

Collaborating for Maternal Mental Wellbeing in Crises

TECHNICAL BRIEF ON PERINATAL MENTAL HEALTH IN
HUMANITARIAN SETTINGS



Inter-Agency Working Group on
Reproductive Health in Crises

TABLE OF CONTENTS

| | |
|---|----|
| I. Abbreviations | 3 |
| II. Introduction | 4 |
| III. MHPSS in Humanitarian Responses | 6 |
| II. Perinatal Mental Health Overview | 7 |
| III. Select Resources and Networks | 9 |
| IV. Suggestions to Improve Collaboration and Provision of Perinatal Mental Health | 12 |
| V. Examples of Service Delivery Collaboration | 15 |
| VI. Call to Action | 16 |
| VII. Annex | 17 |
| A. Toolkits/Resources | 17 |
| B. Learning Platforms | 17 |
| VIII. References | 18 |

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ACRONYM LIST

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| CPMD | Common perinatal mental disorders |
| EPDS | Edinburgh Postnatal Depression Scale |
| GBV | Gender-based violence |
| HIC | High income country |
| IADL | Independent activity of daily living |
| IASC | Inter-Agency Standing Committee |
| IAWG | Inter-Agency Working Group on Reproductive Health in Crises |
| IPV | Intimate partner violence |
| LMIC | Low- and middle-income country |
| mhGAP | Mental Health Gap Action Program |
| MHPSS | Mental health and psychosocial support |
| MMH | Maternal mental health |
| MNH | Maternal and newborn health |
| PMH | Perinatal mental health |
| PTSD | Post-traumatic stress disorder |
| RCT | Randomized controlled trial |
| SRH | Sexual and reproductive health |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations International Children’s Emergency Fund |
| WHO | World Health Organization |

LANGUAGE CLARIFICATION

Mental health: A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, work well, and contribute to their community. ([WHO](#))

Psychosocial wellbeing: Psychosocial well-being is a multidimensional construct consisting of psychological, social, and subjective components which influence the overall functionality of individuals in achieving their true potentials as members of the society. Psychosocial well-being incorporates the physical, economic, social, mental, emotional, cultural, and spiritual determinants of health. Well-being of an individual includes coping with the various stresses of everyday living and realization of the full potential of an individual as a productive member of the society. ([ENUNSDG](#))

Mental health and psychosocial support (MHPSS): A composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat a mental disorder. ([IASC](#))

Common Perinatal Mental Disorders (CPMD): Mental disorders experienced in the perinatal period, most commonly including depression, anxiety, and somatic disorders.

Perinatal period: Period of pregnancy extending up to one year postpartum, unless otherwise specified.

*** Transgender and gender nonbinary inclusion:** This brief recognizes that sexual and reproductive rights are not restricted to cisgender women and includes all individuals who are capable of pregnancy or are assigned female at birth (AFAB).

INTRODUCTION

Mental health and psychosocial support (MHPSS) during the perinatal period is a global issue. This period is characterized by high risk of depression, anxiety, and somatic disorders - often referred to as common perinatal mental disorders (CPMDs) - with one in six pregnant women and one in five postpartum women impacted by a mental health and psychosocial concern during pregnancy or in the first postnatal year.¹ In humanitarian settings, these risks are often amplified by adversity and destabilizing factors including political instability, violence, loss, poverty, and migration. While MHPSS needs occur throughout the life course, the focus of this brief will be the perinatal period, as during this time, these illnesses can have severe, and even intergenerational effects, on maternal and newborn health (MNH) and development. The perinatal period is also a critical time when women are more frequently interfacing with health staff, allowing for more timely identification of mental health and psychosocial concerns and referral for appropriate support.



This brief aims to provide an overview of MHPSS perinatal mental health in emergency response, and then present relevant resources and networks for each, and culminate with suggestions for improving collaboration and provision of perinatal mental health, examples of service delivery collaboration, and then a call to action to progress momentum for perinatal mental health.

Countries with a 2023 UN Humanitarian Appeal contribute to 64% of maternal deaths, 50% of newborn deaths, and 51% of stillbirths.² Perinatal mental health plays a role in determining the outcomes of pregnancy and childbirth, but is often under-recognized in humanitarian settings where the need for context-appropriate, high-quality perinatal mental health treatment is essential.

Recently, the importance of integrated MNH and MHPSS services has gained global attention, particularly in humanitarian and fragile settings. In 2021, one of WHO's research priorities was integrating MHPSS into sexual and reproductive health in humanitarian settings (SRH).³ Similarly, both the Inter-Agency Standing Committee (IASC) and UNHCR have called for humanitarian responses to consider the psychological and physical wellbeing of mothers and their infants through improved collaboration across and between program staff and providers.

In looking to advance these calls to action, this brief aims to accomplish three key objectives:

- **Provide an overview of MNH and MHPSS guidelines, resources, and tools in humanitarian contexts to identify areas of overlap and potential points of integration;**
- **Identify existing gaps and needs for MHPSS guidance and tools for the care of women during the perinatal period in humanitarian and fragile settings; and,**
- **Highlight the need for integrated service delivery and referral opportunities between MNH and MHPSS in humanitarian settings.**

The intended target audiences for this brief are MNH and MHPSS program staff, providers, community health workers, and advisors involved in the design and delivery of MNH and MHPSS services within humanitarian and fragile settings. This brief is primarily focused on health actors with relevant learning and resources for additional key actors providing MHPSS services (e.g., protection, education, ECD, etc.).

BOX 1: PERINATAL MENTAL HEALTH AND NEWBORN HEALTH

The wellbeing of the newborn is inextricably tied to the mental and physical wellbeing of the mother throughout pregnancy and the postpartum period.⁴ Depression and stress in pregnancy can cause changes that are genetically passed on to future generations, providing a physiological explanation for the intergenerational impact of trauma on CPMDs.^{5,6} These trauma-related consequences can negatively affect child outcomes and development, with effects persisting throughout the life course. Studies have shown poor perinatal mental health is associated with:⁷

- Low birthweight, preterm birth, early cessation of breastfeeding, maternal-infant bonding, neonatal mortality, underweight or stunted children, and increased episodes of diarrhea and infections in infants.^{8,9,10,11,12,13,14,15,16,17,18,19,20,21}
- Decreased development in young children in cognition, language, fine and gross motor development, and behavioral and emotional difficulties. Decreased head circumference, biparietal diameter, abdominal circumference and estimated fetal weight on ultrasound measurements, growth restrictions were reported to persist as newborns.^{22,23,24,25,26,27,28,29,30}

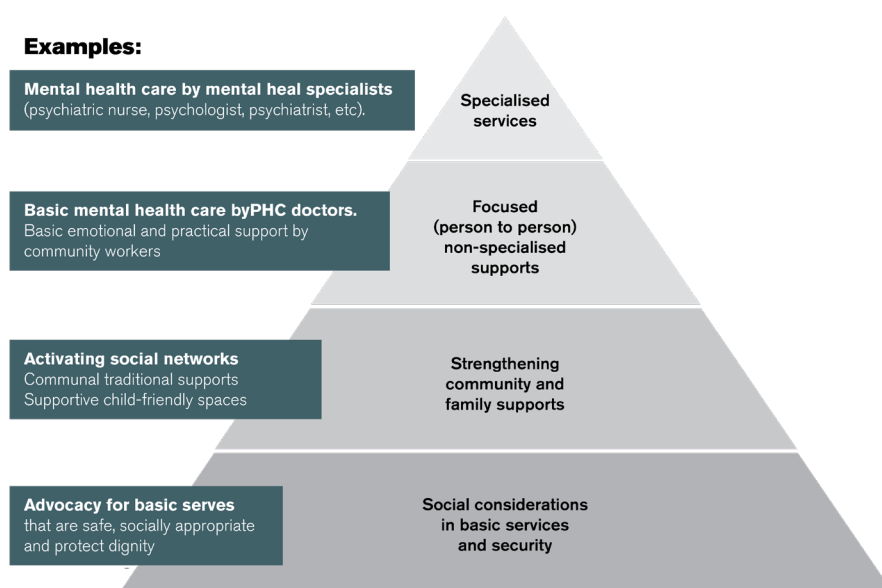
MHPSS IN HUMANITARIAN RESPONSES

MHPSS is a multisectoral and cross-cutting area of work with relevance for the Health, Protection (including Child Protection (CP), Gender-Based Violence (GBV) and Mine Action), Education, Nutrition, sectors/clusters/Areas of Responsibility (AORs) in all emergencies and beyond. International organizations have recognized the need for MHPSS services at all levels of the health system. The IASC published MHPSS guidelines in 2007, establishing minimum common functions to be put in place in the midst of emergencies. In 2008, WHO launched [Mental Health Gap Action Programme \(mhGAP\)](#) which aims to provide health planners, policy-makers, and donors with a set of clear and coherent activities and programs for scaling up care for mental, neurological and substance-use disorders. The combination of the [The mhGAP Humanitarian Intervention Guide \(mhGAP-HIG\)](#) released in 2015 and the [mhGAP Operations Manual](#) in 2018 provided guidance on the clinical management of MHPSS and delivery of evidence-based mhGAP procedures and recommendations specific to humanitarian settings. These guides emphasize that through task-sharing, non-MHPSS actors can be trained and supported to respond at the community level to improve the MHPSS outcomes of their community. However, despite these strong foundations, current guidelines have limitations and gaps in addressing how health actors can appropriately provide MNH and MHPSS services for the care of women during the perinatal period in humanitarian and fragile settings. For example, the [IASC guidelines](#) (2007) do not mention pregnancy or postpartum. Recognizing this gap, recent global guidelines, and resources such as the [IASC MHPSS Minimum Service Package](#) (2022), seek to address key gaps for all humanitarian actors providing MHPSS services, yet more work is needed in this space.

The implementation of the mhGAP Guides contribute to the [WHO Comprehensive Mental Health Action Plan 2013-2030](#) to scale up mental health services and integrate them into non-specialized health settings. The action plan centers around a life course and multi-sectoral approach to equitable and universal mental health coverage through more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research.

When defining what a systems-wide approach may look like, the intervention pyramid (Figure 1), developed by the IASC, offers a helpful and widely endorsed visualization of the continuum of support. This diagram highlights that basic services will benefit the largest number of people, with the reach becoming narrower with each incremental level of specialization. The pyramid requires context-specific considerations, particularly with the disruption of available services and resources (such as in humanitarian settings). Interventions at each layer must also be acutely aware of stigma, discrimination, and power dynamics that might affect the protection of vulnerable groups, including women and children.

Figure 1: IASC MHPSS Intervention Pyramid



PERINATAL MENTAL HEALTH OVERVIEW

The perinatal period, defined here as pregnancy and up to one year postpartum, is an acute phase when women and girls may experience a new onset of mental health and psychosocial concerns, or a re-occurrence or exacerbation of prior mental distress or disorder.³¹ It is widely recognized that there are psychological risk factors for poor mental health in pregnancy.³² This has also been associated with decreased maternal nutrition, fewer antenatal care visits, poor hygiene, pre-eclampsia, low birthweight, preterm delivery, postpartum depression, substance misuse disorders, suicide, and difficulties with independent activities of daily living.^{33,34,35}

Globally, CPMDs are more commonly studied and experienced than other mental health disorders.³⁶ A systematic meta-analysis of over 100 studies in LMICs, many of which are considered fragile or humanitarian settings, reported a 25.3% prevalence of antenatal depression and a 19.0% prevalence of postpartum depression.³⁷ Psychiatric disorders in the perinatal period further include post-traumatic stress disorder (PTSD)³⁸, bipolar disorder, and affective psychosis³⁹, although there are gaps in the literature exploring their prevalence in humanitarian settings.

BOX 2: MMH & GBV IN HUMANITARIAN SETTINGS

CPMDs have a strong association with psychological, physical, and sexual violence, particularly if the exposure was close to, or during, the perinatal period.⁴⁵ A mixed methods systematic review reported that the prevalence of past-year intimate partner violence (IPV) was 19-32% in LMICs compared with 3-6% in high income countries (HICs), with conflict-affected countries among the highest reported rates.⁴⁶ Pregnant adolescents and girls forced into child marriage face even greater vulnerability to harmful and imbalanced power dynamics which have shown to double the odds of experiencing physical and/or sexual IPV.⁴⁷ These findings underline the need for comprehensive maternal healthcare throughout pregnancy, delivery, and postpartum that prioritizes context-specific care. The integration of intentional gender analyses into CPMD program implementation allows for a humanitarian response that protects and supports survivors and their children. While the critical connection between GBV and MHPSS is not the direct topic of this brief, more resources can be found in the training manual: *Mental Health and Gender-Based Violence – Helping Survivors of Sexual Violence in Conflict*.⁴⁸

Women in humanitarian settings experience poorer mental health outcomes due to compounded stress and crisis-related factors including nutritional deficiencies, lack of protection and autonomy, GBV, decreased access to family planning services, separation from social support, and lack of access to MHPSS services.⁴⁰ Pregnant and postpartum women and girls in humanitarian and fragile settings are also at elevated risk of depression and thoughts of self-harm and suicide.⁴¹ The high prevalence of suicidal ideation, even amongst those without a history of mental health issues, highlights the need for concurrent development of screening programs and appropriate referral services for pregnant women. Pregnant adolescents in humanitarian and fragile settings may face additional challenges including a lack of agency in decision-making, limited access to care, and limited knowledge of potential risks accompanying childbirth, all of which exacerbate the potential for common mental disorders.^{42,43}

These risks have only worsened in the context of COVID-19 as health systems are at or over capacity, with a disproportionate impact on MNH outcomes in LMICs and settings with limited resources.⁴⁴ This reality highlights the need to protect and monitor mother-infant health, particularly in countries affected by protracted humanitarian crises.

The perinatal period is recognized as a critical time for MNH intervention by several global strategies including the [Global Strategy for Women's, Children's, and Adolescents' Health, Strategies toward Ending Preventable Maternal Mortality](#), and the [Every Newborn Action Plan](#). Recent evidence-based guidelines outline how to deliver preventative and curative essential health services with multiple contact points during pregnancy and postpartum phases.

- [The WHO Recommendations on Maternal and Newborn Care for Positive Postnatal Experience](#) (2022) is a consolidated guideline that provides 63 recommendations for essential, routine, and dignified postnatal care. In this guide, a minimum of 4 postnatal care contacts are recommended.
- Most importantly, the [WHO Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services](#) (2022) provides evidence-based recommendations on how to integrate mental health care into routine maternal and child health services, and offers guidance on the identification, assessment, and management of perinatal mental health disorders, as well as on providing psychosocial support for women and their families.



Photo source: Kelli Ryan, IRC

SELECT RESOURCES AND NETWORKS - MNH and MHPSS in Emergencies

This section outlines key resources for MNH and MHPSS actors to utilize in emergency responses. Integrated guidance and a strong evidence base for best practices are lacking, but by improving cross-knowledge of foundational resources from both MNH and MHPSS separately, actors may be better able to identify promising practices and ultimately opportunities for sustaining integrated services. These platforms, initiatives, and resources provide a start for raising awareness, knowledge sharing, and operational support:

Humanitarian Response Cluster System: The cluster approach was introduced in 2005 to improve humanitarian coordination. The clusters are broken up into the main sectors of humanitarian action, e.g., water, health, logistics, etc. The clusters exist at a global level and also set up national level groups in each respective response. The clusters are made up of NGOs, INGOs, and UN Agencies engaged in humanitarian crises.

- **Global Health Cluster (GHC):** The health clusters (both global and national) exist to relieve suffering and save lives in humanitarian emergencies. In previous responses the GHC has assigned specific organizations to lead MHPSS services, for example International Medical Corps co-led the MHPSS sub-cluster in Iraq with the national GHC. Additionally, there is a **Global Health Cluster SRH Task Team** and typically a reproductive health working group led by UNFPA or others at a national level in each response.
- **Global Protection Cluster (GPC):** The GPC unites members, partners and communities to work on the four specialized areas of responsibility: child protection, GBV, housing, land and property, and mine action. The GPC notes that no single cluster is responsible for or accountable for MHPSS on their own, but rather it is a shared responsibility of multiple clusters and agencies.
- **Health and Protection Joint Operational Framework (2023):** This framework serves as an entry point to improve strategic and operational ways of working for health and protection actors before, during, and after an emergency. It serves as a strategic and operational tool for cluster partners, the Inter-Cluster Coordination Group (ICCG), and the Humanitarian Country Team (HCT).

Inter-Agency Working Group on Reproductive Health Crises (IAWG): IAWG is a global network of organizations and experts working to address the specific needs of women, girls, and newborns in humanitarian contexts. All sub-working groups offer tools and guidance to be used by providers, responders, and coordinators in crisis settings.

- The MNH sub-working group aims to create connections between MNH and MHPSS actors in these settings, elevate resources and best practices, and support MNH/MHPSS integration where appropriate.



- The [Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings \(IAFM\)](#), developed in 1999 and updated by IAWG in 2018, is a comprehensive field manual that uses a multisectoral integrated approach – involving sectors including health, nutrition, protection, and community services – to provide guidance on SRH programming rooted in human rights, respect, and equitable resource stewardship. It includes The [Minimum Initial Services Package \(MISP\) for SRH in Crisis Situations](#) (life-saving SRH requirements that are critical at the onset of a humanitarian emergency) as well as guidance on transitioning to more comprehensive SRH programming as soon as conditions allow.
- The [Newborn Health in Humanitarian Settings: Field Guide \(NBFG\)](#) also exists to improve care and outcomes for newborns.⁴⁹

Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings (2020-2024): This multi-sectoral five-year strategy identifies nine key actions for the global community to achieve in order to strengthen newborn health in humanitarian settings. Within the strategy are calls to promote maternal MHPSS through the development of appropriate referral protocols together with a non-clinical approach (such as women’s support groups), and to prioritize pregnant and breastfeeding women for psychosocial support services by instituting MHPSS screenings during routine care.

MHPSS Minimum Service Package: The MHPSS MSP, created by WHO and UNICEF, is an interactive digital guide that includes tools, consideration, and recommendations for implementing high-priority MHPSS activities in a response. The MHPSS MSP is a resource for humanitarian actors working across health, education, protection (inclusive of child protection, GBV, min-action), nutrition, and beyond.

- Key MHPSS program activities supporting women and girls include but are not limited to: (a) promote caregivers’ mental health and psychosocial well-being and strengthen their capacity to support children, (b) provide MHPSS as a part of clinical care for survivors of sexual violence and IPV, (c) provide MHPSS through case management services, (d) support new and pre-existing group-based community MHPSS activities; (e) provide MHPSS through safe spaces for women and girls.

The Silent Burden: Understanding Perinatal Mental Disorders in Low- and Middle-Income Countries (2021-2022)

- **Landscape analysis** – A scoping literature review was conducted to explore CPMDs, including an analysis of existing interventions and barriers to their implementation. Core elements of successful community- and health facility-level CPMD programs included detailed needs assessments, respectful maternity care, and supportive task-sharing models.
- **Global call to action**– This document proposed 7 urgent actions to increase access to high-quality and respectful physical and mental perinatal wellbeing. These include establishing global standards for perinatal mental health integration, clear and explicit national policies, and budgetary allocations, SRH integration, strengthened implementation research, task-sharing models, social determinant-based interventions, and the reduction of stigma and shame as a barrier to care-seeking.
- **A Shared Vision for Improving Perinatal Mental Health in LMICs: A Theory of Change and Prioritized Implementation Research Questions** – This framework was developed to align and guide perinatal mental health actors and provide a global vision for programming. A social ecological model was used to identify interventions, outcomes, and impact at the individual, interpersonal, community, service delivery, and policy levels. Illustrative journey maps were also developed to

describe the experiences of women in pre-pregnancy, pregnancy, childbirth, and postpartum periods. While these resources are focused in LMIC contexts, humanitarian settings are mentioned as a gap needing to be further addressed.

Resources also exist for delivering MHPSS through early childhood development (ECD):

- **The MHPSS MSP** includes a comprehensive list of over 60 relevant guidelines, standards and tools for early childhood development (ECD) activities to support young children and their caregivers; resources are available in multiple languages.
- **The Nurturing Care Framework** builds upon state-of-the art evidence of how child development is influenced and the effective policies and interventions that can improve early childhood development. The Framework was developed to provide a roadmap for ensuring attainment of the SDGs and goals of the Global Strategy on Women's, Children's and Adolescents' Health. The Nurturing Care Framework intersects with maternal mental health, and MHPSS more broadly, in all four of its domains.
 - *Good health*: an inextricable link between children's physical and emotional wellbeing to maternal mental health and wellbeing.
 - *Safety and security*: Safe family and play spaces as MHPSS programming.
 - *Adequate nutrition*: breastfeeding abilities and complementary nutrition, food security.
 - *Opportunities for learning*: provider support for learning opportunities, childcare and counseling.
 - *Responsive caregiving*: caregiver mental health's connection to social and community support.



SUGGESTIONS TO IMPROVE COLLABORATION AND PROVISION OF PERINATAL MENTAL HEALTH

Proposed below are suggestions on how to promote multi-sectoral and collaborative approaches to sustainable and effective perinatal mental health programming. The following suggestions are recommendations from both MNH and MHPSS experts solicited by the IAWG Maternal and Newborn Health Sub-working Group.

FOR MNH ACTORS IN HUMANITARIAN RESPONSE

- **Healthcare providers and teams should review recommended training and supportive supervision approaches from the MHPSS community to decide which approaches are best for implementation in their context.** Some training curriculums or intervention models to consider for providers, depending on their context, are survivor-centered approach, do no harm, strengths-based approach, feminist principles, disability and inclusion, and trauma-informed care. While MNH actors are not required to be experts in all of these topics, they may be helpful depending on the context-specific needs.
 - Train all facility-level providers on basic MHPSS skills, inclusive of Psychological First Aid (PFA). PFA covers general techniques in identifying and referring someone in acute distress to MHPSS.
 - Train community-based providers in psychosocial support approaches. For example, [Thinking Healthy](#), is an evidence-based approach guided by mhGAP-IG recommendations, designed to be delivered by community health workers. Based in cognitive behavioral theory, it consists of structured counseling sessions that aim to address perinatal depression.
 - Trauma-informed care training focuses on working with individuals who have experienced trauma in a way that is compassionate and reduces the risk of re-triggering the client. This survivor-centered approach recognizes the ways that trauma can impact an individual's wellbeing and their day-to-day life.

- **Operational considerations in the provision of training programs**
 - Services should meet the unique needs of each client depending on their lived experiences and concerns. Training programs might not necessarily be long, but may require intensive follow-up and supportive supervision throughout the program duration.
- **For safety planning procedures in emergencies**
 - **Safety preparation is essential in all mental health services, particularly in conflict-affected settings.**⁵⁰ It is critical to have a safety plan in place for those at risk of harming themselves or others. Providers should read and understand the safety planning procedures in place at their organization or facility. If none exists, this is an opportunity to collaborate and discuss with MHPSS colleagues to develop one.
 - Safety procedures often include a context-appropriate safety protocol linked with mental health services involving topics including suicide, IPV, and child abuse.
 - Training may include how to assess risk, identify warning signs, implement immediate safety techniques, and move through the referral pathway.

FOR MHPSS ACTORS IN HUMANITARIAN RESPONSE

- **Operational considerations to improve comprehensive care**
 - **Connect women in the perinatal period to MNH programs.** Early identification of high-risk pregnant and postpartum women, and their newborns will strengthen the referral process. MHPSS actors should know what MNH resources, facilities, and programs are available at their organization/facility and in the community writ large. This may also include identifying safe spaces for women, infants, and young children.
 - Providers should understand how women articulate poor mental health in their contexts, both through translation services and a cultural sensitivity of how poor mental health and its manifestations are described locally.
 - **Provide support and screening for all pregnant and postpartum women in conflict-affected settings.** A universal approach to mental health and wellbeing should be implemented that provides care to all women and their children regardless of their diagnostic criteria.
 - Accountable referral pathways must exist that link to services that provide person-centered, culturally sensitive, and dignified care. Referring individuals to services that do not provide appropriate care can lead to inadequate treatment, stigma, and discrimination. We recognize that this goal may be difficult in a limited-resource environment, but, when possible, screening made in conjunction with referrals to person-centered services should be provided for all pregnant and postpartum women.
 - **Learn about GBV in conflict-affected settings and develop linkages with specialists.** MHPSS actors should understand the associations between GBV, protection, and perinatal health to provide care that focuses on context-specific risk factors related to both MNH and MHPSS. For resources, see Box #2,

FOR MULTI-SECTORAL COLLABORATION

- **Collaboration between sectors first requires an understanding of what services and programs exist.** Referral services can be mapped to identify key cross-sector links including MNH, MHPSS, GBV, protection, and child protection.
- **Task-sharing through the provision of services from non-specialists.** With appropriate supervision, community health workers and peer supporters can be trained in interventions such as talk therapy to promote maternal and child health outcomes.⁵¹ This approach can address a shortage of human resources, while also scaling up existing mental health services and programming.
- **Conduct context assessments to tailor programming and interventions.** MHPSS support can be complementary not only to MNH but also other linked MNH sectors such as nutrition and child development. Assessing care holistically, rather than within each sector will lead to comprehensive care for women and girls. For example, Tool 6 from the World Vision [Guide to Maternal, Newborn, and Child Health and Nutrition in Emergencies](#) can be adapted by teams to ensure MNH, GBV, nutrition, child protection, and MHPSS-related unmet needs are identified and addressed.
- **Ensure the mental wellbeing of providers, colleagues, and team members.** The [IASC Guidelines on MHPSS in Emergency Settings](#) provides key actions to ensuring there is sufficient support available for staff and volunteers working in emergency settings. This involves providing peer support including basic psychological first aid, providing referrals to culturally appropriate MHPSS support, offering debriefs, and/or the provision of a stand-by specialist for urgent psychiatric complaints.

EXAMPLES OF SERVICE DELIVERY COLLABORATION

The following examples of collaboration may be helpful for program managers or program coordinators to review and consider for implementation, if appropriate, in their respective settings.



Interdisciplinary mobile health team in Ukraine

In conflict or crisis, it can be difficult for people to reach a health facility, or their nearest health facility may be destroyed. In order to meet the community where they were, a model of an interdisciplinary mobile medical team was tested and evaluated in Ukraine. The team, consisting of a social worker, psychologist, nurse, and legal advisor, provided rapid assessments, referrals, coping strategies, basic medical aid, nutrition assistance (including for mothers with young babies), and legal aid. The mobile health team was located at transit points, border crossings, child-friendly stations, railways, bus stations, and centers for internally displaced persons. Approximately 48,555 people were reached using 63 interdisciplinary mobile health teams.⁵²



Group intervention in Chile

Focused support can be provided to communities that have an existing diagnosis, or particularly high levels of a mental health disorder and require more specialized support. For example, in Santiago, Chile, a group of 208 mothers with major depression were randomly assigned to an intervention to assess depression scores after 3 and 6 months. The intervention included a psychoeducational group, treatment adherence support, and pharmacotherapy as needed. At both 3 and 6 months, participants receiving the multicomponent intervention had lower depression scores as measured by the Edinburgh postnatal depression scale (EPDS) score. Women in the intervention group also had a decrease in antidepressant use after 3 months.⁵³



Robust referral pathway in Colombia

In Colombia, Save the Children established a strong and robust referral pathway, where upon identification, survivors of GBV were provided with MHPSS through trained psychologists, social workers, general physicians, gynecologists and nurses co-located at health facilities offering MNH services.⁵⁴ The individuals could then be connected to shelter support and financial assistance, demonstrating a referral system that prioritizes physical and mental health through the coordination of shelter, food, MHPSS, clinical management, and protection. While not all GBV survivors require specialized care, this approach demonstrates how a successful integrated approach can incorporate specialized services.



Integrated facility care in Cox's Bazar

RTI International developed women and girl's centers in Kutupalong Camp Extension, Ukhiya, Cox's Bazar to provide coordinated care for mental health, GBV case management, crisis counseling, safety planning, and community outreach engagement. The centers promoted respectful maternity care by also providing maternal and newborn care, STI treatment, family planning, abortion care, nutrition, and care for sexual assault survivors.⁵⁵ These interventions promote positive maternal and child health outcomes by prioritizing a comprehensive life course approach, interdisciplinary collaboration, and patient-centered care.



Photo source: KC Nwakalor, IRC

CALL TO ACTION:

Women in humanitarian and fragile settings face increased risk of poor perinatal mental health outcomes that can have long-lasting, intergenerational impacts on development and quality of life. Still, mothers and their families lack the necessary mental health support to which they are entitled. The provision of dignified, sustainable, and high-quality perinatal mental health services requires a multi-sectoral approach that prioritizes the mother and her newborn and integrates context-specific risk factors. The responsibility to collaborate and strengthen the continuum of care lies, in part with MNH and MHPSS actors. In order to increase this collaboration and improve overall perinatal mental health outcomes in humanitarian and fragile settings, we propose that:

- Service providers create an enabling environment, both in health facilities and their communities, for pregnant women, and mothers to both receive care and be referred to the appropriate resources. This involves MHPSS and MNH actors mapping the services and programs in their context, and creating referral pathways that promote opportunities for collaboration.
- MNH actors should receive basic MHPSS training to promote task-sharing opportunities across health clusters.
- The global community must update guidelines and recommendations to better meet the basic needs of women in the perinatal period. For example, the MHPSS Minimum Service Package should include pregnant and postpartum women as an 'at risk groups', the IASC MHPSS in Emergencies Settings guidelines must include MHPSS for women in the perinatal period, and the MISIP needs to integrate MHPSS for women and girls in its existing objectives.
- Finding opportunities for collaboration first begins with communication between MHPSS actors and MNH actors, both internally at multi-sectoral organizations, and across specific agencies. Clear coordination across sectors should be established to create sustainable and integrated programs throughout the pregnancy and postpartum period. For example, the Global Health Cluster can further progress dialogues, such as around the recent Health and Protection Joint Operational Framework, with other clusters to expand collaboration for improving mental health in emergency responses.

Together, as a MNH and MHPSS community we can provide the dignified mental and physical support pregnant women, mothers, their newborns, and entire families deserve, regardless of where they live.

ANNEX

A. Toolkits/Resources

1. [MHPSS Emergency Toolkit](#)
2. [IASC Reference Group MHPSS Assessment Guide](#)
3. [WHO Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services](#)
4. [IFRC Rapid Assessment PSS and Violence Prevention](#)
5. [MAMI Care Pathway Package](#)
6. [Inter-agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007](#)
7. [Inter-agency Standing Committee Mental Health and Psychosocial Support in Humanitarian Emergencies, 2010](#)
8. [WHO mhGAP Humanitarian Intervention Guide](#)
9. [WHO Thinking Healthy Manual](#)
10. [Common Elements Treatment Approach \(CETA\)](#)
11. [Inter-agency Field Manual on Reproductive Health in Humanitarian Settings including the Minimum Initial Service Package \(MISP\)](#)
12. [Roadmap for Every Newborn in Humanitarian Settings](#)

B. Learning Platforms

1. PFA Training
 - [Psychological First Aid Guide for Field Workers](#)
 - [The National Child Traumatic Stress Network](#)
2. [MHPSS Minimum Service Package](#)
3. [Introducing MHPSS in Emergencies](#)

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