

I need policies in place that streamline the mental health care programs, advocacy, and referrals.

Global PMH ToC

The PMH ToC is a conceptual framework grounded in the idea that if program interventions are designed and implemented to address the known barriers to successful programming, and to work with existing community assets, they achieve intended outcomes and contribute to an overall common vision or goal. To support the development of a global PMH ToC, MOMENTUM Country and Global Leadership and Quicksand convened a series of four workshops, held in May and June 2022, with 19 global subject matter experts with diverse perspectives. This group worked to design a global PMH ToC leading to this shared vision for PMH: “Improved perinatal mental health and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.”

The ToC was designed to be utilized and adapted to diverse country contexts by country stakeholders and governments, international organizations, and local NGOs. It is also designed to support relevant sectors and areas of work, including multiple health sectors

(i.e., RMNCAH, nutrition, HIV/AIDS) and sectors outside health (i.e., education, water, sanitation, and hygiene, social protection, gender) to acknowledge the need to integrate PMH interventions into existing programs and platforms, to help develop/design programs, and to expand and mobilize partnerships, in order to make a meaningful difference in the health and lives of women, children, and their families. The global PMH ToC can be referenced in all implementation contexts, but was developed with a focus on the needs of LMICs due to the unaddressed burden of CPMDs in these settings.

The PMH ToC is anchored in the social ecological model with the individual woman at the center and the added impact of her family, community, the service delivery ecosystem, and society at large as further levels of influence. The social ecological model attempts to help organize the relationship between the woman/child and each layer in the system. The interrelationships between these layers, and the ways in which they work synergistically to affect women’s PMH, must be considered as program interventions are designed.

Principles

Early in the co-creation process, the team working on this ToC recognized that it was important to clearly articulate underlying assumptions, or guiding principles. The principles outlined here offer readers some of the recommended foundational components that should be in place in order to realize the impact goal.

1. PMH interventions will create greater impact when accompanied with interventions that address the social determinants of health (i.e., poverty, food insecurity, GBV, racism/discrimination).
2. Interventions that are evidence-based, woman and people centered, and sustainable should be prioritized during implementation.
3. Comprehensive, high quality PMH programs that are available to women throughout the continuum of maternal and newborn care, and delivered by trusted health workers, will support better health outcomes for women and their babies.

4. Programs for PMH should be embedded and integrated within existing service delivery platforms and programs rather than introduced as separate programs.

5. Interventions must also address the needs of vulnerable population groups, including women in humanitarian settings, adolescents, women experiencing intimate partner violence, women experiencing perinatal loss or other obstetric trauma, and women with special needs/ persons with disabilities.

6. Ensure PMH programs are based in local contexts and use contextually appropriate language and terminology. Women must be part of the development and design of PMH interventions, and programs should be responsive to women's expressed needs and preferences.

7. Men's priority concerns at this life stage should be ascertained and addressed in order to enable them to create a more equitable and supportive environment for parents.

8. PMH programming should acknowledge and address the associated mental health needs of health workers.

9. PMH programs should identify the best entry point. When appropriate, PMH programs should focus on the woman as the individual seeking care and services. However, in situations where it is too difficult or stigmatizing to focus on the woman alone, it may make sense for the initial focus to be on child and family health.

10. Comprehensive PMH support includes clinical interventions for affected women as well as gender-transformative interventions aimed at creating a supportive environment for women's and men's transition to parenthood.

11. Interventions must be designed and made adaptable for COVID-19 and other future disasters or pandemics.

12. Multi-sectoral collaborations at scale will best contribute towards the realization of affordable and quality interventions.

13. Governments must demonstrate political will for PMH care to ensure that institutions and health workers provide equitable, quality, and respectful care.

In addition to the core principles, the design team also outlined some key considerations in response to questions, decisions, and discussions that arose during the co-creation process. Key considerations include:

Addressing the needs of particular contexts and populations:

While the PMH ToC does not specifically reference particular populations, we acknowledge that it is critical to address the specific needs of women and families in distinct contexts, such as humanitarian settings, as well as those who are particularly vulnerable to perinatal mental ill health, such as adolescents, those experiencing intimate partner violence, and those who have experienced perinatal loss or obstetric trauma. Addressing these interrelated needs requires a coordinated, collaborative, multilevel response.

Addressing social determinants of health: Discussions around social determinants of health were robust, and there was clear consensus about the need to include them in all conversations about PMH. It is also critical to note that PMH interventions will create the most impact when accompanied by interventions that address the social determinants such as poverty, food insecurity,

GBV, and racism/discrimination. Rather than including all intervention strategies that could impact key social determinants, we chose not to address social determinants directly within this PMH social ecological model. We consider them to be a fundamental set of factors that intersect with every aspect of the ToC.

Relationship between “layers” and networks of care:

The depiction of clear and distinct layers in the social ecological model allows for ease of visualization and comprehension of complex factors across a multi-level system. However, we recognize that these layers are often not cleanly separated from each other, and that relationships exist within and across them. For example, a woman’s network of care may include a traditional birth attendant, a health worker at a community health center, a midwife at a district hospital, and a specialist at a referral hospital. This network of care spans across multiple layers of the social-ecological model, and represents an integrated model of care that is difficult to capture visually. Yet, the fact that a well-coordinated network of care—with trusting relationships among health workers who communicate effectively with each other about a woman’s care and preferences—contributes to the quality-of-care she will receive and the likelihood that she will seek care for herself and her family, is critically important.

Articulation of shared vision or impact statement:

During the co-creation process, we had considerable dialogue about the impact statement, given the diversity of country experiences and the varying stages of PMH implementation. Some stakeholders favored more moderate wording such as “support” or “establish” programs for PMH, while others favored more a more ambitious goal to “accelerate” improvements in PMH. To reflect the broad spectrum of implementation realities, we opted for the term “improve PMH” in our impact statement, as it is relevant to all contexts.

Reality of health system capacity: We recognize that most national and local-level health systems that would be using this PMH ToC will have fundamental health system challenges such as limited human resources, compromised access to drugs and medications, little or no access to mental health specialists, or limited or poorly functioning referral pathways. We also recognize that the inclusion of PMH into health workers’ scopes of practice poses the potential for increased psychological stress and effort for those workers. Each context will need to adapt to the reality of what makes sense within that health system.

List of interventions: The interventions mentioned in this ToC are not meant to represent every possible intervention. Rather, we wanted to include broad interventions that can be adapted to the different contexts. For example, rather than naming a type of talk therapy or specific intervention, we used language that can be inclusive of many approaches that will get the same outcomes of interest, based on the need. Further, these interventions focus on those related to CPMDs. While we acknowledge the vital importance of early identification and treatment of cases of severe depression/anxiety, suicidality, and substance abuse, they fall outside the scope of this PMH ToC.

Use of language and terminology: This ToC favors the use of the terms “mother” and “woman”; this reflects the studies included in the PMH landscape analysis, a recognition that these terms are normative across the world, and a desire to center the mother/baby dyad. This choice is not meant to exclude transgender/gender nonbinary parents, nor to imply that the words “mother” and “woman” represent every birthing person. We also intentionally selected terminology

that was person-centered, and inclusive of male partners, as key actors in a woman’s PMH experience. Lastly, the term “family” may vary for each woman—in this document, it is not meant to refer exclusively to a traditional, nuclear family.

Type of interventions: We chose to not distinguish between prevention, protection, screening, and treatment interventions. We recognize that different stakeholders will likely focus on one aspect at the beginning of their work on PMH, but for the sake of this ToC, the types of interventions are integrated under the larger PMH umbrella.

The Global PMH ToC

A common framework that can guide global thinking, investments, and programming when trying to improve the access and quality of care for PMH services.*

INTERVENTIONS

INDIVIDUAL

- Provide comprehensive maternal health care for all women of reproductive age, which includes support for mental health, nutrition, and sexual rights.
- Provide evidence-based psychological interventions through existing platforms.
- Use locally relevant media solutions for building awareness and behavior change communication around mental health.
- Create self-help modules for women to access PMH support and services at home and in their community through online and offline formats.
- Provide respectful bereavement care and ongoing support for women, partners, and families who have suffered perinatal loss.



All women, regardless of age and context, receive targeted support that protects their mental health and wellbeing, including access to specialized PMH care across the promotion, prevention, and treatment continuum.

OUTCOMES

INTERPERSONAL RELATIONSHIPS

- Engage women/partners/families/companions (especially in vulnerable populations), using evidence-based approaches informed by highly contextualized concepts and language.
- Deliver programs that offer gender-transformative couples education and dialogue around family planning, reproductive health, maternal, newborn, child health (FP/RH/MNCH), as a way towards improving PMH and male engagement.
- Develop activities and educational programs that engage fathers on co-parenting and caring for their infants.
- Help identify, and provide care and support for, any early signs of CPMDs through services for families of small and sick newborns.
- Integrate PMH into existing GBV programs.



Couples communicate effectively and practice non-violent conflict resolution around PMH decisions.

Partners and families are aware of PMH issues and support and respect all women to make decisions for their overall health and wellbeing.

COMMUNITY

- Conduct anti-stigma and discrimination campaigns; strengthen community mobilization and conversation through entertainment and media campaigns to normalize and address challenges with parenting, CPMDs, perinatal loss, and care seeking.
- Train, support, and supervise community health workers (CHWs) to screen, support, and refer women with CPMDs.
- Deliver childbirth education, parenting, and self-care programs to enhance women's psychological well-being.
- Create a mental health cadre to address the maternal health needs of communities.
- Integrate comprehensive PMH screening, support, and referral into existing community-based platforms/groups that provide care, support, and education, such as group antenatal care (ANC)/postnatal Care (PNC) and other peer-support models.
- Introduce knowledge building and behavior-change interventions for men that create spaces for dialogue and reflection around GBV.
- Engage faith-based actors and traditional healers as partners; provide training on CPMDs, resources for referral and support; and identify appropriate roles they can play as part of networks of care.



CHW and stakeholders are able to identify and provide quality support and referrals for PMH care in a timely manner.

Communities work towards providing an inclusive environment to discuss and champion the health and safety of women and newborns during the perinatal period, respecting both their physical and mental health needs.

SERVICE DELIVERY ECOSYSTEM

- Use adapted and validated CPMDs screening/measurement tools for women during individual and/or group ANC/PNC/child health interventions.
- Include CPMD screening and referral for women visiting GBV services.
- Implement a comprehensive, competency-based training strategy that includes PMH for all health workers, ensuring pre-service and in-service trainings use context appropriate technology and language.
- Link providers with CHWs who are providing any CPMD prevention, care, and treatment interventions as part of a stepped-care referral system.
- Provide mental health intervention support and services, beyond self-care options, to health workers to address their own mental health needs.
- Incorporate PMH into existing efforts to improve the quality of service delivery, such as setting up safe spaces in facilities and ensuring respectful care measures are in place for families experiencing perinatal loss.



More women have access to high quality PMH services.

Health workers and stakeholders are supported, empowered, skilled, and have resources to identify and provide timely, high-quality support and referrals for CPMDs.

All women feel safe and satisfied with the quality of care available to them throughout the perinatal period.

POLICY LANDSCAPE

- Integrate PMH into health care curricula for all health workers; with a particular focus on inclusion in pre-service education.
- Support country leadership in the development, or revision, and implementation of health sector guidelines, policies, and protocols that explicitly mention PMH.
- Provide additional education, training, support, and compensation to CHWs as they include PMH services in their scope in line with the global movement to professionalize CHWs and fully integrate them into the health system.
- Increase funding for policy implementation/programming for a package of services at the primary health care level that includes mental health.
- Implement more mental health support programs for public sector staff to destigmatize mental health.
- Select key indicators for PMH and introduce them into data collection and analysis processes; embed accountability mechanisms throughout the health system.
- Implement robust qualitative and quantitative research (prioritizing implementation research) in various contexts focused on improving PMH program delivery in real-world settings and ensuring that research is used to inform program implementation and policy development.



Governments and civil society organizations dedicate resources, enact policies, are accountable for, and effectively implement PMH services to ensure the health and rights of all women.

National and sub-national data systems include core PMH indicators, and collected PMH data is used for decision-making.

IMPACT

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.

*Due to space constraints this Theory of Change does not include outputs.

On the following set of pages, the global PMH ToC is broken down into each individual layer of the social ecological model. This allows for easier, detailed viewing of interventions, outcomes, and impact by layer, and could be useful for users with a particular focus on one or more specific layers.



Individual

The first level addresses individual factors, including the socio-cultural and economic determinants each person acquires at birth, their contexts and capacities, and how their internal disposition influences their PMH. Examples: education/knowledge, economic resources/status, skills, behaviors, beliefs, perceptions, race/ethnicity, gender identity, sexual orientation, geographic location.

Interventions

- Provide comprehensive maternal health care for all women of reproductive age, which includes support for mental health, nutrition, and sexual rights.
- Provide evidence-based psychological interventions through existing platforms.
- Use locally relevant media solutions for building awareness and behavior change communication around mental health.
- Create self-help modules for women to access PMH support and services at home and in their community through online and offline formats.
- Provide respectful bereavement care and ongoing support for women, partners, and families who have suffered perinatal loss.

Outcomes

All women, regardless of age and context, receive targeted support that protects their mental health and wellbeing, including access to specialized PMH care across the promotion, prevention, and treatment continuum.

Impact

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.

Interpersonal Relationships

The second level addresses intimate and personal relationship dynamics that influence women's PMH. A person's closest social circle—peers, partners, and family members—influences their behavior and contributes to their experience.

Interventions

- Engage women/partners/families/companions (especially in vulnerable populations), using evidence-based approaches informed by highly contextualized concepts and language.
- Deliver programs that offer gender-transformative couples education and dialogue around family planning, reproductive health, maternal, newborn, child health, as a way towards improving PMH and male engagement.
- Develop activities and educational programs that engage fathers on co-parenting and caring for their infants.
- Help identify, and provide care and support for, any early signs of CPMDs through services for families of small and sick newborns.
- Integrate PMH into existing GBV programs.

Outcomes

- Couples communicate effectively and practice non-violent conflict resolution around PMH decisions.
- Partners and families are aware of PMH issues and support and respect all women to make decisions for their overall health and wellbeing.

Impact

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.

Community

The third level includes settings, such as schools, workplaces, religious institutions, community groups, and neighborhoods, in which socio-cultural (and gender) norms are defined and re-defined. It includes broad societal factors such as culture, beliefs, values, norms, customs, and practices. It also includes community health workers (CHWs) or frontline workers, who are often the first point of contact for an individual seeking health care services. Communities include settings where people come together either by circumstance or by choice.

Interventions

- Conduct anti-stigma and discrimination campaigns; strengthen community mobilization and conversation through entertainment and media campaigns to normalize and address challenges with parenting, CPMDs, perinatal loss and care seeking.
- Train, support, and supervise CHWs to screen, support, and refer women with CPMDs.
- Deliver childbirth education, parenting, and self-care programs to enhance women's psychological well-being.
- Create a mental health cadre to address the maternal health needs of communities.
- Integrate comprehensive PMH screening, support, and referral into existing community-based platforms/groups that provide care, support, and education, such as group antenatal care (ANC)/postnatal Care (PNC) and other peer-support models.
- Introduce knowledge building and behavior-change interventions for men that create spaces for dialogue and reflection around GBV.
- Engage faith-based actors and traditional healers as partners; provide training on CPMDs, resources for referral and support; and identify appropriate roles they can play as part of networks of care.

Outcomes

- CHW and stakeholders are able to identify and provide quality support and referrals for PMH care in a timely manner.
- Communities work towards providing an inclusive environment to discuss and champion the health and safety of women and newborns during the perinatal period, respecting both their physical and mental health needs.

Impact

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.

Service Delivery Ecosystem

The fourth level, the service delivery ecosystem, is where clients receive services or care for PMH. The health system environment includes links between community interventions, primary health care facilities, and tertiary/national facilities. While the stepped-care model crosses levels, for the purposes of this ToC, the service delivery level focuses on health facilities. It also includes referrals from community level to facility level.

Interventions

- Use adapted and validated CPMDs screening/ measurement tools for women during individual and/or group ANC/PNC/child health interventions.
- Include CPMD screening and referral for women visiting GBV services.
- Implement a comprehensive, competency-based training strategy that includes PMH for all health workers, ensuring pre-service and in-service trainings use context appropriate technology and language.
- Link providers with CHWs who are providing any CPMD prevention, care, and treatment interventions as part of a stepped-care referral system.
- Provide mental health intervention support and services, beyond self-care options, to health workers to address their own mental health needs.
- Incorporate PMH into existing efforts to improve the quality of service delivery, such as setting up safe spaces in facilities and ensuring respectful care measures are in place for families experiencing perinatal loss.

Outcomes

- More women have access to high quality PMH services.
- Health workers and stakeholders are supported, empowered, skilled, and have resources to identify and provide timely, high-quality support and referrals for CPMDs.
- All women feel safe and satisfied with the quality-of-care available to them throughout the perinatal period.

Impact

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children, and families.

Policy Landscape

The fifth level looks at the broad macroeconomic factors that help create an environment in which PMH is influenced. It includes the policy environment, funding commitments, and political will of the leadership.

Interventions

- Integrate PMH into health care curricula for all health workers; with a particular focus on inclusion in pre-service education.
- Support country leadership in the development, or revision, and implementation of health sector guidelines, policies, and protocols that explicitly mention PMH.
- Provide additional education, training, support, and compensation to CHWs as they include PMH services in their scope in line with the global movement to professionalize CHWs and fully integrate them into the health system.
- Increase funding for policy implementation/programming for a package of services at the primary health care level that includes mental health.
- Implement more mental health support programs for public sector staff to destigmatize mental health.
- Select key indicators for PMH and introduce them into data collection and analysis processes; embed accountability mechanisms throughout the health system.
- Implement robust qualitative and quantitative research (prioritizing implementation research) in various contexts focused on improving PMH program delivery in real-world settings and ensuring that research is used to inform program implementation and policy development.

Outcomes

- National and sub-national data systems include core PMH indicators, and collected PMH data is used for decision-making.
- Governments and civil society organizations dedicate resources, enact policies, are accountable for, and effectively implement PMH services to ensure the health and rights of all women.

Impact

Improved PMH and wellbeing through promotion, prevention, early identification, care, and treatment, resulting in better health outcomes for all women, children and families.

Prioritized PMH Implementation Research Questions

On this page, you will find the list of prioritized PMH implementation research questions that emerged from the design sprint. As the group reviewed this list, we realized that the questions naturally fell along a program implementation pathway. On the following page, you will see these same questions organized by implementation phase along such a pathway from user-centered program design, to thoughtful program preparation and implementation with sustainability in mind, to ongoing adaptation and learning.

To begin the development of a global research agenda specific to PMH, MOMENTUM Country and Global Leadership and Quicksand facilitated an implementation research design sprint in May 2022. The purpose of this activity was to create a set of prioritized implementation research questions drawn from a list of 20 implementation research questions that emerged from the landscape analysis and technical consultation discussions. Participants from a diverse set of affiliations—from community-based organizations to United Nations agencies—engaged in the design sprint to discuss and prioritize questions.

Prioritized implementation research questions

- What PMH promotion, prevention, and care and treatment interventions/ services do women, communities, and health workers want in communities and facilities?
- What outcomes are meaningful to these groups?
- How do we work with implementers and beneficiaries to translate their insights into co-designed PMH interventions?
- How can we partner with women and communities to effectively translate these insights into contextualized mental health advocacy and literacy messages that result in more women seeking PMH care and support?
- What inputs are needed across the health system to integrate PMH interventions into existing routine care in communities and facilities?
- What are the most effective strategies for integrating PMH prevention, care, and treatment interventions into existing primary health care systems?
- How can these strategies be adapted to different contexts and implementation realities while maintaining high quality, respectful care?
- How can health systems successfully sustain PMH interventions over time?
- How can we effectively use insights from women, communities, and health workers for continuous learning and adaptation?

These prioritized questions are mapped along an implementation pathway on the next page

PHASE 1: LISTEN

- What PMH promotion, prevention, and care and treatment interventions/services do women, communities, and health workers want in communities and facilities?
- What outcomes are meaningful to these groups?

1

PHASE 2: CO-DESIGN

- How do we work with implementers and beneficiaries to translate their insights into co-designed PMH interventions?
- How can we partner with women and communities to effectively translate these insights into contextualized mental health advocacy and literacy messages that result in more women seeking PMH care and support?

2

PHASE 3: PREPARE

- What inputs are needed across the health system to integrate PHM interventions into existing routine care in communities and facilities?

3

PHASE 4: IMPLEMENT

- What are the most effective strategies for integrating PMH prevention, care and treatment interventions into existing primary health care (PHC) systems?
- How can these strategies be adapted to different contexts and implementation realities while maintaining high quality, respectful care?

4

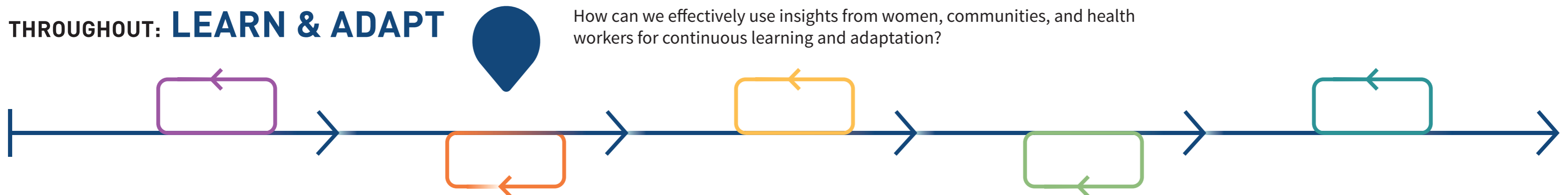
PHASE 5: SUSTAIN

- How can health systems successfully sustain PMH interventions over time?

5

THROUGHOUT: LEARN & ADAPT

How can we effectively use insights from women, communities, and health workers for continuous learning and adaptation?



Next Steps

Stakeholders including policy makers, NGOs, researchers, and others are encouraged to refer to these materials to advance and adapt PMH advocacy and implementation efforts, and are invited to further refine the ToC based on their experiences. Adjustments may also be made in light of changing contexts and future crises and disruptions. Our hope is that this document will provide a base that can be applied to different user needs and programs. Stakeholders can also reference the new “[WHO guide for integration of perinatal mental health in maternal and child health services](#)” for additional guidance on implementing PMH programs. Future efforts to operationalize these materials could include the development of associated indicators and metrics, as well as supporting guidance to aid program implementation.

Additionally, MOMENTUM will soon be launching a PMH community of practice building upon the energy generated by the landscape analysis and ToC. This community of practice will create a collaborative space for people dedicated to learning from each other as we work to expand programs for PMH in LMICs. This [commentary](#) also offers seven critical, concrete actions to move the PMH agenda forward globally in a coordinated way:

- 1. Set global PMH standards and targets**
- 2. Change government policy and allocate clear budgets for PMH**
- 3. Integrate PMH services into existing health system platforms**
- 4. Use research to strengthen current interventions**
- 5. Build on existing community-level strengths**
- 6. Address social and economic risk factors**
- 7. Destigmatize mental health conditions**

Now is the time to work together to ensure that all women everywhere realize the PMH that is their human right.

For any questions or comments about these materials, please contact info@jhpiego.org

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