NATIONAL DIALOGUE ON MATERNAL MENTAL HEALTH POLICY IN NIGERIA

Date: 10th November 2022

Venue: Immaculate Hotel and Suites, Wuse II, Abuja

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ACKNOWLEDGMENTS

Mental Health problems are stigmatized in Nigeria. I wish to commend the organizers of this National dialogue for their foresight in advocating for the recognition as well as development of strategies to bridge the gaps in public awareness and intervention for management of Maternal Mental Health (MMH) in Nigeria. The conduct of the National Dialogue on MMT was made possible by the passion and commitment of Stakeholders from the beginning to the actualization of the event.

Special appreciation goes to the academia from the Tertiary institutions across the country whose wealth of experience enriched the discussions and documentation.

The participation of UNICEF, WHO, IHP, the Psychiatry Association of Nigeria, the Society of Obstetrics & Gynaecology of Nigeria (SOGON), Paediatric Association of Nigeria (PAN), Regulatory bodies, Civil Society Organization, representatives of State Government Officials and the Media is highly commendable.

My sincere gratitude goes to the USAID MCGL-QoC and Jhpiego for financial and Technical support that made it possible for the conduct of the National Confab.

The unalloyed support of the Reproductive Health Division of the Federal Ministry of Health made the processes seamless. The technical inputs and the guidance of Dr. Tunde Ojo, the head of the Mental Health Division of the FMoH is commendable.

Special recognition goes to the Director and Head, Reproductive Health Division, Dr. Tinuola Tailor and her Team, for their invaluable coordination and Contributions. I also commend the good job of the Consultant - Dr. Boladale Mapayi.



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EXECUTIVE SUMMARY

This National dialogue on Maternal Mental Health (MMH) was organized by the Federal Ministry of Health (FMOH) with the support of the USAID Momentum Country Global Leadership (MCGL). Mental health has lagged behind physical health for a long time in terms of attention, funding and action. This is in tandem with the inclusion of mental health as a fundamental aspect of overall health and one of the Sustainable Development Goals (SDG) by the World Health Organization. Mental disorders are among the most common morbidities of pregnancy and the postnatal period and can have adverse effects on the mother, her child and family. Anxiety and depression are common, and women with pre-existing major mental disorders, such as schizophrenia, are at greater risk of compromised maternity care, delivery complications and relapse in pregnancy and the postpartum period. Globally, depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.

Though pregnancy and childbirth are physiologic processes, they can be associated with risks for a number of women. These risk factors are multifactorial and may differ between antenatal and postnatal disorders. Globally recognized risk factors include: Poverty, gender discrimination/GBV, relationship with intimate partner, low educational opportunities, physical health conditions, poor nutrition, unwanted or adolescent pregnancy, difficult birth experiences, conflict and natural disasters.

Perinatal common mental disorders (PCMDs) are a leading cause of years lived with disability in women of childbearing age and are associated with substantial human and economic costs. MMH problems are not only detrimental to a woman's health; they have also been linked to reduced sensitivity and responsiveness in caregiving and to higher rates of behavioural problems in young children.

Research into effective strategies for promoting MMH have recommended that mental health service integration is the most viable option. For most Low- and Medium-Income Countries (LMICs), the constraint of human resource makes service integration imperative.

Against this background of huge burden of PCMDs in Nigeria, the inadequate Human Resource for Health (HRH) across all cadre of Health Care Workers (HCW), dearth in Specialists, inadequate funding for health and a large treatment gap of almost 90%, it becomes imperative to raise awareness on its burden on health in Nigeria. This will also help in developing/implementing evidence-based initiatives to ensure better mental health for women of reproductive age in Nigeria.

Participants were drawn from the FMOH, National Primary Health Care Development Agency (NPHCDA), other Ministries, Departments, & Agencies (MDAs), Medical Experts, Implementing Partners, Civil Society Organizations, Media and relevant State Government representatives. Details of participants are contained

in the list of participants (Appendix I). The sessions were interactive with suggestions and recommendations on the process of developing a maternal mental health policy for Nigeria.

INTRODUCTION AND BACKGROUND

Concepts

Perinatal mental health refers to a woman's mental health during pregnancy and the postpartum period. The World Health Organization (WHO) defines maternal mental health (MMH) as "a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community" (Herrman & Swartz, 2007; p 1195). Mental disorders are among the most common morbidities of pregnancy and the postnatal period and can have adverse effects on the mother, her child and family (Howard et al, 2014). Anxiety and depression are common, and women with pre-existing major mental disorders, such as schizophrenia, are at greater risk of compromised maternity care, delivery complications and relapse in pregnancy and the postpartum period. Pre-existing bipolar disorder, other serious affective disorders and personal history of puerperal psychosis predict a 50% risk of early postpartum major mental illness (RCOG, 2011). The vast majority of research on perinatal mental health has examined non-psychotic common perinatal mental disorders (CPMDs) and the majority of studies focus specifically on anxiety and depression.

Burden

Globally, depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth. During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1,000 women who have given birth. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history (NICE, 2020).

Research from high-income countries has revealed that 7%-15% of women suffer from antepartum depression, and about 10% of women experience postpartum depression. Available evidence suggests that perinatal mental health issues are more common in low- and middle-income countries (LMICs) (Parsons et al, 2012). A systematic review by Fisher (2012) showed higher rates of perinatal common mental disorders (PCMDs) among women from low- and lower-middle-income countries, where the weighted mean prevalence of these disorders was found to be 15.6% (95% confidence interval, CI: 15.4–15.9) in pregnant women and 19.8% (95% CI: 19.5–20.0) in women who had recently given birth. A more recent systematic review based on data from 20 LMICs countries reported an average prevalence of 25% for prenatal depression among women in LMICs, and an average prevalence of 19% for postpartum depression (Gelaye

et al, 2016). Anxiety disorders are reported in 13% of women in African countries (Howard, 2014; fisher et al, 2012) and there is substantial comorbidity with depressive disorders (wisner et al, 2013).

In Nigeria, prevalence of perinatal depression ranges from 8-28%. There are wide variations depending on tool and diagnostic considerations. Anxiety disorders are less researched and show a prevalence between 32-39% (Osiyemi 2021, Adewuya 2006). PTSD and subthreshold symptoms especially in the presence of traumatic birth experience occur in 6% of women (Adewuya, 2006).

Risk factors

Though pregnancy and childbirth are physiologic processes, they can be associated with risks for a number of women. These risk factors are multifactorial and may differ between antenatal and postnatal disorders.

A review by Fisher (2012) identified several risk factors for PCMDs among women in LMICs: having a partner lacking in empathy or openly antagonistic; being a victim of gender-based violence; having belligerent in-laws; being socially disadvantaged; having no reproductive autonomy; having an unintended or unwanted pregnancy; having pregnancy-related illness or disability; receiving neither emotional nor practical support from one's mother, and giving birth to a female infant.

In a Lancet Series paper by Howard and colleagues (2014), a systematic review evidence of risk factors showed that, prior history of psychopathology, anxiety during pregnancy, low Socioeconomic status, exposure to trauma, negative life events and domestic violence were strong risk factors for antenatal depression (AND). While, domestic violence, previous abuse, negative life events, low social support, Low partner support, marital difficulties, depression or unhappiness in pregnancy and history of depression were strong risk factors for postnatal depression (PND).

In Nigeria, several authors (Adewuya, 2006b; Oladeji 2019; Gureje 2022) have delineated specific risk factors in CPMDs. Factors associated with AND included being single, divorced/separated, polygamous, having a history of stillbirth and perceived lack of social support. The correlates of PND included younger age groups, hospital admission during pregnancy, female gender of the baby, preterm delivery, instrumental delivery, caesarean section and single motherhood. The correlates of anxiety disorders included younger age, primiparity and the presence of medical problems (Adewuya et al, 2006b).

Consequences

Perinatal common mental disorders (PCMDs) are a leading cause of years lived with disability in women of childbearing age and are associated with substantial human and economic costs. MMH problems are not only detrimental to a woman's health; they have also been linked to reduced sensitivity and responsiveness in caregiving and to higher rates of behavioural problems in young children. There is growing evidence that, in LMIC, the negative effects of maternal mental disorders on the growth and development of infants and young children are independent of the influence of poverty, malnutrition and chronic social adversity (steward, 2007; Engle, 2009). In low-income settings, maternal depression has been linked directly to low birth weight and undernutrition during the first year of life, as well as to higher rates of diarrhoeal diseases,

incomplete immunization and poor cognitive development in young children (Patel, 2003; Rahman, 2004; Adewuya et al, 2008). Perinatal depression is associated with poorer maternal attitudes and parenting skills in adolescents compared with those in adults (Oladeji et al, 2019). Adverse consequences continue into childhood and adolescence.

Interventions

Research into effective strategies for promoting MMH have recommended that mental health service integration is the most viable option. For most LMICs, the constraint of human resource makes service integration imperative. There is a need to appropriately share tasks with available providers and embrace community-based approaches which are beneficial and might be preferable to stand-alone vertical programmes (Rahman, 2013). Working with Health Care Providers who are not mental health specialists, in the community or in antenatal health care facilities, can expand access to these interventions. Psychosocial interventions delivered by non-specialists are beneficial for PCMDs, especially psychological interventions (Clark et al, 2013; Gureje et al, 2022).

Problem Statement

Despite all the evidence amassed both globally and within the country, there are still significant gaps in public awareness, professional education, access to screening, treatment, support and preventive services. Considering the huge burden of PCMDs in Nigeria, our constraint in human resource for mental health (with a population estimated at approximately 200 million; Community health workers: 136/100,000; Nurse/midwives: 86/100,000; Doctors: 35/100,000; Psychiatrists: 1/750,000), very few specialists, inadequate funding for health care sector with a large treatment gap of almost 90%, it becomes essential to raise awareness of this public health burden in Nigeria so that evidence-based initiatives can be developed and implemented to ensure better mental health for women of reproductive age in Nigeria. This is the first consultative meeting to focus on the problem of maternal mental health in Nigeria and the need to have a policy in place to provide a framework for prevention, education and service-related interventions.

MATERNAL MENTAL HEALTH POLICY IN NIGERIA

The goal aims & objectives: to strengthen national and state-level maternal mental health policy in Nigeria.

Aim: to plan and execute a national dialogue on MMH policy in Nigeria.

Objectives:

- To gather information concerning the concept, burden, risk and protective factors for MMH problems in Nigeria
- To identify the challenges and opportunities for a MMH policy in Nigeria
- To conduct a robust discussion on the issues on MMH policy in Nigeria
- To come up with recommendations from the Experts/Stakeholders on a framework for improving MMH services in Nigeria through Policy formulation

PLANNING MEETINGS

A consultative meeting was held which served to introduce the Team members, to understand roles and responsibilities and to discuss Term of Reference (ToR). The Consultant then conducted a literature review on MMH to develop the concept note. The members of the Team consisted of the Officials from the Federal Ministry of Health (FMoH), the Consultant and the Technical Team from MCGL. An important decision was reached that a new policy on MMH is unlikely to be approved now as Nigeria had a number of policies already. But that this dialogue is occurring at an opportune time that a review of the Reproductive Health policy is being planned. Subsequent meetings were held to review the plans. Participants were drawn across the country as risk factors were different depending on the region and acceptable interventions may also differ. The Agenda and list of Speakers were agreed on. The modalities of the National dialogue were designed to have Presentations by Key Speakers, Group work and Presentation at Plenary. Presentations for the Speakers were reviewed and questions for the group discussions drafted, reviewed and accepted. A communique drafting group was formed who will develop the Communique from the agreement reached from the plenary session.

THE NATIONAL DIALOGUE:

The meeting was well attended with a total of sixty participants consisting of Government Officials from the FMoH, and National Primary Health Care Development Agencies (NPHCDA), Ministries, Department and Agencies (MDAs), Medical Experts, Implementing Partners, Professional Organizations, Civil Society Organizations (CSOs), Media and relevant State Government representatives formed the attendance at this parley. The meeting began with an introduction by the Participants. This was followed by a welcome address by Mrs Tinuola Taylor, Director Reproductive Health (RH) Division, FMoH, represented by Dr Oyeniyi, Head, Safe Motherhood, RH division, FMoH. In her address, she highlighted the types and the impact of mental health challenges on the individual, the family, and the community. She highlighted the importance of including MMH in the existing RH policy towards improving women's mental health. The Country Director of JHPIEGO, Dr Oniyire Adetiloye and a representative from USAID and UNICEF, gave good will messages. Opening remarks were given by Dr Salma Anas Ibrahim, Director Family Health (FH) Department, FMoH who was represented by Mrs Tinuola Taylor.

The Presentations:

These was done with 4 themes in focus, which included:

The mental health policy in Nigeria: This presentation provided an overview of the mental health profile of Nigeria (both in terms of burden, treatment gap/manpower) and the process of getting the MH policy implemented by all stakeholders, where we stand in this process and the implication for the MH of the country, including PMH. It was highlighted that even the current MH Policy has very little information on PMH.

The rationale for MMH in Nigeria: n this session, stakeholders had the opportunity to learn about the latest evidence on maternal mental health in Nigeria and the SSA. Presenter shared her personal experiences with MMH problems, her thoughts on the need for a maternal mental health policy in Nigeria. She discussed the burden of PMH disorders which are common in Nigeria, the risk and protective factors and how these factors are different for the vulnerable sub populations, especially as it concerns various regions of the country.

The Challenges and Opportunities for MMH in Nigeria: The Presenter discussed the challenges of MMH in Nigeria and the opportunities that we have to integrate MMH into existing health care policies based on existing evidence of effective strategies to promote MMH. Questions that were answered ranged from why it is imperative to have a functional MMH policy, how it fits into the existing health care framework and if its inclusion in the RH policy will improve quality of care.

The process of developing a MMH policy in Nigeria: In this presentation, stakeholders learned about the roadmap towards fitting the proposed MMH strategy into existing policies such as the RH policy. One of the lead Speakers; Prof Olumide highlighted the steps needed towards developing a MMH policy which included:

1) generating local evidence

2) Developing and evaluating intervention models

3) Strengthening health systems

4) Capacity development and networking of stakeholders

5) Development of a legal policy framework

6) Stigma reduction and awareness raising

7) Estimation of the financial and human resources to provide enhanced services on the necessary scale

8) Development of indicators to track changes

9) Support for organizations

10) Establishment of adequate funding

She highlighted the steps that will be involved in developing the strategy and relevant stakeholders that will be involved in the process. She emphasized the need to get the policy out quickly so that implementation and evaluation can begin in earnest.

Questions were raised on advocacy, the components of an effective MMH strategy, collaborations between all stakeholders, process of sharing responsibilities and indicators for monitoring and evaluation. A highly interactive session on how to move the process forward ensued.

Plenary

The group work was followed by a plenary to share the resolutions of the various brainstorming sessions. After each panel discussion, participants were encouraged to ask questions and comment on the discussions. The focus of the session was to clarify thoughts, engender robust discussions around the topic and reach consensus concerning recommendations.

The communique group gave a brief presentation on the resolutions of the meeting. This was ratified by the entire group.

The resolutions from the meeting are contained in the report by the communique group (Appendix IV) and include:

1. Maternal Mental Health services should be integrated into existing services and mainstreamed into Primary Health Care using the Basic Health Care Provision Fund (BHCPF) for effective implementation.

2. The Maternal Mental Health Policy should leverage the Task Shifting/Task Sharing Policy for capacity development and networking of stakeholders.

3. The National Health Management Information System (NHMIS) should include indicators on Maternal Mental Health and an M&E framework should be developed to drive decision-making and effective implementation.

4. Adequate funding provision for research on Maternal Mental Health must be a priority for goal setting.

5. There should be multi-sectoral collaboration during development of the policy to include key stakeholders, key and vulnerable populations.

6. The Policy should be extended along the continuum of care including Male engagement as it relates to Mental Health care.

7. The Policy should be internally aligned to global best practices.

8. Consideration should be given to the inclusion of other Reproductive Health matters in the Maternal Mental Health Policy.

CHALLENGES:

Mental health challenges are identified as the 2nd leading causes of disease burden in women in Nigeria. It affects function, the development and wellbeing of the child. Early detection, appropriate treatment, and improvement of social support to mother-child are critical in the management of the conditions. The Government and donor agencies need to provide requisite investment/funding for MMH interventions.

- The aftermath of urbanization is a challenge to MMH. The rural-urban exodus has eroded our seemingly intact family structure.
- Conflicting time of Stakeholders was a challenge, the meetings had to be rescheduled to ensure good attendance
- Insecurity - announcement of security threat in Abuja by international security outfits. Some participants could not attend because of security concerns around travelling by road (and the flight option was unavailable).
- Opportunities identified include the interconnectedness of physical and mental health. This can be leveraged on to strengthens and integrate MMH into the existing RH policies. Task Shifting and Task Sharing policies are opportunities which can be enhanced through the training of community and primary care personnel to be able to identify and intervene early, and to adapt the intervention to the local context.

RECOMMENDATIONS*:*

- A clear plan of roles and responsibilities between all stakeholders towards the inclusion of the MMH strategy into the revised reproductive health policy.
- The need to include a viable research component so that implementation strategy is based on evidence of what has worked
- A follow- up meetings to draw up a draft of the MMH strategy should be arranged.

- It would be helpful to have a printed workshop report to document these activities.

CONCLUSION

MMH is a common health condition in pregnancy. There are gaps in awareness and management of the conditions. There is a need to integrate MMH into the Reproductive Health Policy. More funding, Service integration into the existing PHC services by leveraging on BHCPF, Task Shifting/ Task Sharing and inclusion in the indicators on NHMIS are critical.

References

Adewuya, A. O. & Afolabi, O. T. (2005) The course of anxiety and depressive symptoms in Nigerian postpartum women. Archives of Women's Mental Health, 8, 257–259.

Adewuya, A. O. (2006) Early postpartum mood as a risk factor for postnatal depression in Nigerian women. American Journal of Psychiatry, 163, 1435–1437.

Adewuya, A. O., Eegunranti, B. A. & Lawal, A. M. (2005) Prevalence of postnatal depression in western Nigerian women: a controlled study. International Journal of Psychiatry in Clinical Practice, 9, 60–64.

Adewuya, A. O., Ola, B. A., Aloba, O. O., et al (2006a) Prevalence and correlates of depression in late pregnancy among Nigerian women. Depression and Anxiety, 14, 15–21.

Adewuya, A. O., Ola, B. A., Aloba, O. O., et al (2006b) anxiety disorders among Nigerian women in late pregnancy: a controlled study. Archives of Women's Mental Health, 9, 325–328.

Bibilola D. Oladeji, Toyin Bello, Lola Kola, Ricardo Araya, Phyllis Zelkowitz and Oye Gureje (2019). Exploring Differences Between Adolescents and Adults with Perinatal Depression—Data from the Expanding Care for Perinatal Women with Depression Trial in Nigeria. Frontiers in Psychiatry. doi: 10.3389/fpsyt.2019.00761

Clarke K, King M, Prost A (2013). Psychosocial Interventions for Perinatal Common Mental Disorders Delivered by Providers Who Are Not Mental Health Specialists in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. PLoS Med 10(10): e1001541. doi:10.1371/journal.pmed.1001541

Craig MC (2013). Should psychiatrists be prescribing oestrogen therapy to their female patients? Br J Psychiatry, 202: 9–13.

Engle PL (2009). Maternal mental health: program and policy implications. Am J Clin Nutr, 89:963S–6S. doi: http://dx.doi.org/10.3945/ajcn.2008.26692G PMID:19176734

Fisher J, Cabral de Mello M, Patel V, et al (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. Bull World Health Organ, 90: 139G–49G.

Fisher J, Cabral de Mello M, Patel V, Rahman A, Tran T, Holton S et al (2012). Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. Bull World Health Organ, 90:139G–49G. doi: http://dx.doi.org/10.2471/BLT.11.091850 PMID:22423165

Forty L, Jones L, Macgregor S, et al (2006). Familiality of postpartum depression in unipolar disorder: results of a family study. Am J Psychiatry, 163: 1549–53.

Gelaye, B., Rondon, M. B., Araya, R., & Williams, M. A. (2016). Epidemiology of maternal depression, risk factors, and child outcomes in low-income and middle-income countries. The Lancet Psychiatry, 3(10), 973-982.

Gureje, O., Oladeji, B. D., Kola, L., Bello, T., Ayinde, O., Faregh, N., ... & Zelkowitz, P. (2022). Effect of intervention delivered by frontline maternal care providers to improve outcome and parenting skills among adolescents with perinatal depression in Nigeria (the RAPiD study): A cluster randomized controlled trial. Journal of Affective Disorders, 312, 169-176.

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. The Lancet, 384(9956), 1775-1788.

McNab, S. E., Dryer, S. L., Fitzgerald, L., Gomez, P., Bhatti, A. M., Kenyi, E., ... & Stalls, S. (2022). The silent burden: a landscape analysis of common perinatal mental disorders in low-and middle-income countries. BMC pregnancy and childbirth, 22(1), 1-14.

NICE (2014). Clinical guideline: Antenatal and postnatal mental health: clinical management and service guidance. www.nice.org.uk/guidance/cg192

Parsons CE, Young KS, Rochat TJ, Kringelbach ML, Stein A (2012). Postnatal depression and its effects on child development: a review of evidence from low- and middle-income countries. Br Med Bull, 101: 57–79.

Patel V, DeSouza N, Rodrigues M (2003). Postnatal depression and infant growth and development in low-income countries: a cohort study from Goa, India. Arch Dis Child, 88:34–7. doi: http://dx.doi.org/10.1136/adc.88.1.34 PMID:12495957

Rahman A, Fisher J, Bower P, Luchters T, Tran T, Yasamy T, Saxena S & Waheed W (2013). Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis. Bull World Health Organ, 91:593–601I | doi: http://dx.doi.org/10.2471/BLT.12.109819

Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R (2004). Impact of maternal depression on infant nutritional status and illness: a cohort study. Arch Gen Psychiatry, 61:946–52. doi: http://dx.doi.org/10.1001/archpsyc.61.9.946 PMID:15351773

Royal College of Obstretrics and gynaecology (2011). Good Practice No.14. Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period.

Stewart RC (2007). Maternal depression and infant growth: a review of recent evidence. Matern Child Nutr, 3:94–107. doi: http://dx.doi.org/10.1111/j.1740-8709.2007.00088.x PMID:17355442

Wisner KL, Sit DK, McShea MC, et al (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. JAMA Psychiatry, 70: 490–98.

Social determinants of mental health. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/handle/10665/112828).

Maternal mental health and child health and development in low- and middle-income countries. Geneva: *World Health Organization; 2008 (https://apps.who.int/iris/bitstream/handle/10665/43975/9789241597142_eng.pdf).*

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Appendix 1: Group reports

Group 1: Rationale for a MMH Policy in Nigeria

Common perinatal mental health problems/disorders in Nigeria include: Sleep problems, depression, anxiety and body image problems.

Common PMHDs may affect the physical health of mothers through poor medication adherence or poor compliance with doctor's instructions, seeking help from unorthodox places and deepening poverty through decreased income and/or productivity.

Child survival is dependent on many factors including the mental state of the mother. Evidence abounds that PMHDs may lead to low Birth Weight, preterm delivery, malnutrition, decreased attachment and bonding with the mother, emotional problems, etc.

Some common risk factors for Nigeria include: young single mothers, low level of education, unemployment, absence of supportive partner, obstetric complications, health problems in mother, presence of disability in the child.

Some common protective factors for Nigeria include: having a supportive partner, social support and cohesion, being educated and/or employed, etc.

There is a lot of diversity in the risk factors within the country based on regions and also on some sub populations. Religious and cultural practices differ across locations, which may be a risk or protective factor. For example, in northern Nigeria, it is not uncommon for the new mother to have the delivery and be nursed back to health in her parents' house. This practise where the mother and baby are kept in a room designed for rooming-in may facilitate attachment and bonding between mother and child and may help in early detection and management of perinatal mental illnesses.

Sub populations that are more vulnerable to developing PMHDs include: teenage pregnancy, elderly primigravida, displaced women living in IDP camps.

Recommendations:

1. We recommend that further research has to be commissioned to adequately determine the magnitude of the problem. This will help in allocation of resources to problems which carry the highest burden.
2. We recommend that mental health screening should be integrated into routine maternal health care.
3. Maternal mental health should be looked at from the prism of maternal mental health promotion and education and not only about prevention and management.

Group 2: challenges and opportunities for a MMH Policy in Nigeria

Some of the challenges and barriers mentioned included:

A lack of implementation strategy outlined for the policy integrating MH into PHC, dwindling human resource for health in PHC

Majority of staff at PHC level are volunteers who are highly mobile

No updates in mental health knowledge for most professionals after the statutory training

A systemic lack of attention to & poor financing for mental health (no budget for mental in PHC)

Postnatal clinics relegated to interns who are too busy to screen for mental disorders

Stigma & lack of public awareness of maternal mental health issues

Absent MMH indicators on the HMIS tool

Some of the opportunities highlighted included:

Mental health can be integrated into all existing programmes in PHC through the FMoH (policy development, raising awareness, etc)

Some interventions that have already been tried in Lagos are the problem-solving treatment and the thinking healthy programme.

Also, by leveraging on every service point that a woman passes through within the health care setting and the funding for the various programmes at these service points

Partnership with traditional and faith-based healers

Include capacity building and research in planning the MMH strategy

Include M and E framework for maternal mental health

Group 3: Process of developing a MMH Policy in Nigeria

Vital components of an effective MMH strategy outlined included:

- Integration with existing services and policies
- Inclusivity: including men and vulnerable sub populations

Clarity of objectives:

- Specify the various agencies and their roles in implementation
- Implementation plan and M and E framework
- This policy should be aligned to global best practices
- The policy development process should be built on research
- An immediate dissemination plan is needed for immediate action
- Some of the essential indicators for monitoring and evaluation highlighted included:
- Number of people reached
- Number of townhall meetings for community engagement
- A review of existing policies and documents
- Level of service uptake
- Prevalence of MH problems
- Number of Healthcare workers trained
- How many states have domesticated the policy
- Adoption of policy by private institutions

On dealing with insecurity, dwindling health force and rising poverty, the group thought that it would be helpful to:

- Have a strategy that is dedicated to vulnerable sub population, for example, people in IDP settings.
- Address poverty through skill acquisition, income generation, empowerment schemes, again, leveraging on already existing structures
- Support groups for women – this helps with mental health and finance
- Task shifting and sharing (use existing staff: community pharmacists, PPMV's, etc)
- Continuous training for all cadres of staff, especially at the PHC level.
- Financing and advocacy plan must be built into the strategy.

Appendix II: Communique

A COMMUNIQUE ISSUED AT THE END OF A ONE-DAY NATIONAL DIALOGUE ON THE DEVELOPMENT OF A MATERNAL MENTAL HEALTH POLICY FOR NIGERIA HELD ON THE 10TH OF NOVEMBER 2022 AT IMMACULATE SUITES, PLOT 110 ADEMOLA ADETOKUNBO CRESCENT, WUSE 2, ABUJA

Preamble:

The Federal Ministry of Health in collaboration with Align MNH and MCGL QoC organized a one-day national dialogue on the development of a maternal mental health policy for Nigeria. In Nigeria, the prevalence of perinatal depression ranges from 8-28%. The World Health Organization (WHO) defines maternal mental health (MMH) as "a state of well-being in which a mother realises her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community". Perinatal Common Mental Disorders (PCMDs) are a leading cause of years lived with disability in women of childbearing age and are associated with substantial human and economic costs. Maternal mental health problems are detrimental to a woman's health; having been linked to reduced sensitivity and responsiveness in caregiving and higher rates of behavioural problems in young children.

The main objectives of the meeting were to set the agenda for discussions with stakeholders on the emerging issues on maternal mental health; forge collaborative connections among stakeholders to birth the process for MMH strategy; and develop a detailed plan of action for moving the MMH strategy forward.

Sixty (60) participants cutting across the government Ministries, Department and Agencies (MDAs), Medical Experts, Implementing Partners, Civil Society Organizations, Media and relevant State Government representatives formed the attendance at this parley.

The resolutions arrived at during the dialogue are that:

1. Maternal Mental Health services should be integrated into existing services and mainstreamed into Primary Health Care using the Basic Health Care Provision Fund (BHCPF) for effective implementation.

2. The Maternal Mental Health Policy should leverage the Task Shifting/Task Sharing Policy for capacity development and networking of stakeholders.

3. The National Health Management Information System (NHMIS) should include indicators on Maternal Mental Health and an M&E framework should be developed to drive decision-making and effective implementation.

4. Adequate funding provision for research on Maternal Mental Health must be a priority for goal setting.

5. There should be multi-sectoral collaboration during development of the policy to include key stakeholders, key and vulnerable populations.

6. The Policy should be extended along the continuum of care including Male engagement as it relates to Mental Health care.

7. The Policy should be internally aligned to global best practices.

8. Consideration should be given to the inclusion of other Reproductive Health matters in the Maternal Mental Health Policy.

Appendix III: list of participants

ATTENDANCE MATERNAL MENTAL HEALTH ROUND TABLE EVENT - 10TH NOVEMBER 2022

S/N	NAME	GENDER	DESIGNATION	ORGANIZATION	EMAIL	PHONE NUMBER
1	Abubakar Fatima Makun	Female	Safe Motherhood and MCH Coordinator	NSPHCDA	Fatimaabubakar09@gmail.com	08127215323
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Agenda

National Dialogue Event on Maternal Mental Health Policy for Nigeria

Date: 10th November 2022
Venue: Immaculate Suites, Plot 110 Ademola Adetokunbo Crescent, Wuse 2, Abuja.
Time: 9 AM

Time	Session	Facilitator
9:00-10:00	Opening	
	• Registration	Secretariat
	• National Anthem	All
	• Introduction of Guests	FMoH
	• Welcome	Mrs Tinuola Taylor, HRH, FMoH
	• Goodwill messages	-USAID Rep -WHO Rep -UNICEF Rep -UNFPA Rep -Dr Oniyire Adetiloye, Country Director, Jhpiego
	• Opening remarks	Dr Salma Anas Ibrahim DFH, FMOH
Panel discussions		
10:00-10:20	• Overview of Mental Health Policy in Nigeria	Dr Tunde Ojo NC, MHD,DPH,FMOH
10:20-10:40	• The Rationale for a Maternal Mental Health Policy in Nigeria	Dr Aishat Abubakar
10:40-11:00	• The Challenges and Opportunities for MMH in Nigeria	Prof Abiodun Adewuya
11.00 – 11.20	• Developing a MMH Policy in Nigeria	Prof Adesola Olumide
11.20- 11.40	Questions and Answers	All Participants
Tea break (20 minutes)		
Group work		
12:00-1:00	• Split into 3 groups	Dr Boladale Mapayi - Facilitator
Plenary session		
1:00-1.30	• Report/Feedback from each group	Dr. Boladale Mapayi - Facilitator
1.30 – 2.00	• Communique Presentation	Communique Group
Closing		
2.00-2.30	• Next Steps	Dr. Samuel Oyeniyi – Head Safe Motherhood, FMoH
	• Closing remarks	Dr. Samuel Oyeniyi -Head Safe Motherhood, FMoH
Lunch		