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Policy Brief

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Integrating Postpartum Mental Health into Family Planning Services in Jordan: Evidence and Policy Options for Primary Healthcare Strengthening

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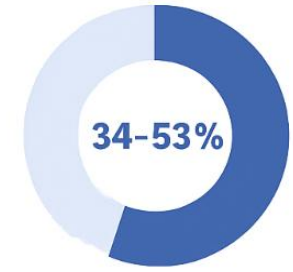
EXECUTIVE SUMMARY

Postpartum depression (PPD) affects 34–53% of Jordanian mothers, among the highest in the Eastern Mediterranean Region. Despite universal access to family planning (FP) services, primary healthcare (PHC) facilities do not provide structured mental health (MH) screening, counseling, or in-house management.



This gap persists due to service delivery barriers (lack of trained staff, limited privacy, fragmented referral systems) and social and behavioral barriers (stigma, gender norms, misinformation, and low male engagement).

Why Integrate?

Global models—including the Thinking Healthy Programme and WHO mhGAP—demonstrate that integrating MH into routine reproductive and postnatal care:

- Increases early detection
- Reduces undetected PPD
- Strengthens holistic maternal care
- Achieves high value at < USD 10 per woman annually

This policy brief proposes a high-impact, evidence-based model that integrates FP and MH into postnatal care using task-sharing, community engagement, routine screening, and strengthened referral pathways.

This model:

- Enhances continuity of care
- Reduces PPD and unintended pregnancies
- Improves maternal wellbeing, family health, and PHC system resilience
- Aligns with Jordan's National Mental Health and Substance Use Action Plan (2022–2026) and Universal Health Coverage (UHC) goals, while supporting the 2024 Mental Health Investment Case, which shows a 3.3× return for community-based MH integration.

Integrating mental health into family planning is not an added burden — it's a missed opportunity turned solution.

INTRODUCTION

Postpartum MH is a critical yet under-addressed component of maternal healthcare in Jordan. While the country has made significant progress in strengthening PHC and expanding universal access to FP services, PPD remains highly prevalent and largely undetected within the health system. International evidence shows that integrating MH into routine maternal and reproductive health platforms—especially FP visits—can greatly improve early detection, timely support, and continuity of care for postpartum women.

Jordan's FP services offer a strategic entry point for integration: they are universally available across PHC facilities, routinely accessed by postpartum women, and delivered by midwives and nurses who maintain trusted relationships with families. However, current PHC structures lack formal MH screening, in-house counseling services, and MH-trained providers.

This policy brief synthesizes findings from a mixed-methods situational analysis, focus group discussions with women and providers, and international evidence to identify practical, cost-effective options for integrating postpartum MH care into Jordan's FP and postnatal services. The goal is to support policymakers in strengthening maternal health outcomes, advancing UHC, and aligning with the National Mental Health and Substance Use Action Plan (2022–2026).

THE APPROACH

The mixed-methods approach was part of the MARIA project (Mental And Reproductive Health Integration and Access for Migrant, Refugee, and Underserved Jordanian Women). It combined quantitative facility-

readiness data, qualitative insights from health providers, postpartum women, and their husbands, and international evidence to ensure that the resulting recommendations are both context-specific and actionable.

Facility assessment: A cross-sectional assessment using a customized mhGAP-based tool was conducted across PHC facilities in Mafraq and Northern Aghwar to evaluate readiness for MH service integration within FP and postnatal care. Data collection covered:

- Infrastructure and service readiness: Availability of private counseling rooms, psychotropic medications, and referral pathways
- Human resources: Training, workload, attitudes of providers toward MH.
- Policies/guidelines: Protocols, screening tools, supervisory mechanisms
- Community engagement: Outreach activities and stigma-reduction efforts

Focus group discussions (FGDs): Six FGDs were held with healthcare providers, postpartum women, and their husbands to explore perceptions, barriers, and enablers related to MH integration and help-seeking behaviors.

- Provider barriers: Lack of training, high workload, and no clear referral protocols
- Community barriers: Stigma, limited awareness, and cultural sensitivity
- Opportunities: Strong provider–client trust within FP visits, openness to basic counseling, and willingness among midwives to receive MH training

Framework mapping: A comprehensive review of global frameworks was undertaken to identify integration models applicable to LMIC. The analysis examined:

- Task-sharing and stepped-care models (e.g., *Thinking Healthy Programme*, *WHO mhGAP*)
- Collaborative and team-based care frameworks (e.g., *MOMCare*)
- Community and peer-support approaches

Stakeholder consultation: Consultations were conducted with the Ministry of Health, NGOs working on FP and/or MH, and public-health experts to validate findings and align recommendations with national priorities.

This combined approach ensured that the proposed policy options are evidence-informed, rooted in local data and global best practices; feasible, leveraging existing FP service infrastructure and workforce; and sustainable, aligned with Jordan's UHC vision and PHC strengthening goals.

THE PROBLEM

High Burden

PPD affects one in three to one in two mothers in Jordan, surpassing global (10–20%) and regional averages (20–30%). Most cases remain undetected and untreated, affecting maternal functioning, infant development, bonding, and breastfeeding.

System Gaps

The mhGAP-aligned situational analysis found no structured MH services in PHCs:

- 0% of PHCs employ MH professionals; supervision systems are weak
- 0% use validated screening tools (EPDS/PHQ-9)
- 82% report "MH services," but these are referral-only
- 55% of PHCs lack private counseling spaces
- 0% stock essential psychotropic medications
- Lack of provider training in MH care and integrated FP-MH care
- Inconsistent referral and feedback pathways between PHC and specialist care
- Limited number of trained community health workers (CHWs) supporting postnatal follow-up

Despite universal FP coverage, no PHC applies MH screening within FP visits, representing a missed opportunity.

Sociocultural Barriers

Cultural norms and stigma surrounding mental illness—particularly in the postpartum period—continue to discourage help-seeking behaviors. Many women associate depression with weakness or failure in motherhood, leading to concealment of symptoms.

Family and community expectations often prioritize physical recovery and childcare over maternal emotional health, while limited awareness among husbands and extended family further restricts support. There is limited male involvement in maternal and FP decision-making, and gender inequities restrict women's autonomy.

In healthcare settings, time constraints and provider discomfort with MH topics exacerbate underdiagnosis.

Economic Cost

The 2024 WHO–MoH Investment Case estimates MH conditions cost Jordan 0.86% of GDP annually (~JOD 251.8 million), mostly due to productivity loss.

International analyses show that every USD 1 invested in MH care yields USD 4 in improved productivity and reduced healthcare costs, underscoring the economic rationale for integration.

KEY EVIDENCE & INSIGHTS

Facility Readiness & Service Availability

- 100% of clinics offer FP services
- 80%+ provide postpartum FP counseling at the first visit
- >50% provide FP counseling at *every* visit
- 0% have MH specialists
- 0% use MH screening tools
- 45% have private rooms
- 0% stock psychotropics
- MH support is referral-based

FP services provide **universal contact**, routine counseling, and a trusted provider–client relationship—making them the most strategic platform for integrating postpartum MH screening and brief interventions.

Provider Capacities & Attitudes

- Providers lack MH or postpartum-specific training
- 60% reported low confidence in identifying PPD
- High workload + unclear referral pathways
- Providers *want* to address MH but lack tools
- Stigma influences provider comfort with MH topics
- Providers repeatedly cited FP visits as ideal moments for early MH conversations.

Providers are willing but unequipped—task-sharing with training and supervision will unlock integration.

Community & Family Perspectives

- Women want support but won't ask unless prompted
- Women hide symptoms due to stigma, guilt, or fear of being judged
- Husbands often interpret symptoms as "stress"
- Women see midwives as trusted and feel FP clinics are "safe" spaces

FP visits can normalize MH discussions and reduce stigma by embedding emotional health into routine care. Community engagement and male involvement can improve norms and support.

Global Evidence for Integration

- Integration into FP/postnatal visits ensures high reach and low cost.
- Task-shared interventions (midwives/ CHWs) reduce PPD by 30–40%
- Stepped-care and collaborative care models increase early detection and improve treatment continuity
- mhGAP models show non-specialists can deliver MH care effectively.

Evidence from LMICs demonstrates that FP-based MH integration is effective, scalable, and affordable.

Alignment with National Strategies

- National Mental Health and Substance Use Action Plan (2022–2026) prioritizes decentralizing MH services and integrating them into PHC.
- 2024 WHO–MoH Investment Case identified community-based MH interventions as cost-effective, with a projected 3.3-fold return on investment.
- Integration within FP and postnatal care directly contributes to UHC and Sustainable Development Goal 3 (Good Health and Well-being).

Integration fits within existing strategic and policy frameworks—no new systems required.

POLICY RECOMMENDATIONS

Integrate routine MH screening into FP/postnatal visits.

Interventions

Introduce validated, brief, and culturally appropriate screening tools—such as the EPDS, PHQ-2, or PHQ-9—into standard FP and postnatal check-ups.

- Midwives administer a 2–5-minute screening during FP sessions or 6-week postnatal visits.
- Women with elevated scores are flagged for on-site counseling or referral.
- Screening results are documented in the maternal file.

High-Impact practice changes

- Routine screening becomes standard of care
- Updated national guidelines and checklists

Why this matters

- FP visits reach nearly all postpartum women at least once.
- Early detection prevents escalation and improves maternal functioning, breastfeeding, and child bonding.
- Higher detection of PPD
- Improved continuity of care
- Early intervention prevents severe MH outcomes

System effects

Creates the first-ever national screening platform for PPD within the PHC system.

Adopt a task-sharing model where midwives deliver brief counseling

Interventions

- Train midwives/nurses to provide brief, structured psychological interventions.

- Train CHWs for follow-up, psychoeducation, and partner engagement.
- Counseling is delivered in 2–4 short sessions during FP or follow-up visits.
- Complex cases are escalated via referral pathways.

High-Impact practice changes
- Monthly case reviews and refreshers by district MH supervisors
- CHWs integrated into postnatal outreach

Why this matters
- Task-sharing is internationally validated, cost-effective, and sustainable.
- Jordan currently has 0% MH specialists in PHC, making task-sharing the only scalable model.
- This will improve provider capacity and postpartum follow-up and strengthen PHC quality and supervision.

System effects
Transforms FP clinics into integrated maternal MH access points without new staffing requirements.

Establish clear referral and follow-up pathways between PHC and MH specialists

Interventions
Create structured pathways so midwives know when and where to refer women needing advanced care.
- Map local MH facilities and community resources.
- Develop simple referral algorithms and decision aids (algorithms and forms).
- Assign focal points in PHC and MH centers for coordination.
- Establish feedback loops so PHC providers receive updates after referral (bi-directional communication between PHC and MH services).

High-Impact practice changes
- Functional referral system operates consistently
- Referral completion tracked through a digital health information system

Why this matters
- Currently, 82% of facilities rely on referral-only MH services, but referral quality is inconsistent and often untracked.
- Family follow-up is limited, causing many women to fall through the cracks.
- This way, women with moderate/severe symptoms receive timely care.
- This will reduce drop-out from MH services.

System effects
Builds a continuum of MH care that links PHC with specialist services.

Upgrade PHC infrastructure to support confidential MH-FP care

Interventions
Enhance the structural and administrative conditions needed for high-quality MH-FP care.
- Create or repurpose private counseling spaces.
- Add MH indicators (screening completed, referrals made, follow-up) to patient files and registers.
- Ensure availability of basic psychotropics as per an MH formulary.

Why this matters
- 55% of clinics currently lack suitable privacy for sensitive MH discussions.
- Lack of guidelines leaves providers uncertain about roles and responsibilities.
- This will improve privacy and increase disclosure
- This will ensure a higher quality of integrated services

System effects
Improves quality, privacy, and standardization of postpartum MH care across the PHC network.

Mobilize community engagement to reduce stigma and support women

Intervention
Engage families and community influencers to normalize maternal MH and reduce stigma.

- Work with husbands, who play a major role in decision-making and support.
- Collaborate with religious leaders to promote acceptance and encourage help-seeking.
- Engage CHWs and peer mothers for outreach, psychoeducation, CHW-led support groups, and follow-up.
- Embed MH messaging into FP outreach, maternal classes, and community campaigns.
- Culturally tailored awareness campaigns.

High-impact practice changes

- Increased community dialogue
- Improved partner communication
- Reduced stigma

Why this matters

- FGDs show stigma is a major barrier—women fear being seen as “weak” or “ungrateful.”
- Husbands often misunderstand symptoms or discourage help-seeking.
- This will increase service uptake and result in a more supportive home environment.
- This will reduce gender inequities

System effects
Creates a supportive environment that increases help-seeking and reduces stigma.

IMPLEMENTATION CONSIDERATIONS

Effective integration of postpartum MH into FP and postnatal services requires sequenced, feasible actions that leverage existing PHC infrastructure. The following considerations support operationalization:

1. Workforce training and supervision

- Deliver mhGAP-based training (3–5 days) for midwives and nurses on postpartum depression, screening, brief counseling, and referral pathways.
- Establish a supervision structure, linking PHC midwives with district-level MH professionals for monthly check-ins, case discussions, and refresher coaching.
- Integrate MH modules into pre-service curricula for midwives and nurses to ensure long-term sustainability.

2. Service delivery adaptations

- Embed MH screening tools (EPDS, PHQ-2, PHQ-9) into routine FP and postnatal visit workflows, ensuring the process is short (2–5 minutes) and standardized.
- Optimize clinic flow to allow brief counseling sessions (10–15 minutes) when needed.
- Prioritize privacy upgrades in facilities lacking confidential spaces; low-cost partitions or space reallocations are acceptable interim measures.

3. Strengthening referral pathways

- Map PHC catchment areas to identify nearest MH facilities, NGOs, and community-based support services.
- Develop simple, visual referral algorithms so midwives know when and where to refer.

- Introduce a bidirectional referral system with feedback loops, enabling PHC providers to track whether women access specialist care.

4. Data systems and monitoring

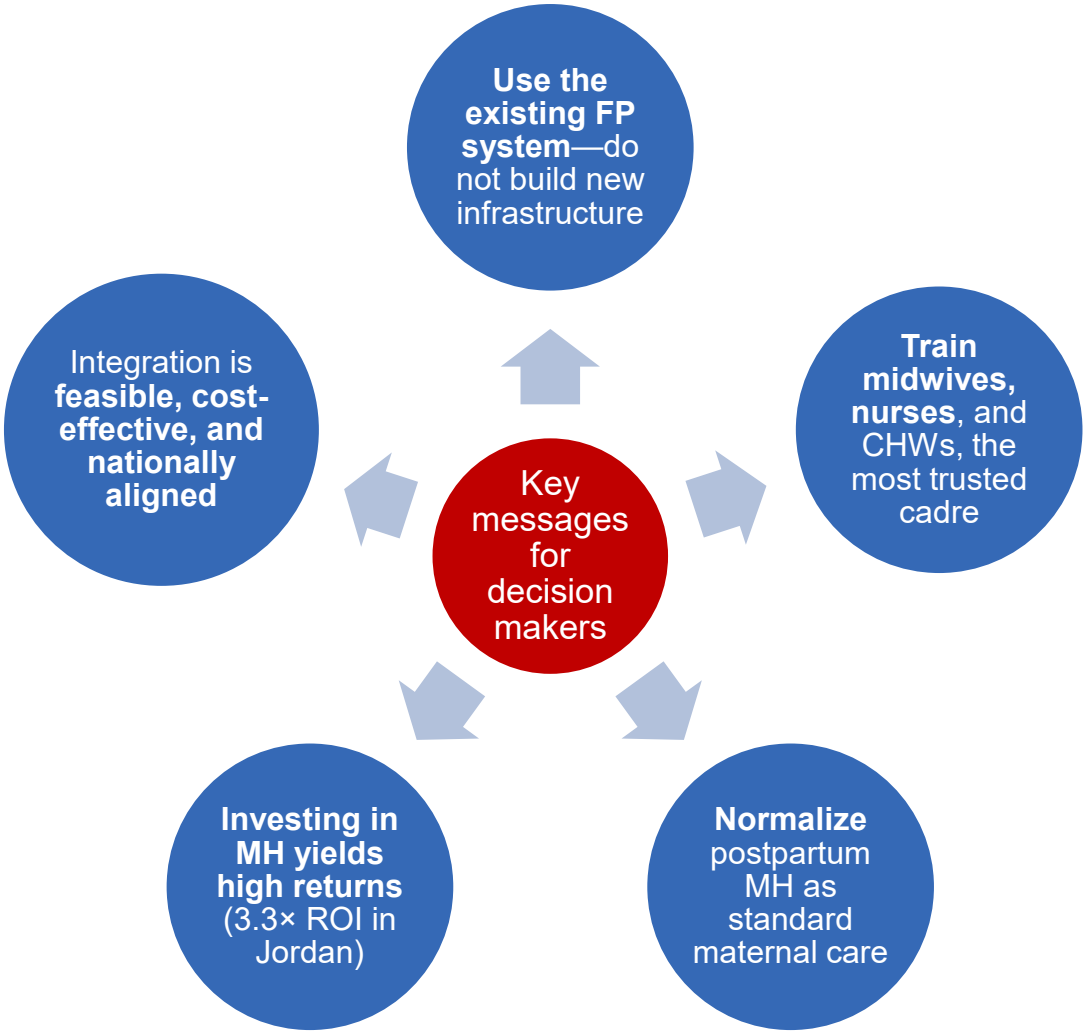
- Add MH indicators to electronic FP/postnatal records:
  - Screening completed
  - Positive screens
  - Counseling sessions delivered
  - Referrals made and completed
- Incorporate MH indicators into routine supervisory checklists and annual PHC performance reports.

5. Community engagement and demand generation

- Engage husbands and family members through targeted messaging to increase support for women's MH needs.
- Collaborate with religious leaders, community influencers, and CHWs to deliver stigma-reduction messages.
- Integrate MH topics into FP outreach, maternal classes, and home visits, emphasizing that emotional health is part of routine postpartum care.

6. Policy and governance

- Update national FP and postnatal care guidelines to formally include MH screening, counseling, and referral standards.
- Ensure inclusion of postpartum MH in budgeting and resource allocation, particularly under PHC and maternal health programs.
- Establish a national technical working group to oversee scale-up, quality assurance, and reporting.



SUMMARY

Postpartum MH remains a critical and under-addressed gap within Jordan's PHC system, despite the high prevalence of PPD and strong international evidence supporting integration. With FP services universally available and midwives serving as trusted providers for postpartum women, Jordan is uniquely positioned to implement a low-cost, high-impact integration model.

Findings from facility assessments, FGDs, and global frameworks show that integration is feasible, acceptable, and aligned with national priorities, including the National Mental Health and Substance Use Action Plan (2022–2026) and the 2024 Mental Health Investment Case. By strengthening provider capacity, standardizing screening, enhancing privacy, and reinforcing referral pathways, Jordan can significantly improve the detection, support, and treatment of postpartum MH issues.

Integrating MH within FP and postnatal care will not only improve maternal wellbeing and infant development but also contribute to UHC, PHC strengthening, and long-term productivity. This policy brief presents actionable, evidence-based options to support policymakers in advancing maternal health outcomes and building a more responsive and inclusive PHC system.

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The Eastern Mediterranean Public Health Network (EMPHNET) is a regional network that focuses on strengthening public health systems in the Eastern Mediterranean Region (EMR) and beyond. EMPHNET works in partnership with ministries of health, non-government organizations, international agencies, private sector, and relevant institutions from the region and the globe to promote public health and applied epidemiology. To advance the work of EMPHNET, Global Health Development (GHD) was initiated to build coordination mechanisms with partners and collaborators. Together, GHD|EMPHNET is dedicated to serving the region by supporting efforts to promote public health policies, strategic planning, sustainable financing, resource mobilization, public health programs, and other related areas.

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