

Letter to the Editor

Perinatal mental health in India and Thailand: A call for collaboration



Chonnakarn Jatchavala, MD, MSc., FRCPsychTH^{a,b}, Sharad Philip, MBBS, MD^c,
Himangshu Malakar, MBBS, MS^d, Lungan Rongmei, MBBS, MS^d,
Nilesh Devraj, MBBS, MD^e and Ramdas Ransing, MBBS, MD^{c,*}

^a DST-India-International Fellow, Department of Psychiatry, Clinical Neurosciences, and Addiction Medicine, All India Institute of Medical Sciences, Guwahati, India

^b Department of Psychiatry, Faculty of Medicine, Prince of Songkla University, Thailand

^c Department of Psychiatry, Clinical Neurosciences, and Addiction Medicine, All India Institute of Medical Sciences, Guwahati, India

^d Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, Guwahati, India

^e Department of Forensic Medicine and Toxicology, All India Institute of Medical Sciences, Guwahati, India

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Dear Editor,

Pregnancy and postnatal periods are markedly uncertain, with an increased risk of developing a mental illness. Women with and without prior psychiatric illness are at increased risk for developing mental illness during these critical periods, but women with a pre-existing severe mood disorder are more at risk.¹ In response to the growing burden of perinatal mental disorders (PMDs), some high-income countries (HICs) started developing perinatal mental services and inpatient mother-and-baby units.² Low and middle-income countries (including India and Thailand), on the other hand, have a high burden of PMDs (e.g., depression, anxiety) that are largely undiagnosed and untreated.^{3,4} Furthermore, both countries are similar in terms of cultural patterns and ethnic diversity, public health system and system-related barriers, the burden of mental disorders, social economics, politics, and stigma associated with mental illness. Thus, exploring the current state of perinatal mental health (PMH) and its services in Thailand and India could be beneficial to develop PMH services in the two countries. This article is a condensed version of a deliberation among perinatal mental health

experts to identify major areas for research collaboration between India and Thailand. This initiative is funded by the Department of Science and Technology, Government of India to promote collaborative and strategic research on women's mental health (particularly perinatal mental health) in Thailand and India. The findings of the discussions are organized as follows: the current state of PMDs among various groups (e.g., mother, father, preconception period, transgender), existing evidence-based interventions and service delivery models (at the individual and population levels), and its research implications in India and Thailand.

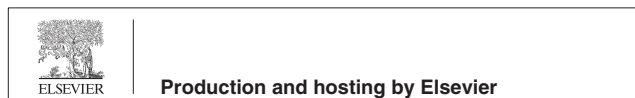
Current state of PMDs in India and Thailand

PMDs are the commonest pregnancy complication and are associated with considerable maternal and fetal/infant morbidity and mortality.⁵ In comparison to HICs, PMDs literature is scarce in India and Thailand. Most of these countries' published research focuses on perinatal depression, psychosis, and anxiety in cisgender women. Despite the fact that there are a considerable number of transgender women (especially in Thailand compared to India) and teenage pregnancy, very few studies have attempted to investigate perinatal mental disorders in them. Furthermore, PMDs, social determinants, and access to PMH services among the LGBTQ+ population is still unexplored. Also, mental health issues during preconception periods are rarely studied in these two countries. Despite the World Health Organization (WHO) recommendations, all suicides during pregnancy and up to 12 months after delivery are still not considered as direct obstetric deaths, resulting in underreporting of severe mental illness, including suicides in India and Thailand.⁶

* Corresponding address: Department of Psychiatry, Clinical Neurosciences, and Addiction Medicine, All India Institute of Medical Sciences, Guwahati, 781101, India.

E-mail: ramdas_ransing123@yahoo.co.in (R. Ransing)

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Interventions and service models for PMDs

Interventions for PMDs can be grouped into two categories viz. individual and public health interventions. Individual psycho-social interventions are of a high intensity (e.g., modified cognitive behavioural therapy, interpersonal therapy) and a low intensity (e.g., exercise, listening visits). Both groups of interventions are effective and cost-effective, with small effect sizes²; however, the majority of these studies are from HICs and there is limited evidence from India and Thailand. In India, a few organisations have attempted to establish mother-baby units⁷ and community-based services for perinatal mental health to improve access to services^{8,9}. However, these services need to be integrated and scaled-up with existing national programs in India to ensure the sustainability and accessibility of such services across the country. Pharmacological interventions, on the other hand, are effective but are associated with safety concerns in pregnant and breast-feeding women² Furthermore, Even though randomized controlled trials are not available, substantial data exist regarding the safety of many psychotropic medications in the treatment of mental disorders in the perinatal period.²

Research implications

Overall, the PMH research in these two countries is still in its early stages. Only few studies are conducted with focus on individual interventions,¹⁰ while evidence for community-level interventions are lacking. In both countries, there are no clear referral pathways for perinatal women with mental

health issues. Furthermore, there are several limitations of ongoing research [e.g., limited use of clinically significant patient-defined outcome measures (e.g., infant care itself can generate certain psychiatric symptoms such as sleep disturbances leading to overreporting of mental disorders).² Thus, collaboration is required to address the growing burden of PMDs in both countries through new screening tools, interventions, and service delivery models in India and Thailand. Furthermore, this collaboration should focus on training, services, and research using various approaches (Table 1).

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Conflict of interest

The authors have no conflict of interest to declare.

Ethical approval

The study was approved by Ethics Committee of the Prince of Songkla University (Approval number: PSU.68104.24/65-00030, Approval date: October 7, 2022).

Authors' contributions

CJ and RR conceived and designed the study, conducted research, provided research materials. CJ, SP, HM, LR, ND, and RR collected and organized data. CJ and RR analyzed and interpreted data. RR wrote initial and final draft of article. All authors have critically reviewed and approved the final draft and are responsible for the content and similarity index of the manuscript.

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Table 1: Recommendations for training, services, research collaborations.

- Capacity building for research and academia is required for research and PMS service development in India and Thailand.
- International faculty/student exchanges or consortiums among research institutions, policymakers, practitioners, and patients will help in the development of locally appropriate and sustainable interventions for improving maternal/fetal/infant outcomes. Priority should be given to scaling up of such interventions, as well as including PMH in policies, guidelines, educational curricula, and relevant legislation.
- Prevention, early intervention, and treatment of common PMDs must be a national priority in order to achieve Sustainable Development Goals 3 (health and well-being) and 5 (gender equality). To achieve this, there is an immediate need to develop the PMH service models and integrate it into existing maternal and child health services of the country.
- Development of national guidelines and establishment of dedicated services for the PMH issues of transgender women and LGBTQ+ population is required in both countries.
- Extension of research to include neglected psychiatric conditions (e.g., complex PTSDs), especially in transgender women, and LGBTQ+ population.

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