COLLEGE OF MEDICINE AND HEALTH SCIENCES
School of Public Health

"A QUALITATIVE STUDY EXPLORINGING PERCEPTIONS OF BENEFICIARIES ABOUT A COMMUNITY-BASED INTERVENTION TO ADDRESS PERINATAL DEPRESSION IN RWANDA"

Dissertation presented in partial fulfillment of the requirements for the award of degree of master in Public Health

by

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DECLARATION

I declare that "a qualitative study exploringing perceptions of beneficiaries about a community-based intervention to address perinatal depression in Rwanda" is my work and all the sources and references I have used, have been indicated and acknowledged in the reference at last pages of this book. I declare also that this work has not been submitted to any other school or institution before for any award of degree.

DEDICATION

I am so grateful to God’s love and mercy all along my studies. I dedicate this book to everyone who contributed directly or indirectly to the accomplishment of this work

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LIST OF ACRONYMS

CWL: Community Women Leaders

DHS: Demographic and Health survey

EPDS: Edinburgh Post- Natal Depression Survey

IHDPC: Institute of HIV/AIDS, Disease, Prevention & Control

LAMIC: Low and Middle Income Countries

MIGEPROF: Ministry of Gender and Fampromotion

MMH: Maternal Mental Health

MOH: Ministry of Health

MNCHR: Maternal Newborn and Child Health in Rwanda

MSSS : Maternal Social Support Scale (MSSS),

NAWOCO: National Women Council

PI: Principal Investigator

RBC: Rwanda Biomedical Center

RNEC: Rwanda National Ethics Committee

SPH: School of Public Health

UNICEF: United Nations Children's Fund

UR: University of Rwanda

WHO: World Health Organisation

YU: ` York University

ABSTRACT

Background

The purpose of this study is to assess beliefs and attitudes and test a sustainable and low cost intervention to improve the mental health of mothers. It is unclear how women's experiences of PND influence their beliefs and attitudes and their choice to seek help. We will also assess the level of efficacy of community-based emotional and information support intervention.

Methods

A qualitative study was conducted to assessing perceptions of pregnant women and new mothers about their perception of community-based-intervention addressing maternal mental health in Rwanda. Twelve in-depth interviews and 8 focus group discussions were conducted in Bugesera district of the Eastern Province. Data were collected in Kinyarwanda and analyzed using a content analysis approach.

Results

Findings suggest the lived experience of PND and associated attitudes and beliefs result in significant barriers to accessing help. Findingns were grouped in five three main themes: (1) stigma and denial; (2) poor mental health awareness; and (3) interpersonal support and other attitudes observed among participants. The community-based preventive and early psychosocial interventions addressing some of the mental health issues among mothers revealed of big role in changing mindset.

Conclusion

There is a better understanding of how a mother's lived experience of postnatal mental illness and her associated attitudes and beliefs that may form barriers to her help seeking. This understanding allows those involved in the care and treatment of these mothers to be better placed to help them restructure their perceptions about the disorder.

Keywords: perinatal depression, Community-based intervention, beliefs and attitudes, Rwanda

CHAPTER ONE GENERAL INTRODUCTION

1.1 Definitions

Depresion: For the purpose of this dissertation, we define depression as a mood disorder characterized by a sense of inadequacy, hopelessness, decreased activity, pessimism and sadness where these symptoms severely disrupt and adversely affect the person's life, sometimes to such an extent that suicide can be attempted or results. And WHO defines it as a common mental health disorder characterized by persistent sadness and a loss of interest in activity that an individual enjoys and accompanied by an inability to carry out daily activities for at least two weeks. (WHO, 2014)

Perinatal Depression: refers to development of depression during pregnancy, around childbirth and/or within the first-year post-partum (Muzik, 2010).

Mental health: is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

1.2 Background

Perinatal Depression is the most common disorder which can occur among pregnant women and new mothers from conception to 12 months of age (Paschetta et al., 2014). It is a common condition with significant negative maternal, fetal, and neonatal and childhood outcomes and family dysfunction when it is overlooked. Consequently, it is a public health concern to the public well-being (Bitew, Hanlon, Kebede, Honikman, & Fekadu, 2017; El-hachem et al., 2014; Kettunen, Koistinen, & Hintikka, 2014). Studies suggest that 10 to 15 percent of women suffer from perinatal depression in general (Fairbrother, Young, Janssen, Antony, & Tucker, 2015). Maternal depression in high income countries is estimated at 10%; in low and middle income countries, the prevalence varies from country to country and due to limited availability of trained professionals, depression may be under reported ; it is estimated to be 5 % to 40% (Bitew et al., 2017; Kathree, Selohilwe, Bhana, & Petersen, 2014). Perinatal depression has considerable impact on the quality of life and

social interaction of the mother and the overall development of the newborn including physical, social, cognitive, emotional, behavioral and even relational aspects. If a woman experiences increased anxiety and depression during pregnancy, it affects the fetus with increased risk of premature birth, low weight at birth, early childhood development delays, labor complications, pre-eclampsia or even miscarriage (B. J. L. Alhusen & Alvarez, 2016). After birth, children may experience attachment problems between the mother and child, with less responsiveness of the mother impacting the overall development and the well-being of the child, including physical and cognitive development and malnutrition (Eastwood et al., 2017).

Mental health problems during pregnancy and post- partum are remarkably frequent and can have devastating consequences for the mothers, but also for infant physical and mental health. Rates of the most common perinatal mental health problem, depression, have been found to range from 10% to 40% in low and middle income countries (LAMICs; WHO, 2008). In a recent study completed at an antenatal clinic in a hospital in one district hospital of Rwanda, Umuziga (2014) found that among women in the antenatal period, 38.6% reported clinical levels of depression. Among those in the postnatal period, 59.0% reported clinical levels of depression. Antenatal maternal mental health problems have been associated with low birth weight, preterm delivery, lower rates of accessing available prenatal care, and increased rates of post-natal maternal mental health problems (Patel, Rahman, Jacob, & Hughes, 2004). Post-natal mental health problems have been associated with child malnutrition, elevated rates of infant stunting (low height for age) and underweight (M. Black, Baqui, Zaman, El Arifeen, & R. Black, 2009; Harpham, Huttly, De Silva, & Abramsky, 2005). Thus, as noted in a recent paper on maternal health (Rahman, Surkan, Cayetano, Rwagatare, & Dickson, 2013), the advancement of maternal and child health can only be fully achieved by integrating maternal mental health into maternal and child health care and policies.

1.3 Problem statement

Risk factors for maternal depression include poverty, low education levels, trauma and prior mental health problems (Patel et al., 2004). All of these factors are widely prevalent in Rwanda. One study has been conducted in Rwanda to explore rates of maternal mental health problems by Umuziga (2014) who measured common

perinatal mental disorders among 165 women attending an antenatal clinic at a district hospital in the Eastern province of Rwanda and reported high clinical levels of depression. Rates may be even higher among women who do not access district hospitals (Fisher et al., 2012).

The use of screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) has gained increased popularity (Buist et al 2006; Austin 2003) as a means of identifying women who are distressed postnatally. However, even when identified women are often reluctant to accept a clinical diagnosis that labels them as 'depressed' (Buist et al 2005; Whitton et al 1996; McIntosh 1993).The reasons behind this attitude are varied. In a survey conducted in Australia, 36% of women recognised depressive symptoms in a hypothetical case compared to 80% of general practitioners (Buist et al 2005), suggesting poor recognition of symptoms as a major factor.

Other beliefs and attitudes that might contribute, have emerged in a number of studies: heightened feelings of failure or of never recovering, uncaring and unknowledgeable health professionals, unsupportive partners and families, perceived ramifications of being identified as mentally ill, minimization of symptoms, stigma/ fear of being labelled as mentally ill and attributing feelings of distress to psycho-social issues such as loss of freedom, financial pressures and housing issues (Carter et al 2005; Ugarriza 2002; Tam et al 2002; Whitton et al 1996). To our knowledge only one other study exists addressing these issues, in a Canadian population (Sword et al 2008). A number of questions remain unanswered including how women's experience of Post Natal Depression (PND) and the related beliefs and attitudes influences their choice to seek help, and how family, friends and health professionals can facilitate help seeking behaviors, because being depressed affect women's ability to actively seek help.

The strategic plan of the Ministry of Health underlines the core aims in regard to maternal health including: Reduction of maternal and child mortality; Control of communicable and non-communicable diseases including mental health disorders; Health promotion, food safety and nutrition, health and environment and improvement of health system performance (WHO, 2009). Therefore, this intervention builds on the existing maternal health strategies by strengthening existing health care systems and educational programs, emphasizes community based initiatives and prevention, and builds

community networks and knowledge to provide mental health support at the level of families and villages. Because of Rwanda's well integrated community-based health care system, the development of a successful community based intervention can make Rwanda a leader in the global effort to include maternal mental health into maternal care and thereby reduce maternal and childhood mortality and morbidity.

1.4 Study justification

This study seek to understand beliefs and attitudes of mothers about maternal mental health issues and tests the efficacy of an intervention that focuses on all new mothers in rural villages in Eastern Province in Rwanda. The study by Umuziga (2014) conducted in the same Province highlighted the high number of maternal depression. The evidence (Patel, Rahman, Jacob & Hughes, 2004) has shown that maternal mental health can impact on child survival. This may be linked to the high rate of mortality in children under five in Eastern Province (DHS, 2010).

The intervention is based on evidence that psychosocial support is an essential determinant of physical and mental health (Cohen, 2004). Research on effective interventions for perinatal maternal mental health in LAMICs suggests that simple support and counseling can improve the well-being of mothers and their infants (Rahman, Sikander, Roberts, & Creed, 2008; Tripathy, Nair, Barnett, Mahapatra, Borghi, Rath, et al., 2010). In fact, a recent systemic review by Clarke, King and Prost (2013) found that common perinatal mental health disorders (i.e. anxiety and depression) could be reduced in mothers in middle income countries through the simple provision of health promotion interventions, interventions where mothers received perinatal health information, but also had the opportunity to simply share their feelings and their concerns and to receive psychosocial support.

This suggests that simply receiving visits from an empathic listener may be sufficient to reduce the incidence and impact of perinatal mental health problems. Moreover, research with home visiting programs for mothers suggests that there are mental health benefits for their children, which may be long-lasting, although evaluating the long term mental health consequences for the children are beyond the scope of this study (Kirkland, 2013). Seeking to understand beliefs and attitudes of mothers about maternal mental health issues is key to know how to design intervention strategies to help mothers

and motivate them to seek help timely. Thus, providing psycho-social support to all mothers may be an efficient way to reduce prevalence rates of maternal depression by preventing the onset of depression for those mothers not currently suffering from distress, as well as reducing the impact of depression for those mothers who are already showing symptoms. Community-based intervention has been proposed to improve maternal mental health of mothers in Rwanda by emphasizing on prevention through emotional and informational support.

1.5 research objectives

The purpose of this study was to assess the impact of a community-based intervention to improve the mental health of mothers in Rwanda.

The specific objectives:

- To understand the targeted villages' attitudes and beliefs about maternal mental health issues.
- Assessing the perceptions of participants about impact of the community-based emotional and information support intervention in Busegesera district.

CHAPTER TWO: LITERATURE RIVIEW

Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after child birth(Bitew et al., 2017). Maternal mental disorders are treatable.Globally maternal mental health problems are considered as a major public health challenge. Though maternal mortality still lies at the heart of maternal health indicators; for the post 2015 agenda for development goals, WHO is considering Universal Health Coverage (UHC) and proposing Healthy Life Expectancy (HLE) related indicators as well. This implies stronger focus on mental health conditions in the integrated delivery of services for maternal and child health. The need is not just felt in high income countries. In fact, some academic and public health institutions in low and middle income countries have already initiated integrated maternal mental health programmes. These have been low cost interventions with the involvement of non-specialized or community health providers. Impact has been demonstrated not only on mothers but also on growth and development of children.

Who is at risk of mental health disorders?

Virtually all women can develop mental disorders during pregnancy and in the first year after delivery, but poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, natural disasters, and low social support generally increase risks for specific disorders.

Effects of maternal mental disorders after birth on the mother and the infant

After the birth, the mother with depression suffers a lot and may fail to adequately eat, bathe or care for herself in other ways. This may increase the risks of ill health. The risk of suicide is also a consideration, and in psychotic illnesses, the risk of infanticide, though rare, must be taken into consideration.

Very young infants can be affected by and are highly sensitive to the environment and the quality of care, and are likely to be affected by mothers with mental disorders as well.

Prolonged or severe mental illness hampers the mother-infant attachment, breastfeeding and infant care(Eastwood et al., 2017).

Factors associated to postnatal depression

For health care providers, understanding the risk factors for maternal depression is very important as it allows them to identify women at risk of developing maternal depression in a timely way. In the literature, many risk factors have been identified by researchers. Most of them confirmed that women with a lifetime history of depression are more likely to be at increased risk for perinatal depression as are women who experience antenatal depression. Socio-economic status predisposes women to perinatal depression; poverty is found to be a high predictor of maternal depression. Experience of stressful events (serious family conflicts, death of a loved one, divorce, separation from a partner and hazardous life condition like a serious illness) also influence the occurrence of perinatal depression among pregnant women or new mothers. A body of studies also support the association of social support available to women and perinatal depression. In the same direction, they focus a lot on the support from the partner, which plays a crucial role in the occurrence of perinatal depression, and thus single mother status is a particular risk. Research also underlined the strong association between intimate partner violence and perinatal depression. In their studies, Alhusen et al., found out that 85% of women who experience intimate partner violence during pregnancy were diagnosed positive for perinatal depression. Most of these women were also at risk of developing suicidal ideation (Alhusen, Ray, & Sharps, 2015; Miura & Fujiwara, 2017; Bullock & Sharps, 2014; Jacksona, Ciciollaa, Crnica, Lueckena & Gonzalesa, 2016; Howard, Flach, Mehay, Sharp, & Tylee, 2011). Bizu Gelaye et al. (2016) also talked about risk factors associated with perinatal depression in terms of increased symptoms and unintended pregnancy and focused also on social support with linkages to negative health behaviors and adverse outcomes such as poor nutrition, increased substance use, low birth weight, and premature birth increasingly leading to postpartum depression and suicide (Gelaye, Rondon, Araya, & A, 2016). Another study also identified perinatal depression's risk factors in terms of stressful life events, unemployment, marital conflicts, low education and caesarean section for mothers who strongly wished to have a vaginal normal delivery but could not due to

other factors related to their physiology (Grote et al., 2010; Seth, Lewis, & Galbally, 2016). Also consistent with the literature, Leigh and Milgrom found in their study that antenatal depression is a dominant mediator between a number of risk factors and postnatal depression such as antenatal anxiety, major life events, low self-esteem, low social support, negative cognitive style, history of abuse, low income and history of miscarriage or pregnancy termination and childhood sexual assault (Leigh & Milgrom, 2008).

CHAPTER THREE METHODOLOGY

3.1. Study design

This study used a qualitative descriptive study design.

3.2. Study setting

This study was carried out in Bugesera District, Eastern province. We have considered 10 villages which received the psycho-social support intervention.

Sampling methods

Purposive sampling

3.3. Recruitment of study participants

Inclusion criteria: new mothers who have been under one emotional and support intervention in Bugesera District and selected villages.

Exclusion criteria: any women from selected villages who didn't go through the emotional and support intervention

3.4. Data collection procedures

Before data collection, all tools were pre-tested on new mothers and community members from one sector of Bugesera district that was not included in the study. Data were collected via interviews and focus group discussion The interviews were conducted in Kinyarwanda by the research assistants who were taking note and transcribe them in order to gain greater insight into beliefs and attitudes around maternal mental health problems and the efficacy of emotional and support intervention. Questions were formulated to reduce socially desirable responses and allow participants to express their opinions in a way that would make them feel safe. Focus groups were used to collect qualitative insights into women's perceptions of their PND experiences. This methodology has been used in a number of previous studies to explore the lived experience of PND; it is an effective way for women to explore personal experiences in a non-threatening environment and allows a naturalistic collection of qualitative data. This approach is also valuable where the goal is to elicit conversation from participants and to explore sensitive issues or where information of this nature may be revealed. Participants were encouraged to respond with whatever level of detail they felt comfortable and issues that arose or were important to participants, but not

included in the guide, were followed up and discussed.

Confidentiality was maintained to the fullest extent possible. Interviews were conducted by the researchers in confidential place. Mothers' identities were noted in cases where there are elevated levels of maternal depression for further transfer. This is necessary in order to provide care for mothers at risk. Any information that includes respondent's identification was stored in a secure place. Before the interview begins, each potential given an opportunity to decide whether they would like to participate in the study. The consent form covers why the respondent was selected, the purpose of the interview, and reassurance that all the information they provide will be treated confidentially. All study participants were asked to sign a consent form; in the case that a potential participant was not read or write, the respondent was advised to seek a witness who can sign the consent form as a witness to the research team explaining the content of the consent form to the participant and the participant's consent to participate in the study.

No Payment was offered to Community Women Leaders and mothers for participating in the study. However, the Community Women Leaders were compensated for transportation and per diem of 10 dollars after each training session and meeting. Additionally, focus groups participants were provided with transportation reimbursement, refreshments and snacks.

3.5 Data management and analysis

Data were stored on secure, password protected laptops, as well as on a secure, password protected. Interpretative phenomenological analysis was used to analyze the data. This process was selected as it allows the researcher to construct an understanding of participants' experiences through their (the participants' personal account, rather than an attempt to find causal explanations or produce an objective description. Thus, it is dynamic research process involving both the participant's experience and the researcher's values and beliefs to assist in understanding and making sense of the lived experience.

Interviews were recorded with the participants' permission and supplemented with hand written notes. Audio recording of the group discussion was transcribed. Each transcript and written notes taken during each group (for example, what was said and what was meant in terms of the context, who said it, what came before, unspoken body language and silences),

was read and reread to facilitate familiarization with the content and to begin to understand the women accounts of their experiences.

Passages and paragraphs were reviewed within the context of the interview to identify any major themes, the intent of the participant's response or any phrases, words, terms or descriptions that illustrated recurring patterns of experience. Statements were organized into logical sub themes which were then aggregated into theme clusters. These theme clusters were used to provide a description of the lived-experience.

Themes that overlapped or had similar content were merged. Transcripts and themes were discussed and agreement was reached as the analysis proceeded. Potential variations between different focus groups were assessed to determine the relative importance to each theme cluster. The resultant theme clusters were checked against the original description in each transcript to maximize objectivity and allow refinement of themes or to highlight relationships between clusters. This process was designed to ensure the developing analysis was systematic and data supported the results.

3.3 Ethical considerations

Authorization letters for this study were obtained from the Ministry of Health, child and maternal health Unit and from the National Research Scientific Committee and the National Ethics Committee.

CHAPTER FOUR: RESULTS

Many people don't understand mental health problems and may have a negative view of people who experience them. This can cause people with mental health problems to be treated badly or labeled in a way that hurts their standing in the community. This is sometimes called 'stigma', and can affect those with mental or emotional problems, their carers and families. Some attitudes and beliefs are attached to mental health problems in the community.

1. Attitudes and beliefs about maternal mental health issues

Stigma and Denial

Women's fear about acknowledging emotional problems and the stigma associated with this, real or imagined, was a constant theme. It was also acknowledged the stigma of being a rejected by their families-in -law and their partners was worse than being labeled depressed. This often resulted in women denying how bad they felt, but associating it with self-reliance and resilience with their stressful situations. Most of the women articulated it in their words: "***I was married, but after the marriage my mother-in-law used to treat me unfairly and insult me very much. After three months, I decided to leave instead of being killed by sadness; because it has reached to the extent of losing interest in food. I think you even know it, when you have a problem, whatever you can eat, whatever you can do; you don't feel any satisfaction. Instead of keeping up with this conflict, I decided to leave hoping to deliver safely by the grace of God for I didn't see any other choice, I tried my best to prepare myself to delivery and all other basics I should need. Today, I don't mind. Whether they accept me or not, I am who I am with my children."***

Poor Mental Health Awareness

Not being able to identify or distinguish between the normal emotional and psychological adjustment associated with marriage phenomenon and parenthood and when they were 'depressed' was identified as women can't identify themselves what they are going trough. She said: "***to me depression is when you can't get out of bed, like you physically cannot function. And I'm like…I can get myself out of bed, I can get myself up and get dressed, but then there's days that I can't… And then I have to drag myself through the day and then spend the rest of the time thinking about how little I've done or how bad I've***

spoken to the kids, I don't have any problem with my mental health status. Yes, I have been broken, I have endured, sometimes I feel hopeless, rejected, regrets, loose interest of doing things and household activities, but I don't have any problem mentally"

For so, women often did not know what services were available to assist them or how these could meet their particular needs. This uncertainty was aggravated by the symptoms of depression with women reporting they felt completely overwhelmed by their emotions. They talked about it in these words: "***everything just got too much for me, and I couldn't go anywhere to get any help and lacking motivation and positive decision making capabilities"***

Interpersonal Support

Many women admitted the power balance within their partner relationship changed once they learnt about their pregnancies and they had their baby; and so, they began experiencing emotional distress. For many women this put significant strain on their relationship and this was, at times, difficult to emotionally and physically sustain. Family background was also identified as having an impact on both acknowledgment of emotional and mental health needs and help seeking behaviour. In families described as having negative attitudes, the understanding was that it was the role of the individual to manage difficulties and so women were struggling alone and her child "***After I gave birth to this child, I live like a divorced woman. Also, because I still live in the house of my father in law, they create frustrations to me. I am always prepared to that they would dismiss me. But I try to be patient in those situations. They would gear at me by telling me that my husband denied me and that I should go. Therefore, I go to ask for food in other houses, and I come to cook them so that I can feed my children."***

Other attitudes observed among participants

Women acknowledged a number of other factors, aside from those already highlighted, such as poor sleep, physical discomfort from delivery complications, and the inability to think clearly and logically, lack of motivation, changes in perception of body image and distinguishing between the symptoms and consequences of depression.

2. Level of efficacy of community-based intervention

Pregnant and new mothers experiencing some kind of mental health problems can have a substantial negative impact on their health and functioning. So, it is important to consider certain effective methods of addressing these kind of issues. However, help-seeking is substantially low in this group due to lack of awareness about the problems as well as help available, stigma, and problems not amounting to clinical diagnosis, makes a strong case for community-based prevention and early intervention, an important option. Though, the community-based preventive and early psychosocial interventions addressing some of the frequently reported mental health issues among mothers revealed of big role in changing mindset**.**

In our case study, women explained very well how the community based intervention is doing great and changing women lives in their own words **"*It was a great support. I cannot track how many times she visited us in a month, but in one month I can remember two times. It helped me to the extent I miss those days she came to visit us. If I were luck to see her again and come to visit me again, because she used to surprise me. During that time, I family was looking different."***

The intervention has been appreciated at high extent by the beneficiaries:"***t has extremely helpful to me. She used to come to visit me, and tell her about all the challenges I face. Because, there was a time when I dared to decide to leave my children alone. Then, she advised me that leaving my children wouldn't be the solution of my problems. She just advised to keep on caring my children and forget about my husband and the problems he left me in. She used to remind me that I am capable to forget my challenges. She would also tell me that I should stay with my kids because I have nowhere to go, since my mother deceased. She reminded me that I shouldn't hurt my children, because we never know they might be the source of my happiness in the future. She would also advise me to try to change the environment in case my mother-in-law is stressing me, such as visiting the community health worker or even her so that I would find a peaceful place to stay for a while.***

The community health intervention was implemented by women community leaders at the village level. They have been trained on maternal mental health problems, specifically in psycho-social support. Through home visits, these women were able to identify women at

risk of developing or have already developed mental health problems for further support and psychological counseling**. *"I would go to visit her and say what brought me there. Then, after welcoming me, we would have an advisory conversation about how she should behave hygienically and generally in life. In addition, we would also talk about daily interaction with her husband.You start by asking how she is feeling in health and her living condition after delivering. She may even tell you that she is feeling weak and you keep asking her questions and she answering you; when you see that sign of shaking her head in despair you immediately tell it. You may, for instance, ask her what the problem is after recognizing her lamenting. Maybe she can tell you that the situation is not good between her and her husband that he didn't give her any rewards after the delivery or carrying this baby during pregnancy was not good. Then, you find that what she passed through are the source of her problems."***

The community Women leaders trained in providing social support testify how they help their colleagues in need of emotional support and how helpful it has been. Not only for the project beneficiaries but also for themselves as individual. When asked about what to do when you find a woman anxious, they responded in these words**"**

"***When you find a woman is sad or anxious, you get close to her and let her tell you about all her worries in details. And when you feel she is going to shut it you try to connect and say a word that will help her go down. Sometimes people lack someone to talk to even if it's to only listen she feels relieved of the weight that it is putting on her shoulders to keep it for herself."***

In general, women expressed a high satisfaction about the community based intervention designed for them and how helpful it has been for them and their families.

CHAPTER FIVE: DISCUSSION

The objective of this study is to assess beliefs and attitudes and test a sustainable and low cost intervention to improve the mental health of mothers in Rwanda and the specific objectives are to understand the targeted villages' attitudes and beliefs about maternal mental health issues and assessing the level of efficacy of community-based emotional and information support intervention.

Attitudes and beliefs about maternal mental health problems

This qualitative study of women experiences of depression suggests that there are significant beliefs and attitudes about mental health issues which also contribute as barriers to accessing help. All of the mothers involved in this study were participating in the community-based intervention and this suggests because they had accepted their distress and had sought assistance, they were perhaps more willing to discuss elements of shame, disappointment and denial they had to overcome as well as negative personal attitudes toward acknowledging and discussing mental health concerns.

The findings of this study reinforce the notion of maternal ignorance of perinatal depression, coupled with feelings of stigma and denial. As in other studies, many women found it difficult to distinguish their distressed mood from normal psychological adjustment in the pregnancy and postpartum period and were likely to dismiss or deny depressive symptoms. It is interesting to attempt to reconcile this observation with the finding non-depressed mothers also experience negative thoughts and emotions during the postpartum period. This has important implications for the way community women leaders discuss these issues with women. For some women acknowledging the emotional changes associated with childbirth and becoming mother and providing simple reassurance can be helpful.

This does not mean that feelings of postnatal distress should be minimized, but seen to lie in a continuum. A key message women conveyed is not to minimize the distress they report. When feelings are not validated or are normalized to the extent that distress is down played, they exacerbate feelings of inadequacy and frustration. Community women leaders themselves may need to be better trained in risk assessment/identification so as to distinguish when reassurance and support are adequate, to when specialized intervention is

needed.

Another key message was that the role of partners and families in providing support and facilitating pregnancy and postpartum adjustments. In general, partners and families were felt to be supportive but consistent with other studies women were hesitant revealing they were unable to cope or were experiencing a mental instability fearing shame and embarrassment. Strategies, which emphases and reinforce utilizing support and accessing services, as a normal part of the perinatal journey, are needed. These could assist fathers to better understand their partner's experience, and attitude toward their disorder, and help them to reach the magnitude of the transformation taking place to their partner, themselves and their relationship. These programs would aim to improve a father's understanding and contribution to pregnancy, birth and early parenting; their role should difficulties arise in maternal recognition of distress and facilitation of motherhood as well.

Community-based interventions among mothers

According to our results, allowing mothers to have enough information about mental health issues and their consequences call them to accept and seek help timely. Studies have underlined that mental health interventions are designed to address women's emotional needs, improve their access to health related information and health services, strengthened their interpersonal bonds, and enhanced their well-being. Though, economic status may be a barrier to them and so several researchers have commented that development interventions need to be integrative so that they address poverty alleviation, strengthen social capital, and empower the poor through self help group interventions. Women community leaders were struggling to convince the mothers about seeking help and be aware of their mental health status because for them the first issue was their economic status.

Though, whenever a woman is open to receive care services and support, it was so helpful and women were benefiting from it. Which improved categorically their resilience within their families and themselves. They were very satisfied with the services provided to them and their families.

Limitation of the study

This study was carried out in a very short time and couldn't establish the comparative

measurements of the baseline and end-line of the community based intervention to make sure the positive results observed among mothers were really due to the intervention itself. Also as a qualitative study, we couldn't control any other confounding related to the interventions.

Recommendations

According to our study results, there is still a great gap in mental health problems awareness at the community level. And whenever a problem is not known, it is not taken into consideration seriously. For this reason, we recommend the Ministry of Health to increase and improve maternal mental health sensitization and campaigns to raise awareness and provide sufficient information about mental health issues. Preparations of psycho-education sessions through media would also be a good tool to improve awareness. We recommend also a scale up of the community based intervention at the national level as we are facing a challenge of mental health personnel in health care settings to manage maternal mental health cases. To future researchers, we recommend them to explore the role of economic status in mental health problem eradication and and cost-effective strategies to address mental health concerns among underprivileged women at the community level.

CONCLUSION

In this study, we found out that there are some attitudes and beliefs related to maternal mental health among others stigma and denial, and even interpersonal support between mothers and their respective family members. Distressed women, isolated at home with their young infants, frequently end up managing their mental health problems on their own and without appropriate support or are offered treatment they are ambivalent about. It is vital for us to develop a range of options and approaches to assist women at risk of depression, and their families, to ease their suffering and to avoid long term consequences. Strategies need to effectively support women so they can access health care services they feel comfortable with in a timely manner. Meanwhile, women who experience distress are very satisfied with a community based intervention for their emotional support and adequate information related to maternal mental health.

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APPENDICES

Appendix A: Consent and assent forms

Survey for new mothers (SNM) Consent Form (Individual)

As part of an assessment conducted in collaboration of the Ministry of Health and University of Rwanda and York University (Canada), we are asking new mothers to participate, to tell us about their experience with maternal mental health issues and community support as a mother. This discussion will help to identify solutions to address challenges for improving maternal mental health.

We will be asking you to answer some questions about how you feel, and about your relationships with other people around you. This information will be shared privately with the nearest health centre via text message so that we can ask for additional health help for you if you need it. We would also like to measure your child's height and weight to assess their health. If there are any health concerns based on their height and weight, we will let you know and also contact local health providers.

You should not have any negative effects from being a part of this study. You may find it a positive experience because you may understand more about how you are feeling. You may also discover if there are health concerns with your child, and learn about health services that are available to mothers.

We expect the Interview to take about one hour. However, you are free to leave the discussion at any time. You can be assured that you will not face any consequence if you do not want to participate. Your answers to these questions will be entered into a computer that is protected by a password. We will keep this information for 7 years. Your privacy will be protected as much as is legally possible.

Please to confirm your permission to participate in the discussion. Signature: _____

Please sign below to confirm your permission for filling the questionnaire. Signature: _____

Name: _____ Date: _____

If you have any further questions about this assessment, please contact **Dr. Fidele** at **0788304750** or **Dr. MUKAMANA Donatilla** at **0788304396**

Any questions about your rights as a interviewee should be directed toward the current chair of the National Ethical Committee of Rwanda, **Dr Jean Baptiste MAZARATI at 0788 309 807** or the RNEC Administrator **Mrs. Valentine INGABIRE at 0788 592 004**.

Survey for new mothers (SNM) Legal Guardian Consent Form

As part of an assessment conducted in collaboration of the Ministry of Health and University of Rwanda and York University (Canada), we are asking new mothers to participate, to tell us about their experience with maternal mental health issues and community support as a mother. This discussion will help to identify solutions to address challenges for improving maternal mental health.

In order to assure a proper data collection, participant answers will be recorded but no personal reference will be made to participants in these discussions. Responses will be kept completely confidential, and can only be accessed by the research team. In order to keep participants identities confidential, we will use numbers instead of names. Names of participants will not be revealed after this discussion. Participation is voluntary and participants have the right to skip any question any time they want. We will answer participant questions at the end of the discussion.

We expect the interview to take about one hour. However, participants are free to leave the discussion at any time. Participants can be assured that they will not face any consequence if they do not want to participate. The discussion will be audio taped so the team will be able to write an accurate summary of the ideas that will be shared with the decision makers.

Please sign below to confirm your permission for the minor to participate in the survey.

Name of minor:_____

Name of legal guardian: _____

Signature of legal guardian: _____Date: _____

If you have any further questions about this assessment, please contact **Dr. Fidele at 0788304750** or **Dr.MUKAMANA Donatilla at 0788304396**

Any questions about your rights as a interviewee should be directed toward the current chair of the National Ethical Committee of Rwanda, **Dr Jean Baptiste MAZARATI at 0788 309 807** or the RNEC Administrator **Mrs. Valentine INGABIRE at 0788 592 004**.

Survey for new mothers (SNM) Assent Form

As part of an assessment conducted in collaboration of the Ministry of Health and University of Rwanda and York University (Canada), we are asking new mothers to participate, to tell us about their experience with maternal mental health issues and community support as a mother. This discussion will help to identify solutions to address challenges for improving maternal mental health.

We will be asking you to answer some questions about how you feel, and about your relationships with other people around you. This information will be shared privately with the nearest health centre via text message so that we can ask for additional health help for you if you need it. We would also like to measure your child's height and weight to assess their health. If there are any health concerns based on their height and weight, we will let you know and also contact local health providers.

You should not have any negative effects from being a part of this study. You may find it a positive experience because you may understand more about how you are feeling. You may also discover if there are health concerns with your child, and learn about health services that are available to mothers.

We expect the Interview to take about one hour. However, you are free to leave the discussion at any time. You can be assured that you will not face any consequence if you do not want to participate. Your answers to these questions will be entered into a computer that is protected by a password. We will keep this information for 7 years. Your privacy will be protected as much as is legally possible.

Please to confirm your permission to participate in the survey. Signature: _____

Name: _____ Date: _____

If you have any further questions about this assessment, please contact **Dr. Fidele** at **0788304750** or **Dr. MUKAMANA Donatilla** at **0788304396**

Any questions about your rights as a interviewee should be directed toward the current chair of the National Ethical Committee of Rwanda, **Dr Jean Baptiste MAZARATI at 0788 309 807** or the RNEC Administrator **Mrs. Valentine INGABIRE at 0788 592 004**.

Icyemezo cy' uwemeye kugira uruhare mu kiganiro

Umubyeyi

Murwego rw'ubushakashatsi buri gukorwa na Minisiteri y' Ubuzima ifatanije na kaminuza y'u Rwanda na kaminuza ya York(Canada). Igice cyubu bushakashatsi burasaba abagore babyaye bwa mbere kugira urahare mu kutubwira icyo bazi kubibazo bwubuzima bwumubyeyi nubufasha abaturanyi bamuha nkumubyeyi. Ibitekerezo muza gutanga bizadufasha kubona umuti w' ibibazo hagamijwe guteza imbere ubuzima bwiza bwo mu mutwe ku babyeyi.

Tuzagusaba gusubiza ibibazo bijyanye nuko wiyumva nimibanire yawe n'abandi bantu mubana. Ayo makuru tuzayageza muburyo bwanditse mwibanga kandi bwihariye ku kigo nderabuzima kikwegereye kugirango babashe kuguha ubufasha bwinyongera igihe bizaba bikenewe. Turifuza kandi gupima uburebure nibiro by'umwana wawe kugirango turebe uko ubuzima bwe buhagaze. Nidusanga hari ibibazo bijyanye nuburebure nibiro bye tuzabikubwira kandi tubimenyeshe abashinzwe ubuzima bakorera aho mutuye.

Kuba umwe muri ubu bushakashatsi nta ngaruka mbi bizakugiraho. Ukwiye kubikuramo ibyiza kuberako uzarushaho kumenya uko wiyumva. Uzabasha kandi no kumenya niba hari ibibazo k'umwana wawe kandi ukanamenya ibikorwa bihari biteganyirijwe ababyeyi.

Turateganya ko ikiganiro kiza kumara isaha imwe nibura. Ariko rero, ushobora guhagarika ikiganiro igihe cyose usanze ari ngombwa. Ikindi tukwizeza ni uko ntangaruka ishobora kukugeraho bitewe n'uko wisubiyeho. Ibisubizo uzatanga bizandikwa muri mudasobwa ifungurwa numubare wibanga. Aya makuru tuzayahamana mugihe cyimyaka 7. Ibanga ryawe rizabikwa nkuko biteganwa n'amategeko.

Niba ubitwemereye, shyira umukono kuri iyi nyandiko wemezako wiyemereye kugira uruhare muri ubu bushakashatsi. UMUKONO: _____

Niba wemeye ko gusubiza ibibazo. UMUKONO: _____

AMAZINA YAWE:

_____ITARIKI: _____

Niba hari ikibazo ufite kuri ubu bushakashatsi, ushobora guhamagara abakuriye ubu bushakashatsio kuri telefoni igendanwa ya Dr. **NGABO Fidele** ifite numero **0788304750**

cyangwa ugahamagara **Dr. MUKAMANA Donatilla** bafatanyije ubu busakashatsi kuri **0788 304396**.

Ku bibazo bijyanye n'uburenganzira bwawe nk'umuntu ukorerwaho ubushakashatsi, wahamagara Umuyobozi mukuru w'iIkigo gishinzwe kurengera abagira uruhare mu ubushakashatsi (National Ethical Committee of Rwanda), **Dr Jean Baptiste MAZARATI** kuri telefoni ye **0788 309 807** cyangwa umukozi uhoraho w'icyo kigo witwa **Valentine INGABIRE** kuri telefoni ye **0788 592 004**.

G 9: **Icyemezo cy' uhagarariye uwemeye kugira uruhare mu bushakashatsi (munsi y'imyaka 21)**

Murwego rw'ubushakashatsi buri gukorwa na Minisiteri y' Ubuzima ifatanije na kaminuza y'u Rwanda na kaminuza ya York(Canada). Igice cyubu bushakashatsi burasaba abagore babyaye bwa mbere kugira urahare mu kutubwira icyo bazi kubibazo bwubuzima bwumubyeyi nubufasha abaturanyi bamuha nkumubyeyi. Ibitekerezo muza gutanga bizadufasha kubona umuti w' ibibazo hagamijwe guteza imbere ubuzima bwiza bwo mu mutwe ku babyeyi.

Kugirango tubashe kwandika ibyavuye muri iki kiganiro, turaza gukoresha akuma gafata amajwi ariko ibisubizo nubwo bayndikwa nta mazina y'uwabitanze tuza kwandika. Ibisubizo uzaduha bizagirwa ibanga. Mu rwego rwo gukora ibintu mu ibanga, tuzakoresha nimeor aho gukoresha amazina y'abo twaganiriye. Kugira uruhare muri ububushakashatsi ni ku ubushake bwawe.Ikindi kandi buri muntu tuganira afite uburenganzira bwo gusimbuka ikibazo icyo aricyo cyose ntagisubuze igihe cyose yakumva kimubangamiye. Nitujya kuragniza iki kiganiro turaza kugira umwanya wo gusubiza ibibazo by'abo tuganira niba hari ibihari.

Turateganya ko ikiganiro kiza kumara isaha imwe nibura. Ariko rero, uwo tuganira ashobora guhagarika ikiganiro igihe icyo aricyo cyose. Ikindi ni uko ntangaruka ishobora kuba k'umuntu waba yanze kuza mubiganiro byacu. Muri iki kiganiro turafata amajwi kugira ngo nyuma yaho tuze kubasha kwandika ibitekerezo byatanzwe tuzageza kubashinzwe gufata ibyemezo.

Ese uremera ko uyu mwana wawe cg uhagarariye aza muri iki giniro hamwe n'abandi bakobwa bari mukigero kimwe?

Niba ubitwemereye, shyira umukono kuri iyi nyandiko wemezako umwemereye kugira uruhare muri ubu bushakashatsi.

UMUKONO: _____ _____ ITARIKI: _____

Ese uremera ko dufata amajwi ibiganiro turi bugirane?

Niba ubyemeye, shyira umukono kuri iyi nyandiko wemeza ko wemeye ko dufata amajwi.

AMAZINA Y'UWO UHAGARARIYE: _____

AMAZINA YAWE: _____

Niba hari ikibazo ufite kuri ubu bushakashatsi, ushobora guhamagara abakuriye ubu bushakashatsio kuri telefoni igendanwa ya **Dr. NGABO Fidele** ufite numero **078830 4750** cyangwa ugahamagara **Dr. MUKAMANA Donatilla** bafatanyije ubu bushakashatsi kuri **0788 304396**.

Ku bibazo bijyanye n'uburenganzira bw'umwana wawe nk'umuntu ukorerwaho ubushakashatsi, wahamagara Umuyobozi mukuru w'iIkigo Gishinzwe Kurengera Abagira Uruhare mu bushakashatsi (National Ethical Committee of Rwanda), **Dr Jean Baptiste MAZARATI** kuri telefoni ye **0788 309 807** cyangwa umukozi uhoraho w'icyo kigo witwa **Valentine INGABIRE** kuri telefoni ye **0788 592 004**.

Assent form

Murwego rw'ubushakashatsi buri gukorwa na Minisiteri y' Ubuzima ifatanije na kaminuza y'u Rwanda na kaminuza ya York(Canada). Igice cyubu bushakashatsi burasaba abagore babyaye bwa mbere kugira urahare mu kutubwira icyo bazi kubibazo bwubuzima bwumubyeyi nubufasha abaturanyi bamuha nkumubyeyi. Ibitekerezo muza gutanga bizadufasha kubona umuti w' ibibazo hagamijwe guteza imbere ubuzima bwiza bwo mu mutwe ku babyeyi.

Urasabwa kugira uruhare mubiganiro mu matsinda aho muzaganira kubyo wize, ibyo uzi mukwegeranya amakuru ajyanye nubuzima bwo mu mutwe bwumubyeyi, ibyo wabonye muri communaute ukoreramo. Ushobora kumva utameze neza mukuvuga ibyo uzi bikaba byatuma wumva utamerewe neza. Ntabwo utegetwe kuvuga amakuru atakumerera neza kandi ushobora guhagarika igihe cyose wumva utamerewe. Rwose

ishyire mu mutuzo ubwire umushakashatsi nyuma yikiganiro mu matsinda kugirango abashe kuguha ubufasha.

Kuba umwe muri ubu bushakashatsi nta ngaruka mbi bizakugiraho. Ukwiye kubikuramo ibyiza kuberako uzarushaho kumenya uko wiyumva. Uzabasha kandi no kumenya niba hari ibibazo k'umwana wawe kandi ukanamenya ibikorwa bihari biteganyirijwe ababyeyi.

Turateganya ko ikiganiro kiza kumara isaha imwe nibura. Ariko rero, ushobora guhagarika ikiganiro igihe cyose usanze ari ngombwa. Ikindi tukwizeza ni uko ntangaruka ishobora kukugeraho bitewe n'uko wisubiyeho. Ibisubizo uzatanga bizandikwa muri mudasobwa ifungurwa numubare wibanga. Aya makuru tuzayahamana mugihe cyimyaka 7. Ibanga ryawe rizabikwa nkuko biteganwa n'amategeko.

Please to confirm your permission to participate in the survey. Signature: _____

Name: _____ Date: _____

If you have any further questions about this assessment, please contact **Dr. Fidele** at **0788304750** or **Dr. MUKAMANA Donatilla** at **0788304396**

Any questions about your rights as a interviewee should be directed toward the current chair of the National Ethical Committee of Rwanda, **Dr Jean Baptiste MAZARATI at 0788 309 807** or the RNEC Administrator **Mrs. Valentine INGABIRE at 0788 592 004**.