

# The Silent Burden:

Maternal Mental Health and the Importance of Engaging Faith Actors

February 3, 2022

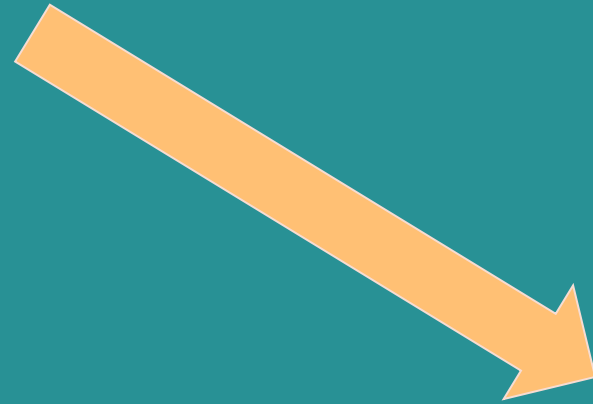


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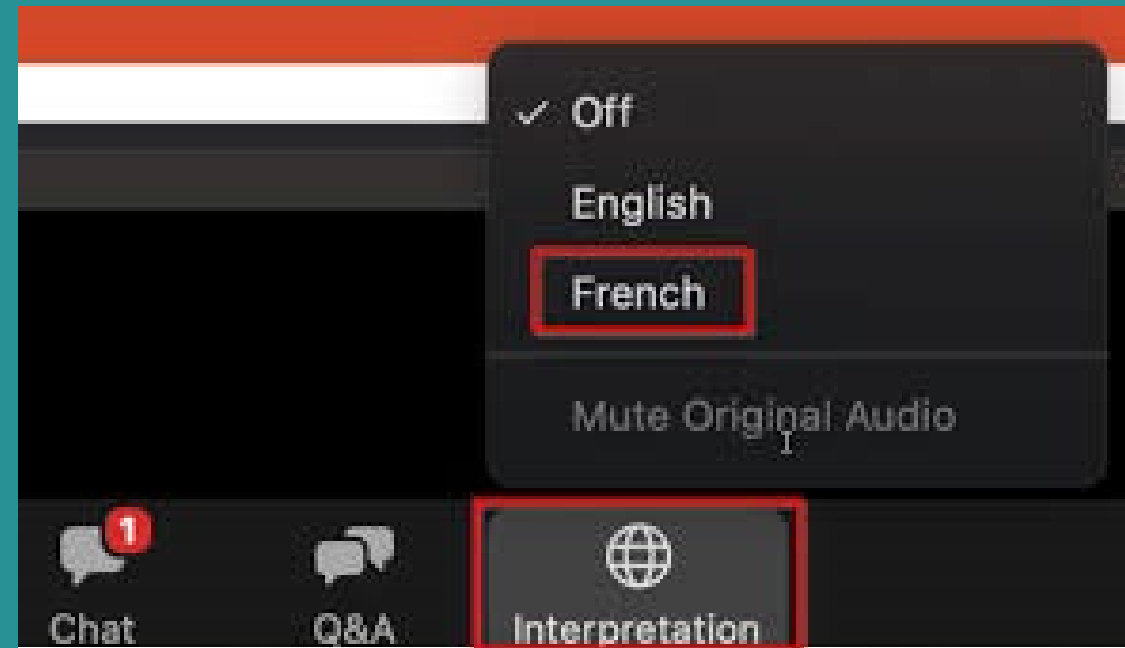


# Traduction?

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# Moderator



**Allison Flynn** is a Senior Program Advisor for Health and Nutrition at World Relief. As a global advisor, Allison has been based in Malawi since 2019, where she provides technical support to World Relief's family-centric reproductive, maternal, newborn and child health and nutrition portfolio with specific emphasis on programs in Sub-Saharan Africa. She focuses on social behavior change through peer support mechanisms such as Care Groups, and has worked to document the ways in which faith communities can be engaged in a meaningful way as a part of community-level behavior change interventions. Allison also serves as the co-chair of CCIH's Health of Women and Children Working Group.



# Panelist



**Karen Hoehn** authored the CCIH study of faith actor engagement in maternal mental health. Karen is a consultant based in Brussels who helps non-profits (NGOs), foundations and multilaterals improve health and reduce poverty. With lifelong roots in faith, mental health, reproductive health and social justice, she is Director of the consulting firm Bonstar, SRL, and a founder of the Faith to Action Network. Her consulting services focus on European donor aid policy and funding research, analysis and mapping; liaison and partnership development; advocacy; message development; resource mobilization, business development; and program evaluation.

# Faith-based engagement in Maternal Mental Health (MMH)

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

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

Thursday, February 3, 2022



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# Overview

## Research inputs:

- 1) Screening survey
- 2) Key Informant Interviews
- 3) Literature review
- 4) Internal expert review



## Questions:

- How do FBOs engage in MMH, and how are they prepared for that?
- What are the unique contributions of religion / FBOs to MMH?
- What factors affect FBO approaches to MMH, positively or adversely?
- What's needed to improve FBO approaches to MMH?

# Why do FBOs matter in the provision of MMH services?

Around 84% of the world's population is religiously affiliated



The world's largest religions share a belief in the importance of caring for the sick.

Provide substantial share of health-care services

Seen as credible and trustworthy

Extensive community outreach for social support

Spiritual leaders contextualize care values and language



In low- and middle-income countries (LMIC), faith leaders influence health-seeking behavior.

They contextualize concepts and interventions using language and approaches that resonate with the cultures and beliefs of the communities they serve.

They have a continuous grassroots presence, particularly in conflict-ridden or hard-to-reach communities where other actors appear intermittently.



*Faith matters to people, and matters to development. In many parts of the world, FBOs and religious leaders (RL) 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.”*



# FBOs provide few services designed specifically for Maternal Mental Health

## Top three FBO services provided:

1. Inpatient mental health services, not designed specifically for MMH
2. Informal peer/women's support groups in the communities
3. Identification of severe mental health conditions during ante- and post-natal care, during presentation for delivery, or during follow-up with newborns

## Examples

- Informal emotional support during maternity and delivery - being present and praying with the woman
- Education and awareness-raising integrated into health-nutrition-education
- Psycho-social counselling to pregnant and postpartum mothers through focused projects and specialty units in mission hospitals
- In disaster response, training Ministry of Health staff, teachers, police officers, lay counselling for violence response; training faith leaders (pastors) on identifying trauma and psychological first aid

# Faith-based organizations and their approaches can accelerate or hinder progress on MMH

Accelerate

- FBO support for mental health may powerfully incentivize care-seeking
- Many religious communities support women who struggle with mental health problems
- Faith-based care takes a holistic, “more-than-medical” approach to wellness and a whole-person (including spiritual) response

- Harmful traditional practices may masquerade as faith related and/or be perpetuated by religious leaders and faith communities
- Stigma against mental health is highly pervasive, including in religious communities

Hinder



*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 (e.g., all-night prayer vigils) that blame the woman for her condition.”*

**Key Informant**

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# What are the unique contributions of religion / FBOs to addressing MMH?

## FBOs see people holistically

- Awareness of spirituality and its connection with mental well-being
- A supportive faith community is highly protective, reducing the likelihood of having a MH issue and more likely for the woman to recover

## FBOs have community trust

- Religious leaders are respected, trusted and in demand
- Faith leaders understand the local context and culture, which helps demystify harmful attitudes and practices
- Women's faith groups help transmit anti-stigma, pro-mental health messages

## FBO missions and purposes align with MMH

- Spiritual health and values enable care for women's whole being
- 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
- Most religious leaders provide counseling

## FBOs are present where others are not

- Religious leaders are involved with women throughout the life cycle
- FBOs are continuously present in communities, eg, rural, in conflict, where other actors come and go





*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.*

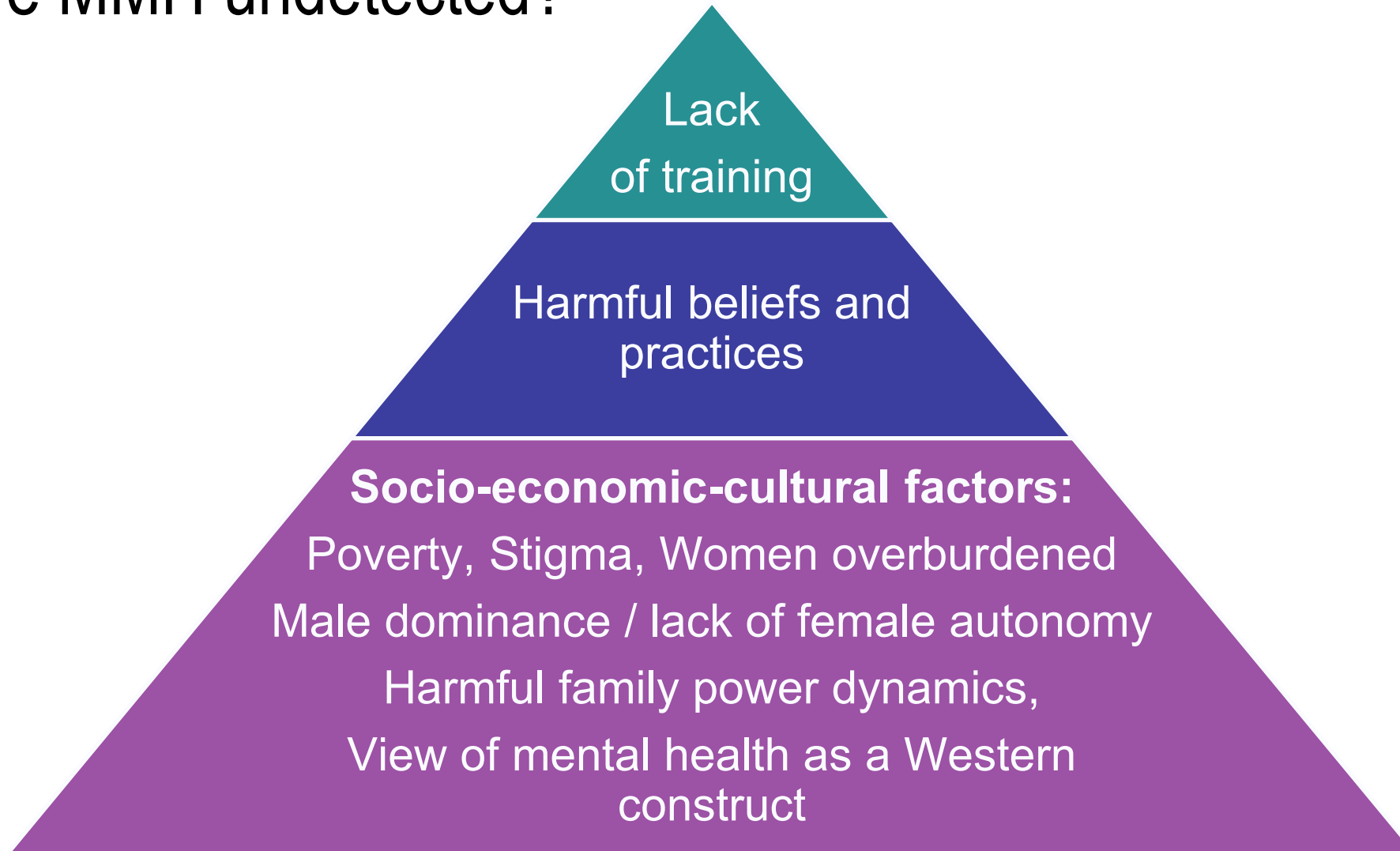
*They are incredibly important in providing that baseline emotional support for women who are having problems.*

*(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**

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What are the challenges in advancing MMH with FBOs that leave MMH undetected?





*Mental health issues are culturally embedded issues. The DSM (Diagnostic and Statistical Manual) 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**

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# How can we support FB-MMH with stronger systems?

## Top Priority

- **Increase training** to identify, diagnose and intervene sensitively at all health system levels, including traditional birth attendants and Community Health Workers

## Important

- **Anti-stigma awareness raising** among FBO clinicians and religious leaders
- **Increase mental health services availability** / resources
- Partnerships and linkages to **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 (current efforts typically not integrated into sustainable systemic change)

## Also mentioned

- Improve service system collaboration across development sectors
- 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 – often out of stock
- Improve clinician sensitivity and cultural appropriateness





*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**

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# Future Research is Needed on Faith and Mental Health

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



*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**

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## Contact us

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# THANK YOU

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# Panelist



**Suzanne Stalls** is Director of the Maternal Newborn Health Team for Momentum Country and Global Leadership, a global technical leadership award funded by USAID in a consortium directed by Jhpiego. In her role, she contributes to global technical leadership and learning, and supports the policy dialogue required for achievement of global MNCH/FP/RH goals through MNCH/FP/RH initiatives, strategies, frameworks, guidelines, and action plans that have been endorsed worldwide.

# Maternal Mental Health

Overview of MOMENTUM Country and Global Leadership Maternal Mental Health Activity

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Suzanne Stalls, Director, MNH

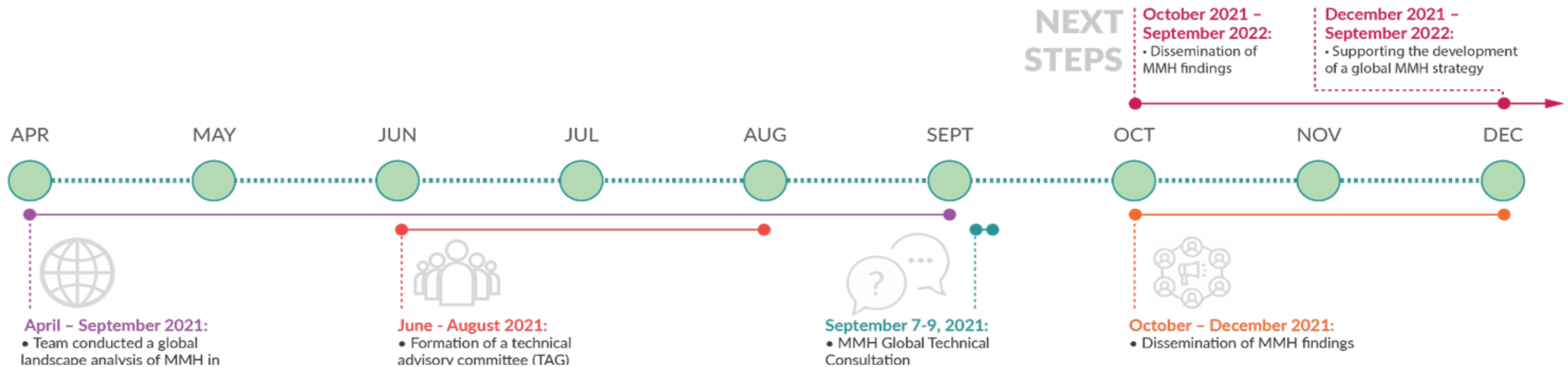
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# Maternal Mental Health Activity Timeline





# Looking Forward

## 1. Focused dissemination activities



AlignMNH Issues page and blog



Blogs and webinars



Publications and manuscripts

2. Co-creation of a global MMH theory of change

3. Co-creation of a country-driven MMH Community of Practice

4. Strategically collaborate with partners to advance MMH globally (and consider how implementation research might be a useful contribution)

# Co-Creation of Theory of Change and Community of Practice

- Reconstitute the Technical Consultation Technical Advisory Committee (TAG) into a **country-led and country-driven Steering Committee** which will lead and inform the development of the theory of change and community of practice.
- Develop an initial theory of change based on findings from maternal mental health landscape analysis and technical consultation.
- Quicksand, a human-centered design firm, will lead steering committee members and other key stakeholders in a co-creation process to validate and finalize a global maternal mental health theory of change.
- MOMENTUM team will conduct a competitive analysis and mapping to build a solid investment case for a country-led maternal mental health community of practice under the direction of the steering committee.

# Where are the gaps in knowledge?

1. Expand the evidence to include findings from different contexts (including vulnerable populations);
2. Expand the evidence base beyond postnatal depression;
3. Center research and practice on the expressed desires of women and girls; and
4. Identification of integrated approaches that improve both women's and children's health.

# Where to begin integrating and expanding MMH services?



## Community level:

Community health workers, peers, grandmothers, or new mental health cadres are able to meet women where they are, as people women trust. This also helps to engage women who are not seeking care at the health facilities.<sup>37</sup>

## Children and family approaches:

Key informants described how many approaches use children as “trojan horses” for entry. This approach can remove the pressure, guilt, and stigma from mothers.

## Facility level ANC and PNC:

Having health care workers who are trained in CPMDs was a core component of most interventions that engaged in health system strengthening.<sup>38</sup>

## Provider pre-service education:

A comprehensive response to CPMDs will require training incoming generations of health workers to diagnose and treat CPMDs.<sup>39</sup>

## Traditional healers and faith-based organizations:

Several key informants noted the powerful link between mental health and spirituality/faith and working with local traditional healers and faith leaders if there is to be any true change in women’s perinatal mental health.

# Recommended discussions to move the agenda forward

## **National Policy Level**

What can be done, or done better, to link research and implementation communities with policy level actors to advocate more strategically for mental health policies that result in actionable changes?

## **Health Systems**

How can/should perinatal mental health be integrated into the existing health systems and initiatives—and where are the best entry points for interventions/programs?

## **Person-centered, rights-based care**

How can any initiative to integrate CPMD into an existing health system ensure that women are centered in the conversation, women primarily drive what interventions and services look like, and are treated with the dignity and respect they deserve?



# Recommended discussions to move the agenda forward

## Facility-level strengthening

How can the mental health needs of health care workers be addressed within the context of their reality? What additional support can be provided to those working in high mortality settings, in humanitarian settings, and working with communities suffering from deeply inequitable access?

HCWs are from the same communities as women they serve. What can be done to break down stigma and discrimination from the facility level to provide respectful and empathetic care?

Where and how to include CPMD lessons or modules in pre-service and in-service training for all HCWs will be important to provide the skills and baseline knowledge to future and existing staff; the adaptable methods to provide these lessons will need to be further explored.

# Recommended discussions to move the agenda forward

## Community level strengthening

How to engage community health workers without contributing to the over reliance on their labor?

Referrals to where? How to ensure simultaneous strengthening of community level mental health programs/support/interventions with facilities that are prepared to provide person-centered, rights-based services to those who need further support? What are the ethical implications of strengthening the community level without having anywhere to refer women?

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