

Preparing For The ‘Blues’: Building Midwives’ Capacity for The Delivery of Perinatal Mental Health Care and Services in Ghana

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Abstract

Background: There is limited empirical evidence on the use of standardized and validated assessment tools such as PHQ-9 and GAD-7 by midwives in Ghana to screen perinatal women for symptoms of anxiety and depression and provide the needed support accordingly. Preliminary studies have reported a lack of sufficient knowledge, skills, and preparedness among medical staff, including midwives for the task of screening pregnant women for mental health disorders [21]. This study intends to inform midwives of the availability of tools to assist them make appropriate diagnostic impression of depression and anxiety and to provide a clear pathway to support the perinatal women in their care. Overall, the aim of this study is to promote the exchange of ideas and collaboration among stakeholders to ensure that the training and practice of midwifery in Ghana become more robust and meet global standards. Additionally, it is meant to inform, prepare competent, resourceful, knowledgeable, and most importantly adaptable midwives who can contribute to and promote the overall health of the women in their care.

Objective: To address the gap in maternal mental health practice by equipping midwives with the requisite knowledge and skills on the use of globally validated and reliable assessment tools for depression and anxiety to support the perinatal women in their care.

Methods: The study involved different two sections. In the first section, a structured questionnaire was used to collect data from 319 participants (midwives) to explore their knowledge on perinatal depression and anxiety assessment tools while the second component involved equipping midwives with the requisite mental health assessment skills through a two-week seminar that was organised and facilitated by the research team. Feedback on the *level of confidence, suitability, and competence as well as the resourcefulness* of the use of the tools was collected from participants (midwives) after three (3) months. The study was conducted in selected hospitals across all 16 regions in Ghana. The regions have several government and private hospitals that provide primary and specialised health care services to the public. They include teaching hospitals, regional hospitals, municipal hospitals, district hospitals as well as clinics

within the sub-districts. Basic descriptive quantitative analysis was used based on frequency tables, pie chart and graphical illustration to interpret the data.

Results: The study revealed that lack of resources and inadequate capacity-building to practically equip midwives are a major setback for the delivery of perinatal mental health services. It also identified perceived discrimination and stigmatisation on the part of the perinatal women as a major barrier in the provision of maternal mental health services.

However, the participants demonstrated having adequate knowledge on the impact of perinatal anxiety and depression on birth and maternal outcomes. Nonetheless, there remains a huge deficit in their ability to use the validated and reliable assessment tools in recognizing clinical cues related to anxiety and depression among perinatal women. Surprisingly, over 50% of the midwives were unfamiliar with the commonly used assessment tools for depression and anxiety such as the GAD-7 and PHQ-9. Additionally, nearly 40% of the participants lack the requisite assessment skills for assessing perinatal anxiety and depression. In furtherance, over 97% of the participants demonstrated an appreciable level of confidence in terms of using the PHQ-9 and the GAD-7 following the post-assessment tool seminar.

Conclusion: Perinatal mental health should be made a critical component of perinatal care, with midwives being well situated to recognize the manifestations of deteriorating mental health among the perinatal women in their care and provide the needed support and required level of supervision. It is therefore imperative to train midwives on basic mental health assessment skills and encourage them to incorporate mental health care into the delivery of routine perinatal care and services.

Keywords: Patient Health Questionnaire-9, Generalised Anxiety Disorder-7, Assessment tools, Perinatal anxiety and depression, Maternal mental health, Perinatal Care, Reliability, Validity.

Introduction

Perinatal mental health (PMH) refers to the mental health of women from conception through the first postnatal year and this period is recognised as a uniquely opportune time for perinatal mental health interventions.^[1] The term perinatal mental health problems (PMHPs) describe the scope of mental health disorders encountered by women from psychological distress to serious mental health problems ^[3,8]. PMHPs are associated with significant morbidity, affecting the wellbeing of the woman, her baby and significant others. Adverse outcomes for women who experience PMHPs include recurrent depression, increased risk of serious mental health problems, less responsive care giving and increased risk of suicide.^[5] For infants, research has identified epigenetic modifications, preterm birth, low birth weight, adverse effect on cognitive, behavioural, psychomotor and socio-emotional development, child and adult psychiatric conditions and rarely child neglect, abuse and neonaticide as impacts of PMHPs.^[6,7,8]

Perinatal mental health in recent times has become a significant focus of interest, with some developed countries investing in new specialist mental health services, and inpatient psychiatric mother and baby units in different settings ^[12]. Life changing moments like pregnancy, birth, and early parenthood can be stressful for women and their partners, and this may cause women to undergo a period of poor mental health or witness a worsening of previous mental health conditions ^[20]. Such phenomenon undoubtedly, may lead to perinatal depression and anxiety. Perinatal depression is defined as depression occurring in a woman during pregnancy or within 12 months of delivery ^[10]. Recent and preliminary studies have brought to the fore the direct impact of perinatal depression and anxiety on the mother, baby, entire family as well its global economic burden ^[18]. Midwives have a fundamental role in facilitating the initial stage of

perinatal mental health risk reduction through inquiring about perinatal mental health, identifying risk factors and current perinatal mental problems, providing support or crisis intervention, referring for treatment and decreasing stigmatisation^[7].

However, much has not been done about the care givers' (Midwives) preparedness and ability to understand and utilize well validated perinatal depression and anxiety assessment tools to help identify perinatal women who may require mental health support during the perinatal period. Many women experience changes in their mental health during the perinatal period and this can negatively impact on their health and the wellbeing of their babies and families^[20]. It is evidently clear that feelings of weepiness and labile emotions, called the "baby blues," do occur in up to 80% of new mothers within several days of delivery due to some biochemical imbalances and these symptoms are usually brief and last no longer than 10 days. However, perinatal depression may last more than 14 days and impairs a woman's normal daily functions^[13]. A longitudinal study explored trends of stress, anxiety, and depressive symptoms from pregnancy to postpartum and understands predictions of stress and anxiety on postpartum depression^[5]. The study revealed that levels of anxiety and depressive symptoms increased from 24 weeks gestation to postpartum, whereas stress levels decreased during pregnancy but increased in postpartum. Globally, about 10% of pregnant women and 13% of women after giving birth suffer from a mental disorder, primarily depression. In developing countries, this is even higher, that is, 15.6% during pregnancy and 19.8% after childbirth.^[10,17]

The World Health Organization posits that almost 1 in 5 women experience a mental health condition during pregnancy or in the year after the birth with about 20% of them experiencing suicidal thoughts or undertaking acts of self-harm^[20]. This clearly indicates that poor maternal mental health including perinatal depression and anxiety could have dire consequences on the mother and the baby. Some reports indicate that about 30% of adults suffer from an anxiety disorder (AD) at some point in their lives, with evidence clearly showing that these disorders are two to three times more common than mood, impulse-control, or substance-abuse disorders over a twelve-month period^[1,8]. This longitudinal study further revealed that mother-child pairs demonstrate a higher rate of ADs in children of mothers with an AD compared to children of mothers without an AD. Additionally, children of mothers in the top 15% for symptoms of antenatal anxiety have been shown to have twice the risk for ADHD at ages 4 and 7^[4,11].

In Africa, Maternal Mental Health Services (MMHS) is seriously lacking within the entire healthcare space due to numerous factors and challenges. Barriers to poor treatment are multifactorial and could be associated with personal behaviour, the severity of the disorder, social norms, and the lack of effective mental health care systems^[7,14]. The issue of Maternal Mental Health Services (MMHS) is not deeply rooted in the Ghanaian health sector which is characteristically reflective of how mental health issues are poorly understood and handled in its entirety. Challenges that have impeded the provision of Maternal Mental Health Services (MMHS) in other parts of Africa are not entirely different from that of Ghana. A prior study provides the evidence that supports this assertion^[1,2]. In this study, they investigated factors that were hampering the provision of mental health services by nurses and midwives to childbearing women to assist in the prioritization and distribution of limited mental health resources. Three hundred and nine (309) nurses and midwives participated in the study. About 77% of the respondents reported unavailability of mental health services as the main challenge during the perinatal period whereas 75.7% of them lamented the lack of knowledge of mental health in women from different tribes as the contributing factor to the menace. The results further revealed that 75.1% of the participants revealed the

lack of a clear mental healthcare pathway as a major hindrance to this important health service while 74.1% of them attributed this challenge to heavy workload.

It is evidently clear that integrating Maternal Mental Health Services (MMHS) in the training and practice of midwives cannot be overemphasized looking at the role they play in taking care of these service user population. Their knowledge in perinatal depression and anxiety is unavoidably needed and therefore serious attention in this direction is required. Much research has not been conducted to assess the knowledge, attitude, and practices of healthcare providers in this regard. In a qualitative study, the respondents explained that depression diagnosis is difficult due to insufficient knowledge among healthcare providers and the hidden signs of postpartum depression^[10]. A study conducted in seven Maternity Services in the Republic of Ireland concluded that Midwives have high levels of knowledge (71.1%) and confidence (72%) in identifying women who experience depression and anxiety. However, they reported less confidence in caring (43.9%) for women. Only 17.8% (n=28) of midwives felt equipped to support women^[16]. Additionally, the Midwives expressed interest to be educated on the spectrum of perinatal mental health problems. A wide knowledge gap about perinatal depression exists among perinatal women, nurses, and medical practitioners^[17]. There are not adequate healthcare providers trained in maternal, newborn, and child mental health, which goes a long way to affect services' ability to identify mental health conditions, provide psychosocial interventions for their prevention and management, and make referrals appropriately^[3,4].

Furthermore, the quality of assessment of the perinatal mother for any sign of perinatal depression and anxiety by the midwife cannot be guaranteed without the use of well-established assessment tools. Screening for perinatal depression and anxiety in community-based maternal and child health settings may help close the detection and treatment gap among women at higher risk of these conditions^[4,9]. Some of the assessment tools include Edinburgh Postnatal Depression Screen (EPDS), Patient Health Questionnaire (PHQ2, PHQ9), Prenatal Anxiety Screening Scale (PASS), Perinatal PTSD Screening Scale (PCL-5), and Clinically Administered PTSD Scale (CAPS-5). Other tools are Generalized Anxiety Disorder (GAD-7) and Perceived Prenatal Maternal Stress Scale (PPMSS). The Edinburgh Postnatal Depression Screen (EPDS) is mostly used to assess for the presence of depression in the pregnant woman or the postnatal mother^[6]. The Edinburgh Postnatal Depression Scale (EPDS) is a questionnaire originally developed to assist in identifying possible symptoms of depression in the postnatal period^[7,11].

METHODS

STUDY DESIGN AND SETTINGS

The study was divided into two sessions. In the first session, a structured questionnaire was used to collect data from the participants (midwives) to explore their knowledge on perinatal depression and anxiety assessment tools while the second component involved equipping midwives with the requisite mental health assessment skills through a two-week seminar that was organised and facilitated by the research team. Feedback on the level of confidence, suitability, and competence as well as the resourcefulness of the use of the tools was collected from participants (midwives) after three (3) months. The study was conducted in selected hospitals across all 16 regions in Ghana. The regions have several government and private hospitals that provide primary and specialised health care services to the public. They include teaching hospitals, regional hospitals, municipal hospitals, district hospitals as well as clinics within the sub-districts.

STUDY PARTICIPANTS AND SAMPLING

A total of 319 midwives with varying degrees/ qualification and experience working at different levels (teaching, municipal, regional and district hospitals) of the health care system in Ghana participated in the study. The purpose of the study was explained to them and consent for same granted by participants.

PARTICIPANTS' RECRUITMENT

The recruitment process is considered the beginning of the consent process to create awareness about the study for potential participants. The study was conducted in several different locations/ sites and for this reason the participants were recruited on-site as and when the researchers got to a specific study location. This was done concurrently with the data collection for the sake of convenience, spanning the period of approval of the study (5th February 2023 to 2nd December 2023) by the Scientific Ethics Committee of the Ghana Health Service (GHS) and the Ministry of Health (MOH). The purpose of the study was explained to participants during the recruitment process to allow interested participants to voluntarily participate in the study. A link to respond to the study questionnaire was sent to participants' email addresses provided to researchers by participants.

DATA COLLECTION AND ANALYSIS

A field survey was conducted based on a structured questionnaire in the first aspect of the study. The second aspect of the study involved a seminar on how to use and interpret two globally validated assessment tools for anxiety and depression (PHQ-9 and GAD-7). Feedback from participants on same was collected three months post assessment tool seminar to the confidence level in using these tools in daily practice. The data collected were analysed with Microsoft Excel and SPSS (Version 24) software. Basic descriptive quantitative analysis was used based on frequency tables, pie chart and graphical illustration to interpret the data.

ETHICS STATEMENT

Ethical approval was sought from the Ministry of Health and Ghana Health Services (MOH/GHS). A written informed consent was obtained from the study participants. The participants were informed that the outcome of the study will be published for a wider readership and consent for same was sought from the participants. The authors also assert that all procedures contributing to this work comply with the ethical standards and principles relevant to the conduct of primary research. The respondents were assured of protecting any personal information that they may provide in accordance with data protection regulation policy of the MOH/GHS. The consent form was anonymously filled out without respondents' names.

RESULTS

Participants' characteristics are shown in tables 1 to 4 (figures 1 to 4 respectively). Overall, a greater proportion of participants (n=180; 57.5%) have 2 to 5 years of working experience while 32.9% (n=103) have 5 to 10 years of working experience. However, only 9.3% (n=29) have over 10 years of working experience. In terms of the qualification or the educational background of respondents (Table 2/ Figure 2), a significant number of respondents (n=195; 62.5%) are diploma holders with a little over a quarter (n=83; 26.4%) of the total number of respondents having their bachelor's degree as registered midwives. Post-basic midwives accounted for only 11.1% (n=35) of the total number of respondents. Additionally, the participants work at different levels across the health care system. Table 3/ figure 3 illustrate the different

workplace of study participants. Most participants work in district hospitals (n=99; 31.8%) while the sub-districts accommodate about 27.2% (n=85) of the participants as their workplace. Similarly, 66 participants representing 21.6% of the study subjects work in teaching hospitals whereas 13 and 49 participants work in regional and municipal hospitals, representing 3.9% and 15.5% respectively.

WORK EXPERIENCE

VARIABLES/YEARS	FREQUENCY (n=312)	PERCENTAGE (%)
2 - 5	180	57.5
5 - 10	103	32.9
10+	29	9.3

Table 1. (Source: Authors' Field Work, 2024)

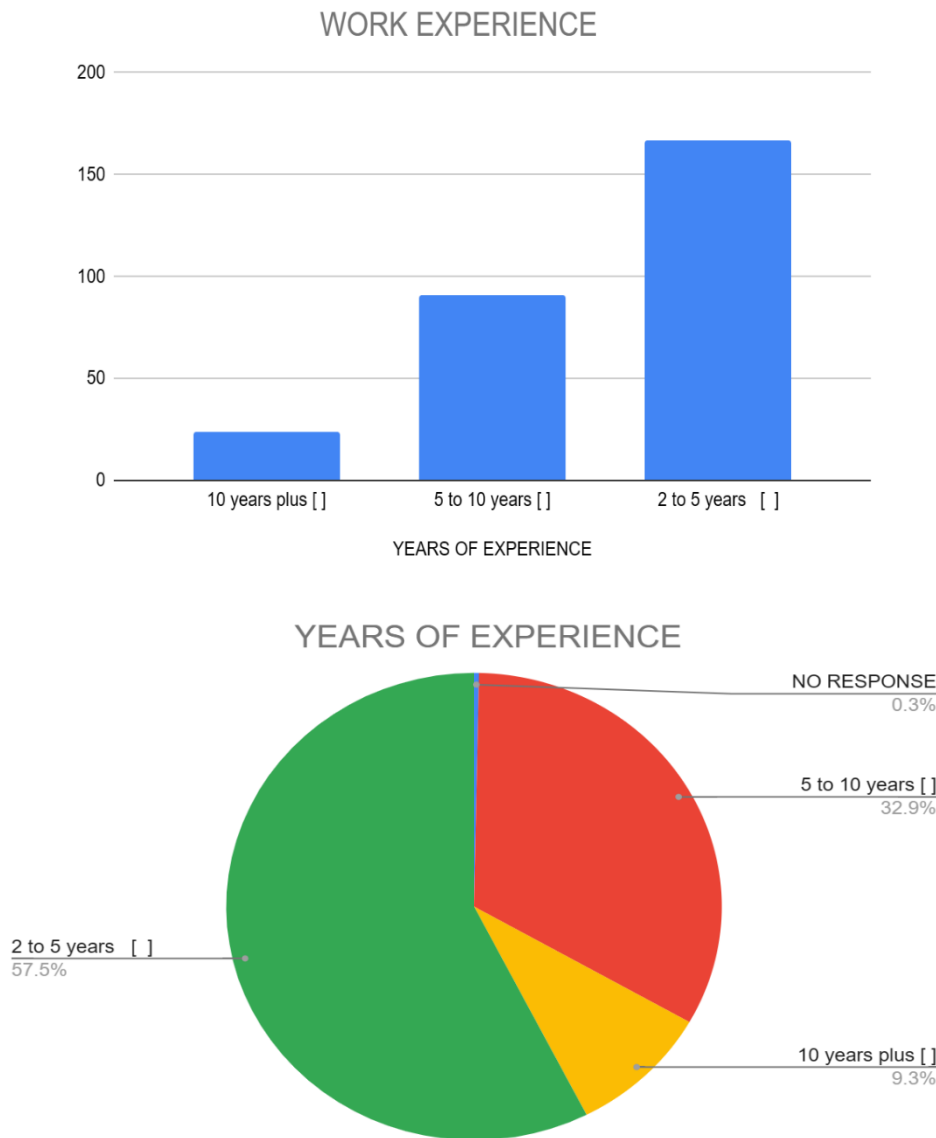


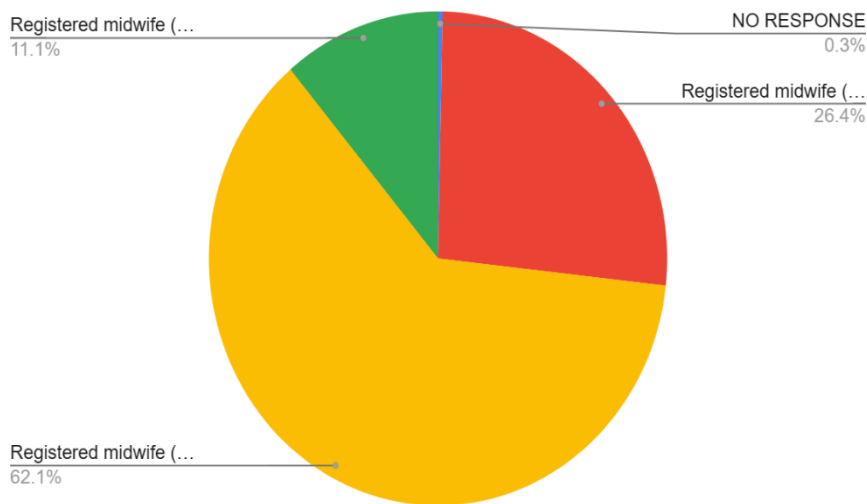
Figure 1

QUALIFICATION /EDUCATIONAL BACKGROUND

VARIABLES (REGISTERED MIDWIFERY)	FREQUENCY (n=313)	PERCENTAGE (%)
Bachelor’s	83	26.4
Diploma	195	62.5
Post-Basic	35	11.1

Table 2. (Source: Authors’ Field Work, 2024)

QUALIFICATION/ EDUCATIONAL BACKGROUND



QUALIFICATION/ EDUCATIONAL BACKGROUND

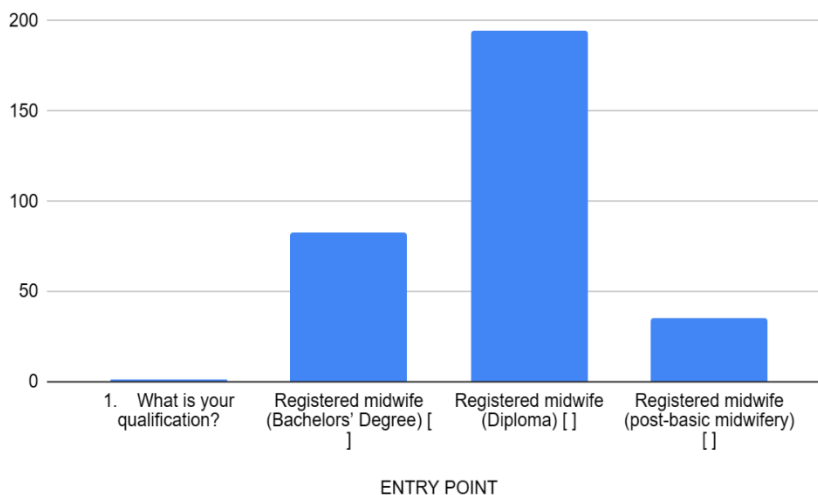


Figure 1

LOCATION/ WORKPLACE DESCRIPTION

VARIABLES	FREQUENCY (n=312)	PERCENTAGE (%)
Teaching Hospital	66	21.6

Regional Hospital	13	3.9
Municipal Hospital	49	15.5
District Hospital	99	31.8
Sub-district Hospital	85	27.2

Table 3. (Source: Authors’ Field Work, 2024)

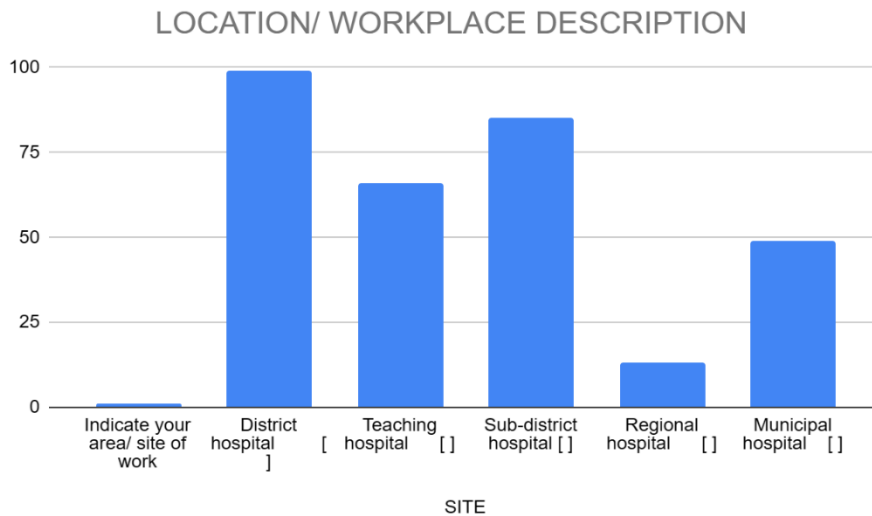
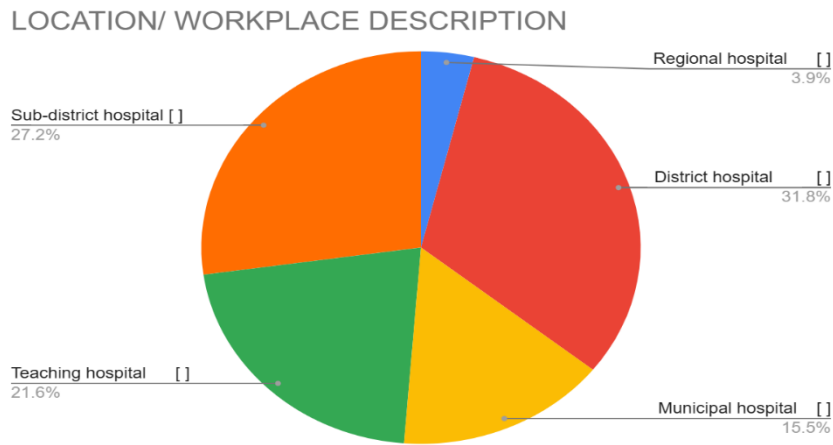


Figure 2

In furtherance, Table 4/ Figure 4 illustrate the “*current job titles*” of the study participants where a significant number of participants (n=127; 40.4%) are Senior Staff Midwives (SSM), 98 (31.2%) are Staff Midwives (SM) and 21.7% (n=68) accounting for the number of Midwifery Officers (MO). Moreover, there are 15 (4.8%), 5 (1.6%) and 1 (0.3%) Senior Midwifery Officers (SMO), Principal Midwifery Officers (PMO) as well as Director/Deputy Director of Midwifery Services (DDMS) respectively.

CURRENT JOB TITLE

VARIABLES	FREQUENCY (n=313)	PERCENTAGE (%)
Staff Midwife (SM)	98	31.2
Senior Staff Midwife (SSM)	127	40.4
Midwifery Officer (MO)	68	21.7
Senior Midwifery Officer (SMO)	15	4.8
Principal Midwifery Officer (PMO)	5	1.6
Deputy Director/Director of Midwifery Services (DDMS)	1	0.3

Table 4. (Source: Authors’ Field Work, 2024)

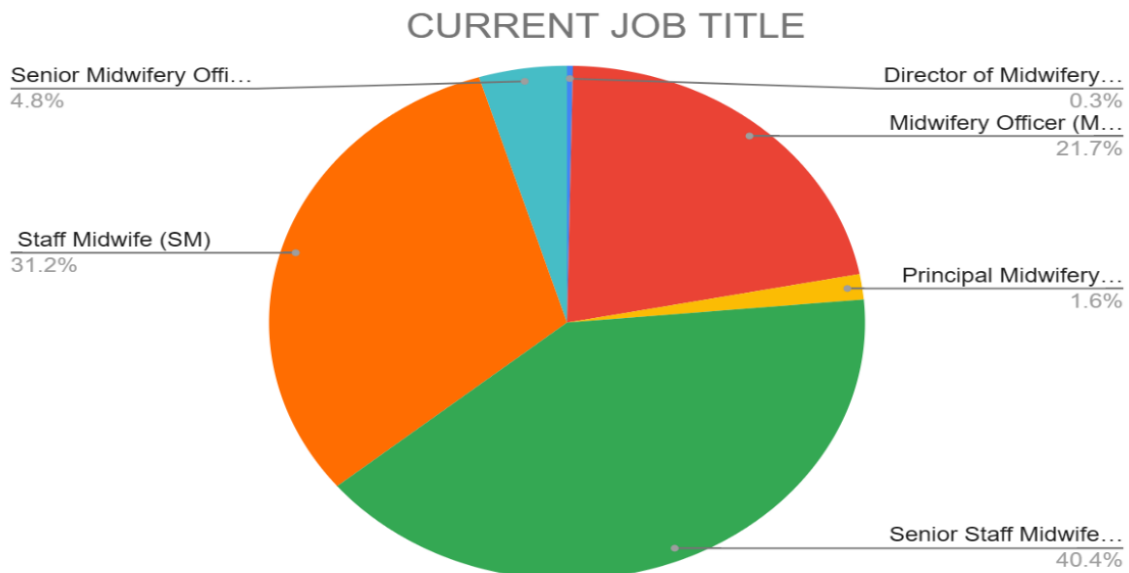


Figure 3

Regarding the “midwives’ knowledge and understanding of perinatal anxiety and depression” (Table 5/figure 5), 116 participants representing 37.1% indicated having a ‘fairly satisfactory’ knowledge and understanding of the subject matter while others indicated having ‘very adequate’ knowledge (n=94; 30.0%). Again, 27.8% (n=87) indicated that their knowledge and understanding of perinatal anxiety and depression is ‘satisfactory’ with a handful of participants (n=16; 5.1%) having ‘inadequate’ knowledge of the subject matter.

Midwives Knowledge and Understanding of Perinatal Anxiety and Depression

VARIABLES	FREQUENCY (n=313)	PERCENTAGE (%)
Satisfactory	87	27.8
Fairly Adequate	116	37.1
Very Adequate	94	30.0

Inadequate	16	5.1
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Table 5. (Source: Authors’ Field Work, 2024)

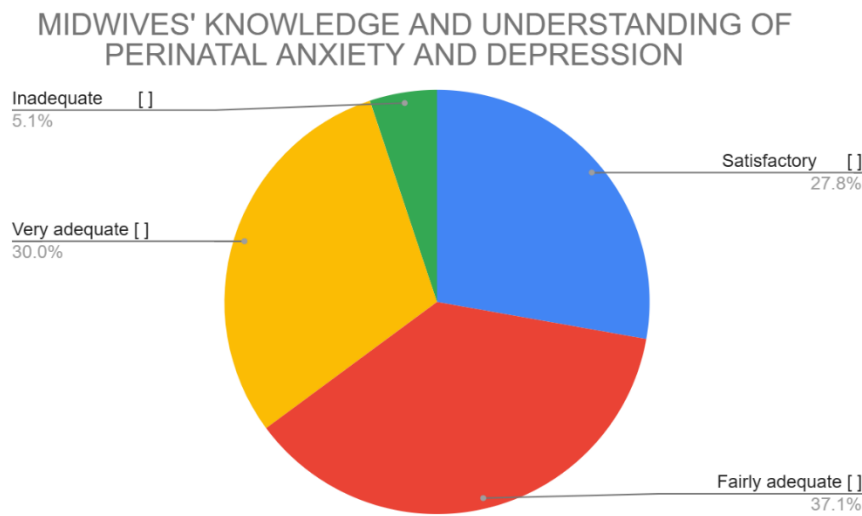
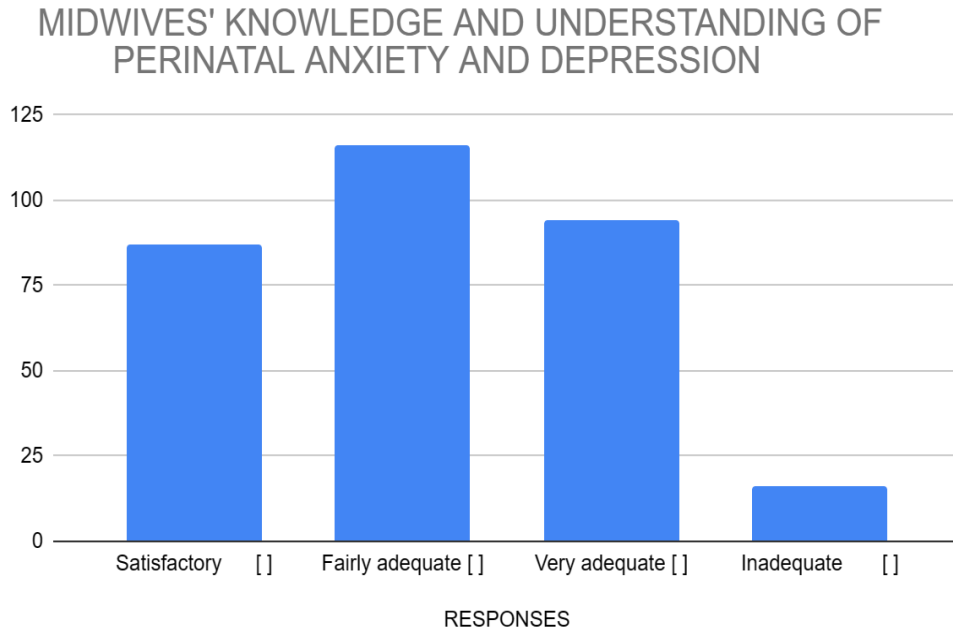


Figure 4

Furthermore, in terms of the “midwives’ familiarity” with validated and reliable perinatal anxiety and depression assessment tools, 55.3% (n=172) of participants are unfamiliar whereas 44.4%(n=139) are familiar with the assessment tools. This is shown in table 6/ figure 6 below:

Midwives’ Familiarity with Anxiety and Depression Assessment Tools

VARIABLES	FREQUENCY (n=311)	PERCENTAGE (%)
YES	139	44.4
NO	172	55.3

Table 6. (Source: Authors’ Field Work, 2024)

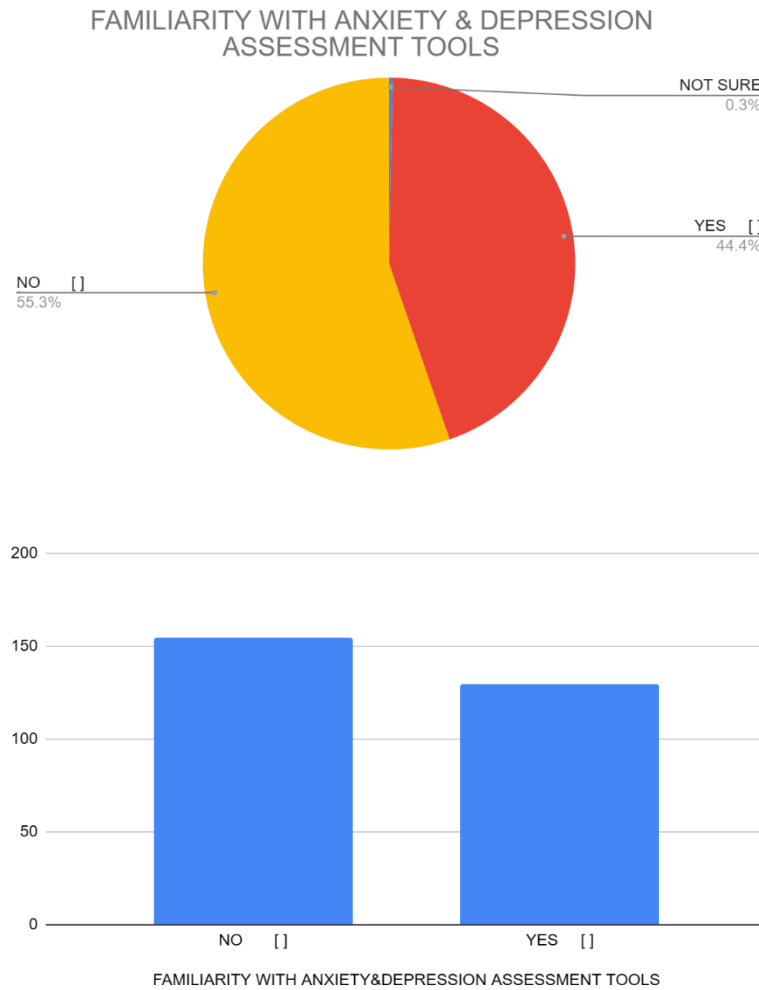
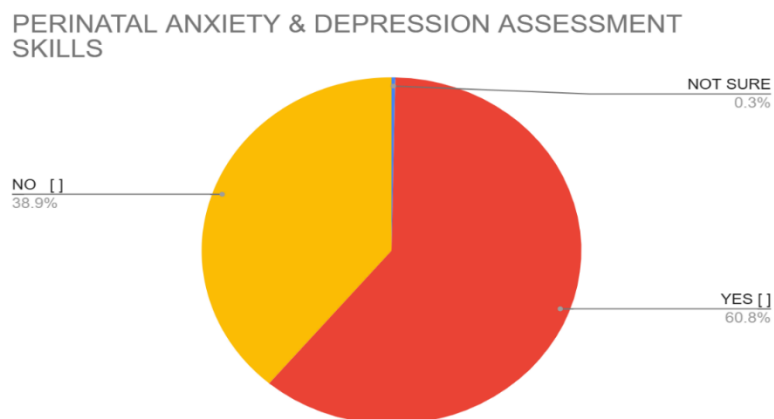


Figure 5

Perinatal Anxiety and Depression Assessment Skills

VARIABLES	FREQUENCY (n=312)	PERCENTAGE (%)
YES	191	60.8
NO	121	38.9

Table 7 (Source: Authors' Field Work, 2024)



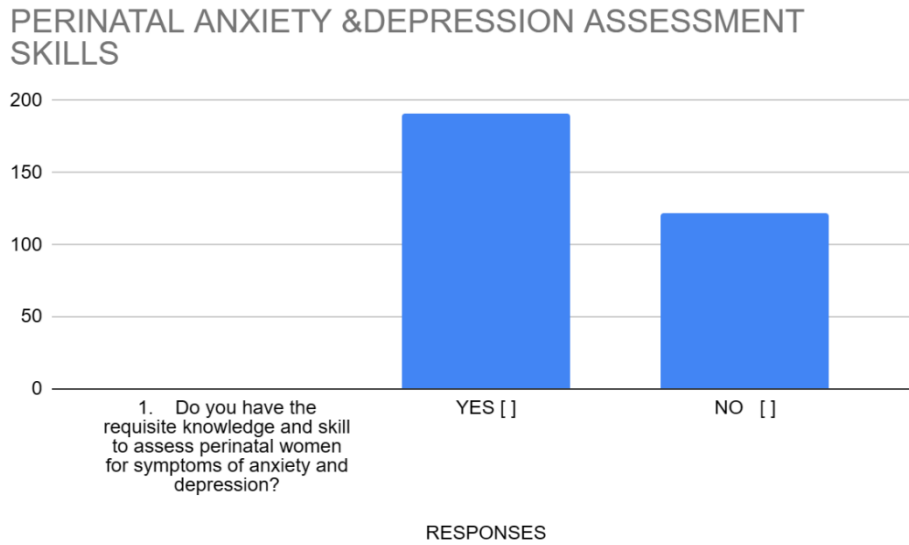


Figure 6

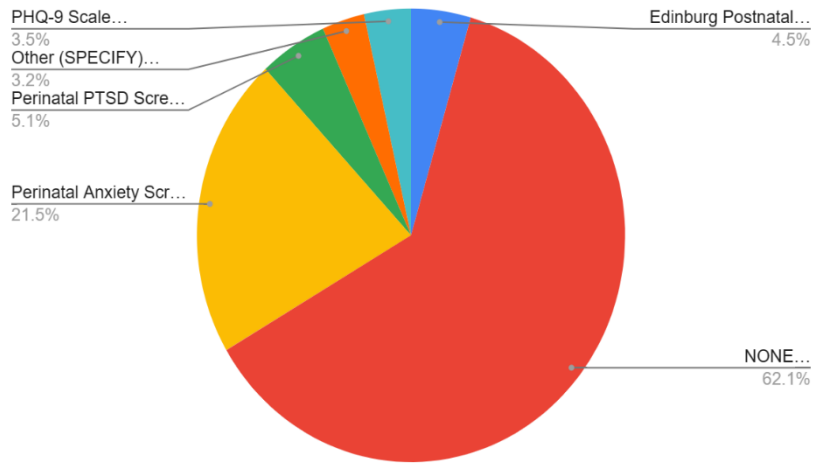
In relation to the “assessment skills” to screen for symptoms of perinatal anxiety and depression by midwives, over 60% (n=191) of participants indicated having the requisite assessment skills while a substantial number of participants (n=121; 38.8%) recorded a lack of same as shown in table 7/figure 7 above. Similarly, in terms of utilization of the assessment tools in routine perinatal care, over 62% (n=192) of the participants do not or have never utilized any of the globally validated and reliable assessment tools in their daily practice. However, a hand full of participants (n=67; 21.5%) indicated that they employ Perinatal Anxiety Screening Scale (PASS) in their daily practice. Other tools such as the PHQ-9, EPDS, and PCL-5 recorded very low representations as seen table 8/figure 8 below:

Utilization of Anxiety and Depression Assessment Tools in Routine Perinatal Care

VARIABLES	FREQUENCY (n=313)	PERCENTAGE (%)
Edinburg Postnatal Depression Scale (EPDS)	14	4.6
Perinatal Anxiety Screening Scale (PASS)	67	21.5
Perinatal PTSD Screening Scale (PCL-5)	18	5.1
PHQ-9 Scale	21	3.5
NONE	192	62.1
OTHER (SPECIFY)	1	3.2

Table 8 (Source: Authors’ Field Work, 2024)

PERINATAL ANXIETY&DEPRESSION SCREENING SCALES



PERINATAL ANXIETY&DEPRESSION ASSESSMENT SCALES/TOOLS

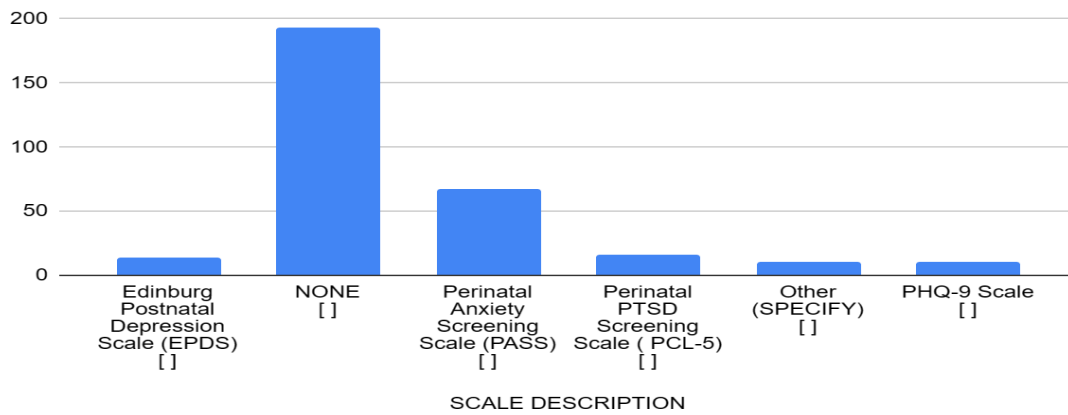


Figure 7

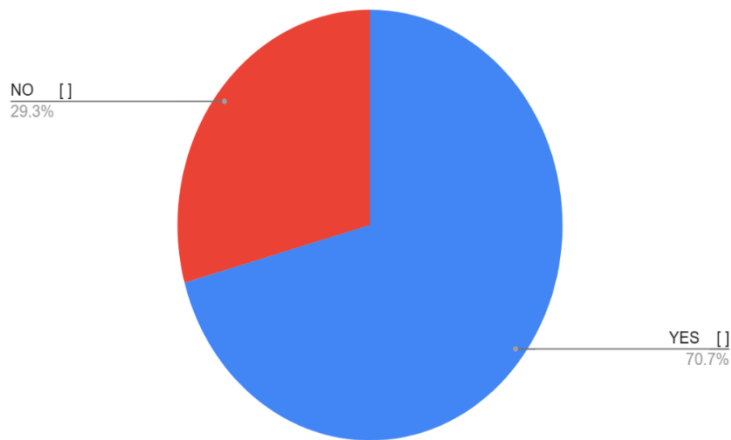
Additionally, considering the “integration of mental health into routine perinatal care”, over 70% (n=217) of the participants indicated that they incorporate mental health services into the care of perinatal women while a considerable number (n=89; 29.3%) of participants reported that they do not incorporate mental health services into perinatal care. Table 9/figure 9 shows participants’ responses in this regard.

MENTAL HEALTHCARE AND ROUTINE PERINATAL CARE

VARIABLES	FREQUENCY (n=306)	PERCENTAGE (%)
YES	217	70.7
NO	89	29.3

Table 9 (Source: Authors’ Field Work, 2 024)

MENTAL HEALTHCARE & ROUTINE PERINATAL CARE



MENTAL HEALTHCARE&ROUTINE PERINATAL CARE

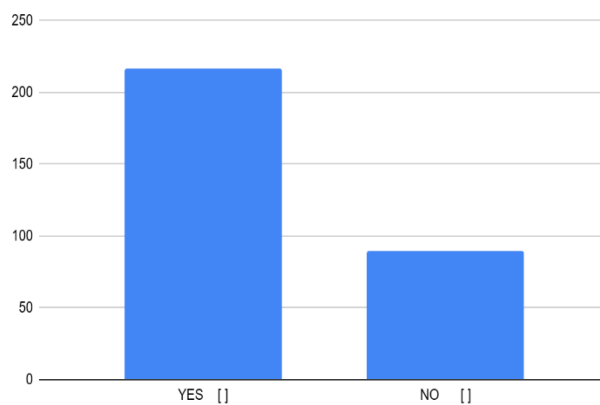


Figure 8

Table 10/ figure 10 shows participants responses regarding “mental health assessment and screening in routine perinatal care”. A little over one-third of the participants (n=106; 33.9%) perform mood and anxiety screening or assessment for the perinatal women in their care whiles 23.0% (n=72) conduct alcohol use screening, with only 7.0% (n=21) of participants assessing perinatal mothers’ psychiatric treatment history. Furthermore, only 5.8% (n=18) of study participants perform substance-use screening whereas 7 and 10 participants carry out trauma and abuse history representing 2.2% and 3.2% respectively. Nonetheless,13.1% (n=41) do not perform any mental health assessments for the perinatal women in their care.

MENTAL HEALTH ASSESSMENT/ SCREENING IN ROUTINE PERINATAL CARE

VARIABLES	FREQUENCY (n=312)	PERCENTAGE (%)
Trauma Screening	7	2.2
Substance-Use Screening	18	5.8
Mood and Anxiety Screening	106	33.9
Alcohol Use History	72	23.0
Mental Status Examination	37	11.8
Psychiatric Treatment History	21	7.0

Abuse History	10	3.2
None	41	13.1

Table 10. (Source: Authors’ Field Work, 2024)

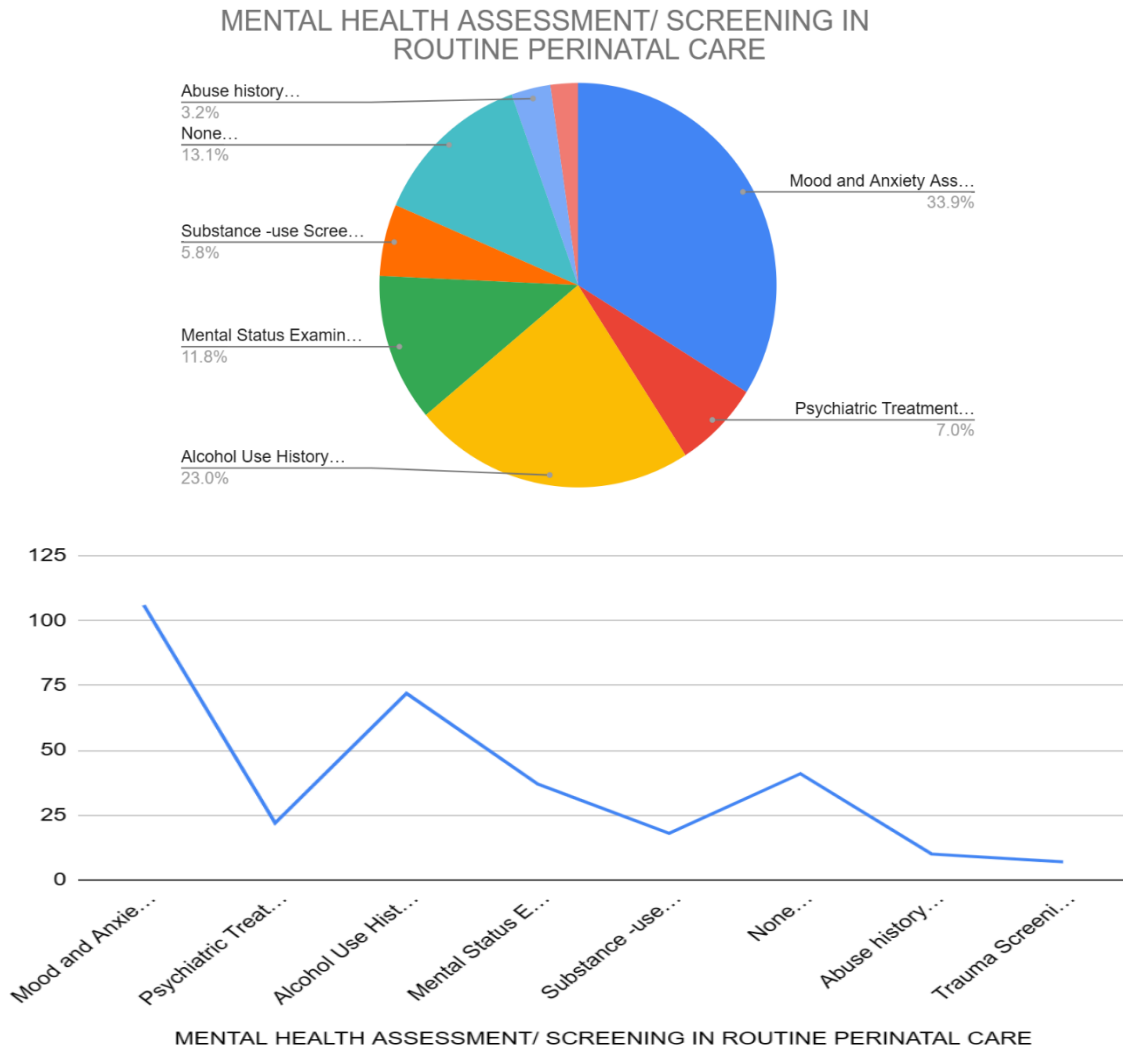


Figure 9

Participants’ responses in relation to the “*mental health support pathways*” are shown in table 11 / figure 11 below. A significant proportion of the respondents (n=105; 32.7%) provide supportive counselling for the perinatal women in their care. However, a greater proportion (n=179; 57.9%) refer perinatal women with mental health challenges to the mental health department for specialist care. Similarly, 4.9% (n=14) of study subjects indicated that they assess mental health challenges that confront the perinatal women in their care whiles 4.5% (n=13) of participants indicated the absence of perinatal mental health services in their respective facilities.

MENTAL HEALTH SUPPORT PATHWAYS

VARIABLES	FREQUENCY (n=311)	PERCENTAGE (%)
SUPPORTIVE COUNSELING	105	32.7

ASSESSMENT OF MENTAL HEALTH CHALLENGES	14	4.9
REFERRAL TO MENTAL HEALTH TEAM	179	57.9
UNAVAILABILITY OF PERINATAL MENTAL HEALTH SERVICES	13	4.5

Table 11. (Source: Authors’ Field Work, 2024)

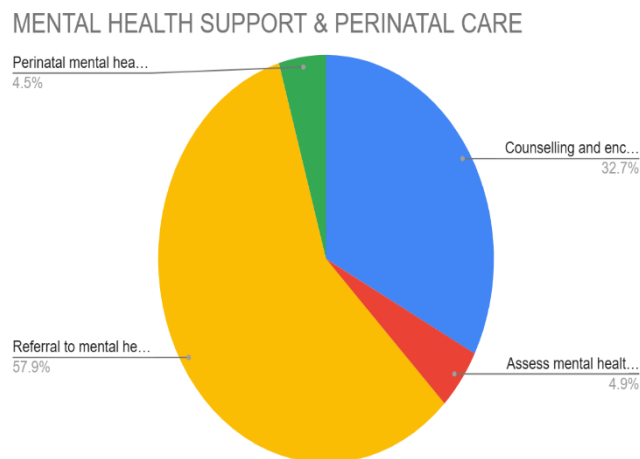
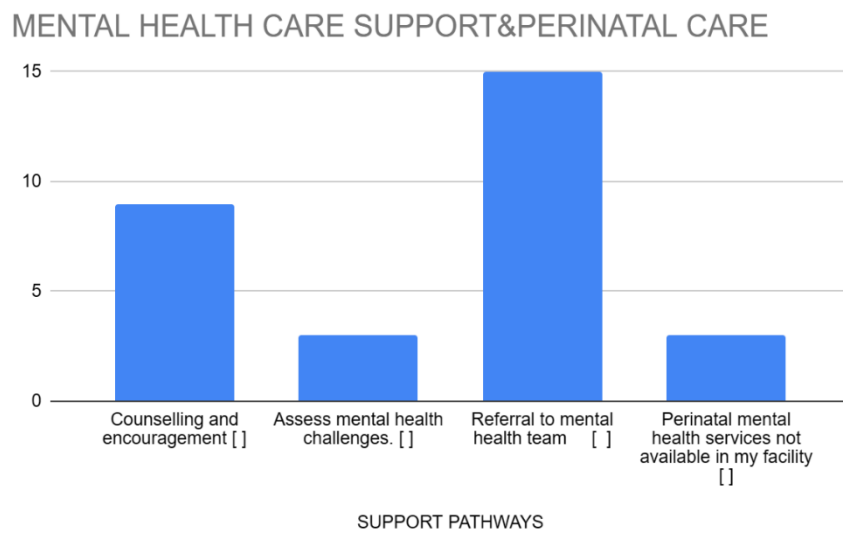


Figure 10

Figure 12 below represents participants’ responses in terms of the “consequences of poor mental health on birth outcomes”. Participants demonstrated the awareness of the impact of poor mental health effects on the newborn as well as the mother. Participants reported such birth outcomes as low birth weight, loss of self-esteem, refusal to breastfeed the baby, still birth and postnatal depression among others as some of the birth outcomes emanating from poor mental health challenges.

POOR MENTAL HEALTH EFFECTS ON BIRTH OUTCOMES

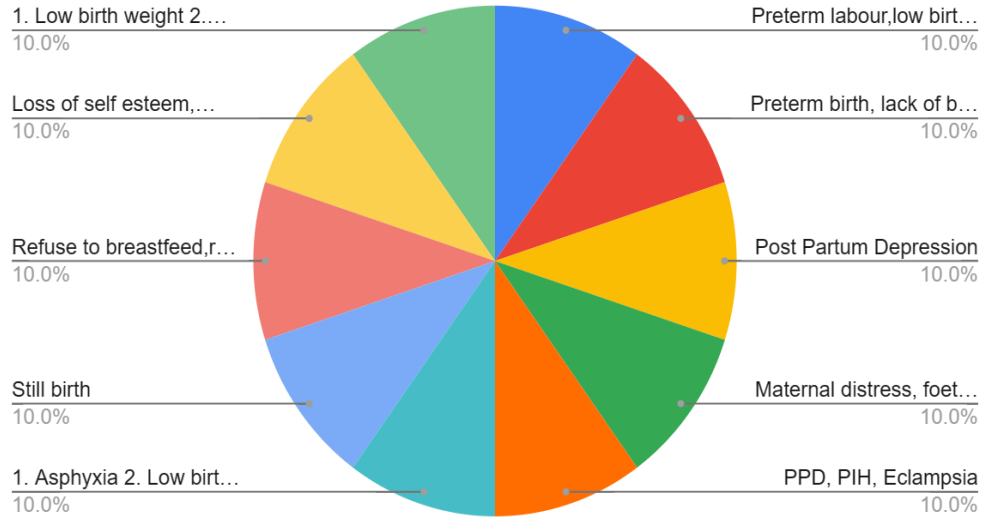


Figure 12

Table 12. Participants’ Feedback of Post- Assessment Tools Seminar

VARIABLE	FREQUENCY (n)	PERCENTAGE (n/N*100) %
Confidence level	312	97.8
Level of Competence	306	95.9
Tool Suitability	313	98.1
Resourcefulness of Tools	311	97.4

(Source: Authors’ Field Work, 2024). *N=319 (Total Responses Received) **n=Actual Responses Over 97% (n=312) of the participants demonstrated an appreciable level of confidence in the delivery of mental health assessment skills using the PHQ-9 and GAD-7 assessment tools in the post-assessment tool seminar. Similar observations were made among participants in terms of competence, tool suitability as well as the resourcefulness of the assessment tools (Table 12).

Table 13. Mental Health Assessment Barriers in Midwifery Practice

VARIABLE	FREQUENCY (n)	PERCENTAGE (n/N*100) %
Considers mental health assessment less important.	298	93.4
Inadequate capacity-building to practically equip midwives	316	99.1
Unwillingness of client to discuss mental health	308	96.6

issues for fear of discrimination and stigmatisation.		
Unavailability of resources e.g assessment rooms that provides enough privacy.	317	99.4

(Source: Authors’ Field Work, 2024). *N=319 (Total Responses Received) **n=Actual Responses

Table 13 illustrates the barriers to mental health assessment in maternity settings. Over 99% (n=317) of the study participants consider the unavailability of resources such as assessment rooms that provides enough privacy to be the greatest barrier hampering their effort to conduct mental health assessment of the perinatal women engaging maternity services. Additionally, inadequate capacity-building to practically equip midwives (n=316; 99.1%) significantly contribute to the failure of midwives to carry out mental health assessment of the pregnant women in their care while a substantial number of participants (n=298; 93.4%) consider mental health assessment less important in the delivery of perinatal care and services. Furthermore, a little over 96% (n=308) of study participants say the perinatal women are unwilling to discuss any mental health challenges for fear of being stigmatised and discriminated against.

Table 14. Incorporating Maternal Mental Health Courses into Midwifery Curriculum

VARIABLE	FREQUENCY (n)	PERCENTAGE (%)
YES	301	94.4
NO	18	5.6

(Source: Authors’ Field Work, 2024). *N=319 (Total Responses Received) **n=Actual Responses

Many of the study participants (n=301; 94.4%) advocate for maternal mental health courses to be incorporated into the midwifery curriculum to prepare and equip them with the appropriate skills relevant to support perinatal women who may present with mental health problems. However, about 5% (n=18) of the participants think otherwise (Table 14).

Discussion

This study was carried out in two sessions. In the first session, we explored midwives’ preparedness to use globally reliable and validated assessment tools in identifying anxiety and depression symptoms in perinatal women engaging maternity services. Overall, a little over one-third of study participants (table 5/ figure 5) have adequate knowledge and understanding about perinatal anxiety and depression. This finding contradicts prior studies suggests that midwives have high levels of knowledge and confidence in identifying women who experience depression and anxiety during the perinatal period [12,15]. However, the midwives demonstrated a better appreciation of the consequences of poor perinatal mental health on birth and maternal outcomes (figure 12). This resonates with earlier reports that found a strong association of maternal depression and anxiety with preterm birth, small for gestational age, stillbirth, low birth weight, and maternal morbidity including perinatal complications, increased operative delivery, and postpartum depression and further propose that to prevent these adverse outcomes, depression should be screened, monitored, and managed appropriately keeping risk-benefit in consideration [15]. Nonetheless, a greater proportion of the participants (table 6/figure 6) were uninformed about anxiety and depression assessment tools which impairs their ability to adequately identify and assess for symptoms of poor mental health

among the perinatal women in their care. Additionally, over 60% of participants (table 8/figure 8) reported that they have never used any of the validated depression and anxiety assessment tools throughout their practice. This is a major hindrance to the provision of quality maternal mental health services during the perinatal period. New and expectant parents have unique mental health needs therefore, it is important to use the most validated screening instruments for this population to screen new and expectant mothers for symptoms of depression and anxiety. Evidently, this is rarely heeded to in most health facilities across Ghana, negatively impacting the provision of holistic perinatal care [3,5].

In furtherance, nearly one-third of participants (table 9/figure9) indicated that they do not incorporate mental health assessment into the provision of routine perinatal care. The perinatal period is a time of huge change and adjustment. For most new parents life settles after a few months but for others pregnancy and early parenthood can trigger symptoms of more serious mental health conditions that require active management. A consistent, early, and effective response by trained health professionals such as midwives during the perinatal period is essentially critical [14]. Therefore, it's necessary to conduct routine and universal screening for perinatal depression and anxiety in both antenatal and postnatal settings [11]. Preliminary report suggests that maternal mental health conditions are arising exponentially in the perinatal period, including depression and anxiety [19,20]. This presents the potential to impact negatively on not only the woman but also her partner, infant, and family. However, the capacity for routine, universal antenatal mental health assessment is lacking in many maternity settings in Ghana despite the potential for reduction of morbidity and mortality in this regard. There are several mental health assessments that ought to be carried out on pregnant women attending antenatal and postnatal reviews so that they may be provided with the needed support as well the required level of care and supervision. These mental health screening include but not limited those as trauma screening or assessment, abuse, mood and anxiety screening, drug and alcohol screening, mental status examination to determine severe forms of mental illnesses, psychiatric treatment screening or assessment among others [17]. In relation to this, it is astonishing that just about 34% of study participants (table 10/figure10) conduct mood and anxiety assessment and screening for the perinatal women in their care. In terms of mental health support given to perinatal women with mental health challenges, a greater proportion of the midwives (table 11/figure 11) placed much premium on ‘*referrals*’ (57.9%) and on the provision of ‘*supportive counselling*’ as the immediate support systems in such instances. This finding is consistent with prior studies that assert that supportive counselling that allows perinatal women to share and discuss their mental health challenges in a respectful manner with health professionals is the most effective way to assist perinatal women in this regard. [10, 16,17]

The second phase of this study examined the participants’ level of confidence, competence, and the suitability in using the PHQ-9 and GAD-7 to screen perinatal women for symptoms of depression and anxiety as well as their opinion on the resourcefulness of these tools after a seminar on how to use and interpret the tools had been organised for them. The participants demonstrated an appreciable level of confidence (n=312;97.8%) where over 95% (n=306) were competent enough to use and interpret the tools. This finding resonates with prior reports that suggest that midwives can be confident in assessing psychological problems using validated tools with the right training and support [16]. There are many barriers to the provision of perinatal mental health services in maternity settings and notable amongst them is the unavailability of adequate resources such as assessment rooms that ensures or provides enough

privacy (n=317; 99.4%). This is directly attributable to the perinatal women unwillingness to discuss any psychological challenges with the midwives due to perceived discrimination and stigmatisation (n=308; 96.6%). This finding is also consistent with earlier reports that identified the lack of privacy and confidentiality as reasons why perinatal women do not engage service providers when faced with psychological problems [1,2,7]. Additionally, the participants identified the lack of capacity-building needed to practically equip and enable them to adequately use these assessment tools as a major impediment to the provision of perinatal mental health services and therefore consider such services less important in providing holistic maternal care and services. These are interesting but also quite shocking responses from participants because the perinatal period is a vulnerable time that presents an increased risk of mental health challenges for perinatal women and midwives must be adequately prepared to support these women in this regard. Furthermore, a greater proportion of the participants (n=301; 94.4%) expressed the desire to have perinatal mental health courses incorporated into their training to equip and prepare them adequately to meet the mental health needs of the women in their care. This observation aligns with preliminary studies that proposed further education for midwives on perinatal mental health issues [7].

Training, Practice, Professional Development and Progression of Midwives in Ghana

Midwifery education is a key solution to the challenge of providing universal and quality maternal and newborn care to meet our Sustainable Development Goals and while improving access to care is critical, ensuring good quality of care has an even greater impact in terms of lives saved [20]. The World Health Organisation posits that midwifery education is designed to address three (3) strategic priorities namely, all midwives should be educated to high standards and enabled to practise to their full scope, midwives should be involved in education policy at the highest level as well as aligning and coordinating midwifery education processes to meet international standards [20]. Despite an understanding of the skills and competencies needed to provide high quality care to women during pregnancy, birth and the post-natal period, there is a marked lack of conformity and standardisation in the approach between countries to the pre-service education of midwives [18]. Report indicates that there is complexity in midwifery education in many countries, which is concentrated in low -and middle-income countries (LMICS). On average, LMICs have a greater number of education pathways and shorter duration of education programmes and are less likely to attain the ICM-recommended minimum duration of 36 months for direct entry [18]. However, in Ghana, candidates presenting themselves for the registered midwifery program are expected to possess strong grades (usually grades A1-C6 in specific subject areas) in the West African Senior School Certificate Examination (WASSCE). The midwifery profession in Ghana is regulated by the Nursing and Midwifery Council of Ghana. The council, together with the ministry of health, Ghana (MOH), the Health Training Secretariat (HTI) and the Ghana Tertiary Education Commission (GTEC) prescribe three different routes to becoming a registered midwife (RM) in Ghana. A candidate could undertake a 3- year diploma program in an accredited nursing and midwifery training college or pursue a 4- year Bachelor of science degree in an accredited university in Ghana. Similarly, post-basic midwifery candidates would have undergone a 2- year certificate nursing assistant clinical or community health nursing program and an additional two-year top-up midwifery training to qualify for registration as a midwife with the NMC-Ghana.

A candidate having received her certification as a registered midwife with the NMC of Ghana begins her career as a staff midwife (SM) and progresses steadily through such ranks as senior staff midwife (SSM), midwifery officer (MO), senior midwifery officer (SMO), principal midwifery officer (PMO), deputy director of midwifery services (DDMS) and director of midwifery services (DMS). Conventionally, it takes a midwife an average of 20 to 25 years to obtain the rank of DDMS OR DMS. However, this could be enhanced through academic development to obtain the same rank and reduced the duration by 5 to 10 years on the average. Traditionally, the professional progression of nurses and midwives in Ghana takes a 5-year stepwise promotion. For instance, it takes an SM 5 years to obtain the rank of an SSM from the first appointment and subsequently another 5 years to become an MO until s/he reaches the last rank. Nonetheless, some nurses and midwives may skip ranks partly due to special appointments to certain positions or through academic developments. Midwives work in a variety of settings and at different levels across the healthcare system, ranging from health centres (sub-district hospitals) to teaching hospitals across the country as shown in table 1-4 (fig. 1-4 respectively).

CONCLUSION

Anxiety and depression disorders are common in women, and this extends into the perinatal period as well. Thus, screening for anxiety and depression symptoms during the perinatal period is crucially important for the proper management and treatment of these conditions. Our findings provide relevant information and pointers to stakeholders in the education, training, regulation, and practice of midwifery in Ghana to prioritise maternal mental health services for all women by equipping midwives who are the major frontliners in the delivery of holistic perinatal care services. Overall, the study revealed the lack of understanding and the ability of midwives to confidently use globally reliable and validated assessment tools to incorporate mental health screening into routine maternity services.

DECLARATION

Ethical Approval: The ministry of health (MOH) of Ghana and the Ghana Health Services (GHS) research ethics committees approved the current study and conforms to the 1964 Declaration of Helsinki Ethical Standards for Human Research.

Consent for Publication: Informed consent was obtained from the study participants. The participants were informed that the outcome of the study will be published for a wider readership and consent for same was sought from the participants.

Availability of Data and Materials: The datasets used in this current study is available from the corresponding author on reasonable request.

Competing Interest: The authors of this paper have no competing interests or any other interests that seek to influence the results and discussions addressed in this paper. Additionally, the results/tables/figures in this manuscript have not been published or submitted elsewhere for consideration. In furtherance, I confirm that I have read the journal submitting policies and hereby submit this manuscript in accordance with these policies. Again, all the materials in this manuscript are owned by the authors and do not require any permission to be published. Lastly, participants' engagement was done in accordance with the relevant guidelines and policies.

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