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Prioritizing perinatal mental health in South Africa: development of a cinematic training package for maternity care workers in low-resource settings

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PRIORITIZING PERINATAL MENTAL HEALTH IN SOUTH AFRICA: DEVELOPMENT OF A CINEMATIC TRAINING PACKAGE FOR MATERNITY CARE WORKERS IN LOW-RESOURCE SETTINGS

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Batho Pele

—A Sesotho adage meaning "People First"

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ABSTRACT

Introduction: Common perinatal mental disorders (CPMDs) are a significant contributor to disability globally for women during and after pregnancy, though the role of occupational therapy in addressing perinatal mental health is only just emerging. CPMDs present a complex challenge for healthcare providers to identify and treat, and often remain undetected and therefore go untreated. The lack of identification in part reflects structural and psychosocial barriers to care that are influenced by mental health stigma. Low and middle-income countries have begun addressing the treatment gap by scaling up psychosocial support through primary healthcare workers, but these providers are often overstretched. Training providers to demonstrate engagement factors through culturally tailored digital methods is an effective and feasible way to scale up psychosocial support.

Methods: A cinematic training package for maternity care workers in South Africa was designed to demonstrate the important role of empathy in mental health promotion during routine perinatal care. Primary objectives included community engagement, film production and editing, and gathering feedback from key stakeholders regarding the film's acceptability and feasibility for dissemination across South Africa. The film aims

to acknowledge typical challenges faced by maternity care workers while introducing accessible methods to integrate mental health into routine maternity care.

Results: Stakeholder feedback revealed that the cinematic training package and its content are contextually appropriate. Feedback was synthesized to include: shortening scenes, adding on-screen text to highlight empathic skills, and inserting interactive discussion points between scenes.

Conclusion: Interdisciplinary stakeholder collaboration that centered community needs led to the development of an innovative and relevant training package to integrate mental health care into low-resource, maternity settings. Recommendations include customizing the training package based on clinic needs, tracking dissemination, and evaluating its impact on maternity care workers and women with CPMDs. The occupational therapy lens was used to engage in strengths-based, person-centered perinatal mental health promotion.

Keywords: perinatal mental health, maternity care, South Africa, occupational therapy

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LIST OF ABBREVIATIONS

BU	Boston University
CPMDs	Common perinatal mental disorders
ENACT	ENhancing Assessment of Common Therapeutic Factors
EQUIP	Ensuring Quality in Psychological Support
LMICs	Low and middle-income countries
MOU	Midwife Obstetric Unit
NDOH	National Department of Health
OT	Occupational Therapy
PMHP	Perinatal Mental Health Project
RCT	Randomized control trial
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

A Background on Perinatal Mental Health

The perinatal period, typically defined as pregnancy and one-year postpartum, is a time in the life course where women are at greatest risk of mental illness (Howard & Khalifeh, 2020). Common perinatal mental disorders (CPMDs), depression, anxiety, and somatic disorders, are significant contributors to the global burden of disease and disability for women during the perinatal period (Lasater et al., 2019; McNab et al., 2022). Women in low and middle-income countries (LMICs) experience higher rates of CPMDs compared to women in high-income countries (McNab et al., 2022). In South Africa, an estimated 20-35% of perinatal women experience depression or anxiety (Lund et al., 2020; Van Heyningen et al., 2017). Although the burden of perinatal mental illness is high, a mental health treatment gap of 75% in South Africa and 93% in low and middle-income countries reflects structural and individual psychosocial barriers that are permeated by stigma, lack of mental health care parity, and social determinants of mental disorders (Lund et al., 2018; Munodawafa et al., 2017; Singla et a., 2017; Spedding et al., 2018; Spedding et al., 2020). Thus, many women experiencing CPMDs do not receive treatment, leading to devastating effects for the mother, baby, and society.

Consequences of untreated CPMDs are of significant concern to the field of occupational therapy (OT) due to the damaging, rippling effects on mothers' occupational performance and the intergenerational impact on childhood development (McNab et al., 2020). Maternal suicide, disruptions in mother-infant attachment, increased substance abuse, social isolation, parenting stress, and reduced antenatal care/postnatal care

appointment attendance are some of the negative impacts of CPMDs (McNab et al., 2022; Spedding et al., 2018). Women with CPMDs also exhibit challenges in functioning that affect their capacity to work, interact with family, fulfill social and community roles, and thus negatively impact their overall wellbeing (Brown et al., 2020; McNab et al., 2022).

Consequences for the child include infant death, preterm delivery, low birth weight, poor physical and cognitive development, emotional and behavioral problems, and the risk of dropping out of school (Bauer et al., 2016; Boisets et al., 2021; Brown et al., 2020; Dagher et al., 2021; Dossett et al., 201; McNab et al., 2022; Spedding et al., 2018). In addition, maternal depression and anxiety affect infants' sensory processing profiles and the co-occupation of breastfeeding (Gee et al., 2021).

For the family of mothers with CPMDs, there is the risk of perpetuating intergenerational trauma and the negative effects on paternal mental health (Dagher et al., 2021; Killian-Farrell, 2020). Finally, untreated CPMDs contribute high costs to society in terms of increased utilization of acute healthcare and social services, and quality of life (Bauer et al., 2016; Masters et al., 2020); the annual global cost of common mental disorders is estimated at $1.5 trillion (Singla et al., 2017).

An Emerging Role for Occupational Therapy

Disruptions to a mother's mental health can affect participation in daily activities, self-identity, and interactions with the baby; however, occupational therapy's role in maternal health is only just emerging (Branjerdporn et al., 2020). Slootjes et al. (2017) argue for the inclusion of occupational therapy in perinatal care by highlighting the

significance of co-occupation between mother and baby and identifying interventions within the OT scope of practice that target aspects of the person, environment, and occupation: mindfulness; improving self-acceptance; client education; improving emotional wellbeing; maintaining meaningful occupational participation; sleep techniques; functional capacity assessments; and advocacy for women in paid employment, parental leave, and returning to work.

In the United Kingdom, the provision of OT services is a policy requirement of inpatient and community standards for perinatal mental health services (Graham, 2020). A special interest group of occupational therapists in the United Kingdom identified Kielhofner's (2002) Model of Human Occupation as the most favored model of practice for understanding the complex needs of perinatal women and guiding intervention planning (Graham, 2020). Although OTs in Australia, UK, Netherlands, Canada, and Ireland address perinatal issues on occupational performance, evidence on the OT role in maternal health services is minimal, especially in the United States and low-resource settings in LMICs (Branjerdporn et al., 2020; Slootjes et al., 2017). Occupational therapists are attempting to address gaps in the evidence by articulating the value of OT in supporting women with perinatal mental health problems through an accessible training package platform (Health Education England, 2019). They are also engaging in health promotion on the population level, as evidenced by Hanish et al.'s (2019) program evaluation of an occupational-based retreat for mothers who had experienced perinatal loss. Participants demonstrated significant improvement in depression, post-traumatic stress symptomology, self-compassion, and social support. Such preliminary evidence

highlights the value of occupation-based interventions in improving maternal mental health.

This emerging role in clinical practice can also be expanded to occupational therapy practitioners in health promotion and prevention who aim to provide interventions with populations (American Occupational Therapy Association [AOTA], 2013). The health inequities, challenges with accessibility, and stigma that surround early identification and treatment of CPMDs point to the need for occupational therapy to "recognize areas of occupational injustice and work to support policies, actions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives" (AOTA, 2020, p. 12). Bass & Baker (2017) describe how several essential services in public health ("mobilize community resources"; "inform educate and empower"; "link people to needed services/assure care") overlap with the scope of occupational therapy. Furthermore, social determinants of health align with the context and environment domains of the occupational therapy practice framework (AOTA, 2020).

Maternal mental health significantly impacts the occupation of motherhood and child development (Burger et al., 2020; Slootjes et al., 2017). Thus, occupational therapists are in a unique position to consider the holistic needs of perinatal women due to the complex psychological, cultural, social, and physical issues faced by mothers during pregnancy and one-year postpartum (Slootjes et al., 2017).

Theoretical Framework

A framework for evaluating safety-net and other community-level factors on access for low-income populations (Davidson et al., 2004) adds community-level

variables to Andersen's Behavioral Model of Health Service Use (1995) to comprehensively explain how both population-level factors and community-level variables are significant predictors of health care access and outcomes. Community-level variables capture safety net populations, health care market and services in a geographic area, as well as public policy support. If community characteristics support the safety net population, defined as the uninsured, public health care beneficiaries, and vulnerable populations, then there will be increased health care access and improved outcomes. Pregnant women are already a vulnerable population, and there is robust evidence to suggest that pregnant women served by safety net systems are less likely to be screened and treated for mental disorders (Dagher et al., 2021; Davidson et al., 2004; Johnson et al., 2020; Kerker et al., 2018; Miller et al., 2019; Sidebottom et al., 2021). Population factors also lead to differences in efficient and effective medical care delivery. For example, ethnic minorities, people with low income, and those with less trust in medical organizations are less likely to access health services.

Conceptual Model of the Problem

Figure 1 has adapted the framework proposed by Davidson et al. (2004) to posit that structural and psychosocial barriers contribute to the lack of early identification and treatment of CPMDs for women served by safety-net systems (referenced as low-resource settings throughout the remainder of this report), and that mental health-related stigma is pervasive at multiple levels. In South Africa, 84% of the population utilizes an underfunded and under-resourced public health sector, and access to this care has remained inequitable since the overthrow of Apartheid in 1994 (Maseko & Harris, 2018).

To address barriers to health care access, South Africa has recently begun shifting toward universal health coverage by implementing a National Health Insurance system (Maseko & Harris, 2018). Thus, consideration of the needs of women accessing maternity care in a public health system is vital. By capturing the complexity of the problem in a simple model, some obstacles/risk factors will inevitably be left behind, especially when tackling an issue as context specific as access to healthcare. In South Africa, and low-resource settings across the globe, models that do not consider the socio-political landscape are too reductive and must involve ongoing engagement with service users (Cosgrove et al., 2020).

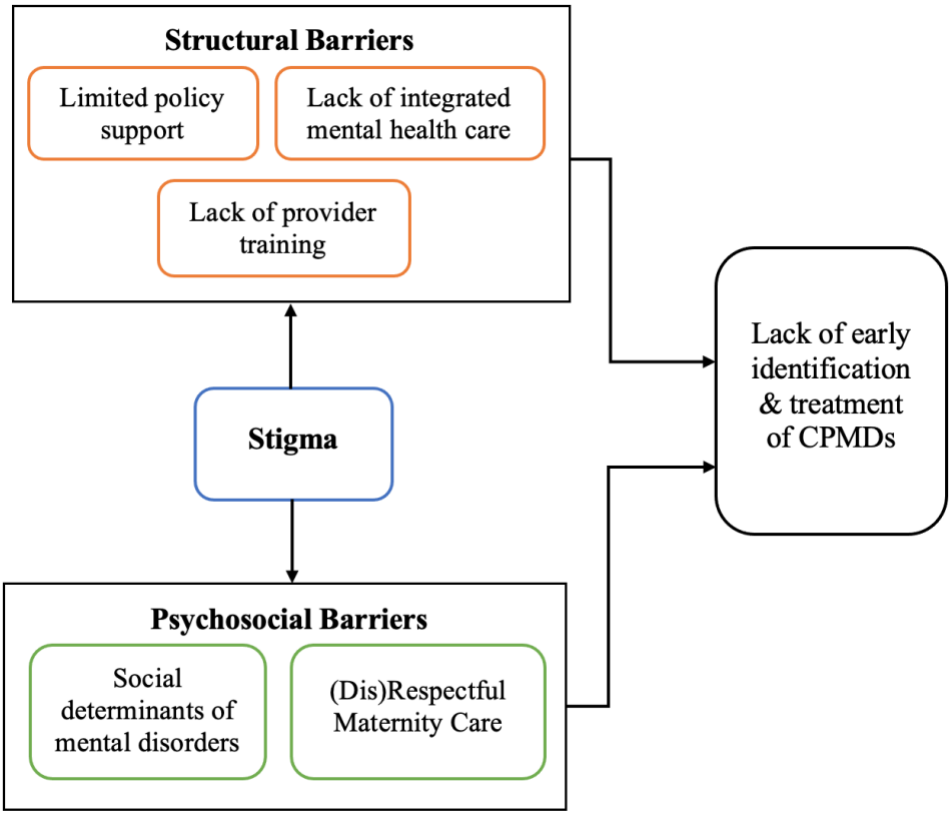


Figure 1. Conceptual Model of the Problem

Structural Barriers: Policy

Although South Africa adopted the National Mental Health Policy Framework and Strategic Plan (2013) with goals to improve detection and management of mental disorders in primary care settings, mental health infrastructure in communities, and supply of mental health professionals, its implementation has been weak regarding the integration of mental health into primary care settings (National Department of Health, 2022). In the National Department of Health's guidelines for maternity care (2016), integration of mental health into antenatal care is not mentioned. South Africa's mental health sector is severely underfunded and under-resourced, receiving only 5% of the national healthcare budget (Docrat et al., 2019). A lack of funding impacts assessment, referral, and provision of optimal mental health care during the perinatal period (Webb et al., 2021).

Political awareness of the importance of perinatal mental health is present, as "detection and management of maternal mental health disorders" is listed under "Essential life-saving intervention packages" in the South African Maternal, Perinatal, and Neonatal Health Policy (2021). However, policy support that includes specific implementation and monitoring strategies as well as funding is crucial to address South Africa's 75% mental health treatment gap. When the National Dept of Health implemented key strategies to improve maternal, newborn, and child health outcomes, maternal and infant mortality were significantly reduced (Bhardwaj et al., 2018). Inaccessible mental health services and staff shortages due to limited policy and funding support reduces the quality of care and negatively impacts the attitudes of healthcare

workers in the public sector (Kohrt et al., 2015; Maseko & Harris, 2017; Munodawafa et al., 2017). “Batho-Pele” policies that champion a person-centered approach to health systems strengthening with service users at the center may begin to confront key obstacles to quality maternal mental health care in low-resource settings.

Structural Barriers: Lack of Integrated Mental Health Care

The lack of integrated mental health care and follow-up services leads to gaps in the early identification and treatment of CPMDs (Dagher et al., 2021; Johnson et al., 2020). According to public health clinic staff members serving low-income women, the lack of follow-up between identification and treatment reflects discontinuity of care and insufficient resources in referring to mental health providers (Tabb et al., 2015). In South Africa, standardized psychosocial support at the primary care level is severely lacking (Boisets et al., 2021; Davies et al., 2017). Integration of mental health into maternity services is recommended to address multiple risk factors of mental disorders associated with pregnancy (Brown & Sprague, 2021). Clearly the lack of integrated mental care is a major organizational barrier that impedes the identification and treatment of CPMDs (Boisets et al., 2021; Brown & Sprague, 2021; Davies et al., 2017; Webb et al., 2021).

Structural Barriers: Lack of Provider Training

Obstacles to quality perinatal mental health care present in policy and health systems further influence barriers at the provider level, most notably a lack of training to detect, refer, and treat CPMDs. In South Africa, service users perceive public hospital staff attitudes as abusive, and suggest that making an improvement in staff attitudes and communication could enhance the quality of care in the public health sector (Maseko &

Harris, 2018). Studies in LMICs report that inadequate training of healthcare workers is a major barrier to scaling up task-sharing interventions (described in more detail in Chapter 3) to provide psychosocial care (Muke et al., 2020; Kohrt et al., 2015). A lack of provider training also reflects poor mental health literacy and poor detection of the signs and symptoms of CPMDs among healthcare workers, impeding the provision of psychoeducation (Abrahams et al., 2019; Brown et al., 2020; Spedding et al., 2018). Improving the competency of healthcare workers in maternity settings to detect CPMDs and provide psychosocial support is an essential step in supporting perinatal mental health.

Psychosocial Barriers: Social Determinants

The consequences of social determinants on mental health in LMICs is well-documented (Lund et al., 2018, McNab et al., 2022). The impact of poverty, HIV, food insecurity, and intimate partner violence on a mother's physical, emotional, and psychological wellness, and the adverse social conditions present in low-resource settings where perinatal women live, work, and play, all lead to harmful effects on their mental wellbeing (Boisets et al., 2021; Brown et al., 2020; Malan et al., 2020; Maseko & Harris, 2018; Sprague et al., 2020). Such "individual-level" factors are not only risk factors for the development of CPMDs, but also obstacles in accessing quality mental health care. Larger social forces at play, such as the post-apartheid socioeconomic and cultural context as well as inequitable gender norms that limit autonomy, prevent perinatal women from seeking and accessing care (Brown et al., 2020; McNab et al., 2022). To better address the maternal health needs of women in low-resource settings, Laurenzi et

al. (2020) conclude that interventions should integrate mental health, food security, and domestic violence components. Poverty, that is so often seen as an individual characteristic, should also be recognized as a global burden and incite large-scale social change (Cosgrove et al., 2020). The Pan-African Network of People with Psychosocial Disabilities declared that "no medicines or sophisticated western technology can eradicate poverty and restore dignity" (2014). Thus, a human-centered and mindful approach is needed when considering the impact of social drivers on the access of quality mental health care for women during the perinatal period.

Psychosocial Barriers: (Dis)Respectful Maternity Care

South Africa's healthcare landscape presents a complex power dynamic between nurses and their patients that plays out most dramatically in the public health sector and affects quality of care. (Brown et al., 2020; Honikman et al., 2020a; Maseko & Harris). Nurses account for the most direct patient contact out of all healthcare providers in South Africa's public health system, maintaining social status and regard as agents of change (Honikman et al., 2020a; Sprague et al., 2020). However, nurses often come from the same socially adverse environments as their patients, carry unresolved trauma, feel overburdened with high volumes of patients, and work in under-resourced health facilities (Brown et al., 2020; Honikman et al., 2020a). In maternity settings such dynamics have led to obstetric violence, in which patients feel disempowered, humiliated, and distressed due to interactions with nurses (Honikman et al., 2020a; Maseko & Harris). Thus, a lack of respectful maternity care within patient-provider relationships is a significant barrier to health system engagement for perinatal women in South Africa.

Stigma

Finally, stigma impacts women, providers, and the community alike, in that stigma of mental health conditions during pregnancy is a barrier to help-seeking, reduces the acceptability of screening in the clinic, and leads to non-engagement of services (Jones, 2019; Kerker et al., 2018; Myors et al., 2015; Tabb et al., 2015; Webb et al., 2021). Stigma among health providers was cited as a barrier to the success of the World Health Organization's (WHO) Mental Health Gap Action Programme (mhGAP), associated with low rates of detection of mental illness and poor clinical competency (Kohrt et al., 2020b). In LMICs, mental health-related stigma prevents detection, referral, and provision of psychosocial support as well as health system engagement (Kane et al., 2019; Nyatsanza et al., 2016; Semrau et al., 2015; Spedding et al., 2020). Perinatal women in Cape Town, South Africa, who were diagnosed with depression reported stigma as a barrier to service engagement and a deciding factor in service location (Nyatsanza et al., 2016; Spedding et al., 2020). Stigma toward mental illness is both an individually held belief with interpersonal consequences, and, perhaps more damaging, a political and economic tool preventing structural change. Thus, stigma is conceptualized in the present model to influence both the structural and psychosocial barriers to the early identification and provision of quality psychosocial care for perinatal women in low-resource settings.

CHAPTER TWO: EVIDENCE TO SUPPORT THE PROJECT

Project Focus

The problem of perinatal mental health is complicated, multilayered, and requires involvement from multiple key stakeholders, from policymakers, global collaborators, and implementation science researchers to an array of healthcare providers and women with lived experience; from maternal and child health departments to non-governmental organizations focused on social development. The following evidence reflects an attempt to address the problem from a global public health and systems strengthening lens.

To address the treatment gap of CPMDs in South Africa and improve the quality of mental health care in low-resource settings, the provision of psychosocial care by healthcare workers will first be evaluated. This approach is referred to as "task-sharing" or "task-shifting" and aims to increase accessibility of mental healthcare by training health providers who are *not* specialized mental health providers (Masters-level counselors, social workers, psychologists, etc.) to detect CPMDs and deliver brief psychosocial treatments. The literature refers to these providers as non-specialist providers, which are comprised of nurses, midwives, primary care providers, lay workers, volunteer peers, community health workers, or teachers depending on the setting. Integration of maternal mental health into primary care and community-based settings is a key initiative of health systems strengthening in low-resource settings (Honikman et al. 2020b).

The therapeutic components of treatment delivery during the perinatal period with an emphasis on engagement as well as the required competencies of providers and

efficacious training methods will also be analyzed. Diverse methodologies are appraised to reflect guiding interventions with realistic application to the South African context and include randomized control trials (RCTs), qualitative research for an understanding of context and culture, and mixed-method implementation science.

Delivery of Mental Health Care in Low-resource Settings

Three out of five high-quality studies (RCTs, systematic reviews, and/or meta-analyses) reveal that task-sharing interventions by providers can improve mental health outcomes in low-resource settings (Gajaria & Ravindran, 2018; Singla et al., 2017; Vally et al., 2016). In two studies, services delivered by trained providers yielded small to moderate effect sizes in the improvement of common mental disorders, representing a clinically important difference (Singla et al., 2017; Vally et al., 2016). Randomization of treatment arms, fieldworkers blinded to allocation, psychometrically sound outcome measures, and treatment fidelity checklists included in the studies increase internal validity and confidence in the use of providers to deliver efficacious mental health treatment in low-resource settings. Two RCTs found no significant differences between intervention (providers) and control (enhanced usual care) in the primary outcome measures of pregnant women with depression (Lund et al., 2020; Sikander et al., 2019). However, both studies noted that the control group received enhanced usual care that provided the opportunity for participants to share their experiences with nonjudgmental providers, which may have mediated effects that would usually be captured in real-world settings. Furthermore, Sikander et al. (2019) found that delivery of the Thinking Healthy Program by volunteer peers reduced disability and improved functioning at 3-months

postpartum, an important outcome for women who experience increased vulnerability during this time.

Although there was heterogeneity in outcome measures, all studies utilized validated and reliable measures of depression, though diagnostic assessment and measurement of anxiety was less common. Providers demonstrated good fidelity to treatment protocol (Lund et al., 2020; Sikander et al., 2019); however, variability in treatment adherence, dosage, and therapeutic elements threatens internal validity and reduces confidence in task-sharing by providers to deliver quality mental health care. Perinatal women in LMICs, including South Africa, experience social determinants of mental disorders that are simultaneously risk factors of mental illness and barriers to quality mental health treatment. Poverty, intimate partner violence, food insecurity, HIV, etc. not only have consequences on mental wellbeing, but also interfere with perinatal women's capacity to engage in treatment or benefit from treatment if social adversity is not addressed. (Boisets et al., 2021; Brown et al., 2020; Brown & Sprague, 2021; Lund et al., 2018).

Large sample sizes that are representative of perinatal women and providers in South Africa increase confidence in the external validity of the studies, all of which were conducted in LMICs, with one RCT specific to South Africa and one meta-analysis including 6 of 14 studies from South Africa (Lund et al., 2020; Vally et al., 2016).

Healthcare providers, receiving ~5 days of in-person training and ongoing supervision, who deliver 6 to 10, hour-long sessions of psychological treatment in primary care or community-based settings for 2-3 months, can improve the mental

wellbeing and functioning of perinatal women with CPMDs in South Africa (Gajaria & Ravindran, 2018; Singla et al., 2017; Sikander et al., 2019; Vally et al., 2016). Specifically, the engagement factors of treatment delivery are related to treatment effectiveness and discussed in more detail below (Gajaria & Ravindran, 2018; Lund et al., 2020; Singla et al., 2017; Sikander et al., 2019; Vally et al., 2016).

Therapeutic Elements of Treatment Delivery

Three studies, two RCTs and a systematic review/meta-analysis of RCTs, indicate that engagement factors such as effective communication, collaboration, empathic care, and active listening provided by healthcare workers significantly improve the burden of CPMDs in low-resource settings (Brock et al., 2017; Fares & Ahmed, 2021; Singla et al., 2017). Brock et al. (2017) included multiple raters of a variety of depression and anxiety measures (self-report, clinician-report) and blinded outcome assessors, increasing confidence in internal validity and that the therapeutic components of empathic listening and collaborative-problem solving are responsible for the significant improvements in mood experienced by low-income, perinatal women and maintained at follow-up. Singla et al. (2017) identified common elements for psychological treatment in LMICs from 27 RCTs examining effectiveness of task-sharing by providers and found that empathy was the most cited treatment element. Interpersonal, emotional, and engagement factors were the strongest associations of elements on intervention effectiveness, highlighting the importance of collaboration, empathy, active listening, and normalization of treatment/mental illness in treatment delivery. Core psychological strategies utilized by providers during treatment sessions include behavioral activation, problem-solving

therapy, and psychoeducation on cognitive and behavioral effects of depression (Boisets et al., 2021; Gajaria & Ravindran, 2018; Lund et al., 2020; Nyatsanza et al., 2016; Sikander et al., 2019; Singla et al., 2017).

Mixed-methods implementation designs and qualitative studies that include key stakeholder perceptions of integrated mental health care emphasize the value of psychosocial support during routine antenatal care appointments and counselling interventions by providers (Boisets et al., 2021; Kazal et al., 2021; Nyatsanza et al., 2016; Spedding et al., 2020). Strengths in qualitative design of these studies include triangulation and in-depth, thematic analysis of the data to ensure that the lived experiences of perinatal women, perinatal women diagnosed with depression, and health providers are represented. Inclusion of qualitative methods is essential in implementing mental health interventions as they provide indicators of intervention relevance in terms of population need and fit with culture and context (Jordans & Kohrt, 2020). Small sample sizes and lack of control groups limit confidence in the effect of impartial, empathic care on the improvement of CPMDs; however, samples are representative of the needs of perinatal women living in low-resource settings in South Africa and therefore increase confidence in generalizability of the results to the population of interest (Nyatsanza et al., 2016; Spedding et al., 2020).

Qualitative designs exploring perceptions of CPMDs by perinatal women and service providers in South Africa point to the need to address stigma and increase mental health awareness (Boisets et al., 2021; Brown et al., 2020; Brown & Sprague, 2021; Nyatsanza et al., 2016; Spedding et al., 2018; Spedding et al., 2020). Perinatal women in

South Africa exhibit low recognition of mental disorders and tend to describe depression in behavioral terms such as “stress” (Boisets et al., 2021; Spedding et al., 2018). Women with CPMDs also report a preference for clinic-based counselling over their home environments due to privacy and perceived stigma (Boisets et al., 2021; Gajaria & Ravindran, 2018; Nyatsanza et al., 2016). Kohrt et al. (2020b) found that their intervention to reduce mental health-related stigma among healthcare providers improved clinical competency and stigmatizing attitudes, supporting collaboration between service users and healthcare providers to enact meaningful personal and structural change. Respectful maternity care, treatment engagement factors, and mental health awareness are essential components of engaging perinatal women in quality mental health care and reducing stigma, yet service providers feel inadequately trained or prepared to address mental health concerns during antenatal care appointments (Brown et al., 2020; Brown & Sprague, 2021; Nyatsanza et al., 2016). Thus, essential competencies and effective training components are evaluated below, along with their feasibility and acceptability.

Training Components for Healthcare Providers

McNab et al. (2022) presented a global call to action to prioritize perinatal mental health, calling for the need to strengthen the capacity of providers through competency-based training that emphasizes skills in mental health promotion, prevention, and detection, as well as respectful, culturally appropriate, person-centered care.

Four studies, including two RCTs, provide support for the use of technology-assisted training of providers to address the mental health care gap and deliver evidenced-based, psychosocial treatment in low-resource settings (Khan et al., 2020; Muke et al., 2019;

Muke et al., 2020; Rahman et al., 2019). Two RCTs randomized providers to receive digital or conventional training in the delivery of an evidence-based treatment for depression in LMICs and found that all groups improved in competency regardless of training format (Muke et al., 2020; Rahman et al., 2019). Rahman et al. (2019) utilized the Enhancing Assessment of Common Therapeutic Factors (ENACT) rating scale to assess competency skills via role-play and observation of a therapy session at a 3-month follow-up by blind raters, increasing confidence that digital training interventions produce significant change in the competency skills of healthcare workers providing treatment for perinatal depression. Effective digital training dosage ranged from 20 hours over 5-days to 48 hours (Khan et al., 2020; Muke et al., 2020; Rahman et al., 2019). Studies included mostly female health workers providing depression or perinatal depression care in rural India or post-conflict Pakistan, so caution is warranted when generalizing to the South African context. Further limitations include small sample sizes which reduce intervention power and the lack of outcome evaluation on women with CPMDs. Focus groups and engagement of key stakeholders in design and development of technology-based training found the digital content acceptable and feasible, though participants' limited familiarity with technology should be addressed (Khan et al., 2020; Muke et al., 2019). Important considerations during the digitization of training content include the following: simple language avoiding technical jargon; gathering video footage and pictures with representation of people and places to increase relevance to context; 3–5-minute role-play videos to increase interest and engagement; and engaging key stakeholders throughout the process (Khan et al., 2020; Muke et al., 2019; Muke et

al., 2020). Digital training that utilizes simple language and context-dependent videos/pictures is effective in improving competency skills in health providers delivering psychosocial treatment, and is acceptable, feasible, and cost-effective compared to conventional training (Khan et al., 2020; Muke et al., 2019; Muke et al., 2020; Rahman et al., 2019).

Many studies acknowledge the poor mental health of healthcare providers, who live in the same difficult social contexts as their patients and work in overburdened health systems (Brown et al., 2020; Brown & Sprague, 2021; McNab et al., 2022). Thus, incorporating mental health education into the training of providers is essential to not only increase knowledge of maternal mental health and reduce stigma to better engage women with CPMDs in treatment, but to also improve the wellbeing of providers themselves (Boisets et al., 2021; Brown et al., 2020; Brown & Sprague, 2021).

Five studies conducted in South Africa examining provider training or treatment delivery highlight the feasibility and acceptability of task-sharing to engage perinatal women in mental health care (Boisets et al., 2021; Honikman et al., 2020a; Munodawafa et al., 2017; Nyatsanza et al., 2016; Spedding et al., 2020). Providers were trained by a mental health practitioner or social worker for 4-5 days which consisted of scenario-based learning activities, role-plays, verbal and nonverbal communication skills, and basic problem-solving skills. Engagement with key stakeholders in implementation led to the identification of core community-based service delivery skills, which included health promotion and empathic listening. In fact, all five studies emphasized the importance of training providers to demonstrate empathy when engaging women with CPMDs in

treatment. Two studies observed moderate to good adherence to treatment protocol with the use of fidelity checks, though there was wide variation among providers (Munodawafa et al., 2017; Spedding et al., 2020). Healthcare workers demonstrate challenges employing guided discovery as a treatment mechanism, as the preference is to give advice rather than collaboratively identify solutions. Study weaknesses include low retention rates of perinatal women, largely due to social adversity (poverty, crime, food insecurity, etc.) as a barrier to care, and lack of control groups decreasing confidence in intervention efficacy. Providers across all studies identified common barriers to the implementation of quality mental health care, including feeling that screening and referral is burdensome, guilt for not being able to help perinatal women who need material assistance, lack of private space to conduct screening/referral or treatment, and concern about adding mental health services to their already large workload. Thus, gaining acceptance and buy-in from providers is paramount to achieving successful mental health training and implementation.

Five days of training in basic counseling and intervention delivery by a specialist provider utilizing digital training content and skill assessment via role-plays may increase the competency of providers in addressing psychosocial needs of perinatal women and engaging those with CPMDs in treatment.

In response to the need to instill an ethos of care among nurses, Honikman et al. (2020a) and the PMHP developed the Secret History method to prepare maternity settings for task-shifting and integration of mental health care. The Secret History method employs participation, collective dialogue, and reflection to examine common social

problems inherent within maternity settings and experiment with more empathic and compassionate behaviors. Strengths of this education approach lie in the transformative power of individuals to change macro-level barriers, such as lack of quality, integrated mental health care in low-resource settings.

Implications

To summarize, task-sharing of mental health care to providers in primary care settings can significantly improve the mental wellbeing and functioning of women with CPMDs. Training providers to demonstrate respectful maternity care, mental health awareness, and engagement factors such as empathy, collaboration, and active listening may be the strongest mechanisms in psychosocial treatment effectiveness. Finally, providing culturally tailored digital training content with competency assessments to providers can be a cost-effective, feasible and acceptable method of scaling up psychosocial treatment in LMICs. In South Africa, 97% of women attend antenatal care appointments, providing an excellent opportunity to increase access to mental health care (McKenna et al., 2017). Effective screening with empathy and psychosocial support in maternity settings by providers is an important entry-point to care to reduce the burden of CPMDs in low-resource settings.

The focus of the Doctoral Capstone will be the development of a training program for non-specialist providers (primary care nurses) working in a low-resource, maternal setting in Cape Town, South Africa to improve the detection of CPMDs and quality of mental health care. Nurses represent a vital component of the public health sector and mental health task-shifting initiatives in South Africa; yet they are simultaneously

marginalized and in positions of power during interpersonal patient interactions, leading to abuse and complex dynamics in health system engagement (Honikman et al., 2020a). Therefore, training and supporting nurses to promote mental health and practice empathic interactions during antenatal care appointments may be an effective method in optimizing the accuracy of screening responses and increasing the likelihood of appropriate uptake of care for women with CPMDs. Demonstrating empathy during patient interactions may be the most effective method in improving mental health among mothers (Singla et al., 2017)

Based on the evidence above, program features will include digital training content in engagement factors (empathy, collaboration, active listening) and mental health promotion to improve mental health awareness. Targeting therapeutic engagement factors and mental health awareness aims to produce change at the structural and psychosocial levels within the conceptual model by not only enhancing the competency of providers, but also reducing stigmatizing attitudes that prevent detection and treatment of CPMDs. A cinematic training package that incorporates role-plays, interactive components, and contextually relevant images and footage will be designed and disseminated to key stakeholders.

To ensure the digital content reflects global competency standards to deliver psychosocial services, resources from the WHO's new platform, Ensuring Quality in Psychological Support (EQUIP) will be valuable (Kohrt et al., 2020a). The ENACT rating scale is a measure with good psychometric properties that has been used to assess clinical competency via standardized role plays (Kohrt et al., 2020b; Rahman et al., 2019;

Sikander et al., 2019). Adaptation of ENACT, principles of behavioral activation and problem-solving therapy, the Secret History method, and cornerstones of occupational therapy practice will be utilized to inform digital content. Additionally, how to screen and refer will be addressed, using the brief mental health screening tool developed by PMHP at Hanover Park's Midwife Obstetric Unit (Abrahams et al., 2019).

Lastly, advocacy for the distinct value of occupational therapy in perinatal mental health will also be explored through engagement with key stakeholders. Throughout the above evidence, the need for the inclusion of occupational therapy in the global mission to promote perinatal mental health is indirectly referred to through treatment mechanisms emphasizing engagement in meaningful activity and the use of outcome measures of daily functioning (Boisets et al., 2021; Lund et al., 2020; Sikander et al., 2019; Spedding et al., 2020). In fact, the mhGAP Intervention Guide lists "promote functioning in daily activities" as a part of essential care and practice for mental disorders (WHO, 2016). The promotion of functioning as a key intervention element supports the inclusion of OT services in maternal mental health promotion and prevention. Advocacy for the expansion of outcome measures beyond symptomology of CPMDs is important, since women with CPMDs experience impairments in occupational functioning in social participation, work, and family/home responsibilities. Furthermore, advocacy for the role of occupational therapy in perinatal mental health promotion and prevention is included.

CHAPTER THREE: DESCRIPTION OF CAPSTONE PROJECT

Objectives

The purpose of the capstone project is to develop a cinematic training package for primary care nurses and midwives in low-resource settings in South Africa, utilizing the occupational therapy lens and client-centered practice to improve the quality of maternal mental health care. The project aims to demonstrate engagement factors (empathy, collaboration, active listening), respectful maternity care, and mental health promotion through a film.

Through research with my site mentor, Dr. Shelley Brown, I developed a relationship with the Perinatal Mental Health Project (PMHP) in Cape Town, South Africa. PMHP, a non-profit organization within the University of Cape Town, aims to address the problem of widespread common mental health conditions amongst pregnant and postnatal women in low-resource settings by supporting the integration of quality maternal mental health care into existing mother and child initiatives. PMHP is a global leader in mental health and respectful maternity care, and thus has been recently tasked by the National Department of Health (NDOH) in South Africa to develop the mental health and respectful maternity care components of the new National Maternity, Perinatal, and Neonatal Care Guidelines (National Department of Health, 2021).

The Doctoral Capstone is a result of this collaboration to support capacity building and the implementation of the guidelines, which will be disseminated through the ‘Knowledge Hub’ resource portal of the NDOH and into national training programs. The NDOH provides healthcare guidelines that provinces then implement, and there are

differences in resource allocation between provinces. The project was based in the Western Cape, where the provision of health services specific to Western Cape were deeply observed. In-country learning opportunities throughout the Cape Flats better informed the capstone project in terms of the conceptual model of the problem, needs assessment, policy and key stakeholder analysis, and script development. Thus, this approach reflects an inclusion of multiple key stakeholder perspectives that encourages a public health and medical anthropology lens for the design and evaluation of the capstone project.

Community Needs Assessment

A key objective of the project is to build partnerships with community stakeholders in South Africa through PMHP's only maternal support service site, Hanover Park. All stakeholders involved in the project are listed in Table 1. Additionally, my role as facilitator of undergraduate student learning with EDU Africa and BU Service Learning allowed me to develop intercultural competence and a deeper understanding of how South Africa's history affects socioeconomics and healthcare challenges of today through community engagement in the Cape Flats of the Western Cape, South Africa. The Group Land Act of 1948 led to the forced removal of non-white residents of Cape Town into townships known as the Cape Flats during Apartheid. Health inequities in the Cape Flats persist due to poor structural design and limited government funding with very few public hospitals and clinics per catchment area. Community engagements involved service learning throughout several townships—Khayelitsha, Macassar, Grassy Park, Manenberg—where community members shared stories that added layers to my

personal understanding of the social, political, historical, and economic landscape of Cape Town. People in the Cape Flats are demanding more for their communities, such as environmental justice and increased access to public green spaces, which is vital for community wellness. Advocates for social justice are redefining place and poverty, taking a "bottom-up" approach to addressing inequities. As one activist stated, "you can feed a person without money or food if you become their friend first." Building relationships with the people most affected by the problems that individuals, organizations, or governments are trying to solve is key to sustaining meaningful change. This is perhaps the most salient wisdom I gained through community experiences in the Cape Flats as I examined how to best effect systemic change in maternal mental health. Daily fieldnotes relating to the community interactions guided by EDU Africa led to deeper personal reflections about global citizenship and intercultural humility.

Stakeholder	Role
Shelley Brown	- Supervise OT Doctoral Student, imparting public global health & perinatal mental health expertise - Support of OT Doctoral Student while conducting capstone activities in South Africa
Simone Honikman	- Director and founder of PMHP - Supervision of OT Doctoral Student in South Africa: review/editing of scripts, providing relevant resources for capstone production - Material support and assistance with management of film production in South Africa: recruiting actors, securing rehearsal space and film location at Mowbray Maternity Hospital, securing props and snacks, - Ongoing collaboration during editing process for revision
OT Doctoral Student	- Facilitator of undergraduate student learning during EDU Africa's programming - Write and develop scripts for 4 scenes - Write funding proposals, engage in fundraising to financially support film production of the project - Assistant Director on film day

	- Secure catering sponsor for film day - Film editing revision as necessary - Advocate for role of OT in PMH
Sargent College	- Financial support for OT student to travel to Cape Town, South Africa as BU Service-learning trip facilitator for undergraduate student learning and cultural competency
PMHP counselors at Hanover Park	- Demonstrate enhanced stepped care model, PPP intervention - Sense-checking script
Nurses/midwives at Hanover Park	- Demonstrate history-taking/patient engagement during ANC appointments - Sense-checking script
Community partners at Hanover Park: Department for Social Development, HIV counseling, Alcardo Andrews Foundation, The Zoe Project, The Parent Center	- Demonstrate importance of community partnerships, including relevant NGOs that fulfill community needs - Present insight into immense challenges faced while working within the Cape Flats
EDU Africa	- Provide global health service & intercultural competence programming - Guide community engagements throughout the Cape Flats and reflections with local facilitator that explore how health, community green spaces, the environment, and social justice intersect - Promote personal, professional, intellectual, intercultural competence and global citizenship growth and evaluate via transformation questionnaire
PMHP, University of Cape Town	- Provide resources and access to UCT & Hanover Park MOU - Front the costs for a 10-hour day of filming - Disseminate film for feedback at Hanover Park MOU with maternity care workers
Actors	- Volunteer time to learn/memorize scripts and participate in 10-hour day of filming
Cutaway Pictures	- Film production: provide equipment and team (director/cinematographer, camera assistant, lighting technician, sound recorder/boom swinger) for a full 10-hour film day
Film director, Ross Cupido	- Develop quote for filming - Director/cinematographer on day of filming - Provide expertise during rehearsal, script development, shooting scenes - Film editing

Table 1. Capstone Project Stakeholders

Hanover Park's Midwife Obstetric Unit (MOU) is in a "coloured[1]" township of the Cape Flats and is known for high rates of violence (Meintjes et al., 2015). The majority (66%) of women who attend PMHP's onsite counseling are "coloured" and the remaining 34% of women are Black (Perinatal Mental Health Project, 2021). Approximately 80% of perinatal women receiving mental health treatment reported problems with lifestyle transitions, including teenage pregnancy, unexpected pregnancy, and adjustment to parenting (Perinatal Mental Health Project, 2021). From an occupational therapy lens and Model of Human Occupation perspective, perinatal mental illness can lead to deficits in occupational adaptation to new roles as a parent. Engagement with MOU staff and community partners in Hanover Park strengthen the capstone project by centering community needs and contextualizing the lived experience of nurses and women with CPMDs in a low-resource, maternal setting. For example, PMHP's promotion, prevention, and preparation intervention facilitates discussions between PMHP counselors and perinatal women in the antenatal clinic waiting room. The counselors described their services, revealed common experiences of depression and anxiety expressed by mothers, and normalized perinatal mental illness while dispelling common myths (e.g., *struggling with these feelings does not mean you're crazy or a bad mother*). The occupational therapy lens was used to speak to the impact of maternal depression and anxiety on daily functioning in the home, at work, and within the community.

[1] The use of "coloured" as a classification of race is deeply and historically problematic. "However, given South Africa's troubled socio-political history, the use of these markers allows for the monitoring of improvements in health and socio-economic disparities that originated within such a classification system" (Spedding et al., 2020).

In line with the need for an interdisciplinary response to the high burden of perinatal mental illness, community partners, non-governmental organizations, and governmental departments that PMHP counselors at Hanover Park work closely with were also explored. This included interactions with the Western Cape Government Department for Social Development, an HIV counselor, the Alcardo Andrews Foundation, the Parent Centre, and the Zoe Project. Each delivered valuable insight about the importance of building connections to enhance the quality of life for vulnerable people in their communities, including perinatal women. The Department of Social Development revealed staff shortages and an overburdened social services system that makes working in their catchment area within the Cape Flats especially challenging (consider the difficulty in locating residents living in informal settlements with limited government support). The Alcardo Andrews Foundation is a non-governmental organization, started by a local Hanover Park resident who desperately saw the need for a peaceful and safe community, that offers psychosocial support to mothers and fathers who have experienced violence, a support structure for youth, and a food project. Despite the challenges faced working or serving in this low-resource setting, the power of building relationships led individuals to become agents of change within their communities. PMHP counselors refer their clients to these partners, and many others, in order to address the social determinants of health and the holistic needs of women with CPMDs (Perinatal Mental Health Project, 2017).

Design

Appendix B contains a detailed logic model for the Doctoral Capstone. Below lists an overview of the development of the cinematic training package:

1. Develop film content: draft & review scripts; contextualization of scripts, expert review & incorporate feedback
2. Film production: shooting the scenes; editing the film to produce first rough cut
3. Stakeholder feedback workshop: group workshop discussion to obtain feedback on content & contextual fit of film; discuss implementation and evaluation strategies
4. Cinematic training package: synthesize feedback from key stakeholders; implement feedback via editing to create final cut of the film

To understand what the early identification and treatment of CPMDs means in the context of Hanover Park's MOU and therefore create the nurse-patient dialogue inherent within screening and referral, PMHP's care pathway was observed and explored. During initial antenatal care appointments that involve taking the patient's medical history, nurses first screen mothers using the 3-item mental health screening tool (Appendix C) (Abrahams et al., 2019). If a patient scores a 2 or above, a referral is then made to an onsite PMHP counselor who performs an Engage, Assess, and Triage session. These sessions explore 14 risk factors (e.g., teenage pregnancy, HIV, current violence in household, etc.) to determine what level of care the mother should receive. Women with more complex needs receive high-level care from a senior counselor while women with a lower risk profile receive low-level care from a junior counselor. This enhanced stepped

care model was developed by PMHP and is specific to service provision at Hanover Park's MOU. The screening and referral dialogue present within the capstone project utilizes the 3-item screen, then explores referral options with the patient (e.g., mental health nurse, community organization, counselor), a likelier scenario in other low-resource settings throughout South Africa where access to onsite counselors within the MOU is not realistic. The resources listed in Table 2, as well as direct observation and experiences at Hanover Park's MOU, were utilized in script development.

Resource	Description
3-item mental health screen	Yes/No screen for anxiety, depression, and suicidal ideation/planning
ENACT tool	Role-play assessment tool of universal competencies for the delivery of effective psychosocial treatment by non-specialist providers
6 empathic skills	Building rapport, verbal and non-verbal communication, reflecting feelings, affirming, getting feedback, knowledge sharing
Maternity Case Records, South Africa NDOH	Standard record book valid for the duration of pregnancy and puerperium and includes all patient encounters
WHO Perinatal Mental Health Implementation Guide Draft	Aims to enable Maternal and Child Health service planners and managers to integrate mental health care into the services they provide. The guide will be further amended based on the global expert review process that took place in late 2021 and the field testing planned for two African countries in 2022.
mhGAP Intervention Guide for mental, neurological, and substance use disorders in non-specialized settings Version 2.0	Tool for providers (primary care doctors, nurses, healthcare workers, etc.) to deliver care for people with mental, neurological, and substance use disorders.
WHO EQUIP Platform	Online resource with training modules to facilitate competency-based training in common factors of psychosocial support and foundational helping skills (communication, empathy, collaboration, etc.).

Table 2. Resources Informing Capstone Project Design

Deliverable: Cinematic Training Package

Cultural representation is an essential indicator for scaling up psychosocial support in low-resource settings (Jordans & Kohrt, 2020). Therefore, film design and production in-country were a priority in creating a successful project. Proposal writing and fundraising were also necessary to ensure film design, production quality, reach, and impact. Thus, key stakeholder collaboration led to the involvement of a local film production team to film the training demonstrations. The reflection of people, places, language, and struggles that South Africans can identify with aims to increase the feasibility and acceptability of the training package. Role-play scenes, engaging key stakeholders throughout the film production process, including contextually representative footage, and utilizing simple language that avoids technical jargon aligns with evidence supporting the effectiveness of digital training in increasing competency of healthcare workers to deliver psychosocial care in low-resource settings (Khan et al., 2020; Muke et al., 2019; Muke et al., 2020; Rahman et al., 2019).

Script revision to ensure cultural relevance led to the four-scene film described in Table 3. A combination of resources and psychosocial support strategies utilized in the scripts reflects the evidence for scaling up mental healthcare in low-resource settings described in Chapter Two. Empathy is the most-cited treatment element in providing psychosocial care and thus the six empathic skills are embedded throughout the positive engagement scene (Honikman et al., 2020a; Kohrt et al., 2020a; Singla et al., 2017). Principles of behavioral activation, problem-solving therapy, and psychoeducation emphasize the value of participating in meaningful occupations, collaboratively

identifying solutions, and normalizing maternal mental illness and treatment (Boisets et al., 2021; Lund et al., 2020; Nyatsanza et al., 2016; Spedding et al., 2018). The character vignette (Appendix D) that formed the basis of the patient's dialogue in the engagement scenes reflects collective experience of perinatal women in South Africa who live in socially adverse environments (Boisets et al., 2021; Brown et al., 2020; Brown & Sprague, 2021; Lund et al., 2018).

Scene	Description	Intervention elements
Scene 1: Tea Room (~8min)	- 4 nurses/midwives gather to chat during their break in the tearoom of a Midwife Obstetric Unit. They express common experiences of distress present within their lives and work lives. staff stress and mental health issues, acknowledging the psychosocial needs of their clients, screening/referring clients - Two nurses express pro-mental healthcare sentiment, and two nurses demonstrate resistance to integration of mental health in maternity settings	- Staff stress and mental health issues based on the evidence - Acknowledging psychosocial needs of clients - Screening/referring clients - Mental health promotion and integration, self-care skills, destigmatizing mental health
Scene 2: Waiting Room Talk (~4 minutes)	- Extras are seated in the ANC waiting room, waiting to be called for their appointments - Two nurses enter, holding pamphlets, and begin a patient education discussion about perinatal mental health promotion, prevention, and treatment	- OT: impact of CPMDs on daily functioning - Behavioral activation principles: participation in meaningful activities - Destigmatizing mental health - Risk factors of CPMDs
Scene 3: Negative Engagement (~3 minutes)	- Structured roleplay between a nurse/midwife and a patient in an ANC clinic. The nurse does not practice respectful maternity care or empathic skills, rotely administers the 3-item mental health screen and does not detect CPMD.	- ENACT tool: unhelpful or potentially harmful behaviors (e.g., inappropriate facial expressions, accusatory statements, minimizes client's problems, criticizes client for letting symptoms impact functioning)

Scene 4: Positive Engagement (~10 minutes)	- Structured roleplay between nurse/midwife and the same patient in an ANC clinic. This nurse demonstrates respectful maternity care and empathic skills, detects CPMD using 3-item screen, provides psychosocial support, makes successful referral	- OT: connecting symptoms to daily functioning and impact on life, teach-back method - 6 empathic skills - Problem-solving therapy - ENACT tool: basic helping skills (open-ended questions, collaborative goal setting, psychoeducation with local terminology)

Table 3. Contents of the Film

Filming Process

Engagement and coordination with multiple key stakeholders resulted in film production of the four scenes during one, 10-hour day at the Mowbray Maternity Hospital in Cape Town, South Africa (Appendix E). I was present on set as script supervisor and assistant director to consult for coordination of actors, scene direction and setup. Simone Honikman was also present on set for consultation. Ross Cupido, cinematographer, was responsible for the creative filming techniques and led the Cutaway Pictures production team to capture quality camera footage and audio during each scene. The actors came prepared and were able to successfully deliver their lines with minimal takes throughout all four scenes. Snapshots of each scene can be found in Appendix F.

The project involves utilizing the power of cinematic storytelling so that thousands of healthcare workers across South Africa will have access to an authentic and innovative training package that expresses typical challenges faced in the field of maternal healthcare and strategies to begin to address them. Specifically, implementation aims to enhance the competency of the maternity care workers to provide psychosocial support, utilize self-care strategies, and reduce stigmatizing attitudes that prevent

detection and treatment of common perinatal mental disorders.

Barriers to Implementation

Feasibility and acceptability within cultural context of South Africa is the most pressing barrier. The barrier aims to be addressed via ongoing communication with key stakeholders in South Africa (Simone Honikman, PMHP, community partners, Cutaway Pictures), as well as gathering stakeholder feedback to assess feasibility and acceptability of the cinematic training film.

Another relevant barrier is the time, cost, and logistical constraints in design and implementation of the cinematic training package. Building connections with key stakeholders, developing fundraising skills, and utilizing free resources accounted for such constraints. A significant amount of fundraising for the production and editing of the film was required. After submitting funding proposals (Appendix G) to three entities who were unable to provide financial support for the project, a fundraising campaign on GivenGain's platform was created and managed. Please see Appendix H for examples of campaign marketing images.

Although the immediate target population is maternity care workers, the impact of the cinematic training package on this population will not be assessed due to the scope of the project. Thus, another key population will also be left out, and that is the women with CPMDs.

CHAPTER FOUR: EVALUATION PLAN & OUTCOMES

Method for Evaluation

Scripts

After creation of the initial scripts for each scene, there were multiple rounds of revision with key stakeholders for language, names, cultural relevance and expression of depression and anxiety, and local idioms of distress. Two PMHP counselors at Hanover Park's MOU, who have experience identifying and treating perinatal women with CPMDs, and one midwife who works with antenatal and postnatal women in a low-resource setting, sense-checked the scripts for local relevance and representation. Simone Honikman also provided revision in local relevance, as well as film content (empathic care, psychoeducation, maternal mental health promotion, screening, and referral). In addition, one Xhosa-speaking actress personalized her character by adding Xhosa expressions to her dialogue.

Cinematic Training Package

Once the film editor finished the rough draft of the film and it was shared with the PMHP team, the next step was to co-host and facilitate a stakeholder feedback workshop via Zoom with Simone Honikman to engage in a group discussion regarding the film's content, editing, and implementation plans. Workshop topics covered:

- Introduction of the project and the occupational therapy lens; project and workshop goals
- Overall impressions of the film
- Psychosocial support strategies used and the role of nurses

- Editing/stylistic comments
- Cinematic training package as a stand-alone or part of a training package
- Intended audience and delivery method
- Evaluation and quantifying impact

The workshop provided an opportunity to advocate for the role of occupational therapy in perinatal mental health to the key stakeholders in South Africa listed in Table 4. Stakeholders who were unable to attend the workshop session provided written feedback via email.

Stakeholder	Professional background	Years of experience	Location	Method of feedback
Stakeholder #1	Embrace activist, movement for mothers	4	South Africa	Email
Stakeholder #2	Maternal mental health, service delivery	17	South Africa	Email
Stakeholder #3	Midwife educator, researcher	20	South Africa	Email
Stakeholder #4	Academic in maternal health	16	South Africa	Email
Stakeholder #5	Maternal health activist, Embrace	8	South Africa	Workshop
Stakeholder #6	PMHP Clinical services coordinator-Hanover Park MOU	11	South Africa	Workshop
Stakeholder #7	Researcher, obstetric violence	2	South Africa	Workshop
Stakeholder #8	Family physician	12	South Africa	Email
Stakeholder #9	Researcher, maternal mental health	3	South Africa	Workshop
Stakeholder #10	Mental health counselor, PMHP	6	South Africa	Workshop
Stakeholder #11	PMHP Mental health counselor-Hanover Park MOU	2	South Africa	Workshop
Stakeholder #12	Maternal health	18 years	South Africa	Email
Stakeholder #13	Researcher, respectful maternity care	n/a	South Africa	Workshop

Stakeholder #14	MOU operational manager	n/a	South Africa	Workshop
Stakeholder #15	MOU operational manager	n/a	South Africa	Workshop
Stakeholder #16	Maternal health activist, Embrace	n/a	South Africa	Workshop
Stakeholder #17	Researcher, maternal health	n/a	South Africa	Email
Stakeholder #18	Researcher, gender inequality	n/a	South Africa	Email
Stakeholder #19	Clinical psychologist, perinatal mental health	17	South Africa	Email

Table 4. Key Stakeholders Providing Film Feedback

To evaluate the film's acceptability and feasibility in relation to capstone objectives and contextual fit within South Africa, a survey was administered to all stakeholders who provided feedback via email or workshop. The film was evaluated based on the criterion of relevance described in Jordans & Kohrt's (2020) 'roadmap to impact' for scaling up mental healthcare and psychosocial support in low-resource settings, because 'fit' with culture and context is a key indicator for intervention relevance. Bowen et al. (2009) also guided development of survey items based on several domains of feasibility. Table 5 lists the items included in the survey and their respective evaluative domain, in which respondents rated each item on a 5-point Likert scale from *1= completely disagree* to *2= completely agree*. Delivery of the survey did not meet Boston University's definition of research according to IRB determination.

Item	Domain of evaluation
1. The roles of nurses portrayed in the film are contextually appropriate, i.e. the film taps into key barriers for nurses working in low-resource maternal settings in South Africa	Acceptability of role nurses: contextual fit
2. The role of the patient (woman with common perinatal mental disorder) portrayed in the film is contextually appropriate, i.e. the film taps into typical lived experiences and key barriers to care for perinatal women living in low-resource settings in South Africa	Acceptability of role of patient: contextual fit
3. The management approaches used within the film (empathic care, psychoeducation, health promotion, basic helping skills, promotion of functioning, screening & referral) are suitable and meet my approval	Acceptability: content
4. The way in which the management approaches are demonstrated within the film (tea room scene with four nurses, waiting room talk, positive engagement scene) is suitable and meets my approval	Acceptability: content delivery
5. Maternity care workers would use the film to better address maternal mental health and demonstrate improved respectful maternity care in their daily practice	Demand
6. The film could be implemented as a stand-alone training resource to maternity care workers/trainers in low-resource settings in South Africa	Implementation in South Africa
7. The film could be implemented as a stand-alone training resource to maternity care workers/trainers in low and middle-income countries other than South Africa	Implementation in LMICs
8. The film could be integrated and utilized within existing training programs in South Africa	Integration
9. The film addresses gaps in education or training approaches to empathic care in South Africa	Capstone objective

Table 5. Evaluation of Film Relevance Survey

Findings: Stakeholder Feedback

Ten stakeholders attended the virtual stakeholder feedback workshop via Zoom, and 9 stakeholders provided written feedback via email. A total of 13 stakeholders completed the Evaluation of Film Relevance survey, and their responses are displayed in Figure 2.

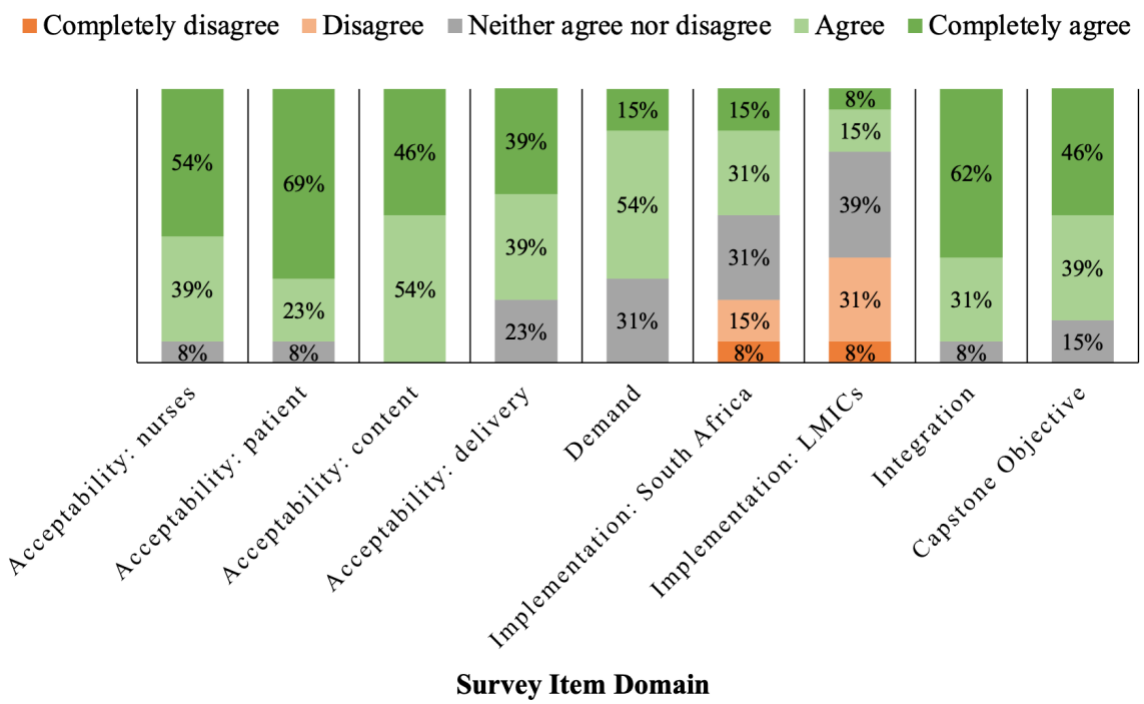


Figure 2. Evaluation of Film Relevance Among Key Stakeholders

Collective feedback from the stakeholder workshop together with written feedback revealed that the film contained relevant portrayals of the main problems facing integration of mental health and respectful maternity care in maternal settings by addressing the issues faced by both providers and patients. Ninety-two percent [12] of the survey respondents agreed or completely agreed that the roles of the nurses and the role of the patient in the film are contextually appropriate. Stakeholders appreciated the film's acknowledgment of nurses' own mental health needs and the typical structural barriers that they face:

- I like the way that the problems that nurses have are acknowledged at the start. It gives context and recognition of their issues. [Stakeholder #2]
- [I] thought this was absolutely great and highlighted a number of issues around common perinatal mental disorder[s], management approaches and limitations faced by nurses trying to provide physical and emotional care to clients [Survey Respondent]

- I also loved the way these were sisters speaking to each other so there was no top-down approach. I found that refreshing. So the modelling of ways of thinking and doing that make space for positive change and positive incorporation of what might be challenging additions into a work day and way of practicing - while acknowledging the difficulties - is an aspect of this film that I think works really well. [Stakeholder #4]

The dismal reality of the patient experience in maternal settings was echoed by several stakeholders:

- The negative engagement scene was heart-breaking and unfortunately true to what a lot of moms experience. It was a great depiction, and also great that it was one of the nurses who was the least sympathetic when discussing patients earlier. [Stakeholder #1]

Stakeholders were generally pleased with aspects of the film's content (respectful maternity care, health promotion, basic helping skills, empathic care, psychoeducation, promotion of functioning), as 100% of survey respondents agreed or completely agreed that these management approaches were acceptable.

- the concept of showing respect, for example, calling the person's name and then checking that you're pronouncing it right is such a simple thing, but it signifies so much and I thought that was really, really powerful [Stakeholder #5]

However, stakeholders raised valuable feedback regarding delivery of the film's content in relation to editing. For example, most stakeholders agreed that the film would greatly benefit from reducing the length of the positive engagement scene and adding on-screen text to highlight learning points and basic helping skills. Some stakeholders expressed concerns about the positive engagement scene being too idealistic and daunting for midwives to implement, as it more closely resembled a counseling session than a routine care appointment where midwives are also tasked to assess physical health and medical history. Additionally, one stakeholder pointed out that we may be reinforcing the idea that some nurses are naturally better at empathy than others, stating:

- In the positive engagement piece, I would have liked to see the same nurse [the disinterested nurse from the tearoom scene] engaging positively with the patient. There is often the idea of one bad apple ruining the bunch. The converse idea that only some nurses are caring and certain nurses are more caring than others is also well ingrained. At the moment, the nurse who was seen doing the negative engagement is sort of demonised. Especially because she already comes across as that nurse in the tea-room scene. So I would have liked to see the transformation in an individual we already know is potentially problematic. [Stakeholder #4]

While presenting issues faced by both providers and patients was appreciated by all, stakeholders felt that the shift in tone between the tearoom scene with nurses and the positive/negative engagement scenes required more deliberate transitions and editing. Some stakeholders indicated a preference for more interactive moments to be added to the film to stimulate discussions around referrals, respectful maternity care, feasibility of mental health promotion in the clinic, solutions to common barriers faced by maternity care workers, and continuity of care. Two stakeholders also noted the need to clarify the importance of patient autonomy and their right to refuse care.

We received mixed feedback about implementation of the film, only 46% [6] of survey respondents agreed or completely agreed that the film could stand alone as a training resource to maternity care workers in South Africa. Stakeholders suggested that information is needed within the film (interactive questions, on-screen text), but even with these added elements, they felt that other resources (manual, toolkit, facilitator) may also need to be provided to complement the film. However, 92% [12] of the stakeholders agreed or completely agreed that the film could be integrated and utilized within existing training programs in South Africa, supporting the film's fit within existing infrastructure. Regarding generalization to other contexts, only 23% [3] of the respondents agreed or completely agreed that the film could be implemented as a stand-alone resource in

LMICs other than South Africa. These feelings confirm the highly contextualized nature of addressing maternal mental health, and that themes from the film may not resonate with providers in low-resource settings beyond South Africa. Finally, one of the primary objectives of the Doctoral Capstone was to address gaps in education or training approaches to empathic care in South Africa, and 85% [11] of the respondents agreed or completely agreed that the film accomplished this.

A concern from several stakeholders was the need to model respectful maternity care through labor and postnatally, though this is beyond the scope and objectives of the cinematic training package. The obstetric violence seen in labor wards is a pressing issue that stakeholders want to see addressed, so perhaps future work in cinematic training can tackle this complex human rights violation.

Additionally, the film was shown by a PMHP counselor to approximately 15 maternity care workers (midwives, nurses, and a doctor), one of the most significant groups of key stakeholders, at Hanover Park's Midwife Obstetric Unit for a group viewing of the film. Much of the feedback echoed concerns from other stakeholders, such as the length of certain scenes, the unrealistic positive engagement scene, and the need for an increased emphasis on addressing the mental health issues of staff. One maternity care worker stated, "We can see ourselves in the sister in the negative scene," and some of the staff raised concern that the scene reinforces bad behavior with no consequences. The film may benefit from humanizing the nurse who performs the negative engagement scene while also allowing maternity care workers and their managers to consider possible consequences to this type of behavior. The film has spurred the staff to consider their

own setting, as one maternity care worker stated, “this is learned behavior, subconscious, we’ve learned it. It is a systemic problem and goes beyond the nurses. There is a lot that is being put on us. It has always been like this, staff are overburdened.” Overall, the staff felt that the film was relatable, could be very useful in training maternity care workers, may be useful for students on rotation at the MOU who may learn from nurses who do not model respectful care, and that the film reinforces the need for staff to hold regular debriefing sessions. The viewing of the film also alerted MOU staff to enact immediate changes regarding patients’ right to privacy and retrieving patients from the clinic in a more appropriate way.

Integration of Feedback for the Cinematic Training Package

Synthesis and integration of the feedback into feasible edits revealed an ongoing tension between capturing a variety of stakeholder perspectives and making the film’s content digestible for its audience. For example, the film has raised many different points regarding consent, patients’ right to refuse care, obstetric violence during labor, confidentiality, and how to manage a patient who reveals suicidal thoughts and plans. While we regard all points as important considerations of quality maternity care, the primary purpose of the film is to demonstrate how to integrate mental health into a part of routine maternity care. Feedback was synthesized with Simone Honikman, and included the following edits:

- Shortening of the positive engagement scene to reflect a more realistic routine, maternity care encounter
- Pauses for interactive discussion points between scenes

- On-screen text to illuminate key learning points (empathic care, basic helping skills)
- Humanizing the nurse in the negative engagement scene
- Title of film: *No Maternal Health Without Mental Health*

The film editor then received these edits and produced the final cut of the film to create the cinematic training package.

CHAPTER FIVE: DISSEMINATION PLAN

A cinematic training package will be disseminated that acknowledges the common barriers and sources of stress that maternity care workers in low-resource settings face and promotes the integration of mental health and psychosocial support into routine perinatal care. The cinematic training package includes a 20-minute film featuring four scenes that follow several midwives as they discuss the challenges of providing psychosocial support to their patients while dealing with their own work and personal stressors, promote mental health care to patients and their family in the waiting room, and demonstrate a positive engagement, screening, and referral of a patient with a common perinatal mental disorder contrasted with a negative engagement.

Dissemination of key messages from the Doctoral Capstone focus on two categories, occupational therapy-related goals, and impact-related goals. A long-term goal is to promote the value of occupational therapy in addressing perinatal mental health and the high burden of CPMDs. This involves enhanced knowledge of CPMDs and their impact on occupational functioning by members of the profession as well as key stakeholders in service delivery and design. Solutions to addressing the treatment gap, proposed in Chapter 1, must be multidisciplinary in nature and occupational therapists are well-equipped to provide expertise in this field.

My long-term impact-related goal is for health systems to better integrate mental health care into maternity settings (scale-up psychosocial support), and thus for women with CPMDs in low-resource settings to experience improved wellbeing and daily functioning. Implementation of national and provincial policy is lacking in South Africa.

Policies and clinics must prioritize perinatal mental health by providing resources to their maternity care workers so that they are better able to instill therapeutic engagement methods into their daily interactions with perinatal women. This involves more funding for mental health resources and making work conditions more desirable for maternity care workers. The cinematic training package aims to point out not only the need for capacity building of the maternity care workforce, but also the need for better structural supports for care workers themselves.

The target audience is maternity care workers and trainers of maternity care workers. Secondary audiences include a multitude of key stakeholders: from clinic staff and physicians in maternity care, to health management teams and governmental health departments, to non-governmental organizations and occupational therapists. Key messages to maternity care workers and their trainers highlight agency among the healthcare workforce in implementing meaningful change: mental health promotion, screening, and referral can be integrated into routine maternity care, even in low-resource settings with seemingly little supports in place; demonstrating empathy toward perinatal women seeking routine maternity care has the power to improve mental health outcomes. Final key messages of the Doctoral Project advocate for the value of occupational therapy in prioritizing perinatal mental health: occupational therapists can evaluate both the contextual factors, or socioeconomic inequities that are often drivers of mental illness, and the mental health needs of perinatal women, while providing client-centered care through the therapeutic use of daily occupations; promotion of perinatal mental health is within the scope of occupational therapy and can include mobilizing community

partnerships, as seen in this Doctoral Capstone, as well as community-centered programs to address disparities in healthcare access (Bass & Baker, 2017).

Specific sources and messengers mentioned throughout the report will be contacted throughout the dissemination process and include Simone Honikman of PMHP, the PMHP team, NDOH in South Africa, and stakeholders who have provided feedback and wish to disseminate the film at their conferences, within their organizations, and to their students.

Dissemination Activities

In partnership with PMHP, the cinematic training package will be implemented within the 'Knowledge Hub' resource portal of the NDOH, and potentially into the Essential Steps in the Management of Obstetric Emergencies (ESMOE) training program. We have also given permission for stakeholders to share the film at the 40th National Congress of the South African Society of Obstetrics & Gynaecologists.

A written report for publication in the Boston University Library will be prepared. Since the Doctoral Capstone deliverable is a cinematic training package, the viewing of the film by a wide range of audiences is a form of electronic media dissemination and consumption. Additionally, the annual magazine *Inside Sargent* provides a potential space for the work of the project and the innovative training package to be shared with colleagues at Sargent College and in the United States. This project is congruent with Sargent College's strategic plan, including the overarching goal to: Be the global leader for health education, research, and practice by 2040. Specifically, this capstone aligns with strategic objective statement M-1—Build Sargent image as global leader—and

promotes health equity, implementation, and health systems strengthening. Thus, an article about the project, that includes a link to the film, could also be shared on the Sargent website.

Disseminating the Doctoral Capstone via person-to-person contact at the following conferences will also be investigated: MAOT, AOTA 2024, AOTA MHSIS 2024, Annual Postpartum Support International Conference, WFOT International Congress and Exhibition 2024, and the 2024 Biennial Conference of the International Marcé Society.

Evaluating success of dissemination efforts may include conference acceptance, quantifying the impact by the number of downloads on the 'Knowledge Hub' website, an article on the Sargent website or *Inside Sargent* magazine, and increased public awareness of maternal mental health and the value of OT in promoting perinatal mental health.

CHAPTER SIX: CONCLUSION

The development of a cinematic training package for maternity care workers in South Africa presents an innovative and contextually relevant method of addressing the high burden of common perinatal mental disorders in low-resource settings. Stakeholders from multiple disciplines and health sectors welcomed the film as a model of integrating maternal mental health into routine care that also acknowledges the challenges experienced by nurses, who are often overworked and underpaid. Dissemination of the cinematic training package to accessible online portals governed by the NDOH will target maternity care workers and their trainers to better address maternal mental health and demonstrate improved respectful maternity care in their daily practice. The project represented a collaborative, interdisciplinary effort to address the lack of early identification and treatment of women with common perinatal mental disorders living in low-resource settings, where the role of occupational therapy is only just emerging. By mobilizing community resources and partnerships to engage in large-scale mental health promotion and capacity-building of providers, the Doctoral Capstone demonstrated that occupational therapy can provide a strengths-based approach to addressing perinatal mental health.

A critical lesson learned throughout the development of this project is the importance of building community relationships when engaging in scaling efforts to enhance the quality and accessibility of psychosocial support in low-resource settings. Cosgrove et al. (2020) argue that such efforts would be better described as “scaling across” versus “scaling up” to encourage strength-based approaches that capitalize on

community resources and center the voices of services users with lived experience, which in the case of this project would be the women with common perinatal mental disorders. Although we were unable to gather feedback from such a vulnerable population, recommendations for centering the service user and other future initiatives are listed below:

- Provide suggestions for the customizability of the cinematic training package (additional resources, toolkits, interactive discussion questions, etc.)
- Field-testing usability on the NODH 'Knowledge Hub' and ESMOE system
- Evaluating the impact of cinematic training package on maternity care workers: pre-/post-test of knowledge or confidence in providing psychosocial support during routine maternal care
- Evaluating the impact on mental health and wellbeing of perinatal women and women with CPMDs (e.g., 1 maternity care worker trained = X number of women impacted)
- Dissemination of the cinematic training package through other mediums (universities, community clinics, continuous professional development, various health discipline curricula)
- Advocate for the role of occupational therapy in perinatal mental health promotion and care: intervention design to improve healthcare access; create community-based programming; referral option for women with CPMDs; integration into maternity care to evaluate, assess and treat

APPENDIX A: Executive Summary

Prioritizing Perinatal Mental Health in South Africa: Development of a Cinematic Training Package for Maternity Care Workers in Low-resource Settings

Leah Smith

Anne Escher, OTD, OTR
Clinical Assistant Professor, Department of Occupational Therapy

Project Goal: The primary goal of the project was to address gaps in training and education approaches to empathic care in South Africa through the development of a contextually relevant film that encourages mental health promotion in routine maternity care. The film was developed for maternity care workers and their trainers. The training package aims to acknowledge the mental health needs of staff in low-resource settings and the key barriers to integrating mental health and empathic care into daily practice. Demonstrating empathy and person-centered care can be effective in addressing the psychosocial needs of women during the perinatal period.

Background: Women are at the greatest risk of mental illness during pregnancy and one-year postpartum. In South Africa, one in three mothers will experience depression or anxiety during this time. Although the burden of perinatal mental illness is high, it is not prioritized in South African healthcare and thus often goes undetected and untreated. Other barriers to treatment include stigma, poverty, and a lack of provider training in addressing psychosocial concerns. Consequences of untreated perinatal mental illness include maternal suicide, poor quality of life, developmental delays for the child, and high healthcare costs. In low-resource settings like those throughout much of South Africa, “task-sharing” or “task-shifting” strengthens existing health systems by training

healthcare workers to provide psychosocial support. Since 97% of South African women attend their antenatal care appointments, the maternity setting is an excellent opportunity to increase access to mental health care. Training nurses to engage in mental health promotion, screening, and referral for their clients, as well as supporting nurses in their own mental health issues, can destigmatize mental health care and increase the number of mothers who receive treatment.

Project Overview: Community engagement and collaboration in Cape Town, South Africa led to the development of film content, production, and editing. Key stakeholders reviewed the scripts and the first draft of the film for contextual relevance. Feedback from a variety of stakeholders in multiple disciplines was synthesized to inform the final cut of the film. The role of occupational therapy in perinatal mental health informed script development and was advocated to key stakeholders in healthcare, research, academia, health facility management, and non-governmental organizations.

Outcomes: Stakeholders welcomed the innovative cinematic training package as contextually appropriate. Although stakeholders appreciated the film's content, they felt that the film would benefit from shorter scenes, interactive elements, and on-screen text to emphasize learning skills.

Recommendations: To capture the impact of the project, dissemination efforts and their effect on maternity care workers and women receiving maternity care should be tracked. Given the highly contextualized nature of maternity care, the training package should be easily customizable and integrated within community clinics. Finally, there should be continued advocacy for the role of occupational therapy in perinatal mental health.

APPENDIX B: Logic Model

Resources	Activities	Outputs	Outcomes: Short-term	Outcomes: Long-term
• Academic and site mentors • PMHP personnel and resources • Consulting mentor • WHO EQUIP Platform • Key stakeholders in South Africa and Boston with contextual expertise and support • Internal/external funding for video production • Required equipment, locations, actors, filming/editing • BU Service Learning & EDU Africa in Cape Town	**Advocacy** • Review OT literature • Present on role of OT in perinatal mental health to PMHP team **Program development** • Needs assessment • Engagement with key stakeholders • Synthesize findings, resources, WHO EQUIP courses, etc. • Secure funding, equipment, volunteers • Production of digital training content (rehearsal, filming, editing) • Gather stakeholder feedback **Capacity Building** • Disseminate digital training to PMHP, South Africa NDOH	• Report of distinct value of OT in perinatal mental health • # of hours spent at PMHP clinic • # of key stakeholders engaged with in South Africa • # of EQUIP courses completed • outcome measures identified • # of digital training modules/scenes created • # of volunteers, actors, equipment & locations identified • Report of improvements & recommendations for the future • Results of feasibility/acceptability analysis	• Enhanced knowledge about the purpose and value of OT in perinatal mental health by key stakeholders in South Africa • Increased knowledge in functional implications of CPMDs by key stakeholders • Creation of accessible and feasible digital training package • Professional development in mobilizing community resources, fundraising, program development skills, cultural humility, advocacy, interprofessional collaboration & capacity building	• Integration of OT services within perinatal mental health promotion • Utilization of measures of occupational functioning in perinatal mental health research • Scaling up of psychosocial support in maternal settings in South Africa • Enhanced understanding of therapeutic engagement methods and mental health literacy among maternity care workers • Cultural shift in patient-provider dynamics and demonstration of empathic care by nurses • Established partnerships in promotion of perinatal mental health • Reduction in treatment gap for women with CPMDs in South Africa • Improved mental wellbeing & daily functioning for women with CPMDs in low-resource settings

APPENDIX C: Mental Health Screen

MENTAL HEALTH SCREEN

ONLY to be conducted if resources are available for referral, e.g. mental health nurse, social worker, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

"We would like to know about all the women who come here: how they are doing physically and emotionally. This helps us to understand the best sort of care we can offer. Please may I ask you three questions about how you are emotionally? Please answer 'yes' or 'no' to each question."

In the last 2 weeks, have you on some or most days felt unable to stop worrying or thinking too much?	Yes [1]	No [0]
In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	Yes [1]	No [0]
In the last 2 weeks, have you on some or most days had thoughts **and** plans to harm yourself or commit suicide?*	Yes [1] **Refer**	No [0]
TOTAL SCORE	1 2 >>>>>>>>>>> refer 3 >>>>>>>>>>> refer	
Offered Counselling	Yes	No
Accepted counselling	Yes	No

**the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.*

APPENDIX D: Character Vignette

You are Sharlene. You are 20 years old and living in Hanover Park. You are pregnant with your second child and your partner is physically abusive. The pregnancy was unexpected and you feel guilty and ashamed for not wanting the baby. You now have been trying to make money in service jobs in the city but are struggling to get enough hours per week. The lack of hours at your new job leaves you very stressed and worried about how you and your baby will manage. You are finding it very difficult to stay motivated and are feeling more tired and sluggish every day. Lately, your entire body will feel painful, and you struggle to get out of bed in the morning to make it to your shifts. You have not told your partner that your hours are getting cut. You are having difficulty deciding if you should tell him. You feel guilty and ashamed and do not want to provoke your partner to violence. You are worried you will not be able to provide nappies and clothes for your baby, and you are not feeling excited about the pregnancy. You are feeling so alone, and it is like you cannot do anything about it. You are not sleeping well and feel very tired all of the time. You have trouble concentrating and sometimes feel like the world is closing in on you. It feels as though your life is falling to pieces and you are afraid that you and your baby will end up homeless. Or what if partner leaves you? You have been smoking a lot to cope with these feelings and fears. You used to enjoy going for morning walks and seeing friends on the weekend. But, with all of your problems, it is hard to find energy for walks and you feel like your friends don't want you around anyway. Since this is your first pregnancy, you are intimidated by questions and directions posed by the nurse at the clinic and make limited eye contact.

APPENDIX E: Call Sheet

Screening & Referral within Negative and Positive engagement PMHP

CUTAWAY PICTURES PTY (Ltd)

Shoot Date 11/06/2022

Producer	Simone Honikman
Director	Ross Cupido
Story-liner	Leah Smith
Nearest Hospital Mowbray Maternity	
Address Line 1	

CAPSTONE SHORT FILM (TRAINING MATERIAL)

		CRAFT SERVICES	
LUNCH	01:00 PM	Simone .H	
SUNRISE		**SUNSET**	
07:48 AM		05:43 PM	
WEATHER	UV 2 of 10	N 29Km.h	27°
Humidity	34%	Partly Cloudy	

Sample Note 1: Individual call times may vary. **NO SOCIAL MEDIA**CLOSED SET**
Sample Note 2: Questions? Simone Honikman **********

CALL	**8 AM**

LOCATION: MOWBRAY MATERNITY HOSPITAL
ESTIMATED WRAP TIME 18:00 PM

SCENES	SET AND DESCRIPTION	CHARACTER #	D/N	PAGES	LOCATION/NOTES
1	**SET 1- Waiting Room Area**	Sr Olivier, Sr Bhengu	Day	3	Scene to be filmed in the "waiting area" all extras plus Sr Olivier, Sr Bhengu. Record time: 09:30-10:30
	Two Nurses are addressing a group of patients waiting to be called for their appointments (extra's needed)				
2	**SET 2- Scene 3 Positive Engagement**	Sharlene, Sr Olivier	Day	6	First section of this scene to filmed in the corridor waiting area and the corridor next to it. Second section to be filmed in the private room. Record time: 11:00-11:45
	Nurse does a screening and referral in a positive way with Patient. (no extras)				
3	**SET 3- Scene 2 Negative Engagement**	Sharlene, Sr Khumalo	Day	3	This is to be filmed almost identical to that of scene 2. Record time: 12:15-13:00
	Nurse does a negative screening and referral with patient, (extra and nurse Avril to be used in this scene)				
Lunch	**Lunch Break**				
	13:00-14:00				
4	**SET 4- Tea Room Scene**	Sr Bhengu, Sr Olivier, Sr Jacobs, Sr Bhengu	Day	3	Scene to be filmed in the tea room. Slider needed for this scene. Record time: 14:00-15:00
	4 Nurses are chatting in their break about their issues faced in the workforce and at home. (no extra's)				
		TOTAL PAGES		15	

#	CAST	CHARACTER	C/W	MU	SET	MINOR?	SPECIAL INSTRUCTIONS
	T.P.	Sherlene Adonis	08:15:00	08:30:00	09:15:00	N	Actor to be on set 30 minutes before record time
	L.H.	St Olivier	08:15:00	08:30:00	09:15:00	N	Actor to be on set 30 minutes before record time
	K.	St Khumalo	10:00:00	10:30:00	10:45:00	N	Actor to be on set 30 minutes before record time
	S.S.	St Bhengu	08:15:00	08:30:00	09:15:00	N	Actor to be on set 30 minutes before record time
	A.H.	St Jacobs	11:00:00	11:30:00	11:45:00	N	Actor to be on set 30 minutes before record time
	Z.N.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	S.M.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	S.Z.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	N.S.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	S.C.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	K.C.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time
	K.A.	Extra	08:15:00	08:30:00	09:00:00	N	Extra to be on set 30 Minutes before record time

PRODUCTION NOTES	
Production Note 1 Production Note 2 Production Note 3 Production Note 4	Allowed Guests No. of Stand-ins Special Props- Pregnant costumes, pamphlets, lunch boxes , coffee mugs and travel mugs Special Atmosphere

POSITION	NAME	PHONE	IN
Director/Dir. of Photography	Ross Cupido		08:00:00
1st AD	Leah Smith		08:00:00
1st AC	O.J.		08:00:00
Key Grip	S.M.		08:00:00
Best Boy Grip	J.A.		08:00:00
Audio Mixer	L.J.		08:00:00
Boom Swinger	S.S.		08:00:00

POSITION	NAME	PHONE	IN

APPENDIX F: Scene Snapshots

Scene 1: Tearoom

Scene 2: Waiting Room Talk

Scene 3: Negative Engagement

Scene 4: Positive Engagement

APPENDIX G: Budget Proposal

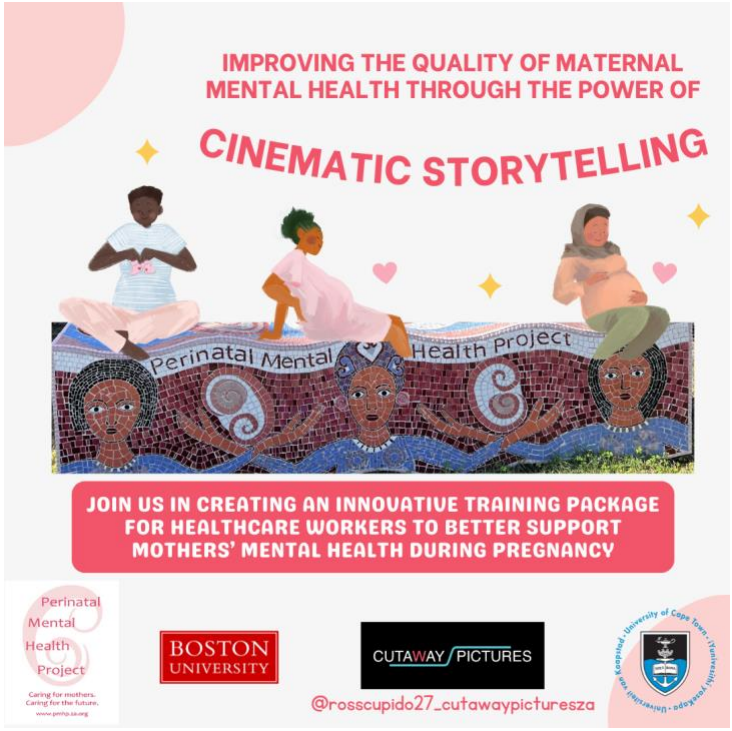
Itemized Budget

Total

R22,022.50

Item	Cost
Director/Cinematographer	R3,000.00
Camera Assistant	R850.00
Lighting Technician	R850.00
Sound Recorder/Boom Swinger	R850.00
Film Equipmennt:	
3x Sony a7iiis Camera Kits	R6,840.00
1x Sony 16-35mm F2,8 Lens	R440.00
1x Sony 24-70mm F2,8 Lens	R440.00
1x Sony 70-200mm F2,8 Lens	R440.00
3x Razyr Panel Light Kit	R1,800.00
3x Radio Lapel Mic Kit	R960.00
1x 416 Radio Mic with Boom Pole	R600.00
1x Zoom F8 Sound Recorder Kit	R680.00
1x 5 In 1 Reflector	R200.00
Dji Ronin SC 3 Axis Gimbal Kit	R1,200.00
VAT (15% tax)	R2,872.50

APPENDIX H: Campaign Images



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