Faith-based engagement in Maternal Mental Health (MMH)

…in LMIC, notably India, Liberia, Malawi, Nigeria, Kenya and Tanzania

Karen Hoehn, Bonstar SRL on behalf of
Christian Connections for International Health
(Momentum Country & Global Leadership, Faith Engagement Team)

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SECTION 01

Introduction, Summary

SECTION 02

Findings

Introduction and Summary

Introduction (1 of 2)

Multiple sources, notably The Lancet (2015), have found:

- Around 84% of the world's population is religiously affiliated (Pew 2015), and the world's main religions share a belief in the importance of caring for the sick.
- In low- and middle-income countries (LMIC), faith leaders play an important role influencing health-seeking behavior, and faith-based organizations (FBOs) provide a notable share of healthcare information, services and supplies.
- Anywhere from 30% to 70% of health-care services are provided by faith-based entities of various forms worldwide and in Africa.

Introduction (2 of 2)

Multiple sources, notably The Lancet (2015), have found:

- FBOs are seen as credible and trustworthy through their continuous presence at the grassroots level, particularly in conflict-ridden or hard-to-reach communities where other actors appear only intermittently.
- FBOs can help contextualize concepts and interventions by using language and approaches that resonate with the cultures and beliefs of the communities they serve.
- When FBOs provide leadership supporting mental health, they may contribute powerful incentives in favor of seeking care.

Summary of Findings (1 of 3)

- Supportive religious communities provide invaluable psychosocial support for women who are struggling with mental health problems, eg, pastors accompanying women to health care/delivery to provide comfort through prayer.
- Harmful traditional practices sometimes masquerade as faith-related and/or are perpetuated by religious leaders and faith communities. Examples range from child marriage, to social pressure to have male babies, to harmful family power dynamics, to "spiritual healing" centers that inflict extreme harm.
- Stigma against mental health is highly pervasive, including in religious communities.

Summary of Findings (2 of 3)

- Faith-based health care seeks to take a holistic, more-than-medical-model approach to wellness, which includes a whole-person (including spiritual) response that can be helpful for Maternal Mental Health (MMH).
- Health systems in Low- and Middle-Income Countries (LMIC) are reported as being very often:
  - *insufficient* (eg, not enough trained personnel, medications)
  - *unavailable* (eg, limited to one inpatient psych ward for a large region, clinics inaccessible due to poor roads/transport), and
  - *sometimes actively harmful* to women seeking mental health care (eg, unkind/unsympathetic practitioners, misdiagnosis/mistreatment, use of physical restraints)
- As a result, women often prefer to go to traditional and nontraditional community (faith) healers, who respond in a culturally relatable way to their symptoms, though whose effectiveness has not been studied.

Summary of Findings (3 of 3)

- Faith leaders and FBOs stand well-positioned to make a tremendous difference in MMH outcomes:
  - They have the trust and respect of their communities
  - They have extensive community outreach with structures which can facilitate training and dissemination
  - They attend to the spiritual wellness of their people, which places their values and language within the sphere of mental health
  - They can provide the social and community support which is essential to mental health and well-being
- To do this, they need training and funding.

Evidence inputs for this study (1 of 2)

- Screening survey
  - 31 received of 92 responses surveyed
- Interviews
  - 16 interviews completed of 21 interviews requested
  - Countries:
    - multi-national (5)
    - India (3), Kenya (3), Malawi (2)
    - Ghana (1), Liberia (1), Nigeria (1)
  - Religion: Christian (12), Muslim (2), non-affiliated

Evidence inputs for this study (2 of 2)

- Literature review - search terms used in various combinations:
    - Religion, faith, Christian, Muslim, Islam, Islamic, Hindu
    - Low-resource settings, low-income countries, LMIC, Africa, Asia, India, Liberia, Malawi, Nigeria, Kenya, Tanzania
    - Perinatal, maternal, postpartum, mental health, depression, mental disorders, depression, anxiety
    - Adolescent pregnancy, adolescent mental health gender-based violence, GBV, violence against women, psychosis
- Databases searched: Joint Learning Initiative on Faith and Local Communities; PubMed; ScoPlus
- 21 relevant journal articles + 20 gray (non-peer-reviewed but institutionally reviewed) documents

Observations about conducting research on faith and mental health (1)

- This research left the definition of «FBO» deliberately broad, to include any actor or institution affiliated with or sponsored by a religion, including organizations and health service providers affiliated with a religious community as well as religious leaders / institutions themselves.

- Research on the healing effects of prayer is riddled with assumptions, challenges and contradictions that make the subject a scientific and religious minefield.

- As a result, there is very little systematic evidence on how religious communities as a whole deal with maternal mental health. Anecdotal evidence shows both supportive and harmful effects, but almost nothing empirically rigorous.

- The vastly differential knowledge, backgrounds and cultural and linguistic filters of key informants related to mental conditions, gender dynamics, social power and religion mean that key informant responses do not always fit naturally into the sort of data/inputs that might be expected.

Findings

Findings (1 of 13)
What MMH services do FBOs provide?

- FBOs currently provide very few services designed specifically for maternal mental health
- Top three FBO services provided, according to key informants:
  - Inpatient mental health services, not designed specifically for MMH
  - Informal peer/women's support groups in the communities
  - Identification of severe mental health conditions during ante- and post-natal care, during presentation for delivery, or during follow-up with newborns

Many women (e.g., with psychosis) get a wide range of support from Churches and Mosques ranging from fairly helpful, formal or informal to inappropriate, judgmental and sometimes quite abusive (eg, all-night prayer vigils) that blame the woman for her condition

Key Informant

Findings (2 of 13)
How do women with MMH get help from FBOs?

Most key informants indicate that MMH goes largely undetected. When women get MMH from FBOs, it’s likely to be:

- In FBO maternity wards when presenting for ante-natal care or delivery
- In FBO mental hospitals, which do not provide maternity-related care
- Community religious leaders referring women for MMH care
- Peer support / women's groups providing informal psychosocial support
- Religious leaders providing prayer and counseling
- In FBO gender-based violence (GBV) survivor services
- FBOs provide some education/awareness raising, but this is usually in the framework of a time-limited grant-funded project.

Findings (3 of 13)
How are FBOs trained for MMH?

Generally, FBOs and faith leaders are not trained specifically on MMH

- Formal, academic curricula for health service providers may address mental health
- Rare, time-limited projects sponsored by donors may address mental health or MMH
- One or two international FBOs use a cascade training approach that ultimately reaches women with psychosocial support in the community. These are either in pilot phase or limited in scope.

Findings (4 of 13) How do FBOs identify, refer, diagnosis and treat women with MMH needs?

- Very few women with MMH are identified. When FBOs identified them, it occurs:
  - In the community, through pastors, faith-affiliated traditional birth attendants or midwives
  - In faith-affiliated clinics or facilities when women come for medical care
- Following identification, FBOs refer the women to specialists for care.
- Diagnosis and treatment occurs formally in FBO facilities. To avoid the risk of triggering harmful stigma or mis-diagnosis, mental health diagnosis is left to the medical experts, of whom there are very few who specialize in mental health.

People often prefer to work with clerics and spiritualists because they are treated well by them, as contrasted with how poorly they are treated by the formal health system.

Key Informant

Findings (5 of 13)
Improving the Systems for FB-MMH engagement

The near-universally cited way to improve faith-based MMH engagement:

Increase training

on how to identify, diagnose and intervene sensitively

with patients on mental health issues

at all health system levels,

including traditional birth attendants (TBAs)

and Community Health Workers (CHWs)

Findings (6 of 13)
Improving the Systems for FB-MMH engagement

Other frequently cited ways to improve faith-based engagement in MMH:

- Anti-stigma awareness raising among FBO clinicians and religious leaders, and then awareness-raising by by religious leaders in the community
- Increase mental health services availability / resources, including inpatient, but especially outpatient, and for CHWs
- Partnerships and linkages: improve service system collaboration on mental health, including across development sectors (as poverty is a root cause)
- Increase systemic resources for FB outreach in communities. This work is often donor-funded for time-limited projects not integrated into sustainable systemic change

Findings (7 of 13)
Improving the Systems for FB-MMH engagement

Also mentioned:

- Improve service system collaboration on mental health, including across development sectors (as poverty is a root cause)
- Ensure all health care service providers can screen for MMH
- Make sure that mental health is integrated into maternal health
- Make sure that needed drugs are available - they are usually out of stock
- Improve clinician sensitivity and cultural appropriateness

Mental health issues are culturally embedded issues. The DSM and other rich-world clinical approaches do not mostly meet people where they are, so you see lots of women being put on the wrong meds.

This does not help, and it is poor quality care.

FBOs are well placed to contextualize care, rather than copy-paste diagnostic protocols. (If asked), the women themselves would say that they want more supportive communities, pastors, family members…that the social factors would be more open and helpful, with less stigma.

Key Informant

Findings (8 of 13)
What types of programs do FBOs support or implement for MMH?

- Informal emotional support during maternity and delivery by being present with the woman and praying with her
- Informal peer support / women's groups in the community.
- Education and awareness, integrated into health-nutrition-education, some group therapy and referral.
- Psycho-social counselling to pregnant and post-partum mothers through focused projects as well as through specialty units in mission hospitals
- In disaster response, training Ministry of Health staff, teachers, police officers, lay counseling for people who have experienced violence; training faith leaders (pastors) on identifying trauma and psychological first aid

Faith organizations are often the center of the community support system, it's where people turn when they need help, eg, the women's fellowship/group, some sort of financial system available for people in desperate straits, where people find informal networks of support.

They are incredibly important in providing that baseline emotional support for women who are having problems.

(It's) where people go first when they need emotional support. They go to church/mosque because that's the cultural understanding, of this being a spiritual issue. In the best cases, they can facilitate that by being thoughtful, caring in response to people's needs.

Key Informant

Findings (9 of 13)
Social & cultural factors helping FBOs provide MMH services

- Respect for messages coming from religious leaders, belief that they are looking out for the person's whole (body-mind-soul) well-being.
- Many FBOs, whose concern is with the soul, the whole being of the person, are open to integrating mental health as part of wellness.
- Community faith leaders understand the local context and culture, which gives them a lot of power to demystify harmful attitudes and practices.
- FBO structures in communities, such as women's groups, mother-to-mother groups are well placed to transmit anti-stigma, pro-mental health messages

Faith communities are essential to people's lives.

Those connections and community networks are very strong protective factors for mental health.

People are less likely to develop MH issues in contexts with strong social support.

Key Informant

Findings (10 of 13)
Social & cultural barriers to FB MMH engagement

- Poverty
- Pervasive stigma, in communities and among healthcare practitioners, victim-blaming
- Belief that mental illness is caused by supernatural forces, demonic possession or punishment by God – and can be solved by prayer alone
- Male dominance and lack of female autonomy, eg, permission required to seek medical care
- Harmful family power dynamics, eg, dominant, controlling elders with archaic beliefs
- Women – directing all their energy toward caring for others – having no reserves to care for themselves (“they just get on with their lives, numb”)
- View of mental health as a Western construct/imposition

At the community level, having culturally appropriate care would help.

It’s hard to translate western MH care into different cultures. Sitting one-on-one in an office with a counselor would not be welcome or helpful (or even possible) in a lot of contexts.

Digging in deeper into the cultural appropriateness of taking care of women’s mental health needs is needed.

Key Informant

Findings (11 of 13)
Unique contributions of religion / FBOs to addressing MMH

- Religious leaders are involved with women throughout their entire life cycle. Most religious leaders serve also as counselors. They know the people in their communities and can identify changes in mental health.

- Religious leaders have a respect in the community. People trust them and will accept help from them.

- Religious leaders have tremendous outreach capacity in their communities. FBOs also run conferences, which provide an opportunity for training and outreach.

- Having a supportive faith community is highly protective. It reduces the likelihood of having a MH issue and more likely for the woman to recover.

Faith matters to people, and matters to development. In many parts of the world, FBOs and religious leaders are influential in both the political and social spheres, and have a broad following in society.

Their presence in local communities, coupled with their capacity to deliver critical services, allow them to mobilize grassroots support, earn the trust of vulnerable groups, and influence cultural norms – all of which make them vital stakeholders in development.

With their involvement in local communities and their standing as moral leaders, many FBOs and RLs command the respect of local and national authorities, which can make them valuable…

UNDP

Findings (12 of 13)
Unique contributions of religion / FBOs to addressing MMH

- People in FBOs see people holistically, they see the person at a spiritual level, not just physical. Mental health is closer to spiritual well-being than physical from non-expert points of view.

- FBOs have language for spiritual health and values that enable staff and adherents to care about a woman’s mental health because they are already caring about her as a whole being, as a spiritual person.

- FBOs’ awareness of spirituality and how it connects with mental well-being is helpful. Women don’t see intervention by their faith leaders as a forced conversation, they see it as someone trying to help them.

- Most religions believe that people should be kind, help others, be generous. Faith adherents are called to love and care for others and offer them hope.

Findings (13 of 13)
Aspects of religion / FBO practices that may negatively affect MMH

- Religious communities often perpetuate or support harmful attitudes and practices
- There are some religious communities (across faiths) that look at mental health as a curse, or a punishment. This further stigmatizes the woman and the family. People coming from that religious perspective see mental health as a curse, possibly contagious, and as something that cannot be treated.
- Some faith communities believe that mental health is a supernatural intervention that can be “treated” only by prayer.

It is not possible to deal with the aspect of mental health that comes from stigma and discrimination without (working with) faith, because faith communities are the source of a lot of that stigma and discrimination.

Key Informant

Contact us

Karen Hoehn, karen@bonstar.be

Mona Bormet, mona.bormet@ccih.org

Deirdre Church, deirdre.church@ccih.org

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