

Screening and Management of Perinatal Depression in Nepal: The Need for Urgent Action

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ABSTRACT

Perinatal depression is one of the most neglected public health concerns among reproductive-age women in resource-limited countries, such as Nepal. Currently, there is a lack of standardized protocols to screen and treat women for depression during pregnancy and the postpartum period in Nepal. Additionally, healthcare providers are often not adequately trained to identify and treat perinatal depression. This, coupled with the stigma related to mental health issues and a lack of community resources, can delay the identification and treatment of perinatal depression among women. The purpose of this paper is to highlight the need for routine screening and management guidelines for perinatal depression utilizing standardized and validated instruments and the establishment of community resources to enhance the outcomes of mothers and infants. Perinatal depression is the most common mental health issue among women of reproductive age. Collaborative efforts among healthcare workers and policymakers are essential to enhance maternal and child well-being. Fostering a comprehensive and culturally sensitive program Nepal can take a significant step toward reducing the burden of perinatal depression and improving the quality of life for women and their families. Routine screening for perinatal depression at different time points during pregnancy and postpartum for one year following childbirth as well as implementation of standardized screening and treatment guidelines to improve outcomes for women and their families.

Keywords: Infants; perinatal depression; postpartum; pregnancy; screening.

INTRODUCTION

Perinatal depression is a subtype of major depression experienced by women during pregnancy (i.e., antenatal depression) or within a year following childbirth (i.e., postpartum depression).¹ This is the most common public health issue among women of reproductive age worldwide² and is a leading cause of maternal mortality and morbidity.³ Symptoms of perinatal depression include a low mood, persistent sadness, changes in sleep and appetite, feelings of hopelessness, and anhedonia. ¹ Perinatal depression can be caused by several factors, including hormonal changes during pregnancy or the postpartum period, significant life stress, the physical and emotional demands of childbirth, and the burden of infant care.⁴

According to the WHO (2024), globally approximately 10% of pregnant women experience mental health

issues, specifically depression during pregnancy. The prevalence of depression during pregnancy (also known as, antenatal or prenatal depression) is much higher (15.6%) in developing countries. ² Available community-based studies in Nepal indicate that 18-33% of women suffer from antenatal depression. ⁵⁻⁸

Similarly, postpartum depression affects more than 10-20% of women globally.^{1,2,9} Compared to higher-income countries, postpartum depression is twice as prevalent in Lower Middle Income Countries (LMICs) such as Nepal, with one in four postpartum women suffering from postpartum depression.¹⁰ Prior studies indicate the prevalence of postpartum depression in Nepal ranges from 9.4% to 33.7%. ¹¹⁻¹⁵ In a recent study, 28% of women 6-12 months postpartum in Nepal had higher levels of depressive symptoms requiring referral for mental health services.¹⁶ The onset of postpartum depression can present anytime throughout the first

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year of childbirth¹⁰ and has been identified as a key factor for increased maternal mortality and morbidity.¹⁷ Additionally, untreated depression during pregnancy can often persist throughout the postpartum period and beyond.

Despite its higher prevalence, perinatal depression is often under-identified and untreated, affecting the health and overall well-being of both mothers and infants.^{2,16, 18,19} Symptoms of perinatal depression can be debilitating for women. Along with low or depressed mood, women may experience issues with sleep and appetite, anhedonia, low energy, feelings of guilt, hopelessness, excessive crying, difficulty concentrating, and thoughts of harming themselves or their infant.¹ One out of every 10 postpartum women report experiencing suicidal thoughts putting them at a significant risk for suicide attempts, a leading cause of increased maternal morbidity and mortality.^{3, 10, 20}

Evidence also indicates that postpartum depression may contribute to poor outcomes for infants and children including, significantly reduced rates of breastfeeding.²¹ impaired growth and development^{20,22} and Women with postpartum depression are often unable to provide developmentally sensitive care and form a positive bond with their infants leading to impaired mother-infant bonding,²⁰⁻²⁶ which can have a substantial negative impact on a child's growth and development.² Two recent studies in Nepal indicated that postpartum depression is associated with impaired mother-infant bonding²⁵ and neurodevelopmental delays in infants.¹²

Maternal mental health is a growing concern worldwide, conditions like perinatal depression can cause significant impact on mothers and their infants if untreated. Improving maternal and infant well-being is a priority in the United Nations Sustainable Development Goals (SDGs).²⁷ Early identification of women at risk for perinatal depression using validated tools and timely treatment and referral are of utmost importance to reduce the risks of poor maternal and infant outcomes. However, there are currently no standardized protocols for perinatal depression screening in Nepal. The high morbidity and mortality associated with perinatal depression require a multifaceted approach to care for women and their infants. The Socio-ecological Model can serve as a framework to examine a phenomenon of interest such as maternal and infant well-being by focusing on the various levels of influence including individual, interpersonal, organizational, environmental, and policy factors.²⁸⁻²⁹ Utilizing current evidence, this model can be used to design multilevel

interventions to improve maternal and infant outcomes associated with perinatal depression in Nepal. The WHO Nurturing Care framework can also support mothers in providing nurturing care and helping infants and children survive and thrive.³⁰ Both policy and practice changes are necessary to address this public health issue.

METHODS

This study was based mainly on secondary sources of data. A comprehensive review of the existing policies and guidelines related to perinatal depression in Nepal and pertinent research publications was conducted to gather the required information.

RECOMMENDATIONS FOR POLICY AND PRACTICE SCREENING AND EARLY DETECTION

Current research and guidelines indicate the need for ongoing screening for perinatal depression for up to one year after childbirth. The use of standardized and validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) are essential for early identification and management of perinatal depression.¹⁷ Both the EPDS and PHQ-9 screening tools have been culturally translated and validated for use in the Nepali language.³¹⁻³² Pediatric and obstetric departments can aid in screening, prompt identification, and treatment of women at risk for perinatal depression. Immunization clinics are a regular point of contact for postpartum women in Nepal, where routine screenings and referrals can take place throughout the first year following childbirth.²² Based on current evidence-based guidelines, routine screenings should occur at the following times.

Screening for depression should occur at least three times during pregnancy

At the first antenatal visit or during the first trimester (1st)

At least once during the second trimester (2nd)

At least once during the third trimester (3rd)

Screening for postpartum depression should occur at multiple times:

During childbirth at birthing hospitals/health centers

Within 6 weeks postpartum follow-up visits with obstetrician/midwife

At 3, 9, and 12 months postpartum at pediatric office visits for immunization and/or well-infant check-ups.

STANDARDIZED TREATMENT AND REFERRAL

Standardized treatment and referral protocols for perinatal depression are warranted to enhance outcomes for both women and their children. Utilization of evidence-based treatment and referral protocols can promote early recovery and minimize risks associated with perinatal depression among women by providing recommendations for medications (i.e., antidepressants), cognitive behavioral therapy, and utilization of community resources. Early identification and prompt treatment of perinatal depression can prevent long-term sequelae (such as ongoing depressive symptoms, risk of suicide, marital discord, poor mother-infant bonding, and emotional and behavioral problems in children) associated with untreated mental health issues among women in Nepal.

One emerging evidence-based strategy to promote continuity of care and enhance patient outcomes is the use of a “warm handoff” as a referral mechanism for women identified at risk for perinatal depression. A warm handoff is usually carried out in the primary care setting prior to the patient leaving their appointment and is described as the practice of connecting patients to another provider and oftentimes provides assistance with scheduling and facilitating follow-up care.^{33 34 35} Warm handoffs have shown to be especially effective when referring patients to services that are often stigmatized such as the treatment of mental health issues and substance use disorders, psychological counseling, and other psychiatric treatment modalities.

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Utilizing a warm handoff strategy in clinical practice can positively impact patient and family outcomes once the need for mental health services for a patient has been identified. Warm handoffs are an easy and low-cost strategy to promote prompt treatment and follow-up care. By adopting standardized treatment and referral protocols, including evidence-based strategies like warm handoffs, Nepal can address the challenges of perinatal depression and improve health outcomes for women and children.

AWARENESS and DESTIGMATIZATION

Mental health education and counseling to women during perinatal visits can play a positive role in reducing

the risks associated with postpartum depression.^{15,36} Recognizing and implementing strategies to reduce the stigma associated with maternal mental health issues such as depression and anxiety is a crucial first step in minimizing women’s barriers to mental healthcare.^{37, 38} Improving public awareness regarding mental illness and providing education emphasizing the importance of both physical and mental health may encourage women to seek care when needed. Enhanced education for healthcare providers regarding the signs and symptoms of maternal mental illness and the availability of treatment options and community resources can positively impact outcomes for Nepali women and their families.

DEVELOPMENT of COMMUNITY RESOURCES

Resources within the community may also be beneficial for women with perinatal depression. Holistic social and family support during the postpartum (perinatal) period has been identified as a significant factor in decreasing symptoms of depression.^{19,38} Support groups and social networking with other women who are also struggling with mental health issues can be helpful. Educational sessions regarding recognition of depressive symptoms and availability of treatment options and promotion of a healthy lifestyle and coping strategies could also be provided within the community. Evidence-based community interventions are required to meet the needs of this vulnerable population and their children.

CONCLUSIONS

Perinatal depression is the most common mental health issue among women of reproductive age. It is stigmatized, and often unrecognized and untreated leading to adverse effects on women, and their children and families. To address these challenges routine screening during pregnancy and postpartum period is crucial for early identification and timely intervention. This paper provides practice recommendations for routine screening for perinatal depression at different time points during pregnancy and postpartum for one year following childbirth. This paper advocates for the implementation of standardized screening and treatment guidelines to improve outcomes for women and their families. It has significant implications for obstetric, family, and pediatric providers and nurses for routine screening, early identification, and prompt treatment and referral of women to enhance positive outcomes. Collaborative efforts among healthcare workers and policymakers are essential to enhance maternal and child well-being. By fostering a comprehensive and

culturally sensitive program Nepal can take a significant step toward reducing the burden of perinatal depression and improving the quality of life for women and their families.

CONFLICT OF INTEREST

Authors declare there are no any conflicts of Interest.

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