



Perspective of Postpartum Depression Treatment in Iran

Fatemeh Abdollahi^{1,2}, Munn-Sann Lye³ and Mehran Zarghami^{id} 4,5,*

¹Health Science Research Center, Addiction Institute, Mazandaran University of Medical Sciences, Sari, Iran

²Department of Public Health, Faculty of Health, Mazandaran University of Medical Sciences, Sari, Iran

³Department of Community of Health, Faculty of Medicine and Health Sciences, University Putra Malaysia, Serdang, Malaysia

⁴Psychiatry and Behavioral Sciences Research Center, Addiction Institute, Mazandaran University of Medical Sciences, Sari, Iran

⁵Department of Psychiatry, Faculty of Medicine, Mazandaran University of Medical Sciences, Sari, Iran

*Corresponding author: Zare Hospital, Taravat St., Neka Rd., Postal Code: 48431-85774, Sari, Iran. Tel/Fax: +98-1133285109, Email: mehran.zarghami@gmail.com

Received 2019 November 12; Accepted 2020 April 14.

Keywords: Mental Health, Post-Partum Depression, Primary Health Care, Iran, Treatment

1. Introduction

Postpartum depression (PPD) is a major public health problem and is considered as a risk factor for the mother, her baby, and their family (1, 2). In Iran, PPD manifests itself mainly with somatization of depressive symptoms and feelings of guilt (3). The incidence of this disorder is about 15% worldwide (4, 5). The prevalence of PPD ranges from 19% - 43% in Iran (6, 7). Several factors contribute to this disorder, including physical, biological, psychological, obstetric/pediatric, socio-demographic, and cultural factors (5). There is a concern that many PPD patients remain undiagnosed, hence untreated or undertreated, particularly in developing countries such as Iran (1). It is estimated that about 50 percent of women who experience PPD are remained undiagnosed (5).

It is important to obtain socially and culturally appropriate intervention and treatment.

2. Integrated Mental Health System in Iran

Iran is one of the largest countries in the Middle East, with almost 77.5 million populations (8) with a population growth rate of 1.29 (9). There are 17 hospital beds, 0.89 physicians, and 1.41 nurses and midwives per 10,000 populations in this country (8). Public sector has the main lead in the provision of health services, and 85% of hospital beds and almost all primary health care (PHC) facilities are public (10, 11).

A pyramidal District Health System (DHS) with a well-developed PHC network covers the entire population across the country. DHS consists of general hospitals and PHC facilities. Urban and rural health centers are peripheral units of PHC system in urban and rural areas that

general practitioners and a number of technicians provide a package of essential curative and preventive services through their sub-units to the catchment area population. Health centers and health houses are the sub-units of health centers in urban and rural areas, respectively. These sub-units are the first point of contact with DHS and are staffed by multipurpose community health workers. Volunteer health workers collaborate with frontline health workers in communicating, encouraging, and supporting their neighbors (12, 13).

Mother and child health care are the most utilized services in these facilities. Maternal care, including prenatal, antenatal, and postnatal care is delivered and filed based on guidelines and formats. Currently, almost all pregnancies are delivered under trained staffs in hospitals or delivery centers in public or private sectors (10, 11, 13).

Both the public and private sectors in Iran are involved in providing a wide range of psychiatric and psychotherapy services in terms of inpatient and outpatient care. Due to the concern of the policy makers regarding mental disorders, mental health care was integrated into Iran's PHC network in 1998. Based on a centrally established guideline, the program consists of case finding, referring, diagnosis, treatment with record filing, and surveillance of mental disorders in general with no emphasize on certain problems such as PPD (14). However, public and private sectors usually serve caretakers by responding to their demand (passive approach) with no appropriate prevention, follow up, and record filing.

3. PPD Treatment and Approaches in Iran

In Iran's health care system, there is no program specifically devised for screening PPD. Women's denial, help-

lessness, and cultural barriers, together with lack of organized, extensive family education and psychotherapy programs focused on PPD, are factors that contribute to the misery of mothers trying to seek help. The most common reasons for seeking treatment among women later diagnosed with depression are somatic complaints (3).

Different approaches are available for the treatment of PPD, including pharmacotherapy, psychological, and social support, or a combination of them (15). In Iran, governmental support for female employees and workers include a paid maternity leave for nine months and a six years allowance for their kid's kindergarten fee.

Focus on ritual practices such as prayer and almsgiving for depression is influenced by Islam. In most regions of Iran, postpartum women choose traditional care before resorting to medical treatment. There are a variety of postpartum traditional recommendations, such as an at least 40-day period of mandated rest without being left alone, balanced diet, and practical/emotional support from family members, mother, and mother-in-law traditional birth attendant, giving a party, visiting family members, getting help in taking care of other children, and avoiding bad news, as well as neonatal practices during the postpartum period in Iranian communities (16, 17).

All of the above customs may potentially provide social and emotional support for new mothers who are at risk of PPD; although, none of them are originally tended to address PPD.

In some PPD cases, complementary/alternative/traditional treatments are also prescribed for care and treatment. Some medicinal plants (such as Saffron, Rose, Geranium, and *Asperugo procumbens* and foods (such as fish, garlic, milk, oregano, mint, and spinach) are prescribed for their antidepressant effects (18-20).

In the southern parts of Iran, there is a rare traditional rite for the treatment of depressed mothers, named "Zar". In this situation, women go to practice mindfulness meditation. The pregnant or postpartum woman accompanies a traditional midwife and stays on a campus near the sea for 3 - 14 days. The traditional midwife massages the woman with a manual ointment containing 21 kinds of herbal medicines. On the last day, the patient asked the traditional healer who has a stick in her hands to help to extract "Al" (a fearful creature who is the persecutor of the parturient woman) from her body.

In conclusion, although all health workers in the integrated health care system are generally involved in case findings and providing appropriate services to all mentally ill people, there is no specific emphasis on PPD. Moreover, no instrument such as a relevant questionnaire has been introduced for screening mothers during their postnatal

care when they attend to their corresponding local PHC unit within two months after giving birth. Nonetheless, appropriate intervention, in particular early detection and treatment of PPD, is now the concern of many experts in Iran.

The well-integrated referral-based mental health care system of the PHC network, along with the involvement of volunteer workers and family members who are in contact with new mothers, are the opportunities for additional interventions that enhance the supportive care for these women.

As a result of lifestyle changes, it seems that the trends of psychologic and psychiatric treatments are going to play an increasing role in PPD in Iran.

Footnotes

Authors' Contribution: Fatemeh Abdollahi, Munn-Sann Lye, and Mehran Zarghami conceived and designed the manuscript. Fatemeh Abdollahi drafted the manuscript. Mehran Zarghami revised it critically for important intellectual content. All authors read and approved the final manuscript.

Conflict of Interests: The authors declared no conflict of interests.

Funding/Support: The authors declared no funding/support.

References

- Milani HS, Azargashb E, Beyraghi N, Defaie S, Asbaghi T. Effect of telephone-based support on postpartum depression: a randomized controlled trial. *International journal of fertility & sterility*. 2015;9(2):247.
- Letourneau NL, Dennis C, Benzies K, Duffett-Leger L, Stewart M, Tryphonopoulos PD, et al. Postpartum depression is a family affair: addressing the impact on mothers, fathers, and children. *Issues in mental health nursing*. 2012;33(7):445-57.
- Jablensky A, Sartorius N, Gulbinat W, Ernberg G. Characteristics of depressive patients contacting psychiatric services in four cultures: A report from the WHO collaborative study on the assessment of depressive disorders. *Acta psychiatrica scandinavica*. 1981;63(4):367-83.
- Almond P. Postnatal depression: a global public health perspective. *Perspectives in public health*. 2009;129(5):221-7.
- Klainin P, Arthur DG. Postpartum depression in Asian cultures: a literature review. *International journal of nursing studies*. 2009;46(10):1355-73.
- Veisani Y, Delpisheh A, Sayehmiri K, Rezaeian S. Trends of Postpartum Depression in Iran: A Systematic Review and Meta-Analysis. *Depression Research and Treatment*. 2013;2013:8. doi: 10.1155/2013/291029.
- Abdollahi F, Sazlina S, Zain AM, Zarghami M, Asghari Jafarabadi M, Lye M. Postpartum depression and psycho-socio-demographic predictors. *Asia-Pacific Psychiatry*. 2014;6(4):425-34.
- World Health Organization. *Atlas of EHealth Country Profiles: The Use of EHealth in Support of Universal Health Coverage: Based on the Findings of the Third Global Survey on EHealth 2015*. 3. World Health Organization; 2016.

9. Erfani A, McQuillan K. The changing timing of births in Iran: an explanation of the rise and fall in fertility after the 1979 Islamic Revolution. *Biodemography and social biology*. 2014;**60**(1):67-86.
10. Khangah HA, Jannati A, Imani A, Salimlar S, Derakhshani N, Raef B. Comparing the health care system of Iran with various countries. *Health Scope*. 2017;**6**(1). e34459.
11. Javanparast S, Baum F, Labonte R, Sanders D, Heidari G, Rezaie S. A policy review of the community health worker programme in Iran. *Journal of public health policy*. 2011;**32**(2):263-76.
12. Forouzan AS. *Assessing responsiveness in the mental health care system: the case of Tehran [dissertation]*. Umeå universitet; 2015.
13. Mehrdad R. Health system in Iran. *JMAJ*. 2009;**52**(1):69-73.
14. Mansouri N, Gharaee B, Shariat SV, Bolhari J, Nooraie RY, Rahimi-Movaghar A, et al. The change in attitude and knowledge of health care personnel and general population following trainings provided during integration of mental health in Primary Health Care in Iran: a systematic review. *International Journal of Mental Health Systems*. 2009;**3**(1):15.
15. Henshaw CA. What do women think about treatments for postnatal depression? *Clinical Effectiveness in Nursing*. 2004;**8**(4):170-5.
16. Abdollahi F, Etemadinezhad S, Lye M. Postpartum mental health in relation to sociocultural practices. *Taiwanese Journal of Obstetrics and Gynecology*. 2016;**55**(1):76-80.
17. Alian-Nezhadi V. *Women, childbirth, midwifery and infertility; Postpartum care. Shiite medicine*. 2020. 2020, [cited 2020 April 4]. Available from: <https://shiateb.com/pages/?current=viewdoc&langid=1&sel=778>.
18. Farzin D, Zarghami M, Khalaj L. Evaluation of antidepressant activities of rose oil and geranium oil in the forced swim test in mouse. *Iranian Journal of Pharmaceutical Research*. 2010:70.
19. Zarghami M, Chabra A, Khalilian A, Asghar Hoseini A. Antidepressant effect of *Asperugo procumbens* L. in comparison with fluoxetine: a randomized double blind clinical trial. *Research Journal of Pharmacognosy*. 2018;**5**(3):15-20.
20. Tavakkoli-Kakhki M, Motavasselian M, Mosaddegh M, Esfahani MM, Kamalinejad M, Nematy M. Food-based strategies for depression management from Iranian traditional medicine resources. *Iranian Red Crescent Medical Journal*. 2014;**16**(2).