neonatal hypothyroidism, it is assumed that she will provide care for those detected to be sick. In the 55 villages in our community programme, we track all major illnesses for which people seek healthcare. When individuals fail to follow-up, we contact them and encourage them to continue care.

For a hospital-based system, how far does the responsibility extend? Does the responsibility end when the patient leaves its premises or does it continue until the diagnosis is made and an evidence-based treatment plan is prescribed; or does it extend to factor in the unique social circumstances and values to restore health and dignity; or does it extend even beyond that?

We believe that the hospital is an important 'citizen' in the community. It bears witness to ailments of the society and has an ethical obligation to make that full diagnosis and prescribe treatment by advocating for systemic changes. Seema's life course would have been different if her father's problem of alcohol abuse had been addressed.

These are lofty goals. Yet a journey of a thousand miles begins with one step. For us, that first step is to build a workflow using our electronic medical records to ensure that patients are informed about critical reports and advised next steps, even if they miss the follow-up appointment. This will be extra work with its own demands but one hopes for long-term improvements by avoiding delay in care for treatable conditions such as sickle cell disease. A disease that took Seema's life.

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Letter from Bristol

ENGAGING FATHERS IN THE TREATMENT AND PREVENTION OF POSTNATAL DEPRESSION

Depression during the perinatal period is common. Between 11% and 15% of mothers experience clinical depression during pregnancy and in the 3 months after giving birth.[1] Depression during pregnancy is strongly associated with postnatal depression, which is, in turn, a strong risk factor for future chronic depression.[1] Mental health problems in fathers are also common during the perinatal period, affecting almost 1 in 10 fathers in the period between the first trimester and 1 year postnatal.[2] In addition, maternal depression is strongly linked to paternal depression and partners of depressed mothers are twice as likely to develop depression.[2]

It is well known that maternal depression during the perinatal period can have adverse consequences for the health and well-being of the mother, her children and her family if it goes unrecognized and untreated.[1] However, the health and development of children is also influenced by the mental health of fathers.[3] When fathers also become depressed, the combined effect of depression in both parents increases the risk for a range of negative outcomes in children.[3] On the other hand, involvement of a non-depressed father may be particularly important for children in families in which the mother is depressed. Involved fathers may buffer against the adverse effects of maternal depression by providing the child with a sensitive and responsive environment necessary for healthy development. There is a need for greater understanding of the mechanisms by which fathers protect their children from the adverse impact of maternal depression. These insights will contribute towards development of early interventions aimed at improving postnatal mental health in parents and children.

Lack of partner support during pregnancy and in the postnatal period is a strong risk factor for postnatal depression.[2] In contrast, women whose partners are emotionally and practically supportive during pregnancy and after the birth of the child report improved postnatal physical and mental health.[4] Partners are also instrumental in supporting mothers from depression and in encouraging them to seek help.[4] Half of postnatal depression cases in women go undiagnosed and women often report reluctance to seek help because their partners are dismissive of their symptoms.[5] It is therefore important to educate men about depression and how it may affect their partner during pregnancy. This may improve the early detection of symptoms, encourage help-seeking and facilitate preventive interventions to improve mental health in both parents.

Maternal depression does not happen in isolation and is likely to affect the whole family unit. This includes fathers who are also adjusting to fatherhood as well as trying to cope with the distress of their partners. Qualitative studies suggest that fathers experience fear, confusion, concern for their partners and a sense of hopelessness when it comes to helping their depressed partners.[6] Moreover, fathers primarily turn to their partners for emotional support, particularly after the birth of the child. When the mother is depressed, she may be less supportive of her partner which may further contribute to his stress. The long-term adverse effects of parental depression call for interventions that acknowledge the role of fathers in supporting mothers through depression. Such interventions should also be sensitive to the emotional needs of fathers. So far, only a small number of studies have included fathers into therapeutic efforts to prevent postnatal depression in mothers. None of these focused on depression in fathers.[7]

Because of frequent contact with the health services, pregnancy provides an ideal window of opportunity to address parental mental health. Antenatal efforts to prevent postnatal depression often focus on enhancing social support.[8] Increasing emotional and practical support of partners has also been found effective in treating maternal postnatal depression.[9] On the other hand, low

success rates of interventions to improve maternal depression are increasingly being attributed to lack of efforts to engage fathers in the therapeutic process. Despite this evidence, a limited number of randomized controlled trials have evaluated the effectiveness of promoting father engagement in interventions to prevent postnatal depression. These studies suggest that inclusion of partners into additional antenatal educational and communication classes that teach partners about challenges of pregnancy, childbirth and postnatal adjustment, as well as provide couples with strategies to manage stressful situations, may be effective in preventing postnatal depression when compared to standard care.[10,11] Due to methodological limitations, such as small and heterogeneous samples, high attrition and lack of appropriate control conditions, interpretation of these findings should be cautious. Nevertheless, this preliminary evidence offers promising avenues for design of future father-inclusive interventions to prevent postnatal depression. To date, the best evidence-based treatment for maternal postnatal depression is interpersonal psychotherapy (IPT), followed closely by cognitive behavioural therapy (CBT).[12] A recent adaption of IPT to include partners in the therapeutic sessions (partner-assisted interpersonal psychotherapy, PA-IPT)[13] was found feasible and acceptable to mothers and their partners. Large randomized controlled trials are needed to evaluate the efficacy of such psychological interventions.

Summary

Parental depression during the perinatal period has wide-reaching implications for the health and well-being of children and parents, indicating a strong need for preventive and treatment interventions for families at-risk. Early interventions that engage fathers may improve mental health of the whole family through facilitating transition to parenthood, promoting parent–infant relationship, mutual support between partners and reducing parental conflict. They could also indirectly improve the mental health of fathers and increase maternal adherence to the intervention. Although several prevention and treatment programmes to enhance partner support have been developed, rigorous evaluation of these interventions is lacking. The majority of these interventions provide limited opportunities for the active involvement of fathers and remain primarily focused on the mother while paternal needs remain overlooked. Future efforts should acknowledge the important role that fathers play in supporting the mother and promoting child development in the design of the interventions.

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Letter from Mumbai

MEDICAL RESEARCH IN INDIA

What is medical research? As commonly understood it refers to attempts made to advance knowledge on a specific topic or in a chosen field in medicine. Two examples: experiments or observations over time; the application of findings made in the laboratory to benefit patients in clinics and wards. The goal is to further the limits of current expertise and, if possible, point to avenues for further investigation or improved therapy. The emphasis is on science and not on individual.

Such research demands long hours of dedicated work, often with single-minded concentration on the topic being studied. The work of weeks or months may be nullified by the turn of one experiment and the work starts all over again. Worse, just as you complete your studies, rejoice in the discovery of a nugget and prepare to put your findings on paper, you open the latest issue of the journal on your table to find that someone else has pipped you to the post.

Especially tragic is the discovery that your findings and conclusions, scientifically proven, are irrationally dismissed by the bigwigs in your field and consequently ignored by your colleagues and juniors. Semmelweiss' work on puerperal fever is an outstanding example, especially heartbreaking as hundreds more delivering babies in teaching hospitals died needlessly. The British medical and administrative establishments in Bombay (now Mumbai) towards the end of the 19th century did not accept N.F. Surveyor's work on the plague in Bombay till Alexandre Yersin