Perspectives of midwives on perinatal mental health screening in maternity facilities in the Cape Metropole

Thesis presented in (partial) fulfilment of the requirements for the degree of Master of Nursing Science in the Faculty of Medicine and Health Sciences Stellenbosch University

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights, and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Background: The prevalence and aetiology of perinatal mental illnesses has been largely documented in previous studies. Despite the far-reaching impact that untreated perinatal mental illnesses may have on women and their families, policies and funding to address mental health needs remain poorly prioritised. Due to increased utilisation of health care, pregnancy has been identified as an ideal opportunity to screen for perinatal mental distress. The purpose of this study was to explore the perspectives of midwives working in maternity facilities regarding perinatal mental health screening and reviewing strategies to integrate perinatal mental health with routine physical care.

Methods: A qualitative study with a descriptive exploratory approach was employed to conduct the study. The study was conducted at four midwife and obstetric units in the Metro West District, Cape Metropole. The nine participants were purposefully selected based on predetermined criteria and the insight which they could potentially offer in view of perinatal mental health screening.

Results: The study elicited three major themes in relation to perinatal mental health screening. The themes identified include appreciating perinatal mental health screening, perinatal mental health screening provision and effective integration of perinatal mental health screening.

Conclusion: Staff shortage, increased workload, inadequate competencies, and a lack of referral pathways were identified as major barriers to addressing perinatal mental health needs. These findings will be submitted to the Metro West health services so as to optimise the provision of perinatal mental health care to all women accessing the services.

Key words: Midwives, perinatal mental health, perinatal mental illness, maternal distress

OPSOMMING

(nie meer as 500 woorde nie, moet ooreenstem met Engelse vertaling)

Agtergrond: Die voorkoms en etiologie van perinatale geestesiektes is wyd gedokumenteer in vorige studies. Ondanks die verreikende gevolge van onbehandelde perinatale geestesiektes op ‘n vrou en haar familie mag hê, is beleide en befondsing swak geprioritiseer. As gevulg van verhoogde benutting van gesondgeidsorg, word swangerskap as ‘n ideale geleentheid geidentifiseer om te sifting vir geestelike noode. Die doel van die studie was om die perspektiewe van vroedvroue wat in kraamfasiliteite werk rakende perinatale ondersoek na geestesgesondheid te ondersoek en die hersiening van strategiee om perinatale geestesgesondheid sifting te integreer met roetine- fisieke sorg.

Metode : ‘n Kwalitatiewe studie met ‘n beskrywende verkennende benadering was gebruik om die studie uit te voer. Die studie was by vier kraam eenhede in die Metro Wes Distrik, Kaap Metropool uitgevoer.Die negedeelnemers was doelgerig gekies op grond van voorafbepaalde insluitingskriteria en die insig wat hulle potensieel kon bied in die lig van perinatale geestegesondheid ondersoek.

Resultate: Die studie het drie hooftemas ontlok met betrekking tot perinatale geestesgesond ondersoek. Die temas wat geidentifiseer is, sluit die waardering van perinatale geestesgesondheidsifting, die voorsiening van perinatale geestesgesondheid sorg en die effektiewe integrasie van perinatale ondersoeke vir geestesgesondheid in..

Slotsom: Personeeltekorte, verhoogde werslading, onvoldoende bevoegdhede en ‘n gebrek aan verwysingsroetes is geidentifiseer as belangrike struikelblokkeom perinatae ondersoek na geestesgesondheid aan te spreek. Hierdie bevindings sal aan die Metro-Wes gesondheidsdienste voorgele word om die voorsiening van perinatale geestesgesondheid sorg te optimaliseer aan alle vroue wat toegang tot die diens het.

Sleutelwoorde: Vroedvroue, perinatale geestesgesondheid, perinatale geestesiektes, perinatale geestelike nood

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Abbreviations

MOU	Midwife and Obstetric Unit
LMIC	Low- and Middle-income countries
BANC	Basic Antenatal Care
MCR	Maternal Case Record
CHC	Community Health Centres

1. CHAPTER ONE
FOUNDATION OF THE STUDY

1.1 Introduction

The prevalence and aetiology of perinatal mental illness, particularly postnatal depression, has been at the centre of much discussion. Perinatal mental illnesses may have far-reaching consequences for a woman, her child, and her family. Pregnancy has been identified as a period that may precipitate mental illness and may impact on a woman, her child, and her family (Du-Toit, Jordaan, Niehaus, Koen & Leppanen, 2017:1). Women living in adversity are particularly susceptible to perinatal mental illnesses. Du Toit et al. (2017:2) postulate that only 8% of women requiring perinatal mental health care in developing countries may have access to appropriate care.

Despite nearly 92% of South African women accessing healthcare facilities during their pregnancy, the primary focus of antenatal care is on the physical wellbeing of clients (Du-Toit et al., 2017). Due to a lack of screening initiatives and poor implementation of policies related to perinatal mental health care, the mental health needs of women during pregnancy remain largely unattended to. According to Du Toit et al. (2017:1), perinatal mental illness has furthermore been associated with poor obstetric outcomes, increased likelihood of substance abuse, and underutilisation of prenatal care.

In South Africa, maternity care is provided to women triaged as having uncomplicated pregnancies. Midwives are therefore usually the most accessible to women and could potentially identify the women at risk of a mental illness. According to Bayrampour, Hapsari, and Pavlovic (2018:48), midwives are inadequately prepared in the screening and management of women with perinatal mental health issues.

Despite the significant health burden that mental illnesses pose, policies regarding maternal mental health screening are either limited or poorly adhered to. Furthermore, it is unclear whether perinatal mental health screening is offered consistently to clients throughout their pregnancies. This leaves a treatment gap in perinatal mental health care.

1.2. Significance of the problem

Perinatal mental illness in South Africa presents a major societal and health burden. Although the World Health Organization advocates for integrated perinatal mental health screening, the mental health of South African women remains largely unaddressed. South African policies regarding perinatal mental health screenings have been described as comprehensive (Baron, Hanlon, Mall, Honikman, Breuer, Kathree, Luitel, Nakku, Lund, Medhin, Patel, Petersen, Shrivastava & Tomlinson, 2016: 5). However, large discrepancies exist between policies and practice.

Previous studies regarding perinatal mental health predominantly focused on quantifying the problem (Rochat, Tomlinson, Baringhausen, Newell & Stein, 2011:366; Stellenberg & Abrahams, 2015:6) and identifying contributing factors to the development of mental illnesses (Rochat et al., 2011: 363), but no studies which seek to explore the midwives' perception regarding perinatal mental healthcare have been identified within the South African context.

The intended study was aimed at determining the feasibility of perinatal mental health screening by midwives in order to gain insight into their perceptions regarding the phenomenon of perinatal mental health screening. Moreover, the researcher intended to explore potential barriers and facilitators to providing such screening. By identifying barriers to providing perinatal mental health screening, the researcher hopes that these can be addressed to adequately attend to the mental health needs of women.

1.3. Rationale

The rationale for this study was myriad: a dearth of previous research regarding perinatal mental illnesses focuses largely on quantifying the phenomenon. Despite the health burden that mental illnesses pose it remains a low priority area within healthcare practices. With the exception of significantly depressed patients or those who have a psychotic episode, most women with mental illnesses remain undiagnosed (Fonseca, Gorayeb, Canavarro, 2015:1178) and untreated.

The researcher acknowledges previous involvement with a Perinatal Mental Health Project at her facility. Perinatal mental health screening and counselling was well received by clients. Possibly due to depleted funding, the project was suddenly

withdrawn from various institutions. This created a mental health treatment gap, with most women currently accessing the facility not receiving perinatal mental health screening and appropriate perinatal mental health care.

As a midwife, the researcher often observed that mental health issues negatively impacted on women's pregnancy outcomes. Many of these women accessed healthcare services late in pregnancy or not at all. The researcher furthermore observed an increase in substance use during pregnancy and in survivors of intimate partner violence, but perceived referral pathways for women in crisis as inadequate. Midwives are often the primary point of contact and may offer invaluable input in terms of bridging the gap between perinatal mental health needs and care.

Therefore, the purpose of the study was to broaden the perspectives of practicing midwives regarding perinatal mental health screening and providing appropriate, timely care in order to improve maternal, neonatal, and family outcomes. The study furthermore sought to identify potential strategies to integrate mental health services with routine physical care.

1.4. Problem statement

Perinatal mental illnesses remain a public health problem. The prevalence and of perinatal mental illnesses in high and low- and middle-income countries are well documented. According to Du Toit et al. (2017:2), less than 8% of women who present with perinatal depression are adequately diagnosed and treated. Most women therefore remain undiagnosed and untreated.

This increases the likelihood of perinatal complications, as well as predisposing infants exposed to maternal depression to long-term cognitive and behavioural challenges (Letourneau, Dennis, Cosic & Linder, and 2017:2). Unaddressed maternal mental health needs are also associated with preterm births, low birth weight of infants, undernourishment in the first year of life, and early cessation of breastfeeding (Rahman, Surken, Cayetano, Rwagatire & Dickson, and 2013:1). Perinatal mental illnesses furthermore predispose women to violence, abuse, and economic insecurity (Turner & Honikman, 2016:1166).

Midwives are often the primary point of contact and may play a central role in screening at-risk women. Within a primary health care setting, midwives initiate antenatal care and may have ongoing contact with women during their pregnancies. For some clients, midwives may be the final point of contact until a dire emergency requiring medical intervention forces them to a healthcare setting. Furthermore, midwives often possess counselling skills, which may play a pivotal role in addressing maternal mental health. The inadequacy and/or lack of perinatal mental health screening during pregnancy, birth, and motherhood predisposes women to poor perinatal outcomes. The consequences of untreated perinatal mental illnesses, therefore, add to an already burdened health care system. The aim of the study was to explore the perspectives of midwives regarding perinatal mental health screening and subsequently elucidate practical points to integrate perinatal mental health screening with routine care.

1.5. Research question

What were midwives' perspectives of perinatal mental health screening during pregnancy in maternity facilities in the Cape Metropole?

1.6. Research aim

The aim of the study was to explore midwives' perspectives on perinatal mental health screening during pregnancy in maternity facilities in the Cape Metropole.

1.6.1 Research objectives

The objectives of the study were to:

RO 1: Describe the midwives' understanding of perinatal mental health screening during pregnancy in maternity facilities in the Cape Metropole

RO 2: Explore midwives' perspectives of providing perinatal mental health screening during pregnancy in maternity facilities in the Cape Metropole.

RO 3: Explore potential strategies to integrate perinatal health screening with care in maternity facilities in the Cape Metropole.

1.7. Research methodology

The three main types of research are quantitative, qualitative, and mixed methods. According to Grove, Gray, and Burns (2015:32), quantitative research is a formal and objective process which generates information about the world). A qualitative research approach was identified as most suited to reach these objectives, as it focuses on the multiple realities of participants (Grove et al., 2015:67). Qualitative research furthermore acknowledges that time and context may influence an individual's perspective. The researcher furthermore purposively sampled participants in view of the insight they may offer in relation to the study subject. One midwife working in the antenatal clinics, labour wards, and postnatal clinics at four MOUs was invited to participate in the study.

The study was submitted to and reviewed by the Ethics Committee of Stellenbosch University and institutional permission was granted by the Department of Health: Western Cape.

1.7.1. Research design

The researcher employed an exploratory descriptive approach. Descriptive qualitative research seeks to obtain new information and gain insight into a specific clinical problem, and the intended outcome of this design is to elicit potential solutions to address the study subject (Grove et al., 2015:77). The researcher, therefore, intended to provide an in-depth description of and explore perspectives regarding perinatal mental health screening rather than to quantify perinatal mental illnesses.

1.7.2. Study setting

The study was conducted in the Metro West District within the Cape Metropole, Western Cape. The researcher conducted the study at four Midwife and Obstetric units (MOUs) in the Metro West District within the Cape Metropole, Western Cape. The MOUs are Gugulethu, Mitchell's Plain, Hanover Park, and False Bay Hospital. False Bay Hospital provides basic maternity care similar to the services rendered at the other MOUs. The MOUs are located in periurban settings and service clients from predominantly lower socioeconomic backgrounds.

1.7.3. Population and sampling

A population refers to the entire aggregation the researcher is interested in (Polit & Beck, 2010: 306). For this particular study, the entire population comprises all midwives working at the specific institutions. The target population is sampled by means of inclusion and exclusion criteria (Grove et al., 2015: 250). The researcher therefore reduced the population to midwives that have at least 2 years' working experience at the specific institution, and who were active in in-patient care.

The researcher purposefully sampled participants based on their eligibility to participate in the study. This method entails deliberately choosing certain participants based on their knowledge and experiences regarding a specific subject (Grove et al., 2015: 272). Most of the participants rotated throughout the facility and were able to provide rich information from multiple perspectives in relation to patient care.

1.7.4. Data collection tool

Data was collected via semi-structured interviews. The interview guide has been attached as an appendix. The interview guide consists of open-ended questions and probes to facilitate engagement with participants. The interviews were conducted in English only.

1.7.5. Pilot interview

One pilot interview was conducted with a midwife who met the inclusion criteria to refine the clarity of the questions asked. The supervisor furthermore assessed the interviewing skills of the researcher and provided feedback. The findings of the pilot interview were included in the report as a means to validate and acknowledge the participant's interpretations.

1.7.6. Trustworthiness

Trustworthiness ensures that the research findings are an actual representation of the participants' rather than the researcher's perceptions and may be facilitated by sharing preliminary findings with participants to confirm congruence with their perceptions or experiences (Polit & Beck, 2010: 79). Trustworthiness furthermore relates to the credibility (authenticity of findings), transferability (generalisability of findings), dependability, and confirmability of the study process and management of data

extracted (Polit & Beck, 2010: 106). The principles of trustworthiness and the application thereof will be discussed in detail in Chapter 3.

1.7.7. Data collection

Data was collected by conducting semi-structured interviews with the identified participants after the study was explained and informed consent was obtained. Interviews were conducted at the participants' convenience in terms of timing and venue. The researcher conducted all of the interviews. Interviews with participants were audio recorded and notes were written soon after each interview. Interviews were only conducted in English as it is the medium of communication at the facilities, and each interview lasted for approximately 40 minutes. The researcher has basic interviewing skills which were assessed and critiqued by the supervisor after the pilot interview.

1.7.8. Data analysis

The interviews were audio recorded and transcribed verbatim. Data was transcribed and analysed according to the Framework Method. The steps of data analysis are discussed in more detail in Chapter 3.

1.8. Ethical considerations

According to Moodley (2017:4), ethics is the study of morality and doing what is deemed proper in a specific situation. The ethical principles of autonomy, self-determination, beneficence, and non-maleficence were observed in the study.. A thorough risk/benefit analysis reflects that the study poses a minimal physical risk to participants. Although participants would not directly benefit from inclusion in the study, their participation and input offered invaluable insight into promoting mental health and providing holistic patient care. The study was reviewed and approved by the Health Research Ethics Committee of Stellenbosch University with Ethics Reference number 9006.

1.9. Operational Definitions

Midwife: According to the South African Nursing council, a midwife is a person registered in a category under section 31(1) (b) of the Nursing Act, No 33 of 2005 who

promotes, maintains, restores, and supports the health status of a woman and her child during pregnancy, labour, and puerperium (Republic of South Africa, 2005). For the purposes of the study, a midwife is a healthcare worker who attends to pregnant women during their pregnancies and labour and postnatally.

Perspective: A mental view or outlook (American Heritage English Dictionary, 2016). In this study, perspectives are the viewpoints or opinions of the participants regarding perinatal mental health.

Perinatal mental health: Mental health of women from conception through the first year post-delivery (Noonan, Jomeen, Galvin & Doody, 2018:e359). For this study perinatal mental health relates to the mental wellbeing of women during and soon after pregnancy.

Perinatal mental illnesses: Mental illnesses associated with pregnancy, including depression, anxiety disorders, post-traumatic stress disorders, bipolar mood disorders, schizophrenia, and puerperal psychosis (Austin, Priest & Sullivan, 2008).

Table 1.1: Duration of study

Year	Month	Activity
2019	February	Submission of proposal to Ethics Committee
2019	May	Provincial / institutional permission
2019	June	Pilot interview
2019	June-August	Data collection
2019	June- August	Data analysis
2019	Continuous	Writing of thesis with continuous review by supervisor
2019	October	Technical and grammar editing
2019	November	Submission of thesis

Ethical approval was obtained in February 2019. Data collection and analysis commenced concurrently in June 2019. The final thesis was submitted November 2019 for examination.

1.10. Chapter outline

Chapter One: Foundation of the study

The Introduction and background aims to introduce the reader to the topic and provide insight in view of the significance of the subject to be researched.

Chapter Two: Literature review

The literature review will include previous research relevant to this particular study. The literature review will furthermore provide an overview of current perinatal mental health practices.

Chapter Three: Research methodology

This chapter will describe the research methodology in terms of the research methods to be used in the study, the study setting, and the sampling methods to be employed.

Chapter Four: Results

The findings of the research study will be discussed in this chapter according to the emerging themes and sub-themes.

Chapter Five: Discussion, conclusions, and recommendations

In chapter five, the findings and implications of the study will be discussed, and recommendations will be made accordingly. Recommendations will be made to potentially mobilise policy makers to be cognisant of and make provision for perinatal mental health needs.

1.11. Significance of the study

Most studies regarding perinatal mental illnesses have focused on prevalence and aetiology. Mental illnesses remain largely unrecognised and/or unmanaged, with far reaching consequences. Institutions that do provide perinatal mental health services rely largely on non-government organisations to render such care. By exploring

ground workers' perceptions on the need for perinatal mental health screening, the researcher can establish the need for and acceptability of rendering such care alongside basic perinatal care.

1.12. Summary

In summary, perinatal mental health screening remains an unmet challenge within maternal health care provision. Perinatal mental illnesses may impact on a woman, child and family. Midwives are ideally placed to facilitate perinatal mental health screening. A qualitative study with a descriptive, exploratory approach was employed to meet the objectives of the study. The study was conducted at level one MOUs in the Metro West district. Participants were purposively selected based on the insight they could deliver regarding the phenomenon. Semi structured interviews were conducted on nine midwife participants. The research was conducted after ethical approval was obtained from the Health and Ethics Committee at Stellenbosch University. Permission was furthermore, obtained from the Department of Health: Western Cape to access the various facilities.

1.13. Conclusion

At present, perinatal mental healthcare remains largely unaddressed in South Africa with far reaching consequences for women and children and their support systems. Given the health-seeking tendencies during pregnancy, midwives are placed in an ideal position to render such care. Evidence, however, shows that midwives feel poorly equipped to manage perinatal health issues. A lack of organisational guidelines and inadequate referral pathways further complicate the provision of perinatal mental healthcare. The literature review done for the study furthermore solidifies the need to focus on the healthcare workers' perceptions on service delivery, as this angle has been largely ignored within the South African context.

2. CHAPTER TWO
LITERATURE REVIEW

2.1. Introduction

Previous studies regarding perinatal mental illnesses have focused largely on its prevalence and aetiology. The literature review has been aligned with the objectives of the study as discussed in Chapter one. The literature pertinent to this particular study relates to providing a brief overview of perinatal mental illnesses, discussing midwives' understanding of perinatal mental illnesses, and researching midwives' perceptions of perinatal mental illnesses and the integration of perinatal mental health screening. Legislation regarding mental health and the various health settings in South Africa will also briefly be discussed. According to Grove et al. (2015: 165), literature reviews may be conducted to understand a situation or problems better and to find appropriate solutions.

2.2. Electing and reviewing the literature

Literature was collected from the following search engines: PubMed, Google Scholar, Cochrane, and CINAHL. The following key words were used in various combinations to search for articles: "midwives", "healthcare workers", "nurse", "nurse practitioner", "perinatal mental health", "maternal mental illness", "common mental illnesses", "perinatal mental health screening", and "postpartum depression". The search was expanded using Boolean operators "AND" and "OR". Qualitative and quantitative research designs were included for literature search.

2.2.1. Overview of perinatal mental illnesses

The World Health Organization in Herman, Saxena and Moodie (2006:2) defines mental health as "a state of wellbeing in which a person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community'' Conversely, perinatal mental illnesses encompass all psychiatric and mood disorders that typically emerge during pregnancy and which may persist up to one year postpartum (O'Hara & Wisner, 2013:3,4). Distinguishing between perinatal mental illnesses and normal physiological

changes post pregnancy is pivotal for this study and in practice. Postpartum blues, caused by hormonal fluctuation, may affect up to 84% of women postpartum (O'Hara & Wisner, 2013:6). Women with postpartum blues may experience mood and minor physical symptoms which should resolve spontaneously within 10-12 days (O'Hara & Wisner, 2013:6).

Perinatal depression is characterised by low mood, a sense of low self-worth, excessive guilt, low energy levels (Rahman et al., 2013: 2), and changes in sleep and eating patterns. Depressive symptoms may often be misinterpreted as normative pregnancy changes. Perinatal depression may impact on a woman, her family, and her ability to care for her child. According to Turner and Honikman (2016: 1166), women with perinatal mental illnesses are less likely to access health care and have a greater likelihood to self-medicate with drugs and substances and engage in risky sexual behaviour.

Anxiety disorders, characterised by excessive worrying, avoidance, and obsessiveness, may cause mild to moderate impairment in daily functioning (O'Hara & Wisner, 2013:5). Midwifery training and current literature tends to focus predominantly on perinatal depression, yet anxiety disorders may be equally as prevalent (Viveiros & Darling, 2018:116).

In contrast to postpartum blues, postpartum psychosis is more severe but has a lower prevalence, affecting approximately two women per 1 000 births (Turner & Honikman, 2016: 1166). Women with known bipolar mood disorder have a greater predisposition for psychosis (O'Hara & Wisner, 2013:6).

2.2.2. Perinatal mental health in developed countries

Perinatal depression and anxiety are estimated to have prevalences of up to 12,9% and 13% respectively in high-income countries (Fellmeth, Fazel & Plugge, 2017: 742). According to Wilkonson Trustees and Medical Advisers perinatal mental illness is the greatest contributor to maternal deaths during the perinatal period in high-income countries (Sambrook Smith, Lawrence, Sadler, and Easter 2018:1). Furthermore, Lewis in Hauck, Kelly, Dracovic, Butt, Whittaker, and Badcock (2014:248) reiterate

that suicidality resulting from mental illnesses during the perinatal period is the leading cause of maternal deaths in developed countries.

2.2.3. Perinatal mental health in South Africa

According to Honikman, Van Heyningen, Field, Baron and Tomlinson (2012:1) perinatal mental illnesses are three times more prevalent in low- and middle-income countries than in high-income countries. This is supported by research reflecting that women facing abject poverty and with low education levels were more predisposed to perinatal mental illnesses (Hartley, Tomlinson, Greco, Comulada, Stewart, le Roux, Mbewu & Rotheram-Borus, 2011:3,4). Due to poverty, exacerbated by gender inequalities, women in LMIC are especially vulnerable to mental illnesses during the perinatal period (Tsai & Tomlinson,2012: 1).

In South Africa, perinatal depression may have a prevalence rate of up to 47% (Honikman et al., 2012:1). Stellenberg and Abrahams (2015:7) postulate a depression rate of up to 50,3% of participants in their study conducted in a rural Western Cape district. Van Heyningen, Honikman, Myer, Onah, Field, and Tomlinson (2017:767) conducted a cross sectional study using self report questionnaires to determine psychosocial risk factors for perinatal anxiety. Van Heyningen et al. (2017:770) postulate that anxiety may have a similarly high prevalence rate of up to 39% in low- and middle-income countries. The researchers however, recognize that women susceptable to perinatal mental illnesses may be less likely or unable to attend healthcare facilities (Van Heyningen et al., 2017: 772).

The consequences of perinatal mental illnesses are particularly harrowing in communities faced with adversity and poverty (Van Heyningen, Myer, Onah, Tomlinson, Field & Honikman, 2016:129-130). These consequences may affect the mother-child relationship and infant development, and contribute to unhealthy social behaviours for the mother (Goodman, 2009: 61). The study conducted by Van Heyningen et al. (2016:128) makes a valuable contribution to the incidence of depression in LMIC. The researchers, however acknowledge that the study relied on self report regarding depression experienced by particpants and that women with

severe pycho pathologies tended to not attend antenatal clinics (Van Heyningen et al., 2016:129).

Numerous South African studies were found that quantify perinatal mental illnesses. However, literature focusing on the perspectives of South African midwives regarding perinatal mental health screening was limited.

2.3. Understanding of perinatal mental health screening by midwives

Recognition of predisposing factors and implications of perinatal mental illnesses may reflect midwives' understanding of perinatal mental health screening. Hence, risk factors for and the impact of perinatal mental illnesses was reviewed.

2.3.1. Risk factors for perinatal mental illnesses

Midwives are cognisant of physiological changes during pregnancy which may impact on a woman's mental state. Hormonal fluctuations, especially in the first and last trimester of pregnancy, may contribute to symptoms of fatigue, mood swings, and tearfulness. Normative pregnancy may mask depression. Conversely, signs of depression may be perceived as normal physiological pregnancy changes (Sambrook Smith et al., 2018:4, Bayrampour et al., 2018:53).

Postnatal blues may affect up to 84% of women postpartum (O'Hara & Wisner, 2013:6) and are attributed to rapid hormonal changes. Postnatal depression, however, has a later onset, but symptomology is more severe than postnatal blues. Patients at MOUs are followed up on every alternate day for up to ten days postnatally. Healthcare workers, specifically midwives, may therefore play a pertinent role in identifying women with postnatal mental illnesses. However, midwives may be the least likely maternity healthcare worker to identify and appropriately manage perinatal mental illnesses (Bayrampour et al., 2018: 48).

A systematic review conducted by Sambrook Smith et al. (2018: 3) sought to assess barriers to accessing perinatal mental health services. The study revealed that midwives lacked perinatal mental health awareness and knowledge to identify and

appropriately manage women with perinatal mental illnesses (Sambrook- Smith et al., 2018:3). Perinatal mental health knowledge is mostly acquired during clinical practice (Bayrampour et al., 2018:55). Despite having limited knowledge, midwives express a desire to acquire competencies relating to perinatal mental health matters (Hauck et al., 2014:254).

Environmental or social stressors may exacerbate perinatal mental illnesses. Women subjected to poverty have an increased likelihood of developing perinatal mental distress. Van Heyningen et al. (2016:129) reaffirm that abject poverty may predispose women to perinatal depression. Pregnancy and the associated financial responsibility of having to take care of a child are thought to perpetuate the stress associated with poverty.

Turner and Honikman (2016:1166) postulate that perinatal mental illnesses increase a woman's predisposition to drug and alcohol use as a means to self-medicate. Alcohol and other substances are often used to mask mental illnesses or as a coping mechanism A study conducted at MOUs in the Western Cape revealed a 36,9% and 8,8% prevalence of alcohol and drug abuse respectively during pregnancy (Petersen Williams, Jordaan, Mathews, Lombard & Parry, 2013: 5,7). Recent literature regarding the association between substance abuse and pregnancy within the South African context is limited.

Fellmeth et al. (2017:742) conducted a systematic review and meta-analysis to determine the prevalence, associated factors and interventions or perinatal mental illnesses in migrant women. Perinatal depression may affect nearly one in three refugee women (Fellmeth et al., 2017:747), making them a particularly vulnerable group. Fellmeth et al. (2017: 747) postulate that poor social support or isolation may exacerbate perinatal mental illnesses. Furthermore, refugees often experience previous acts or crimes of violence (Turner & Honikman, 2017: 1165). Midwives, however, lack the knowledge and competencies to deliver culturally-sensitive perinatal mental health care (Viveiros & Darling, 2018:116).

Despite the availability of various free contraceptive methods, unplanned or unwanted pregnancies still present a major challenge within the South African context. Van

Heyningen et al. (2017:770) reaffirm that unwanted or unplanned pregnancies increase a woman's predisposition for perinatal mental illnesses. Unwanted pregnancies furthermore predispose women to multiple social, economic, and physical consequences.

A quantitative, descriptive study was conducted by Du Toit et al. (2017:323) to assess socio- demographic factors and variables associated with mental illnesses and the incidence of unplanned pregnancies. The study was conducted in the Western Cape at two mental facilities and reflected that nearly half of the participants' experienced an unplanned pregnancy (Du Toit et al., 2017: 327). Du Toit et al. (2015: 329) furthermore, postulate that women with perinatal mental illnesses are unlikely to seek adequate perinatal health care when pregnant.

Adolescents have a greater predisposition to perinatal mental illnesses. Adolescents are classified as being between 15 and 19 years of age, although children as young as 12 have conceived. Turner and Honikman (2017:1165) emphasise that teenagers are predisposed to perinatal mental illnesses which may persist throughout adulthood. This may be attributed to financial dependence or a lack of social or partner support.

A woman's perception of social support from family and/or a partner may impact on her ability to cope with the pregnancy and postnatally. Biaggi, Conroy, Pawlby, and Pariante (2015: 64) conducted a systematic literature review to identify the main psycho social and environmental factors associated with the onset of anxiety and depression. Having a supportive partner may soften and aid the transition into parenthood (Biaggi et al., 2015: 67). Biaggi et al. (2015:74) postulate that having excluded high risk groups, such as those who experienced a natural disaster, from their review may limit the generalisability of findings to these populations.

2.3.1. Impact of perinatal mental illnesses

According to Du Toit et al. (2017:1), unresolved perinatal mental illnesses are associated with poor obstetric outcomes, increased likelihood for substance abuse, and poor adherence to prenatal visits. Studies reflect disparities in health care utilisation among women with perinatal mental illnesses. Turner and Honikman (2017:

1164) affirm that women with perinatal mental illnesses are less likely to avail themselves of healthcare services. Non adherence to antenatal care presents a major challenge to mental health, as women with perinatal mental illnesses are less likely to utilise or access healthcare (Turner & Honikman, 2017:1164).

This furthermore implies that a vast number of women with antenatal mental illnesses may not be included in statistics and that prevalence rates for perinatal mental illnesses may in fact be higher. The tendency of women with perinatal mental illnesses to not access healthcare facilities may be attributed to an inability to recognise mental distress or complacence regarding mental illnesses.

Conversely, Bitew, Hanlon, Kebede, Medhin, and Fekadu (2016:7) postulate that women with perinatal mental illnesses tend to access healthcare facilities more frequently. Increased healthcare utilisation may be attributed to the somatic or physical complaints associated with perinatal mental distress.

Stein, Pearson, Goodman, Rapa, Rahman, McCallum, Howard, and Pariente (2014: 1806-1807) postulate a relationship between perinatal mental illnesses and intimate partner violence (IPV). It is difficult to establish whether IPV causes perinatal mental illnesses or whether women with mental illnesses are more likely to experience IPV. Perinatal mental illnesses may furthermore erode interpersonal relationships and impact on a woman's parenting ability (Stein et al., 2014:1183).

Perinatal mental illnesses compromise a woman's ability to take care of her child. The impact of poor maternal-child attachment may have long-standing consequences. Turner and Honikman (2017:1166) affirm that children of depressed mothers are more likely to be abused or to develop mental disorders as adults. Plant, Pariante, Sharp, and Pawlby (2015:213) postulate an association between maternal depression and sexual or physical assault of offspring.

2.4. Provision of perinatal mental health screening by midwives

Midwives are ideally placed to identify women at risk of perinatal mental illnesses, yet receive inadequate training in terms of mental health concerns (Sambrook Smith et

al., 2018:6). Bayrampour et al. (2018:55) furthermore reiterate that midwives acknowledge responsibility for perinatal mental health screening but face multiple barriers in addressing such needs. Conversely, factors within the healthcare system enable perinatal mental health screening and care.

2.4.1 Barriers to providing perinatal mental health screening

Viveiros and Darling (2018: 9) conducted a qualitative descriptive study to explore women's perception of factors that prevented or facilitated their access to perinatal mental services. One of the study was that stigma presented a major barrier to women utilizing or accessing perinatal mental health care (Viveiros & Darling, 2018: 11). Despite increased recognition of mental illnesses, stigmatism remains one of the greatest challenges in addressing the mental health needs of society (Viveiros & Darling, 2018:11). Fonseca et al. (2015:1178) postulate that stigma is often a contributing factor to women not acknowledging a mental health problem or seeking medical attention. Stigmatism however, is one of the barriers which healthcare workers can change.

Often, women may not seek medical attention for a mental illness out of fear of being labelled as "crazy" or a bad mother (Hansotte, Payne & Babich, 2017: 11). Women typically may not vocalise mental distress, fearing that their maternal competence may be judged or that their child may be removed from their care (Sambrook Smith et al., 2018: 2). Similarly, women may experience guilt when experiencing mental distress during a life event synonymous with joy (Viveiros & Darling, 2018:10). Women may therefore minimise or deny their feelings out of guilt.

Bayrampour et al. (2018:47) conducted an integrative review to determine midwives' perceived barriers to perinatal mental health screening and management. The findings of the review were grouped as either provider level or system level barriers (Bayrampour et al., 2018: 49). Time constraints, lack of knowledge and inefficient training were identified as provider level barriers and a lack of policies; referral pathways were identified as system level barriers (Bayrampour et al., 2018:53-55). Bayrampour et al. (2018: 56) acknowledge that one of the limitations of their review is that the studies included focused mainly on depression and anxiety, which is more common, was dismissed.

Pregnant women may also face judgement from healthcare workers whose primary purpose during consultations is to address the physical needs of the woman (Du Toit et al., 2017: 2). Mental health may be considered an additional chore for an already-heavy workload. Likewise, women may perceive mental health care to be insignificant during routine visits.

Time constraints have similarly been identified by Bayrampour et al. (2018:53) as a major barrier in addressing mental health needs, as physical care is often prioritised during a routine antenatal visit. Midwives are often the primary point of contact for women in LMIC. The main focus during routine checks is to establish maternal physical wellbeing and to ensure adequate foetal growth (Viveiros & Darling, 2018:115). A heavy workload, exacerbated by staff shortage as well as patient morbidity may hinder midwives' ability to provide holistic care.

Noonan et al. (2018) conducted a cross sectional survey amongst midwives in Ireland to determine their knowledge and confidence to identify and manage perinatal mental illnesses. Data collected in the study reflected that midwives had high knowledge and confidence levels to identify perinatal mental illnesses but felt inadequately skilled to support women with mental health problems (Noonan et al., 2018 e363-364).

A survey conducted in the United States revealed that despite midwives' knowledge regarding the importance of perinatal depression and having valid screening tools to assess maternal mental health, there are no clear guidelines regarding the consistent implementation thereof (Rompala, Cirino, Rosenberg, Fu & Lambert, 2016: 601). Similarly, within the South African context, policies and guidelines regarding the consistent screening of mental illness during perinatal period have also been poorly implemented.

A lack of knowledge in healthcare workers presents as a barrier to addressing perinatal mental health needs, and patients subsequently remain undiagnosed or untreated (Corrigan, Kwasky & Groh, 2015:48). Sambrook Smith et al. (2018:3) reaffirm that health care workers' inability to recognise mental distress presents as one of the greatest barriers to providing such care. Noonan, Doody, Jomeen and Galvin's integrative review (2018: 58) reflects that midwives felt poorly equipped to provide culturally-sensitive mental health care.

Similarly, Bayrampour et al. (2018:53) reaffirm that dismissive attitudes of healthcare workers may also limit early detection and management of perinatal mental illness. A lack of knowledge relating to an inability to distinguish between mental distress and adjustment to new parental roles furthermore compromises the perinatal mental health needs of women (Bayrampour et al., 2018:53).

Fonseca et al. (2015: 1177) conducted a cross sectional internet survey to determine characterize the help seeking behaviours of women who had screened positive for perinatal depression. The study, conducted in Portugal, revealed that only 20-40% of women with mental health concerns sought medical intervention, despite help being available (Fonseca et al, 2015: 1178). The study furthermore revealed that mental illnesses were only addressed if the client expressed concern over them or presented with significant mental instability (Fonseca et al., 2015: 1178). Given that partipants were recruited via social media, the researchers acknowledge that selection bias may have influenced the findings as the study was limited to women with internet access (Fonseca et al., 2015: 1184).

Only 20-25% of the entire South African population requiring mental health interventions obtained such care (Turner & Honikman, 2016: 1164). Turner and Honikman (2016: 1164) affirm that this is indicative of the scarcity of mental healthcare workers, lack of public awareness, and stigma and discrimination associated with mental illness. However, based on the aforementioned study findings (Turner & Honikman), it is unclear whether low treatment uptake is related to inadequate diagnosis or an actual lack of resources.

Financial and logistical barriers have implications in terms of committing to segregated healthcare visits (Goodman, 2009:61). Orengu-Aguayo & Segre (2016:38) reaffirm that women incur additional costs when healthcare is segregated. If clients are given separate appointments for routine antenatal care and mental health debriefing sessions, they are more likely to prioritise their physical wellbeing. A lack of childcare or having to pay additional money for a child minder may present a barrier to women seeking mental healthcare (Hansotte et al., 2017:11). This is particularly relevant within the communities the MOUs service, which are predominantly exposed to abject poverty, crime, and HIV/AIDS. This is reaffirmed by Honikman et al. (2012:1), who propose that additional costs incurred for transportation and childcare may present a

barrier to committing to segregated mental healthcare. The ideal would be that both consultations should occur at a single point of contact and on similar days.

Women with mental health issues often remain undiagnosed because of an inability to recognise and/or to vocalise symptoms (Bayrampour et al., 2018: 47). Furthermore, these clients may not disclose their difficulties because of presumed negative feelings associated with what ought to be a joyful event (Biaggi et al., 2015:63). Viveiros & Darling (2018:13) reaffirm that unrealistic expectations of motherhood further hinder a woman's ability to seek mental health care. Fonseca et al. (2015: 1178) highlights knowledge barriers to seeking help with mental illnesses. These include an inability to distinguish between maladjustment to parenthood or actual depression, and uncertainty regarding the severity of symptoms (Fonseca et al., 2015: 1178). Many women may normalise mental symptoms and be unaware that they have a mental illness.

Rahman et al. (2013: 2) recognise the social exclusion and negative attitudes towards mental illnesses as barriers to facilitating mental health care. Viveiros and Darling (2018:116) identify midwives' discomfort with addressing mental health as a barrier to providing such care. Similarly, women may face judgement from society for acknowledging that they have a perinatal mental illness. Mental disorders remain largely ignored or underestimated, with grave consequences. According to Honikman et al. (2012:1), suicidality related to mental illnesses is the leading cause of maternal deaths during the perinatal period. Information regarding suicide trends in South Africa is lacking (Honikman et al., 2012:1). Alarmingly, Viveiros and Darling (2017: 115) highlighted that midwives considered suicide risk assessments as the second-least important of four skills to have.

Unclear or limited referral pathways may also hinder perinatal mental health screening efforts (Bayrampour et al., 2018:54). Perinatal mental health screening should only be offered if appropriate referral groups or specialists are available.

The South African National Department of Health (2013: 9) states that mental health care remains under-resourced compared to other health priorities. Despite the Mental Health Care Act requiring Government to improve and integrate mental health care with other health components (Western Cape Government, 2014:25), perinatal mental health remains largely neglected.

2.4.2 Enhancing factors for providing perinatal mental health screening

Dixon and Dantas (2017: 118) postulate that the scarcity of mental healthcare workers and inadequate referral systems may stifle efforts to address the mental healthcare needs of clients. Furthermore, if the disparities in healthcare delivery are observed, a significant 84% of the South African population utilises public healthcare facilities, compared to the 16% who have access to private healthcare (Benatar, 2013: 154). Similarly, Honikman et al. (2012:5) emphasise substantial disparities in the availability and quality of healthcare resources in the South African rural and urban settings. Mental healthcare needs to be addressed by incorporating cost-effective and creative interventions.

According to Bayrampour et al. (2018: 54), universal screening initiatives for maternal mental illness increased the likelihood of screening and, conversely, absent or unclear state guidelines or organisational policies hinder consistent screening of maternal mental health. Similarly, unclear referral pathways and limited referral options were identified as potential barriers to addressing perinatal mental illnesses (Bayrampour et al., 2018: 54). Honikman et al. (2012: 3) concurs that established protocols and referral systems may enhance screening for perinatal mental disorders. Noonan et al. (2017: e364), however, question the plausibility and efficacy of routine perinatal mental health screening.

Bayrampour et al. (2018:55) recommends that the inclusion of perinatal mental health training as a component of midwifery education programmes ought to be mandatory, as well as the provision of training opportunities for practicing midwives to expand and update their existing knowledge and skills. Adequate training of midwives to do perinatal mental health screening, in conjunction with adequate referral systems, may reduce nursing workload and minimise the risk of staff burnout (Honikman et al., 2012:3,5) relating to unidentified or untreated mental disorders.

Screening and management of maternal mental illnesses can be successfully integrated with physical care (Rahman et al., 2013:2). Rahman et al. (2013:2) postulate that the holistic nature of wellbeing is acknowledged when mental health care is incorporated with routine physical care. A perinatal mental health project

(PMHP) headed by Honikman et al. (2012:2-3) generated positive results in view of offering clients mental health screening and appropriate referral to lay counsellors by employing midwives to offer screening at routine antenatal visits. The PMHP positively reflected that midwives were able to provide mental health screening and referral in low-resource settings (Rahman et al., 2013:5).

A qualitative study conducted by Orengu-Aguayo and Segre (2016: 43) endorses that integration of mental health with routine physical care yielded largely positive responses from participants, as additional transport and childcare costs were eliminated. Continuity of care was found to impact women's acceptability of mental health screening and care (Viveiros & Darling, 2018:11). Women were more likely to engage with and disclose mental distress to healthcare workers with whom they had established rapport.

Midwives' ability to recognise distress was shown to have a mediating effect on the impact of mental illnesses (Viveiros & Darling, 2018: 11). The patient advocacy role, established with frequent contact sessions, is furthermore identified by Viveiros and Darling (2018: 14) as a facilitating factor in providing perinatal mental health screening and care.

Task sharing can be successfully implemented in resource-depleted facilities as a means to bridge the treatment gap for perinatal mental health illnesses (Mendenhall, De Silva, Hanlon, Petersen, Shidhaye, Jordans, Luitel, Ssebunnya, Fekadu, Patel, Tomlinson & Lund, 2014: 40). Task sharing entails the training of non-specialist counsellors to address fewer complex cases, but under specialist supervision and guidance.

2.5. Integration of perinatal mental health screening into routine care

Integrating perinatal mental health screening increases detection of perinatal mental illnesses and may enhance access to mental health services for women. The integration of perinatal mental health care furthermore eliminates logistical and financial barriers created by having segregated healthcare visits. Bayrampour et al.

(2018:54) reaffirms that linking healthcare visits strengthens perinatal mental health screening efforts.

The South African National Mental Health Policy Framework and Action Plan (2013-2020) emphasises the integration of perinatal mental health with routine antenatal and postnatal care and intervention packages to reduce substance abuse during pregnancy (2012: 25). Healthcare workers are, however, poorly informed regarding mental health policies. Moreover, despite having a comprehensive perinatal mental health policy, resources allocated to address mental health needs as stipulated are scantily provided for. Policies and available resources to address mental health needs should therefore be aligned to realise the predetermined objectives. Policies regarding perinatal mental health screening and care should, furthermore, be appropriately communicated to relevant staff.

According to Carolle, Downes, Gill, Monahan, Nagle, Madden, and Higgens (2018:35), midwives felt poorly equipped to utilise perinatal mental health screening tools. There is a tendency for healthcare workers to rely on their intuition and clinical experience instead. Noonan et al. (2017: e364) question the practicality and feasibility of using perinatal mental health screening tools and recommend that screening tools should be used alongside clinical judgement. However, training with reference to preferred perinatal mental health screening tools should still be implemented during undergraduate midwifery curricula.

Although midwives accept responsibility for mental health matters, they may lack the knowledge and skills to provide perinatal mental health screening and care (Hauck et al, 2014:248). Screening and counselling skills should therefore be reinforced during clinical practice. Viveiros and Darling (2018:116) reaffirm that increased knowledge, acquired through training, promotes confident practitioners and acceptability of perinatal mental health screening. Training is pivotal for perinatal mental health screening by midwives to be feasible and sustainable (Honikman et al., 2012:3).

Non-government organisations and community involvement may alleviate the burden placed on an over-extended healthcare system. Western Cape Government (2014:18) encourages community building and involvement as a means to improve wellness.

Absent or unclear referral pathways within and out of facilities may hinder perinatal mental health screening. Adequate referral pathways therefore need to be established for routine perinatal mental health screening to be beneficial (Goodman, 2009:61). Bayrampour et al. (2018:55) recommends that available community resources should be communicated to staff during in-service training.

Baron et al. (2016:2) recommend task sharing and stepped care as a means to effectively integrate perinatal mental health screening with routine care. Task sharing entails the training of non-specialist workers to address mental health needs cost effectively (Department of Health, 2012:28). Training of non-specialist health workers furthermore utilises existing resources and reduces the need for specialist mental health practitioners (Honikman et al., 2012:3).

Universal routine screening offered to all women accessing a maternity facility may reduce stigma associated with mental illnesses. Viveiros and Darling (2018:115) recommend routine screening to enhance early detection and management of perinatal mental illnesses. Honikman et al. (2012:3) reaffirm that universal screening narrows the mental health treatment gap and allows for early detection of perinatal mental distress.

2.6. Policies and perinatal mental health

The World Health Organization (WHO), as a universal entity, recommends the integration of mental health with other health care. Efforts should be made to provide mental health care when contact is made with each and every healthcare worker. Similarly, the South African Department of Health (2013:13) advocates for integrating mental health care with general visits but acknowledges that mental health care remains under-resourced compared to other health priorities.

South Africa's National Department of Health (2013:15) furthermore highlights the disparities that exist inter-provincially in terms of available services and resources to address the public's mental health needs. Efforts should be made to train health care workers in mental health care, with emphasis being placed on health promotion and disease prevention (National Department of Health, 2013: 15-16). However, the aims

and recommendations made in the national policy remain unrealised due staff and resource shortages.

At a provincial level, the Western Cape Government (2014:24) echoes the recommendations of the WHO and South African Department of Health: perinatal mental health care ought to be integrated with routine antenatal care. Western Cape Government furthermore prioritises maternal, child, and mental health (2014:8), yet the resources to address the mental health needs of women are inadequate. Since November 2018 the updated maternal case record provides a simplified three-point questionnaire to assess the mental wellbeing of pregnant women at booking. The questionnaire is accompanied by a caption that advises that screening should only be conducted if appropriate referral resources are available for at-risk women.

2.7. Healthcare facilities in South Africa

Within the South African context, healthcare is provided by the private and public sectors that function mostly independently from each other, with little to no collaborative efforts between them. The private sector addresses the health care needs of a mere 16% of the South African population, while the vast majority (84%) attends public health facilities (Benatar, 2013: 154). Greater disparities in terms of resource allocation exist within rural versus urban settings (Honikman et al., 2012:5).

Considering the disparities between private and public healthcare utilisation, it is obvious that most women will access a public health facility during their pregnancy. In the Western Cape, MOUs were established to render obstetric and midwifery care to women classified as being low risk or as having uncomplicated pregnancies. There are currently 11 MOUs in the Cape Metropole. These MOUs generally provide basic antenatal care, intrapartum, and postnatal care by midwives. The study was conducted at 4 of the 5 MOUs in the Metro West District. Only 1 of the MOUs accessed for the study is known to the researcher as providing integrated perinatal mental health screening and appropriate referral to counsellors assigned by non-government organisations. The MOUs are mostly situated on the Cape Flats and are plagued by gang violence, crime, poverty, and unemployment, which make these

communities particularly vulnerable to mental illnesses (Western Cape Government, 2014:5).

2.8. Summary

In summary, multiple predisposing factors are identified for perinatal mental illnesses. Most women remain undiagnosed and/or untreated for multiple reasons. Inadequate screening policies and time and resource constraints were identified in previous literature studies as presenting the greatest barriers to healthcare workers prioritising mental health (Du Toit et al., 2017:2; Turner and Honikman, 2016:1164). The consequences of untreated or unmanaged perinatal mental illness impacts negatively on maternal and child health (McDonald, Antoine, Liao, Lee, Wahab & Coleman, 2017:2) and subsequently increases the workload in resource-depleted healthcare settings.

3 CHAPTER THREE
RESEARCH METHODOLOGY

3.1. Introduction

The literature review in Chapter two discussed the understanding of midwives of perinatal mental health, the perspectives of midwives regarding perinatal mental health, and exploring ways to facilitate the integration of perinatal mental health with routine care. The literature review furthermore elaborated on policies regarding perinatal health and gave a brief overview of health services in South Africa. Chapter three will discuss the research design, data collection methods, data collection procedure, data analysis, and ethical predisposition. The researcher employed a qualitative methodology with a descriptive exploratory approach. The purpose of the study was to explore the perspectives of midwives regarding perinatal mental health screening. Midwives from various MOUs were interviewed to gain insight into practices and experiences in relation to perinatal mental health screening at the respective facilities.

3.2. Research methodology

Qualitative research is a subjective research approach which may provide rich descriptions about the experiences and perspectives of individuals, so as to gain a deeper understanding of a phenomenon (Grove et al., 2015: 67). Previous studies regarding perinatal mental health focus largely on statistics. Qualitative research, however, acknowledges that participants attach individual meaning to events based on their past and current experiences, as well as that they are influenced by their behavioural, psychological, and social contexts (Grove et al., 2015:67-68).

Guba in Creswell (2009: 8) makes a similar analogy between qualitative research and social constructionist worldviews. Researchers who adopt a social constructionist worldview acknowledge that individuals may have multiple constructed realities which may be situational and time bound (Creswell, 2009:8). The researcher was therefore cognisant that the participants' perceptions regarding the study phenomena may be influenced by their environment and personal experiences. The researcher adopted

qualitative research to gain insight into perinatal mental health screening as perceived by the participants.

3.3. Research design

The researcher employed an exploratory descriptive design for the study. Descriptive qualitative research seeks to obtain new information and gain insight into a specific clinical problem, and the intended outcome for this design is to elicit potential solutions to address the study subject (Grove et al., 2015:77). Gaining insight into ground workers' perceptions of perinatal mental health may alert policy makers and institutional management to the need to acknowledge and attend to the mental health of maternal clients.

The researcher acknowledges involvement in a previous perinatal mental health project by providing pregnant clients with an assessment tool to establish their mental wellbeing. The researcher was thus aware of preconceived ideas and personal bias which could negatively influence the findings of the study. The researcher employed reflexivity throughout the research process. According to Polit and Beck (2010:110), reflexivity is the process of critically reflecting on one's viewpoint and personal values which may relate to the research topic. This allowed for the research findings to be representative of the participants' responses, rather than being skewed by researcher bias.

3.4. Study setting

The study was conducted in the Metro West District within the Cape Metropole, Western Cape. The Metro West District comprises two central hospitals, namely Red Cross Memorial and Groote Schuur hospitals, with New Somerset and Mowbray Maternity hospitals operating at a secondary level. There are also four district hospitals, namely Wesfleur, Victoria, False Bay, and Mitchell's Plain district hospitals.

Services are furthermore provided by five midwife and obstetric units (MOUs) who render basic antenatal, intrapartum, and postpartum care to women who have been identified as having uncomplicated pregnancies. The researcher conducted the study at four midwifery and obstetric units (MOUs) in the Metro West District within the Cape

Metropole, Western Cape. The MOUs are Gugulethu, Mitchell's Plain, Hanover Park, and False Bay hospital. The MOUs are located in peri-urban settings and service clients from predominantly lower socioeconomic backgrounds.

The MOUs are based on the premise of community health centres which offer primary health care to communities in the immediate surroundings. The CHC's consist of a 24-hour trauma unit, comprehensive day hospital, psychiatric nurse, social worker, and the MOU. The services function somewhat interdependently, and healthcare workers will often refer patients to the various components of the CHC. All of the MOUs have the same setup.

The MOUs render antenatal, intrapartum, and postnatal care to women identified as having uncomplicated or low risk pregnancies. If complications arise at any point during the pregnancy or labour, the patient is discussed with a doctor at Mowbray Maternity Hospital, with the exception of Mitchell's Plain MOU which, depending on the diagnosis, will discuss with Mitchell's Plain District Hospital.

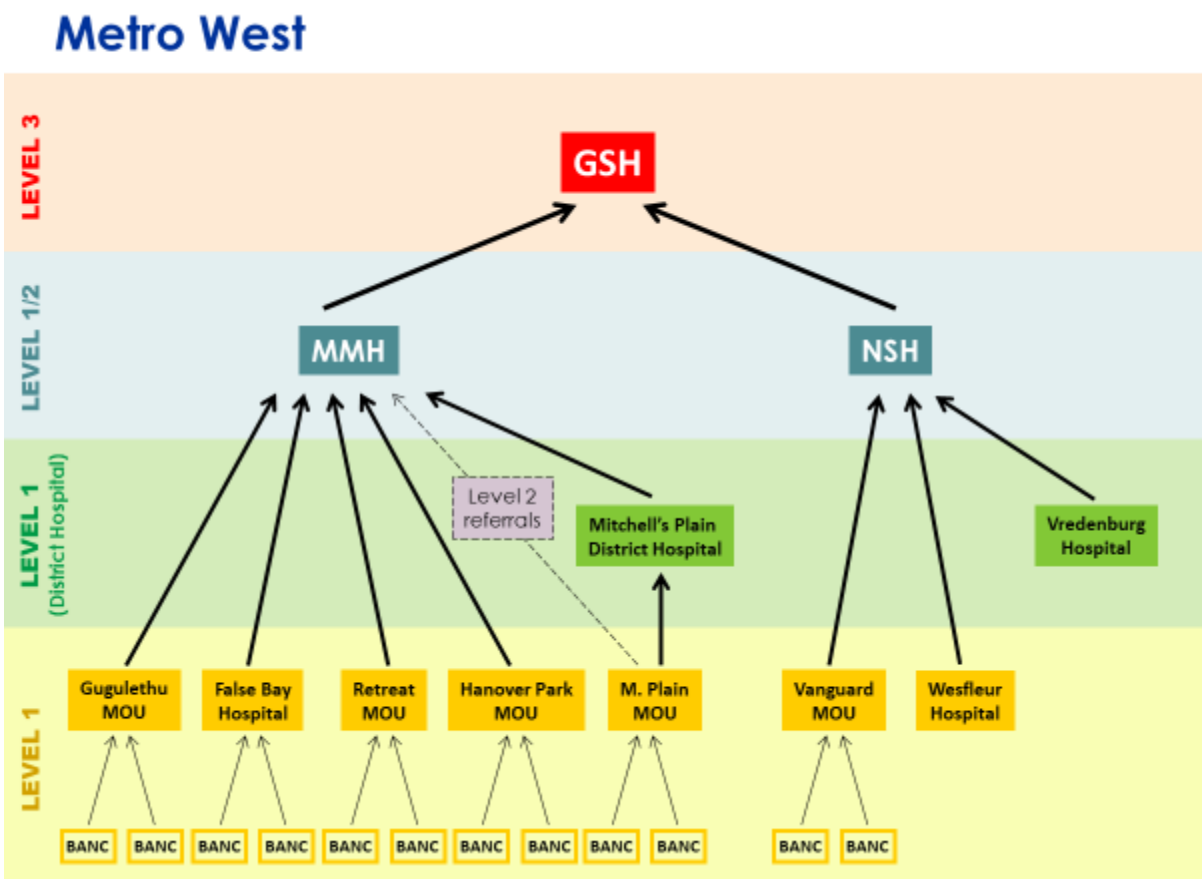


Figure 3.1: Metro West District Health Services (Moore, 2018)

3.5. Population and sampling

A population refers to the entire aggregation the researcher is interested in (Polit & Beck, 2010: 306). For this particular study, the entire population comprised all midwives working at the specific institutions. The target population was sampled by means of inclusion and exclusion criteria (Grove et al., 2015: 250). The researcher therefore reduced the population to midwives that have at least two years' working experience at the specific institution and who are currently active in in-patient care.

Table 3.1: Midwifery obstetric units' participants

MOU	Sample
False Bay Hospital	Three
Mitchell's Plain	One
Gugulethu	Two
Hanover Park	Three

The researcher employed a purposive sampling method as a sampling strategy. This method entails deliberately choosing certain participants based on their knowledge and experiences regarding a specific subject (Grove et al., 2015: 272). Most of the participants had rotated throughout the facility and were able to provide rich information from multiple perspectives in relation to patient care.

3.5.1. Inclusion criteria

Midwives with at least two years' experience of working in midwifery obstetric units were approached to participate in the study. There were no exclusion criteria.

3.6. Data collection process

The researcher, by way of the unit manager, introduced herself to participants at a prearranged staff meeting. The researcher acknowledges that as a midwife working in a secondary maternity facility, she had telephonic interactions with most of the participants previously. The researcher identified staff members who were eligible and interested in participating in the study. The researcher visited the facilities two to four times during the study. One midwife in the antenatal clinic, labour and postnatal ward, or clinic was invited to participate in the study. Participants were issued with an information leaflet, as well as the contact details of the researcher should they wish to withdraw from the study or cancel a scheduled appointment.

Participants were informed about their autonomous right to decline participation and their right to exit the interview at any point without any repercussions. The interviews were conducted in English as it is the medium of communication at the facilities and participants vocalized that they were comfortable with the interviews being conducted in English.

Data was collected by conducting semi-structured interviews with the identified participants after the study was explained to them and informed consent had been obtained. Interviews were conducted at the participants' convenience in terms of timing and venue. In view of the descriptive nature of the study, semi-structured questions facilitate the purpose of the study (Grove et al., 2015:83). Interviews with participants were audio recorded and notes were written soon after each interview. Data collection and analysis often occur concurrently. The researcher has basic

interviewing skills which were assessed and critiqued by the supervisor after the pilot interview.

Audio recordings were made of the interviews and were saved on the researcher's password-protected computer. Participants were reassured that their identities would remain confidential and that codes would be used to identify them. The audio recordings were transcribed and assigned numbers to protect the identity of participants.

Saturation of a qualitative study occurs when further interviewing of participants yields no new information and data becomes repetitive (Grove et al., 2015:274). The sample size for a qualitative study is therefore determined by the point at which the study reaches saturation. After the researcher conducted eight in-depth interviews with the midwives, data saturation was achieved when no new information was obtained during the interviews. The researcher conducted a ninth interview which yielded no new information. Rather than to quantify a problem, the focus of qualitative research is on in-depth knowledge regarding the subject. The midwives were requested to participate in a semi-structured interview lasting for approximately 40 minutes and all the interviews were conducted in approximately two months.

3.6.1. Data collection tool: Interview guide

According to Creswell (2009:181), interviews consist of semi- or un-structured and open-ended questions, so as to elicit a viewpoint and opinion from participants. Semi-structured interviews are used when the researcher has broad questions which need to be addressed (Polit & Beck, 2010: 341). Data was collected via a semi-structured interview guide as per appendix. The interview guide consisted of open-ended questions and probes to facilitate engagement with participants. Semi-structured interviews allowed for some structure to address pertinent questions, yet were flexible enough for participants to elaborate and speak freely.

The interviews started off with easy open-ended questions to put participants at ease and allow them to express themselves freely. The types of questions asked include "What is your understanding of perinatal mental health screening?", "Let's talk about

your perspectives on perinatal mental health screening?", and "How do you think we can integrate perinatal mental health screening with routine follow ups?" The questions posed seek to meet the objectives identified for the study.

The interviewer furthermore probed and summarised between questions and responses to gain more clarity about uncertainties. The researcher was cognisant of potential barriers and alerted participants that counselling would be arranged in the unlikely event that they became emotionally distressed. The interviews were all conducted in English.

3.7. Pilot interview

The pilot interview was conducted on the 14th June 2019 at one of the approved MOUs. The researcher conducted one pilot interview with a midwife. The pilot interview was conducted to establish the clarity of the questions being asked. The pilot interview is a representation of the study and is done to determine the feasibility of the study (Grove et al., 2015: 45) and to assess the appropriateness of the interview guide, as well as to assess the researcher's interviewing skills.

The researcher requested permission from the participant after providing her with an information leaflet. Informed consent was provided by the participant for the researcher to conduct the interview. The participant was requested to allow for recording of the interview, and she agreed to the interview being audio recorded. She was reminded of her autonomous right to withdraw from the study at any point. The interview was conducted in the operational manager's office and the phone was removed from the hook to ensure no telephonic disruptions.

The participant was reassured that confidentiality would be maintained and that her name would not be made public when the study is published. A reliable voice recorder was used to record the interview on. The pilot interview was assessed by the supervisor, who provided the researcher with feedback regarding the data collected during the pilot interview. The questions asked in the pilot interview were adjusted minimally for future interviews so as to meet the objectives of the study more efficiently. The data collected from the pilot interview was included in the final findings as a means to validate and acknowledge the participant's expressions.

3.8. Data analysis

Data was transcribed and analysed according to the Framework Method. This method, also referred to as an analytical framework, entails that the researchers involved in the study collectively develop codes to manage and organise data (Gale, Heath, Cameron, Rashid & Redwood, 2013:1). The Framework method provides clear steps to follow and is ideally suited for data collected via semi-structured interviews (Gale et al., 2013: 2). The seven-step framework method as described by Gale et al., (2013: 4-5) is as follows:

Stage 1: Transcription

During the first stage, the researcher acquired a good audio recording which was transcribed verbatim. Qualitative data needs to be in text form before it can be analysed (Gale et al., 2013:2). Transcripts are a visual recording of the interview. Transcription thus enables the second stage of data analysis. Transcripts were formulated with large margins so as to make additional notes and coding. Transcription was done by S. Malan – see appendix 5.

Stage 2: Familiarisation with interview

During this stage, the researcher re-listened to the interviews she had conducted and made reflective notes. The researcher then became familiar with the interview content. The researcher acknowledged previous experience in perinatal mental health screening. During the second stage of analysis, the researcher used the large margins to record impressions and analytical notes whilst listening to the audio recordings and reading the transcripts. A reflective journal was therefore kept, identifying any preconceived ideas or bias which may have skewed the research findings (Polit and Beck, 2010:110).

Stage 3: Coding

Coding is the process of processing data into meaningful chunks of texts (Creswell, 2009:186). Codes are descriptive labels assigned to raw chunks of data (Gale et al., 2013:2). After becoming familiar with the interview, the researcher read the transcripts and attached labels or codes to describe what had been interpreted. The researcher read through the transcripts and applied a code to every sentence or response from

the interviewees. Coding of all information enables the identification of previously missed concepts (Polit and Beck, 2010:467).

Stage 4: Developing a working analytical framework

After coding the first few transcripts, the researcher, and supervisor for this study, met to compare the labels applied and agreed on a set of codes to be applied to subsequent transcripts. Codes were attached to all data and then grouped together into categories. The categories formed then created a working analytical framework (Gale et al., 2013:4).

Stage 5: Applying the analytical framework

Subsequent transcripts were indexed using the codes agreed upon. Each code was assigned a number or abbreviation and data may be organised and stored via a computerised programme. Computerised data analysis may speed up the process and allows for the easy retrieval of data at a later stage. The researcher, however, manually analysed the data as the researcher felt more comfortable with this method.

Stage 6: Charting the data into a framework matrix

Qualitative interviews generate large volumes of data which need to be managed and summarised (Gale et al., 2013; 5). During this stage, a spreadsheet was used to generate a matrix onto which the large volumes of information retrieved from the interviews were charted. Managing qualitative data so as to reduce data, yet capture the essence of the interviewees' perspectives, is an essential step in the research process (Gale et al., 203:5).

Stage 7: Interpreting the data

Data was analysed manually, and thematic analysis was applied. The researcher kept separate notes to jot down impressions and early interpretations of data (Gale et al., 2013:5). By doing this, differences and similarities between data were identified. Connections between categories were subsequently formed. The written data was reviewed and verified against the transcriptions by the researcher's supervisor.

3.9. Trustworthiness

Trustworthiness ensures that the research findings are an actual representation of the participants, rather than the research which may be facilitated by sharing preliminary findings with participants to confirm congruence with their perceptions or experiences (Polit & Beck, 2010: 79). Trustworthiness furthermore relates to the credibility (authenticity of findings), transferability (generalisability of findings), dependability, and confirmability of the study process and management of data extracted (Polit & Beck, 2010: 106). The researcher will discuss the application of trustworthiness in the study.

3.9.1. Credibility

Credibility refers to the extent to which the findings are a true representation of participants' views (Grove et al., 2015:392). The researcher introduced herself and recruited participants on one day and scheduled an interview appointment for another day. During the recruitment phase, the researcher introduced herself and the study to participants. An information sheet regarding the purpose of the study was offered and explained to the participants. An appointment was scheduled at the convenience of the participants. The interviews were initiated with casual questions to facilitate rapport between participants and the researcher. The credibility of the study was enhanced by peer debriefing. Critical peer checks were done by the researcher's supervisor to assess the interpretation of data in the study.

The researcher furthermore kept a reflective journal to become cognisant of her personal viewpoints, which may create bias or distort study findings. According to Polit and Beck (2010:110), reflexivity is the process of critically reflecting on oneself and personal values which may influence data management and analysis.

3.9. 2. Transferability

Lincoln and Guba (1985) in Polit and Beck (2010: 111) refer to transferability as the extent to which the study findings can be transferred to other settings. To facilitate transferability, thick descriptions of the research setting, and participants was documented so that others may make inferences about the usefulness of evidence collected. Interviews were conducted until data saturation occurred, so that information pertinent to the study was identified. The researcher purposefully selected

participants to ensure that they were able to give robust descriptions of perinatal mental health screening.

3.9.3. Dependability

Grove et al. (2015:392) describe dependability as a process of ensuring that all the steps of the research process were adhered to and documented. The interviews conducted followed the questions as reflected in the interview guide. The audiotapes and transcripts were reviewed and verified by the supervisor and researcher.

3.9.4. Confirmability

Confirmability of the study was improved by keeping an audit trail of how themes and subthemes were formulated. According to Polit and Beck (2008:539), confirmability reflects the objectivity of a study. The researcher also kept an audit trail of how the data was collected, transcribed, and analysed. The analysis was done with the researcher and the supervisor listening to the interviews to ensure the interview process was appropriate and reliable. During the data analysis the researcher paid attention to ensure the perspective of the participant enabled the creation of the themes. Confirmability of the study was furthermore enhanced by bracketing. According to Grove et al., (2015:69) bracketing is a process of being cognisant of and setting aside any bias or perceptions related to a respective research topic.

3.10. Ethical considerations

The proposal was reviewed by the Health and Ethics Committee at Stellenbosch University. Approval for the study with ethics number 9006 was obtained on 28 February2019. Permission to perform the study at the MOUs was obtained from the Western Cape Department of Health research sub-directorate, on the 13 May 2019 (Reference: WC_201904_003). Furthermore, approval was obtained from the facility managers at the respective MOUs.

3.10.1. Right to self-determination

Respect for participants' right to self-determination was facilitated by explaining the nature and extent of the study. Participants were given an information sheet and informed consent was obtained via the signing of a consent form. Participants were informed regarding their autonomous right to refuse to participate or withdraw from the

study at any point without repercussions or incurring penalties. After obtaining consent from participants, the interviews were scheduled for a time and location most convenient for the participants.

3.10.2. Right to confidentiality and anonymity

The interviews were transcribed, and the confidentiality of the participants was protected by omitting their names from the transcripts. The findings of the study were disseminated to the participants of the study. Privacy and dignity of participants was ensured by conducting the interviews in a private and quiet room to avoid excessive distractions. The researcher was the only person who had access to the names of the participants. Interviews were audio taped and transcribed data was stored on a password-protected computer, and a backup copy was maintained. Privacy of participants was also ensured by assigning each participant a number for transcribing and reporting purposes.

3.10.3. Right to protection from discomfort and harm

Researchers are obliged to avoid or minimise the risk of harm or discomfort to participants (Polit & Beck; 2010: 121). Participants were informed of their right to exit the interview if they became too emotionally distressed. Participants were not coerced to participate in the study and were informed that counselling would be arranged in the event that they were emotionally distressed. None of the participants withdrew during the study.

3.10. Summary

The aim of the study was to explore the perceptions of midwives in providing perinatal mental health screening in maternity facilities. The researcher employed a qualitative design with a descriptive, exploratory approach to meet the aim and objectives of the study. The participants were purposefully selected from four MOUs in the Metro West District. The interviews were conducted at venues most convenient for the participants and were audio taped. Written, informed consent was obtained from the participants prior to conducting the interviews. Trustworthiness of the study was enhanced by implementing the elements of credibility, dependability, confirmability, and transferability. Data was analysed according to the framework method. Chapter four will highlight the findings that arose transpired from the interviews.

3.11. Conclusion

A qualitative study with a descriptive, exploratory approach was most suited for this study. The researcher wanted to explore the perceptions of midwives regarding perinatal mental health screening, rather than to simply quantify a phenomenon.

4 CHAPTER FOUR
STUDY FINDINGS

4.1 Introduction

The previous chapter gave an indication of the research methodology. This chapter will indicate the findings of the study while highlighting the emerging theses within the study. The study analysis was done as described in Chapter four and there were three main themes, which included appreciating perinatal mental health screening, perinatal mental health provision, and effective integration of perinatal mental health screening. Furthermore, there were sub-themes which emerged from the categories created from the coding process. This chapter will give brief biographical data of the participants, followed by each of the themes and their sub-themes.

4.2 Biographical data

The biographical data was collected during the semi-structured interviews conducted with the nine participants. The pilot interview was conducted with an operational manager and was included in the findings. She is a coloured female and has one child. She has been in a managerial position for 19 years and liaises closely with the perinatal mental healthcare team providing services at the facility.

Participant two is a black female with seven years' working experience as a midwife. She was previously involved with a perinatal mental health project at her facility. The project has been removed from her facility two years ago. She currently works in the antenatal ward. At present there are no specific mental health services for pregnant women at her facility. Women with psychosocial problems or perinatal mental illnesses are either referred to the social worker at the community health centre or to the referral district hospital.

Participant three is a white female midwife with twenty-seven years of experience. She is married and has one child. She was previously exposed to a perinatal mental health project which was rendered at her facility. She is currently placed in the labour ward on night shift. At present, there are no perinatal mental health services rendered at the facility. The participant mentioned that the social worker post at the facility was

also vacant, which posed a major challenge in addressing perinatal mental health needs.

Participant four is a coloured female midwife with 28 years' working experience. She is married and has one child. She also had previous interactions with a perinatal mental health team which operated at her facility. She works in the labour and postnatal wards. Currently, there are no perinatal mental health services at the facility. The participant acknowledged that NGOs had recently been identified in their area to refer distressed clients to.

Participant five is a black female midwife with five years' experience. She is married with two children. She previously engaged with a perinatal mental health counsellor at her facility. The perinatal mental health services have been withdrawn from her facility since 2017. She currently works in the antenatal ward but rotates to different units in the facility as per operational requirements.

Participant six is a black female midwife acting as a temporary operational manager. She has nearly thirty years' work experience and has worked at various public facilities within the Cape District. She thus has extensive midwifery knowledge and experience. At present, she is the acting operational manager and assists in the antenatal clinic when necessary.

Participant seven is a black female with seven years' working experience. She is unmarried and has two children. According to the participant, perinatal mental health services were never offered at her facility. She was selected to participate as she had worked at numerous facilities and could potentially acknowledge differences in clinical practice at the various facilities. Moreover, she was selected to offer insight into the current perinatal practices at her current facility. The participant currently works in the labour ward, although she has worked in the antenatal clinic.

Participant eight is a black professional nurse with three years' working experience. She is married and has two children. She currently liaises with perinatal mental health services which are offered at her facility. She was placed in the labour ward recently after working in the antenatal clinic for nearly two years.

Participant nine is a black female professional nurse with five years' working experience. She works at a facility which offers comprehensive perinatal mental health services to clients. She currently works in the labour and postnatal ward.

Table 4.1: Biographical data of participants

Participant	Years' experience	Race	Gender
One	20 years	Coloured	Female
Two	7 years	Black	Female
Three	27 years	White	Female
Four	28 years	Coloured	Female
Five	5 years	Black	Female
Six	30 years	Black	Female
Seven	7 years	Black	Female
Eight	3 years	Black	Female
Nine	5 years	Black	Female

4.3. Themes emerging from the interviews

During the data analysis process the codes that emerged from the data were grouped into categories and these categories were summarised into sub-themes. The sub-themes were further clustered into three themes, namely: appreciating perinatal mental health screening, perinatal mental health screening service provision, and effective integration of perinatal mental health screening. The sub-themes that emerged under the theme of appreciating perinatal mental health screening included acknowledging communities are at risk of perinatal mental illnesses and recognising the risk of perinatal mental illnesses.

Further, the theme of perinatal mental health screening service provision emerged from the sub-theme's healthcare professional dynamics and institutional factors. The third theme, effective integration of perinatal mental health screening, emerged from the sub-themes of improving midwives' competencies and advocating for resources.

Each of the themes and sub-themes will be discussed with references to the interviews.

4.3.1. Theme one: Appreciating perinatal mental health screening

The first theme emerged as a reflection of the midwives' perceptions of why perinatal mental health is important. They acknowledged that the communities are at risk of perinatal mental illnesses and the outcomes associated with perinatal mental health illnesses. Theme one and its emergent sub-themes, which include acknowledging communities are at risk of perinatal mental illnesses and recognising the risk of perinatal mental illnesses, are displayed in Table Four below, with the various categories that they were induced from.

Table 4.2: Theme one and sub-themes

Themes	Sub-themes	Categories	Codes
Appreciating perinatal mental health screening	Acknowledging communities are at risk of perinatal mental illnesses	Psychological changes in pregnancy	Pregnancy changes
		Social problems	Poverty • Substance abuse • Unwanted pregnancy • Teenage pregnancies • Intimate partner violence • Homelessness
	Recognising risk of perinatal mental illnesses	Poor health care utilisation	• Unbooked • Complications of pregnancy • Non-adherence to treatment • Drug relapse
		Defaulting treatment	
		Risk for violence Child neglect	

4.3.1.1 Sub-theme one: Acknowledging communities are at risk of perinatal mental illnesses

The sub-theme of acknowledging communities at risk emerged from theme one. The participants recognise that certain risk factors predispose women to perinatal mental illnesses. The categories that emerged from sub-theme one includes psychological changes during pregnancy and social problems.

Psychological changes in pregnancy

Pregnancy was identified as a particularly vulnerable phase caused by hormonal fluctuations and possible environmental stressors. Participants recognised that hormonal fluctuations during pregnancy sensitised women to perinatal mental distress.

One participant reiterated that normal psychological and physiological changes in pregnancy were often exacerbated by social risk factors. She reports that some women may feel pressured to conform to societal norms and values, such as being married before having children, or face being ostracised.

> *"…because some patients come from different backgrounds which said you weren't supposed to have a baby before marriage then she's at her own because she breaks the rules or bend the rules, now maybe she doesn't have anyone to support…"* (Participant 8)

Participants elaborated on the fact that women were at risk of perinatal mental distress post-delivery. The adjustment to motherhood may be overwhelming for many women. As one participant reported:

> *"…this baby is crying, I am also crying then just help the mother to just check how are you finding yourself as a new mom, are you enjoying, is this baby depressing you or do you have any problems with this new baby that you have or do you have any problems with yourself after birth?"* (Participant 8)

> *"…after delivery she's also quite vulnerable."* (Participant 4)

Social problems

Most of the participants presented contextual examples to highlight mental health needs and challenges within their communities. The findings of this study reaffirmed that the majority of women accessing MOUs were from low socio-economic backgrounds. The participants at all four facilities recognised **poverty**, **violence,** and **substance abuse** as prevalent within the communities they served:

> *"We get a low socioeconomic, is it a township. I don't know if it's a township or a suburb but it's a township. It's a low socioeconomic place, a high unemployment rate, a high substance abuser and yes, it's very low educated*

> *people in this place so it's a very compromise with a high violence rate also, one of the most-highest violence rate in Cape Town places, yes*." (Participant 9)

> *"…what is very difficult to see is that a lot of them cannot afford to have a baby but they just having babies anyway…"* (Participant 4)

Despite patients being referred to a specialised mental healthcare worker, some patients were unable to commit to appointments due to financial constraints. One participant reflected on the impact poverty had on patients' ability to attend healthcare:

> *"And even if you refer the patients to for example Mowbray, not all of them have money to go. And then "Ok, I'm not going coz I don't have the money to go" so they don't go. It's a really …because Mowbray at least have a social worker…"* (Participant 3)

Teenage pregnancies were identified as a common occurrence. Adolescent mothers were often financially dependent on their caregivers and were perceived as emotionally unprepared to care for a child. Teenagers are regarded as a particularly vulnerable group who may be exposed to violence or abuse due to risky behaviour or dependence on adults. Being young and exposed to abuse or trauma multiplies the risk of perinatal mental illnesses. According to one participant, conception through non-consensual sex with adolescents occurred commonly at her facility:

> *"…it was like we find out lot of underage people they were abused to be pregnant."* (Participant 2)

One of the pertinent issues raised by the midwives relates to the phenomenal levels of **substance abuse** in their communities. Women tended to continue drug abuse during their pregnancies. As one midwife reports:

> *"90% of them lie about the drug. 90%...sometimes they are so smoked you will do the delivery and you can smell it and you get tripped from the dagga ok?"* (Participant 3)

The midwives furthermore elaborated on the prevalence of **unwanted pregnancies**. One participant commented on her personal experience with women attempting to terminate their pregnancies illegally:

> *"Sometimes the mommy will come here in pain and you will still see the tablets in the vagina. Serious, it happened several times because…and then they're far! They bought it online! The tablets."* (Participant 3)

Another midwife voiced her concern over the prevalence of **homelessness** of clients accessing her facility. Interactions with clients with no abode left the midwife feeling frustrated:

> *"I'm sure it's very frustrating. It's not nice to not have shelter…It's very frustrating…even to you the listener you don't feel ok when someone says, 'I don't have a shelter'. We do get cases like that."* (Participant 2)

Intimate partner violence exacerbates a woman's risk of perinatal mental illness. One participant elaborated on her frustration with dealing with a woman who had experienced intimate partner violence and sending her back into the same conditions:

> *"She was blue, like purple and she came to the clinic…. She said, 'No it's my boyfriend…she came to my house yesterday and she assaulted me yesterday.'…the patient is going to Mowbray and the next thing the patient came back to us. Bearing in mind that the patient is going back to her situation but what has been done…"* (Participant 5)

Social problems including teenage pregnancies, homelessness and intimate partner violence are prevalent within the study setting. These social problems impact on support available to women and their subsequent ability to adjust to motherhood.

4.3.1.2 Sub-theme two: Recognising risk of perinatal mental illnesses

Perinatal mental health issues remained mostly unaddressed. Most of the participants acknowledged the far-reaching consequences of perinatal mental health problems and confirmed the need for perinatal mental health screening, but admitted that perinatal mental health was largely ignored. One participant reflected on previous perinatal mental health assistance that was offered by an NGO but had subsequently been withdrawn:

> "*There was a need for the patients to have that…and then after that lady left, I didn't see anybody and there is a need*." (Participant 2)

The consequences of perinatal mental illnesses were observed by the participants. These included poor health care utilisation, default treatment, risk for violence, and child neglect.

Poor healthcare utilisation

Despite facilities being accessible, most of the midwives identified that women in the postnatal period only sought help when they experienced a medical problem. This could potentially hinder mental health screening postnatally.

> *"…they don't even come for the postnatal routine; they don't do that. If they came, some of them, you must know it's whereby there's a problem."* (Participant 7)

Services which are readily and freely available are therefore not utilised. The first contact and assessment by a health worker during pregnancy is referred to as the booking. During this episode multiple universal blood tests are performed, and a comprehensive history is obtained from clients.

However, most of the women predisposed to mental distress tend to **not book** their pregnancies. This was thought to be related to psychosocial factors which impacted on a woman's ability to take care of her. Booking is pivotal to identifying women who may require psychosocial support. One participant reflected on an unbooked woman who had come in in labour shortly before our interview:

> *"Like now when you came in, I was busy with unbooked...You can see that woman, she never washed..."* (Participant 2)

The participant furthermore elaborated that she sensed that the woman had psychosocial issues but due to time constraints felt compelled to focus on her physical wellbeing:

> *"But did you see I asked my part only because there's no time. But deep down I feel there is something and I wish I can sit with her and find out more."* (Participant 2)

A common perception among participants was the tendency of women abusing substances to either deny their habits or to be unbooked. As one participant reported:

> *"Remember, those who are on drugs, first of all they don't book."* (Participant 7)

Poor utilisation of healthcare services means that the women are not seen early and the diagnosis is not made swiftly to prevent depression during pregnancy and postpartum.

Defaulting treatment

Once contact was made at healthcare facilities, women were noted to generally be noted to be non-compliant to treatment or tended to default clinic appointments. One midwife vented her frustration with a perceived disinterest by women in her community to adhere to healthcare:

> *"The way they're actually defaulting, the way they are not listening to us."* (Participant 7)

Clients are also assessed and triaged, based on the history obtained, as either low or high risk. Clients identified as having high levels of risk or complications during pregnancy are referred to secondary-level hospitals for further care and management. Certain health conditions require immediate referral to tertiary-level institutions as per district protocol. One participant verbalised the tendency of women with known psychiatric or mood disorders to default care:

> *"ja like in bipolar or ….. depression patients…they will also be referred but some patients do not come because they don't see the need."* (Participant 3)

Clients are advised to report to the respective healthcare facilities for any obstetric-related complaint or complication. One participant vocalised that, despite clients being referred to a secondary- or tertiary-level hospital, they still ended up accessing health care at the MOU when pregnancy-related complications arose. One participant reflected on her abusive encounter with a woman. The client was referred antenatally to Mowbray Maternity Hospital based on her obstetric history. She however experienced pain and accessed the MOU intoxicated on a public holiday. The participant attended to the woman, nonetheless:

> *"…you must not come here because she was not even attending with us. She was sent to Mowbray…"* (Participant 7)

The aforementioned woman subsequently absconded from the MOU only to return to the MOU a few days later, again intoxicated but in preterm labour. The baby sadly demised and the mother started to haemorrhage secondary to a retained placenta:

> *"But now she was feeling that then she had to come and then on the 3rd she came back in labour. Drunk, in the morning. Drunk, she couldn't sleep and then her membranes ruptured, I don't know, three o'clock in the morning but she came and then ambulance was booked for her. She came at 6cm, but she delivered here and then the baby couldn't…didn't make it. It was another story and then she was retaining placenta, she was PPH'ing…. [having post-partum haemorrhage]…"* (Participant 7)

One participant perceived poor mental health to contribute to non-compliance with treatment. Currently, all pregnant or breastfeeding women are initiated on life-long antiretroviral therapy. This means that women who were diagnosed and put on antiretroviral therapy will continue their treatment for life. The participant reflected on a woman with a known mood disorder and who was diagnosed HIV positive with a previous pregnancy. The woman repeatedly used her medication during the pregnancy only and stopped her treatment after she gave birth:

> *"Every time when she's pregnant, it's only then she's getting ARVs. After she delivered, she was no taking the ARVs, so she's defaulting."* (Participant 7)

It was unclear whether the woman had stopped taking her medication for her mental disorder.

Risk for violence

One participant perceived that women with perinatal mental illness were predisposed to being violent, particularly to their children. As perceived by one midwife:

> *"It worries me, because what I've seen from the patient who, from the mothers who has this mental health issue, they are losing it sometimes and they might be dangerous to their kids."* (Participant 7)

Similarly, another participant had a personal encounter with a new mom who was verbally abusing her baby:

> *"She was very emotional, and my experience was that sometimes she would be aggressive to the baby, swearing at the baby while she was breastfeeding."* (Participant 9)

Two participants verbalised a fear for their safety, although the threat for violence stemmed from the area in which the MOU was based. One of the participants, however, reported that she was cautioned by a relative of a woman with a known mental disorder. She reported:

> *"So she said to us, you need to be careful because she is a danger to everyone. If she's around, be careful, security needs to be around."* (Participant 7)

Suicidality in the postnatal period is the leading cause of maternal deaths in developed countries. This is thought to be related to depression. Statistics reflecting similar rates in developing countries is lacking. Interestingly, only one participant implicitly acknowledged the need to establish risk for self-harm as part of perinatal mental health screening:

> "*So, you ask things like are you happy, are you depressed, are you feeling like hurting yourself" (*Participant 4)

The risk of violence among women predisposed to perinatal mental illnesses was viewed by participants as a concern that needs to be addressed swiftly.

Child neglect

One participant vocalised her frustration with clients who used drugs relapsing. Babies were often left in the care of grandparents who had limited resources to take care of an infant:

> *"Some of these clients are on drugs, substance abuse, so they end up dumping their children with their parents or grandparents… Look, we don't get milk and stuff to formula feed, so it's very difficult on those grandparents or family members to have to provide and sort out."* (Participant 1)

Participants observed a tendency for women with perinatal mental distress to emotionally neglect their babies. One participant vocalised her experience with a woman who appeared emotionally detached from her baby:

> *"She ignored that baby completely! The baby was crying, the baby was wet, the baby was hungry. She ignored that baby! Totally ignored that child and maybe if she got…. She got better but she was angry with this baby."* (Participant 3)

Similarly, the participant expressed her concern about discharging babies with women she intuitively knew would not be able to care for them:

> *"And it's terrible, it's really terrible! Because you just know, you will find that baby in the system somewhere, ehm for being given up or one of the family members will take the baby. And she will come back again. It's really not nice."* (Participant 3)

In conclusion, the midwives recognised the risk of untreated perinatal mental health as a danger to the community, as well as increasing the risk of violence and child neglect and abandonment.

4.3.2 Theme two: Perinatal mental health screening service provision

The second theme seeks to answer objective two, namely to explore midwives' perspectives on providing perinatal mental health screening. The sub-themes that emerged include midwives' dynamics and institutional factors.

Table 4.3: Theme two and subthemes

Theme Two	Sub-theme	Categories	Codes
Perinatal mental health screening provision	Midwives 'dynamics	Professional hurdles	• Knowledge • Skills • Cultural practices
		Improving professionalism	• Building rapport • Staff adaptability
	Institutional factors	Health care system challenges	• Staff shortage • Burnout • Increased workload • Over-concern with physical wellbeing • Administration • Referral pathways • Space restrictions • Stigma • Fear for safety • Time constraints
		Providing enabling environment	• Accessibility to care • Support services • New documentation • Integrated care

4.3.2.1 Sub-theme one: Midwives' dynamics

Sub-theme three relates to the individual characteristics of the participants. Professional hurdles and improving professionalism were identified as categories.

Professional hurdles

The professional hurdles to providing perinatal mental health screening relate to the participants' perceived level of knowledge and skills to provide such screening and care. The general perception among the participants was that they had little or no exposure to perinatal mental health screening. Some participants felt that they lacked the skills to effectively counsel a mentally distressed client.

Knowledge

The participants depict a clear understanding of the concept of perinatal mental health. The midwives were cognisant of the complexity of perinatal mental health. As one midwife reports:

> *"Perinatal mental health is how you think about your pregnancy, how you feel from day one of pregnancy, how you are going to or keep yourself healthy as well…how are you going to equip yourself."* (Participant 2)

The midwives were cognisant of perinatal mental health problems and the impact they could have on the mother, pregnancy, and baby. Some participants, however, felt they lacked the knowledge to use and interpret perinatal mental health screening tools. The perinatal mental health information received during basic nurse training was regarded as insufficient. As one nurse reflected:

> *"We did a bit of perinatal mental health training not training but it was like basic stuff. I can't even tell you what really stuck in my mind."* (Participant 4)

A new mental health screening tool has been devised and formally adopted by Western Cape Government since November 2018. Most of the participants acknowledged that they had seen the questionnaire in the revised Maternal Case Record;

> *"Now there are questions in the MCR."* (Participant 6)
>
> *"I understand we've got this three-question questionnaire in the MCR…"* (Participant 4)

Despite a simplified three-point questionnaire being readily available for all clients accessing any maternity facility in the Western Cape and receiving a MCR, most participants acknowledged that screening was not offered consistently. There was a tendency to rather rely on experience and intuition.

> *"I will be honest with you, you know, you get these screen tools hey, but you also get this gut feeling when you look, and you talk to someone."* (Participant 4)

Participants were able to refer women with a pre-existing mood or psychiatric disorder to a secondary- or tertiary-level hospital upon disclosure by the women:

> *"If there's serious mental illness like depression and anxiety any schizo, depression, bipolar, we send to Groote Schuur."* (Participant 8)

A pertinent category relating to sub-theme three reflects participants' limited knowledge regarding policies and guidelines regarding perinatal mental health screening. One participant, however, referenced destigmatisation of mental health:

> *"I think government will say that we must combat the mental illness and try to reduce the stigma against it..."* (Participant 8)

Skills

Some participants affirm that they felt poorly equipped to counsel women that were in distress. They vocalised a concern regarding their ability to resolve and counsel distressed women. Women with mental health issues, once identified, were either referred to the facility social worker or to a secondary hospital. According to one participant:

> *"We're not trained to handle the situation and sometimes you go home and you're like "Ah I feel so sorry for that poor woman."* (Participant3

In contrast, one participant felt competent to counsel patients. She however felt that counselling was a rather time-consuming process and removed her from other clinical responsibilities:

> *"So, I don't have a problem as an individual but I do have a concern I will be agitated because I'm thinking there's a patient that is eight cm, there's a baby at the back, there's something, there's something that like that that needs to be attended and it cannot be attended by two of them…"* (Participant 9)

Participants were knowledgeable about early detection of perinatal mental health illnesses through screening. One participant shared her justification of early detection of mental health problems:

> *"…act on something and actually prevent further damage or the intensity of the problem if you can pick it up early and refer them appropriately antenatally."* (Participant 4)

Knowledge and skills were seen as vital to providing PMHCs effectively, as well as the need to be aware of the information required and be available to provide these services.

Cultural practises

Differing cultural practices was recognised by two participants as a potential barrier to communicating with women. Language barriers were identified as a potential communication barrier. The languages predominantly spoken at the facilities include English, Afrikaans, and isiXhosa. Participants encountered difficulty communicating, particularly with asylum seekers. One participant acknowledged this challenge:

> *"Sometimes there is the language issue, so that might be a bit of a hindrance."* (Participant 1)

Language barriers were identified as a major hindrance to the offering of perinatal mental health screening. Participants vocalised a concern with not being able to effectively communicate with some women:

> *"…because it will be difficult if they cannot speak English, to screen those patients as well."* (Participant 7)

One participant alluded to variances in cultural practices which could potentially be a hindrance in service delivery. Some clients were perceived as flexible, whereas others adhered strictly to cultural practices:

> *"There is cultural stuff in between that could also be a bit of a problem at times, and then you will kind of liaise to get to hear and see, because some of them aren't so concerned about the culture. You know, they're not so strict on their culture, and then there are others who are very strict on the culture…"* (Participant 1)

Improving professionalism

This category relates to characteristics inherent to participants that enable perinatal mental health screening. These include rapport and staff adaptability.

Rapport

Continuous contact with clients on antenatal visits allowed for relationships to be established and midwives to gain a sense of trust with clients. Relationships were furthermore strengthened by midwives being present and just listening to clients:

> *"If you can just sit and talk to them, it's nice too because you sometimes build up a relationship with them and you like to see how they…how they're doing afterwards."* (Participant 4)

Confidentiality was identified as a key element in establishing and maintaining relationships with clients. One participant reflects on the perinatal counsellor based at her facility:

> *"… Confidentiality is very high on her list."* (Participant 1)

Despite facing major challenges in delivering optimal patient care, four participants were enthusiastic and amenable to implement a perinatal mental health project. For these participants, quality care was equated to job satisfaction:

> *"And you get this great job satisfaction which is priceless. It's nice if you've got the time to sit and talk to the patient."* (Participant 4)

One participant acknowledged that counsellors at her facility had established long-term relationships with patients. Even after giving birth, some patients still frequented the facility and engaged with the counsellors:

> *"…because you will also find that a lot of …… clients, those that she has counselling sessions with, even after the babies have been born, look, they do keep contact, but whenever they are in a mess or whatever, you will see, there they are standing round the corner, waiting to speak to Liesel."* (Participant 1)

Staff adaptability

The willingness of participants to initiate projects and improve patient care was evident. One participant was eager to commence a perinatal mental health project immediately at her facility. She vocalizes:

> *"So it's easier to implement that here. If you've got something, we can try it for you!'* (Participant 3)

Participants elaborated on additional services that were provided at their facility but which weren't necessarily the core responsibility of MOU staff. One participant verbalised that as a means to ensure adherence to contraception, staff would often render family planning services to clients if the clinic on the CHC premises was closed:

> *"Those patients that are due on the appointment but the day hospital is closed, if they are due they are happy with the family planning we just give then we inform that they must go to that side again but they can't stay away because day hospital is closed and they are due."* (Participant 5)

Social support is strongly encouraged during pregnancy. Partners of women are offered HIV counselling and testing together as a means to facilitate involvement and responsibility. Partners are generally referred to the day hospital if they screen positive for HIV or have a suspected sexually transmitted disease. However, one participant reflected on staff's flexibility to treat a woman's partner who had been diagnosed with a sexually transmitted disease:

> *"So, we treat STIs, VDS, genital ulcers, then we give contact slip. That is for the partner to be treated as well. He asked to be treated by us here, so we didn't have a problem. We also treated the partner."* (Participant 6)

An appointment system approach may potentially reduce patient waiting times at facilities. The idea is to schedule non-emergency appointments at different intervals during the eight-hour working day. Staff members at one healthcare facility were willing to adopt the appointment system. However, the approach failed due to client preference:

> *"Ja but the system of the times; we tried it; it didn't work with us. Like you have a seven o'clock clinic, ten o'clock clinic; 12 o'clock. Ah, ah it didn't work. Patients preferred to come to the seven o'clock clinic."* (Participant 6)

4.3.2.2 Sub-theme four: Institutional factors

Institutional factors are categorised into healthcare system challenges. These challenges relate to factors.

Healthcare system challenges

Despite most of the midwives recognising the need for perinatal mental health screening, various challenges were identified in the effort to provide consistent screening. Challenges were illuminated by the fact that the participants often felt challenged in terms of resources to address perinatal mental health.

Staff shortages, which often stifled optimal patient care, were identified as a key barrier to addressing mental health needs. The midwives reported that staff shortages resulted in them not having enough time to spend with clients:

> *"So there is not enough time to sit there and have a whole discussion with the mommy.'* (Participant 3)

According to one participant, staff shortages negatively impacted on patient waiting times. This often created client dissatisfaction. She reports:

> *"There's a…the waiting period is longer. Ja, we can't even take lunch; the patients are moaning."* (Participant 6)

Staff shortage was recognised as ultimately precipitating **burnout**. Absent staff members were often not replaced, resulting in skeleton staff caring for vast numbers of women:

> *"Staff shortage is a major, major, major problem. And it gives burnout to us practitioners because you will be replacing someone who is not around, and you are seeing a lot of patients."* (Participant 7)

Numerous factors which compounded an existing heavy **workload** were identified. Staff shortages and large volumes of clients attending the health facilities were reported to impact on the quality of care rendered to clients:

> *"Ok there is a lot of workload in here. Due to shortage of staff like we each month we have plus minus 300 deliveries."* (Participant 2)

Women who booked at satellite BANC sites were referred to the respective MOUs at 36 weeks for expectant delivery. The BANC sites were initiated to alleviate the burden from MOUs.

The workload at MOUs is described as quantitative in nature. Due to the rapid patient turnover, midwives often ensure the physical wellbeing of a woman before moving on to the next. This impersonal means of health care is attributed to a number of factors, including an increased workload and subsequent time constraints:

> *"We don't have enough time to spend with patient because I'm going to focus on this one, make sure that she's fine, then go to next one."* (Participant 8)

Owing to high numbers of women attending the antenatal clinic or the volatile nature of the labour wards, the midwives felt compelled to excessively **focus on the physical wellbeing,** rather than the mental health, of women:

> *"We miss everything but we focus on the tummy, on the growing tummy and the growing baby and the fetal heart rate; not knowing that this is a container keeping this growing tummy."* (Participant 5)

One participant acknowledged that perinatal mental health matters were largely neglected.

Participants acknowledged being so consumed with focusing on women's' physical wellbeing that they often neglected their mental status. One midwife acknowledged that perinatal mental health matters were largely neglected:

> *"When I heard about it I realised that it is a part that we don't worry about, we the midwives. We don't worry about how this mother feels. What is going on her life and all that."* (Participant 6)

Some midwives acknowledged documentation and **administrative** functions as a barrier to patient care. The midwives felt compelled to ensure documentation was up to date, especially in adverse pregnancy outcomes. Preoccupation with documentation often resulted in less time to spend with women in crisis. One midwife affirms:

> *"When the baby is a loss, you know for a fact that folder is going to be scrutinised. So, you've got this, you know, there's like histology request forms, there's consent form, there's this documentation. So, there is like that barrier that will sometimes that will stop you from getting to the patient because you need to get your paperwork done quickly…"* (Participant 4)

A participant expressed that her facility was a pilot site for the introduction of new stationery. Despite the stationery being more comprehensive than documentation previously used, the completion thereof was deemed as rather time consuming:

> *"We've got that stationery. I think we were the pilot site here. Because we have to record twice in this stationery and in the MCR. Now it takes long."* (Participant 6)

Similarly, a lack of specialist mental health professionals was highlighted as a challenge in providing adequate mental health services. In some facilities, the sudden withdrawal of perinatal mental health services meant that the options and **referral pathways** to refer mentally distressed women was limited. As one midwife commented:

> *"We used to have a lady screening the mommies for their mental health in the antenatal clinic, we don't have that lady anymore. She used to be with us for a lengthy time and stopped about two years ago."* (Participant 4)

One participant reflected on the disparities in resources in private versus public facilities:

> *"You only see the psychologist in the private areas but not in, where it is needed most…yes."* (Participant 2)

Despite most of the facilities having a social worker to refer clients to, most participants felt that the respective social workers were overloaded with work already. One participant vocalised the need to have specialists focusing specifically on maternal welfare:

> *"but I feel as though if our mothers would have their own social worker that sees to them because there are some…but it's rare cases whereby the mother wants a adoption, you see, so in that cases whereby they need adoption or whereby they need a place to stay I'm not comfortable them sending to the counsellor. I just wish…I don't know if there was a specific social worker that will say okay this one is just dealing with perinatal or pregnant ladies"* (Participant 9)

One participant verbalised a sense of helplessness about being unable to provide distressed clients with concrete solutions to their dilemmas. Clients subsequently were not truthful about their circumstances. She reports:

> *"That's why they end up not telling us the truth because every time you're going to ask me about the same thing but what are you going to do about it."* (Participant 5)

Similarly, participants expressed frustration due to inadequate referral pathways. One participant described a vicious cycle of drug abuse:

> *"Really because now let's say I'm counselling then I'll find out she is a tik abuser and a tik abuser woman, there's nowhere that I'm going to refer her, she's going to deliver and have her baby and then she's going to go home.*

> *She might be wanting to quit tik but doesn't have any means or resources to go to a rehabilitation place."* (Participant 9)

Conversely, a few participants reported the ease with which they were able to refer clients. This was particularly relevant when clients had a known psychiatric or mood disorder:

> *"Having to refer, it hasn't been difficult for me because I remember I had a patient that was pregnant, she was depressed, and she had suicidal thoughts and she needed immediate referral. So, in that instance it wasn't so difficult because depending on who received the patient at that specific hospital because the patient had to go to Groote Schuur, yes."* (Participant 9)

One participant perceived **stigma** as a barrier to women accessing mental health services. The participant reported that after women were informally assessed they were referred to social workers within the community, but often faced prejudice from community members:

> *"And there is a social worker in Ocean View but it's a stigma…They don't want to go there because "I saw you at the social worker".* (Participant 3)

Some participants identified **space restrictions** as a barrier to providing optimal care. Partners were encouraged to attend antenatal visits and the birth of their babies, yet some facilities lacked the space to accommodate them. Consultation cubicles were described as small and impersonal and most of the facilities lacked the space to provide one on one counselling. One participant laments:

> *"We do not have enough space here. We have a lot of patients we are seeing."* (Participant 7)

One participant vocalised that, despite having sufficient midwives, the facility still lacked adequate spacing to be used as additional consultation cubicles. This subsequently resulted in longer waiting times for clients. She reports:

> *"…I think besides the staffing, it's also the space issue, because it's pointless me putting more staff and there's not enough space."* (Pilot interview)

Interestingly, two participants expressed a **fear for their personal safety**. They felt threatened by clients and the community. One midwife experienced physical abuse by an intoxicated woman. She reports:

> *"There was a patient, she was intoxicated, She now then, because she wanted to leave, oooh, she was pulling my face like this, haibo!"* (Participant 7)

A second participant similarly reported that she felt unsafe at her place of work. She explained that when client complaints arose staff were often verbally abused and received little support from management:

> *"It's like you are attacked now. The manager is attacking you and the patient is also attacking you in front. I feel that we are not safe as nurses here at Mitchell's Plain MOU."* (Participant 2)

A few participants acknowledged that they were amenable and able to support clients experiencing trauma but found that counselling was a rather time-consuming process:

> *"So, I think specifically I don't have a problem sitting with somebody and talking to her and finding out was is the problem but I think the problem will be is that we are the three sisters in the labour ward and it's busy, talking with somebody like for plus minus 45 minutes and I have to finish what I started because now this woman she is crying…"* (Participant 9)

Despite the participants striving to deliver quality patient care, they identified **time constraints** as a major challenge to providing holistic patient care. Owing to time constraints the participants were unable to spend quality time with women:

> *"But behind my back I love my nursing but the only thing that it's like frustrating me is the quality care that it's like starting to be gone on us because of this load that we have. You don't get what you want. Oh, I have seen this patient, but I*

still need to spend more time with that patient…but now here is another case coming…" (Participant 2)

Providing enabling environments

Providing enabling environments was one of the categories drawn from sub-theme four and relates to characteristics of facilities which enable perinatal mental health screening. These include accessibility to care, support services, and new documentation.

The availability and **accessibility** of the facilities acted as an enhancing factor in providing care. Most of the facilities tend to all women accessing the healthcare facilities, regardless of whether or not clients lived within the service areas of the respective MOUs. One midwife reported:

"And we don't send any patients away whose coming will be seen." (Participant 3)

The participants also mentioned a multitude of available tests and procedures available to clients. Clients were amenable to a range of procedures available to them, particularly at booking. One participant observed that women were receptive to tests, especially when appropriately educated:

"So, as I was working there, I never encounter not even a single patient that is like refusing because you know when you're working in general patients you get those patients that refuse. They say I refuse to do this; I refuse to do HIV testing. As long as you explain each and everything that you're going to do to them they're happy." (Participant 5)

The MOUs furthermore partnered with BANC (Basic Antenatal Care) sites. These satellite clinics within the communities and within close proximity to the MOU render basic antenatal care to clients assessed as having uncomplicated pregnancies. The BANC sites subsequently refer clients to the respective MOUs at 36 weeks gestation for intrapartum and postpartum care. One participant vocalised that monthly meetings among BANC sites and the respective MOU presented an ideal platform to teach and to exchange information:

> *"It's also a teaching meeting I can say. We are teaching them. They also give us feedback about problems they experience with the MOU because they don't only speak to me they might be speaking to another sister who says something else".* (Participant 6)

The Perinatal Mental Health Project was a NGO which provided perinatal mental health services at three of the studies accessed during the research. Due to a lack of funding, these services were withdrawn but perinatal mental health services continued to be provided at one facility. The participants at this particular facility acknowledged that perinatal mental health screening was done consistently at their institution. One reports:

> *"If she's not on duty the patient must be done during the pregnancy but all of them, they have seen ….. for mental screening even if she didn't get same day the patient she will come and check who hasn't done mental screening then write a note on the folders that please refer to Liesel then we'll see her on appointment and say go to …..…"* (Participant 8)

Participants at the facility which offers perinatal mental health services highlighted the accessibility of the mental health counsellor as advantageous. Clients who the midwives perceived as requiring additional mental support were referred to the counsellor:

> *"I said now our counsellor, she is very easily accessible."* (Participant 9)

The availability of mental health **support groups** enabled certain facilities to offer universal perinatal mental health screening. The participants at one facility acknowledged the recent availability of non-profit organisations to assist with women with mental distress:

> *"We are grateful for our resources which we never had before. It's only about two or three weeks ago we got a list of all the people we could contact in event a mommy needs assistance with unstable emotional affairs."* (Participant 4)

All the participants acknowledged the vital roles that HIV and breastfeeding **counsellors** played within their facilities. Although the counsellors were portrayed as rather task specific, the assistance they offered in their field was considered invaluable. One participant reflects on the duties of the HIV counsellors at her facility:

> *"They will give them a little bit advice about the HIV or discuss HIV; the precautions; everything even before they test the patient…...The breastfeeding counsellors are also important because they can help when we don't get to it."* (Participant 3)

Collaboration within the **multidisciplinary team** enabled strengthening of referral pathways. According to one participant, alliance with various health professionals at her facility enhances perinatal mental health screening and care:

> *"We work well with each other. The psychiatric unit, the mental health sister, they have one sister there, the social worker, they work well with us. We also have a good relationship with the occupational health therapist and the physio. So the relationship between them and us is good."* (Participant 1)

Women who had experienced a perinatal loss were often appropriately emotionally affected. In situations where women had experienced a stillbirth or miscarriage, culturally-sensitive counselling and support should be provided. Participants vocalised the need for immediate crisis resolution at times. One participant reflected on the advantage of having a perinatal mental health counsellor on site:

> *"…if …. (counsellor) was here I could just phone downstairs and she'd be up in a flash. If you're sitting with a crisis and you need someone to assist the first hour or two you can get them here its beneficial to both us and to the client. "* (Participant 4)

One of the facilities still provides a comprehensive perinatal mental health service. A perinatal mental health counsellor ensures that all women accessing the facility have been mentally screened and offered appropriate counselling:

> *"Also, we screen mentally whereby we've got our counsellor that screens the mothers, because we do have cases whereby we've got our bipolar mothers, our depression, some of them even IDC, they've got disabilities, we also see them there in the book because then we will refer according to the criteria and where they are eligible to go to, to which hospital whatsoever."* (Participant 9)

Conversely, one participant verbalized that when they referred clients within the multidisciplinary team they were uncertain regarding the further management of such women as future treatment plans were often not communicated to them.

"We're sending them to Mowbray. We're sending them to Mowbray. Those problem we're just transferring. We never get any feedback from them. Ah, but they are okay, yes, because we were discussing the patient before anything.") Participant 7)

The involvement of **non-government organisations and community** enabled one facility to provide comprehensive care to destitute clients. According to one participant:

> *"If there are too many, she (counsellor) will refer out to Mosaic and other places. Then we have people like the Parent Centre that also lodge on and collect patients and recruits patients from us."* (Participant 1)

The introduction of technology facilitates information sharing. Participants commented on the valuable input patients received via Mom Connect. Mom Connect is a national information system provided free of charge to all pregnant women. Women that initiate antenatal care for the first time are guided step by step by a healthcare worker to register on the site using their cell phones. Mom Connect is an application that disseminates pregnancy-related education and information to the user. The use of the application is based on the premise that most of the women utilising the healthcare facilities have a cell phone:

> *"Mom Connect is for the patients to get advice, or education like if you see this go to your clinic. They can also ask questions and get reply."* (Participant 6)

The Maternal Case record is a booklet issued to each client booking her pregnancy at a public healthcare facility. With the exception of minor differences, these booklets are used nationwide and ought to be issued to the patient until she gives birth. According to the participants, the Maternal Case record, introduced in November 2018, reflects only two opportunities to do perinatal mental health screening. This poses a challenge and created confusion as to what the ideal time would be to do perinatal mental health screening. A participant at one facility, however, acknowledged that with the introduction of **new stationery** at her facility, provision is made to review a patient's mental status at every visit, as is the case for TB screening. According to her:

> *"So, for each visit, a column for each visit ne there is a space for TB screening. Always, it asks about the mood, mental health, mood."* (Participant 6)

Perinatal mental health screening was more effective when offered alongside routine care. Integrated care eliminates additional costs that women may incur if consultations are scheduled for different days or at different facilities. One participant relays her experience of **integrated** perinatal mental health services:

> *"I never heard that she brings the patient, make a specific appointment for her, when the patient comes to hospital, she will just catch that patient."* (Participant 8)
>
> *"Nobody was "Err I'm not going to do it and I'm not crazy". Everybody did it. That was nice."* (Participant 3)

A multidisciplinary team approach coupled with community and NGO involvement enhanced perinatal mental healthcare services provided by midwives. Conversely, time constraints stigma and limited knowledge regarding mental illnesses posed major challenges in addressing perinatal mental healthcare needs.

4.3.3 Theme Three: Effective integration of perinatal mental health screening

Reviewing practical suggestions to integrate perinatal mental health screening with routine care sought to meet the third objective as set out in Chapters 1 and 3. The

sub-themes that emerged included improving midwives' competencies and advocating for resources.

Table 2.4: Theme three and sub-themes

Theme Three	Sub-theme	Categories
Effective integration of perinatal mental health screening	Improve midwife competencies	• Improve knowledge on PMH • Ensure skilled midwives • Improve midwives' behaviour
	Advocating for resources	• Effective referral system • Counselling services

4.3.3.1 Sub-theme one: Improve midwives' competencies

Virtually all of the participants acknowledged that they lacked the competencies to offer perinatal mental health screening. The midwives had little or no exposure to perinatal mental health screening tools and did not feel competent to counsel women who were distressed. The participants therefore suggested training with reference to perinatal mental health in order to bridge knowledge gaps. One participant proposed that monthly workshops or meetings provided an ideal opportunity to receive training on perinatal mental health matters:

> *"When we're doing the workshops, those things need to be mentioned. We need training on those things."* (Participant 7)

The participants furthermore proposed that perinatal mental health should be emphasised and taught more in-depth during undergraduate training and be re-emphasised in postgraduate training:

> *"…the girls coming through college and training make them aware that it is a vital component of the lady walking through this door."* (Participant 4)

Although most of the midwives depended on their intuition to assess a woman's mental wellbeing, some participants recognised the need to utilise perinatal mental health screening tools. The participants, however, proposed that they receive

additional training to complete some perinatal mental health screening tools. As one midwife reports:

> *"I think maybe people the staff can go for training. Training and they must be trained on how to screen." (*Participant 6)

Monthly meetings were held at one of the facilities when a perinatal mental health service was still offered there. During the meetings, training was offered on a range of midwifery-appropriate practices. The meetings were attended by the perinatal mental health team who furthermore provided teaching regarding perinatal mental health matters via simulation to midwives. One midwife reflects on her previous experience of learning through simulation how to behave or approach a situation appropriately:

> *"And even when we had our perinatal meetings with Mowbray, one of them would have come with. We had a whole session and they would give us scenarios and "how would you treat this situation" and they not coming anymore."* (Participant 3)

4.3.3.2 Sub-theme two: Advocating for resources

When exploring the feasibility of routine perinatal mental health screening, the midwives emphasised the need for perinatal mental health counsellors. On probing the midwives further on integrating perinatal mental health screening with routine care, they recommended that counsellors that specialise in perinatal mental health should be employed at facilities:

> *"They must just find or employ someone that is specific to mental screening to all maternal regardless there is a risk or not."* (Participant 8)

Despite three of the facilities having a social worker to refer clients to, one participant recommended that a social worker specific to maternity matters should be assigned to the MOUs. She reports that social workers are often inundated with their workload and may not be up to date with resources available for pregnant women, such as maternity homes:

> *"I feel like she's got a lot to do already and I feel like because she doesn't deal with maternity-based issues she won't be able, I'm not saying that she won't but I don't know, I'm not saying she won't, I'm not judging her but I don't feel at ease when our patients they are referred to that side it's like I want a social worker that is working the maternity-based section that at least it deals with these issues because let's say the patient needs a place to stay, you see then I think maybe the other social worker will be able to assist better because that person is dealing more with these kind of issues."* (Participant 9)

The participants felt that a perinatal mental health counsellor may bridge the gap by addressing the mental health needs of pregnant women. The perception, thus, was that perinatal mental health screening ought to be done by a perinatal mental health counsellor:

> *"I think if we can have more counsellors being trained so that they can be distributed in the different MOUs."* (Participant 9)

Participants vocalised a need for resources to be established. On enquiry as to how perinatal mental health screening could be integrated with routine care, the participants suggested that relevant referral systems or support services are identified and made known to staff. The participants recommended a robust list of homes or rehabilitation centres to refer women to:

> *"…if maybe we had a list.."* (Participant 9)

Participants furthermore suggested that more specialised mental health professionals be trained and employed to enhance the referral process:

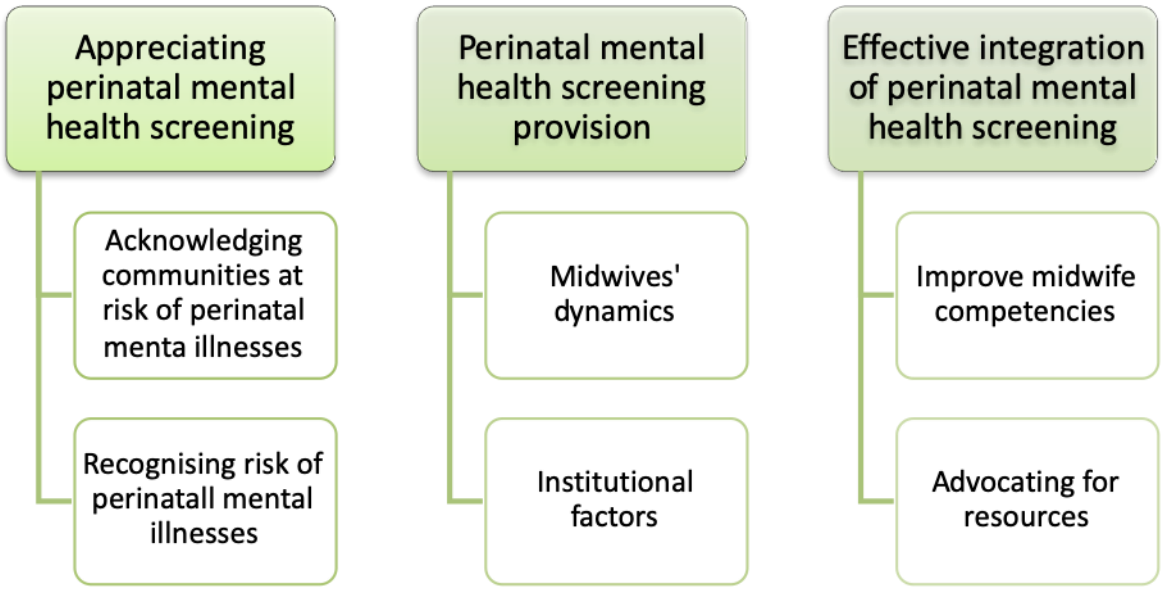
> *"If we can have the social worker and the psychologist it will help."* (Participant 2)

Three major themes were identified by the researcher. The themes and sub-themes are depicted in the above table. The theme providing perinatal mental health

screening is deduced from the objective: “describe the midwives’ understanding of perinatal mental health screening.” This objective sought to explore participants’ knowledge and capabilities in relation to perinatal mental health screening. The categories that were identified from the sub-theme “providing perinatal mental health screening” include barriers and facilitators to providing perinatal mental health screening.

The barriers are furthermore categorised as professional and institutional barriers as interpreted from the study. Similarly, the facilitators have been categorised according to staff matters and institutional facilitators.

Figure 4.1. Summary of themes and sub themes



4.4. Summary

The findings of the study were identified in this chapter. The data collected from the interviews highlighted the dire need for universal perinatal mental health screening. However, midwives are often challenged in providing quality patient-centred care. In this particular study, numerous barriers were identified that hinder consistent perinatal mental health screening, including staff shortage, workload, and a lack of referral pathways. The midwives also acknowledged that they lacked the knowledge and skills to address perinatal mental health needs. Similarly, multiple facilitators to providing perinatal mental health screening were elicited from the study. Various suggestions

were made to integrate perinatal mental health screening with routine physical care. Training and strengthening of referral pathways was recognised as pertinent to improving perinatal mental health services.

5 CHAPTER FIVE
DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

5.1. Introduction

The preceding Chapter 4 discussed the results of the study based on the themes that emerged from the midwives' perspectives. The results were coded and categorised, and sub-themes and themes that emerged were discussed with supporting statements. Chapter 5 addresses the discussion of the findings of the study in relation to available literature. The researcher will furthermore make recommendations based on the study findings and review whether the objectives of the study have been successfully met. The conclusions drawn by the researcher will also be discussed.

5.2 Discussion

The aim of this descriptive exploratory study was to explore the perspectives of midwives on perinatal mental health screening in maternity facilities in the Cape Metropole. The problem identified was that, despite recommendations by the National and Provincial Department of Health, universal perinatal mental health screening and care is still not realised at most health facilities. Three objectives were scrutinised to explore and gain insight into the perspectives of midwives in providing perinatal mental health screening. The findings of the study illuminated three main themes, which included: appreciating perinatal mental health screening, perinatal mental health screening service provision, and effective integration of perinatal mental health screening, as discussed in Chapter Four. This chapter will focus on discussing the principle findings of this study and the relevant literature supporting these findings.

5.3 Describing midwives' understanding of perinatal mental health screening

The first objective was to describe the midwives' understanding of perinatal mental health screening in maternity facilities in the Cape Metropole. One theme that emerged was appreciating perinatal mental health screening and its implications by midwives. The midwives acknowledged that pregnancy exacerbated by unfavourable

psychosocial factors predisposes women to perinatal mental illnesses. The sub-themes that emerged under this theme include acknowledging communities are at risk of perinatal mental illnesses and therefore require monitoring during pregnancy, birth, and the postpartum periods. Further, the second sub-theme that emerged was recognising the risk of perinatal mental illnesses.

5.3.1. Acknowledging communities at risk of perinatal mental illnesses.

Most of the participants provided their personal experiences with clients to emphasise the need for perinatal mental health screening and subsequent care. The findings in the study support previous literature in terms of factors predisposing women to perinatal mental illnesses. Two pertinent factors associated with mental distress in the current study were women with unwanted pregnancies and women who lacked social support (Biaggi et al., 2015:69). Unwanted pregnancies are a serious concern as they may predispose women to an array of social, economic, and physical consequences. Despite multiple methods of family planning being freely available at government facilities, unwanted and unplanned pregnancies remain a social challenge.

The participants vocalised a sense of frustration and helplessness at not being able to adequately assist clients with mental health needs. According to Hauck et al., (2014: 253), perceived inability of midwives to provide mental health care during pregnancy may impact on motivation and elicit a sense of frustration in the women needing this care.

It was recommended that perinatal mental health screening should preferably be done at booking (Hauck et al., 2014: 253). The perception was that early detection could improve patient outcomes. The initial consultation, however, is already a lengthy process, with clients being preoccupied with talks, assessments, and history taking for nearly the entire day. A study by Bayrampour et al. (2018:53) therefore questions the feasibility of perinatal mental health screening at booking. Owing to hormonal fluctuations and volatile social circumstances, frequent perinatal mental health screening was suggested by some participants, regardless of the hormonal fluctuations.

5.3.2. Recognising risk of perinatal mental illnesses

The participants perceived that women at risk of mental illnesses were less likely to access healthcare facilities. Furthermore, when contact was made, women with perinatal mental health distress tended to be non-adherent to care and treatment. This is in contrast to a study conducted in Ethiopia, which illustrated that women with perinatal mental illnesses were more likely to attend unscheduled antenatal visits or frequent emergency units at maternity facilities (Bitew et al., 2016:7). However, Turner and Honikman (2017: 1164) reaffirm that women with perinatal mental illnesses are less likely to access healthcare facilities.

One participant regarded women with perinatal mental illness as posing a risk to their children, as well as a physical threat to healthcare workers. Strong associations are shown between child maltreatment and maternal mental illnesses (O'Donnell, Maclean, Sims, Morgan, Leonard & Stanley, 2015: 1179), although not all women with perinatal mental illnesses neglect their children. Healthcare workers should therefore be careful not to amplify the stigma already associated with mental illnesses.

5.4 Exploring midwives' perspectives of perinatal mental screening

The second objective was to explore the perspectives of midwives regarding providing perinatal mental health screening in maternity facilities in the Cape Metropole. All of the participants explicitly recognised a need for mandatory perinatal mental health screening and care.

5.4.1 Midwives' dynamics

Despite the participants emphasising the need for comprehensive perinatal mental health screening and services, numerous barriers to providing perinatal mental health screening were highlighted in the study. Sambrook Smith et al. (2018:2) cited insufficient knowledge as a particular barrier to providing routine perinatal mental health screening. Participants felt that the training received during basic nursing was inadequate and that they lacked the necessary skills and competencies to provide universal perinatal mental health screening. It was established during the study that perinatal mental health screening was never conducted by the midwives. The participants therefore acknowledged their inexperience in the use of PMH screening tools. The participants were amenable to receiving training regarding relevant

perinatal mental health screening and the relevant tools required. Noonan et al. (2017: e364), however, question the practicality and feasibility of, and over-dependence on, using perinatal mental health screening tools. Perinatal screening tools should therefore be used alongside the healthcare worker's clinical judgement.

South African policies pertaining to perinatal mental health have been described as comprehensive (Baron et al., 2016: 5). Despite the new Mental Health Policy Framework and Action Plan for South Africa (2013–2020) formulated and adopted six years ago, the participants had limited knowledge regarding policies and guidelines pertaining to perinatal mental health services. This may reflect that policies and guidelines are not always communicated to staff members, nor reinforced during clinical practice.

Differing cultural practices and language barriers were identified as barriers to providing care to refugee groups specifically. This is a point of concern as women with asylum-seeking status are recognised as a particularly vulnerable group, and are considered to be at greater risk for perinatal mental illnesses. A study by Fellmeth et al. (2017:747) revealed that perinatal depression may affect as many as one in three refugee women. Furthermore, most of the participants provided their personal experiences with clients to emphasise the need for perinatal mental health screening and subsequent care.

5.4.2 Institutional factors

Additional barriers to providing perinatal mental health screening in this study are supported by previous literature on the subject. Staff shortages had a catalytic effect on existing workload and other resources, ultimately contributing to burnout. Perinatal mental health screening may therefore be perceived as an additional burden. This reflects the need for additional human resources to be allocated to a depleted workforce.

Midwives felt challenged by time constraints, leading them to prioritising physical care. Time constraints as a barrier to providing perinatal mental health screening are supported by the study of Bayrampour et al. (2018: 49). Limited time may prevent

midwives from focusing on perinatal mental health screening. Some of the participants felt competent to counsel patients but found the process rather time consuming.

A lack of clear referral pathways was identified by most of the participants as another barrier to providing perinatal mental health screening. Unclear referral pathways were similarly identified by Bayrampour et al. (2018: 54) as a barrier preventing midwives from realising their role in providing perinatal mental health screening.

The midwives in the study furthermore reflected that perinatal mental healthcare was rather fragmented and, when patients were referred within the interdisciplinary team, they were never provided with feedback regarding future management of clients. Sambrook Smith et al. (2018: 5) recognise that fragmented care may erode inter-professional relationships and stifles women's access to perinatal mental health care. The participants, however, acknowledged confidence in liaising with and referring women with a known psychiatric or mood disorder to a secondary- or tertiary-level hospital. This is validated by the findings of Fornseca et al. (2015:1178), who acknowledged that many women who have not formally been diagnosed or who are perceived to have a less severe mental disorder are likely to be missed and untreated.

There was a general over-reliance on specialist mental health services, with only three midwives recognising that just "being present" and talking with clients served as a mediating factor for distressed women. According to Goodman (2009:61), having someone to talk to, as well as peer or family support, was identified by women with mental health problems as preferred methods of intervention. This is furthermore supported by a Cochrane review which suggests that non-specialist counsellors, including midwives, may improve the outcomes for women suffering from perinatal depression (Van Ginneken, Tharyan, Lewin, Rao, Meera, Pian, Chandrashekar & Patel, 2013:3).

Interestingly, the infrastructure of health facilities was identified as a barrier to providing optimal patient care. Despite advocating for partner involvement, most of the facilities were unable to accommodate birth companions, particularly during the labour process. This is concerning seeing as one of the greatest contributors to perinatal

mental illnesses has been associated with poor partner or social support (Biaggi et al., 2015:66).

Based on previous literature, stigma towards women with potential mental disorders may present as a potential barrier (Rahman et al., 2013:2). During the study, a few participants suggested that perinatal mental health screening ought to be done with other baseline observations as a means to normalise mental health. Universal screening for all women accessing healthcare facilities is therefore recommended as a means to reduce stigma and normalise perinatal mental health screening.

Numerous facilitators to providing perinatal mental healthcare were elicited from the study. Facilities were described as accessible and generally had an open-door policy to all clients, regardless of whether they lived within the respective catchment areas. Services at the facilities were furthermore portrayed as comprehensive, particularly in the facility with an existing perinatal mental health programme.

Staff matters relating to staff attitudes and willingness to enhance patient care was identified as a facilitator to providing perinatal mental health screening. During the study, work pride and fulfilment was evident from the responses given during the interviews. An integrative review by Noonan et al. (2018: 66) recognises that staff attitudes were pertinent to participants' professional adaptation.

Some of the participants had multiple contact sessions with clients. This facilitated the therapeutic relationship and enabled the midwives to establish rapport with clients. Prolonged engagements with participants furthermore enhanced relationships between the midwives and patients. Viveiros and Darling (2018:13) endorse that the principles of advocacy community and continuity strengthen perinatal mental health screening.

The introduction of new documentation enables perinatal mental health screening to be done at each consultation. Paperwork was therefore completed in the existing MCR and the newer documents. Although the recently-piloted paperwork allowed for more regular perinatal mental health screening opportunities, the completion of

numerous administrative tasks was regarded as laborious. This may exacerbate time constraints.

Collaboration with support services enhanced perinatal mental health care at the various facilities. Noonan et al. (2018: 69) recommend an integrative and collaborative approach to delivering perinatal mental health screening and care. The participants at one facility acknowledged the recent addition and support from NGOs and their respective communities to assist when clients were identified as requiring mental health support.

5.5. Exploring strategies to integrate of perinatal mental health screening with care

The third objective was to identify potential strategies to integrate perinatal mental health screening with care in maternity facilities in the Cape Metropole.

5.5.1 Improve midwife competencies

Despite the prevalence of mental illnesses, especially in low socio-economic settings, the movement towards addressing such needs has been minimal or inconsistent. The midwives felt that training with reference to perinatal mental health screening and counselling skills was pertinent to providing such care to women. The previously-existing Perinatal Mental Health Project demonstrated that training midwives with regards to perinatal mental health screening was a feasible means to identify women with potential mental health issues (Honikman et al., 2012: 4).

The midwives relied on expertise and intuition to identify women with perinatal mental illnesses. Most of the participants thus felt that training regarding perinatal mental healthcare should commence during basic nursing training and be reinforced via various platforms within the clinical setting. Noonan et al. (2017: e365) proposed that organisational support is equally as important as providing staff with training opportunities in a bid to sustain perinatal mental health screening.

5.5.2 Advocating for resources

Although South Africa adopted a comprehensive mental policy framework, all of the participants were unfamiliar with policies in relation to perinatal mental health screening. The current MCR is issued and utilised nationally in South Africa, with minor variances based on the province the booklet was issued in. Since November 2018, the modified MCR provides a three-point questionnaire to screen the mental health of pregnant women. Although a screening tool is provided, referral pathways are limited. The need for adequate referral pathways to be established and maintained was therefore emphasised.

Perinatal mental health was previously offered at three of the facilities that were used in this study, by a nongovernmental organisation. The services were withdrawn abruptly from two of the facilities, presumably due to depleted funds. Community participation and involvement at two of the study facilities offered some alleviation for the social problems encountered at the facilities. The WCG (2014:17) endorses community building and empowerment as a means to promote health and reduce the burden of disease.

Task sharing via non-specialists is suggested by Mendenhall et al. (2014: 40). As a cost-effective means to bridge the treatment gap, non-specialist people are trained to provide basic perinatal mental healthcare.

Communication within the multi-disciplinary team was often not reciprocated. When clients were referred to secondary facilities, the midwives were not updated or informed regarding the future management of clients. This frustration was shared by numerous participants in the study. A study by Sambrook Smith et al. (2018: 5) opined that fragmented care and poor communication within the interdisciplinary team may hinder perinatal mental health care for women and leave colleagues feeling unsupported. Collaboration within the multidisciplinary team is thus essential to cultivate mutual respect and cooperation amongst colleagues.

The participants at the facility offering perinatal mental health services described a fluid referral system. Clients were mainly screened at booking and offered appropriate

care when necessary, although some referrals were made ad hoc by the midwives postnatally. Appointments made during the antenatal period were usually scheduled on the same day as the routine appointment. Integrated perinatal mental health screening is strongly advocated for by Baron et al. (2016: 11) as a means to destigmatise perinatal mental illnesses.

5.6. Limitations of the study

The researcher was dependant on permission from the Western Cape Department to access the healthcare facilities. Permission was granted timeously; however, the researcher encountered a delay in liaising and setting up an appointment at one of the facilities. This delayed the collection and analysis of data. Given that permission was granted by higher authorities, the researcher nonetheless accessed the facility.

The researcher acknowledges previous involvement with perinatal mental health screening. She, however, adhered to ethical considerations during the research process. The researcher acknowledges inexperience in conducting interviews, which may have contributed to the depth of knowledge obtained during the study. Further research is essential to get the perspectives of the women on perinatal mental health experiences and possible solutions, in order to provide better support.

5.7. Conclusion

The overall aim of the study was to explore the perspectives of midwives on providing perinatal mental health screening. The findings indicate that the midwives were cognisant of how hormonal fluctuations during pregnancy may impact on a woman's mental wellbeing. Certain environmental or social stressors may further exacerbate a woman's risk of perinatal mental distress. The participants recognised that perinatal mental illnesses may impact on a woman's commitment to healthcare utilisation and adherence to treatment. The midwives, however, lacked the necessary competencies to offer perinatal mental health screening. The study found that numerous barriers imposed on the midwives' ability to provide perinatal mental health screening. Shortage of staff, time constraints, and heavy workload were identified as some of the major barriers to providing consistent perinatal mental health screening. However,

facilitators to providing perinatal mental health screening, including staff adaptability and accessibility of care, were also identified during the study.

Continuous in-service training of staff was recommended to improve perinatal mental health screening at facilities. The participants furthermore recommend that referral pathways need to be established and that active NGOs that may assist with mental health matters should be identified within the relevant communities. Government policies should be properly communicated, and the resources to realise the stipulated objectives need to be provided for staff.

5.8. Recommendations

The recommendations are grounded on the findings of the study. These recommendations are: community outreach, allocating adequate resources for PMH screening, and the integration of PMH into basic care during pregnancy, birth, and motherhood.

5.8.1. Community outreach

The midwives were cognisant about psychosocial risk factors that could predispose women to perinatal mental illnesses. As part of community outreach initiatives, healthcare facilities could consider liaising with schools in their community to provide schoolgoing children with sexual reproductive health education. Patient education improves symptom recognition and may reduce the stigma associated with perinatal mental illnesses. Health education talks provided to clients should include information about psychological changes and possible mental health complications which may occur during pregnancy.

Maternity facilities should explore the possibility of involving community members in providing emotional support to women. Laywomen could potentially be trained to provide basic counselling and support to women during their pregnancies, echoing the concept of task sharing. Community projects should furthermore be identified and effectively utilised and collaborated with.

5.8.2 Allocate adequate resources to enhance perinatal mental health screening

The study found that the midwives were able to appropriately identify women at risk of mental distress based on their experience and intuition. Although the Western Cape

Government has drafted a comprehensive mental healthcare policy, resources to meet such needs are limited. The participants felt that they lacked the necessary resources to consistently offer perinatal mental health screening. Staff shortage was a barrier which negatively impacted on available time and workload, and subsequently contributed to staff burnout. Allocating a specific midwife to do perinatal mental health screening will ensure that routine care continues alongside consistent mental screening.

It was evident from the study that heavy workloads often forced the midwives to prioritise physical wellbeing of clients. Burnout results when work demands exceed work outputs. Regular debriefing should be arranged to minimise the risk of burnout in staff. During the study, the participants recognised that referral pathways were unclear or absent. Each facility should therefore formulate an algorithm depicting the steps of referring a client with perinatal mental illness or psychosocial problems requesting additional support.

Participants identified unclear referral pathways as a barrier to meeting perinatal mental health needs of women. A list containing the names of active NGOs and community projects should be formulated. All the facilities have non-specialist counsellors who were trained to provide counselling and support on matters relating to infant feeding and HIV. According to partipants, some counsellors were amenable to providing support to women beyond their topic of interest. The training of non-specialist or lay counsellors may enable perinatal mental healthcare and bridge the mental health treatment gap.

5.8.3 Integrating perinatal mental health screening with basic perinatal care

The National Department of Health and Western Cape Government advocate for the integration of mental healthcare when contact is made with a healthcare worker. It was apparent in the study that the midwives lacked the necessary knowledge and skills to do perinatal mental health screening. During the study, participants opined that monthly workshops and staff meetings present an ideal opportunity to facilitate teaching and training of staff in relation to perinatal mental health screening. During

these training sessions, the rationale for screening, evidence-based findings, and screening tools should be discussed with staff.

Participants vocalised challenges in providing culturally sensitive screening and/or counselling. Language interpretation services are available at Mowbray Maternity Hospital. The feasibility of availing such a service to MOUs should be reviewed. Policies regarding perinatal mental health were, furthermore, inadequately relayed to healthcare workers. Issuing new staff members (upon employment) with a policy booklet specific to their job description may promote communication and information sharing.

During the study, the participants acknowledged that they received little training during undergraduate nurse training. Higher learning institutions should be encouraged to adjust the midwifery curricula so as to acknowledge the importance of mental health, especially during pregnancy. Training from undergraduate and continuing through to postgraduate should emphasise the importance of maternal mental wellbeing. It was evident during the study that the midwives lacked the relevant knowledge and skills to conduct perinatal mental health screening. It is recommended that monthly workshops and training should include a perinatal mental health component.

During the study, participants voiced frustration regarding poor interdisciplinary communication. Patients with perinatal mental illnesses were referred by midwives to social workers or medical officers. The care plans for such patients were never communicated back to the midwives. Communication and collaboration in the multidisciplinary team should be encouraged.

5.9 Future research

The following areas for future research are proposed:

- The accessibility and availability of perinatal mental health screening or care as experienced by healthcare users
- Assessing the feasibility of initiating a maternal support group
- Review competencies gained by midwives with reference to perinatal mental health during workshops or in-service training.

- The experiences of women with perinatal mental illnesses during pregnancy, birth, and motherhood.

5.10 Dissemination

A research report will be forwarded to Western Cape Government to highlight the shortfalls with regards to perinatal mental health screening. The researcher furthermore intends to send a copy of the research report to all the facility managers where the research was conducted, and recommendations will be highlighted so that management can assess whether these are feasible. Participants will be notified either electronically or personally of findings as well.

The findings of this study will be published in a peer-reviewed journal. Furthermore, the articles will be presented at a perinatal care conference. The thesis will also be published electronically by the University on SUN Scholar.

5.11. Conclusion

In this chapter, the findings of the study were discussed in relation to the study objectives. The findings reflected that midwives were able to identify women at risk of perinatal mental illnesses based on their experience and intuition. The midwives furthermore acknowledged the need for routine perinatal mental health screening. However, the participants felt that they lacked the relevant competencies to screen and counsel women.

Numerous barriers which may compromise routine perinatal mental health screening efforts were identified in the study. Managerial support and input is essential in order to strategically reduce potential barriers to providing perinatal mental health screening and care. Cost-effective task sharing initiatives should be adopted to further minimise the impact of the barriers reflected in Chapter four. As primary caregivers, midwives should receive ongoing training and clinical supervision in view of perinatal mental health screening.

REFERENCES

- Austin M.P., Priest, S.R. & Sullivan, E.A. 2008. Antenatal psychosocial assessment for reducing perinatal mental health morbidity (Review). *Cochrane Database of systematic reviews.* Issue 4. Art. No.: CD005124.

- Baron, E.C, Hanlon, C., Mall, S.,1, Honikman, S.,Breuer, E., Kathree, T., Luitel, N.P., Nakku, J., Lund, C., Medhin, G., Patel, V., Petersen, I., Shrivastava, S. & Tomlinson, M. 2016. Maternal mental health in primary care in five low- and middle-income countries: a situational analysis. *BMC Health Services Research.* (16)53: 1-16

- Bayrampour, H., Hapsari, A.P. & Pavlovic, J., 2018. Barriers to addressing perinatal mental health issues in midwifery settings. *Midwifery*, *59*, pp.47-58.

- Benator,S.R. 2013. The challenges of health disparities in South Africa. *S Afr Med J.* 103(3):154-5.

- Biaggi, A., Conroy, S., Pawlby, S. & Pariante, C.M. 2015. Identifying the women at risk of anxiety and depression: A systematic review. *Journal of Affective Disorders*. 191: 62-77

- Bitew, T., Hanlon, C., Kebede, E., Medhin, G. & Fekadu, A., 2016. Antenatal depressive symptoms and maternal health care utilisation: a population-based study of pregnant women in Ethiopia. *BMC pregnancy and childbirth*, *16*(1), p.301.

- Carolle, M., Downes, C., Gill, A., Monahan, M, Nagle, N., Madden, D. & Higgens, A. 2018. Knowledge, confidence, skills and practices among midwives in the republic of Ireland in relation to perinatal mental health care: The mind mothers study. *Midwifery.* 64(2018): 29-37

- Corrigan, C.P., Kwarsky, A.N., & Groh, C.J. 2015. S. Social support, Postpartum Depression, and Professional Assistance: A survey of mothers in the Midwestern United States. *The Journal of Perinatal Education*. 24(1): 48-60

- Creswell, J.W., 2009. *Research design: Qualitative, quantitative, and mixed methods approaches*. 3rd Edition. Sage publications.

- Dixon, S. & Dantas, J.A.R. 2017. Best practice for community-based management of postnatal depression in developing countries: a systematic review. *Health Care for Women International.* 38(2): 118-143 Available at: DOI: https://www.tandfonline.com/doi/full/10.1080/07399332.2016.1255213

- Du Toit, E., Jordaan, E., Niehaus, D., Koen, L. and Leppanen, J., 2018. Risk factors for unplanned pregnancy in women with mental illness living in a developing country. *Archives of women's mental health*, *21*(3), pp.323-331.

- Fellmeth, G., Fazel, M. & Plugge, E., 2017. Migration and perinatal mental health in women from low- and middle-income countries: a systematic review and meta-analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(5), pp.742-752.

- Fonseca, A., Gorayeb, R. & Canavarro, M.C., 2015. Women's help-seeking behaviours for depressive symptoms during the perinatal period: Socio-demographic and clinical correlates and perceived barriers to seeking professional help. *Midwifery*, *31*(12), pp.1177-1185.

- Gale, N.K., Heath, G., Cameron, E., Rashid, S. & Redwood, S. 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology.*13:1-8

- Goodman, J.H. 2009. Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. *Birth*. 36(11): 60-9

- Grove, S.K., Gray, J.R., & Burns, N. 2015. *Understanding Nursing Research: Building an Evidence-Based Practice*. 6th Edition. Elsevier: St. Louis, Missouri

- Hansotte, E., Payne, S.I., & Babich, S.M. 2017. Positive postpartum depression screening practices and subsequent mental health treatment for low-income women in western countries: a systematic review. *Public Health Reviews*. 38(3): 1-17

- Hartley, M., Tomlinson, M., Greco, E., Comulada, W.S., Stewart, J., Le Roux, I., Mbewu, N. & Rotheram-Borus, M.J. 2011. Depressed mood in pregnancy:

prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health.* 8(9): 1-7

- Hauck, Y.L., Kelly, G., Dracovic, M., Butt, J., Whittaker, P. & Badcock J.C. 2014. Australian midwives' knowledge, attitudes and perceived learning needs around perinatal menatl health. *Midwifery31*(1):247-255

- Honikman, S., Van Heyningen, T., Field, S., Baron, E. & Tomlinson, M., 2012. Stepped care for maternal mental health: a case study of the perinatal mental health project in South Africa. *PLoS medicine*, *9*(5), p.e1001222. doi:10.1371/journal.pmed.1001222.Epub 2012 May 29.

- Herrman, H., Saxena, S. & Moodie, R. (2006). *Promoting mental health: concepts, emerging evidence, practice*. Geneva: World Health Organization

. Letourneau, N.L., Dennis, C.L., Cosic, N. & Linder, J., 2017. The effect of perinatal depression treatment for mothers on parenting and child development: A systematic review. *Depression and anxiety*, *34*(10), pp.928-966.

- McDonald, L., Antoine, D.G., Liao, C., Lee, A., Wahab, M. & Coleman, J.S. 2017. Syndemic of Lifetime Mental Illness, Substance use Disorders, and Trauma and their Association with Adverse Perinatal Outcomes. *Journal of Interpersonal Violence*. 1-20

- Mendenhall, E., De Silva, M.J., Hanlon, C., Petersen, I., Shidhaye, R., Jordans, M., Luitel, N., Ssebunnya, J., Fekadu, A., Patel, V. & Tomlinson, M., 2014. Acceptability and feasibility of using non-specialist health workers to deliver mental health care: stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social science & medicine*, *118*, pp.33-42.

- Moodley, K. (ed). 2017. *Medical Ethics, Law and Human Rights. A South African Perspective* . 2nd Edition. Van Schaik, Pretoria.

- Moore, K. 2018. *Mowbray Maternity Hospital Presentation*. June 2018, Cape Town. [Unpublished].

- National Department of Health, 2013. National mental health policy framework and strategic plan 2013–2020.
- National Mental Health Policy Framework and Strategic Plan 2013-2020.(2012) Pretoria: Department of Health
- Noonan, M., Doody, O., Jomeen, J. & Galvin, R., 2018. Midwives' perceptions and experiences of caring for women who experience perinatal mental health problems: an integrative review. *Midwifery*, *45*, pp.56-71.
- Noonan, M., Jomeen, J., Galvin, R. & Doody, O., 2018. Survey of midwives' perinatal mental health knowledge, confidence, attitudes and learning needs. *Women and Birth*, *31*(6), pp.e358-e366.
- O'Donnell, M., Maclean, M.J., Sims, S., Morgan, V.A., Leonard, H. & Stanley, F.J. 2015. Maternal mental health and risk of child protection involvement: mental health diagnoses associated with increased risk. *J Epidemiol Community Health.* 69:1175–1183. Available at: doi:10.1136/jech-2014-205240
- O'Hara, M. & Wisner, K.L. 2013. Perinatal mental illness: Definition, description and aetiology. *Best Practice Research Clinical Obstetrc & Gynaecology.* Vol 28, Issue 1: 3-12
- Orengu- Aguayo, R.E., & Segre, L.S. 2016. Depression treatment delivered at the point of care: a qualitative assessment of views of low-income US mothers. J Reprod Infant Psychol.34(1): 35-48
- Petersen Williams, P., Jordaan, E., Mathews, C., Lombard, C. & Parry, C.D.H. Alcohol and other Drug use during Pregnancy among Women attending Midwife Obstetric Units in the Cape Metropole, South Africa. *Advances in Preventive Medicine.* Vol 2014, Article ID 871427: 1-10

  http://doi.org/10.1155.2014/871427 [Accessed 31 January 2018]

o Plant, D.T., Pariante, C.M., Sharp, D. & Pawlby, S. 2015. Maternal depression during pregnancy and offspring depression in adulthood: role of child maltreatment. The British Journal of Psychiatry. 207: 213-220

- Polit, D.F., & Beck, C. 2010. *Essentials of Nursing Research Appraising Evidence for Nursing Practice.* 7th Edition. Wolters Kluwer| Lippincott Williams &Wilkins: Philadelphia.

- Rahman, A., Surken, P.J., Cayetano, C.E., Rwagatire, P., & Dickson, K.E. 2013. Grand challenges integrating maternal mental health into maternal and child health programmes. *PLoS Med*. 10(5):1-7

- Republic of South Africa (RSA). The South African Nursing Council (SANC). 2005. *Nursing Act 33 of 2005*. Pretoria: Government Printers.

- Rochat, T.J., Tomlinson, M., Baringhausen, T., Newell, M.L., & Stein, A. 2011. The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders*. 135(1-3): 362-73

- Rompala, K.S, Cirino, N., Rosenberg, K.D., Fu, R., & Lambert, W.E. 2016. Prenatal Depression Screening by Certified Nurse- Midwives, Oregan. *J Midwifery Womens Health.* 61(5): 599-605

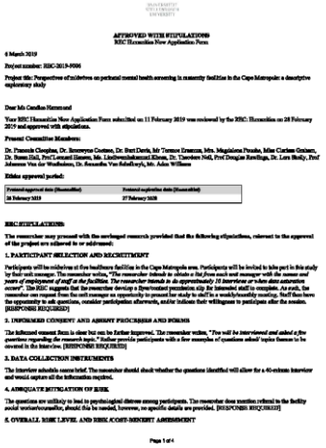
- Sambrook Smith, M., Lawrence, V., Sadler, E., & Easter, A. 2018. Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ Open.* 9: 1-9Stein, A., Pearson, R.M, Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M. & Pariente, C.M. 2014. Effects of perinatal mental disorders on the fetus and child. *The Lancet*. 384 (Nov): 1800-19

- Stellenberg, E. & Abrahams J.M. 2015. Prevalence of and factors influencing postnatal depression in a rural community in South Africa. *African Journal of Primary Health Care& Family Medicine*.Vol7(1):a874 DOI: https://phcfm.org/index.php/phcfm/article/view/874

- *The American Heritage® Dictionary of the English Language (AHD),* 2016. Fifth Ed. Boston: Houghton Mifflin. [Online] Available: http://ahdictionary.com [2019, August 23]

-
- Tsai, A. & Tomlinson, M. 2012. Mental health spillovers and the Millennium Development Goals: The case of perinatal depression in Khayelitsha, South Africa. *Journal of Globl Health.* June 2(1):1-7
- Turner R.E. & Honikman, S. 2016. Maternal mental health and the first 1000 days. *The South African Medical Journal*. 106(12): 1164-1167
- Van Ginneken, N., Tharyan, P., Lewin, S., Rao, G., Meera, S.M., Pian, J., Chandrashekar, S. & Patel, V. 2013. Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low and middle-income countries. *Cochrane Database of Systematic Reviews*. Issue 11. Art. No.: CD009149.
- Van Heyningen, T., Honikman, S., Myer, L., Onah, M.N., Field, S. & Tomlinson, M. 2017. Prevalence and predictors of anxiety disorders amongst low income pregnant women in urban South Africa: a cross sectional study. *Arch Womens Ment Health*. 20:765-775
- Van Heyningen, T., Myer, L., Onah, M., Tomlinson, M., Field, S. & Honikman, S. 2016. Antenatal depression and adversity in urban South Africa. *J. Affect Disord.* October; 203:121-129
- Viveiros, C.J. & Darling, E.K. 2018. Perceptions of barriers to accessing perinatal mental health care in midwifery: A scoping review. *Midwifery.* 70:106-118
- Western Cape Government Health, 2014. Healthcare 2030: The road to wellness.Western Cape Government: Health. Healthcare 2030: Road to Wellness.

Available at URL:https://www.westerncape.gov.za/assets/departments/health/healthcare2030.pd (Accessed 7 April 2019)



approval from Stellenbosch University

UNIVERSITEIT
STELLENBOSCH
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APPROVED WITH STIPULATIONS
REC Humanities New Application Form

6 March 2019

Project number:
REC-2019-9006

Project title: Perspectives of midwives on perinatal mental health screening in maternity facilities in the Cape Metropole: a descriptive exploratory study

Dear Ms Candice Hammond

Your REC Humanities New Application Form submitted on 11 February 2019 was reviewed by the REC: Humanities on 28 February
2019 and approved with stipulations.

Present Committee Members:

Dr. Francois Cleophas, Dr. Bronwyne Coetzee, Dr. Burt Davis, Mr Terence Erasmus, Mrs. Magdalena Fouche, Miss Clarissa Graham, Dr. Susan Hall, Prof Leonard Hansen, Ms. Lindiwemhakamuni Khoza, Dr. Theodore Nell, Prof Douglas Rawlings, Dr. Lara Skelly, Prof Johannes Van der Westhuizen, Dr. Samantha Van Schalkwyk, Mr. Aden Williams

Ethics approval period:

Protocol approval date (Humanities)	**Protocol expiration date (Humanities)**
28 February 2019	27 February 2020

<u>REC STIPULATIONS</u>:

The researcher may proceed with the envisaged research provided that the following stipulations, relevant to the approval of the project are adhered to or addressed:

1. PARTICIPANT SELECTION AND RECRUITMENT

Participants will be midwives at five healthcare facilities in the Cape Metropole area. Participants will be invited to take part in this study by their unit manager. The researcher writes, "*The researcher intends to obtain a list from each unit manager with the names and years of employment of staff at the facilities. The researcher intends to do approximately 10 interviews or when data saturation occurs*". The REC suggests that the researcher develop a flyer/contact permission slip for interested staff to complete. As such, the researcher can request from the unit manager an opportunity to present her study to staff in a weekly/monthly meeting. Staff then have the opportunity to ask questions, consider participation afterwards, and/or indicate their willingness to participate after the session. [RESPONSE REQUIRED]

2. INFORMED CONSENT AND ASSENT PROCESSES AND FORMS

The informed consent form is clear but can be further improved. The researcher writes, "*You will be interviewed and asked a few questions regarding the*

research topic." Rather provide participants with a few examples of questions asked/ topics themes to be covered in the interview. [RESPONSE REQUIRED]

3. DATA COLLECTION INSTRUMENTS

The interview schedule seems brief. The researcher should check whether the questions identified will allow for a 40-minute interview and would capture all the information required.

4. ADEQUATE MITIGATION OF RISK

The questions are unlikely to lead to psychological distress among participants. The researcher does mention referral to the facility social worker/counsellor, should this be needed, however, no specific details are provided. [RESPONSE REQUIRED]

5. OVERALL RISK LEVEL AND RISK /COST-BENEFIT ASSESSMENT

Participants are unlikely to benefit directly from the study, but results may well provide valuable information and hence the risk/ cost- benefit is considered acceptable

6. INSTITUTIONAL AND EXTERNAL PERMISSIONS

Authorisation is required from the Provincial Health Research Committee: Metro West District. The Request letter was included. The researcher should apply for permission via the WCHD online system. Recruitment and data collection may only commence once permission is secured. A copy of the permission letter should be submitted to the REC once this is available. [ACTION REQUIRED]

HOW TO RESPOND:

Some of these stipulations may require your response. Where a response is required, you must respond to the REC within **six**
(6) months of the date of this letter. Your approval would expire automatically should your response not be received by the REC within
6 months of the date of this letter.

Your response (and all changes requested) must be done directly on the electronic application form on the Infonetica system: https://applyethics.sun.ac.za/Project/Index/13650

Where revision to supporting documents is required, please ensure that you replace all outdated documents on your application form with the revised versions. Please respond to the stipulations in a separate cover letter titled "**Response to REC stipulations**" and attach the cover letter in the section **Additional Information and Documents**.

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the
REC of these changes.

Please use your SU project number (9006) on any documents or correspondence with the REC concerning your project. Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further
modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	128771_Candice_HAMMOND_Research_Proposal_550702_120977447 (003) (2)	20/01/2019	1
Data collection tool	Appendix 3 - Interview guide	20/01/2019	1
Request for permission	Institution letter	20/01/2019	1
Default	Cover letter	20/01/2019	1
Default	Candice CV	20/01/2019	1
Default	22-01-2019 Investigator Declaration V4.2 (Eng)	22/01/2019	1
Default	20150224 Investigator Declaration V4 2 (Eng) updated	22/01/2019	1
Default	Protocol synopsis	22/01/2019	1
Default	HOD signature	23/01/2019	1
Informed Consent	Appendix 1 and 2 - Participation information leaflet and Consent -updated	11/02/2019	2

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,
Clarissa Graham

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities' investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enrol participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; Adverse or unanticipated events; and all correspondence from the REC

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrollment, interactions or interventions) or stopped work on your research, you must submit a Final
Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

Appendix 2: Permission obtained from institutions / Department of Health

Western Cape Government
Health

HEALTH IMPACT ASSESSMENT
HEALTH RESEARCH SUB-DIRECTORATE
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201904_003
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Private Bag X1

Matieland

7602

For attention: Ms Candice Hammond

Re: **Perspectives of midwives on perinatal mental screening in maternity facilities in the Cape Metropole: a descriptive exploratory study**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

False Bay Hospital	**Dr Wendy Waddington**	**021 927 1147**
Gugulethu CHC	**Lunga Makamba**	**021 633 0020**
Hanover Park CHC	**Dr Mumtaz Abbas**	**021 927 1147**
Mitchells Plain CHC	**Dr Mumtaz Abbas**	**021 927 1147**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

Title of the research project: Perspectives of midwives on perinatal mental health screening in a maternity facility in the Cape Metropole: A descriptive exploratory study.

Principle investigator: Candice Hammond
Address: Faculty of Medicine and Health Sciences: Division of Nursing, Francie Van Zijl Drive, Tygerberg 7500, South Africa
Contact number: 073 237 6203

Dear participant
My name is Candice Hammond and I invite you to participate in a research project. The project aims to explore the perspectives of midwives regarding perinatal mental health screening.

Please take some time to read through the information presented here, which will explain the details of this project. Do not hesitate to contact the principal investigator if you are uncertain about any part of the project. It is essential that you fully understand what the project entails and how you will be involved. Remember that your participation is **entirely voluntary** and you are free to decline to participate. If you decline to participate, it will not affect you negatively in any way. You are also free to withdraw from the study at any point, even though you initially agreed to participate, and information collected from you will be deleted.

The study has been approved by the **Research Ethics Committee; Social Behavioural and Education Research at Stellenbosch and the hospital you are currently working in** and will be conducted according to the ethical principles of the International Declaration of Helsinki, the South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this study about?

The study is about midwives' perspectives and understanding of providing perinatal mental health screening and care to women. The study will be conducted at four Midwife and Obstetric units in the Metro West area. Approximately ten midwives will be interviewed for the study. No medication will be used during the study.

Why have you been invited to participate?

You have been invited to participate because you are a midwife and have been practising for at least two years, and you may make a valuable contribution to exploring midwives' perspectives on perinatal mental health.

What will your responsibilities be?

You will be interviewed and asked a few questions regarding the research topic. The interview will last for approximately 40 minutes and will be conducted at a time and place most convenient for you. Some of the questions that will be posed to you include "What is your understanding of perinatal mental health screening?" and "How do you think we can integrate perinatal mental health screening with routine care?"

Will you benefit from taking part in the study?

You will not benefit from taking part in the study. There are also no incentives involved in participating in the study.

Are there risks involved in participating in the study?

There are no direct physical risks involved in participating in the study. You may be inconvenienced as the interview will last approximately 40 minutes. You may also become emotionally distressed when certain aspects of the study are discussed with you, although this is unlikely. Should you become distressed, the interview will be stopped. If you require further counselling, I can provide you with contact details for ICAS, which provides free short-term counselling to all government employees.

Who will have access to the transcriptions of your interview?

Information collected will be treated confidentially and be protected. If used for the publication of a thesis, the identity of participants will remain anonymous. Only the researcher and her supervisor will have access to the information. All audio recordings and transcripts will be kept in a safe place to which only the research team will have access.

A number will be allocated to you and the data collected will not reflect any of your personal details. All interview data will be allocated a number, and for the duration of the study participants will only be referred to by a number. Your identity will therefore remain anonymous.

Is there anything else that you should or would like to know?

You may contact Candice Hammond on cell number 073 237 6203 if you have any queries regarding the study.

You may contact Ms Maléne Fouché at the Division for Research Development (mfouche@sun.ac.za; 021 808 4622) if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

If you are willing to participate in the study, please sign the attached Declaration of Consent.

Yours sincerely
Candice Hammond
(Principal Investigator)

Appendix 4: Consent form

Declaration by participant

By signing below, I ……., agree to take part in a research project entitled “Perspectives of midwives on perinatal mental health screening in a maternity facility in the Cape Metropole: A descriptive exploratory study”.

I declare that:

- I have read the information and consent form and that it is written in a language in which I am fluent and comfortable
- I have had a chance to ask questions and my questions were answered adequately
- I understand that partaking in the study is voluntary and that I haven’t been coerced to participate
- I understand that I may withdraw from the study at any point and will not be prejudiced in any way.

Signed at (Place)…… on

(Date)……..

Signature of participant……

Signature of witness……..

Declaration by investigator

I, Candice Hammond, declare that:

- I explained the information in this document to…….
- I encouraged him/her to ask questions and took adequate time to answer
- I confirm that I will keep confidential all information obtained

Signed at (Place)…… on

(Date)…….Signature of

investigator…… Signature of

witness……

Appendix 5: Instrument / interview guide / data extraction forms

Biographical data

- Years of experience
- Gender
- Race

Interview guide

Q1. Tell me about yourself.

Q2. Let's talk about the MOU.

a) What services do you provide at the MOU?

Q3. Let's talk about perinatal mental health screening.

a) What do you think perinatal mental health means?

b) What do you think about perinatal mental health screening?

c) What are the barriers to providing perinatal mental health screening?

d) Which factors facilitate perinatal mental health screening?

Q4. Let's talk about integrating perinatal mental health screening in routine care.

a) What do you think will enable perinatal mental health screening with routine care?

Appendix 6: Confidentiality agreement with data transcriber (if applicable) / permission for use of an instrument

Transcriber Confidentiality Agreement

1. I, (name) MS Malan herewith undertake to keep all information disclosed or submitted to me for transcription by Candice Hammond as confidential.
2. I will not make copies of any audio files or transcripts without the approval of Candice Hammond
3. To store all audio recordings in a password protected computer., secure location for as long as they are in my possession
4. To delete all electronic files containing study related documents or audio files from my hard drive or back up devices on completion of transcription.
5. I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio files which I have access to.

Signed on (date) 10 July at (place) Goodwood

Signature

Appendix 7: Extract of transcribed interview (if applicable)

INTERVIEWER: Okay. Tell me, what do you think perinatal health means?
INTERVIEWEE: Perinatal. It's…perinatal. Peri woman. So, it deals with pregnant women's psychological and sometimes physical problems.
INTERVIEWER: Wonderful. What is your perception…so remember my perception is different from your perception and sometimes your perception is about your feelings; your experiences and not seen what those are about perinatal health. What is your perception about mental health?
INTERVIEWEE: I think mental health is one of the things that needs more attention. It needs more attention. Let me just put it like that because there is so many things in closet that we can't get through as midwives.
INTERVIEWER: Yes. Why do you think we as midwives are not getting through to patients?
INTERVIEWEE: Like, social cases, and some other because like the things that I just told you now.
INTERVIEWER: Yes.
INTERVIEWEE: A very few of us that can dig up until that stage because we don't have time.
INTERVIEWER: Time. Okay.
INTERVIEWEE: We don't have time.
INTERVIEWER: Okay.
INTERVIEWEE: So, we miss everything. We miss everything but we focus on the tummy, on the growing tummy and the growing baby and the foetal heart rate; not knowing that this is a container that is keep this growing tummy. In order for this growing tummy to be healthy we need to make sure that the container is well built or closed or protected. (Abstract from Participant 5)

Appendix 8: Declarations by language and technical editors

(add address)
74 Graham Road
Shere
Pretoria East
0081

To whom it may concern

Re: Copyediting and proofreading of

PERSPECTIVES OF MIDWIVES ON PERINATAL MENTAL HEALTH SCREENING IN MATERNITY FACILITIES IN THE CAPE METROPOLE: A DESCRIPTIVE EXPLORATORY STUDY

By Candice Hammond

I, Chanel Serfontein, hereby confirm that the changes made to the above thesis were to ensure consistency of grammar and language. No changes were made to the body of work submitted to me by the researcher.

Yours sincerely

Chanel Serfontein
Signature:
Email: chanel@pageturner.co.za
Cell: 081 015 8813