Development of mental health guidelines to be followed throughout the perinatal period in Zimbabwe

By

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ABSTRACT

This study was carried out as part of efforts to analyse the maternal mental health interventions that are done by midwives on women and then develop mental health guidelines to be followed throughout the perinatal period in Zimbabwe. The objectives were to: analyse the effectiveness of the mental health interventions offered by midwives; measure and analyse the extent to which the levels of the psychosocial markers reflect effectiveness of the mental health interventions; explore and describe the experiences of women, midwives and key informants on the effectiveness of the mental health interventions and to develop mental health guidelines that will direct mental health interventions throughout the perinatal period in Zimbabwe.

The sequential explanatory mixed method design comprising both quantitative and qualitative methods was employed. The study was divided into three phases; the quantitative then qualitative and finally the development of guidelines phase. In the quantitative phase, a Quality of Life Enjoyment and Satisfaction Short form (Q-LES-SF) scale was used to measure the psychosocial scores on a purposive sample of 300 women in the third trimester of pregnancy, who had attended at least three antenatal reviews. In the same phase, a document analysis checklist was also used for retrospective analysis of the recordings of the mental health interventions on women's maternity records from the antenatal period till discharge after childbirth. The population for the document analysis comprised 499 maternity records of women who had attended antenatal reviews and had delivered normally.

Interview guides were used to conduct in-depth interviews with women, midwives and key informants. Sixteen (16) women within the age range of 22 to 38 years participated in the study. These were women who had a normal vaginal delivery and were within two months post childbirth. In-depth interviews were also conducted on 17 midwives and nine (9) key informants who participated in the study. Quantitative data for the two instruments were analysed using descriptive statistics on SPSS Version 23 package. Qualitative data were analysed through data reduction, data display and generation of categories and themes.

The Q-LES-Q-SF psychosocial scale and the document analysis revealed that women have psychosocial challenges but there was lack of mental health interventions to ameliorate these challenges. The psychosocial scores were generally poor indicating that perinatal interventions are lacking or are not making much impact on the mental and social wellbeing of women in the third trimester of pregnancy. All the demographic variables were not necessarily linked to the quality of life enjoyment and satisfaction of the expectant women. It became apparent that the need for scaling up psychosocial assessments and interventions cannot be overemphasized. Document analysis clearly revealed deficient recording of the mental health attributes of midwifery care which indicates a serious gap in implementation of mental health interventions by midwives.

Midwives and key informants concurred with women on several aspects; lack of knowledge and incompetency by midwives, varied attitudes with heavier inclination towards negative attitudes, disempowered midwives with resultant inability to empower women. Poor coverage of mental health in midwifery curricula, lack of standardized mental assessment procedures, heavy workloads were the other findings. Suggested ways of improving mental health were educating midwives, mentorship and preceptor ship, curriculum review, utilization of mental health protocols and validated screening tools.

The findings of the study led to the development of mental health guidelines to be followed throughout the perinatal period. It is recommended that the Ministry of Health and Child Care, Zimbabwe adopt the guidelines and provide an enabling environment for their effective implementation. Further research efforts could be directed towards conducting targeted research to support implementation of the mental health guidelines.

KEYWORDS: pregnant women, perinatal interventions, mental health, guidelines, midwife, childbirth

DECLARATION

I hereby declare that this research report on development of mental health guidelines to be followed throughout the perinatal period in Zimbabwe, that I submit for the degree of Doctor of literature and Philosophy, at the University of South Africa, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature:  Date: 5th February 2020

Calleta Gwatiringa

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- The participants who took part in the study.

DEDICATION

This research report is dedicated to my husband Stephen and children Kundwayi, Farai, Nyarai and Ticha.

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS

AHRQ	Agency for Healthcare Research and Quality
ANC	Antenatal Care
ART	Antiretroviral Treatment
ARV	Antiretroviral
BC's	British Council's
BiTS	Birth Trauma Scale
CBT	Cognitive Behavioural Therapy
CES-D	Centre for Epidemiological Studies Depression Scale
CHCF	California Health Care Foundation
CMD	Common Mental Disorders
CNS	Clinical Nurse Specialist
ECT	Electroconvulsive Therapy
EFA	Exploratory Factor Analysis
EPDS	Edinburgh Post-natal Depression Scale
EPI	Expanded Programme of Immunization
FNMWC	First Nations Mental wellness Continuum
GAD	Generalized Anxiety Disorder
HCP	Health Care Professionals
HEEADSSS	*H = Home environment, E = Education / employment, E = Eating / body image, A = peer-related Activities, D = Drugs/alcohol, S = Sexual health / sexuality, S = Suicidality / mood, S = Spirituality*
HLE	Healthy Life Expectancy
HMIS	Health Information Management System
HPA	Hypothalamic-Pituitary-Adrenal
ICF International	International Classification of Functioning Disability and Health

ICM	Information Classification and Management
IPT	Interpersonal Psychotherapy
IQR	Interquartile Range
IRB	Institutional Review Board
LMICs	Low-Income and Middle-Income Countries
MCH	Maternal and Child Health Services
MDG	Millenium Development goals
MDHB	MidCentral District Health Board
MICS	Multiple Indicator Cluster Survey
MIHA	Maternal and Infant Health Assessment
MMHA	Maternal Mental Health Alliance
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOHCC	Ministry of Health and Child Care
MSE	Mental Status Examination
MSF	Médecins sans Frontières
MTA	Multi-Trait Analysis
NCBI	National Center for Biotechnology Information
NEST-S	Nutrition, Exercise, Sleep, Time for yourself, Support
NHS	National Health Strategy
NHSZ	National Health Strategy for Zimbabwe
NICE	National Institute for Health and Care Excellence
NPDI	National *Perinatal Depression* Initiative
PCN	Primary Care Nurses
PDT	Psychodynamic therapy
PER	Preliminary Environmental Report
PHC	Primary Health Care
PHQ	Patient Health Questionnaire
PND	Postnatal Depression

PPTSD	Postpartum Post Traumatic Stress Disorder
PRO	Patient-Reported Outcome
PSQI	Pittsburgh Sleep Quality Index
PTSD	Post-Traumatic Stress Disorder
Q-LES-Q	Quality of Life Enjoyment and Satisfaction Questionnaire
Q-LES-Q-SF	Quality of Life, Enjoyment, and Satisfaction Questionnaire-Short Form
Q-LES-SF	Quality of Life Enjoyment and Satisfaction Short Form
QOL	Quality Of Life
RCN	Royal College of Nursing
SDG	Sustainable Development Goals
SMHMs	Specialist Mental Health Midwives
SPSS	Statistical Package for the Social Sciences
UHC	Universal Health Coverage
UK	United Kingdoms
UN	United Nations
UNICEF	United Nations International Children’s Emergency Fund
US	United States
VHW	Village Health Worker
VR	Veterans RAND
WHO mhGap	World Health Organization Mental Health Gap Action Programme
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency
ZMPMS	Zimbabwe Maternal and Perinatal Mortality Study

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

The perinatal period is realized as a time where the woman and her newborn are exposed to great danger after delivery and within the initial month after giving birth (Beyondblue, 2011:38). Severe mental pathology is a great danger in women who would have delivered. The provision of “emotional, informational and tangible support throughout the stages of labour has been shown to fulfil the women’s expectations about childbirth and can increase their satisfaction with birth experience” (WHO, 2013:593).

According to McCauley, Elsom, Muir-Cochrane, Lyneham (2011:787), adverse mental adjustment of women can place one at an increased danger of developing complications related to pregnancy and child birth, particularly among those with a pre-existing mental condition. These can include the woman causing damage to herself, to the newborn and a disturbed interaction between the mother and her offspring. Fenton and Newton (2015:1) estimate that “between 10% and 20% among pregnant women and within the initial year after childbirth develop some mental instability. McCauley-Elsom, Cross and Kulkarni (2009:185) concurs that when a women succumbs to insanity they increasingly become a threat to their own survival as well as to the newborn.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Psychological instability perinatally results in deficient care during the antenatal period, underweight births, premature delivery, poor emotional attachment, inattentiveness and aggression on the new-born” (Satyanarayana, Lukose and Srinivasan, 2011:352). Wealthy countries have a predominance of depression during the antenatal period of 7% to 20% (Melville et al., 2010:1064), whilst countries with moderate and poor economies report a higher proportion of 20% or more, although there is paucity of research in these settings (Golbasi et al., 2010:486; Husain et al., 2012:268; Husain et al., 2011: 295).

After childbirth the occurrence of depression ranges from 7% and 30% in poor, moderate and wealthy countries (Parsons et al., 2012:58). In 22 out of 28 poor and moderate wealth countries and depression rates after childbirth were much more than those in wealthy countries, and Zimbabwe, with a prevalence rate of 33% was among the countries which rated highest (Parsons et al., 2012:58). Others with highest rates were Vietnam with a score of 33%, Guyana with a higher rate of 50%, whilst lowest prevalence rates were noted in Uganda with a score of 7.1% and Nepal which rated 4.9%.

Fisher, Cabral de Mello and Patel (2012) realised that mental disturbances after childbirth are particularly common where mothers of low socio-economic status are victims of gender violation. These may include harassment by mate, prejudice against feminine babies, fussiness about house chore and baby care responsibility demarcations and previous mental disturbance. The National Institute for Health and Care Excellence (NICE) Guideline (2014:136) emphasises that perinatal mental instability has consequences on the growing fetus, on the newborn and on the mother too.

Midwives, apparently, do not have skills, understanding, beliefs as well as attitudes to offer the mental aspect of midwifery care with some viewing it as not important (McCann & Clark, 2010:231). Midwives are not appropriately literate concerning psychological and emotional care and hold defaming outlooks despite the fact that they are the essential linkage between the susceptible women and professional midwifery care (Rahman et al, 2013:593). Present-day training of health personnel does not sufficiently prepare nurses to manage emotional wellbeing nor are they equipped to manage the stress they experience in the professional setting, with little or no support available to them (Rahman et al, 2013:593). McCauley, Elsom, Muir-Cochrane and Lyneham (2011:788) note the accelerated need for inclusion of mental state examination and psychiatric assessment which are not currently included in many midwifery course curricula. Such inclusion would ensure that vulnerable women and their families have appropriate access to mental health and community support services.

Similarly, there is a clear deficiency in mental health knowledge and skills among the midwives in Zimbabwe. The Zimbabwe National Health Strategy (2010-2011:11) as well as the latest for the period 2016-2020 only mention mental health briefly but does not anchor it to direct mental status assessments in general, let alone during pregnancy and after delivery. Effective midwifery interventions in mental health are essential for promoting a passionate rapport with women which is characterised by empathy, support, trust and empowerment which enables informed decision making (Jolivet, 2011:472). Alleviating mental health instability impacts positively on pregnancy outcomes, on mother-infant relationship, as well as the linkage with her significant others. The increase in psychosocial pressures such as those due to ARV therapy in pregnancy, harsh economic conditions and marital disharmony in Zimbabwe has augmented the need to proactively provide psychological support perinatally (Zim Health, 2010:9).

Jolivet (2011:469) noted the detrimental effects of poor mental interventions that range from comparatively elusive contempt in affording woman's independence and promoting self-worth to absolute exploitation; carnal attack, use of foul language, exclusion and rejection. However, studies clearly reveal that the midwives in practice have inadequate understanding and abilities, which demands urgent commitment towards uplifting their competencies. Higgins, Carroll, and Sharek (2016:364) reiterate that despite the fact that the practical situation that midwives are exposed to is fertile ground for them to possess the requisite aptitude to cope with and even explore issues pertaining to women' mental wellbeing, but it is unfortunate that they lack the ideal capability. As an alternative, they disregard or detach themselves from anything to do with the mental aspects of women's care.

McCauley et al. (2011:4) realised the importance of enhanced assimilation of mental assessments perinatally towards promotion of improved specialist care by midwives. Such understanding ensures that the susceptible women, partners and significant others get suitable attention to mental and community support service essentials. Milgrom and Gemmill (2014:13) reiterate that midwives should take it upon themselves that the care they provide should always incorporate the psychological welfare.

The Commonwealth Government of Australia, National Perinatal Mental Health Action Plan (2008:28) recommends the importance of performing psychosocial assessment on all women perinatally during pregnancy and even after childbirth, which should include use of a tool such as the Edinburgh Postnatal Depression Scale. Buist et al. (2008:11) further emphasizes the distinguished role that midwives have to play, especially pertaining to propelling the performance of prenatal valuations of the psychological and social statuses of women. Exacerbated rates of emotive pressure in expectant women result in numerous adversarial effects mentally and physiologically both for the woman and her offspring (van Bodegon, Homberg and Henckens (2017:1). They further explain that the effects are conveyed partly by the hypothalamic-pituitary-adrenal (HPA) axis, which is comprised of one of the main stress-response mechanism, inclusive of the hormone cortisol. Glover (2014:25) emphasize the importance of a two way relationship between midwife and the woman as the main mediation approach that begins in pregnancy. This relationship apparently has long haul benefits for the conduct of the kid, although a few different intercessions are also probably useful too. The same author highlights that discouragement, nervousness, and worry during pregnancy mostly escape undetected by wellbeing experts, and therefore goes untreated.

McCann and Clark (2010:231) conducted a study on students undertaking a bachelor's degree in midwifery to uncover their knowledge on the mental status of mothers with schizophrenia postpartum and findings revealed deficient knowledge which could be compared with that prevailing among untrained individuals. Evidence from literature reveals that the midwives are faced with several drawbacks which interfere with the delivery of all-inclusive psychological and emotional health in perinatal care approaches. Buist et al. (2008:13) contend that there is limited information about the extent to which midwives are equipped with the requisite expertise, philosophies and approaches necessary for provision of mental health services during the prenatal period.

Sullivan and King (2006:120) reiterate that it is important to evaluate the psychological and social threats on all expectant women, whilst at the same time proposing that midwives must be capacitated through relevant training on performing mental

examinations risk identification. McCauley-Elsom (2009:66) concurs that the panacea for many mental and other challenges associated with organisation and the psychic welfare of women is vigilance in coming up with blueprints. The planning must be effected through partnerships by involving all stakeholders; health experts, women themselves, their mates as well as their families. Such initiatives usually produce best aftermaths for women and their babies. McCauley-Elsom and Kulkarni (2007:107) and Kulkarni et al. (2008:38) reiterate that midwives are poorly capacitated, yet they have a distinct role of managing the psychic aspect of midwifery care of expectant women, as well as mitigating any mental challenges. They further highlight that midwives cited mentally disturbed women as frequently problematic when relating to them, or as resistant to interventional modalities, and tended to be viewed as a tentatively hostile and were therefore deemed to be extremely dangerous.

Several studies proffered intervention modalities to ensure that the mental welfare of the woman is catered for during the perinatal era. Austin (2014:179) contends that there are many opportunities for improving mental health so that clients receive optimal care during the perinatal period. The initiation of timely mitigatory initiatives which focus on those families who are at greater danger would facilitate attainment of optimal mental stability and prevent mental breakdown perinatally (Priest et al., 2008:19). Milgrom and Gemmill, (2014:13) and Priest et al. (2008:19) further allude to the role of midwifery services as provision of strategies to advance the perinatal emotive welfare of women. Midwives have a distinguished role of excelling in stimulating women to take full precedence of their mental welfare (Vik et al., 2009:34), however, the ideal capacitation of midwives in order to effectively execute such responsibility is yet to be attained (Austin, 2014:179). A psychosocial assessment is a comprehensive and multidimensional procedure which should be used to evaluate every woman's psychosocial circumstances (Milgrom & Gemmill, 2014:13). Examples are, sources of support, quality of her relationships, recent life stressors, past or current physical or sexual abuse as common practice for all women during the antenatal period. This assessment would help in identifying those women who are potentially exposed to a great danger but are not presently exhibiting features of mental disturbance such that

circumvention measures would then be offered early (Austin, 2014:179; Milgrom & Gemmill, 2014:13).

In a study on midwifery students by McCann and Clark (2010:231), it became apparent that several midwives evade women who are mental disturbed. The majority of participants were senior staff with midwifery experience in excess of 10 years. Apparently, in spite of having acquired this much practice, there were gross deficiencies pertaining to appreciation of their obligation to evaluate the mental status of women during perinatal care. Some even relegated mental health to be the responsibility of other disciplines, like social welfare officers or experts in mental health. Nevertheless, this dearth in appreciation of their integral role demands comprehension and urgent redress, particularly as it focuses on a worrisome aspect which impacts on the woman's mental adjustment, even in the Zimbabwean midwifery context and it must be addressed through plugging deficits in midwifery education curricula as well as midwifery practice units. Howard (2012:2) notes the increased need for psychosocial assessments in order to monitor maternal mental wellbeing throughout the antenatal and postnatal periods, which presently do not appear in most midwifery programmes. Such inclusion would ensure promotion of the mental wellbeing during the perinatal period through timely inception of perinatal mental interventions during admission through to care after discharge.

Scrutinizing the woman's mental predisposition, as well as valuation of the psychological and social status should be urgently incorporated into midwifery programmes in order to ensure that midwives are educated on provision of optimal psychosocial comfort. A small number of respondents in an enquiry by McCann and Clark (2010:231) indicated the conspicuous absence of any teaching on mental health and most of the times mental issues and expertise was visualized as an unnecessary aspect of their services. Similarly, there is a clear deficiency in awareness and capacitation about mental aspects of care among midwives in Zimbabwe. Effective perinatal interventions in mental health are essential in promoting a passionate interaction between the woman and her midwife which is characterised by empathy, support, trust and empowerment which enables informed decision making. Alleviating

mental health instability impacts positively on pregnancy outcomes, on mother-infant relationship, as well as the interfaces among mothers, their mates and significant others.

Zimbabwean midwifery curricula in the various programmes, diplomas up to master's degrees are either silent or mention mental health briefly. Although, to a lesser extent, some midwifery programmes at tertiary level have realized the need to include the mental aspect of midwifery care, more still needs to be done because undoubtedly this is a crucial area. The increase in psychosocial pressures such as those due to ARV therapy in pregnancy, harsh economic conditions and marital disharmony has accelerated the need to proactively provide psychological support perinatally (Zim Health, 2010:5).

McCann and Clark (2010:231) denounce the lassitude in admitting the fact that mental health should be included in midwifery input and in the clinical areas. Further to this, the same authors argue against the notion of excluding mental health from the scope of midwifery practice, whist endorsing that such ideas should no longer be accepted. Undeniably, midwives would definitely have varying levels of knowledge and capabilities which would make it improbable to train all the midwives such that they would catchup with requisite knowledge acquisition for the national perinatal assessment (McCann & Clark, 2010:231).

1.3 STATEMENT OF THE PROBLEM

Globally, pregnancy and eventually giving birth are historic events for women and their families which should primarily be joyous but unfortunately, at times there is extreme susceptibility to complications. Zimbabwe adopted focused antenatal care which has goal-oriented interventions which emphasise maternal and fetal wellbeing assessments of pregnancy but generally omit mental health attributes. Mental health is only relegated to be loosely mentioned as counseling or support with no mechanism of assessing and ensuring mental stability. The gap is further perpetrated in the antenatal booking and subsequent visit record where mental health is not probed. The ICM Midwifery competencies, which Zimbabwe adopted as a standard to midwifery practice also

emphasise interventions for maternal and fetal wellbeing which exclude mental health interventions. Therefore, meeting mental health needs would be by default rather than being enforced by guidelines. Midwifery curricula in various programmes, diplomas up to master's degrees are generally silent or more theoretical with deficient application which withers away once students complete the programmes. Some shift in mental health content in certain tertiary midwifery education programmes has been noted but, clearly midwives have to be well equipped to meet the mental and social demands of women.

Midwives are better positioned to assist the women with mental health coping strategies; however, midwives clearly lack the requisite understanding and judgemental attitudes to address the women's mental issues. The lack of clarity on mental health interventions in midwifery protocols and absence of distinct utilisation of mental health assessment checklists is a cause for concern. The quest towards promoting positive memories of the perinatal experience and mental stability of women, prompted the researcher to analyze the extent to which the current perinatal interventions address the mental health aspect. This facilitates gap identification and gives guidance as to how to develop mental health guidelines to be followed throughout the perinatal period.

1.4 PURPOSE OF THE STUDY

The study sought to investigate the mental health interventions in order to determine the development of mental health care guidelines for childbearing women throughout the perinatal period in Zimbabwe.

1.5 RESEARCH OBJECTIVES

1. To identify the mental health interventions offered by midwives.
2. To measure and analyse the extent to which the levels of the psychosocial markers reflect effectiveness of the mental health interventions.
3. To explore and describe the experiences of women, midwives and key informants on the effectiveness of the mental health interventions.

4. To develop mental health guidelines that will direct mental health interventions throughout the perinatal period in Zimbabwe.

1.6 RESEARCH QUESTIONS

1.6.1 Broad Question

How can mental health guidelines to be followed throughout the perinatal period in Zimbabwe be developed?

1. What are the mental health interventions that are offered by midwives?
2. What are the levels of the psychosocial markers to reflect effectiveness of the mental health interventions?
3. What are the views of women, midwives and key informants on the effectiveness of the mental health interventions?
4. What guidelines can be developed in order to direct mental health interventions throughout the perinatal period?

1.7 SIGNIFICANCE

Appropriate mental health interventions within the perinatal period promote mental stability which is essential for the women's adjustment to pregnancy and childbirth, yet the mental health aspect of midwifery care is not distinct. Furthermore, midwives lack the requisite knowledge and skills and are not confident to offer mental health interventions. This study, therefore, analyses and unveils the current perinatal interventions and their adequacy on mental health. The study utilises the psychosocial markers as a yardstick to measure the effectiveness of these approaches in provision of sound mental health and mitigation of mental challenges. Mental wellbeing is used here as an indicator of the effectiveness of the interventions in provision of sound mental health. Measuring of psychosocial attributes, women's, midwives' and key informants' perceptions and analysis of the women's' documents is used to substantiate interventional modalities. The findings from this study will unveil the current status of the mental health aspect of the midwifery interventions. This will facilitate development of mental health guidelines to be followed throughout the perinatal period in order to capacitate midwives with requisite mental health knowledge and skills. The practice

guidelines will in turn translate into psychological comfort for women and their families in the perinatal period and probable mandatory adoption of using psychosocial markers for managing the mental health aspect of midwifery.

1.8 DEFINITION OF TERMS

1.8.1 Conceptual definitions

1.8.1.1 Pregnant women

Women who are the recipients of health care and education provided during pregnancy, labour and after childbirth (Dippernaar & Da Serra, 2012: 23). In this study these are the recipients of the mental health interventions offered by midwives.

1.8.1.2 Perinatal

Perinatal is the period which extends from pregnancy to a year after childbirth (McCauley et al. 2011:185). In this study, focus is on the pregnancy period up to two months after childbirth.

1.8.1.3 Perinatal interventions

The assessment, care planning and management of women within the period of pregnancy up to 12months (McCauley et al. 2011: 185). In this study focus in on intercessions within the perinatal period ends at two months after childbirth.

1.8.1.4 Mental health

A state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014). In this study the concept is synonymous with maintenance of women's mental and emotional stability within the perinatal period.

1.8.1.6 Guidelines

Recommendations or protocols based on the findings of the study which are designed to direct health care, improve quality and consistency (Australian Clinical Practice

Guideline, 2017:13). In this study they are crafted to direct midwives on protocols to follow so as to ensure optimal provision of mental health to women in maternity institutions.

1.8.1.7 Midwife

A person who has been trained and has qualified to attend to women during pregnancy and when in labour (Beyondblue, 2019:11). In this study the midwife is expected to be the expert in spearheading mental health interventions for women under her care.

1.8.1.7 Childbirth

Refers to the situation of having gone through the process of labour until delivery or giving birth such that one is immediately ready for post-natal services (Beyondblue, 2019:11). Childbirth is the beginning of the peuperium which extends into the next two months, marking the end of the perinatal period in this study.

1.9 THEORETICAL GROUNDING OF THE RESEARCH

The British Council's (BC's) Health Authorities Framework of perinatal depression focuses on four dimensions, namely; education and prevention, screening and diagnosis, treatment and self-management and, coping and support networks. The framework facilitates recognition, diagnosis, management and follow-up of women with identified mental health challenges. There were adaptations of the framework in order to meet the focus of the study.

In this study recognition is visualised as the provision of mental health education in order to empower women with maintenance of mental wellbeing and to recognise signs of mental illness and refer self for treatment. Diagnosis is likened to interventional modalities to diagnosis of the mental status; management is to do with the psychological and mental health interventions to prevent or manage mental illness. Follow-up is likened to the psychological support offered by midwives, family, community and other support networks. The goal is to promote collaborative and

supportive care of women's mental health challenges, their babies and their families in order to attain optimal mental stability throughout the perinatal period.

Figure 1.1: Pillars of maternal health stability

Source: Adapted from the British Colombia (BC) (2006) "Framework of Perinatal Depression"

1.10 RESEARCH METHODOLOGY

1.10.1 The research design

The study utilises the *s*equential explanatory mixed method which starts with collection and analysis of quantitative data in phase one, followed by a collection and analysis of qualitative data in the second phase (Creswell, 2014:44). The design is based on a pragmatic approach. Mixed methods research is ideal in this study in order to overcome the limitations of a single design as well as overcoming the weaknesses of a single design. It offers the best of both worlds; the in-depth, contextualized, and natural but more time-consuming insights of qualitative research coupled with the more-efficient but less rich or compelling predictive power of quantitative research. It also facilitates

addressing a question and a theoretical perspective at different levels. The choice was necessitated by the need to quantify data from the psychosocial scale and women's documents then triangulate with women's, midwives' and key informants' perceptions.

The study was conducted in three distinct phases which are elaborated below:

Phase 1. Quantitative: conducted a retrospective study of women's records guided by a document analysis checklist and utilised a psychosocial scale to assess the psychosocial wellbeing of women

Phase 2. Qualitative: utilised an interview guide to explore and describe women's experiences on the mental health care they receive. Used an interview guide to elicit the perspectives of midwife and key informant participants.

Phase 3. From the results of phase 1 and 2 development of the guidelines to direct mental health interventions throughout the perinatal period ensued.

1.10.3 Sample and sampling technique

Purposive sampling was used to select participants in both phases. In phase one, the population for document analysis comprised 499 women's maternity records and a sample of 300 women in the third trimester of pregnancy on which the psychosocial scale was administered, was chosen.

In phase two, 16 women in the postnatal period that had normal vaginal delivery and were within two months post childbirth were chosen for interviews. Seventeen (17) midwives and census sampling of the entire population of 9 key informants on whom interviews were held were chosen.

1.10.3 Data collection

In phase 1 data collection was as follows:

Document Analysis: The documents of those women who had normal vaginal delivery were viewed retrospectively in order to track the psychological interventions from antenatal booking through to discharge post childbirth.

Descriptive: The psychosocial scale was administered to women during the third trimester of the antenatal period.

In phase 2 data collection was qualitative: In-depth interviews were conducted on women in the postnatal period who had a normal vaginal delivery and were within 2 months post childbirth. In-depth interviews were also held with midwives and key informants.

1.10.4 Data analysis

Phase 1: Data from the psychosocial scale and retrospective data from women's documents was analysed using descriptive statistics on SPSS Version 23 package.

Phase 2: Thematic analysis was used to analyse qualitative data from women, midwives and key informants' perspectives.

Finally, triangulation of data from all the instruments was done to ascertain the adequacy of the current perinatal interventions on mental health and this was followed by development of the mental health guidelines in phase 3.

1.10.5 Validity and reliability/Trustworthiness

Establishing the validity and reliability of the instrument is an important aspect of instrument development and testing. Validity and reliability are the benchmark criteria for assessing the quality of the instruments and instrument testing was done before the instrument was administered to the target population. Reliability is used synonymously with accuracy, dependability, consistency, and stability. A panel of experts were consulted to review the instrument in terms of content, format, wording, suitability, clarity and audience appropriateness. In order to test for validity and reliability the questionnaire was pretested on 5 people who did not participate in the main study in order to analyse and revise the instrument.

Trustworthiness is the ability of the methodology to capture the reality of those being studied. The investigator believes the results of this study were trustworthy for several reasons: women's accounts are largely in agreement with each other even though the

women might not know one another; data saturation was reached when similar points continued to come up. Furthermore, the researcher previously worked at the same hospital in the same setting and was well acquainted with women's normal attitudes and behaviours. The interviews were also conducted in the women's native languages, which are Shona and Ndebele. The trustworthiness of the data analysis was further ensured by peer debriefing sessions, using tape recorded interviews.

The researcher ensured that the interview process was done according to the research protocol. Data was collected until saturation occurred. To ensure that the results are credible the researcher used the following techniques to gauge the accuracy of the findings; data triangulation, triangulation through multiple analysts, member check, attention to negative cases and providing verbatim quotes. Dependability ensures that the research findings are consistent and could be repeated. This was measured by the standard of which the research was conducted, analysed and presented. The researcher reported the processes in the study in detail. Conformability evaluates the extent to which findings are qualitatively confirmable. The researcher used the following techniques to ensure the conformability of the findings; debriefing, examination of the audit trail and researcher reflexivity. Transferability refers to the degree to which the research can be transferred to other contexts, and the researcher provided a highly detailed description (thick description) of the study.

1.10.6 Ethical considerations

Ethical clearance was sought from the higher degrees committee of the University of South Africa, the Medical Research Council of Zimbabwe and the Institutional Review Board (IRB) of the Central Hospital. The women were informed about the parameters of the study and how they were participating and informed consent was obtained. The researcher was aware that the interviews could harm the women psychologically, thus, great precaution was taken not to ask very sensitive questions. Interviews were stopped when the woman was uncomfortable about giving more information and to make sure that the interview was conducted at a place where the woman felt safe and relaxed. The women were assured of the confidentiality and anonymity. The interviews were carried

out in privacy, where no one could hear what was being discussed. The researcher did not use anything that would identify the women, such as the name of the interviewee, their children, neither spouse, nor their place of residence. The code numbers given during analysis did not necessarily follow the order of the interviews.

1.11 CONCLUSION

This chapter covered the background which clearly indicated deficiency in midwifery mental health skills in several maternity settings. Authors generally agreed on the need to upgrade mental health knowledge and skills in midwifery. The other aspects which were covered are the statement of the problem, objectives, questions, significance and scope of the study. The theoretical grounding and the study design and methodology were described. The next chapter gives a detailed explanation of the theoretical framework guided by literature review.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1 INTRODUCTION

The preceding chapter gave the background, problem statement, objectives and the general layout of the study. This chapter covers a detailed explanation of the theoretical framework based on literature. The British Council's (BC's) Health Authorities crafted the Framework of perinatal depression in 2006. Based on the BC's Framework, Williams, Ryan and Thomas-Peter (2014:6) developed the best practices guidelines to improve collaborative and supportive care as it applies to perinatal health care and client-centred childbirth. The guidelines were anchored on the realisation that a high incidence of one woman in every five would succumb to a significant mental health challenge in the perinatal period, but regrettably, only a small number of them would look for assistance. Without treatment, mental illness can lead to increased obstetric complications, and compromised mother-infant relationship (Williams, Ryan &Thomas-Peter (2014:6).

The guidelines were premised on the idea that use of the ideal strategy and a coordinated approach results in timely identification and effective management of mental pathology. The guidelines would therefore support practitioners in the early diagnosis and synchronized management of women with mental health challenges at all phases of the perinatal period. In the guiding principles, Williams, Ryan and Thomas-Peter (2014:6) reviewed each of the four mental conditions common in the perinatal period as depression, anxiety disorders, bipolar disorders and psychotic disorders including postpartum psychosis, as guided by the four pillars of the BC's Framework.

The focus of the BC's Framework tends to address mental psychopathologies, particularly depression, and other mental ailments. On scrutiny of the framework and the resultant guidelines, it is clearly apparent that the instruments guard against disturbances in the mental wellbeing of the women, whilst excluding presence of the mental disorders. In this study, therefore, the BC's model of perinatal depression was

adapted because of its applicability to the study objective and its applicability to directing the analysis of mental wellbeing in the perinatal period. This discussion clearly demonstrates that incorporating aspect of BC's conceptualization of the four pillars is necessary in providing a fully encompassing and comprehensive approach to the analysis of the mental health interventions with a view of developing contextual mental health guidelines.

The literature search extracts pertaining to utilisation of the framework in general and precisely in perinatal care is proffered. The First Nations Mental Wellness Continuum Framework (FNMWC) (2015:5) contends that those who enjoy a life of wellness have hopefulness, knowledge of where they belong in the world, derive meaning and have a unique and specific purpose in life. The FNMWC (2015:6) mental wellness continuum centres around the more extensive idea of mental health instead of psychological sickness and goes beyond the perinatal period to address communities and several issues like culture and economics. Some aspects of the FNMWC framework such as wellbeing advancement, avoidance and instruction, early detection and mediation, care planning, support and aftercare concur with aspects of the BC's model. The elements of the BC's model are discussed below.

2.1.1 Pillars of the Framework

The four pillars of the framework address four dimensions namely instruction and avoidance, assessing and the verdict, therapy and self-administration, then finally adapting and backup linkages. An outline of some prescribed procedures and supporting proof for every one of the pillars is spelt out. The framework facilitates recognition, diagnosis, management and keeping track of ladies with identified mental health challenges (Williams, Ryan and Thomas-Peter (2014:7). In this study, emphasis is placed on conceptualisation of the four pillars as recognition, diagnosis, management and follow-up as this gives a more promotive and preventive flair.

The four mainstays of this structure comprise well-characterised administration framework exercises that ought to be considered at key phases of a perinatal woman's ideal progression, from gestation inception to parenthood. Alderdice, McNeill and Lynn

(2012:2) discovered that ladies who got psychosocial or mental mediation were distinctly less inclined to succumb to mental ailments after giving birth than those that got regular attention. The most encouraging intercessions included escalated individualized postnatal home visits by general wellbeing community caretakers or maternity specialists; lay peer-based phone backup services; and relational psychotherapy.

2.1.1.1 Pillar 1: Recognition (Education and Prevention)

The BC's framework emphasizes identification and education on risk factors like personal previous occurrence of wretchedness in the perinatal period, family history of psychiatric illness, extreme uneasiness during pregnancy, deprived social backup, recent relocation, destitution, social or linguistic concerns. Other risk factors are family strife, fresh unfriendly life occasions, survival stresses, monetary pressure, close accomplice brutality, unintended pregnancy, unsureness towards pregnancy, maternal medical conditions and newborn children with health issues or alleged troublesome personalities and.

A systematic audit conducted in Scotland by Alderdice, McNeill and Lynn (2012:2) presumed that without distinguished hazard factors, the scientific proof doesn't bolster explicit intercessions for the counteraction of depressive illness and other psychological sicknesses during pregnancy. The study emphasized the requirement for top notch randomized controlled preliminaries to advise a cutting edge tactic to deal with advancing maternal emotional well-being in midwifery practice. Essential anticipation methodologies, for example, pre-birth data, instruction support through being conscious of communal assets would probably encourage efficiency in early detection of mental illness then offer timely intercession (FNMWC, 2015:3).

Furthermore, expanding consciousness about perinatal psychopathology among women of childbearing age, their relatives and the communal network everywhere can result in targeted ways to reinforce defensive factors and optimise mental well-being. The BC's framework also emphasises targeted prevention activity to focus on vulnerable women with emphasis on risk factors; past dysfunctional behavior,

unpleasant life occasions, and absence of social backup, conjugal disharmony, obstetric complications and other socio-economic issues.

Wellbeing advancement, unwellness counteraction, and instruction seek to increase awareness, attitude and behavior. It facilitates engagement in safer and healthier lifestyles as well as supportive family relationships (FNMWC, 2015:5). Further to this, attention to the physical aspects and safety during pregnancy is a critical aspect of improving mental wellbeing, which is interconnected to physical wellness. Wellbeing advancement, unwellness counteraction, and instruction procedures centre around reestablishing associations to cultural qualities, upgrading self-governance of women and their significant others. This would spill to increasing participation in communal networking, reinforcing resistance to mental illness, expanding defensive factors, and diminishing danger factors.

In this study, adaptations of the model were made to meet the focus of the study, recognition is visualised as the provision of mental health education in order to empower women with maintenance of mental wellness and to recognize signs of mental illness and refer self for treatment. The concept of recognition guides analysis of the extent to which the women get the critical input on health promotion, prevention and empowerment for mental resilience in order to maintain mental wellbeing during the perinatal period. Use of the concept of recognition stimulated proactivity in checking on history taking, observation and whether pertinent aspects of education and prevention of mental illness are being addressed.

Education is an important aspect which the researcher should assess with a thrust to address the numerous aspects of the research. The quantitative analysis assesses how education and counseling would have impacted on psychosocial adjustment by the third trimester through measuring the psychosocial scales. Similarly, review of the documents is quizzing the proof of having rendered mental health education as reflected by the educational interventions. The women should be subjected, not only to education on physical aspects of maternal and fetal care, but also to psycho-education which is important towards ensuring mental health in women and preventing mental

illness. Studies have emphasized the importance of educating women on mental health. Apparently, January and Chimbari (2018:1127) realized that, in Zimbabwe there are opportunities for universal mental health education but inadequate instruction in mental wellbeing mediation among midwives and primary health care providers was a serious constraint. They recommended the necessity to avail assets and means towards the capacitation of midwives as well as the various preliminary level health care workforce, specifically for mental health challenges affecting women.

2.1.1.2Pillar 2: Diagnosis (Screening and Diagnosis)

Screening and Early Detection is essential because psychological sickness in the perinatal period has expansive adverse outcomes on the mother, child and family. What's more, is the tendency to negatively affect the youngster and the mother-baby relationship when the mother is suffering from a depressive condition. Therefore timeous identification and mediation can assist with disposing of or decrease these effects (BC's Expert Panel, 2014:19). The framework explains fundamental ways to deal with the early discovery of psychopathology; screening all expectant women and postnatal mothers for mental illness, paying particular attention to those with recognized hazard factors or potentially showing clinical indications of illness.

However, in spite of the agreed fact that health service suppliers ought to be aware of clinical signals of psychopathology in perinatal ladies, investigation has demonstrated that their healthcare providers do not recognise many perinatal women with symptoms of mental illness (Alderdice, McNeill & Lynn, 2012:20). Furthermore, numerous clinicians feel that perinatal women are not likely to report mental illness indications on account of social desires and feel that the methodical utilisation of a self-managed screening apparatus is fundamental, as it would empower ladies to communicate these sentiments more effectively (FNMWC, 2015:8).

The BC Expert Panel (2014:3) concurs with continuation with the current practice of screening all women for despondency and other psychological illness in any event twice during the perinatal period (once in the prenatal and once in the postpartum period) with

the use of scales, for example, the Edinburgh Postnatal Depression Scale (EPDS). They realized the greater potential benefits as opposed to harms from screening, such that the consensus recommendations included carrying out research until better proof is accessible to additionally control changes, practically speaking. There was also a need to advocate for circumstances and assets to lead top notch studies that give information about the advantages and damages of widespread screening in the perinatal populace.

In this study, diagnosis is likened to interventional modalities, including screening to appraise the mental status and diagnosing of the mental disorders early. In the study, the inclination towards mental wellbeing as opposed to mental illness has given rise to use of a more wellness friendly tool as opposed to a depression scale such as the EPDS. This study, therefore utilizes a psychosocial tool, the Quality of Life Enjoyment and Satisfaction (Q-LES-SF) by Endicott (1993:321). Use of this scale is only dedicated to a single portion of the study where the psychological wellbeing is assessed at 36 weeks gestation and above, that is towards term pregnancy. The assumption is that women would have had psychological interventions since earlier on, as they attend antenatal visits. The assessment is then used as a measure of the effectiveness of the mental interventions.

The Q-LES-SF is a personal-reporting scale comprising 16 items acquired from the broad-spectrum activities scale of the initial 93-item form. The psychological wellbeing tool is a theoretically grounded instrument that specifically focuses on measuring fourteen (14) facets:

- Satisfaction with one’s wellbeing.
- Social relationships
- Ability to work in day by day life
- Physical versatility
- Affect or Mood
- Family relations
- Sexual drive and intrigue

- Ability to perform leisure pursuit
- Graft or work
- Leisure exercises
- Household exercises
- Economic standing
- Existence/ accommodation circumstance
- Futuristic view and general wellness

Every one of the aspects is appraised on a 5-point scale that demonstrates the level of happiness or fulfillment over a specified period.

The framework guides this study in attempting to assess the levels of psychosocial adjustment and further explores the women's, midwives' and key informants' views on maternal mental health care offered by midwives. Studies point at the importance of diagnostic competencies, yet alarming at the shortfalls in that essential aspect of care. Carroll et al. (2018:30) expressed that midwives tend to have reduced confidence in inquiring about sensitive topics, as they only attend to them sparingly with women considered to be in danger. Mames and Hall (2013:e112) examined the benefits of a number of psychological and therapeutic valuations and emphasized the importance of health screening whilst proffering suggestions like the use of scientifically proven assessment tools, practical dialogue, bodily examination, conversation with companion and observing mother and baby communications. January and Chimbari (2018:1127) also concur with the absence of locally validated mental health screening tools within the Zimbabwean context.

2.1.1.3 Pillar 3: Management (Treatment and Management)

This pillar is premised on management and treatment of psychological and mental health interventions to prevent or manage mental illness. BC's framework proposed the following guiding principles in the avoidance and mediation of mental ailments:

A. Psycho-instruction

B. Self-care: The NEST-S Program

C. Psychotherapies

I. Cognitive social treatment (CBT)
II. Interpersonal treatment (IPT)
III. Psychodynamic treatment (PDT)
IV. Group treatment (specialist as well as friend driven)
V. Parent-baby psychotherapy
VI. Couples and family treatment

D. Brilliant light therapy

Psycho-instruction

Williams, Ryan and Thomas-Peter (2014:24) argue that psycho-instruction is powerful in both singular and in settings where many people are gathered. The goal is to support women and their relatives with comprehending their prevention and symptoms of mental disorders, learn about effective coping strategies and available treatments. Explicit content critical to cover in psycho-education incorporate risk factors, data about the particular psychopathology, predominance, manifestation, symptoms, and advantages of timely treatment. Other topics may be on possible treatments and expected prognosis.

Self-care: The NEST-S Program

Personal-Management happens as a result of empowering on Mind-Body approaches that are “Exercise”, “Time for self”, the “rest” part of “Sleep and rest” and the “Backup” capacity too (Williams, Ryan &Thomas-Peter, 2014:26). Expanding the quantities of women who practice at least one or more brain-body modalities for the sentiments of manifestation help and feeling of health that they give is a positive move (Alderdice, McNeill &Lynn, 2012:20). Mind-body connections have complicated connections and the capacity to adjust thinking states through integrative bodywork. "Psyche" includes contemplations, feelings, convictions and mental pictures. Brain to bodily intercessions have been proven to help in diminishing tension and improving by and large state of mind in perinatal ladies. Psyche and body approaches, for example, yoga, reflection and breathing activities may likewise assist with improving birth weight and diminish premature births.

In BC's self-care is the "NEST-S" programme, which has acronyms, standing for self-care aspects:

- Nourishment: Eating nutritious foods for the duration of the day.
- Exercise: Getting normal exercise. There is considerable research on the benefits of exercise for improving pessimism.
- Sleep and rest: Sleep is significant for both physical and psychological well-being. Getting adequate sleep in the perinatal period can be a real challenge
- Time for self: Availing self-time is a territory that new moms frequently disregard. This is worrying particularly in women who are suffering from a depressive disturbance, as well as those encountering other psychological wellness problems.
- Support: Social help assumes a significant job in helping new moms conform to the livelihood changes that go along with being a mother. Sound connections are a defensive factor against melancholy and other emotional well-being challenges and are a significant factor in recuperation.

Adapting to depression during pregnancy and following labour are both useful assets for women with depression and anxiousness (Williams, Ryan and Thomas-Peter, 2014:26). They deliver real-world information on depression and anxiousness during the perinatal period, just as various activities and exercises (self-care systems) that will help lead to positive changes. The guidelines utilise the standards of intellectual behavioural mediation to direct women in making adaptations.

Psychotherapies and psychotropics

Williams, Ryan and Thomas-Peter (2014:26) purported that treatment guidelines for a particular woman relies upon numerous components including:

- The type of the mental and emotional wellness challenge
- The seriousness of the manifestation.
- Her prior reaction to treatment.
- The backup situation, assets and requirements of the women

For women with minor to medium intensity manifestation, non-pharmacological interventions are prescribed recommended before pharmacological therapy. Therapies are effective when provided on an individual interactive basis or in a gathering setting. Therapists trained in the particular approaches should conduct psychotherapies. For instance, Cognitive Behavioural Therapy, Interpersonal Psychotherapy and Psychodynamic Therapy are appropriate in the mediation of mental pathology and may be used singularly on their own or can be used together. Notwithstanding, not all therapists, intercessors or psychologists have training in all forms of therapy and practical differentiation will facilitate heavy reliance on matching the expertise with the expertise of a therapist or counsellor.

Cognitive Behavioral Therapy (CBT) centres around how contemplations can influence feelings, which, thus, can influence conduct and body (physiological) reactions. A trademark of extreme sadness and uneasiness is "negative, contorted reasoning". Interpersonal psychotherapy (IPT) centres around role changeovers, including changing jobs or job obligations and relationships with other people. It shows the aptitudes that are expected to conform to changing jobs and to improve cooperation. Psychodynamic treatment (PDT) is additionally alluded to as understanding focused treatment. The objective of PDT is to augment mindfulness and comprehension of the impact of the past on present conduct. It centers on unconscious procedures as they become noticeable in the present behaviour. For example injury in early life may have prompted the present mental illness. In its short structure, PDT enables an individual to analyse uncertain clashes from past useless connections and their effect on present conduct (inclusive of parenting). PDT is regularly utilised in combination with other mental strategies (most usually CBT) to influence change.

In cases where non-pharmacological therapies are ineffective, medicinal treatment may be needed. Drugs might be commenced as the primary line treatment and non-pharmacological treatments added when women have struck the ideal stabilization for psychotherapeutic approaches in cases of severe symptoms. Drugs might be started as the primary line treatment and non-pharmacological medicines included when the time is proper for ladies with serious manifestations. Women who are intensely self-

destructive will require escalated home management or hospitalization. Psychotropic drugs, blended with psycho-education, self-care and psychotherapies, are frequently important for treatment of women with moderate to serious PND as well as other psychological well-being issues. Endorsing psychotropic drugs in pregnant or breastfeeding ladies, be that as it may, is extremely testing. The dangers of medication impacts on the embryo or the infant must be weighed against the danger of depression (or other emotional wellness challenge) in the lady.

Electroconvulsive therapy (ECT) is sometimes used a last resort for women encountering extreme sadness who have not reacted well to prescriptions and is likewise utilized when a fast or higher likelihood of reaction is required, for example, ladies encountering an incident of intense psychosis as well as those who are self-destructive. In the post childbirth period, ECT offers a treatment choice that is secure for the infant and takes into account progression of the breastfeeding plan with just minor interruptions at the hour of the treatment. ECT is generally safe and effective but ought to be performed in a medical facility with the capacity to oversee maternal and fetal crises. Consultation with an obstetrician is mandatory.

In this study, this pillar directs the analysis of the promotive and preventive strategies mainly. Emphasis is placed more on analysis of preventive interventions that address mental wellbeing, but this is not immune to appraisal of any psychological disorders, which might have arisen, and their management. The results inform the ensuing development of mental health guidelines. In the study management focus is on quizzing the several woman-midwife interactive processes; such as communication, respect empowering women in decision-making, continuity of care, attentiveness, counselling and other psychotherapeutic interventions, treatment and referral. Guidelines are therefore developed to support the interventional modalities. The relationship between the woman and midwife is one of the significant components that decide the nature of the labour experience since it pervades all aspects of activities and is one significant compelling element that encroaches on ladies' fulfillment with care (Srivastava et al, 2015:8). Williams, Ryan and Thomas-Peter (2014:6) found it necessary to develop the best practice guidelines (based on the BC’s Framework), to improve collaborative, and

supportive care as it applies to perinatal health care as it applies to perinatal human services and woman focused labour. The guidelines were tied down on the acknowledgment that one out of every single cluster of five ladies will encounter a critical mental wellness challenge in the perinatal period, yet sadly just an ignorable number will look for help.

2.1.1.4 Pillar 4: Follow-up (Coping and support networks)

The BC Expert Panel (2014:22) emphasizes the importance of the role of social support in facilitating psychological adjustments to pregnancy, childbirth and motherhood. Williams, Ryan and Thomas-Peter, (2014:80) proffers support networks such as Family Physician/Midwife/Nurse Practitioners, Local Public Health Nurses, Mental Health Team, Health Link BC, Mental Health Support Crisis Line, Suicide Line. Other support mechanisms are through provision of information and communication materials and e-resources for women, partners and families. As a guiding document for the public health system, the Guiding Framework unifies resources.

In this study, this pillar is conceptualised as 'Follow-up' which is likened to the psychological support offered by midwifes, family, community and other support networks. The analysis is premised on the goal of promoting collaborative and supportive care of women's mental health challenges, their babies and their families in order to attain mental stability throughout the perinatal period. There is also further realization that healthy relationships protect women from mental health disorders and speed up the recovery process (FNMWC, 2015:12). William, Ryan and Thomas-Peter (2014:6) contend that lack of psychosocial support can result in women developing mental illness which can lead to increased obstetric complications, and compromised mother-infant relationship. In a similar study, Dako-Gveke et al (2013:7) concurs that woman and their spouses should get psychosocial and emotional support from midwives to avoid seeking for it elsewhere. They can seek for it from other sources, such as from nonconventional providers like spiritualists to discuss pregnancy, childbirth and motherhood (William, Ryan and Thomas-Peter, 2014:6; The BC Expert Panel, 2014:22), as well as other support mechanisms like provision of information and communication materials and e-resources for women, partners and families (William,

Ryan and Thomas-Peter, 2014:6). As a guiding document for the public health system, the guiding framework ensures accumulation of resources.

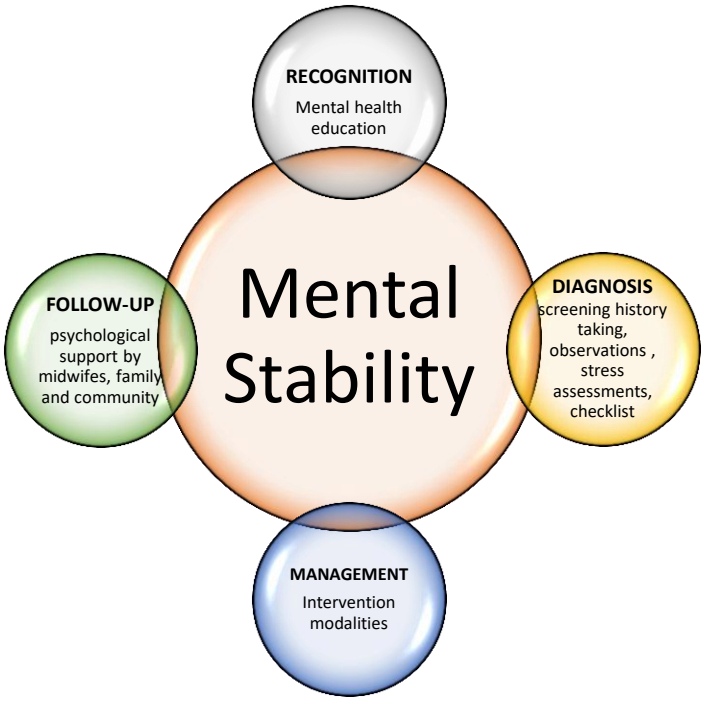

Figure 2: Pillars of mental health stability
Source: Adapted from the British Colombia (BC) (2006) "Framework of Perinatal Depression"

2.2 ADOPTION OF THE BC'S PILLARS IN MENTAL HEALTH CARE

Best practice guidelines were crafted in response to the BC's mainstays of the framework. Williams, Ryan and Thomas-Peter (2014:6) developed the Best Practice Guidelines for Mental Health Disorders in the Perinatal Period under the BC Reproductive Mental Health Program & Perinatal Services BC. The motivation behind these guidelines is to assist healthcare practitioners in this early identification and synchronized treatment of pregnant and postpartum women with mental wellbeing challenges. The consequences of untreated perinatal mental disorders include compromised antenatal care, amplified danger of pregnancy related complications, self-medication or substance misuse, insecure mother/infant interactions (BC's Framework, 2006:1). Other risks are emotive and behavioral damages in the growing child, whilst

the most catastrophic consequences of untreated perinatal depression are maternal suicide and infanticide (BC's, Framework 2016:1).

Haring (2013:7) developed a cognitive behaviour therapy-based resource and self-management guide for women and health care providers based on the BC framework concepts. This guide was created to deal with anxiety during pregnancy and following childbirth. The goal was educating women and health care providers about anxiety, on effective treatments and empowering women with effective coping skills and positive lifestyle changes. Other frameworks were derived to guide interventions for mental wellbeing. The Ministry of health British Colombia (2017:4) crafted a BC's Guiding Framework for Public Health, with a theme to "Promote, Protect, and Prevent: Our Health Begins Here". The framework purposed at supporting a population health approach, connecting to, and supporting self-care, primary care, and clinical prevention, among other obligations.

The "Mother First Maternal Mental health strategy" was developed in Saskatchewan to direct creation of policies to improve the mental healthcare of mothers, as well as increase public and professional awareness. A multi-stakeholder working group explored the strengths of diverse partnerships, relationship building and public awareness campaigns. They also explored the challenges that were encountered in the decision-making and implementation stages and compared the prescribed steps of the policy cycle framework to the actual process. The resultant strategy borrowed concepts of education, screening and treatment from the BC's Framework. There was realisation that the lessons of the Mother First project could inform other jurisdictions wanting to develop policies to improve maternal mental health.

Another wellness framework developed by Orpana, Vachon, Dykxhoorn, McRae, and Jayaraman (2016:2) was a 'Positive Mental Health Surveillance Indicator Framework', to provide a picture of the state of positive mental health and its determinants in Canada. Data from this surveillance framework would be used to inform programs and policies to improve the mental health of Canadians. Four components were integrated into an overarching conceptual framework that provided the base on which indicators

were selected. Firstly, positive mental health applies to everyone and therefore holds promise as a mechanism to positively shift the population distribution of well-being.

Secondly, determinants of positive mental health were identified as important components of the framework. Thirdly, a socioecological model representing the domains; self-rated mental health, happiness, life satisfaction, psychological wellbeing and social wellbeing. Fourthly, the life course was represented in the conceptual framework because risk and protective factors vary and accumulate and experiences in early life may continue to affect positive mental health in later life and the way these concepts are measured changes according to each stage.

2.3 CONCLUSION

In this chapter, the BC's framework of perinatal depression as espoused by Williams, Ryan and Thomas-Peter (2014) in the Best Practice Guidelines for Mental Health Disorders in the Perinatal Period was explained as the conceptual framework that underpinned this study. The rationale for the choice of the model was put forward. The components of the model were integrated into the conceptual framework and an explanation of how they guided the analysis of the various aspects of mental wellbeing was done. The use of the model was guided by the objects of the study, which culminate in development of the mental health guidelines for the perinatal period.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

The previous chapter gave a detailed explanation of the theoretical framework, namely the BC's framework allowed comprehensive analysis of the mental health interventions. Literature review is a survey of scholarly sources for current knowledge, identification of applicable theories, methods, and research gaps (Polit & Beck, 2012:40). Several literature sources including two hundred and thirty published and twenty unpublished ones were reviewed.

Evidence across the last four decades, revealed prevalent rates of perinatal mental health problems ranging from 10-15% in high-income countries, whilst the occurrence in low and middle-income countries could be double than that (WHO mhGap, 2012:1). The WHO mhGap (2012:1) noted that mental health problems constitute a severe liability on the wellbeing of women and increasing global information shows that affective disorders in mothers impact negatively on growth and development their off springs, that is the newborns and young ones. In developing countries, depression in mothers has direct association with increased incidences of diarrhoea, communicable ailments and hospitalization and an increase in unimmunized or partially immunized children (WHO mnGap, 2012:1). It also has consequences on the physical, intellectual, interactive, communicative aspects of child development, and may increase child deaths (Awuah-Peprah, 2014:105). This literature expands on the background works and mental wellbeing of women, psychological and social interventions. Distinctive consideration is paid to variables discovered as essential to women with respect to psychometric test as well as protocols of managing the mental aspects of midwifery care. Several literature sources to include both published and unpublished ones were reviewed.

3.2 THE CONCEPT OF OPTIMAL PERINATAL MENTAL HEALTH

According to Marriott and Ferguson-Hill (2012:347) perinatal mental health refers to mental stability with ideal emotive responsiveness in women, their offsprings, mates and significant others during pregnancy, delivery and after childbirth. In other words, maternal mental wellbeing is about a woman's appropriate mental status during the expectancy period through to the initial year following birth, and it takes cognisance of any mental disturbances that were prevalent prior to pregnancy, and those that are aggravated by perinatal upheavals (Nyanyiwa, 2016:e1). It is a period where emphasis should be placed on infant attachment, on the understanding and responding to culture and ways of working with families in this sensitive life stage (Marriott &Ferguson-Hill, 2012:347).

According to the Australian Clinical Practice Guideline (2017:13), perinatal refers to a time span where there is pronounced alterations in women and in the majority of cases, in this period women and relatives become excited as they derive pleasure from expectancy and its outcomes through to parenting. Conversely, some women unfortunately become victims of the tendency to a great danger of developing mental disorders or even recurrence of previous mental disorder and this risk is much more increased than at other times of the lifespan of a woman. (Australian Clinical Practice Guideline, 2017:13). Farrelly et al. (2014:127) highlighted that the prenatal period up to the birth of a baby indicates an interval of incomparable adjustment and optimism about the impending future but it is an inspiration for numerous women. For a smaller number of women this spell can be obscured by mental disturbances, heightened by extensive humiliation (Howard, Piot &Stein, 2014:1723).

Awuah-Peprah (2014:104-105) conducted a study in Ghana which revealed that individualised attention, attention to specific needs of patients, politeness, appropriate interaction, imparting knowledge, and positive outlook by midwives, are major aspects which promote emotional stability in women. Prince et al. (2007:859) emphasized optimal quality maternal mental health in a strong statement about ensuring that mental health is always provided alongside all the other types of health care, more so during the perinatal period. Excellence in health has evolved through sequences of

modifications from as far back as the Hippocrates era (De Jonge, Nicolaas, Van Leerdam & Kuipers, 2011:338; Raven, Tolhurst, Tang & Van den Broek 2012: 677). Women-centred care has progressively gathered such momentum as to be viewed as the best-practice approach to excellence enhancement health care which is grounded on the evolving scientific proof that a maternity unit that is strictly woman-centred is expected to deliver higher quality mental interventions based on superior proficiency plus improvement of the woman's experience (Clif, 2012:86).

3.3 PREVALENCE OF PERINATAL MENTAL DISORDERS

According to WHO (2018:4), approximately 10% of expectant mothers and 13% of the recently delivered women succumb to a mental condition, mainly depression globally and the rates are greater in low economic countries, namely 15.6% for the duration of pregnancy then 19.8% after giving birth. Extreme cases of depressive incidences may even result in suicide by those affected and in some cases the incumbents may experience disturbances in functional capability thereby impacting negatively on the upbringing of children and developmental milestones (WHO, 2018:6). WHO (2018:2) conducted a meta-analysis of developing countries, which indicates that nearly 20% of mothers get affected by clinical depression following childbirth. This has a resultant impact of disturbing or retarding the ideal growth and progressive development of the young ones.

WHO (2014:3) also proffers that the frequency of women who develop mental conditions such as postpartum depression is quite elevated to an intensity of 1 in 5. According to the California Health Care Foundation, (2019:1), the Maternal and Infant Health Assessment (MIHA) revealed that 21% of expectant and postpartum Californian women succumb to mental pathology. The incidence is projected to be much greater in other population groups. For instance, in the state, one in every four African-American and Latina mothers develop depressive features, just like half of all mothers living below the poverty dartum indicator.

3.4 FACTORS THAT INFLUENCE ATTAINMENT OF OPTIMAL MATERNAL MENTAL HEALTH

McBride and Kwee (2016:4) highlighted that attainment of optimal perinatal mental stability is an integral quality outcome in expectant women and after giving birth. However, even if there is demand for attention to the mental state, women may fail to access the ideal services due to limited health workforce and resource constraints (McBride & Kwee, 2016:2743). The same authors argue that care pertaining to the roles of mothers has been somewhat ignored despite significant existing mental health needs. Epstein, Fiscella, Lesser and Stange (2010:1492) posit that realistic execution of emotional care rests on three influences: a well-versed, empowered client and her household. Secondly, amenability and responsiveness with focus on uniqueness on care attributes and knowing the woman and thirdly, a synchronized and interconnected maternity unit that ropes in determinations by women, their households and midwives.

Morgan and Yoder (2011:6) support the view as they concur with the precursors for creation of a woman-centred propensity within the health milieu, as comprising: focus and guarantee by leadership; upright administrative outlooks and actions; and joint governance. Accordingly, the condition of the woman and the ethnic affiliation determines the demarcations of care such that they may nurture the parameters for care and either foster or asphyxiate provision of individualized attention.

Manley, Hills and Marriot (2011:37) reiterate that providing some report back and monitoring; participation by woman, significant others and society; capacitating the personnel; advancement of functional governance; accessibility and persistent announcement of the strategic direction are essential aspects of care. Other important aspects are involving targeted boards and subdivisions dedicated to women-centred promotion initiatives; collaborative research; appropriate technology and structural support.

3.5 RISK OF DEVELOPING MENTAL DISORDERS

According to WHO (2012:4), virtually all women can develop mental disorders during pregnancy and in the first year after delivery, but poverty, migration, extreme stress, exposure to domestic, sexual and gender-based violence, emergency and conflict situations, natural disasters, and low social support generally increase risks for specific disorders. Affective and tension related mental disturbances are most common during the expectancy spell and after giving birth such that the frequencies of developing either mood disturbances, nervousness, or both in California is one in every five women (California Health Care Foundation, 2019:1). McBride and Kwee (2016:2743) reiterate that a number of social determinants influence the risk of experiencing perinatal mental health challenges. These may include the socioeconomic status, race/ethnicity, poor social support and sometimes fear of stigma which can also prevent women from seeking care.

Beyondblue (2011:11) purports that mental health conditions during the perinatal period can affect anyone regardless of their culture and proffers the factors that increase the likelihood that a woman who is expecting or is in the initial phase after giving birth can become mentally disturbed. There are a combination of factors which would cause depression and anxiety disorders, such as the individual or a blood relation who has had a previous mental disturbance or is presently having some mental pathology, present or previous abuse physically, psychologically and sexually, and absence of concrete or emotive backing. Other factors include nonexistence of a supportive companion or disharmony, existing alcohol and/or drug difficulties and undesirable or traumatic present or previous experiences, such as miscarriage or neonatal loss, having lost employment, or shifting to new accommodation (Fisher et al., 2012:139G). More factors include an indifferent companion who is openly aggressive, exposure to gender-based harassment, confrontational in-laws, difficult relationship with own parents and drug and/or alcohol misuse (Fisher et al., 2012:139G; Marriott & Ferguson-Hill, 2012:341-342), being socially disadvantaged and delivering a female baby (Fisher et al., 2012:139G). Additional factors include lack of reproductive autonomy, unintentional or unwelcome gestation, suffering from some disease or infirmity as a result of

pregnancy (Fisher et al., 2012:139G; Beyondblue, 2011:12). A cross-sectional analysis in United States revealed that marital violence, substance abuse and medical conditions increased the odds of developing stress pertaining to pregnancy by three to four times more (Woods et al., 2010:61).

Marriott and Ferguson-Hill (2012:341-342) highlighted more perinatal risk factors and also perinatal mental health protective factors. The risk factors include:

- Marital disharmony or nonexistence of a companion.
- Stressful birth events or unanticipated birth aftermath.
- Existing key traumatic issues causing tension like bereavement, or shifting accommodation or economic pressure.
- Previous occurrence of mood and anxiety disorders or other mental pathology.
- A companion with a mood disorder, either prenatally or soon after childbirth.
- Reduced social functioning.
- Unemployment.

Beyondblue (2011:12) proposes these as factors that would increase stress in women:

- Previous obstetric problems, inclusive of those related to fertility.
- Prolonged labour and/or birth complications.
- Serious baby blues post-delivery.
- An apprehensive, perfectionist disposition or sustained worry.
- Reduced self-esteem and self-criticism.
- Problems pertaining to breastfeeding.
- Preterm delivery or difficulties with either own health or baby's, inclusive of separation tension.
- Sustained absence of sleep or rest.
- Discomfort in baby such as feeding and sleep challenges.
- When one is a single parent.
- A parent who is a teenager.
- Parenting an excess of one baby, such as twins or more.

Continuing distress increases the likelihood of succumbing to mental pathology like mania and depression, as well as psychosis and schizophrenia after childbirth, family related susceptibility and chances of relapse due to pregnancy and childbirth (Beyondblue, 2011:11).

Marriott and Ferguson-Hill (2012:341-342) identified perinatal mental health protective factors or strengthening or resilience-building concepts and as they recognize the need for intensifying individual's or family members' self-confidence, coping capacity or resilience, by strengthening the protective factors applicable specifically to that family as opposed to attempting adjust susceptibility factors. In population-based community health, these would include bibliographies and success narratives, open-ended discussions, jokes, and therapies for coping with bereavement. They proffered a list of protective factors for perinatal mental health and wellbeing and continuity of care as follows:

- Interplay among cultural norms, spiritual affiliation, individual distinctiveness, household and communal ties, linkage to the country.
- Durable household relations and networks.
- Credence in customary therapeutic activities used to manage life traumatic situations.
- Individual perspective about of wellness, contentment about living, and bright future outlook.
- Elevated level of self-assurance in own child-rearing ability.
- Existence of community backup structures.
- Right of entry to suitable backing amenities.
- Fiscal safety.
- Robust surviving mechanism, and problem-solving skills.
- Sufficient nourishment.

However, there are possible infant outcomes that can unfavorably impact on the way the mother care for her baby, resulting in the likelihood of disrupting the delicate or

harmonious relations between mother and baby (Marriott & Ferguson-Hill, 2012:341-343). Examples include; unplanned premature delivery, compromised association between mother and her baby, impaired intellectual, emotive, interactive and corporeal growth, crying, restlessness and diarrhoeal illness. Evidence indicate that extreme tension in the woman, nervousness and melancholy can give rise to amplified irritability of the baby and weak neurological ratings in newborns, as well as elevated anxiety in women during the third trimester of expectancy and an raised possibility of children developing hyperactivity at the age of four years.

Marriott and Ferguson-Hill (2012:343) appreciate that young mothers have the potential for extra pressures and challenges on themselves, their infant, partner and family, hence an appreciation of adolescent phase of the lifespan drives the propensity to offer developmental age specific mental health care. The women in this phase are presumably full of dynamism and curiosity pertaining to the new skills and learning that they acquire usually facilitates ideal communication and attention to their infants, therefore ideal backing up systems should be freely accessible to avoid detrimental effects on parental or child mental health. There is an initiative that has proven to be exceedingly operative, and it is called the Balga Teen Parent Program which supports youthful mothers towards realising their academic and occupation intentions (Marriott &Ferguson-Hill, 2012:341-343). The initiative is coordinated by a Teen Family Centre to assist in promoting families of new parents towards future financial independence and improved psychological and social health and attainment of life skills through targeted education and training.

3.6 MENTAL HEALTH INTERVENTIONS

Despite the advancing trends, examination and caring for the psychological and social aspects of maternity care, which are essential in promoting mental stability in expectant women and adjustment after childbirth, have trailed behind despite the fact that women feel disempowered, stressed and have emotive upheavals (Kwee & McBride, 2015:2743). Dennis and Dowswell (2013) discovered that therapeutic mental protocols such as, interpersonal psychotherapy, home visits conducted by knowledgeable

professionals, peer backup through telephone conversation meaningfully impact positively by decreasing the frequency of women who get affected by depression after delivery of their babies. Emerging evidence shows that application of creative mental and social approaches which are, incorporated into day to day perinatal activities, opens room for extensive accessibility to psychosocial assets for women and networking for attainment of optimum attention (Kwee & Mcbride, 2015: 2746).

Camacho and Shields (2018: e022022) realized that interventions can prevent unnecessary tension, hence the need to be able to proactively identify any mental challenges and institute appropriate mitigation and treatment of the identified disorders. They assert that the approach has been incrementally harnessed in numerous settings such as general practitioner and primary care settings, although, more needs to be done. Chatterji and Markowitz (2012:61-67) highlighted an important finding that intervention during pregnancy might “mitigate fetal programming associated with maternal stress and improving financial support and length of family leave during the first year of a child's life might decrease risk for maternal depression.” When mothers suffering from mental pathology are afforded the ideal support, it has been realized that there are undisputable merits on bonding and resultant behavior of the child (Stein, Netsi, Lawrence, et al., 2018:134; Bee, Bower, Byford, et al., 2014:25).

There is need for innovative styles of providing realistic perinatal mental health interventions that are tailored towards addressing the exceptionality of the needs of women in the perinatal period in order to achieve appropriate mental health outcomes (Lavender, Ebert & Jones, 2016:399). Carroll et al. (2018:19) emphasized the need for well-timed and suitable intervention which would essentially bring out the best results as women would attain optimal mental stability, hence the need for midwives with an upgraded understanding of mental health so as to ensure provision of support and information to women and their households, as well as identifying when specialist attention is needed. Educating midwives and providing other operational tools, like care protocols and documenting interventions, are necessary in supporting provision of mental health care and collaboration interventions (Carroll et al., 2018:19).

WHO (2018:2) reiterates that it is possible to treat mental ailments if active intermediations are done by health cadres who have attained the requisite competencies. There is a need to completely incorporate mental aspects of maternal care into the services package through routinely screening women during the prenatal period of pregnancy and in the postpartum periods as a means of ensuring that suitable, well timed interventions are employed (WHO, 2018:2). Similarly, in Zimbabwe maternal health care is usually incorporated into other aspects of primary health care (Zimbabwe National Statistics Agency and ICF International Zimbabwe Demographic and Health Survey, 2015:15; Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2016:8).

According to the Comprehensive Mental Health Action Plan (2013–2020:4-5), the current health service structures are not yet sufficiently geared towards coping with the strain of mental disturbances; consequently, there is a big discrepancy between the demand for managing mental challenges and the capacity for its provision globally. Alderdice and McNeill (2016:400) conducted systematic reviews which clearly revealed gaps as they realised the paucity of scientific evaluations that buttressed the explicit role of the midwife in addressing the mental health functional capacity in expectant women, despite the realisation that midwives are the lynchpin for comprehensive exchange. Lavender, Ebert and Jones (2016:402) emphasise the requirement for upcoming amplification of mental health approaches that bring on board versions of Cognitive Behavioral Therapy, Behavioral Activation and/or Mindfulness-based methods as therapeutic means of achieving desirable mental status aftermaths in women during the perinatal spell. Tehari et al. (2018:73) concur that there is accelerated need to improve on irrefutable practical tactics and propose upcoming approaches that deter occurrence of undesirable as well as painful events linked to childbirth. They proposed the undisputed idea of being compassionate to women who are in labour, preparing them for the eventualities and empowerment through minimal intermediation during intrapartum confinement, as means of yielding enjoyable birthing aftermaths through use of highly plausible approaches.

The Health Action Plan (2013–2020:5) has an overall goal of promoting mental stability, preventing mental pathology, providing attention, enhancing recuperation, promoting civil liberties and reducing deaths, maiming, and incapacitation for individuals with mental ailments. The following are objectives of the action plan:

a. *To strengthen effectual headship and governance for mental health.*
b. *To provide all-inclusive, combined and responsive mental wellbeing and collective care amenities in community-based locations.*
c. *To implement approaches for advancement and prevention in mental health.*
d. *To reinforce information systems, evidence and research for mental health."*

The broad targets were crafted for every objective as a means of collectively benchmarking accomplishments towards global goals by member states, but should not necessarily refute the creation of other innovative country specific national targets, especially for the countries which would have already attained global ones. Advancement of "mental health" and inhibition of mental pathology by coopting "emotional and mental health" into the "home and health facility-based antenatal and postnatal care" package for nursing women and their newborns which also must include teaching of child-rearing expertise are some of the intensions of the Health Action Plan (2013-2020:25).

In support of interventions for parenting skills, BeyondBlue (2019:11) proposes some useful interventions towards parental readiness which encompass: having dialogue with others, networking amongst pregnant and parenting women, such as, "mother's group" and "reading parenting books". Other interventions are inclusive of "attending antenatal classes", being conscious about what is expected of you as an expectant woman, during delivery and child upkeep as well as awareness of those available to back you up as need arises (BeyondBlue, 2011:11).

Sharma et al. (2019:26) contend that "existing evidence, although scarce, supports a clinical staging model" where susceptible women who are likely to develop affective disorders following childbirth are exposed to various "behavioural and pharmacological

interventions aimed at preventing bipolar disorder". However, prevention of the disorder is possible with intensive observation and prompt intermediation which is targeted at reducing the likelihood of developing "hypomanic or manic symptoms" in those who are susceptible post-delivery, whist cautiously balancing merits of timely diagnosing and managing against further dangers for the affected (Sharma et al., 2019:26).

Most of the "research and policy" has concentrated on "postnatal depression" up until the present moment. Scientific inquiry has proven that there are operative approaches for "postnatal depression", such that in "low-income and middle-income countries (LMICs) trained non-specialist health workers can provide these" (Howard et al., 2014:1775-1788). Conversely, the scientific base for "perinatal mental disorders" with heightened severity and other mental pathological conditions besides "postnatal depression" is inadequate (Howard, Piot & Stein, 2014:1723).

Diagnosing and managing mental instabilities in the perinatal period is imperative, not only for suicide "which is a major cause of maternal deaths in high-income countries" but there are further repercussions (Cantwell et al., 2011:1-203). Unidentified mental challenges and not instituting interventions in cases of mental pathology impact adversely on mothers and also adversely affect attachment between mothers and their babies and their continuing physical, intellectual growth and development. (Cantwell et al., 2011:1-203). Furthermore, there are substantial financial implications of mental conditions that are left without treatment, which include increased utilization of critical care services, and increased rates of nonattendance at the workplace (California Health Care Foundation, 2019:1; Cantwell et al., 2011:1-203). Luckily, the mental ailments can be treated and interventions which allow prompt recognition are able to result in substantial favourable outcomes, hence the current need to fund projects on "maternal mental health care" innovations (California Health Care Foundation, 2019:1).

Throughout the world, challenges associated with the mental status of women are of utmost concern in public health. (WHO, 2018:3). McBride and Kwee, (2016:5) contend that agreeably "maternal mortality" remains a major "maternal health indicators; for the post 2015 agenda for development goals", but despite that WHO is considering "Universal Health Coverage (UHC) and proposing Healthy Life Expectancy (HLE)

related indicators" additionally. Mental Health Europe (2016:41) emphasized the concept of 'Towards Universal health coverage (UHC)' where one of the essential components is increasing importance of investing with new quality in mental health Goal 3 in Agenda 2030. These developments implied stronger concentration on mental health aspects of care within the "integrated delivery of services for maternal and child health" in all the countries rather than reserving it for developed countries only. McBride and Kwee (2016:5) report that incorporation of mental health initiatives like "low-cost interventions" has already been taken on board by some educational and community institutions for health in "low and middle-income countries". The programme package which is delivered by cadres who are not professionally specialized but are oriented to be provide health services in the community yields favourable outcomes, not only on the mother but also on growth and developmental aspects of offsprings.

California Health Care Foundation (CHCF) (2019:1) alarms at the increased frequency of mental challenges in women, with only a limited number of them receiving therapy. CHCF is thereby searching for ground-breaking, hands-on answers for proffering attention to mental aspects of care to pregnant and postpartum women in California through collaboration with interested parties. Other innovations include the "Blue Dot Project" which "hosts the universal symbol for maternal mental health". The Blue Dot is a "robin's egg blue circle" which represents consciousness about mental disturbances in the mother, back-up systems and working in unison (Los Angeles Maternal Mental Health Awareness Week, 2019:2). The Blue Dot Project is an initiative by "the non-profit organization 2020 Mom" that communicates daily inspiring, realistic messages on social media platforms. The Project is basically anchored on attentiveness to "maternal mental health social media awareness campaign and national symbol" The Blue Dot, representative, Jen Schwartz, pronounced the theme for the 2019 campaign as "#MakingOverMotherhood". It made day-to-day presentations with an aim to "make over" the view of "perfect motherhood and the notion that moms can do it all without support". The campaign entailed a "5-Day Challenge" where mothers joined in and shared "daily real motherhood photos and messages to social media with the campaign hash tag". This was purposed at empowering mothers, as it exposed what actually goes on when they are in the confines of their homes, as well as accepting the demanding

role of motherhood. This acknowledgement is crucial towards possibly averting pathology through assistance in establishing genuine prospects, and also ensuring that the affected realise that they have backup from others. This is also premised on shattering the certainty that there are pure mothers without flaws, whilst emphasizing that they should be realistic without fear of being evaluated or humiliated (Schwartz, 2019:1). Furtermore, they should find solace in proving that being a mother is difficult, shambolic and quite unpleasant at times.

The Department of Education and Early Childhood Development (2013:5) applauds the Victorian Government for committing "$14.03 million over 5 years" for advancing of avoidance and timely recognition, as well as enhancing handling and therapy of depressive disorders during pregnancy and after giving birth. The key components of the National Perinatal Depression Initiative (NPDI) are: "routine and universal screening for perinatal depression and anxiety in both antenatal and postnatal settings. Others are follow up support and care for women assessed as being at risk of or experiencing perinatal depression and workforce training and development for health professionals. Another component is research and data collection and National Clinical Guidelines on perinatal mental health."

3.7 PSYCHOSOCIAL ASSESSMENTS AND SCREENING

3.7.1 Importance of screening

Austin, Fisher and Reilly (2015:227) emphasise that there is progressive realization that "perinatal mental health" is multidimensional, therefore approaches towards identification of mental disturbance must not be restricted to the likelihood of only one condition, for example depression. Studies have shown the importance of psychosocial screening. Kingston et al. (2015:1371) discovered that Canadian womenfolk viewed examination of the mental predisposition during pregnancy as extremely invaluable with minimal risk, this dispels widespread worries that assessing for mental well-being is a harmful practice. The Australian Clinical Practice Guidelines (2017:13) have principal emphasis on timely screening and singling out of those who are subjected to psychological and social difficulties plus those affected by mental illnesses during the

perinatal spell, in order to offer well-timed back-up and careful handling. The timeous drive has intentions of enhancing an improved quality in the way women handle themselves during the expectancy period through to motherhood, namely having more positive mental wellness and security personally and amongst their households. With such an action-oriented approach, parenting even among those with mental pathology becomes so efficient that most of the babies are not specifically underprivileged (Australian Clinical Practice Guidelines, 2017:13). Nithianandan et al. (2018:150) discovered that health cadres viewed validated assessments of the mental status women of the immigrant context as essential, including the most predictable assessment for “post-traumatic stress disorder (PTSD) screening.

January and Chimbari (2018:1127) conducted a study in the same context with this study on Zimbabwe. Findings revealed that because of the high numbers of prenatal attendances and also of women who would have given birth, there is fertile ground to screen for depressive disorders. However the possibility of performing the assessments on every individual is limited by diminished staff and economic depletion. Educating preliminary level health workers on mental issues and absence of scientifically proven questionnaires and checklist for measuring the extent of mental adaptability were the other restraints. An endorsement on ensuring that funds, equipment and supplies are directed towards mental health capacity building of midwives and preliminary level health cadres as a means of ascertaining effective psychological and social stability in perinatal women was made. Carroll et al. (2018:30), in an inquiry by US National Institute of Mental Health, realised that midwives were not well-versed with every aspect of mental health which made them to avoid certain areas, with inclination towards reduced confidence in inquiring about sensitive topics, but only addressed them sparingly on the obviously vulnerable women. Viveiros and Darling (2018:70) also identified inconsistent screening practices and recommended use of validated screening tools in midwifery practice.

3.7.2 Utilisation of the Quality of life enjoyment and satisfaction short form (Q-LES-Q-SF) tool

Several psychosocial assessment tools can be used for perinatal screening and research. The “Quality of life” assessment tool was utilised for this study. The first 14 aspects of “The Quality of Life Enjoyment and Satisfaction Questionnaire- Short Form (Q-LES-Q-SF)” were used to craft the psychosocial scale. The Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF) was patented by Jean Endicott in 1993. Stevanovic (2014:1299) noted that the “Q-LES-Q-SF” is amongst the very regularly used product measure tools in assessing mental stability and the responsiveness boundaries specified that the “Q-LES-Q-SF is 80% sensitive and 100% specific measure.” Endicott (1993:321) developed a 16 item Q-LES-Q-SF self-report scale which stemmed from the general activities scale of the original 93-item form. It consists of fourteen items assessing satisfaction with one’s physical health, social relations, and ability to function in daily life, physical mobility, mood, family relations, sexual drive and interest, ability to perform hobbies, work, leisure activities, and household activities, economic status, living/housing situation, vision and overall well-being.

Several researchers have used the tool to assess the quality of life. For example, Stevanovic (2011:744) noted that the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) and its short form (Q-LES-Q-SF) are among the most frequently used outcome measures in psychiatry research. Psychometric evaluation of fifty-seven adults with a psychiatric diagnosis, using descriptive analysis, internal consistency, test-retest reliability, validity, sensitivity and responsiveness analysis was done. Findings showed that the responsiveness parameters of the Q-LES-Q-SF is 80% sensitive and 100% specific measure and analysis of the Q-LES-Q-SF demonstrated reliable and valid clinical assessments of quality of life.

Bourion-Bédès et al. (2015:172) assessed the integrity of the tool among French drug abusers and discovered that the questionnaire is an essentially forceful tool for estimation of one’s own health standing on substance users. Hope, Page and Hooke (2009:647) decided to move away from the commonly used assessment mechanisms

for irrefutable aftermaths when they based their mundane assessment sequence in a psychiatric unit on the period of confinement even when signs of melancholy and fretfulness would have been considered. Findings revealed factors that have a substantial influence on feelings of contentment with the “quality of life” of incumbents with long-tern ailments, namely chronological age, apprehension, melancholy, education, economic standing, and mobility. Stevanovic et al. (2017:168) also used the tool to examine the “quality of life” in patients with long-standing conditions undergoing rehabilitation.

Harnam, Wyrwich, Revicki, Locklear and Endicott (2011) conducted a study to investigate the “reliability, validity, responsiveness, and interpretation of the Q-LES-Q-SF) scores” amongst the associates of a “group-model health care delivery system with generalised anxiety disorder (GAD).” Their study findings authenticated the “psychometric properties of the Q-LES-SF) and gave additional support for its use as a patient-reported outcome (PRO) tool in this mental health condition.” Reliability was constantly strong, with “Cronbach’s alpha at 0.88 or higher at all time points (baseline, three months, and six months)”. It is well known that GAD has serious adverse effects on the state of well-being and general livelihood position (Revicki, Hays, Cella, & Sloan, 2008:102). Therefore, this evaluation showed that “Q-LES-Q (SF)” is a compact, directional and psychometrically comprehensive tool which comprises an assortment of outcome attributes and is a “PRO” for the evaluation of features of GAD in patients looking for therapeutic interventions (Harnam, Wyrwich, Revicki, Locklear & Endicott, 2011).

Riendeau, Sullivan and Meterko et al. (2018:2953) examined the possible factor structures of the “Quality of Life, Enjoyment, and Satisfaction Questionnaire-Short Form (Q-LES-Q-SF)” in an “enrolled mental health population who were not necessarily actively engaged in care.” Comparison was made between the “Q-LES-Q-SF and Veterans RAND 12-Item Health Survey (VR-12) on 576 patients across nine medical centers using a split-sample approach.” “An exploratory factor analysis (EFA) and multi-trait analysis (MTA)” was conducted. “Comparison with VR-12 assessed construct validity” was done. After removing the item on work satisfaction in view of the increased

rate of unemployment, results of the EFA showed a unidimensional configuration. The MTA revealed a single factor composed of ten items laden on one solid psychosocial factor (α = 0.87). Merely three items existed on a physical factor (α = 0.63). “Item discriminant validity” was “strong at 92.3%”. “Correlations with the VR-12” were consistent with the “existence of two factors”. Study conclusions revealed the soundness, consistency and the merits of the self-report nature of the Q-LES-Q-SF instrument in assessing the excellence of life. The factor structure is to a great extent appropriately described as synonymous with a robust psychosocial factor. Identified variations in the “underlying factor structure across studies” could result from the restrictions in using EFA on Likert scales, linguistic and cultural inquiries, locus of enrolment of respondents, disease burden, and means of administration (Riendeau, Sullivan & Meterko et al, 2018:2953).

Rush et al. (2018:1016) developed and evaluated a “new brief 7 items self-report measure of satisfaction/quality of life in depressed outpatients”. The items selected for rating on the brief “Mini-Q-LES-Q” are “satisfaction with work, household activities, social and family relations, leisure time activities, daily function and sense of well-being in the past week”. Besides detecting the anticipated enhancement of the “quality of life in acute treatment” settings, the “Mini-Q-LES-Q” scale further uncovered remaining deficits commonly occurring when many people seemingly recover from the acute phase of mental disturbance. Findings wrap up the clinical advantages of the “7-item Mini-Q-LES-Q self-report measure satisfaction/quality of life” as having standard psychometric properties, reflecting modification with declining depressive features and detecting residual deficits.

3.7.3 Use of other assessment tools

Klein, Goldenring, Adelman (2014:1-27) discusses uses of the HEEADSSS interview tool for psychosocial interviews with adolescents. The tool focuses on assessment of; “H = *Home* environment*, E = Education / employment, E = Eating / body image, A =* peer-related *Activities, D = Drugs/alcohol, S = Sexual health / sexuality, S = Suicidality / mood, S = Spirituality,”* The “HEEADSSS interview” is a hands-on, repeatedly validated strategy that can be readily used for the “psycho-social review of scan stems” for

adolescent clients. Adolescence is a developmental phase with threats to health including psychological and sexual harassment which may result in “sexually transmitted infections” or unplanned gestations (Bradford & Rickwood, 2012:112). It is unfortunate that the unbecoming repercussions of stress on adolescents such as “obesity, eating disorders, depression or other mental disturbance”, are not obviously identifiable in the absence of suitable psychosocial screening, whilst inability to pick the challenges timeously can have severe consequences like adolescent indisposition and death (McGorry et al., 2011:301; Bradford & Rickwood, 2012:112).

Murray and Carothers (2018:288) validated the Edinburgh Postnatal “Depression Scale (EPDS) on a community sample of 702 women at six weeks postpartum” using “Research Diagnostic Criteria for depression”. Findings revealed that using estimates of “sensitivity, specificity and positive predictive value,” on a large randomly selected sample, would offer better-quality guidelines that direct use of the EPDS among primary care cadres. In another South African study, van Heyningen, Honikman, Tomlinson, Field and Myer (2018:97) compared scales for mental status screening specifically used to detect “antenatal depression and anxiety disorders” on women. The assessment tools used were the “Edinburgh Postnatal Depression Scale (EPDS)”, the “Patient Health Questionnaire (PHQ-9)”, the “Kessler Psychological Distress scale (K10)”, “Whooley questionnaire” and the “two-item Generalised Anxiety Disorder scale (GAD-2)”. Results indicated that all five tools demonstrated varying levels of moderate to high performance in detecting mental pathology. To sum it up, the study endorsed the authenticity of using various frequently used tools for universal screening with the aim of identifying and diagnosing mental illnesses in low-income settings

The “Patient-Practitioner Orientation Scale” as well as additional screening tools to measure insights and proficiency in practical and interactive expertise concerning a couple of measurements of client-centred care “(caring and sharing) among 525 student nurses and 108 nurses” exposed deficiencies in staff’s aptitude towards being supportive in information allotment and empowering patients to partake in decision-making process (Grilo et al., 2014:38).

Handelzalts, Hairston and Matatyahu (2018:89) developed a “City Birth Trauma Scale (BiTS)” in order to ensure that there is an instrument which would accurately tap into the criterion aspects of “postpartum post-traumatic stress disorder (PPTSD)” based on the DSM-5 manual for diagnosing mental conditions. The BiTS “self-report questionnaire”, encompasses every “DSM-5 PTSD” criterion, which states four groups of symptoms namely, “re-experiencing”, “avoidance”, “negative mood and cognitions” as well as “hyperarousal”. An on-line survey was done to validate the efficacy and give a description of the “psychometric” attributes of the “Hebrew version of the BiTS” as compared to the other tools, that is, “the impact of event scale-revised (IES-R)”, the “Edinburgh postpartum depression scale (EPDS)”, and the “Pittsburgh Sleep Quality Index (PSQI)”. Findings revealed a “high internal consistency” “(Cronbach’s α = 0.75–0.85) for the subscales” as confirmation of the authenticity of “Hebrew version of the BiTS” which demonstrated “(Cronbach α = 0.90)”. The convenience and efficacy of utilising the Hebrew BiTS for “clinical and non-clinical research” was genuinely endorsed in view of its psychometrically sound properties. The “exploratory factor analysis (EFA) and cluster analyses” clearly demonstrated that there are finer qualitative differences pertaining to symptoms of particular facets of trauma, thereby supporting the distinction between features of “dysphoria and hyperarousal from childbirth trauma specific symptoms”, unlike the broad symptomatology linked to the “phenomenology of PPTSD”.

3.8 PSYCHOLOGICAL AND EMOTIONAL NEEDS INFLUENCING WOMEN

Beyondblue (2011:11) describes “emotional health” as “a state of wellbeing”, when one experiences feelings of wellness and contentedness, has appropriate coping capability in times of stress, maintains connectedness and enjoys living. Furthermore, women and their offsprings who similarly enjoy living healthy livelihoods and are in good physical shape, to reap the many benefits from being healthy emotionally (Beyondblue, 2011:11). There is realization that you cannot always prepare for all occurrences and it becomes pivotal to remember that some things surpass our control, despite the logical fact that it is essential to make preparations for anticipated outcomes. There is a general understanding that giving birth is a pivotal but traumatic experience for

numerous women Boorman, Devilly, Gamble, Creedy and Fenwick, 2013:4). Research studies put forward the notion that strong sentiments and anticipations pertaining to this experience are prevalent.

Preis, Lobel and Benyamini (2018:37) conducted a “longitudinal study of 330 Israeli first-time mothers” and utilised a theoretical model of tension and stress control to discriminate among physical, emotive, and intellectual influences which are fundamental to the mechanism of contentment. Results showed that precise emotions facilitated the relationship between fulfillment and observed self-governance such that increased perceived self-control pertaining to the birthing atmosphere tentatively resulted in more favourable emotional feelings, reduced apprehension, and enhanced observed carefulness. Whereas the greater the discrepancy between the intended and the resultant childbirth experience forecasted lower gratification, umpired by guiltiness and feelings of perceived care, thereby casting more light on the relationship between contentment with birthing and the lived experiences that the women would have undergone. The study underscored the importance attached to make things easier for women to facilitate attainment of satisfaction with birthing by allowing a two-way discussion of their expectations, provision of a platform that promotes positive experience for women and plugging the gap concerning their anticipations and resultant experience through offering the ideal support. Respecting the uniqueness of the preferences for each woman, whilst reducing condemnation may advance their healthiness and comfort, provision of support that is tailor-made to meet their inclinations should be done through assisting women to deal with the identified expressive and mental challenges (Preis, Lobel & Benyamini, 2018:37).

3.9 COMMUNICATION AND INFORMATION GIVING FOR MENTAL WELLBEING

It is essential to provide “education and information” to the woman, partner and significant others in order to facilitate informed decisions and ideal practices during expectancy and childbirth. All expectant women are obliged to receive frank, current and comprehensive information on which to base their decisions about care choices as

stated in the several health care statutes and protocols (Goldberg, 2009:35). Women get information from several sources, inclusive of members from their families and various mass media (Martin & Robb, 2013:2-6), whereas some women strongly believe in getting the information from the health teams (Akin-Otiko & Bhengu 2012:e895-e896), others prefer to use “paper-based and electronic media”, for example televisions, internet based information, information education and communication material like pamphlets and bulletins (Metzler, Sanders & Rusby, 2012:264). Some of the other women indicated preference for receiving information from health workers who would have conducted home visits, whilst a minimum number of women in that study suggested the idea of sharing information through using parenting networks (Metzler et al., 2012:264). Martin and Robb (2013:3) alluded to the variances in the educational and informational requirements to address the uniqueness of every woman’s situation. Similarly, participants in a study by Akin-Otiko and Bhengu (2012:e895-e896) craved for increased information pertaining to understanding their health circumstances, their treatments and ways of averting complications. Martin and Robb (2013:3) further concur that the trimester of the pregnancy determines differences in the information which should be imparted.

Grilo, Santos, Rita and Gomes (2014:38) and Øvretveit (2012:30) emphasised the need for a consistently professional approach when interacting with clients whilst alarming at the inability to generate an atmosphere and association that is conducive to appropriate interaction despite the predisposition of the patient. Fowler et al. (2011:700) further proffered stages which stimulate active interaction as well as impartation of knowledge to clients as, affording the clients an unprejudiced, impartial demonstration of realistic alternatives, whilst allowing them to contemplate on the benefits and consequences of those preferences. Another stride is encouragement of the clients to constantly talk so as to engage the health cadres in additional deliberations about their apprehensions and desires and permitting an ample enough spell for thinking through their eventualities and misgivings, as they scrutinize the impact of how every choice which they make may possibly affect the anticipated outcomes.

Furthermore, Jucks, Paus and Bromme (2012:181) alarmed at the inability to follow the dynamics of effective communication which would include the importance of stimulating the forces behind effective interaction, through encouraging clients to exhibit their practical understanding and or to openly admit their information deficiencies on particular aspects of interest. (Fowler et al., 2011:700). Results of an inquiry which was conducted in Ghana exposed concerns about women's inability to ask questions, which shortfall was blamed on conducting educational sessions predominantly in clusters without privacy and failure to use utilise resources for "information, education and communication" (Akin-Otiko & Bhengu, 2012:e895-e896).

Research evidence shows that health cadres habitually overrate the magnitude of the knowledge that they impart, yet the clients would be craving for additional information. (Hollander et al., 2017:515). An observed fact is that the health personnel characteristically fail to avail time and in most cases do not even possess requisite aptitude to give a comprehensive, sensible account of the merits and demerits of realistic therapeutic alternatives (Fowler et al., 2011:701). Dzomeku (2011:32-34) conducted a study which unveiled the outcry by women that they were being snubbed and were failing to receive timely enlightenments about care initiatives, which would contribute to inability to use facility-based health services. Martin and Robb (2013:6) reiterated that women did not easily gain access to information sources and they also re-counted that they were not acquaintance with where they could get some of the existing amenities.

Numerous means of ensuring that knowledge impartation is upgraded and interaction is enhanced are proffered. They are inclusive of the utilisation of check-off boxes to keep track of the prominence of interaction as a way of exposing whether clients have received information as well as having been part of the development; using utilities for decision-making; reinforcing the know-how and anticipated outcomes through use of survey mechanisms on clients (Fowler et al., 2011:702-3). Mattocks et al. (2011:127) applauded the necessity of using pamphlets and brochures as well. In all occasions, whatever input and mechanisms have to be premeditated whilst taking into consideration the experiences and desires of clients.

3.10 MATERNAL MENTAL HEALTH CARE IN ZIMBABWE

Undisputedly, the mental aspect within the context of perinatal health services in Zimbabwe is an essential issue which should be understood. Nyanyiwa (2016:1e) highlighted that Zimbabwe, alongside several other United Nations (UN) member states committed itself to attainment of Sustainable Development Goals (SDGs) 3 and 4 of the 17 SDGs which purposes at instituting preventive and therapeutic strategies to reduce untimely deaths caused by non-communicable ailments by a third, and enforcing mental health promotion as a means of ascertaining the attainment of well-being by year 2030. According to the Ministry of Health and Child Care, Maternal Mortality Report of 2016, Zimbabwe is included within the six countries in Africa which have the highest rates of depression which, in the majority of cases is due to challenges faced by women (Nyanyiwa, 2016:1e). The remaining five countries are "Uganda, Senegal, Ethiopia, Nigeria and South Africa". Psychological and mental health care in Zimbabwe is frequently incorporated into primary health services because there are no free-standing amenities which are dedicated to mental health in most areas (Zimbabwe National Statistics Agency and ICF International Zimbabwe Demographic and Health Survey, 2015:15; Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2016:8).

Opportunities for assessing and probably identifying symptoms of mental pathology are availed during prenatal and postpartum encounters and these afford perfect chances for health professionals to respond appropriately and in so doing possibly improve the aftermaths of pregnancies. According to the Demographic and Health Survey for Zimbabwe, approximately all (93%) mothers who had delivered within the 5-year epoch prior to the investigation had attended the antenatal (ANC) clinic where they had been attended to by a qualified maternity care professional and had been seen at least once (Zimbabwe National Statistics Agency (ZIMSTAT), 2015:22).

With the realisation that Zimbabwe is among the African states which have maximal predominance of women who succumb to perinatal mental disorders, the country's health segment has consequently been summoned to pursue further scientific investigation pertaining to mental disorders in women (Nyanyiwa, 2016:1e). Studies

revealed the factors that contribute to the increased susceptibility to PND in Zimbabwe as HIV, discrepancies in the socio-economic standing, gender-related harassment, and eminence of one's life (January, Burns & Chimbari, 2017:294). In a study by Chibanda et al. (2016:55) on 264 adults, living with HIV, a greater frequency of probable common mental disorders (CMDs) (67.94%) was discovered and the prevalence of depression was found to be higher (68.5%) more than those without HIV. In Zimbabwe, "common mental disorders (CMDs)" such as depressive disorders and ailments due to nervousness are rampant amongst the womenfolk (Chibanda et al., 2011:2). They used the "Center for Epidemiological Studies-Depression Scale" for assessment during the perinatal era, when they conducted a survey in Harare and discovered that the prevalence of depression after childbirth was 21.4% among the participants, that suicidal ideation was 21.6% and 4% had attempted to commit suicide.

January and Chimbari (2018:1127) expressed a serious concern about the inability to assess for depression on every woman as a mandatory exercise, yet they realized that perinatal is an appropriate time for maternity professionals to perform such screening and then offer interventions for those diagnosed as being depressed.

The "mhGAP Intervention Guide" conducted a collaborative workshop in Harare in June 2016 to train the trainers and provide input on adaptation to mental challenges. Professional who were trained were from several institutions, namely "Ministry of Health and Childcare", "University of Zimbabwe", "prison services", hospitals and "Friendship Bench project" designed for women who are coping with "HIV and AIDS" and those who suffer from depression. In the initial phases of the capacitation initiative, Holland from "Médecins Sans Frontières (MSF)" facilitated the training of nurses from health and prison organizations on various topics inclusive of essentials of care and other mental health aspects, namely psychotic conditions, mood disorders, epilepsy, drug misuse disorders, mental health issues in children and utilisation of mhGAP implements.

In the wake of increasing fiscal and societal tensions and the predominance of mental pathology, WHO mhGAP (2019:1) further identified the need for training cadres who offer psychosocial support in Zimbabwe to redirect their focus towards provision of services for mental health in the community and in general health institutes, as opposed

to sticking to the existing trends of caring for the mentally ill in mental institutions. WHO mhGAP (2019:2) endorsed the capacitation staff, through instituting stop-gap measures like teaching nurses and other health workers to incorporate mental health into other community health activities, which then becomes an effective means of moving specific tasks from qualified staff to lower level with shorter preparation period, although the crucial role of clinical mental specialists remains invaluable. This task-shifting capacitation further improves the effectiveness of the prevailing important initiatives, as already demonstrated by improved recognition and therapeutic interventions for depression in the perinatal period, better developmental aftermaths in children and enhanced compliance to HIV and AIDs regiments (WHO mhGAP 2019:2).

3.11 BARRIERS TO PROVISION OF PERINATAL MENTAL HEALTH

Studies uncovered several barriers and enablers to the usual screening, subsequent examinations and therapy perinatally. Nithianandan, et al. (2018:150) highlighted some barriers and enablers that are linked to eight realms; awareness, abilities, professional obligations, opinions around proficiencies and concerns, ecological perspective, societal effects and behavioural adaptation. Higgins et al. (2018:9-10) contend that barriers negatively affect the mechanisms of integrating mental health aspects of maternity care into practice and the barriers are divided into organisational, practitioner related and women related.

3.11.1 Organizational barriers

Studies identified several constraints which hinder mental health care among women. These include; economic status, scarcity of resources, inequitable services and unclear mental health service delivery protocols. Higgins et al. (2018:9-10) conducted a study under the auspices of US National Institute of Health and discovered structural obstacles which included unavailability of mental services for perinatal women, nonexistence of care channels, substantial amounts of work, deficient time, absence of confidentiality and not having frequent enough encounters for development of a rapport with the woman. Viveiros and Darling (2018:70) identified other barriers which include broken referral pathways, shortage of specialised care, and protracted waiting period for anticipated services.

According to the Mental Health Action Plan (2013-2020:15), there are severe deficiencies in the numbers of both the staff with the requisite expertise as well as those who are general workers but involved with mental health in countries with poor and moderate economies. The shortage is so critical that the average ratio of psychiatrist to people needing attention is 1 to 200 000 and above, when considering virtually half of the people in the world and the scarcity of those trained to perform specific mental examinations and screening which is even more pronounced. In a similar fashion, statutory instruments, legislature and strategies are more prominent in wealthy as opposed to poorer countries, for example, a much higher percentage (92%) of people residing in wealthy economies are protected by mental legislation as opposed to a lower percentage (36%) of those in low economy countries.

Disparities in accessing treatment incline heavily on the country's economic status. The WHO Mental Health Action Plan (2013-2020:5) realised that low-income as well as middle-income countries, are faced with limited access to treatment of mental pathology such that no therapy is availed for 76% to 85% of people with serious mental disorders as opposed to a similar category in wealthy countries which has lower percentages of 35% to 50% for those who do not receive treatment. An exacerbating factor is the failure to implement and monitor the clients' treatment regimens so as to ensure quality. WHO Mental Health Atlas (2011) provides statistical substantiation to elucidate the paucity of resources required for mental health service delivery within states, whilst placing heavier emphasis on failure to either distribute the resources equitably or utilize the resources effectively.

Deficient funding of mental health services can be a hindrance to delivery of maternal psychological services. Globally, an amount which is below US$2 is spent per individual on issues relating to the mental status and it is much lower in poor countries where US$0.25 is spent on each person (Mental Health Action Plan 2013-2020:5). Further to this, the allocation is skewed towards independent mental institutions which receive 67% of the funds although they are linked with bad aftermaths in health, as well as abuse of the people's rights. The action plan recommended increasing access to improved cost containment care initiatives through adjustments in funding which would

now direct funds towards health services in the community for incorporating mental aspects into the other general health care interventions and other programs, like maternal and child services, sexual and reproductive care, long-standing non-communicable ailments and HIV and AIDS services.

Contrary to the inadequate funding situation, better economic strides have been taken elsewhere, an example is the New Zealand MidCentral District Health Board (MDHB) (2015:20) which created a new funding to boost maternal mental health services that allows clinical nurse specialist (CNS) to augment the attention that the recently delivered women get. The approach entails harmonization of therapeutic interventions for stabilisation of the mental status from the period of expectancy through to one year following childbirth. The aim of the intervention is to reach out to those needing urgent assistance with mental challenges timeously and thereby avoiding exacerbation of their mental condition. A very encouraging feedback has been realised, with mothers strongly acknowledging the timely help in what can be a very stressful period. The funding enhanced work in maternal mental health and has even provided better care to mothers and their children. The NHS England (2018:1) also provided an extra funding for improving the mental status and this was targeting a minimum of 3,000 expectant women as well as mothers who would have delivered recently. Besides this, an additional 30,000 women were allocated £23 million by NHS England towards expert mental health attention, face to face or via the online-based sessions such as skype, in the initial phases of being mothers. This was a preliminary fund which formed a portion of the main upgrading and investment initiative with forecasted total expenditure of £365m, up to year 2021.

3.11.2 Barriers related to practitioners

Hindrances related to practitioners centred on midwives' incompetencies in delivering appropriate mental health care interventions. Inadequate knowledge about mental health and women's cultural standing, incapacitation in skilled mental health skills and fears of offending and distressing women were some of the identified barriers (US National Institute of Health, Higgins et al., 2018:9-10). Viveiros and Darling (2018:70) conducted a scoping review on perceptions about perinatal mental health and

discovered several supply-side or midwifery related barriers that were inclusive of failure to equip the maternity cadres with the required broad-spectrum and multicultural education, awareness and self-assurance on mental health perinatally.

Other barriers were unreliable assessment endeavors, fundamentally dishonoring or stigmatising individuals with perinatal mental health apprehensions and views by midwives about excluding mental health from their perinatal practice parameters. Kwee and Mcbride (2015:2746) lament the inadequacy of access to psychosocial care which they say is due to the fact that cadres who should ensure mental health upkeep in the prenatal, intrapartum and after delivery periods because perinatal health care providers are unsatisfactorily geared up to address emotive characteristics when caring for women. They also realised that traditional, compartmentalised mental attention is ill-timed with limited assistance which is skewed towards only a restricted subset of perinatal women. Another study by US “National Institute of health” revealed that the largest number of midwives who offered clinical practice services for women with mental challenges were only conversant with a limited range of mental issues such as anxiety and depression and could barely understand mental problems further than that (Carroll et al., 2018:29). Other authors identified several other hindrances as harassment by intimate mate, psychotic illness, being ill-equipped to initiate a conversation on delicate concerns of women, for instance sexual abuse, inability to tactfully provide educate women and their significant others (Carroll et al., 2018:29), deficient time, inadequate knowledge and deprived access to amenities for mental health (Kim et al., 2010; Byatt et al., 2012). Documented evidence spells out the mechanisms of relieving these constraints singularly through devising creative methods of screening, educating women and following e-referral modalities (Carroll et al., 2018:29).

Kwee and Mcbride, (2015:2748) reiterated that while reproductive rights have been a focus of advocacy pertaining to issues affecting the womenfolk, facilitating caring by the nursing mothers has not received the desired attention despite significant existing mental health needs. Emotional distress is clearly normative among perinatal women, but they often do not receive psychosocial support during routine perinatal care, yet evidence reveals that practical and cost-effective psychosocial interventions can reduce

negative emotional outcomes and promote positive emotional outcomes (Kwee & Mcbride, 2015:2746). Studies show that the context of primary care is able to better support women, holistically, through the perinatal period, when practitioners are equipped with information and resources that contribute to the implementation of psychosocial interventions (Tehari et.al. 2018:73; Kwee & Mcbride, 2015:2746). Viveiros and Darling (2018:70) emphasized the need to alleviate the hurdles through increased awareness of societal resources, adherence to referral protocols, receiving supplementary mental health education pertaining to the perinatal spell so as to enhance awareness knowledge and self-reliance, and utilizing an evidence-based instrument for examining the mental status of perinatal women, while using it as a antecedent to initiation of dialogue on mental issues.

3.11.3 Women related barriers

Demand-side or women related constraints were identified as emotive segregation, solitude, regularisation of perinatal mental health concern as normal occurrences during expectancy, cultural affiliations related to the mental health of the mother and underlying symptomatology and mental health problems in women that deter the propensity to seek assistance (Viveiros & Darling, 2018:70). More hindrances include inability to distinguish abnormal from normal feelings and expressions, humiliation, viewing health cadres as disinterested and not having time, normalization of mental instability by the family, eagerness to tackle mental challenges personally, and choosing to deliberate on mental status with family members (Highet et al., 2014; Kingston et al., 2015a; Kingston et al., 2015b). Improvement can thus be realized when timeous, appropriate input about attaining emotive and mental stability is imparted to perinatal women, whilst taking cognizance of the fact that the frequent perinatal mental ailments are not easily identifiable (Highet et al., 2014). In addition, it may become difficult for women and their families to seek help because of being afraid of the stigma or the humiliation they might face. The stigma issue can be circumvented through incorporating mental health intermediations into usual systematic work events because initiatives for the mental health of the mother and the development of the baby seemingly move together, such that ample integration priviledges are imminent during the perinatal period (Highet et al., 2014; Kingston et al., 2015a). It has become apparent that mental initiatives that are

done in community settings are of immense benefit and have become better desirable when compared with individualized vertical single-based approaches and they are also gaining momentum in developed countries, because the provision of mental health care with equity dimensions has become progressively exorbitant (Patel & Kirkwood, 2008:868-9).

The BCs Best practice guidelines (2014:15) also identified several barriers to women seeking mental health services:

- “Stigma” (fault, humiliation and ruling) related to mental challenges or looking for assistance.
- Inability to comprehend what normal adaption to the parenting role means and knowing whether one has mental disturbance that deserves assistance
- Taking symptomatology to be trivial and envisaging that it will disappear on its own
- Ignorance about mental pathology and the possibility that it can be treated.
- Inadequate knowledge on the consequences of untreated mental ailments
- Constraints related to inability to speak or interpret a language.
- Apprehension about the baby being taken away from the custody of the parents
- Unavailability of childcare & transport to access reviews.
- Unavailability of facilities.

The majority of women have to be supported by their significant others, associates or the health personnel in finding help for their mental instability (Viveiros & Darling, 2018:70).

3.12 PSCHOSOCIAL CONSEQUENCES OF NEGLECTED MENTAL STATUS PERINATALLY

It is fundamental to note that the mental predisposition of the woman affects her mental and emotive wellbeing, therefore the stability of both the physical state and the mental status with women cannot be underscored, making both aspects core to every encounter with women because failure to take heed has serious reparations during the

expectant period and after childbirth (WHO, 2018:2). Challenges range from disturbing the emotional state and joy of the woman to worsening the mental status during the pregnancy spell and even during parenting, and can be accompanied by an escalated danger of obstetric and newborn difficulties, as well as sometimes serious disturbance to attachment between mother and newborn, and subsequent long lasting mental development of the child (WHO, 2018:2). When a mentally ill woman does not receive treatment to stabilize the mental condition in the perinatal period, the fetus becomes exposed and this adversely affects the resultant psychological health of the infant (Australian Clinical Practice Guideline, 2017:6).

Apparently, severe types of mental pathology usually reduce the mother's capacity to carry out her normal activities, more so the caring capacity towards her baby, with resultant disruption of attachment between the two and this may give rise to concomitant shoddier intellectual, and developmental consequences in children (Australian Clinical Practice Guideline, 2017:13). Since the majority of the Australia maternal deaths from year 2008 to 2012, in the perinatal time occurred as a result of committing suicide (Humphrey et al., 2016:345-6) and the escalation in mortality as a result of psychological and social pressures (Humphrey et al., 2016:345), the guideline therefore attempts to uphold the security issues pertaining to perinatal women.

In severe cases of psychosocial conditions, the anguish of the mothers becomes so critical with resultant suicide and another issue is that those mothers who are victims of the ailments fail to discharge their duties appropriately (WHO, 2018:2; Humphrey, 2016:345-6). Treating depression results in enhanced developmental outcomes for the children and reduction in chances of having diarrhea or malnutrition and is also a panacea for mitigating the excessive anguish and infirmity as well as reduced responsiveness to the demands of the child (McBride & Kwee, 2016:2744). Suicide was identified as a major cause of mortality in women during pregnancy and after childbirth, whilst insanity (psychosis) was of lower prevalence although it could result in one committing suicide or causing harm or inflicting injury to the baby in some instances (McBride & Kwee, 20162744). Following childbirth, the danger of deterioration in health is high since mothers who have depression struggle a great deal and most of the times

do not eat sufficiently, and even fail to attend to their general upkeep, such as neglecting their overall care, including failure to bath (McBride & Kwee, 2016: 5). An important very serious threat is the possibility of infanticide, which is unusual, but it is worth guarding against it proactively (WHO, 2018:2). The mother's depressed state can spill to poor quality of care earlier in infancy because of the extreme sensitivity to the surroundings and this protracted or serious mental ailment impedes the ideal bonding between the mother and her newborn, the general motherly care and effective breastfeeding (Beyondblue, 2011:11; Abel, Hope & Swift et al., 2019:e291).

In a retrospective cohort study nationally which analysed the occurrence of mental pathology in children and adolescents born of mentally ill mothers, Abel, Hope and Swift et al., (2019:e29-30) noted that in UK between 2005 and 2017, the danger of being in contact was greatest in the initial three months after birth, with variations according to the ecological region, the mother's age, and her ethnic affiliation. The highest threat was found among children who had been born of mothers suffering from mental illness, especially depressive conditions and anxiety and geographical predisposition was also found to be an important aspect; being subjected to locations with elevated rates of deprivation thus resulting in increased incidences of mental illness.

Several studies have cited various adverse aftermaths in offsprings that are linked to maternal mental health problems. These include problems with cognitive development, (Bennett, Schott, Krutikova & Behrman, 2016:168-173), physical conditions such as asthma, (Giallo, Bahreinian, Brown, Cooklin, Kingston & Kozyrskyj, 2015:e0121459), and interactive conditions like "attention deficit hyperactivity disorder" (ADHD) and anxiety (Barker, Copeland, Maughan, Jaffee & Uher, 2012:124).

Bauer, Parsonage, Knapp, Lemmi and Adelaja (2014:5) contend that mental ailments during the perinatal period pose a serious public health concern because failure to treat these conditions has a devastating bearing on womenfolk and their significant others. They also emphasized the detrimental effects of mental pathology, and visualized it as one of the prominent reasons why mothers die during pregnancy as well as within a year post delivery. Handelzalts, Hairston and Matatyahu (2018:89) highlighted that prevalence rates of postpartum post-traumatic stress disorder (PPTSD) related to

childbirth in USA communities differs among studies. They discovered that about 2 to 5% of the women were likely to develop PPTSD and a large number of up to a third among the women viewed their childbirth experience as traumatic.

3.13 CONCLUSION

Literature revealed the importance of upholding optimal maternal mental health, whilst unfortunately realising the general deficiency in knowledge and skills on mental health among maternity personnel, against the seriousness of the implications of not attending to the mental health needs of women. It also clearly spelt out the need for active interventions and screening using validated tools and portrayed the organisational, midwife related as well as woman related barriers, whist recommending ways to mitigate them. Literature pertaining to contextual issues in Zimbabwean was explore and the global propensity towards funding maternal health initiatives was also unveiled.

CHAPTER 4

METHODOLOGY

4.1 INTRODUCTION

The previous chapter covered pertinent literature review on maternal mental health, mental interventions, mental screening and contextual issues. This chapter gives the research design and methodology. As outlined in earlier chapters, the objectives of this study were to:

4.1.1 Identify the mental health interventions offered by midwives.

4.1.2 Measure and analyse the extent to which the levels of the psychosocial markers reflect effectiveness of the mental health interventions.

4.1.3 Explore and describe the experiences of women, midwives and key informants on the effectiveness of the mental health interventions.

4.1.4 Develop guidelines to direct mental health interventions throughout the perinatal period in Zimbabwe based on the findings from the study.

This chapter outlines the study design, population, sampling technique, sample, data collection and data analysis. Issues of validity and reliability of quantitative methods as well as measures employed to ensure trustworthiness and authenticity of qualitative approaches are described.

4.2 STUDY DESIGN

The study design directs the techniques and judgements made by the researchers in the course of their studies and guides the reasoning behind making interpretations towards the end of their studies (Creswell & Clark, 2011:53). It is a strategy that shapes how data are gathered, from whom the collection is done and how data were scrutinized to provide answers to the research question(s). Study designs are rational prototypes

that guide investigators at each of the various steps of the research. The study utilised the *sequential explanatory* design which takes place in two distinctive interactive phases, which start with the gathering and scrutiny of quantitative data followed by the subsequent assortment and analysis of qualitative data (Creswell & Clark, 2011:71).

Mixed methods research is ideal in this study so as to overcome the limitations of a single design as well as overcoming the weaknesses of a single design. It proffers the best of both domains; the profound, contextualised, and natural but more time-consuming insights of qualitative research coupled with the more efficient but less rich or compelling predictive power of quantitative research. It correspondingly facilitates addressing a question and a theoretical perspective at different levels. The choice was necessitated by the need to quantify data from the psychosocial scale and women's documents then triangulate with women's, midwives' and key informant' perceptions. According to Creswell and Clark (2011:61), the major reasons for utilising mixed methods which could be triangulation of results, complementarity, development, initiation, and extension. This entails initiation and then building on the quantitative results, by conducting a second qualitative phase to obtain deeper insights of some of the findings in the first phase and then interpreting the two results together (Creswell & Clark, 2011:71). Despite the fact that the research approaches, are diverse in their accentuation, they all address the general issue of intrigue, the purpose, objectives and research questions guiding the examination (Creswell & Clark, 2011:60).

Cronholm and Hjalmarsson (2011:92) contend that one strength is that uncertainties concerning interpretations from the quantitative study could be reduced in the subsequent interviews. Another strength was that the identified problems in a natural way could be transferred to formulation of suitable question areas for the interviews. Cronholm and Hjalmarsson (2011:87) concur that use of mixed methods increases the possibility of achieving findings that are more trustworthy and relevant than using the approaches separately. Developing guidelines for implementation made it imperative to use this pragmatic approach which entails the importance of the descriptive analysis of the psychosocial attributes of women and the documents, followed by exploring as

widely as possible views and experiences of women, midwives and key informants. Following the above discussion, the study was conducted in the following three phases:

Phase 1. Quantitative: By conducting a retrospective study of records utilising a checklist and by utilising a psychosocial scale to assess the psychosocial wellbeing of women.

Phase 2. Qualitative; Utilising a semi-structured interview guide to explore and describe women's experiences on the care they receive in order to meet their mental health needs. Semi-structured interviews were conducted with the midwives and Key informants in the unit.

These responses were facilitated by exploration of experiences on meeting mental health needs from the women, midwives and key informants.

Phase 3. From the results for phase 1 and 2, development of the guidelines that will direct mental health interventions ensued.

4.2.1 Descriptive Study

The most important purpose of quantitative and qualitative research is the description of phenomena (Polit & Beck, 2010:21-22). Descriptive studies "describe, observe, and document aspects of a situation" (Polit & Beck, 2010:236). Kothari (2009:37) contends that a descriptive study targets depicting the situation as it exists in regards to an occasion or potentially among specific people or gatherings and/or the frequency with which certain phenomena occur (Polit & Beck, 2008:752).This is done to generate more understanding about the characteristics of entities within a particular field of study, by providing a clear picture of the situation as it occurs naturally (Polit & Beck, 2010:236).

Enlightening approaches are utilised for quantitative research , such that , the quantitative depiction concentrates on the predominance , occurrence , size , and quantifiable characteristics of phenomena (Polit and Beck, 2010:236). Two descriptive tools were used for the study, namely, the psychosocial scale which measures the psychosocial wellbeing of women during the third trimester of the antenatal period (Appendix 1). The other tool was the document analysis checklist which guides viewing of the documents of those women who would have had normal vaginal delivery in order

to track the psychological interventions from antenatal booking through to discharge post childbirth. The psychological scale and the document analysis were then analysed using frequencies and percentages.

4.2.2 Exploratory study

In addition to the descriptive study, a qualitative study further explores the perspectives and encounters of women, midwives and key informants (phases 2). Exploratory research approach was utilised in light of the fact that the procedure is targeted at the revelation of thoughts and knowledge. Burns and Grove (2009:51) explain exploratory or subjective research as a precise emotional methodology used to portray livelihood encounters and giving them essentialness, to gain knowledge through finding connotations through a perception of the entirety. Exploratory subjective research is valuable in investigating the way in which a phenomena manifests and the underlying fundamental processes (Polit and Beck, 2010:22; Wood and Ross-Kerr, 2011:121). Exploratory research is versatile and adaptable to change such that researchers can alter course when new outcomes and new bits of knowledge rise (Wood & Ross-Kerr, 2011:121). Williams (2011:71) posits progressively valuable data cannot be reduced to numbers and furthermore that people's decisions, sentiments of solace, feelings, thoughts, convictions and numerous other such perspectives must be portrayed in words; henceforth the requirement for subjective examinations.

Exploratory research is adaptable, equipped for adjusting to new data and enables the investigator to examine full circumstances of a phenomenon, how the phenomenon manifests and factors related to it (Polit & Beck, 2012:48). These researchers affirm that subjective research necessitates that the scientist turns out to be personally engaged with the examination, in order to comprehend the phenomenon, and that the specialist applies progressive data analysis, to decide consequent techniques for collecting information and whether data immersion has been attained. As to assortment during the examination, the scientist turns into the exploration instrument. Very little is known about interventions for perinatal mental wellbeing of women in Zimbabwe (January & Chimbari, 2017:4), therefore an exploratory study to further understand the issues became inevitable. This was afforded through conducting semi-structured individual in-

depth interviews with women in the postnatal period that would have had a normal vaginal delivery and were within 2 months post childbirth.

Semi-structured individual in-depth interviews were held with midwives and key informants, that is, the maternity administrative personnel, namely, midwifery educators, senior midwifery officers and medical staff in the unit. A semi-structured interview is possibly the most common qualitative research data gathering method in health and social care research; it is relatively straightforward to organize (Hancock, Windridge & Ockleford, 2007:17).

Besides, numerous examinations surveying perspectives and encounters in the wellbeing area have to a great extent been exploratory, for instance, Tuncalp et al. (2015:1045) utilized an exploratory, subjective investigation configuration to analyse the nature of care for pregnant ladies and infants. The study culminated in the realisation that quality of care is a multi-dimensional concept, namely, safety of health care needs, as well as effective, timely, efficient, equitable, and people-centred interventions. In this way, the quality ascribes helped WHO to build up a system with significant areas of estimation and pathways to accomplish the ideal wellbeing results so as to recognize the activity focuses to improve the nature of care. WHO imagines a reality where 'each pregnant lady and infant gets quality consideration all through pregnancy, labor and the postnatal period.

Also, Howarth et al. (2012:490-492) inspected the impact of the connections between midwives and obstetricians on birth encounters among early postnatal moms through utilisation of semi-structured and eye to eye interviews. The examination uncovered that most ladies had the option to set up a decent passionate association with the midwives, however not with the obstetricians even in the event that the privilege would have been availed. Cornally, Butler, Murphy, Rath and Canty (2014:89) investigated women' encounters of care in labor and found that ladies' view of care are unequivocally impacted by their desires, which thus are interceded by past encounters, their groundwork for the birthing task, the help from maternity specialists and parental figures. Another significant viewpoint is education during the antenatal period which enables women to plan satisfactorily for labour and take an interest adequately in

decision-making. Vedel et al. (2012:77-79) used direct observation, records review and face-to-face interviews to study the adoption of a clinical information system for chronic care and wrote that the use of interviews allowed them to better understand how the system diffused among nurses. Vedel et al. (2012:77-79) utilized direct perception, records survey and up close and personal interviews to examine the appropriation of a clinical data framework for chronic care and discovered that the utilisation of interviews permitted them to have an enhanced awareness of how the framework diffused among health caretakers.

4.2.3 Philosophical context of the study

The phenomenon under study is mental health interventions, its meaning and how it is being practiced as well as how women and health professions experience it. In deciding on the research design, the researcher analysed the extent to which the concept might have penetrated the service delivery system and the extent to which it is being practiced using quantitative approaches. Answering these questions further required exploring individual women's views within the context of the environment where the service was being provided. Midwives and key informants are the direct providers of mental health interventions; their perceptions in particular were deemed to be important to understanding the implementation of the approach to care within the context of health facilities. Equally imperative was the need to understand the lived experiences of women regarding service delivery as well as obtain data from maternity records on the whole continuum of mental health care from antenatal through to post-natal to guide improvements.

The study was, thus, grounded in an inductive process using discrete studies with appropriate methodologies in mixed quantitative and qualitative enquiry. Minnie, Klopper and Van der Walt (2008:52) indicated that a study can be deemed as contextual if validity of the findings is claimed only in the specific context in which the study was conducted. This study was largely contextual since validity of the findings is claimed only in the specific maternity units in Zimbabwe where the study was conducted. In addition, a rich description of the context is provided. This is supported by the AHRQ (2013:2-3) who suggests that paying attention to context in designing,

conducting, and reporting research in health, regarding client-centred care has great potential, since what works in one context often does not work in another.

4.3.1 Characteristic of Zimbabwe health system

The study was conducted in Zimbabwe, which is a land locked country located in Southern Africa. According to the Zimbabwe Population Worldometers (2018:2), the country has a population of 16,900,757 translating to the population density of 44 per Km^2. The country has 8,281,371 males and 8,619,386 females. The total land area is 386,850 Km2 (149,364 sq. miles). The urban population is 31.1 % (5,252,850 people in 2018) and the rural is 68.9% (11,647,907). The median age in Zimbabwe is 19.1 years. Over 50% of the population is youth. The total fertility rate is estimated at 4.3 children per woman, and the age-specific fertility rate for women aged 15-19 years is 120 births per 1000 women (MICS, 2014:4). The population growth rate is estimated at 2.7% per year.

According to the National Health Strategy For Zimbabwe (2016-2020:26), life expectancy for Zimbabweans increased from 34 years in 2006 to 58.5 years in 2015, with women at 61.3 years compared to men at 56.2 years (WHO, 2013:3). This positive trend is also reflected in the major achievements which were made in reducing the Maternal Mortality Ratio (MMR) from 960 maternal deaths per 100,000 live births in 2010-2011 (ZDHS) to 614 in 2014 (MICS). However, this still remains unacceptably high in comparison with the sub-Saharan regional average of 510 (2013) and falls short of the Zimbabwean MDG target of 174.

According to the World Health Organisation Global Health Data (2014:27), 2,100 maternal deaths reported in Zimbabwe in 2013 were due to causes that are known, preventable and treatable. The major direct causes of maternal deaths were haemorrhage (34%), pregnancy induced hypertension (19%), unsafe abortion (9%), sepsis (9%) and the indirect causes included AIDS defining conditions and malaria (18%), and mental illness and other direct causes (11%). According to the Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS 2007:2), the majority of maternal deaths (63%) occur in the postpartum, 24% in the antenatal, and 6.6% in the intrapartum periods. The same study also revealed that successful treatment of direct

causes of maternal death could reduce maternal mortality by 46%. The 2013 HMIS data showed that 87% of the reported maternal deaths occurred at health facilities and 13% at home (although the picture could have been distorted by under-reporting of community maternal deaths).

Adolescence, emotional and social challenges associated with young people contribute significantly to maternal deaths. Zimbabwe has a youthful population, with two thirds of the population below the age of 25 years. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for youth are either deteriorating or remaining high. The adolescent fertility rate in 2014 was estimated at 120 births per 1,000 women aged 15-19 years (MICS 2014:6). According to 2010/11 Zimbabwe Demographic Health Survey, 20.5% of women aged 20-24 years have had at least one live birth before the age of 18 years. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become a mother as their urban counterparts. The decline of the Maternal Mortality Ratio among women of 15-19 years at 21% is much slower than the average decline of 43% for women of 15-49 (MICS 2014).

The Zimbabwean Government is the major financier through the Ministry of Health. According to NHSZ (2016-2020:10), government funding for health improved since 2009 reaching a peak in 2012 of 8% of total government expenditure which remained below the Abudja Declaration commitment of 15% of total government expenditure. During the same period external funding significantly increased from $167 million in 2009 to $428 million by 2012. Such funding has greatly contributed to gains made in health systems strengthening, particularly retention of health workers, procurement and distribution of essential health commodities amongst other things. In 2009, per capita expenditure was $9 and this is estimated to have increased to $24 in 2015 but that remained well below the Cartarm House recommendation of per capita benchmark of $86 (NHSZ, 2016-2020:10).

NHSZ (2016-2020:46) highlighted that vacancy levels are as high as 89% for midwives, 64% for government medical officers and 49% for nursing tutors. Although demand for

midwifery training is high, only 13 of the country's 20 midwifery schools are currently functioning, with plans and funding now in place to revive all 20 schools. In an effort to address high vacancy levels, MOHCC has trained over 4,000 Primary Care Nurses (PCNs) since 2004. PCNs are deployed to rural health centres following one-year training. A donor-funded Health Retention Scheme has assisted in retaining some staff, but a long-term solution for retaining qualified health staff is urgently required. To compensate for staff shortages, the Government has also introduced 'task sharing,' allowing health workers to perform new tasks. For example, Primary Counsellors were recently approved to provide HIV testing and counseling, and MOHCC is advocating for nurses to initiate antiretroviral treatment (ART). Currently every district has at least 2 doctors; every primary health care centre has at least 2 qualified nurses. It is worth noting that the staff complements described are based on a human resource establishment that has not been reviewed based on current service delivery needs.

The National Health Service in Zimbabwe is based on the Primary health care (PHC) concept which was adopted in 1980 to deliver health care to the majority of the population through increased community access to health services. PHC was launched primarily to improve maternal, neonatal and child health (MNCH), and included high impact and cost effective interventions, such as comprehensive antenatal and postnatal care, an expanded programme of immunization (EPI) as well as community level health promotion, child monitoring and surveillance through Village Health Workers (VHWs). By 1990, about 85% of the population had access to basic health services. Health services in Zimbabwe are integrated, so that every health facility offers a full range of available services, which are both curative and preventive services. Thus all health services offer maternal and child health services (MCH), including family planning.

Zimbabwe’s health system is organized according to a referral system, which is a four-tiered pyramidal system with the lower level primary health facilities (clinics), secondary level (district hospitals), tertiary level (provincial hospitals) and quaternary level (central hospitals) (NHSZ, 2016-2020:49). The primary level incorporates the first point of contact between the people and the formal health sector, the Rural Health Centre or clinic. This is the most peripheral unit of the health delivery system, which is the Primary

Care facility. Each Rural Health Centre is expected to cover a population of 10,000 and should be accessible to the community.

There are six national (central) referral hospitals. Each of the eight administrative provinces has a tertiary (provincial) hospital that acts as a referral centre for other hospitals in that province. There is a district hospital or designated hospital in each of the districts. Mission hospitals contribute a significant number of beds mostly at secondary and primary care level with some being run as designated district hospitals. Hospitals are managed by policy prescribed boards and executives. Hospitals are an important part of a health care system as they provide essential curative, rehabilitative and supportive services to primary care facilities. However, they consume significant and disproportionate amounts of resources compared to non-curative services.

In the financial year 2014, central hospitals accounted for more than 30% of total health expenditure (PER, 2015). Despite this skewed expenditure pattern, problems of hospital cost escalation continue unabated. Claims that public hospitals are under-funded, with very little disbursements from Treasury remain. For example, by September 2015, Harare Central Hospital had only received $560,000 out of a budget application of $17,500,000. This means that hospitals are primarily operating at very poor cash flow positions funded by charging patients for services and overstretching creditors thereby increasing debts. Maternity services are offered free of charge at major referral government hospitals, which has led to an influx of women, thereby increasing the strain on the already under resourced units.

According to NHS (2016-2020:26) mental health is faced with a lot of challenges in its management in the community because of long standing cultural stigmatisation. This directly impacts on the health seeking behavior of the population, and support for the mentally ill from families and communities. The bottlenecks identified are inadequate commodities (40%) and low initial utilisation (20%). The low initial utilisation is due to the stigma and cultural barriers. The health delivery system has not adequately paid attention to the availability of commodities and specialist personnel (doctors, nurses, clinical psychologists, etc.) to be able to provide quality mental health services. It is

clear from the strategy documents, indicators and statistics that the mental interventions and mental illnesses are not given due attention, despite the fact that failure to attend to the mental status contributed to maternal and neonatal mortality and morbidity. This is also evident in the midwifery protocols on management of women in the perinatal period, which are silent on mental health assessment and psychosocial approaches.

January, Burns and Chimbari (2017:294) conducted a study on primary care screening and risk factors for postnatal depression (PND) which revealed that the prevalence of PND ranged from 16% to 34.2% in Zimbabwe. Apparently, PND exerts a significant burden on the global public health system, globally affecting approximately 10 to 20% of women. They also noted with concern that despite the recently reported high prevalence of PND in Zimbabwe, it is rarely diagnosed or appropriately managed in primary care settings. Significant risk factors for PND identified among women in Zimbabwe included multi parity, having a spouse who was older than 35 years, poorer relations with spouses or partners, having experienced an adverse event, being unemployed, and having experienced intimate partner violence. Psychosocial factors are implicated in PND occurrence among Zimbabwean women. January and Chimbari (2017:4) also alarmed at the paucity of data on the utility of the screening tools, like EPDS, PHQ-9 and CES-D for PND among women in Zimbabwe. In order to fully integrate mental health into maternal health services, there is need to routinely screen women during the antenatal and postnatal periods so that appropriate and timely interventions can be instituted (January & Chimbari 2017:4).

Zimbabwe has 10 provinces (Figure 4.1) including two cities Harare and Bulawayo which have provincial status. It had 63 administrative districts as shown in Figure 4.2.

Figure 4.3: Zimbabwe Provinces Map
Source: https://www.google.com.gh/search

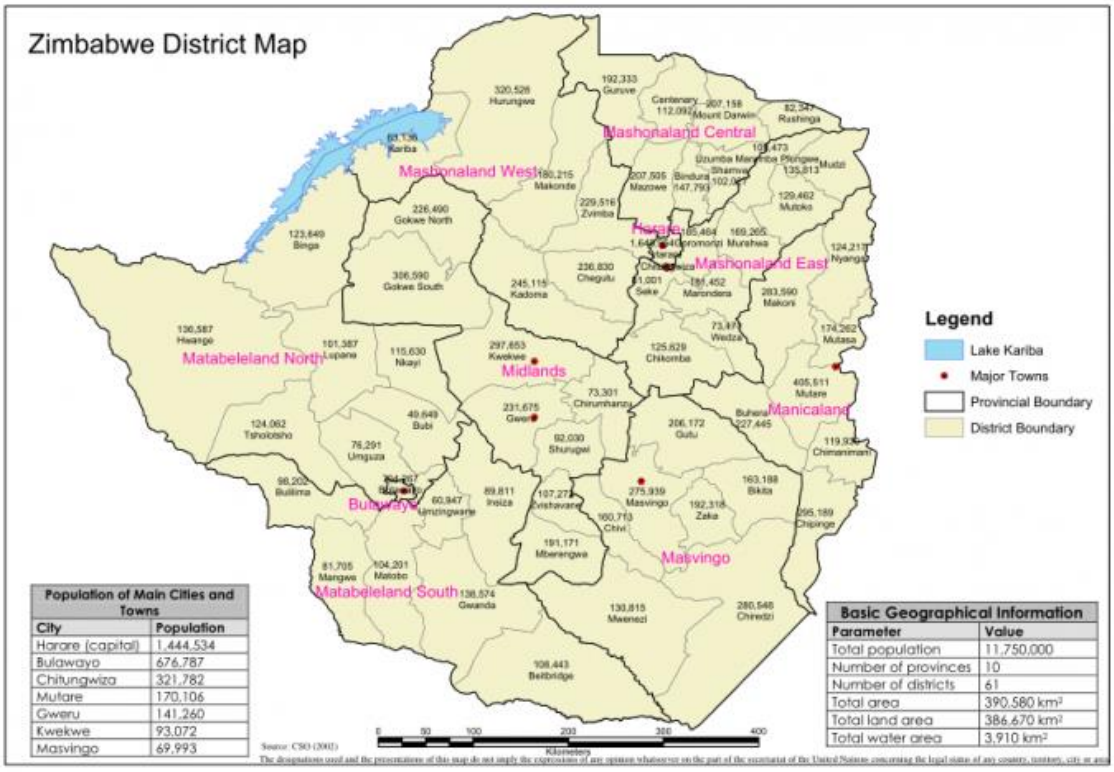

Figure 4.4: Zimbabwe Districts Map

Source: Zimbabwe CSO (2012)

4.3.2 The demographic characteristics of the study region

The study was conducted in Bulawayo, which is one of the 10 Provinces in the country. It lies in the southern region of the country and has an estimated population of 676,787 and a land area of approximately 1,707 square metres. According to the Zimbabwe Population Census (2012:3), the Bulawayo population of child bearing women (15-49 years) is estimated at 56.2%, crude birth rate of 27.3, teenage marriages 9.4% and under five mortality rate of 955/1000births. Regarding maternal health data in Bulawayo, in 2015, the percentage of skilled birth delivery was 94.8%, antenatal coverage was 70.5%, total institutional deliveries was 90.3%, postnatal coverage was 69.1% (UNICEF, 2015:7).

4.3.3 Site sampling technique

Zimbabwe, like other member states to the UN, signed to fulfil among the 17 SDGs, goal 3.4 which aims, “By 2030, (to) reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.” The Mpilo Maternity hospital was purposively selected for the study. The main reason for selecting the hospital was that it is the second largest referral maternity hospital which receives women referrals from five out of the 10 provinces in the country, namely Bulawayo, Matebeleland North, Matebeleland South, Midlands and Masvingo provinces. The total population is almost 50% of the country’s population. The maternity department has five units and the staff is composed of 135 midwives whose duties are scheduled on a 24-hour roaster. There are three obstetricians with 15 doctors working under the consultants. The antenatal bookings are about 250 a month; repeat antenatal visits are about 450 a month. The number of deliveries is around 30 a day. There are other nurses, midwifery students, paramedics and supporting staff. Of note, here is the lack of mental health care specialists dedicated to neither the maternity unit nor midwives who are specifically groomed for mental health care.

In phase 1, the population comprised of 300 women in the third trimester of pregnancy on which the psychosocial scale was administered. The population for the document analysis comprised of 500 women’s maternity records in one month.

In phase 2, the population of women in the postnatal period, who had had a normal vaginal delivery and were within two months post childbirth was 300 a week. The women were at least 18 years of age. The intention was to capture them when they had reasonably recovered from child birth, had experienced community life and were still fresh enough to recall the experiences of pregnancy and delivery.

In phase 2, the population for the midwives on whom un-structured interviews were conducted using an interview guide was 135 and the population for the Key Informant interviews was 10.

4.3.4 Consent from the hospital

Letters detailing information on the proposed research were sent to the hospital administration (Appendix 5). On receipt of written consent, a notice was placed on the notice board in the maternity section by the researcher to inform the staff of the purpose and objectives of the study and to request their support.

4.4 PHASE 1: QUANTITATIVE

4.4.1 Design

Creswell (2014:44) suggests that the quantitative approach is best if the study aims at identifying factors that influence an outcome, or at understanding the best predictors of outcomes. Phase 1 was designed to address objective 1 of the study which was to identify the mental health interventions offered by midwives and objective 2 on measuring how psychosocial markers reflect mental health interventions.

4.4.2 Population, sampling technique and sample

Polit and Beck (2012:738) define a research population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. In phase one, the sample comprised 300 out of a population of 960 women in the third trimester of pregnancy within the two months period of data collection on whom the psychosocial scale was administered. The weekly samples over the eight weeks ranged from 32 to 41 participants. The sample for the document analysis comprised 499 out of around 2,100 women's maternity records in one month. These were records of women who would have been attending antenatal reviews and would have delivered normally.

Purposive sampling was used to select the sample of women in the third trimester of pregnancy on which the psychosocial scale was administered. These were women who had had at least three antenatal visits. The assumption was that these women would have benefited from the mental health interventions which would have been done prior to that particular visit. Purposive sampling of the documents of those women who would have had normal vaginal delivery and would have given consent was done in order to track the psychological interventions from booking through to discharge post childbirth.

4.4.3 Preparation for data collection (quantitative)

Two research assistants were recruited and they underwent a two day training session on the data collection process and tools. The research assistants were midwives that did not work in the sampled hospitals. The research assistants also participated in the fieldwork session to pre-test the tools.

4.4.5 Field work: Administration of the psychosocial scale and document analysis

Before collecting data, the researcher and the research assistants met the management of the hospital to brief them on the plan of work. The team then introduced themselves to the maternity unit administration and staff following which data was collected through use of a psychosocial scale which was administered to women who were in the third trimester (at least 36 weeks gestation) and were above 18. The validity and reliability of the psychosocial tool was already tested since it was adapted from The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) tool which was tested by many authors. A panel of experts was consulted for review of the wording and adjustment of the tool to allow better comprehension.

Data were also collected retrospectively from women's documents. The documents were accessed on discharge post childbirth after obtaining informed consent from the women concerned. These were documents of those women who would have had normal vaginal delivery and they were viewed in order to track the psychological interventions from antenatal booking through to discharge post childbirth.

4.4.6 Quantitative data analysis

A data entry template with legal values was designed to capture psychosocial scale data using excel. Data were checked for completeness, coded and checked for

accuracy. Missing data were addressed by calculating the mean score of the total number of responses. Items that were amenable to scoring were grouped under the different dimensions and scores were assigned on a scale. The scores were recorded such that positive responses with higher scores were compared with negative responses. This was guided by referring to the chart with the calculations and interpretation of the computed scores (see Annexure section). The psychosocial tool which is based on the Q-LES-Q(SF) has a total score which is derived by summing scores from the first 14 items, with each score on a response scale ranging from 1 (very poor) to 5 (very good). The raw total score, which can range from 14 to 70, was then expressed as a percentage of the maximum (or % maximum) total score possible (ranging from 0–100) for ease of interpretation, with higher scores indicating greater enjoyment or satisfaction. The raw total score is transformed into a percentage maximum possible score using the following formula:

$$\frac{\text{(raw total score} - \text{minimum score)}}{\text{(maximum possible raw score} - \text{minimum score)}}$$

On the other hand, the document analysis data were analysed from the recordings against the attributes on the checklist. Items that were amenable to scoring which were grouped under the different dimensions and scores were assigned on a scale. The scores were recorded such that positive responses with higher scores were compared with negative responses.

4.4.7 Statistical analysis of Quantitative data

The data were cleaned and analyzed using SPSS version 23 package. Descriptive statistics, which include means, standard deviations, and medians, were calculated for all continuous variables that were normally distributed and frequency tables were computed for all items and then presented as tables and graphs.

Data obtained from the women's documents using the document analysis checklist were analysed using descriptive statistics on an SPSS Version 23 package. Descriptive statistics, which include means, standard deviations, and medians, were calculated for all continuous variables that were normally distributed and frequency tables were computed for all items and then presented as tables and graphs.

4.5 PHASE 2: INTERVIEWS WITH WOMEN, MIDWIVES AND KEY INFORMANTS

4.5.1 Design

Research designs are procedures for collecting, analysing, interpreting, and reporting data in research and are useful at guiding the methods and decisions that researchers must make during their studies (Creswell & Clark, 2011:53). The design also sets the logic by which researchers make interpretations at the end of their studies. This phase addressed the third objective of the study: To explore and describe the experiences of women, midwives and key informants on the effectiveness of the mental health interventions during the perinatal period in Zimbabwe. The objective lends itself to a qualitative, explorative and contextual research design (Kothari, 2009:36). The in-depth interview technique provided the opportunity to further explore some of the findings from the quantitative portion of the study. Using face-to-face interviews enabled the researcher to explore issues through probing, as well as to clarify issues. Being a qualitative explorative and contextual study, semi-structured interviews, as suggested in DiCicco-Bloom and Crabtree (2006:315), were used.

4.5.2 Pre-testing of the process

- **Women**

The draft semi-structured interview guide comprising seven questions which facilitate probing of the women's perceptions' on the mental health interventions by midwives was pre-tested and then used for the interviews. All the questions requested women to tell the researcher about their experiences as they interact with the midwives from antenatal care through to delivery and discharge. The several questions tapped into the broad question of exploring and describing the experiences of women with regards to effectiveness of mental health interventions during the perinatal period. DiCicco-Bloom and Crabtree (2006:316) agree with this method and posit that apart from an initial broad question, additional five to 10 specific questions are usually developed to delve more deeply into different aspects of the research issue. Additionally, Gill, Stewart, Treasure and Chadwick (2008:292) suggest that the initial question should be one that is easy to understand and should not deal with sensitive issues. This can help put

respondents at ease, build up confidence and rapport and often generates rich data that subsequently develops the interview further.

Pre-testing of the interview guide was done on two women who did not to participate in the main study and on whom pretesting of the psychosocial scale was not done. The main objective of pre-testing was to ascertain whether the process of interviewing would generate the required information. This resulted in adjustments of the interview guides such as removing some questions and modification of others to explore themes that would be emerging.

- **Midwives and Key informants**

A draft interview guide of six questions was used to elicit responses from midwives and key informants after extensive review of the literature. The five question interview guide was discussed with the supervisor and then was pre-tested on two midwives and one key informant who was one of the midwifery administrators from another hospital and obviously was not included in the main study. The pre-test was done to ascertain the flow, flexibility of formats and the feasibility of the guide to elicit the required information. This pretesting culminated in adjustment of the interview guide as identified.

4.5.3 Population, sampling technique and sample

Population is the totality from which cases are sampled based on specific criteria and a sample is a sub-set of that population (Robinson, 2014:25-26). Another guiding principle in deciding on population and sample is ensuring that there is enough data to support credible analysis and reporting (Marshall, Cardon, Poddar & Fontenot, 2013:11). In qualitative studies, it is acknowledged that the aim is obtaining insights into phenomena, events or individuals and not to generalize, which entails selecting groups, individuals, settings and individuals to a population but to obtain insights into a phenomenon, individuals, or events, then purposefully selecting groups, individuals and settings that increase understanding of the phenomena (DeJonckheere & Vaughn, 2019:1; Onwuegbuzie & Leech, 2007:242; Polit & Beck, 2008:338). Purposive sampling was used to ensure that a specific representation of the entire population was selected.

Onwuegbuzie and Leech (2007:242) suggest that sample sizes in qualitative research should not be too large that it becomes difficult to extract thick and rich data

- **Women**

In phase 2, the sample for in-depth interviews was 16 participants and was chosen from a population of 1200 women who had normal vaginal deliveries and were within two months post childbirth. In phase 2, a sample of 17 was chosen from a population of 135 midwives on whom in-depth interviews were conducted and the population for the Key Informant interviews was nine.

Purposive sampling was used to select a sample from the population of women in the postnatal period who had delivered and were within two months post childbirth. The tentative sample was 20 but the real sample of 16 was determined by the point of saturation. The intention was to capture them when they had reasonably recovered from child birth, had experienced community life and they were still fresh enough to recall the experiences of pregnancy and delivery.

To select the sample, prior arrangements were made with the midwives in-charge of the maternity units of the hospital for recruitment. All women who delivered in the hospitals were contacted by the ward in-charge to discuss the purpose of the study and elicit their willingness to participate in the study. Once the women agreed to participate the information would be relayed to the researcher who paid a visit to the women in the postnatal clinic or at home as scheduled, for further discussion and possible interview. However, the researcher visited the postnatal clinic and made arrangements with some of the women to interview them immediately or at a later date and venue as arranged.

This method was convenient because it would have been difficult to obtain a suitable sampling frame of women to facilitate the use of a more objective sampling method. The timing of the interviews was also appropriate as it offered the opportunity to limit recall bias due to time lapse. The sample was difficult to pre-determine but this was confirmed by data saturation.

- **Midwives and Key informants**

In view of the objectives of this study, it was imperative not only to ensure that there was enough data for effective analysis and reporting (Marshall et al., 2013:11), but also to maintain a measure of sample homogeneity so that the study could remain contextualized within a defined setting (Robinson, 2014:27). The population of midwives is clearly specific to that level of a cadre and key informants are the maternity administrative personnel, namely, midwifery educators and senior midwifery officers in the unit.

Purposive sampling was used to select a sample of midwives who participated in the structured interviews. The participants would have worked in the maternity unit for at least six months. The tentative population was about 15 but the exact sample was 17 as determined by the saturation point. The inclusion criteria for midwives were as follows:

a. Working in the maternity unit and offering direct care to women.

b. Should have worked at the maternity unit for at least six months.

After obtaining consent, the contacts of all midwives and key informants were sought from the hospital administration. All the tentative participants were contacted personally by the researcher and invited to participate. All the participants were contacted by phone, digitally or physically to discuss the purpose of the study and to elicit their participation and make an appointment for the interview. However, despite the number of participants who agreed to participate, the interviews were terminated when the point of theoretical saturation was reached. The theoretical saturation theory which has its roots in the grounded theory methodology (Bowen, 2008:137), entails bringing new participants continuously into the study until the data set is complete as indicated by data replication or redundancy (Bowen, 2008:40). Theoretical saturation signifies the point at which to end the data collection (Morse, 1995 cited in Bowen, 2008:40).

For the key informants, a census population was done such that as many of the 9 key informants was recruited. The objectives of the study demanded that the selection of the sample include categories of individuals who had unique or important perspectives on

the phenomenon in question. Cohen et al. (2007:115) also recommend that if the goal is not to generalise to a population but to obtain insights into a phenomenon, individuals, or events, then the researcher could purposefully select individuals, groups, and settings to maximise understanding of the underlying phenomenon.

4.5.4 Field work:

- **Interviews with women, midwives and Key Informants**

The individual interviews with women were done in phase 2. Semi-structured interviews were conducted on women in the postnatal period and had had a normal vaginal delivery and were within 2 months post childbirth. Following approval from the hospitals and verbal agreement from the midwives and key informants to participate in the study, the researcher drew a schedule based on the availability of the participants. However, this was subject to adjustments depending on availability of participants.

The researcher made all the arrangements for the selection of the participant as described under the section on sampling technique in line with the processes suggested in DiCicco-Bloom & Crabtree (2006:315). The researcher made appointments to interview participants in an allocated room in the respective hospital at the stipulated times. The purpose of the study and the processes involved, including explanation of the content of the consent form were discussed with the women, midwives and Key Informants. Their concerns were given attention and solutions were provided where needed. Discussing and explaining the importance of further contacts and the process to assure confidentiality and anonymity ensued. They were informed regarding the use of pseudonyms to be used during the interviews.

The researcher then started the interview by asking the first question and then proceeded with the questions according to the interview guide in the preferred language. The first question was designed to further help put respondents at ease and build up confidence and rapport (Gill et al., 2008:292). The participants were stimulated to further open up through use of more probes to boost their confidence.

The use of the semi-structured interview format is frequent in health care as it provides participants with some guidance on what to talk about, which many find helpful. Gill et al. (2008:291) contend that the flexibility of the approach also allows both the

participants and the researcher to elaborate on emergent issues that were not previously thought of. Demographic data were collected at the end of each interview. Interviews were audio taped. In addition, field notes were taken on reflections and observations.

Interviews were transcribed at the end of each day's work or as soon as practicable to inform the next interview. It was anticipated that some of the women could be disturbed by attention needs to their babies causing some interruptions. Therefore, prior arrangements were made to get someone to care for the baby during the interview. The interviews took between one to one and half hours. Field work was carried out from 15 to 31 January 2019.

As is common with qualitative methods, data analysis usually occurs concurrently with data collection so that researchers can generate an emerging understanding about research questions, which in turn informs both the sampling and the questions being asked (DiCicco-Bloom & Crabtree, 2006:317). After each day's work, the researcher reflected on the process to make meaning and understand the key issues that came up and listened to the recordings to familiarise self with the content. Transcription of the tape recordings started as immediate as possible after each interview. It usually started within a few hours by more experienced transcriptionists in health interview data and if fluent in the local dialect in the study area. This made it possible for the researcher to obtain the scripts in time to read, extract codes and identify emerging themes before the next interview. Information from the review of the scripts was used to modify and or drop some of the questions in subsequent interviews. The interviews were stopped when the point of theoretical saturation was reached. The theoretical saturation is the stage at which the researcher would not be obtaining any new information and can predict responses from subsequent interviews (DiCicco-Bloom & Crabtree, 2006:317-318). No incentives were given for participating in the study.

4.5.5 Field notes

Field notes taking started immediately after each interview and throughout the process of the study. Good field notes should be descriptive to include verbal portraits of the participants, a reconstruction of the dialogue, and a description of the physical setting as well as accounts of particular descriptions of the observer's behaviour (Muswazi & Nhamo, 2013:13). Notes should also be reflective such that they include reflections of methods of data collection, analysis, ethical dilemmas and conflicts as well as the observer's frame of mind and emerging interpretations. The field notes should include

discussion sessions, arrangement for meetings and phone contacts. After each interview, the researcher reflected on the process to make meaning and understand the key issues that emerged.

4.5.6 Data analysis

Bradley, Curry and Devers (2007:1760), spell out the purpose of qualitative data analysis as "generating taxonomy, themes and theory". There is no singularly appropriate way to conduct qualitative data analysis, although there is general agreement that analysis is an ongoing, interactive process that begins in the early stages of data collection and continues throughout the study (Bradley et al, 2007:1760). This study capitalised on concepts of proposition for quality data analysis from Miles and Huberman's (1994:10-11) which constitute three concurrent flows of activities – data reduction, data display and conclusion drawing and verification. Data reduction refers to the process of selecting, focusing, simplifying, abstracting and transforming the data in the transcript. The data display consists of using an acceptable visual format to systematically present information to facilitate conclusion drawing. The third process is conclusion and verification which entails identifying regularities, explanations, propositions, patterns and themes. This third component often begins at the initial stages of the study.

4.5.6.1 Preparations for data analysis

Prior to analysis, it is important to organise the data in hard or electronic copy for easy identification and retrieval. This process becomes an integral part of the research process from the initial planning stage. The transcripts (both electronic and hard copy) for women were labelled sequentially with the first one as 'Ws1', second 'Ws2' and so on. Those for midwives and key informants were labelled sequentially according to how the interviews were conducted with the first one as 'Mp1', second 'Mp2' and so on, for midwives and 'Kp1', 'Kp2' and so on, for key informants. The researcher read through all the transcripts comparing them with the audio tapes. An independent reviewer was engaged to review 30% of the transcripts against the audio tapes. The transcripts were then discussed with midwives and key informants on the phone for agreement.

4.5.6.2 Reading and data reduction/coding

Bradley et al. (2007:1761) opine that reading data without coding to generally understand the scope and context helps to identify emerging themes without losing connection between concepts and their text. The transcripts typed in Microsoft Word were printed to facilitate easy reading. In addition, the researcher read and re-read the transcripts several times to familiarize with the text. The researcher also re-listened to tape recordings to better understand the importance of what the participant was expressing. Furthermore, Bradley et al. (2007:1761) note that coding offers a formal system to organise the data, uncovering and documenting additional links with and between concepts and experiences described in the data. The same authors define codes as tags or labels for assigning units and meaning to the descriptive or inferential information compiled during the interviews. Furthermore, the coding or data reduction initially follows a deductive approach starting with a predetermined framework based on the objectives of the study, the research questions and the literature. The coding was done manually through highlighting with different colours as well as making notes in the computer. This process is laborious and time consuming. The researcher reviewed all transcripts line-by-line to identify codes. In the process, the researcher wrote down impressions.

4.5.6.3 Data display

After reduction and coding, the next step was data display to help determine patterns and themes. A matrix comprising rows and columns was designed in Microsoft Word. The research conceptual framework informed the format which was reviewed several times as new ideas were generated. The researcher scanned the codes and extracted coded segments in the form of block of text, quotes, phrases and symbols and then entered them in the matrix.

4.5.6.4 Conclusion and verification

A critical examination of the data was carried out noting regularities of issues, similarities, relevant ideas to the purpose of the study and patterns to come out with

themes. Bradley et al. (2007:1766) purport that themes are general propositions that emerge from diverse and detail-rich experiences of participants and they provide recurrent and unifying ideas regarding the subject of inquiry. Themes typically evolve not only from the conceptual codes but also from the relationship that exists in the codes. In the process of generating themes, the researcher has to return to the data several times to check the evidence supporting each theme. An independent reviewer was sought to review the transcripts once again, namely the list of codes, the matrix and the themes. A meeting was held with the independent reviewer to discuss areas of disagreements. The codes, matrix and themes were further reviewed by the supervisor and then jointly discussed in a meeting.

4.6 RELIABILITY AND VALIDITY OF THE PSYCHOSOCIAL SCALE

Establishing the validity and reliability of the instrument is an important aspect of instrument development and testing. Validity and reliability are the benchmark criteria for assessing the quality of the instruments and instrument testing was be done before the instrument was administered to the target population (Daymon & Holloway, 2011:79). In order to test for validity and reliability the psychosocial scale was pretested on 10 people who did not participate in the main study in order to analyse and revise the instrument.

4.6.1 Validity

Validity is about the soundness and rigor of the study (Daymon & Holloway, 2011:79). Validity in quantitative research means that the test measures what it is supposed to measure and that the study accurately assesses the phenomenon that the researcher intends to assess (Daymon & Holloway, 2011:79). The types include face, content and construct validity. In quantitative data, validity might be improved through careful sampling, appropriate instrumentation and appropriate statistical treatments of the data (Cohen et al., 2007:133). In this study, face validity was assured by conducting an extensive literature review on the concepts under study. The psychosocial scale was

based on a validated tool that has been used extensively internationally, namely the Quality of Life Enjoyment and Satisfaction–Short Form (Q-LES-Q-SF) questionnaire by Endicott (1993). The draft psychosocial scale was discussed with the supervisor and then with a cross-section of 10 senior midwifery personnel drawn from Mpilo Hospital Midwifery administration and education to determine its relevance, comprehensiveness, readability and applicability. In other words, the panel of experts was consulted to review the instrument in terms of content, format, wording, suitability, clarity and audience appropriateness.

4.6.2 Reliability

Reliability is used synonymously with accuracy, dependability, consistency, and stability. This concept refers to the ability of the instrument to yield similar results when repeating the same study under similar conditions. Reliability concerns the stability of what is being measured on more than one occasion (Langdridge, 2004:35). Reliability was ensured by documenting all procedures that were carried out in the development and conducting of the study so that future researchers could replicate it. Additionally, the research assistants were given a 2-day training to enable them to conduct the psychosocial scale in the same manner for all the participants. This was done as a means of standardising the processes to limit external sources of variations. The researcher re-interviewed at least (20%) of the women who were helped by the research assistants to complete the psychosocial scale during the training session to ascertain inter-rater reliability. The internal consistency reliability of the tool was α=0.83. These notwithstanding, the study needed to be repeated in future to confirm whether or not it would produce similar results.

4.7 TRUSTWORTHINESS OF QUALITATIVE STUDY

It has also been noted that a good criteria for demonstrating and judging quality of qualitative research is trustworthiness and authenticity (Daymon & Holloway, 2011:84). Trustworthiness is the ability of the methodology to capture the reality of those being

studied. Trustworthiness and authenticity are shown by researcher's careful documentation of the process of the research and the decisions made on the way (Daymon & Holloway, 2011:84). A study is authentic when the strategies used are appropriate for the true reporting of the participant's ideas, when the study is fair and when it helps participants and similar groups to understand their world and improve it. The four criteria of trustworthiness put forward by Williams (2011:73); credibility, transferability, dependability and applicability were used to establish the trustworthiness of this qualitative study.

The investigator believed the results of this study would be trustworthy for several reasons: women's accounts are largely in agreement with each other even though the women might not know one another; data saturation would be reached when similar points continued to come up. Furthermore, the researcher worked at the same hospital in the same setting and was well acquainted with women's normal attitudes and behaviours. The interviews were conducted in English with a choice to use the women's native language, which was Ndebele or Shona, according to the preference of the participants. The trustworthiness of the data analysis was further ensured by peer debriefing sessions, using tape recorded interviews.

The researcher ensured that the interview process was done according to the research protocol. Data were collected until saturation occurred. To ensure that the results are credible the researcher used the following techniques to gauge the accuracy of the findings, such as data triangulation, triangulation through multiple analysts, member check, attention to negative cases and providing verbatim quotes. Dependability ensures that the research findings are consistent and can be repeated. This is measured by the standard of which the research is conducted, analysed and presented. The researcher reported the processes in the study in detail. Conformability evaluates the extent to which findings are qualitatively confirmable. The researcher used the following techniques to ensure the conformability of the findings: debriefing, examination of the audit trail and researcher reflexivity. Transferability refers to the degree to which the research can be transferred to other contexts. The researcher provided a highly detailed description (thick description) of the study.

4.7.1 Credibility

Credibility refers to the confidence one can have in the truth of the findings. Cohen and Crabtree (2008:334) and Williams (2011:73) state that activities that increase the credibility of findings are: triangulation, peer review or debriefing, external audits/auditing, member checking, prolonged engagement, negative case analysis, interactive questioning, background qualifications and experience of the investigator and examination of previous research findings. In this study, two approaches; semi-structured interviews and field notes were used to assure credibility. The study also compared documents and views from different perspectives such as women, midwives and key informants to enhance data source triangulation. Furthermore, the research process was reviewed by an independent reviewer and my supervisor. The interview guides were subjected to a number of reviews by teams of experts in qualitative studies and applied research.

4.7.2 Transferability

Transferability or fittingness of research findings refer to the study findings' fitting outside that particular study setting (Jeanfreau & Jack, 2010:613). In other words, transferability relates to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. Williams (2011:73) outlines that to enhance transferability researchers should clearly indicate: the number of organisations taking part in the study, inclusion and exclusion criteria, number of participants, data collection methods, duration and time periods of data collection. Furthermore, Bhattacherjee (2012:111) implores researchers to provide rich, detailed descriptions of the research context ("thick description") and thoroughly describe the structures, assumptions, and processes revealed from the data so that readers can independently assess whether and to what extent the reported findings are transferable to other settings. Transferability in this study was attained through rich description of the study sites and clear description of the methodology.

4.7.3 Dependability

According to Bhattacherjee (2012:110), dependability, is likened to reliability in quantitative research and can be viewed as repeat research by different researchers assessing the same phenomenon using the same set of evidence independently and arriving at the same conclusions. To achieve this, researchers must provide adequate details about their phenomenon of interest and the social context in which it is embedded so as to allow readers to independently authenticate their interpretive inferences (Bhattacherjee, 2012:110). Dependability is primarily achieved through the use of audit trails. In this study, dependability was promoted through providing enough documentation to facilitate inquiry audit. One independent reviewer reviewed at least 20 to 30% of the interview transcripts independently against the audio tapes and this showed consistency with the original transcripts. The same independent reviewer examined the codes and themes that were generated by the researcher from the data. The supervisor reviewed the codes and themes, and examined documentation on all the steps in the research process and the findings. The write-up on the methodology, tape recordings of interviews, transcripts and outline of data analysis were authenticated by the supervisor. The study as a whole was reviewed by a panel of experts constituted by the university.

4.7.4 Confirmability

Confirmability refers to the extent to which others (Bhattacherjee, 2012:110-111) can independently confirm the findings reported in a study. Confirmability is often demonstrated if the study's participants agree with the inferences derived by the researcher. In this study, the transcripts were discussed with the midwives and key informants who participated in the study. Consensus meetings were held with the mothers at subsequent appointments or postnatal visits to discuss the transcripts. A comprehensive literature review validates the findings. The supervisor and another expert in qualitative studies supported the whole process.

4.8 PHASE 3: DEVELOPMENT OF GUIDELINES ON CLIENT-CENTRED CHILDBIRTH

The process of guidelines development follows the key steps recommended by the World Health Organization (2003:5). The researcher utilized the findings from the studies in phases 1 and 2, in addition to extensive literature review, to draft the guidelines using the Delphi Consensus method. The draft document was initially reviewed by a group of eight senior health professionals to build consensus on the content and to determine its feasibility in the Zimbabwean context. The document was then reviewed by the supervisor. The second draft guidelines document was then presented to senior health professionals made up of directors of the Zimbabwe Health Services, director of nursing/midwifery services, the nursing and midwifery council, the confederation of midwives, and other policy makers, obstetricians, mental health specialists, midwives and health services administrators, in order to build consensus for facilitation of effective implementation of the guidelines.

4.9 Ethical considerations

It is generally accepted that all research should be carried out both ethically and with utmost integrity. Request for ethical approval for the whole study was obtained at two levels. Ethical clearance was sought from the Higher Degrees Committee of the University of South Africa, the Medical Research Council of Zimbabwe and the Institutional Review Board (IRB) of the Central Hospital, which is the study site (See the Annexure section). The ethical principles that were applied to this study are: consent, confidentiality and anonymity, beneficence and non-maleficence. The women were informed about the parameters of the study and how they were participating and informed consent was obtained. The researcher was aware that the interviews could harm the women psychologically, thus, great precaution was taken not to ask very sensitive questions. Interviews were stopped when the woman was uncomfortable about giving more information and to make sure that the interview was conducted at a place where the woman felt safe and relaxed. The women were assured of confidentiality and anonymity. The interviews were carried out in privacy, where no one could hear what was being discussed. The researcher did not use anything that would identify the women, such as the name of the interviewee, their children, or spouse, nor

their place of residence. The code numbers given during analysis were not necessarily following the order of the interviews.

4.9.1 Consent

Informed consent is a voluntary agreement to participate in research and consists of a process whereby research participants are provided with adequate information on their rights, the purpose and procedures to help them understand before committing to participate (RCN, 2011a:3). Letters to Mpilo Hospital administration, which is in charge of the maternity hospital where the study was carried out outlined the purpose and objectives of the study, women, midwives and key informants that would be involved, mode of recruitment, and how data were to be gathered and used. Documented consent was received (see annexure).

The participation in the study followed consent from the participants (verbal and written). The participants were made aware of the purpose and objectives of the study. They were also informed that they could opt out of the research at any stage without being penalised or victimised. Refusal to participate or to continue did not lead to any loss of personal benefit. Confidentiality was also affirmed in the letter to the hospital and the consent form for participants. These issues were reiterated at recruitment and at the beginning of each interview. A copy of the participant's informed consent form is attached in the Annexure section.

4.9.2 Confidentiality and anonymity

Confidentiality and anonymity were maintained throughout the study by not attaching names to the collected data but using unique identifiers. Though the list of names and contacts for the midwives and key informants were, they were only used to contact them to seek their participation in the study. No direct identifiers were obtained on the women during the interviews. No names were provided on the interviews and responses cannot be linked to any individual professional or woman. The participants were also assured that the tapes that contained the interview information would be erased after transcription of the interviews.

4.9.3 Beneficence and non-maleficence

Beneficence refers to providing benefits and balancing benefits, burdens, and risks in a study (Beauchamp & Childress, 2009 cited in Ebbesen, Andersen & Pedersen, 2012:1) while non-maleficence means not causing harm to others (Lawrence, 2007:36). When applied to the context of research, it implies that researchers should take actions that will help others or do good to the participants and in the process should not injure or cause harm to any of the participants. The participants were accorded the utmost respect throughout the process. The researcher was mindful and sensitive when dealing with personal issues. They were assured that their time and information would be put to good use and could go a long way to help improve the quality of services. The participants were also assured that they would not be exposed to any harm. The researcher provided the participants with her contact details should they need to enquire about any aspects of the study.

4.10 CONCLUSION

This chapter outlined the study design, population, sampling technique, sample, data collection, data analysis, the validity and reliability of quantitative methods as well as measures employed to ensure trustworthiness and authenticity of qualitative studies. Included also was how ethical considerations were addressed. The study design was sequential explanatory mixed method which employed both quantitative and qualitative methods. The study comprised of three phases, phase one where psychosocial data were collected from pregnant women in the third trimester and from documents of women after childbirth. The second phase was qualitative which entailed the use of mainly purposive sampling techniques, to gather data from women, midwives and key informants. While relevant statistical methods were used for quantitative data, the analysis of semi-structured interviews was inductive.

CHAPTER 5

RESULTS AND DISCUSSION OF THE QUANTITATIVE STUDY ON MENTAL HEALTH INTERVENTIONS IN THE PERINATAL PERIOD

5.1 INTRODUCTION

The preceding chapter four gave clarity on the methodology whilst clearly spelling out the phases of this study as quantitative (Phase 1) and qualitative (Phase 2). This chapter presents the findings of the quantitative phase which involved use of two data collection tools, namely, the psychosocial scale on pregnant women and the retrospective analysis of the documents of women.

5.2 PART 1: RESULTS OF STUDY ON PSYCHOSOCIAL ASSESSMENT OF WOMEN IN THE THIRD TRIMESTER OF PREGNANCY

The psychosocial scale was used to assess the extent to which perinatal interventions had impacted on the mental and social wellbeing of participants in the third trimester of pregnancy. These were women who would have had at least three (3) antenatal visits. The assumption is that these women would have benefited from the mental health interventions which would have been done prior to this particular visit. The Quality of Life Enjoyment and Satisfaction questionnaire (Q-LES-Q) was adopted for the study (see Appendix 1).

5.2.1 Demographic characteristics

A total of 300 women attending for Antenatal care at Mpilo Maternity Unit were subjected to a psychosocial scale, with an objective to assess the extent to which perinatal interventions impact on the mental and social wellbeing of participants in the third trimester. The median age in years among the study subjects was 26 (range: 15-43). The majority of the women, 215 (71.7%), were married and only 85 (28.3%) were single. The First-time women (Parity 0) constituted the largest proportion, 98 (32.7%), followed by the parity of one (30.3%) and the least proportion were those with a parity of four, seven (2.3%). The prevalence of medical conditions was very low, in this

population. The majority of the women, 277 (92.3%), had secondary basic education and only 23 (7.7%) indicated that they had attended school up to primary education. Median satisfaction level in percent with life among this population was 53.6 (1.8-83).

Table 5.1: Demographic characteristics of the respondents (N=300)

Variable	N	%
Age(years), median (IQR)	26(15-43)	
Marital status		
Single	85	29.3
Married	215	71.7
Parity		
0	98	32.7
1	91	30.3
2	77	25.7
3	27	9.0
4	7	2.3
Medical conditions		
Yes	292	97.3
No	8	2.7
Educational status		
Primary	23	7.7

Secondary	277	92.3
Total satisfaction score (%), median(range)	53.6(1.8-83)	

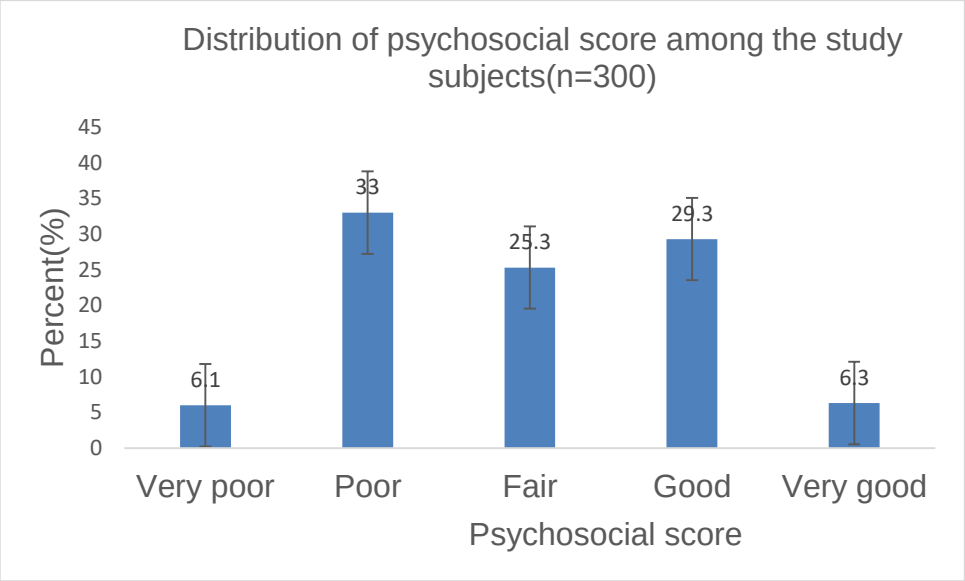

Figure 5.5: Percentage distributions of psychosocial scores

Psychosocial score is poorly distributed in this population with the largest proportion (39.1%) on the poor and very poor side, whilst those under the fair category constituted 25.3% of the participants. Only 35.6% of the participants had a psychosocial score which was either good mostly and a few fell under the very good category. This means that the majority (64.4%) had a low psychosocial score. The results, therefore indicate that perinatal interventions are either deficient or they are not making much impact on the mental and social wellbeing of participants in the third trimester of pregnancy.

Non-parametric tests were performed to determine whether there were variations and association in satisfaction scores and psychosocial status with demographic variables. Results from Manny Whitney and Kruskal Wallis test indicate that all demographic characteristics were not significantly associated with satisfaction of life during the past

four weeks. Similarly, psychosocial status was not associated with marital status, education level, medical conditions, parity and age of the study participants. Overall, findings of this study indicate that there is need to scale-up or to closely monitor these perinatal interventions.

5.2 PART 2: RESULTS OF THE DOCUMENT ANALYSIS ON RECORDING OF THE MENTAL HEALTH INTERVENTIONS

Table 5.2: Recording of mental health interventions during the antenatal period (N=499)

`	**No Recording n (%)**	**Deficient Recording n (%)**	**Fair Recording n (%)**
Antenatal Period			
1 full history of the woman's personal mental health at the booking appointment	30 (6.02)	461 (92.57)	7 (1.41)
2 full mental risk assessment or MSE.	436 (86.06)	67 (13.54)	2 (0.40)
3 Referral for identified high risk of mental illness	485 (98.38)	6 (1.22)	2 (0.41)
4 Individual management plans depending on the mental health needs	467 (94.15)	25 (5.04)	4 (0.81)
5 Counseling services provided according to identified need	150 (30.12)	306 (61.45)	42 (8.43)
6 Woman's current mental health each antenatal clinic visit	458 (91.78)	39 (7.82)	2(0.40)
7 Assessment for social care involvement to support parenting and	417 (83.57)	82 (16.43)	0

the welfare demands			
8 Use of mental health assessment tools	492 (98.80)	6 (1.20)	0
9 Management of identified mental challenges such as self-help strategies, psychosocial support, appropriateness of referral	496 (99.60)	2 (0.40)	0

The recordings of nine items pertaining to the antenatal period were analysed. Findings revealed poor recording on all the items. Deficient recording was noted on taking full history of the woman's personal mental health at the booking appointment on 92.57% of the documents, whilst there was no recording on 6.02% and 1.41% had fair recording. There was no recording of full mental risk assessment or MSE on the majority (86.6%) of the documents, with deficient recording on 13.54%. No comment was written on referral for identified high risk of mental illness on 98.38% of the documents and 94.15% of the documents reflected that there were no individual management plans as dependent on mental health needs.

Recording of the counseling services which were provided according to identified need was deficient on 61.45% of the records and there was no recording at all on 30.12% of the records. The woman's current mental health status was not documented at each antenatal clinic visit in 91.78% of the documents, with deficient recording in 7.82% of the documents. Documentation of the assessment for social care involvement to support parenting and meeting welfare demands was not done in 83.57% of the records. No comments were made in relation to utilization of mental health assessment tools in 98.80% of the documents and 99.60% of the records did not reflect on any information on management of identified mental challenges such as self-help strategies, psychosocial support, and appropriateness of referral.

Table 5.3: Care during labour

	No Recording n (%)	**Deficient Recording n (%)**	**Fair Recording n (%)**
Care during labour			
10. Documented mental health plan and assessment during delivery	494 (99.00)	5 (1.00)	0
11. Written plans for pain relief in labour	499 (100.00)	0	0

It is glaringly clear that the documentation during labour was extremely poor, with no documented mental health plan and assessment during delivery on 99% of the documents. All the records did not reflect written plans for pain relief in labour.

Table 5.4: Care during the postnatal period

	No Recording n(%)	**Deficient recording n(%)**	**Fair recording n(%)**
12. Postnatal assessment and documentation of the client's mental health and emotional wellbeing as part of every postnatal check	454 (90.98)	43 (8.62)	2 (0.40)
13. Prompt records of changes in the mental status	499 (100.00)	0	0

Documentation of the care aspects in the postnatal period revealed that on 90.98% of the records there was no reporting of the postnatal assessment and documentation of

the woman's mental health and emotional wellbeing as part of every postnatal check. There were no prompt recordings of changes in the mental status on all the documents.

Table 5.5: Discharge planning

	No Recording n(%)	**Deficient recording n(%)**	**Fair recording n(%)**
14. Clear lines of communication between services that are crucial for quality care.	467 (93.78)	31 (6.22)	0
15. Community Referral Pathway for ongoing care; to counselors, psychologist, social services, specialist Mental Health Team/Psychiatric services	130 (26.05)	338 (67.74)	2 (0.40)

The majority, 93.78% of the documents did not reflect recordings on clear lines of communication between services crucial for quality care. There was deficient recording of 67.74% and no recording of 26.05% on community referral pathway for ongoing care; to counsellors, psychologist, social services, and specialist Mental Health Team/Psychiatric services.

5.3 DISCUSSION OF THE FINDINGS OF THE QUANTITATIVE ANALYSIS (PHASE ONE)

The quantitative data were obtained using the psychosocial scale and the document analysis checklist, therefore the findings are initially discussed separately and they are then merged finally.

5.3.1 Discussion of findings from the (Q-LES-Q-SF) Psychosocial assessment tool

5.3.1.1 Introduction

This portion of the quantitative study attempted to facilitate a deep appreciation of the psychosocial adjustment, thereby giving a general impression of levels of mental wellbeing of the expectant in their third and final trimester of pregnancy. Using this approach is supported by Creswell (2014:44) who suggests that the initial quantitative phase is worthwhile in identifying factors that influence an outcome such as impact of mental health interventions. In this sequential explanatory study, the quantitative results of the initial phase are then explained further with the qualitative data. The Australian Clinical Practice Guidelines (2017:13) focuses mainly on early screening and identification of those women who are subjected to psychological and social difficulties as well as mental ailments during the perinatal period, for well-timed backing and repair. This initiative has the intention of promoting a women's emotive welfare, their experiences during the pregnancy spell and earlier on in parenthood, the wellbeing of their families and their personal security. With such an action oriented approach, the majority of women that may be suffering from mental ailments become effective in parenting such that most of the newborns do not become particularly deprived (Australian Clinical Practice Guidelines, 2017:13).

January and Chimbari (2018:1127) conducted a study in the same context with this study in Zimbabwe. Findings revealed that the prospects for probable widespread perinatal screening are plagued by constrictions of human and fiscal resources, although the chances for such assessments are supposedly rife in the wake of high prenatal and postpartum service coverage. Other restraints are incapacitation in mental aspects of care amongst primary health care personnel and the nonexistence of scientifically proven depression screening tools for local use. Carroll et al. (2018:30), in an inquiry by US National Institute of Mental Health, realized that midwives were not well-versed with every aspect of mental health which made them to avoid certain areas, with inclination towards reduced confidence in inquiring about sensitive topics, but only addressed them sparingly on the obviously vulnerable women. Viveiros and Darling

(2018:70) also identified inconsistent screening practices and recommended use of validated screening tools in midwifery practice.

Although the presentation of the study results was mostly in; line with the layout of the psychosocial scale, the organisation of the discussion of the findings was largely done according to the dimensions of mental and social adjustment.

5.3.1.2 Demographic characteristics

A psychosocial scale was completed by participants who comprised of 300 women in the study with an objective of determining the extent to which perinatal interventions have impacted on the mental and social wellbeing of participants in their final trimester of pregnancy. The median age in years among the study participants was 26 and most of the women were married. The majority, were either first-time women (Parity 0) or had a parity of one. The majority of the participants had secondary basic education. The median satisfaction level with life in percent among this population was 53.6 (1.8-83).

5.3.1.3 Discussion of findings from the Psychosocial Scale

These study results show evidence of poor psychosocial adjustment among the pregnant woman. Another important revelation is the fact that all the demographic variables are not necessarily linked to the “quality of life enjoyment and satisfaction” of the expectant women. It could probably be a consequence of paucity of mental health interventions or the fact that the mental health interventions may not be making enough impression on the mental status and social comfort of the women. The study clearly exposes the need for scaling up or monitoring the psychosocial interventions, particularly with the use of the (Q-LES-Q-SF) assessment tool. Contrary to the findings in this study, Hope, Page and Hooke (2009:647) discovered attributes that have a substantial influence on the feeling of contentment with the value of life in patients with long-lasting ailments like nervousness, extreme sadness, learning, economic status, consecutive age and freedom of movement.

Utilisation of the (Q-LES-Q-SF) tool has been authenticated by several other researchers who have used the scale to assess “the quality of life”. For example, Stevanovic (2011:744) noted that the “Quality of Life Enjoyment and Satisfaction

Questionnaire (Q-LES-Q)" and its "short form (Q-LES-Q-SF)", are aftermath valuation tools that are included amongst the most habitually used in psychic studies. For example, it was used for psychometric evaluation on fifty-seven (57) grown-ups who were suffering from mental pathology, using "descriptive analysis, internal consistency, test-retest reliability, validity, sensitivity and responsiveness". Findings showed that the Q-LES-Q-SF scored 80% sensitivity on the receptiveness parameters, had a specific measure of 100% and scrutiny of the Q-LES-Q-SF established reliable and valid scientific calculations of "quality of life". Bourion-Bédès et al. (2015:172) also discovered that the Q-LES-Q-SF questionnaire is fundamentally a rigorous depicter of health status in self-reported assessments on substance users.

Harnam, Wyrwich, Revicki, Locklear, & Endicott (2011) immensely bank on the psychometric attributes of the Q-LES-Q-SF and presented further substantiation on adopting it as a "patient-reported outcome (PRO)" tool in patients with generalized anxiety (GAD). Reliability was unswervingly robust, with a high Cronbach's alpha at 0.88 or more at all intervals (baseline, at three and at six months). Given the impact of GAD, this post-hoc study showed that Q-LES-Q-SF comprises a trim and focused psychometrically sound PRO that supplements an assortment of outcome evaluations of features related to those searching for therapy for GAD (Harnam, Wyrwich, Revicki, Locklear, & Endicott, 2011).

Raghuraman, Balasundaram, Sarkar, and Subramaniam (2019:192) conducted a cross-sectional study on individuals attending for preventive health services at a tertiary institution to assess mental pathology and the value of life. Findings revealed that psychiatric disorders were prevalent in one-fourth of the participants attending preventive health-care services. The existence of a mental ailment was connected with a considerably inferior quality of life (QOL) and therefore emphasis should be placed on mundane screening of the mental status as an invaluable exercise in such setups.

5.3.2 Discussion of findings from the Document Analysis

Analysis of the documents clearly revealed deficient recording of the mental health attributes of midwifery care which situation reveals a serious gap in implementation of

psychological interventions by midwives. It was disturbing to note that the highest recording was ‘deficient recording’ on two items out of nine, taking the mental health history and counseling given, which ranked 61.45% to 92.57%. Apparently the scale comprised of five attributes which ranked up to ‘very good’ with the lowest being ‘no recording’. The rest of the attributes which were measured under the antenatal period fell under the lowest ranking, no recording, with percentages ranking from 83.57% to 99.60%. These included mental risk assessment, referral, mental health management plan, mental health assessment at each antenatal review, assessment for social care, use of mental assessment tools and identified mental challenges.

Documentation on care during labour, postnatal care and discharge planning also indicated that the recordings fell under the lowest rankings of no recording mostly and deficient recording. Percentages ranked from 90.98% to 100% for no recording and from 1% to 8.62% for deficient recording on care during labour and postnatal care. Under Discharge planning, the highest ranking of deficient recording was 67.74% and that of no recording was 93.78%.

Other studies have alluded to reporting flaws whilst emphasizing the importance of documentation of interventions and other structural supports. Carroll et al. (2018:19) highlighted the need for teaching and providing other operational supports, like care protocols and documentation, as necessary for training and supporting midwives in their mental health care and collaboration interventions. They alarmed at deficiencies in timely and appropriate care, whilst impressing on a better appreciation of mental health by midwives during the perinatal period, to enable them to produce the best outcomes in perinatal mental health care for mothers and their significant others, and also to timeously recognize the need for expert intermediation (Carroll et al, 2018:19). The Health Action Plan (2013–2020:5) reiterates the need to reinforce information coordination, proof and research for mental health and this can only be achieved through appropriately documented interventions.

The Department of Education and Early Childhood Development (2013:5) applauds the Victorian Government for funding innovations which include upgrading the capacity of the health professionals through trainings, scientific inquiry, and data gathering and

development of National Clinical Guidelines on perinatal mental health. All these are heavily inclined towards proper documentation of perinatal mental health interventions. Jolivet (2011:469) highlights the detrimental effects of poor mental interventions that range from a somewhat elusive lack of respect of the women's self-governance and poise to complete exploitation; physical attack, confrontational utterances, discernment and rejection.

Beyondblue Clinical Practice Guidelines (2011:13) identified distribution of evidence, such as, by writing all examination findings as one of the factors that may improve on offering seamless care. This enhances a mutual viewpoint and collective appreciation of care passageways by all health cadres partaking in perinatal care, with an intention of decreasing disjointed attention and contradictory counsel to women. It subsequently lessens repetition and the possibility for misconstrued conclusions of examinations.

5.4 CONCLUSION

This study was specially intended to develop guidelines to be followed throughout the perinatal period. This could only be done after addressing the two phases of the research, namely the quantitative which is then complemented by the qualitative phase. This section gave the quantitative findings which were obtained following utilisation of the Q-LES-Q-SF psychosocial scale and the document analysis, which revealed that woman definitely had psychosocial challenges but documents indicated a lack of mental health interventions to ameliorate these challenges.

The psychosocial scores were generally poor which indicated that perinatal interventions are lacking or are not producing a noticeable influence on the mental and social welfare of participants in the third trimester of pregnancy. Apparently, all the demographic variables are not necessarily linked to "the quality of life enjoyment and satisfaction" of the expectant woman. It became apparent that the need for scaling up psychosocial assessments and interventions cannot be overemphasized.

Document analysis clearly revealed deficient recording of the mental health attributes of midwifery care, thereby clearly exposing the serious gap in the implementation of "mental health" interventions by midwives. The documentation showed that there was

either no recording or there was deficient recording throughout the different phases of midwifery care, namely, antenatal, during labour, postnatal care and also on discharge planning.

CHAPTER 6

FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH WOMEN ON THEIR VIEWS ABOUT MENTAL INTERVENTIONS BY MIDWIVES

6.1 INTRODUCTION

The results of the quantitative study on the psychosocial analysis of women in the third trimester of pregnancy and the document analysis of women's records following postnatal discharge were presented in chapter 5. This chapter presents results of one of qualitative studies in phase 2, which was done specifically on women. It was crucial towards proffering further analysis, refinement and explanation of the quantitative results which provide a general picture (Creswell 2014:48). In this case a more holistic assessment of how women perceived the mental health care offered by midwives was done, despite the fact that the quantitative study had offered very useful responses.

The interviews generated information relating to women's perceptions about how midwives cope with the mental health requirements of women, whether midwives raise adequate alertness on the importance of being mentally stable, as well as the consequences of women keeping worries and concerns to themselves. Interviews also explored how supportive midwives are to the mental wellbeing of women, how they facilitate reduction of stigma around mental health issues, women's' expectations, factors hindering provision of appropriate mental health interventions and ways of improving mental health. Table 6.2 outlines the categories and themes that originated from the data.

6.2 DEMOGRAPHIC CHARACTERISTICS

Table 6.1 presents the demographic characteristic of the women. Sixteen women within age range of 22 to 38 years and mean age of 30 years participated in the study. Eight (50%) were aged between 22 to 30 years and another 8 (50%) were in the age range 31 to 38 years. All the participants attended school up to 'O' level with four having

attained tertiary level diplomas, one in primary education, and the other in adult education. Another obtained a diploma in secretarial studies and the other in catering. The mean number of children (alive) that the women had was two with the minimum being one and maximum four children. The number of children included the current child to which they had given birth. All the women had live births but one woman with a parity of five had lost an eight month old child due to ARI. Twelve (62%) were married women while six (38%) were single mothers. The majority (75%) of the women had delivered before and only four (25%) were first time mothers. Eight (67%) of the women had used delivery services in the hospital before and for the other four (33%) this was their first time. This excluded the four who were first time mothers. Regarding residential location, all the women lived in the urban settings; 14 (88%) in high density and two (12%) in low density suburbs. All of them used antenatal services in the hospital in which they delivered.

Table 6.6: Frequency and percentage distribution of demographic characteristics of women

Demographic characteristics	Frequency n=16	Percentage %
Age		
22-30	8	50
31-38	8	50
Highest educational level attained		
'O' level	16	100
Tertiary	4	25
Number of children		
1	4	25
2	6	38
3	5	31
4	1	6
5	1	6
Marital Status		
Married	10	62
Single	6	38
Prior delivery in the hospital (minus 4 first time mothers)		
Yes	8	67
NO	4	33

Location of Urban residence		
High Density Low Density	14 2	88 22
Antenatal attendance at hospital		
Response	16	100

The demographic characteristics of the study participants are very similar to those of the study region. The age range and pattern of number of children is supported by the national demographic data of women in the childbearing age as well as the fertility data (Zimbabwe Population Worldometers, 2018:2). According to the Zimbabwe Population Census (2012:3), the Bulawayo population of child bearing women (15-49 years) is estimated at 56.2%, crude birth rate of 27.3, teenage marriages 9.4%. The median age in Zimbabwe is 19.1 years. Zimbabwe has a youthful population, with two thirds of the population below the age of 25 years. Over 50% of the population is the youth. Adolescence and emotional and social challenges associated with young people contribute significantly to maternal deaths. The youth is one of the key affected population groups as most of the sexual reproductive health indicators for the youth are either deteriorating or remaining high. The total fertility rate is estimated at 4.3 children per woman, and the age-specific fertility rate for women aged 15-19 years is 120 births per 1000 women (MICS, 2014:4). The population growth rate is estimated at 2.7% per year. The urban population is 31.1 % (5,252,850 people in 2018) and the rural is 68.9% (11,647,907) (WHO, 2013:3). According to 2010/11 Zimbabwe Demographic Health Survey, 20.5% of women aged 20-24 years have had at least one live birth before the age of 18 years. The rural-urban differential in teenage fertility is striking, as rural girls were twice as likely to become a mother as their urban counterparts. The decline of the Maternal Mortality Ratio among women of 15-19 years at 21% is much slower than the average decline of 43% for women of 15-49 (MICS 2014).

The antenatal attendance and the tendency to deliver in hospital in this study is not surprising since country profiles indicate that about 85% of the population had access to basic health services by 1990 (NHSZ, 2016-2020:49).Regarding maternal health data in Bulawayo, in 2015, the percentage of skilled birth delivery was 94.8%, antenatal coverage was 70.5%, total institutional deliveries was 90.3%, postnatal coverage was 69.1% (UNICEF, 2015:7). Health services in Zimbabwe are integrated, so that every health facility offers a full range of available services, which are both curative and preventive services. Thus, all health services offer maternal and child health services (MCH), including family planning.

Table 6.7: Categories and themes on findings of interviews with women

Category/theme	**Number that responded** **n=16**
Meeting mental health needs	
• Mental health education and assessment • Psychosocial and emotional support	**16** **16**
Relationship with midwives	
• Respect and courtesy • Communication and attentiveness • Stigmatisation • Continuity of care	**12** **14** **9** **15**
Expectations from women's perspectives	
• Pleasurable experience • Partnership in care • Respectful communication and attentiveness by midwives	**16** **8** **14** **6**

• Mental health education and Counseling	
Women also have a role to play	
• Some mothers are to blame	**4**
Hindrances from women's perspectives	
• Too many women but Inadequate staff • Incompetent midwives • Unacceptable attitude by midwives • Poor communication	**15** **14** **12** **16**
Enhancement of mental health	
• Increase staff • Enforce partner involvement • Maintain standards • Respect women • Re-educate and supervise midwives on women care	**15** **10** **9** **16** **15**

6.3 MEETING MENTAL HEALTH NEEDS

Meeting mental health needs is essential for emotional wellbeing of women throughout the perinatal period. Mental instability perinatally is associated with inadequate antenatal care, low-birth weight and preterm delivery, as well as diminished emotional involvement, neglect and hostility towards the newborn (Satyanarayana, Lukose and Srinivasan, 2011:352). Coates and Foureur (2019:797) reiterated the importance of meeting perinatal mental health needs, whilst commenting on the impact of unmet

mental health needs which they said are linked to poor outcomes for mothers, babies and families. Despite recognition of the significance of this issue, women often do not receive the care they need and fall between the gap of maternity and mental health services (Coates & Foureur, 2019:797). Improved understanding of perinatal mental health by midwives improves specialist care, ensures that vulnerable women and their families have appropriate access to mental health and community support services (McCauley et al., 2011:4). Milgrom and Gemmill (2014:13) reiterate the need for midwives' involvement in providing care that encompasses their mental well-being.

The two themes that emerged from this category were:

- Mental health education and assessment.
- Psychosocial and emotional support.

6.3.1 Mental health education and assessment (N=16)

Provision of information during the antenatal period, education and ensuring support through being conscious of community amenities are strategies of primary prevention that may possibly enable appropriate, timely recognition of mental ailments so as to proffer well timed interventions (FNMWC, 2015:3). Health promotion and education increases awareness, attitudes and behavior, whilst facilitating engagement in safer and healthier lifestyles as well as supportive family relationships (FNMWC, 2015:5). Further to this, attention to the physical aspects and safety during pregnancy is a critical aspect of improving mental wellbeing which is interconnected to physical wellness. FNMWC (2015:5) further highlight that strategies for educating on health issues, and promoting and preventing mental pathology, should be directed at reestablishing connections to the strong cultural inclinations and augmenting the autonomy of women as well as their families. This would spill to collective participation in communal activities, solidification of defense against mental illness, boosting of elements that shield against mental pathology, whilst reducing the perilous aspects.

The BC Expert Panel (2014:3) impresses on the practice of screening all women for depression and other mental illness for a minimum of two times in the worst off

scenario, which entails that they can be screened once during the prenatal spell and also once after giving birth with the use of scales such as the “Edinburgh Postnatal Depression Scale (EPDS)”. They realized the greater potential benefits as opposed to harms from screening, such that the consensus recommendations included carrying out research which would culminate in prominent adjustments to practice, which are strongly reliant on excellence in evidence provision. There was also need to equip staff with the knowhow about the merits of screening and dangers of not screening every woman during the perinatal sequel through excelling in advocating for chances and amenities for embarking on upgraded quality. A systematic review by Alderdice, McNeill and Lynn (2012:2) in Scotland revealed that the risk factors must necessarily be identified in order to craft mitigatory strategies that are tailor-made to explicitly address those aspects in order to prevent depression and other mental ailments during the expectant period. The study emphasized the need for a strategic tactic to stimulating mental health for women through development of the propensity towards randomized trials which should be controlled and must be of an elevated quality.

Apparently, January and Chimbari (2018:1127) realised that because of the high numbers of prenatal attendances and also those women who would have given birth, fertile ground to screen for depression disorder is afforded, however the possibility of performing the assessments on every individual is limited by diminished staff numbers and economic depletion. Educating preliminary level health workers on mental issues and absence of scientifically proven questionnaires and checklist for measuring the extent of mental adaptability were the other restraints. An endorsement on ensuring that funds, equipment and supplies are directed towards mental health capacity building of midwives and preliminary level health cadres as a means of ascertaining effective psychological and social stability in perinatal women was then made. Carroll et al. (2018:30), in an inquiry by US National Institute of Mental Health, realised that midwives were not well-versed with every aspect of mental health which made them to avoid certain areas, with inclination towards reduced confidence in inquiring about sensitive topics, but only addressed them sparingly on the obviously vulnerable women.

The participants of this study, spoke about how health education is imparted and challenges which are encountered. Most of the health counsel takes place at the antenatal phase through group educational sessions and health topics which are designed for a group by the staff on their own, without any input from women. The participants generally alarmed at the paucity of information on mental wellbeing. One-on-one sessions to further educate and provide clarifications should ideally be conducted when midwives now attend to women on individual basis but these seem erratic. Some of participants gave accounts of the issue as follows:

> *'The education sessions are done in a group but I think that if the midwives would continue when you are alone, it would be helpful since I now could have a chance to ask other about other things which I would not ask when others are listening'* (Ws9).

> *'They talk to us in a group on topics like HIV, delivery, baby care, but they do not tell us about keeping ourselves mentally well…not even when you are being attended to on your own'* (Ws10).

The statements above clearly indicate that there are deficiencies in offering additional education when women meet with midwives during personal interactions. Some of the participants ascribed this shortfall to the inability of midwives to cope with the large volumes of women. Other studies support these findings. Akin-Otiko and Bhengu (2012:e895-e896) discovered variances in preferences because, whilst some women were disgruntled about using the group method to impart knowledge in maternity institutions, others found the modality plausible. Further to this, education and information needs are also different due to the uniqueness of women (Martin & Robb, 2013:3), such that the variance is further compounded by the peculiarities of the different trimesters as well as the person to person preferences (Martin & Robb, 2013:3).

Further descriptions clearly emphasize the absence of information on mental health:

> *'They do not give information about being mentally well…it is about the pregnancy, giving birth and child care….'* (Ws11).

'…I was never told anything about mental wellness, neither were others…' (Ws12).

*'…they don't make us aware about the importance of keeping well mentally. The talk they give is about the prog*ress of pregnancy*'* (Ws15).

This study also indicated that mental health assessments are generally not done. This is evidenced by comments from some of the participants as follows:

'They do not ask well enough for you to say everything such that you have nobody to tell your worries, unless if there is somebody with an obvious mental illness' (Ws3).

'…when they look at you they do not ask deep enough about mental wellness to make you feel like exposing your thoughts. They do not examine the mental part from the look of things. It is only the pregnancy…' (Ws1).

On the contrary, findings from a study in Australia by Marnes and Hall (2013:e112) which examined the benefits of psychological, societal and therapeutic assessments, emphasised the importance of health screening. Suggestions in that study included assessing essential psychosocial aspects using scientifically approved screening tools, clinical dialogue, examination of the body, conversation with mate, awareness of the relationship between mother and her baby and establishing issues around baby's pattern of sleep and nutrition.

Some participants reported having received information about mental wellbeing from the internet and other sources. One of them had this to say:

'*I have never heard midwives talk about mental wellness, but I have read on internet and in magazines about how to stay mentally well…* ' (Ws 6).

Other studies support the use of various media of communication. For example, some women indicated that they were interested in reading information primarily from paper sources like pamphlets and bulletins, whilst others preferred information from electronic technology including online resources and television (Metzler et al., 2012:264), despite

the fact that quite a number of women heavily depend on the health personnel to give them the requisite information (Akin-Otiko & Bhengu, 2012:e895-e896).

6.3.2 Psychosocial and emotional support (N=16)

For a lot of women expectancy and giving birth are occasions that bring insurmountable mental tension (Boorman et al., (2013:4), such that it usually prompts women and families to search for psychological and social backup from numerous sources as a means of trying to cope with uncertainties and apprehensions related to the period of expectancy (Dako-Gyeke et al., 2013:7). Williams, Ryan and Thomas-Peter (2014:6) found it necessary therefore to develop the best practices guidelines (Based on the BC's Framework), to improve collaborative, and supportive care in relation to caring for woman in the perinatal period and ensuring that the care is focused on the woman. Guidelines were anchored on the realisation that a considerable number, that is, for every five women, one will succumb to a significant mental health challenge during pregnancy through to after childbirth, but unfortunately only a few will seek help. McNeill and Lynn (2012:2) noted that those women who were exposed to psychological and social mitigatory measures had reduced likelihood of developing mental pathology after childbirth when compared the ones where only the regular care was offered. The study brought about an interesting observation that all the participants were aware of the fact that pregnancy causes stress and they were aware of the various impacts of stress:

> *'…raised blood pressure and causes heart problems* (Ws10), *headaches and miscarriages* (Ws 11)*, physical illness, mental illness and depression* (Ws 14)*, premature deliveries and poor relationships'* (Ws16).

Beyondblue (2011:11) describes "emotional health" as having feelings of being mentally sound, satisfied and better poised to face challenges head on, being able to sustain connections with others and appreciate the pleasures of life, such that eventually, women and their babies should benefit from being emotionally healthy. Giving birth is understood within the context of being a pivotal but traumatic occurrence for numerous womenfolk, which is difficult to prepare for but it evokes strong emotions and

expectations regarding the experience (Boorman, Devilly, Gamble, Creedy & Fenwick, 2013:4).

The views on offering emotional support had a mixed flair generally. The participants echoed the accelerated need for midwives to render psychosocial and emotional support. Some of them gave a mixture of encouraging and undesirable affirmations, although the widely held view by most was that they found it difficult to deliberate on their uncertainties and apprehensions with the midwives. For instance, some responses on how midwives starved women of time for adequate support were as follows:

> *'…not supportive because they have neither time nor intention to want to know more about you or to comfort you. They just walk up and down past you like you do not exist…they add stress'* (Ws10).
>
> *'…do not spend enough time with women during antenatal reviews and also during labour and for child care'* (Ws15).
>
> *'They do not give you the necessary support…like during labour and after childbirth they do not supervise child care'* (Ws13).
>
> *'…do not talk to you most of the time…they talk and laugh to each other and you are very frightened to talk or ask anything because you are afraid of being scolded'* (Ws4).*'*
>
> *'…they should not put us into panic mood by saying things like 'you will lose the child….you will die… or even threaten you with caesarian section (Ws5).'*

A first time mother narrated her experience:

> *'… not supportive…do not tell you what to expect in labour…you rely on what you heard others say. They even ignore when you call for help and may even tell you that you don't know anything about labour'* (Ws16).

A narration example of the two who had both negative and positive comments is:

> *'Some of them are somewhat supportive but most don't have the heart to care passionately. They remain detached and only attend to crucial aspects like delivery, even if they ignore you when you are in pain'* (Ws11).

Only one of the participants outwardly narrated a very supportive exposure as:

> *'…very impressed by the support I received from the midwives throughout…it was really excellent. Those who complain do not come to maternity early enough for booking, and do not attend lessons'* (Ws9).

Participants considered the ability to discuss pertinent issues with health staff as extremely indispensable. Despite their awareness about the impact of stress, many of the participants described some occasions where they were disregarded at a time when they would have needed attention to their psychological and emotional requirements. Sentiments pertaining to this issue were seemingly dampening throughout the various stages from antenatal, intrapartum, through to postnatal stages. The majority indicated that midwives do not proffer the requisite support. For the antenatal stage, the main worries of women were about the failure to provide enough time to pay more attention to their psychosocial and emotional needs. During labour the concerns were about receiving undivided psychological support throughout and also there was further concern about support during the postnatal phase.

It is saddening to note that without psychosocial support women can develop mental illness, which could result in increased difficulties during pregnancy, and compromised mother-infant relationship (Williams, Ryan & Thomas-Peter (2014:6). Dako-Gyeke et al. (2013:7) conducted a similar study which concurred with the need for the woman and her mate to get "psychosocial and emotional support" which they could seek elsewhere, such as from nonconventional providers like spiritualists if not provided by midwives. The BC Expert Panel (2014:22) emphasizes that supporting woman socially has an invaluable role of facilitating psychological adjustments to pregnancy, childbirth and motherhood. Williams, Ryan and Thomas-Peter, (2014:80) proffers support networks such as "Family Physician/Midwife/Nurse" Practitioners, "Local Public Health Nurses", "Mental Health Team", Health Link "BC", Mental Health Support Crisis Line, Suicide

Line. Other support mechanisms are through provision of information and communication materials and e-resources for women, partners and families. The Guiding Framework was intended for use as an administrative manuscript for amalgamating resources for the communal wellbeing.

6.4 RELATIONSHIP WITH MIDWIVES

The superiority of the childbearing experience has its roots in establishing passionate relationship where women liaise with their health providers freely. Ability to relate effectively infiltrates all aspects of any undertakings and is among the most important powerful factors that encroach on contentment with care among women (Srivastava et al., 2015:8). The uniqueness of the interaction patterns of each and every health cadre and the organisation's capacity to harness relational innovativeness are key to optimal health care (Andrissi et al., 2015:2). Four thematic areas emerged under this category:

- Respect and courtesy.
- Communication and attentiveness.
- Stigmatisation.
- Continuity of care.

6.4.1 Respect and courtesy (N=12)

According to Dillon (1992) cited in Ali (2011:74), three scopes of respect; paying "attention and valuing of the particularity" which entails truly valuing and incrementally treasuring the sole existence of each unique person, secondly, "understanding" which means avoidance of taking people for granted but seriously committing oneself to try and fully appreciate an individual on their own specific basis. Finally "responsibility" which means taking it upon yourself to assist another individual to achieve their intended satisfaction levels. Reducing denunciation whilst simultaneously demonstrating kind regards to people as well as taking cognizance of their preferred choices can enhance the health predisposition of women, therefore, appropriate supportive

mechanisms that are well aligned with women's inclinations can help out when tackling the mental and emotive challenges (Preis, Lobel & Benyamini, 2018:37). Sentiments in this study were heavily inclined towards lack of courtesy and disrespect for women. Examples of women's account of disrespect included the following:

> *'…was harassed by rough talk and accusations for delayed antenatal booking'* (Ws 2).
>
> *'…some of them (midwives),….really trouble us by the way they attend to us because when I had given birth and was tired and weak they made me clean up my mess saying they did not have gloves…it was not good at all'* (Ws1).
>
> *'…they were rough at times, such as calling me a liar when I was telling the truth that I had been calling for help before the midwife found me almost giving birth by myself'* (Ws 8).
>
> *'They do not worry about respecting each person's different life occurrences'* (Ws12).

The waste scenario *was of o*ne participant who was actually in tears as she related her experiences as follows*:*

> *'Midwives are rough…when I was almost giving birth…eish…my experience was terrible…what I saw, I will never come back to the same maternity unit….never ever again'* (Ws 4).

Studies report several incidences of ill-mannered attention and offensive treatment in the perinatal period. WHO (2014b) and other authors sheds more light on such mishandling which not only interrupts the privileges to handling women with dignity, but also moves on retrogressively to intimidate their rights to survival, wellness, wholeness of the body, and lack of restrictions from desired life parameters. The incumbents were disregarded, humiliated, ignored, profound humiliation, lack of confidentiality and abused verbally and physically (WHO, 2014b; Dzomeku, 2011:32; Bowser & Hill,

2010:3-8), were subjected to deliver alone without assistance or were made to stay on benches for long durations even despite being in labour (WHO, 2014b).

Other violations included failure to provide timeous responsiveness and not including the consumers in their upkeep Dzomeku (2011:32), not getting informed consent, depriving them of pain relief therapy, extreme dishonoring of personal space, denying them the right to hospital confinement, and unnecessarily excessive stay of women and their babies in institutions due to failure to settle financial obligations (Bowser & Hill, 2010:3-8). Lin, Lee, Kuo, Cheng, Lin, Lin, Chen and Lin (2013:4) proposed that this challenge could be addressed through substantial enhancements in the woman's privacy, as well as enhancing contentment through modifications of the working area and the processes in institutions.

However, on the contrary, a few women reported some positive episodes of having been being spoken to courteously, pleasantly and having had suitable communication. The participants narrated their experiences at varying stages of the perinatal period from antenatal to labouring. Some of the sentiments which were expressed were:

> *'… I was welcomed well and they asked me well about the pregnancy and how I felt but I am not sure about anything to do with the mental state… they spoke politely to me. When I arrived here, everyone who attended to me, talked politely to me'* (Ws 6).
>
> *'…very impressed…they were kind and good to me…really excellent'* (Ws9).

The participants in this study were content with the honour they got inclusive of the times when midwives performed fundamental tasks like examinations, childbirth attendance and assisting mothers to care for their babies. Some studies concur with the positive findings. According to Dzomeku (2011:32), women considered health workers to be having an optimistic outlay if they were calm, did not yell at clients and were sympathetic with a logic of funniness. Lekberg et al. (2014:40), reiterates that women feel respected when they are addressed well.

6.4.2 Communication and attentiveness (N=14)

Hollander et al. (2017:515) made some retrospective inquiry of women who had experienced psychological trauma and discovered that they blamed their distressing childbearing exposure predominantly on diminished or absence of control, poor interactive ability and absence of hands-on as well as passionate support. They assumed that most of the times, their distress could be have been lessened or stopped if their caregivers would have better communication. Awuah-Peprah (2014:104-105) conducted a study in Ghana which revealed that individualised attention, attention to specific needs of patients, politeness, active interactive ability, imparting knowledge, and positive attitude of staff, as major aspects that promote emotional stability in women. However, in this study, participants expressed various sentiments about lack of communication and inattentiveness by midwives:

> *'They have no time to listen to you talk, even to ask if you are worried, or there is anything you need. They do not even report on what has happened because when others come they repeatedly ask about what had been done to you'* (Ws1).
>
> *'When I was in labour, I had called the midwife early and she came and said the way had opened by 4cms but then she never came back to look at me again until I screamed and called for help when the baby was almost coming out'* (Ws12).
>
> *'They (midwives) do not spend enough time with us women during antenatal visits. It is worse when you come in labour…they do not talk to you even when you call for help'* (Ws1).
>
> *'They are aloof and do not pay attention to you until it is a time to give birth'* (Ws2).
>
> *'…they do not talk meaningfully to you or even continuously look at you when you are in labour My mother who had come to visit me had to*

receive my baby and then called out to the midwives as the baby had just come out' (Ws3).

The disheartening sentiments which were presented by the participants in this study tend to concur with Øvretveit (2012:30) who realized that generating an atmosphere and relations that facilitate appropriate communication with all kinds of clients is often a seemingly impossible task for health care providers. To promote effective communication, Fowler et al. (2011:700) proffered stages which stimulate active interaction as well as impartation of knowledge to clients as, affording the clients an unprejudiced, impartial demonstration of realistic alternatives, whilst allowing them to contemplate on the benefits and consequences of those preferences. Another stride is encouragement of the clients to constantly talk to engage the health cadres in additional deliberations about their apprehensions and desires and permitting an ample enough spell for thinking through their eventualities and misgivings, as they scrutinize the impact of how every choice which they make may possibly affect the anticipated outcomes. Apparently, sentiments by the participants clearly show deficiencies in such effective communication. Similarly, research evidence shows the health cadres habitually overrate the magnitude of the knowledge that they impart, yet the clients would be craving for additional information (Hollander et al., 2017:515), the lack time and skills to present comprehensive information on interventional options (Fowler et al. 2011:701).

6.4.3 Stigmatisation (N=9)

Kingston et al. (2015a) identified stigma as a barrier which would result in family members visualising the emotive problems as if they are usual and yearning to cope with mental challenges personally, without professional assistance. In such cases they would prefer to share concerns with family members and fail to differentiate normal from abnormal sentiments, whilst they perceive health providers as not keen or lacking the opportunity. The BCs Best practice guidelines (2014:15) also identified stigma (guilt, shame and judgement) as one of the barriers accompanying mental pathology or preventing one from seeking assistance. According to (NHS 2016-2020:26) mental health is faced with several obstacles which impact on its management within

communal setups because of perpetual cultural stigmatisation. This has an unswerving negative influence on the way people in the society attempt to get help from health professionals, and transparency in provision of backup for those with mental ailments in the family and in the society. The drawbacks which were discovered were insufficient resources, preliminary underutilisation of services due to fear of humiliation and ethnic hurdles. This study gives a mixture of negative and positive comments about protection from stigma with heavier inclination on midwives failing to protect women from being stigmatized. Some of the comments from women who felt unprotected were:

> *'They talk loudly about you and sometimes scorn and laugh at you whilst other people look on'* (Ws10).
>
> *'Midwives do not protect you from stigmatization. They talk whilst others listen…would rather keep your situation to yourself'* (Ws11).

The findings concur with those in a study by Rahman, Fisher, Bower et al. (2013:600) whose findings revealed that women and significant others are hesitant hunt for help because they are frightened of being stigmatised. The studies that they reviewed revealed that health professionals incorporated the mental aspects of health into their systematic work routines, and the stance was viewed as masking the stigmatisation attached to mental issues. McBride and Kwee (2016:4) reiterate that a number of social determinants influence the dangers of developing mental challenges during the perinatal period. These may be inclusive of the socioeconomic status, race/ethnicity, poor social support and sometimes fear of stigma which can also prevent women from seeking care.

On the contrary, some participants expressed better comments:

> '*Some midwives try to cover up for you, although there are others who do not care'* (WS6).
>
> *'You are well protected from stigma because midwives talk calmly and to you only'* (WS9).

6.4.4 Continuity of care (N=15)

"Continuity of care" is viewed as a process facilitates building of passionate face to face linkages between women and their midwives with the propensity towards upholding the sentiments of better courteous approaches during the expectant period and following the delivery of a baby (William et al., 2010:619). The current health care models have a bias towards enforcing "continuity of care" through integration of an approach which is directed towards enhancement of the experience for a particular woman by a familiar midwife (Editorial, 2009:47). In this study, women generally expressed the need for availability of a midwife throughout the intrapartum period and smooth handover takeover by another midwife which would result in a seamless service provision. There was no clarity as to the "continuity of care" during the prenatal and postpartum phases. Women were exposed to a mixture of both negative as well as positive experiences pertaining to this intrapartum continuity aspect of care. Several participants had negative experiences on their care having been being taken over during intrapartum, as exemplified by these sentiments:

> *'…they (midwives) never tell us when they are leaving and they do not introduce you to the one (midwife) who is taking over. The next thing you are seeing a different person (midwife) who starts asking you what has been asked about before. It is disturbing because you do not feel safe when they do not know your labour progress so far'* (Ws4).
>
> *'Sometimes the one (midwife) who received you when you came abandons you, only to be delivered by another whom you never had prior contact with and you are not used to…'* (Ws 1).
>
> '*Midwives should improve on telling each other about picking it (care) from where the other left'* (Ws 2).

One participant had a typical positive experience:

> *'I received very good care from one midwife who kept checking on me and remained calming me until she helped me to deliver my baby'* (Ws 9).

One participant who had a chance of being delivered by a student midwife narrated her experience:

> *'She (the qualified midwife) had been working with student midwives but eventually it was the two students who continued checking on me and talking nicely to me and they assisted each other to deliver me well. Students are better because they are kind. I even overheard them gossiping that the midwife on that shift was cruel'* (Ws 3).

Messages from the participant comments tally quite well with the current trends of midwifery management as visualised by Tehari et al. (2018:73) in their newly found assortment of successful plans to formulating optimistic perceptions of the birthing experiences. Techniques included passionate help programs for childbearing ladies which ought to be actualised in nations' maternal wellbeing plans. These projects can contain a blend of effective procedures, for example, constant work support by a natural individual, consoling physical contact utilising knead, and the progression of maternity care. Avoidance of negative birth experience utilising these effective practices prompts the advancement of vaginal birth, top notch maternity care and the decrease of ceaseless mental inconveniences (Tehari et al., 2018:73). Beyondblue Clinical Practice Guidelines (2011:13) contends that coherence of care is the point at which a named proficient, for example, a maternity specialist, who is known by the lady, gives all her mind as proper, therefore empowering the advancement of a relationship. Variables that may improve congruity of care incorporate legitimate documentation, communitarian advancement of the board plans, creating linkages and systems, just as adjusting fruitful ways to deal with care. Models are, case conferencing, shared close interaction, customary gatherings of help giving networks or particular vested parties and community campaign strategies may improve coherence of care in certain settings.

6.5 EXPECTATIONS FROM WOMEN'S PERSPECTIVES

Four themes emerged under this category:

- Pleasurable experience.
- Partnership in care.
- Respectful communication and attentiveness by midwives.
- Mental health education and counseling.

6.5.1 Pleasurable experience (N=16)

The perinatal is a period of incredible change in a lady's life and most ladies and their families, pregnancy, labour and child rearing are a period of extraordinary bliss and satisfaction (Australian Clinical Practice Guideline, 2017:13). Farrelly et al. (2014: 127) also highlighted that pregnancy and the appearance of another child signal a period of unmatched change and trust later on, in spite of the fact that it may move on very well, it may be a difficult time for some ladies. Evidently, this period is sadly connected with a high hazard for beginning and backslides of emotional well-being conditions, significantly higher than at numerous different occasions in a lady's life (Australian Clinical Practice Guideline, 2017:13). Nonetheless, organisation of women focused attention, which is progressively being viewed as outstanding amongst other practice ways to deal with higher caliber maternal mental health care leads to greater efficiency and improvement of the woman's experience (Clif 2012:86). Tehari et al. (2018:73) realised the accelerated need to improve clinical approaches and design future approaches which utilise the most effective strategies to support women during childbirth, intrapartum and aftercare, in order to create positive birth experiences.

Simwaka et al. (2014:10) refer to certain determinants behind disappointment as disregard of the passionate needs of ladies and their objections about maternity specialists not investing a lot of energy with them or offering no inspirational statements to them. Participants in this study expressed the desire to have a pleasant stay and leave the hospital happy. Sentiments expressed by some of them were:

> *'…a friendly atmosphere where women are free to talk, to get enough information on all the aspects of motherhood and getting good care throughout'* (Ws13).

'…to have a pleasant time, and come out well informed and happy' (Ws14).

'…to have a pleasant journey up to delivery childcare and discharge' (Ws16).

Participants in this study underscored the benefit of helping ladies accomplish fulfilling births through talking about their desires with them, meeting their psychological well-being needs and offering help so as to plug the loophole between their desires and experience. Similarly, an Israeli longitudinal study by Preis, Lobel and Benyamini (2018:37) discovered that, more noteworthy, the autonomy over the birth atmosphere forecasted progressively positive feelings, less dread, and better apparent reflection; while more empowerment prominence over the birthing procedure itself result in increasingly positive feelings, less dread, and less blame. This investigation unraveled the linkage between contentment with the birthing procedure and the ladies' lived birth understanding. Similar assertions of discontent were revealed by Handelzalts, Hairston and Matatyahu (2018:89) in a study on women in USA community where above 33% of the ladies visualized their child bearing experience as awful. Despite the fact that pervasiveness rates differed between research inquiries, around 2–5% of ladies in the USA people group tests would succumb to labour related post-delivery traumatic pressure situation (PPTSD).

6.5.2 Partnership in care (N=8)

Morgan and Yoder (2011:6) highlighted the need for creating a woman-centred climate which should include shared governance, vision and commitment of leaders. Manley, Hills and Marriot (2011:37) reiterate that involvement of woman, family and community, provision of feedback and measurement, availability and constant communication of strategic vision are essential aspects which would promote partnership in care. In this inquiry respondents spelt out that they preferred to partake in their care considerations. The need for involvement in their care was spelt out by one of the participants as follows:

'…we need to help each other…' (Ws8)

Beyondblue Clinical Practice Guidelines (2011:11) stresses that the connection between the maternity specialist and the lady ought to be founded as an open, community oriented process, where there is defining of commonly concurred objectives and errands and ordinary help, as well as empowerment and support in cases where referral becomes necessary. Epstein, Fiscella, Lesser and Stange (2010:1492) agree that successful execution of wellness mediation relies upon three factors: an educated and included patient and significant others; open and receptiveness with the focal point around uniqueness on care qualities and knowing the lady; a well-organized and well-incorporated human services condition that backs up the endeavors of ladies, significant others and their maternity specialists.

6.5.3 Respectful communication and attentiveness by midwives (N=14)

Preis, Lobel and Benyamini (2018:37) noted that respecting singular inclinations while bringing down fault may improve ladies' wellbeing and prosperity, thus ladies can be helped to manage these passionate and mental difficulties by offering help frameworks that are customised to their inclinations. The aspect of respect and communication has already been discussed at length earlier on. Some of participants proffered the following expectations:

> *'…if only they (midwives) possess long hearts (patience), they should be observant and should respond early because only a few can do that…*'

> *'…should be talked to kindly and on one to one basis, they should be able to pick changes quickly and respond, quickly'* (Ws11).

> *'…to be talked to, to get constant attention especially when labouring.'* (Ws10).

> *'To be given attention, and to be free to express what I want with peace of mind'* (Ws12).

The participants were clearly pleading for passionate emotional and physical presence of the midwife. Similarly, discoveries of an examination by Hollander et al. (2017:515) on ladies who had encountered mental injury uncovered that their injury could have been decreased or forestalled if their caregivers would have afforded them better communication, emotional support and empowerment with decision-making skills.

6.5.4 Mental health education and Counseling (N=6)

The need for mental health education cannot be overemphasized. Carroll et al. (2018:19) accentuate the need for education such that midwives offer help and offer data to ladies and their families, and distinguish when expert mediation is required. It has likewise been seen that care suppliers normally don't have time and regularly do not have the right stuff to show a total, adjusted introduction of the advantages and disadvantages of sensible restorative alternatives (Fowler et al., 2011:701). Organisation of promising, pertinent data and instruction about emotive and psychological well-being in the perinatal period may improve evaluation of passionate challenges, while understanding that regular perinatal mental issues are hard to perceive (Highet et al. 2014). Participants generally felt that education and counseling was important with two of them expressing the following:

> *'…getting all the information with a smile'* (WS12).

> '*…to come out of maternity well informed. They should also talk about keeping our minds well and encourage us to exercise because they do not…they only tell you about pregnancy and childbirth' (Ws14).*

Health education needs are not peculiar to participants in this study only. Fowler et al. (2011:700) found the requirement for efficient correspondence and data giving. They illustrated the means for viable correspondence and data giving as: giving customers a target, fair-minded introduction of sensible alternatives to consider and the upsides and downsides of those choices. At that point giving satisfactory time for them to consider their objectives and concerns and how every choice is probably going to happen

according to those objectives and concerns; and offering the guidance for women to cooperate with their care attendants to additionally talk about their objectives and concerns. Dennis and Dowswell (2013) found that psychosocial and mental intercessions, for example, relational psychotherapy essentially diminish the quantity of ladies who give in to post birth anxiety. Instructive Mediations in which moms are educated about baby advancement and are told the best way to draw in and invigorate their babies and to be increasingly responsive and loving towards them, seem to improve the maternal state of mind, notwithstanding reinforcing the mother–newborn child relationship and prompting better baby wellbeing and improvement results (Rahman, Fisher, Thicket et al., 2013:599). They likewise communicated that along these lines, mediations explicitly intended to improve maternal psychological well-being positively affect the babies' wellbeing and advancement. They further argue that reconciliation of maternal and newborn child information and the counsel on baby wellbeing is a direct, instead of a coincidental focal point of the mediation which brings about a more grounded impact on newborn child wellbeing and improvement.

6.6 WOMEN ALSO HAVE A ROLE TO PLAY

On the side of mediations for child rearing abilities, BeyondBlue (2019:11) proposes some accommodating strengthening intercessions which prepare women for parenthood which include: addressing others, dialogue with other pregnant or child rearing ladies, for example, moms' gathering and perusing child rearing books. Different mediations are going to antenatal classes, attention to your assumptions regarding pregnancy, birth and turning into a parent and contemplating emotionally supportive networks (BeyondBlue, 2019:11).

One primary theme was produced from the conversation on the responsibilities of ladies. This was:

'Some women are to blame'.

6.6.1 Some women are to blame (N=4)

A number of participants indicated that some of the women choose not to follow the maternity protocols, hence tend to put themselves at a disadvantage. They had this to say:

> '*Some women do not attend health talks and they miss out on important information. Sometimes we women do not talk…we should feel free to talk to the midwives about what we want'* (Ws6)*.*
>
> *'Some women have dirty habits and also some women are to blame because they do not answer. I think sometimes it may be due to lack of knowledge because some do not attend the health talks'* (Ws8)*.*

Other participants also blamed the attitudes of some women. The two expressed the following sentiments:

> *'There are some women who come with negative attitudes such that they do not respond according to what is demanded or even resist following what the midwives instruct them to do'* (Ws9)*.*
>
> *'Some women are just difficult to get along with'* (Ws11)*.*

What participants blamed on women, namely missing health talks, lack of knowledge and negative attitudes could be due to deficiencies in strategies to reach women with appropriate information. The Health Action Plan (2013-2020:25) crafted mitigatory measures like implementing systems for advancement and avoidance in psychological wellness through consideration of passionate and emotional wellness as a major aspect of home and wellbeing institution based antenatal and postnatal consideration for new moms and infants, including child rearing aptitude preparation.

6.7 HINDRANCES FROM WOMEN'S PERSPECTIVES

Studies identified several constraints which hinder mental health care among women. These include; economic status, scarcity of resources, inequitable services and unclear

mental health service delivery protocols. Higgins et al. (2018:9-10) discovered that institutional obstructions included absence of perinatal psychological wellness orientation, nonappearance of care pathways, substantial remaining task at hand, absence of time, absence of protection and not seeing ladies frequently enough to develop a relationship. Nithianandan, et al. (2018:150) presented a few obstacles which are identified within eight areas: information, aptitudes, proficient jobs, convictions about abilities and outcomes, ecological setting, social impacts and conduct guideline. Higgins et al. (2018:9-10) argue that boundaries contrarily sway the capacity to consolidate psychological wellness care into their career and they divided the barriers into organisational, practitioner related and women related. The four themes that came up under this category were:

- Too many women.
- Incompetent midwives.
- Unacceptable attitude by midwives.
- Inadequate staff and poor communication.

6.7.1 Too many women but Inadequate staff (N=15)

Higgins et al. (2018:9-10) discovered that lack of staff to provide perinatal emotional well-being administrations, nonappearance of care pathways and substantial outstanding task at hand where among the authoritative obstructions to arrangement of satisfactory psychological well-being administrations. Likewise, concurring the Mental Health Action Plan (2013-2020:15), agrees that the quantity of specific and general worker staff managing psychological wellness in low-pay and center pay nations is extremely deficient. Participants in this study generally showed displeasure with the obtaining overpopulated maternity unit, whilst somewhat sympathizing with the midwives' inability to cope with the mental needs. Some of the comments were:

> *'There are too many women compared to the fewer midwives'* (Ws10).

'*The place is also too overcrowded and they are also overworked because of the large numbers of women*' (Ws13).

*'The midwives are few with big numbers of women, so maybe this causes them not to worry about our mental state' (*Ws7*).*

'…probably because they are overworked…the place is too crowded…' (Ws13).

Sentiments by participants in this study are supported by revelations from the Mental Health Action Plan (2013-2020:15) that practically a large portion of the total populace lives in nations where, by and large, there is one specialist to serve at least 200,000 individuals; other psychological well-being care suppliers who are trained in the utilisation of psychosocial mediations are significantly scarcer. Essentially, a much higher extent of developed nations than low income nations reports having an approach, plan and enactment on psychological well-being; for example, just 36% of individuals living in low-income nations are secured by emotional well-being enactment unlike 92% in high income nations.

6.7.2 Incompetent midwives (N=14)

Incompetence can be linked to expert related boundaries, for example, absence of information on perinatal psychological well-being and social issues, absence of emotional wellness abilities, and fears of offending and distressing women (US National Institute of Health; Higgins et al., 2018:9-10). Kwee and Mcbride (2015: 2746) lament the inadequacy of access to psychosocial care because perinatal health workers are inadequately equipped to deal with passionate parts of maternal health. They additionally understood that customary, compartmentalized mental amenities are advantageous to just a subsection of perinatal ladies, regularly in an inauspicious way. Another scientific inquiry at the US National Organization of wellbeing uncovered that most of birthing assistants who thought about ladies with perinatal psychological wellness issues in their clinical practice had constrained information on perinatal emotional wellness issues surpassing despondency and uneasiness (Carroll et al., 2018:29). Studies show that wellbeing experts every now and again overestimate the

measure of data they supply yet ladies need more data than they get at present (Hollander et al., 2017:515). It has likewise been seen that care suppliers ordinarily regularly do not have what it takes to impart well-adjusted knowledge with clear explanation of the upsides and downsides of sensible treatment alternatives and seem not to have time (Fowler et al., 2011:701). Participants in this study expressed similar sentiments about the midwives:

> *'…probably they are overworked, maybe they have no knowledge and are not sure about what to do'* (Ws13).

> *'I really think that they are now too used to the work such that work has become too routine and repetitive such that they no longer care'* (Ws2).

> *'I think they do not do their work well because they are under pressure, but it can also be due to laziness and wanting to relax'* (Ws3).

Contrary to the other comments, one participant had a radical view:

> *'...not sure and really wonder what prevents them from giving proper care because they were trained and we expect ideal care…'* (Ws14).

6.7.3 Unacceptable attitude by midwives (N=12)

Midwives apparently, lack the ideal attitudes to provide mental health with some viewing it as not important (McCann & Clark, 2010:231), and some hold disparaging frames of mind towards those with psychological maladjustment (Rahman et al., 2013: 593). Participants in this study expressed negative perceptions on the attitudes of midwives:

> *'Some midwives have negative attitudes towards the mental health of women. I could tell by the way they shun handling and talking to women'* (Ws16).

'They (midwives) are against us (woman) and do not seem to find anything good in making sure that we are mentally comfortable, maybe they also lack knowledge on how to do it' (Ws11).

'…are not interested, careless and find blame most of the times' (Ws16)

However, an explanation about the negative attitudes by Viveiros and Darling (2018:70) that some negative attitudes were due to the midwives' perception that perinatal psychological well-being is not within their work parameters, could also explain the negative outlay as spelt out by participants in this study.

6.7.4 Poor communication (N=16)

BeyondBlue (2011:11) proposes some supportive intercessions to plan for parenthood which include: communicating with other pregnant or child rearing ladies, getting explanations on their assumptions regarding pregnancy, birth and turning into a parent and contemplating support systems. However, participants in this study expressed that there was poor communication between them and the midwives. Two of them had this to say*:*

'…poor communication with midwives… they look at you in a hurry and quickly move on…they do not spend time with you' (Ws12).

'They do not quite tell you what to do but they complained to me saying you are a silent pusher yet they had not given instructions on when to push' (Ws8).

There are several different ways by which correspondence and data giving could be improved. These incorporate utilization of study instruments to survey patients' information and objectives; utilisation of choice guides; and observing the nature of correspondence through utilisation of verifying boxes to proof that patients have been educated and their input is coopted into the procedure (Fowler et al., 2011:702-3). Mattocks et al. (2011:127) prescribed the utilization of handouts and booklets. In all cases, the methodologies and substance ought to be structured dependent on the encounters and needs of the specific womenfolk.

6.8 ENHANCEMENT OF MENTAL HEALTH

The five themes that were generated under this category were:

- Increase staff.
- Enforce partner involvement.
- Maintain standards.
- Respect women.
- Reeducate and supervise midwives on women care.

6.8.1 Increase staff (N=15)

Staff shortage is among the contextual and individual staff factors which were identified by Cockcroft, Milne, Oelofsen, Karim & Anderson (2011:4). The other factors included poor working conditions, lesser employment fulfillment of staff, and absence of resources which all encroach on how work is sorted out. McBride and Kwee (2016:5) declare that ladies may neglect to get to the perfect psychological wellness benefits because of restricted wellbeing workforce and asset imperatives. The propositions of the participants were:

> *'…more midwives should be availed…'* (Ws2) *…should increase the staff…'* (Ws3).

6.8.2 Enforce partner involvement (N=5)

McCauley-Elsom (2009:66) concurs with development of a careful plan in conjunction with the lady and her accomplice as this would facilitate avoidance of many mental and other different challenges with such an organised care arrangement. The plans which are done as a joint effort with all included parties; wellbeing experts, the lady, her accomplice or potentially her family have proven to give ideal results to the mother and infant. Mediations that encompass the family can relieve some significant hazard factors for depressive ailments in women: a poor feeling of individuality, scornful and constraining sexual orientation generalizations, absence of monetary independence and

tense companionship and brutality (Rahman et al., 2013:593): One of the participants had this to say:

> *'They must ask everyone about whether they have brought their partner or relatives'* (Ws3).

The sentiments are similar to the family-centred approach model which was proffered by Beyondblue Clinical Practice Guidelines (2011:33). The model involves asking the woman whom they might want to be associated with their upkeep and, with their assent, look for this contribution early and furthermore monitoring the emotive wellness state of other family members and offering support if necessary.

6.8.3 Maintain standards (N=14)

The woman's encounter of expectancy, childbirth, and coping with the aftermath is usually described by sentiments of debilitation, injury, and emotive torment but then psychosocial perinatal attention has lagged behind despite advancing trends (Kwee & McBride, 2015:2743). Upcoming scientific proof shows that down to earth and creative psychosocial directions, incorporated into routine perinatal attention, can give across the board access to psychosocial assets for moms and reinforce health personnel in conveying ideal care (Kwee and Mcbride, 2015: 2746).

Perinatal psychological wellness results can be enhanced through use of imaginative methods of giving powerful perinatal emotional wellness mediations that address the one of a kind needs of ladies in that period (Lavender, Ebert and Jones, 2016:399). WHO (2018:2) echoes that maternal mental issues are treatable if viable mediations are conveyed even by well-prepared wellbeing providers. There is need to completely incorporate emotional wellness into maternal wellbeing care through routinely screening ladies during the prenatal and postpartum periods with the goal that suitable and auspicious mediations can be established (WHO, 2018:2). Some sentiments which were expressed by participants were:

> *'…maintain standards and understand woman'* (Ws9).

'…proper supervision by their superiors…proper examination, care and continued support throughout…maybe re-training of midwives' (Ws16).

'…*should have a similar way of giving mental health education and education on diet, episiotomy and should explain and support postnatal care and baby care'* (Ws3).

'…should have standards such that every one of the midwives is forced to pay more attention especially for beginners (first time mothers) and also have a similar way of handling, talking to, caring and being with women at necessary times, not to be called as if they don't know their work'… (Ws15).

Carroll et al. (2018:19) emphasized the requirement for convenient and suitable attention which is fundamental for the best results for perinatal emotional well-being; thus the requirement for a more noteworthy comprehension of institutionalized perinatal psychological well-being among maternity specialists is required to empower them to offer help and data to ladies and their families, and to distinguish when expert intercession is required.

6.8.4 Respect women (N=16)

Documented proof demonstrates that numerous ladies experience insolent and damaging treatment during the perinatal period. WHO (2014b) gives records of such violations that don't just damage the privileges of ladies to being given deferential attention, but goes on to compromise their privileges to life, wellbeing, real respectability, and avoidance of being excluded. Participants in this study were yearning for respect from the midwives.

An emotionally charged participant who was almost in tears emphatically said:

'…should show that women are humans…should talk properly and talk to you such that others cannot hear your matters and must smile' (Ws4).

A study by Lin et al. (2013:4) impressed on respecting the woman's space, through staff lowering their voice tone while having dialogue with ladies, and ought to abstain from

talking about their data in treatment regions or open workstations where others could spy their discussion. If there is a way, feasible, private rooms could be given.

Other participants echoed similar sentiments:

> '*Women should be handled with kindness, should be shown respect and be asked about their feelings'* (Ws10).

WHO (2014b) emphasises that each lady has the privilege to the most elevated feasible standard of wellbeing, which incorporates the privilege to noble and courteous attention to their wellbeing.

6.8.5 Re-educate and supervise midwives on women care (N=15)

Lin et al. (2013:4-7) advocated for reviewing and redesigning procedures, for instance, preparing of wellbeing staff members to change their demeanor and conduct in order to become increasingly touchy to clients and furthermore to be progressively aware of client security and secrecy. Such education and supervision would promote optimal staff behaviours like lowering voice tone while talking to singular patients, abstaining from talking about personal data in treatment zones or open workstations where others could listen stealthily to their discussion and careful handling of patients (Lin et al., 2013:4-7).

> *'Should be taught again or supervised to handle women so that they learn to give themselves time to talk to women and pay more attention'* (Ws13).
>
> *'They should be trained again to handle women properly'* (Ws14).
>
> *'…maybe re-training of midwives…'* (Ws16).

Carroll et al. (2018:19) emphasized the need for instruction and other basic backings, for example, care protocols and recordings, which are necessary for training and supporting midwives in their mental health care and collaboration interventions, as well as timely and appropriate mental health care. This entails that midwives should have a more prominent comprehension of perinatal psychological wellness to empower them to offer help and data to ladies and their families, and to distinguish when expert mediation is essential (Carroll et al., 2018:19). Studies uncover various factors that encourage or

block the procedures of data giving or giving clarifications to customer on health issues (Martin and Robb 2013:3; Associated Otiko and Bhengu's, 2012:e895-e896). These relevant and individual personnel factors incorporate, staff deficiencies, poor working circumstances, low employment fulfillment, and absence of resources which all encroach on how work is sorted out (Carroll et al., 2018:19).

6.9 CONCLUSION

The results emanating from the exploration of the perspectives of women culminated in several themes emerging under the categories; meeting mental health needs, relationships with midwives, women's expectations, women's role, hindrances to emotional wellness arrangement and upgrade of psychological wellness. Respondents were surprised by the unavailability of data on psychological wellness. They communicated that the significant portion of customer instruction happens at the antenatal stage through group educational sessions and input is pre-determined by the midwives. They would prefer reinforcement through one-on-one education sessions personal midwives which they deemed erratic. It was apparent that midwives did not provide the ideal emotional and psychosocial support. The participants indicated that midwives did not relate appropriately with women since they lacked continuity of care, respect, courtesy, attentiveness with poor communication and had a tendency to promote stigma. Women's expectations were to have pleasurable experience, partnership in care, respectful communication and attentiveness by midwives as well as receiving mental health education and counseling. Aspects which hinder provision of mental health where identified as having too many women versus inadequate staff, incompetent midwives, unacceptable attitude by midwives and poor communication. Women's recommendations for enhancing mental health were to increase staff, enforce partner involvement, maintain standards, respect women and finally to re-educate and supervise midwives on the mental health care aspect of women.

CHAPTER 7

FINDINGS AND DISCUSSION OF IN-DEPTH INTERVIEWS WITH MIDWIVES AND KEY INFORMANTS

7.1 INTRODUCTION

The provision of emotional, informational and tangible support throughout pregnancy and all the stages of labour has been shown to fulfill the women's expectations about child birth and can increase their satisfaction with birth experience (WHO, 2013:593). Effective perinatal mental health interventions are essential in promoting a passionate relationship between the midwife and the client which is characterised by empathy, support, trust and empowerment which enables informed decision making (Jolivet, 2012:10). Alleviating mental health instability impacts positively on pregnancy outcomes, on the mother-newborn child relationship, just as the connections between the mother and her accomplice, and the remainder of the family (Jolivet, 2011:469). Maternity specialists are well-set to recognize and address the emotional wellness need of ladies whom they attend to (Higgins, Carroll, and Sharek, 2016:364), carry a recognized responsibility and can have any kind of effect in psychological well-being advancement (Vik et al., 2009:34). Notwithstanding, the status of birthing specialists for compelling execution of this job is questionable (Austin, 2014:179).

The in-depth interviews with midwives and key informants which were done in phase 2, generated information relating to understanding of mental health interventions being offered by midwives, the qualities and or behaviour expected of midwives, and the organisational factors that facilitate and or hinder effective implementation of perinatal mental health care. The information likewise gave data identified with perspectives and encounters of midwives and key informants on evaluation of emotional wellness issues, abilities of midwives in managing psychological well-being issues, meeting psychological well-being needs of women and recommendations on enhancements. Table 7.1 shows the personal attributes of the midwives and key informants, whilst Table 7.2 presents the categories and themes.

Table 7.8: Demographic characteristics of midwives and key informant participants

Demographic Characteristics	Midwives		Key Informants	
	Frequency n=17	Percentage %	Frequency n=9	Percentage %
Age				
30-40	13	76	2	22
41-50	4	24	4	45
51-55	-	-	3	33
Years of midwifery Experience				
1-5	7	41	-	-
6-10	7	41	2	22
11-15	3	18	3	33
16-20	-	-	3	33
21-30	-	-	1	12
Sex				
Male	3	18	1	12
Female	14	82	8	88

Department				
Labour Ward	6	35	-	-
Antenatal Ward	6	35	-	-
Postnatal Ward	5	30	-	-
Midwifery Administration	-	-	9	100

The midwives and key informants had their interviews done in offices within their departmental buildings. Table 7.1 shows that seventeen were interviewed as determined by theoretical saturation which was achieved at that stage despite twenty-six midwives who had agreed to be interviewed. The age of the youngest participant was 32 years and the oldest was 44 years. Seven had a working experience of between one to five years, another seven had worked from six to ten (10), while the remaining three had between eleven to fifteen years work duration in the maternity units. All the respondents were working at various maternity units. It was noted that six worked at the labour ward, another six at the antenatal unit and five were at the postnatal segment. The information additionally demonstrated that midwives were swapped at six monthly intervals and moved around various units of the maternity division. This allowed them the chance to routinely rehearse information and aptitudes at the various areas.

The same Table 7.1 indicates that nine key informants were interviewed as theoretical saturation was achieved then. This was out of the 12 who had agreed to be interviewed. The minimum age was 35 and the maximum was 55. They had vast maternity exposure which ranged from a minimum of eight (8) years to a maximum of 26 years of experience. All of them were working in maternity administration posts.

Table 7.9: Categories and themes of findings of interviews held with midwives and key informants

Category/Theme	No of respondents by Category		Total responses per attribute n=26
	Midwives n=17	Key Informants n=9	
Knowledge and attitudes about women's mental health			
Midwives' lack knowledge on mental health	10	7	17
Poor coverage of Mental Health in the midwifery curriculum	12	6	18
Varied attitude towards mental health	6	2	8
Midwives' competency in dealing with mental health issues			
Incompetent	17	9	26
Lack of standardized mental assessment procedures	12	7	19
Protecting women from stigma/labelling			
Stigmatisation	15	9	24
Meeting mental health needs			
Gap in maternal mental health care	13	9	22
Empowering women	8	6	14
Factors hindering mental health care			
Lack of knowledge and skills	11	7	18
Negative attitudes	9	5	14
Heavy workload	7	4	11

Enhancement of mental health			
Educate midwives on mental health	13	6	19
Following Mental Health Protocols	7	7	14
Midwifery Curriculum Review on the Mental Health component	9	6	15
Mentorship and preceptorship	3	3	6

7.2 KNOWLEDGE AND ATTITUDES ABOUT WOMEN'S MENTAL HEALTH

Midwives, apparently, have deficient information and lack the ideal aptitudes and to give emotional wellness care (McCann and Clark, 2010:231). Jolivet (2011:470) noticed the negative impacts of poor mental intercessions that range from moderately unobtrusive lack of regard of customer's self-governance and respect to general maltreatment; physical ambush, verbal insult, separation and, desertion. In any case, contemplates obviously uncover that the midwives, practically speaking have an information and aptitudes shortfall which must be tended to direly. Higgins, Carroll, and Sharek (2016:364) echo that in spite of the way that midwives are well-put to distinguish and address the emotional well-being need of ladies in their consideration, many report falling short of the capacity to do as such. Rather they consequently, disregard or brush aside ladies' psychological well-being needs. The three themes that emerged under this category were:

- Midwives lack knowledge of mental health.
- Poor coverage of mental Health in the midwifery curriculum**.**
- Varied attitudes towards mental health**.**

7.2.1 Midwives lack knowledge on mental health

Wellbeing providers in maternity units have low emotional wellness education (Rahman et al., 2013: 593). Viveiros and Darling (2018:70) discovered that absence of information was one of the supply-side barriers to provision of perinatal emotional

wellness interventions. Noonan, Jomeen, Galvin and Doody (2018:e358) in their investigation, uncovered that midwives reported having insufficient knowledge and skills, as well as reduced poise to deal with women's obligations. Correspondingly, McCauley et al. (2011:786) found that midwives felt that they needed information and they were not prepared enough to work with ladies with mental challenges. They were not by any means mindful of the assets accessible to them and to the ladies.

Participants expressed various sentiments which clearly indicated limited knowledge on mental health:

> '*We midwives do not have enough knowledge but we are trying'* (MP1).
>
> *'We (midwives) are not knowledgeable on mental health or on assessing the mental status of women'* (MP 5).
>
> *'During my experience as a midwife, I have noticed that the attention to the mental health aspect of care is not there in the perinatal period. Focus is on pregnancy and only the physical side of woman...we midwives clearly lack knowledge on mental health'* WP 15.
>
> *'We the midwives are not knowledgeable in carrying out mental health assessments in pregnant and postpartum women. We still are not empowered in that field and this affects our midwifery service delivery'* (KP6).
>
> *'The knowledge of us midwives is inadequate although we care for women holistically. Mental health is often dealt with on basic terms because there is no full psychological assessment which is done'* (KP 8).

In a study to elicit Australian maternity specialists' information, demeanors and education needs around perinatal emotional well-being, Hauck et al. (2015:247) revealed that most of the midwives recognize that it is their job to survey the psychological well-being status of ladies however they said that many feel ill prepared to do as such. They communicated a powerful urge for additional information and abilities over a range of perinatal emotional well-being subjects. Obviously, scientific enquiries

investigating women's encounters have underlined the significance of taking cognizance of psychological well-being (McCann and Clark, 2010:231; Jolivet 2011:10), while noticing that absence of information on perinatal emotional wellness among maternity specialists is a hindrance to getting emotional wellness care by women (Byatt et al., 2013:143; Higgins, Tuohy, Murphy & Begley, 2016:28).

7.2.2 Poor coverage of mental health in the midwifery curriculum

Beyondblue Clinical Practice Guidelines (2011:12) intimated that, all wellbeing experts giving care in the perinatal period ought to get the necessary preparation in psychological well-being, psychosocial appraisal and woman focused relational abilities. Current wellbeing personnel teaching doesn't sufficiently prepare midwives to attend psychosocial care nor are they prepared to deal with the pressure they come across within the practice setting, with next to zero help accessible to them (Rahman et al, 2013:593). McCauley, Elsom, Muir-Cochrane and Lyneham (2011:788) note the accelerated requirement for incorporation of mental state assessment and mental appraisal which are not as of now implemented in some maternity care course educational plans. Such incorporation would guarantee that helpless ladies and their families have befitting access to emotional wellness and community based networks. McCauley-Elsom and Kulkarni (2007:107) and Kulkarni et al. (2008:86) reprise that midwives get little instruction, yet caring for pregnant women with psychological wellness issues gives them extraordinary apprehension. Similarly, Zimbabwean midwifery curricula in the various programmes, diplomas up to masters degrees, are either silent or mention mental health briefly. While there has been some move in certain tertiary maternity care instruction programs, plainly midwives need information about the mental and emotional wellness of the woman.

The increase in psychosocial pressures such as those due to ARV therapy in pregnancy, harsh economic conditions and marital disharmony has accelerated the need to proactively provide psychological support perinatally (Zim Health, 2010:5). Sentiments by most participants in this study unveiled the deficiencies in coverage of the mental health content in midwifery:

'Midwives are to some extent given information on mental health during pre-service training, however not so much of training hours are directed to mental health' (MP 3).

'Student midwives should undergo a course on mental health so that they become aware of how important it is to assess and manage mental challenges of women when they are now qualified' (KP 9).

'...should make sure that the mental health component or course is in the midwifery diploma curriculum as well as a strong follow-up and supervision component. We were never taught with emphasis about the mental health care of women...' (KP 6).

'Midwives need extensive training and sensitization especially during their midwifery training curriculum' (KP 3).

Similarly, Jarrett (2015:32) made recommendations about the need for updating the educational content of the bachelor's degree in midwifery education with reference to mental health during the perinatal period after realising that student midwives often under-estimated the mental health risks. These included, failure to identify mental problems, as well as the danger of failing to mitigate exacerbation of prevailing mental challenges, thereby preventing resultant degeneration into more critical mental health problems whilst one is expecting or after giving birth.

7.2.3. Varied attitudes towards mental health

Studies emphasise the importance of having positive attitudes towards mental wellbeing whilst exposing the detrimental effects of negative attitudes. Epstein, Fiscella, Lesser and Stange (2010:1492) postulate that applicability of approaches to emotional care is determined by receptiveness and responsiveness with focus on uniqueness on care attributes and knowing the woman. Midwives, apparently, lack the ideal beliefs and attitudes to provide mental health with some viewing it as not important (McCann & Clark, 2010:231), and some hold slandering frames of mind towards those with dysfunctional behavior, yet this wellbeing workforce is the essential lynchpin for linkage between helpless women and health staff (Rahman et al., 2013:

593). However, Viveiros and Darling (2018:70) observed that some negative attitudes were due to midwives viewing perinatal psychological and emotional wellness as not being within their scope of practice. Participants in this study expressed varied attitudes towards provision of maternal mental health, with heavier inclination towards negative attitudes. Examples of the negative comments are:

> *'...midwives mostly have negative attitudes towards mental health...they try to avoid anything to do with that area of care'* (MP 10).
>
> *'Attitude is not usually good as midwives mostly dwell on purely reproductive health issues. It is therefore, a challenge to attend to woman with mental challenges. As a result, attention reveals concentration on reproductive health issues.'* (MP 17).
>
> *'Most midwives have a negative view and believe that mental health is for those trained in mental health, hence management and attention to the issues is overlooked'* (KP 7).

However, some participants observed that there were varied attitudes among the midwives as expressed here that:

> *'...attitudes towards women's mental health are varied...the majority have good attitudes but quite a number have negative attitudes even if sometimes they could be having reasonable knowledge on mental health'* (MP 5).

Viveiros and Darling (2018:70) further cited negative attitudes as midwives expressed that mentally challenged ladies are frequently problematic during communication or are resistant to interventions, and are most likely viewed as a tentative threat and are henceforth regarded as extremely dangerous. Butt et al. (2015:S9) also realised that despite midwives having positive attitudes towards fulfilling their obligation of screening for mental status, negative stereotypes continue to exist, thereby prompting the need to be mindfulness of prospective prejudice so as to contradict the effects of the stereotypes on care.

7.3 MIDWIVES' COMPETENCY IN DEALING WITH MENTAL HEALTH ISSUES

Competency is about improving perinatal psychological wellness through creative approaches of giving successful perinatal emotional wellness intercessions that address the exceptional needs of ladies in the perinatal period (Lavender, Ebert and Jones, 2016:399). Carroll et al. (2018:19) accentuated the requirement for convenient and suitable attention which is fundamental for the best results for perinatal emotional well-being, subsequently the requirement for a more noteworthy comprehension of perinatal psychological well-being among maternity specialists, in order to offer help and data to ladies and their families, while recognizing when expert intercession is required. Two themes emerged under this category:

- Incompetent.
- Lack of standardized mental assessment procedures.

7.3.1 Incompetent

Studies reveal that midwives are mostly incompetent in mediating emotional wellness concerns of perinatal women. They lack the knowhow on perinatal psychological, emotional and societal norms as well as mental health skills; they also have fears of offending and distressing women (Higgins et al., 2018:9-10; Viveiros & Darling 2018:70). Viveiros and Darling (2018:70) linked the incompetence to midwives' inadequacy in acquisition of the perinatal mental health mediation skills, and self-assurance, both generally and cross-culturally. Kwee and Mcbride (2015: 2746) lament the inadequacy of access to psychosocial care which they say is due to the fact that professionals are ill equipped to cope with the mental health demands of women when dealing with perinatal health. Midwives lack skills which enable them to initiate and sustain dialogue with ladies on delicate issues, like sexual harassment, gender based violence and mental pathology, and in giving data to ladies, their mates and other family members (Carroll et al., 2018:29). Even the participants in this study generally expressed incompetence in provision of mental health care.

'We (Midwives) are not competent due to inadequate information on mental health which would otherwise equip us with adequate skills to deliver mental health care approaches' (MP 10).

'As midwives we are not quite competent....I mean competency is to a lesser extent. Yes we have a limited knowledge base relating to mental health but more needs to be done in terms of including a lot more mental health input during midwifery training to give us the efficiency...' (MP11).

'I am not well versed just like many other midwives who are not competent and often the mentally at risk women are missed during antenatal and intrapartum periods...which means midwives need more theoretical content and practical emphasis on mental health during training or some refresher courses to help us gain enough confidence' (MP 3).

*'Midwives are not competent in mental health mostly due to inadequate input and lack of clinical exposure' (*KP 3 & KP 7).

The Maternal Mental Health Alliance, Specialist Mental Health Midwives (MMHA SMHMs) Report (2018:6) notes the growing scientific proof on the diminished poise of midwives in providing backup to women with emotional challenges due to poor as well as insufficient training, which affects the care they provide. For example, researchers have found that midwives are deliberately hesitant to inquire about any issues surrounding the mental status of women because of fear of uncovering issues that become problematic to them and practically impossible to resolve. Other revelations of incompetent perinatal emotive wellbeing practice included undocumented histories, disjointed care provision, inadequate backup amenities and unwillingness or hesitancy of women to open dialogue on emotional matters.

7.3.2 Lack of standardized mental assessments procedures,

Assessments of the mental status are progressively gaining momentum since such abilities have become imperative in the current midwifery trends, however such subject

matter is not explicitly coopted in several curricular for midwives. A small number of respondents who took part in an inquiry by McCann and Clark (2010:231) reported that they never received any input on psychological, social and emotional health, resulting in midwives not taking mental health seriously in their practice and also not being equipped to mediate emotional health issues. Nagle and Farrelly (2018:6) intimated that all maternity care specialists working with prenatal and postpartum women have to be educated on utilization of standard screening tools to recognize women who are exposed to the danger of succumbing to emotive or mental challenges which may encompass deterioration of the preexistent perinatal mental ailments. This entails asking all women about the past mental statuses of the individual and their family, as well as the psychosocial environment through use of validated measurements as a means of backing up detection of deviations from the normal mentality of the ladies in question. Sentiments from the participants in this study revealed a distinct gap in guided mental health assessments:

> *'As midwives we do not pay attention to assessments of the mental status of women...nothing compels us...unlike assessments of the woman's physical health, pregnancy, delivery and aftercare which has some predetermined written protocols on the maternity records...you therefore cannot miss anything'* (MP 7).

> *'Midwives are failing to identify women who have problems with their thinking because of not having standard procedures which can be used so that everyone gains the knowledge on how to conduct mental assessments in women who are pregnant and even post childbirth'* (KP 6).

> *'Full physical assessments may be done but there are no ways or instruments to enforce or remind you, the midwife, to examine the mental state'* (MP12).

Apparently, midwives have a distinct role of making a difference pertaining to promoting appropriate emotional wellness in perinatal ladies (Vik et al., 2009:34), although, their readiness for effective fulfillment of this role is questioned (Austin, 2014:179).

Participants in this study spelt out the deficiencies in fulfillment of this midwifery role. Milgrom and Gemmill, (2014:13) explain with emphasis the need for performance of comprehensive and multidimensional procedures as imbedded in psychosocial assessment which should evaluate every woman's psychosocial circumstances. These would include making it mandatory to tap into backup networks, eminence of associations, life span tensions, physical or sex related aptitude for every lady who is in the prenatal period. Examination of different traits would help in recognizing ladies at a higher danger of perinatal emotional ailments, which is not currently symptomatic with subsequent institution of preventive interventions (Milgrom & Gemmill, 2014:13; Austin, 2014:179). Nagle and Farrelly (2018:22) recommended adherence to standardized care when asking about psychological well-being and emotive wellness at each perinatal encounter and utilization of screening questions or instruments to aid the discovery of ladies in danger of encountering perinatal emotional wellbeing difficulties. The Zimbabwe National Health Strategy (2009-2013:11) and the latest for the period 2016-2020 only mention mental health briefly but do not anchor it to direct mental status assessments in general, let alone in the perinatal period.

7.4 PROTECTING WOMEN FROM STIGMA/LABELLING

7.4.1 Stigmatisation

Viveiros and Darling (2018:70) realized that there is hidden disgrace toward those with perinatal emotional wellness concerns and this is heightened by midwives' discernment that perinatal psychological wellbeing isn't inside their extent of training. Sentiments from the participants in this study indicate that women are generally exposed to stigma:

> *'Women with mental challenges are not protected from stigmatisation as midwives distance themselves from them'* (MP 10).
>
> *'Women are not protected enough as stigma begins in the community and all the way to hospitals where they are even made fun of by others and even by the midwives themselves'* (KP 8).

'Protection of women from stigma is not there...they are not protected ...they are often quickly removed from others without properly addressing the root cause...the baby is removed from them and often given to relatives and that is also a source of stigma' (Mw 3).

'...not protected from stigma as midwives tend to stigmatise issues to do with the mental condition such that when women have psychosocial challenges, midwives talk loudly whilst others hear and includes even negative comments... ' (KP 4).

Rahman et al. (2013: 593) agree that birthing assistants and other wellbeing staff in maternity settings have low psychological well-being proficiency and hold slandering frames of mind concerning those with mental difficulties, yet these maternity staff members are the essential crossing point between powerless ladies and maternity care.

7.5 MEETING MENTAL HEALTH NEEDS

Perinatal mental health outcomes can only be optimal if inventive methods of giving successful emotional wellness mediations that take precedence of the exceptional needs of ladies can be employed (Lavender, Ebert & Jones, 2016:399). Carroll et al. (2018:19) emphasis the use of timely and appropriate approaches towards attainment of the best perinatal outcomes, which can only be achieved through a serious appreciation of perinatal emotional wellbeing by midwives. Two themes were identified under this category as follows:

- Gap in maternal mental health care.
- Empowering women.

7.5.1 Gap in maternal mental health care

Preis, Lobel and Benyamini (2018:37) distinguished a shortfall between desires and involvement with emotional well-being. They accentuated the benefit of helping ladies

accomplish fulfilling births when midwives examined their desires with them, by this manner giving them intercessions that address their issues and bolster the void. Alderdice and McNeill (2016:400) conducted systematic reviews which clearly uncovered gaps as no surveys were recognized that upheld a particular midwifery responsibiity in maternal psychological well-being and mental status in pregnancy, but then, this is the point of most serious contact. Sentiments from the study participants clearly point at shortfalls in mediation of perinatal maternal emotional wellbeing services:

> *'...most midwives believe that mental health care is for those trained in mental health such that they feel unable....hence management and attention to the issues is overlooked'* (KP 7).
>
> *'Midwives fail to satisfy the ideal mental health care since only those women with an already existing mental illness are managed reasonably, but those not yet identified or diagnosed face the risk of complications from mental problem, of which the mental illness will be identified when it has become severe. The preventive interventions for mental illness are really lacking in midwifery'* (KP 6).
>
> *'Mental requirements of women are partially taken care of as these women receive little attention concerning their welfare from midwives and health authorities. These women are not catered for before and after delivery. Some women with mental problems are neglected by their families leading to them staying in the streets'* (MP 12).

Contrary to the findings, the Health Action Plan (2013–2020:5) assigns midwives and different experts to grasp the general objective of advancing mental stability, forestalling mental ailments, giving mediation, advancing human rights and lessening the mortality and grimness during the perinatal period. Marriott and Ferguson-Hill (2018:341-342) proposed the promotion of prenatal and postpartum emotional well-being and congruity of care through appropriate social support systems and building strong coping styles in women.

7.5.2 Empowering women

Kwee and McBride (2015:2743) advance the invaluable midwifery role of empowering women with the realization that ladies' exposures during pregnancy, childbirth, and postpartum changes are regularly portrayed by sentiments of debilitation, injury, and passionate agony. Empowerment can be accomplished through regarding each person's inclinations while lessening accusations, and this would improve the level of women's' wellbeing both mentally and physically. They should therefore, be assisted to deal with these emotions (Kwee & McBride, 2015:2743). Preis, Lobel and Benyamini (2018:37) emphasised plugging of the empowerment deficit through providing psychological support systems that are tailored to women's preferences. Kwee and McBride (2015:2743) further alarm at the rate at which psychosocial perinatal care has lagged behind despite advancing trends , let alone attaining the audacity to be able to empower women in turn. Participants in this study expressed disempowerment. Some had this to say:

> *'Midwives fail to empower women on ways to attain mental stability or on coping with mental challenges because they feel incapacitated themselves due to not knowing how to conduct assessments related to the mental state during pregnancy and post childbirth'* (KP 6).

> *'We midwives do not feel free to discuss on mental health...we are unsure of what to say... or even to assess properly, so women just keep quiet and will not reveal their concerns neither will we probe...'* (MP 6).

Midwives generally lacked communicative ability with one of the participants expressing complete disempowerment and uncertainty in the midwives themselves with a ripple effect on ability to empower the women

> *'...fear of the unknown that women can do anything like being violent or just deliver without calling the nurse and midwife...'* (MP 15).

Jolivet, (2011:10) endorses the undisputed necessity for effective perinatal interventions in mental health which promote a passionate encounter between the midwifery

attendant and the lady, namely, empathy, support, trust and empowerment which enables informed decision making. However, there are factors which negatively impact on empowerment of women, such as lack of reproductive autonomy, unplanned for or undesirable conception, ailments or infirmity due to conception (Fisher et al., 2012:139G; Beyondblue, 2011:12). Jolivet (2011:10) laments the detrimental effects of poor mental interventions that range from comparatively intangible disregard of customer's independence and self-worth to absolute exploitation; battering, use of obscene language, discernment and desertion. Marriott and Ferguson-Hill (2018:341-342) proffered a list of empowerment attribute for attainment of mental acumen and emotional wellness including promotion of self-reliance in child-rearing ability, attainment of capacity to make appropriate decisions, fulfillment of life, feeling of self-contentedness and a positive outlook to life. Manley, Hills and Marriot (2011:37) reiterate the need for provision of a system of reporting back and evaluation, as well as participation of woman, significant others and the public as essential aspects in offering care.

7.6 FACTORS HINDERING MENTAL HEALTH CARE

7.6.1 Lack of knowledge and skills

Factors that hinder provision of the ideal mental health care consist of, although not restricted to inadequate knowledge, nonexistence of training and reduced access to amenities for emotional wellbeing (Byatt et al., 2012). Use of creative initiatives to diagnosing, imparting knowledge and use of electronic referral systems can relieve each one of the hindrances (Carroll et al., 2018:29). As alluded to earlier on, several participants showed concern about the lack of knowledge which is prevalent among the midwives as exemplified by comments from these midwives and key informant participants:

> *'The knowledge towards mental health during the perinatal period remains very limited as we the midwives mostly focus on the pregnancy*

and only the physical side of the woman...we really have a lack of knowledge towards worrying about the mental health of women' (MP 15).

*'They (midwives) are not knowledgeable at all and they do not even discuss mental health nor even assess for any mental health concerns and the women just keep quiet and won't reveal their concerns' (*KP 5).

Similarly, Higgins et al. (2018:9-10) identified obstacles to provision of perinatal mental health as deficient information and capabilities among midwives, cultural issues, as well as fears of offending and distressing the ladies. Viveiros and Darling (2018:70) also concurred that the midwives fall short of the ideal capacitation to mediate mental and emotive demands, they are therefore ignorant of the issue and do not possess the requisite poise, both generally and cross-culturally, prohibiting effective provision of perinatal mental health.

7.6.2 Negative attitudes

Morgan and Yoder (2011:6) expresses the importance of creating a woman-centred climate through possession of positive institutional outlooks and characters; and collective decision-making within an appropriately synchronized and cohesive practice atmosphere towards supporting the determinations of women, significant others and respective midwives. However, McCann & Clark (2010:231) argue that midwives, apparently, lack the ideal attitudes to provide mental health with some viewing it as not important. Similarly, in this study, assertions about negative attitudes dominated the participants' responses:

'*Most midwives have negative attitudes especially towards mental health care…I can emphasise that they have poor attention to mental health care*' (MP 7).

'midwives have negative attitudes towards mental health in that as long as the woman has delivered and she is out of danger she does not need talking to anymore and ensuring that she is emotionally stable which

contribute to poor care…focus is only on attending to the childbirth process without worrying about the mental aspect' (MP 6).

In support of these findings other studies revealed that midwives pay no attention to or push away emotional wellbeing requirements (Higgins, Carroll, & Sharek, 2016:364), 'difficult' to interact with, or as resistant to mediation, with a tendency to be regarded as tentatively violent and were in this way deemed as a great hazard (Kulkarni et al., 2008:86). McCann and Clark (2010:231) suggest that it is never again conceivable to acknowledge misinterpreted frame of mind from midwives that the emotional wellness care of ladies is 'out of their extent of training'.

7.6.3 Heavy workload

Studies reveal that perinatal emotional wellness care and mental evaluation place an extra burden on the already strained midwife. McBride and Kwee (2016:5) argue that limited health workforce and resource constraints may obstruct women from accessing the ideal mental health services despite being privy to it. In a study by Mellor and Payne (2016:82) in Auckland midwives felt over-burdened and overpowered as they explained that they were taking on an additional burden once maternal emotional wellness issues were uncovered to them and described this as disturbing the continuity of normal midwifery care.

'Workforce shortages. In most settings midwives are understaffed hence no time is reserved for specialized cases such as mental health programmes for women' (MP 16).

'There is almost always overcrowding of women leading to inadequate midwife-woman interaction and early discharge before psychological evaluation' (MP14).

'shortage of staff is a serious constraint because it limits the midwife in many ways... too busy to offer enough care and attention to the woman's pregnancy and giving birth... let alone her mental status' (MP 8).

'There are workforce shortages...in most settings midwives are understaffed hence no time is reserved for attention to specialized cases such as emotional well-being and related psychological well-being programs for ladies' (KP 9).

The Perinatal Mental Health Project (2015:1) proffered a means of addressing the deficiency of manpower and connecting the treatment shortfall for perinatal mental management through incorporation of psychological wellness care into routine antenatal and postnatal encounters. The resultant effect of the venture was that midwives effectively figured out how to spare time by joining emotional wellness screening into routine methodology with resultant significant levels of adequacy of the coordination.

7.7 WAYS OF IMPROVING MENTAL HEALTH

7.7.1 Educate midwives on mental health

Instruction and other auxiliary help, for example, care protocols and recordings, is necessary for training in addition to supporting midwives in their mental health care and collaboration interventions (Carroll et al., 2018:19). Coates and Foureur (2019:797) conducted a scoping review which indicated that the deficit in midwives' confidence and knowledge could be tended to with suitable preparation and institutional help, as there is some proof that midwife-led guiding intercessions are powerful. Viveiros and Darling, (2018:70) agree that birthing specialists ought to participate in extra perinatal emotional wellness preparing so as to support their insight and certainty, become mindful of network assets and referral pathways and start conversations about perinatal psychological wellness with all ladies with the assistance of an approved screening instrument. McCauley et al. (2011:786) emphasizes that birthing specialists need to have befitting training, knowledge and aptitudes to work with the intellectually powerless clusters of ladies. Some participants made these comments:

'*There is need to boost midwives' knowledge on mental health through continuous education, effective attachment to mental units during training of diploma and Bachelors degrees'* (WP 9).

'...they should incorporate mental health input in the midwifery curriculum as well as teach mental health as continuing education' (KP 7).

'Midwives should undergo a course on mental health ... most midwives are not aware of the importance of assessing women and taking care of the mental health and wellbeing of women.' (KP 9).

'Incorporate mental health training in midwifery at each stage. Mental health nurses should also be allocated to maternity' (MP 17).

Nagle and Farrelly (2018:22) recommended education and training for HCPs involved in antenatal and postnatal care such that specialist or advanced mental health midwives become a visible point of contact. January and Chimbari (2018:a1127) emphasise the necessity to direct assets towards the preparation of midwives and other essential preliminary level health cadres on psychological wellness issues influencing ladies perinatally. Noonan, Jomeen, Galvin and Doody (2018:358) hinted that birthing specialists require further instruction on perinatal psychological well-being across societies with accentuation on an abilities focal point.

7.8.1.1 Mentorship and preceptorship

Beyondblue Clinical Practice Guidelines (2011:12) detects that as a base, all wellbeing experts giving attention to women in the perinatal period ought to get preparation and tutoring in lady focused relational abilities and psychosocial appraisal. As a rule, guidelines suggest on-going support and mentoring for wellbeing experts engaged with ladies' emotional wellness during the perinatal period. Likewise, participants in this study expressed similar sentiments:

'mentorship programmes for new midwives are very important towards prevention of burnout and when the junior midwives are mentored properly they develop interest to attend to the mental health of women...managers in the units can also lead from the front and can be

visionary so that they can be role models in dealing with mental issues of women' (KP 1).

'train midwives on mentoring and preceptorship including for mental health so that they provide individualised care including women with identified mental according to the scope of midwifery and refer timely' (MP 5).

'...also train midwives on mentoring and preceptorship in midwifery including emphasis on mental health care so that midwives provide holistic care...' (MP 4).

"I recommend that more midwives be trained specifically on psychosocial care so that they are able to mentor other midwives and teach them how it's done. This will also mean more midwives become able to attend to the mental demands of mothers" (MP 7).

7.7.2 Following mental health protocols

Vivilaki, Haros, and Iliadou (2016:9-10) emphasised the need for mental health protocols which enforce routine assessments of all clients attending for prenatal care for history about mental disorder by midwives using approved screening tools. They pointed out that Edinburgh Postnatal Depression Scale or other screening tools should form part of screening by the midwife. It became inevitable that distinct nearby home-grown rules and conventions for the recognition and the mediation of perinatal psychological well-being issues ought to be created (Vivilaki, Haros, & Iliadou, 2016:9-10). Viveiros and Darling, (2018:70) also recommended the use of validated screening tools. Similarly, several participants in this study echoed the need to utilize some mental health protocols which are inclusive of validated screening tools:

'...Should have procedure manuals to direct on how to perform mental assessments.' (MP12).

'To have an obligatory commitment by institutions so that midwives can have protocols which they can lay hands on how to manage the mental component of women.' (MP 14).

'Midwives are failing to pick problems related to the mind due to inadequate knowledge base on how to conduct mental health assessments in pregnant and post childbirth, hence some guides should be used' (KP 6).

Nagle and Farrelly (2018:6) expressed similar sentiments when their results echoed that maternity care experts associated with prenatal and postpartum mediation ought to be prepared to utilise standard assessment devices to distinguish ladies in danger of developing or encountering mental or emotional wellness troubles, inclusive of worsening of past psychological well-being issues, in the perinatal period. This involves asking all ladies on information about their psychosocial conditions and about their own and family emotional wellness history and utilizing standard screening questions and screening devices to help experts in distinguishing ladies encountering psychological wellness issues.

7.7.3 Midwifery Curriculum Review on the Mental Health component

Current wellbeing specialist preparation does sufficiently provide trainees with passionate skills to mitigate emotional welfare, nor prepare them to deal with the pressure they are exposed to in the practice arena, with practically zero help accessible to them (Rahman et al., 2013:593). Muir-Cochrane and Lyneham (2011:788) notes the accelerated need for inclusion of psychological assessments and mental evaluations which are not presently coopted in most midwifery course educational plans. Such incorporation would guarantee that underprivileged ladies and their families have the befitting access to psychological well-being and public backup network. Reactions from most participants showed that they were in full assent of the addition of mental and emotional wellness in curricula as distinct content items. Some had this to say:

'The midwifery curriculum should have a strong component of mental health... should also include effective attachment to mental units during training of midwifery diploma and degree programmes' (MP 9).

'...Including the mental health course in the midwifery diploma curriculum, with follow-up and supervision and to test students on conducting mental assessments' (KP 6).

'...reviewing of curriculum in midwifery education such that mental health is given the attention that is necessary for improved practice' (MP 16).

'Midwives should undergo a course on mental health...most of them are not acquainted with the necessity of assessing women and taking note of the mental wellbeing of woman...surely getting such input would go a long way in helping us to give quality midwifery care which is fully encompassing' (KP 9).

7.8 CONCLUSION

The results for the most part evoked thematic areas normally found in the writings on perinatal emotional well-being. As indicated by the category on information and demeanors about ladies' emotional well-being, three themes emerged; midwives lack knowledge on "mental health", poor coverage of "mental health" in the midwifery curriculum and varied attitudes towards provision of maternal mental health, with heavier inclination towards negative attitudes. In terms of the category on competency, it was apparent that midwives were incompetent and there was lack of standardized mental assessment procedures and women indicate that midwives generally expose women to stigma. Under the category of meeting mental health needs, two themes were identified; gap in maternal mental health care and empowering women. Participants clearly exposed loopholes in organisation of perinatal maternal emotional well-being and expressed disempowerment which threads through to women's lack of communicative ability. Factors hindering mental health care were identified inadequate awareness, incapacitation, adverse outlooks and heavy workloads. Suggestions on

ways of improving mental health were educate midwives on mental health, mentorship and preceptorship, utilisation of mental health protocols which are inclusive of validated screening tools and revisiting of the mental and emotive wellbeing health component of the midwifery curricula.

CHAPTER 8

GUIDELINES ON PERINATAL MENTAL HEALTH

8.1 INTRODUCTION

The perinatal period is a spell of incredible change in a woman's life and for most of them and their families, pregnancy, labour and child rearing bring extraordinary euphoria; in any case, this period can be related with a high hazard for developing and backsliding of ailments of the mind, much higher than various other occasions in a their lives (Australian Clinical Practice Guidelines, 2017:13; Farrelly et al., 2014:127). Beyondblue (2011:11) purports that mental conditions during the perinatal period can affect anyone regardless of their culture and proffers the factors that can intensify the chances of a woman to succumb to mental pathology during the perinatal period, like abuse, lack of support and stress. Current trends support innovative and effective perinatal mental health interventions (Lavender, Ebert & Jones, 2016:399), training and supporting midwives (Carroll et al., 2018:19) and routinely screening women (WHO, 2018:2). A definitive endpoint of this thesis was development of guidelines to be followed all through the perinatal period in Zimbabwe. The objectives of this study were to:

- Identify the mental health interventions offered by midwives.
- Measure and analyse the extent to which the levels of the psychosocial markers reflect effectiveness of the mental health interventions.
- Explore and describe the experiences of women, midwives and key informants on the effectiveness of the mental health interventions.
- Develop mental health guidelines that will direct mental health interventions to be followed throughout the perinatal period in Zimbabwe.

The results of the quantitative analysis (Phase 1), namely the psychosocial scale and the document analysis were proffered and a discussion based on pertinent supporting evidence was done in Chapter 5. This was followed by the presentation and discussions

of the insights from the in-depth interviews held with women (Phase 2) under Chapter 6. Likewise, Chapter 7 presented and discussed the results from the in-depth interviews with midwives and key informants (Phase 2). Chapter 8, which is Phase 3 of the study, condensed the discoveries of the two phases of the research study, clarified the way towards crafting the guidelines to be followed throughout the perinatal period through use of the Delphi Consensus method and now presents the final product.

8.2 SUMMARY OF FINDINGS FROM THE TWO PHASES OF STUDY

Literature indicates the effectiveness of the BC framework in facilitating recognition, diagnosis, management and follow-up of women with identified mental health challenges (Williams, Ryan & Thomas-Peter, and 2014:7). The four mainstays of this structure include well-characterized emotional well-being mediations that ought to be considered at key phases of a perinatal lady's ideal excursion, from origination to parenthood. The four pillars were used to assess the psychosocial adjustment of women and analyse the effectiveness of the mental health interventions. The pillars were utilised to examine how mental health interventions had influenced mental health care of perinatal women.

The overall findings indicated deficiencies in institution of maternal mental health interventions because interventions were heavily skewed towards physical aspects of women, pregnancy and childbirth and mother-child aftercare despite the realisation that the women had diminished psychosocial scores. Documents of the women also revealed gross deficiencies in recording of any psychosocial interventions. Both approaches; quantitative and qualitative produced outcomes that backed up the scarcity of mental health interventions. Interventions as revealed by the quantitative study, namely scarcity of recordings on women’s documents despite recording of low psychosocial scores were confirmed by the findings obtained in the qualitative studies from conception to motherhood, giving credibility to the notion about paucity of mental health interventions, whilst unveiling how significant the mediations were to the experience of ladies. The discoveries further demonstrated that there are still more

opportunities to get better in implementation of the interventions and the possibility of co-opting validated mental health screening tools.

In the initial quantitative study, the researcher considered the importance of measuring the psychosocial attributes which would provide evidence of psychosocial adjustment or absence of it. On the whole, the findings showed poor scores despite the assumption that the women would have attended at least three antenatal sessions where mental health intervention should have been utilised on them. In the same phase, retrospective document data also indicated that there was virtually no recording or minimal recording in the women's maternity records. The qualitative findings in phase two which entailed in-depth interviews with woman, midwives and key informants unanimously supported the quantitative results. The findings were not surprising, as alluded by several authors. They were also alarmed at the paucity of mental health interventions despite the fact that midwives are strategically placed (McBride & Kwee, 2016:5; Alderdice & McNeill 2016:400; Tehari et al. 2018:73).

Summary of other findings are presented under the following subheading:

- Knowledge and skills on mental health
- Attitudes towards mental health
- Competency, Respectful communication and attentiveness
- Stigmatisation
- Meeting mental health needs
- Empowering women
- Hindrances
- Enhancement of mental health

8.2.1 Knowledge and skills on mental health

The findings in this study indicated that women participants are clamouring for attention to their mental wellbeing, yet midwives clearly have limited knowledge and skills on mental health aspects and carrying out mental health assessments in midwifery. Sentiments by most midwives and key informant participants in this study also unveiled

the deficiencies in coverage of the mental health content in midwifery. Similar findings were echoed in many other studies, which also revealed lack of knowledge and skills (McCann & Clark, 2010:231; Rahman et al., 2013: 593; Viveiros &, Darling 2018:70; Noonan, Jomeen, Galvin, & Doody, 2018:e358). Studies also expressed negative impacts of poor mental health which included disrespect of the woman's autonomy and dignity (Jolivet, 2011:469), even if midwives are strategically placed to offer such care (Higgins, Carroll & Sharek, 2016:364).

8.2.2 Attitudes towards mental health

Participants in this study expressed varied attitudes towards provision of maternal mental health, with heavier inclination towards negative attitudes. Midwives were mostly viewed as having negative attitudes and they avoid or overlook mental health assessments and care. The sentiments were echoed by the women, midwives as well as key informants. Studies emphasise the importance of having positive attitudes towards mental wellbeing whilst exposing the detrimental effects of negative attitudes. Butt et al. (2015:S9) noted the existence of negative stereotypes despite midwives having positive attitudes towards fulfilling their obligation to screen for mental stability thereby prompting the need for taking cognisance of tentative awareness of potential prejudice so as to counter the effects of the stereotypes on care.

8.2.3 Competency, respectful communication and attentiveness

The professional participants clearly spelt out that midwives are ill equipped for the provision of mental health care and they said this could be due to inadequate input and lack of clinical exposure. Incompetent practice has a negative effect on service quality as shown in this study when women expressed that they are not handled with due respect and courtesy by the midwives, who lack the ideal communication capability. The women also wished for seamless care, preferably from one particular midwife or proper transference and take over, as well as having midwives who could be more attentive to their mental health needs. Current trends of midwifery management contain a blend of effective methodologies, for example, ceaseless support during labour by an individual whom one is acquainted with, consoling physical contact utilising massage

technique, and the progression of persistent assistance by midwife (Tehari et al., 2018:73).

8.2.4 Stigmatisation

Sentiments from all the participant groups indicate that women are generally exposed to stigma since midwives sometimes talk loudly, scorn and laugh at women in the midst of other people. The midwife and key informant participants also felt that stigma begins in the community and all the way to hospitals where women are even made fun of by others and even by the midwives themselves. Rahman et al. (2013:593) was concerned about midwives' stigmatising attitudes and low mental health literacy and yet they are the essential link channel between powerless ladies and maternity care.

8.2.5 Meeting mental health needs

Findings from all perspectives of the study reveal a shortfall in mediation of maternal emotional wellbeing health care. Women participants talked about the approaches to health education indicating that most of the health information is imparted at the antenatal phase through group educational sessions and health topics which are a sole choice of the midwife without client involvement and are an undifferentiated message for every woman. Subsequently, not all women were offered additional education on a one-on-one basis to further educate and provide explanations on individual interactions with personal midwives. The professional participants expressed that midwives try to relegate mental health care to those trained in mental health, thereby overlooking the aspect.

Women participants were aware of the undisputed role of psychosocial and emotional support, however despite mixed views, the majority expressed paucity of psychosocial and emotional support. They asserted that it was difficult to discuss their fears and worries with midwives and were starved of the time for adequate support. Unfortunately, without psychosocial support women can develop mental illness, which can lead to increased obstetric complications, and compromised mother-infant relationship (Williams, Ryan & Thomas-Peter, 2014:6).

8.2.6 Empowering women

Empowerment can be achieved through respecting individual preferences, assisting women to deal with emotions while lowering blame with resultant improvement in the health of women and their mental stability. However the women participants in this study felt disempowered, much as they expressed the desire to have a pleasant stay and leave the hospital happy but this was not the case most of the times. Their sentiments were heavily inclined towards lack of courtesy and disrespect for women. They expected partnership in their care, as they expressed the need for involvement thereof and also acknowledged that they had a proactive role to play. Marriot and Ferguson-Hill (2018:341-342) reiterates that empowerment can be achieved through promotion of an individual's feeling of security, fulfillment with life, hopefulness, trust in possession of child rearing capacity and development of problem-solving skills.

8.2.7 Hindrances to provision of mental health care

Women, midwives and key informants who participated in this study cited similar factors which hinder provision of appropriate mediation of mental health and attention to women during the antenatal through to the postpartum period. The factors were:

- Incompetent midwives due to knowledge and skills deficit.
- Unacceptable attitudes by midwifes.
- Heavy workload.
- Poor communication.

8.2.7.1 Incompetent midwives due to inadequate knowledge and skills

Incompetence of midwives in provision of psychological wellbeing care was cited by all participant groups and it was found to be closely linked to inadequate knowledge and skills on mental health.

8.2.7.2 Unacceptable attitudes by midwives

The general outcry across all participating groups was the negative attitudes of midwives towards the mental health of women which caused them to shun handling and talking to women.

8.2.7.3 Heavy workload

Heavy workload was a major barrier to attention to the mental health aspect of women. As all the participants cited that there were too many women as opposed to inadequate midwives. The women participants generally showed displeasure with the obtaining overpopulated maternity unit, whilst somewhat sympathising with the midwives' inability to cope with the mental needs.

8.2.7.4 Poor communication

All the participating groups, especially the women alarmed at the diminished communication from the midwives, coupled with inattentiveness and disruption in continuousness of care. This impacted adversely on the capability to offer the requisite psychosocial and emotional support.

8.2.8 Enhancement of mental health

Recommendations on enhancement of mental health from women, midwives and key informants responded accurately to the deficits and the stated hindrances.

The recommendations were:

- Reviewing avenues to improve staffing in order to cope with the excessive task at hand and furthermore encourage stress-free progression work which co-opts mental health assessments and interventions.
- Enforce psychosocial support even through partner involvement.
- Ensuring that women are respected at all times.
- Provision of the relevant education, training and supervision of midwives on maternal mental health.
- Ensure the existence of operative mentorship and preceptorship programmes regarding maternal mental wellbeing.
- Reviewing the midwifery curriculum on the maternal mental health component
- Developing and following mental health protocols and standardised mental assessment procedures.

- Devising ways of ascertaining that the standards of maternal mental health care are adhered to.

8.3 GUIDELINES TO DIRECT MENTAL HEALTH INTERVENTIONS THROUGHOUT THE PERNATAL PERIOD IN ZIMBABWE

8.3.1 Introduction

Assessment of maternal mental health has become a great concern worldwide with several guidelines having been developed for utilisation in different perinatal contexts; examples are the NICE, NCBI, BC's. Most of the guidelines are skewed towards recommendations pertaining to mental pathology, whilst a few are based on an approach which focuses on routine appraisal of passionate wellbeing and health during the perinatal period. It is critical to ensure hearty psychological wellness for both mother and family in the perinatal period for passionate and physical improvement in newborn children and streamlining of child rearing, sustaining and care capacitation, and family formation (Perinatal Mental Health Consortium, 2008). Similarly, the guidelines in this study focus on proactive assessment of mental health of every woman that can be incorporated into ladies' ordinary wellbeing checks by midwives, maternal and baby wellbeing caregivers. Such evaluation incorporates inquiries concerning psychosocial influences and extends to the identification of components that may improve a lady's probability of developing emotional well-being challenges, and furthermore mental illness as a worse off scenario. If a woman has psychosocial challenges, the midwife uses clinical judgement to determine the intensity of follow-up care.

Assessment of the connections among mother and infant, and awareness of any indications of puerperal psychosis or bipolar issue, especially in ladies who have had these disturbances before is a necessary part of the early postnatal period. Follow-up comprises of a pathway which empowers the lady and her family to get the most befitting wellbeing mediation and backing during the perinatal period and is dependent on the seriousness of the lady's hazard or indications, together with her inclinations and social setting. If a woman has psychosocial factors or minor features, she may get assistance from watching, re-evaluation and counselling on way of life. Minor to

moderate features might be subjected to passionate and useful help, such as, peer backing, guiding psychologically and mental therapies, whilst severe cases require more intense interventions. Where hospital admission is desirable, mother and child ought to be kept together at every possible opportunity. Explicit restorative intercessions might be suitable for selected situations like early child rearing aggravated by lack of sleep, counselling for parents who would have experienced perinatal loss and difficult mother-infant relationship.

Utilisation of these guidelines will differ according to information, abilities and job requirements, also with the care location. Consumers of these guidelines should always take cognisance of the need for cultural responsiveness and family-centredness, as well as synergistic basic interactions with the lady and her family. Significant appropriate training and skills of the midwives and other health professionals who are utilising these guidelines should be undertaken and provision of congruity of care for ladies and their families should be a key aspect of these guidelines. The guidelines are designed for use notwithstanding different approaches and benchmarks working system records that are accessible in the nation. The format is organized in three fundamental segments. Segment One layouts the way toward building up the guidelines, meaning of terms, extent of utilization, reason, destinations, core values of the record, meaning of maternal psychological wellness, its traits or standards. Segment Two focuses on the technical perspective of maternal mental health, focusing on the major factors that influence maternal mental health interventions. Segment Three presents issues on institutional variables required to help in successful provision of maternal mental health.

8.4 SECTION 1: INTRODUCTION TO GUIDELINES

8.4.1 Process of developing guidelines

The plan for building up these guidelines was provoked by the worries about the deficiencies in meeting the emotional wellness needs of ladies. The drafting of the guidelines emanated from the discoveries from Chapters 5 to 7 of this study and from all-encompassing literature survey. The tentative record had to be exposed to appraisals by a number of senior maternity and emotional well-being experts to produce

a concurrence on the substance and to decide its attainability within the Zimbabwean setting. The reasonable system for creating guidelines is shown in Figure 8.1. The crafting and the review experts were aware of the setting of maternal psychological well-being health services delivery and the interplay of these guidelines and the other pre-existing protocols. Efforts were made to utilize straightforward language while guaranteeing that the substance fulfills the intended basic practical principles satisfactorily and to make the document portable. The design permits meeting of the needs of women and also promotes good professional practice among midwives.

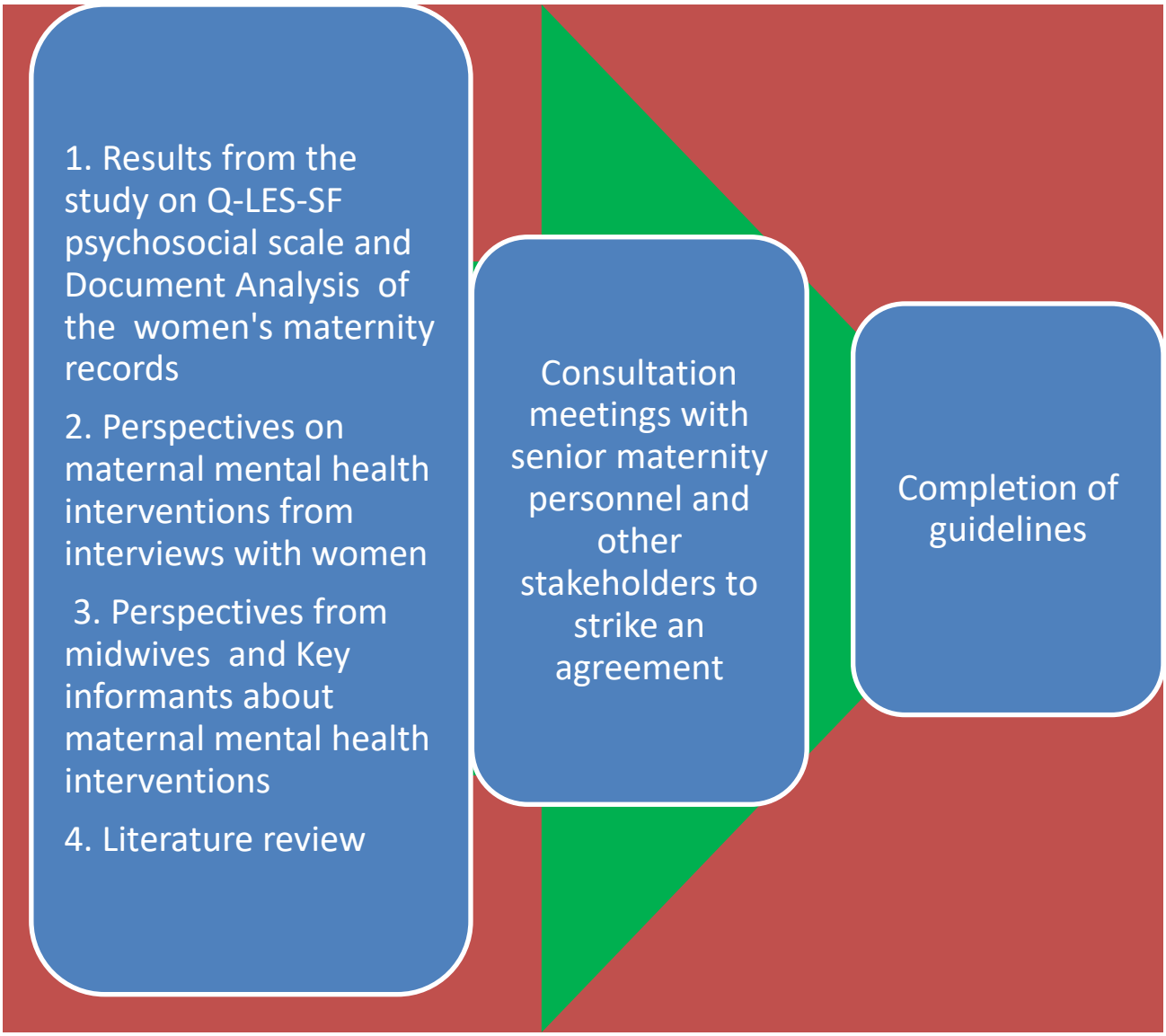

Figure 8.6: Framework for developing mental health guidelines to be followed throughout the perinatal period

8.4.2 Scope of application of guidelines

These Guidelines cover psychosocial and mental health components that usually influence the health and wellness of women and their families during the perinatal period and they are intended for application in hospital and community institutions that offer maternity services. The main focus of the Guidelines is proactive assessment of

the mental health status, early identification of mental illness and maladjustment, management and referral, as appropriate, of every woman whom the midwife and other health professionals come into contact. The primary target group are the midwives who are involved in direct interaction with the women and significant others and the communities. Other key groups to focus on are the maternity professionals who are provide unswerving attention to women, the health institution's administrative staff and the policy making teams.

8.4.3 Purpose of the guidelines

The purpose of the document is to facilitate optimisation of the mental wellbeing of women through utilisation of evidence-based guidelines to direct mental health interventions throughout the perinatal period in Zimbabwe.

8.4.4 Objectives of the guidelines

The objectives are to:

- Address a salient aspect of substantial liability to womenfolk and their significant others.
- Broaden awareness of perinatal maternal mental health and increase consistency of mental health care.
- Enhance support for women and their significant others in this period.
- Encourage research to further inform practice.

8.4.5 Guiding principles of maternal mental health

The guiding principles are:

- A developmental approach to assessment and management
- Reciprocal relationship and Partnership in care.
- Early identification and intervention.
- Culturally appropriate mental interventions.

8.4.6 Definition and meaning of maternal mental health

Steen and Francisco (2019:11) describe maternal mental health as relating to a person´s emotional, psychological and wellbeing status which can, therefore, influence how a pregnant woman and a postpartum mother attains her sense of purpose and connectedness to others. This implies that it becomes important to support pregnant women so that they can build and maintain resilience, develop coping strategies to promote health and wellbeing as an important aspect of maternity care (Steen, Robinson, Robertson & Raine, 2015:93). The same authors argue that being resilient smoothens the transition to motherhood as women become better able to cope with anxiety and stress, thereby reducing the fear associated with childbirth and maintaining health and wellbeing throughout the perinatal period. The mother´s mental health status in turn impacts positively or negatively on the infant's physical, emotional and psychological development; which entails that emphasis should be placed on infant attachment, on appreciation of how culture is important and how to work with families in the sensitive post childbirth phase of life (Marriott & Ferguson-Hill, 2012:347). As cited earlier in chapter 3, defective maternal mental stability can give rise to problems with cognitive development, (Bennett, Schott, Krutikova & Behrman, 2016:168-173), physical conditions such as asthma, (Giallo et al., 2015:e0121459), and conditions linked to disturbances of behaviour, like attention deficit hyperactivity disorder (ADHD) and ailments which are due to anxiousness (Barker, Copeland, Maughan, Jaffee, & Uher, 2012: 124).

8.4.7 The attributes of maternal mental health and their explanations

Table 8.10: Attributes of maternal mental health and their explanations

Attribute	Explanation
Culturally responsive perinatal mental	It may seem unreasonable to take a solitary tactic to perinatal mental health care, taking a culturally receptive style and devising tools to support mothers experiencing mental health stresses, along with their

health care	family unit may assist women to gain emotional stability (Weerasinghe, 2019:906)
Understanding the woman's context	Different women are faced with varying situations such as gender inequality, economic and educational disparities and other social determinants, this, therefore calls for a midwife who takes cognisance of the prevailing contexts.
Family-centred approach	The influence of problems associated with the mental health of women spill over to extends beyond the woman herself to embrace the child, partner and the family at large. Whatever initiatives are intended to help the woman should co-opt her whole social backup system.
Respect and courtesy	Respect and courtesy are terms which are frequently used interchangeably. Respect is when one feels they have a serious obligation to uphold the requisite regard for the rights, wishes, capabilities and accomplishments of other people. (Beauchamp & Childress 2001 cited in Beach et al., 2007:693). Courtesy is having an attitude that can be viewed as decent conduct or displaying graciousness towards others.
Psychoeducation	Care in the perinatal period is vigorously subject to conversation about emotive wellbeing and health, strengthened by providing important and socially touchy data and is not an erratic occasion but rather it proceeds through all encounters during pregnancy and the postpartum period. It is essential to take note that all through the perinatal period, education needs change, especially if psychosocial elements or signals of pathology are recognized or a choice concerning mediations is required
Maintaining the therapeutic	In most ladies, pregnancy and the year following the birth is a period of significant emotional change, hence the need to provide psychosocial

relationship	care which includes building up and keeping up a helpful connection between the midwife and the lady and her family. Key parts of the helpful relationship incorporate a trusting relationship, certainty, commonality, undivided attention and empowering of the woman (Simpson & Creehan, 2008).
Inclusive means to mental health care	The inclusive means to mental health consideration in these guidelines comprises mundane examination of psychological plus social factors, then the subsequent care pathway will be determined by the intensity of identified psychosocial challenges and their manifestations, whilst taking cognizance of the preferred choices of the woman and her prevailing specific situations. This care also entails collaborative decision-making about treatment option strategies for preventing deterioration, ongoing tracking and persistent follow-ups.
Capacitation and support for midwives and other maternity professionals	Capacitation of midwives and other maternity professionals should be a mandatory exercise towards ascertaining the requisite abilities and the aptitude for efficiency in screening, detecting, mediating, provision of backup services and referring women with mental challenges timeously in the perinatal period.
Psychosocial assessment	Performing psychological and social valuations should be freely incorporated into day to day perinatal care activities. Quite a number of psychosocial factors are somewhat probed in the usual interfaces with clients (such as asking gender related harassment, intoxicating drinks and substance abuse), as well as supplementary inquests and use of a validated screening tool such as Q-LES or EPDS scales must be co-opted depending on the location and situations.
Continuity of	This viewpoint entails offering seamless services and is strategically based on a collective indulgence in the care trajectories by all midwives

mental health care	which are purposed at decreasing fragmented approaches and contradictory counsel. Here, the midwife in attendance gets to be well acquainted to the woman, is responsible for attending to her unique care aspects appropriately, thereby cementing their relationship. Continuity of care has been well acknowledged by numerous authors as a panacea to provision of optimal maternity services (Homer et al., 2008).
Partnership in mental health care	Partnership in mental health care is to do with shared governance (Morgan & Yoder, 2011:6). Manley, Hills and Marriot (2011:37) reiterate that promotion of partnership involves woman, family and community, provision of feedback and measurement, availability and constant communication of strategic vision are essential aspects which would in optimal mental health care.

8.5 SECTION 2: TECHNICAL GUIDELINES ON MENTAL HEALTH INTERVENTIONS

This section makes available the practical guidelines in relation to carrying out mental health intermediations on women for the duration of the perinatal period. It is worth noting that the recommendations may have been presented under detached sub-headings here, but the fact remains that the majority of them are interconnected.

8.5.1 Culturally responsive perinatal mental health care

FNMWC (2015:5) realised the importance of focusing on restoring linkages to cultural strengths through health promotion, prevention, and education strategies as a precursor to enhancing empowerment of women and their families. This would spill to strengthening resilience to mental illness, increasing protective factors, decreasing risk factors and increasing participation in community life. Weerasinghe (2019:202) alludes to the prominence of providing training that equips midwives to provide a culturally responsive and family-inclusive treatment when dealing with perinatal women. Suggestions for provision of a culturally responsive perinatal mental health are as follows:

- Midwives must fully understand the historical and cultural context that affect women at every stage of the perinatal period, despite their cultural background.
- Midwives must be trained on maternal mental health interventions whilst placing emphasis on a high standard of respect for the woman.
- Maternal mental health interventions should be culturally responsive and should be inclusive of the family.
- Strategies to have tools to support mothers experiencing mental health stresses, along with their families should be tailor made to suit individual preferences of women.
- Midwifery practice should advance pertinent strategies that are applicable to the country's context, in order to guarantee that every woman and her community members receive suitable, culturally receptive psychological and social services.

8.5.2 Understanding the woman's context

The perinatal passé is unfortunately connected with a high hazard for beginning and backsliding of psychological well-being conditions even greater than at numerous different occasions in a lady's life (Australian Clinical Practice Guideline, 2017:13). However, contextual issues can be addressed through provision of a women-focused interaction, which is progressively being viewed as extraordinary when compared with other practice approaches to higher quality maternal mental health (Clif, 2012:86). The guidelines for improving midwives' understanding of contextual issues are as follows:

- Midwives ought to guarantee that correspondence with ladies in the perinatal period is empathic and non-judgmental, and that conversations are woman-centred
- Empathy requires that the midwife has the ability to comprehend the woman's context, perspective, and feelings, to convey that understanding and check its precision, and finally to follow up on that comprehension in an accommodating helpful manner

- The least possible requirement is that all wellbeing experts caring for woman in the perinatal period ought to be prepared in woman-focused relational abilities and psychosocial appraisal.

8.5.3 Family-centred approach

The family-centred approach strengthens the concept of support systems which is essential in promoting mental status the expressive capability of women. Guidelines to achieve the family-centred approach include:

- Encompassing supporters of the woman's backup network as earlier on as conceivable from the initial antenatal encounter which promotes opportunities for all involved to understand the influence of conception and child rearing on emotive health and wellness.
- Involvement of the support networks also facilitates screening for psychosocial factors impacting on significant others family members and household relations.

8.5.4 Respect and courtesy

Midwives should always treat women, their partners and families with respect and courtesy. Women deemed midwives to be courteous if they would not yell at them, were benevolent and were inclined towards the enjoyable funny side (Dzomeku, 2011:32) and they also felt respected when they were addressed well (Lekberg et al, 2014:40). The guidelines for addressing these are as follows:

- Introduce yourself and share some information about yourself at every encounter with the woman, for example, stating your professional reasons for the contact with the woman.
- Honour, politeness, poise and privacy are enormously valued everyday interactions; demonstrate these characteristics in your interaction with women.
- Demonstrate respect, caring and value for clients by being appropriately attentive, being empathetic and listening with openness.

- Explain and consult women on aspects of their care such that they become involved in decisions.
- Women feel regarded when tended to cordially and pleasantly, and when 'conversed with well'
- Women derive psychological comfort as well as feeling respected when midwives assist them with specific things, including holding and giving a bath to your baby.
- Be non-judgemental and non-discriminatory when dealing with women.

. **8.5.5 Psycho-education**

Mental health promotion, and education increases awareness, attitude and behavior, whilst facilitating engagement in safer and healthier lifestyles, as well as supportive family relationships (FNMWC, 2015:5). Regular perinatal mental issues are hard to perceive. In this manner, giving of pertinent, applicable psycho-instruction on passionate and emotional well-being improves appraisal of emotional difficulties (Highet et al., 2014:14).

- Psycho-education, which is inclusive of psychological well-being discussions and giving of instructive materials ought to be a standard segment of care for ladies and their partners and family in the perinatal period.
- Psycho-education should be given to antenatal and postnatal women as a group education. This should be followed strictly by individual educational sessions on subsequent one-to-one interactions.
- Women may be advantaged by provision of dependable exhortation on way of life issues and rest and also incorporation of this advice into their everyday happenings during this time.

8.5.6 Maintaining the therapeutic relationship

The type of relationship between women and midwives is one of the significant elements that decide the nature of the pregnancy and understanding of labour. Relationship penetrates all features of undertakings and is one of the major persuasive variables that encroach on ladies' fulfillment with care (Srivastava et al., 2015:8). The

individual wellbeing expert's social styles just as how the institute manages social issues are altogether significant in mental health care (Andrissi et al. 2015:2). Therapeutic relationships can be achieved through following these guidelines:

- Ensure eye contact and sit near the woman instead of standing.
- Take cognisance of the way you conduct your body and its subconscious meaning.
- Reassure the woman whenever there is need even through touch in order to instill psychological comfort.
- Avoid communication barriers by enquiring language she is agreeable to utilize because ladies lean towards midwife who speaks their language.
- Elucidate what you need to state to the lady bit by bit, whilst tolerating that they have sufficient time to process the data. Allow the woman to give report back or to rephrase.
- Encourage peer support such that women share their knowledge and skills.
- Craft a maternal mental health record booklet which should contain useful information that can be used as a teaching aid. A personalised information package for the woman should be developed.

8.5.7 Inclusive means to mental health care

The way to deal with care in these guidelines includes routine appraisal of psychosocial factors and the subsequent care pathway will rely upon the degree of seriousness of identified psychological and social challenges, whilst taking cognizance of the lady's inclinations and explicit conditions**.** This care also entails collaborative decision-making about treatment option strategies for backslide avoidance, keeping track and insistent following up. Dennis and Dowswell (2013) discovered the merits of psychosocial and psychological interventions such as, interpersonal psychotherapy including noteworthy decrease for the frequency of postpartum depression optimal infant health as well as development. Guidelines on the mental health approached should include:

- Integrate mental health assessment and risk screening into antenatal, intrapartum and postnatal assessment protocols.

- Make a baseline mental health assessment (MSE) with the guidance of a validated assessment tool, on every woman at the initial visit.
- Explore the psychosocial progress at every antenatal visit. The women can monitor themselves through being urged to keep a little book where they could archive issues they might want to think about and those talked about.
- Interaction with women should afford sufficient interval for women to consider their goals and apprehensions and every choice is probably going to be exploited with relevancy to those objectives and apprehensions.
- Use of strategies to monitor the nature of therapeutic correspondence through utilisation of tools such as verification boxes, surveys and exit interviews should be made at every stage of the perinatal period.
- Pertaining to every occurrence, tactics and subject matter have to be planned dependent on the encounters and individualised desires of the particular ladies.

8.5.8 Capacitation and support for midwives and other health professionals

Improved comprehension of perinatal emotional wellness by midwives advances specialisation, guarantees that helpless ladies and their families have befitting access to psychological well-being and communal backup networks (McCauley et al., 2011:4). The guidelines emphasise the importance of training mentoring and supporting midwives:

- Midwives associated with dealing with women' mental and emotional wellness during the perinatal period should look for progressive support or guidance.

- Psychological treatments during the perinatal passé ought to be carried out by enlisted professionals with certified preparation in the applicable treatment aspects.

8.5.9 Psychosocial assessment

- Tools should be used to assess all women within psychosocial fields as part of standard practice as timely as applicable in early gestation and at 6 to12 weeks following childbirth. If psychosocial challenges are identified, the woman should be consulted need for assistance and the parameters of the help pertaining to the issues.
- A validated psychosocial assessment tool such as the Q-LES-SF should be utilised by midwives as constituent of the examination of every woman during the antenatal period.
- As a fundamental aspect in the encounter with women in the postpartum period midwives should evaluate the mother and baby interaction.
- If any noteworthy complications become apparent pertaining to the relations between mother and baby with concern on the mom's mental status, an appraisal of the degree of danger to the child must be done.
- When a woman experiences significant mental health challenges with difficulties interacting with her infant, there is need of addressing both problems, whilst the wellbeing of the infant is given priority at all times.
- Where there are noticeable alterations in temperament, judgements, acuities and conducts earlier on after childbirth, the midwife should ensure that comprehensive mental health assessment are done.
- Women who would be recognised as having a tentative suicidal danger during clinical screening with or without use of a validated tool need some specific assessment. Following this, identified immediate risk should be managed, as well as offering backup and therapeutic choices. The security of the offspring should also be upheld.
- Comprehensive mental health assessments by midwives and other health professionals should be well linked to identified referral options and active support systems for women.
- Community midwives should pursue an ongoing role in provision of psychosocial attention to women, as well as the babies plus their families in the perinatal

epoch for continued support then refer to mental health expertise as necessary in singled out cases.

8.5.10 Continuity of mental health care

Continuity or congruity of care can be decided as a process which facilitates development of women's individual associations with their midwives and which likewise advances sentiments of progressive responsiveness to the courteous treatment during pregnancy and labour (William et al. 2010:619). Numerous wellbeing health entities have now transformed their care frameworks to slot in a system that spotlights on enhancing the experience for every lady by permitting uninterrupted care by a recognized midwife (Editorial, 2009:47). Elements that may improve congruity of care incorporate appropriate proper documentation, cooperative development of executive strategies, creating partnerships and networks, as well as adjusting to fruitful ways of caring. For instance, models are: case conferencing, collective care methods, systematic meetings of sustenance services or specific interest clusters and collective discharge preparation may enhance continuity in some care settings. The following guidelines facilitate achievement of continuity of mental health care at all phases of the perinatal period; antenatal, intrapartum and post childbirth:

Antenatal period

- Mental health assessments and mental risk screening using a validated tool should be performed and findings should be documented on the booking visit on every woman.
- On every subsequent antenatal visit, mental health assessments should be done and findings should be documented.

- All Women should receive some helpful empowerment interventions to prepare them for parenthood which include: attending antenatal classes, instilling awareness on assumptions regarding pregnancy, birthing and turning into the parenting role. They should also be afforded a chance to identify and mobilise

support systems, and every network with other pregnant or parenting women, such as mothers' group and reading parenting books (BeyondBlue, 2019:11).

Intrapartum period

- Women should receive persistent labour support by an identified midwife, consoling physical contact utilising massage technique, and the congruity of birthing assistance care. This is part of a package on the emotional backup approaches for those in the childbearing phase. Counteraction of negative birth experience by utilising these fruitful practices prompts the advancement of vaginal birth, top notch maternity care and the decrease of interminable mental complexities (Tehari et al., 2018:73).
- Vigilance, attentiveness and respect should be upheld by the midwife in attendance.
- Pain relief in labour should be afforded on demand, within calculated safety precautions in order to ensure psychological comfort of women.
- If it becomes necessary that another midwife takes over care and also assist in the intrapartum care, a smoothening of the transition should be afforded through proper explanation of the situation and consent from the woman concerned.

Post childbirth

- Psychosocial assessment, using a validated tool should be conducted on every woman in the postpartum period.
- As an integral aspect of the care of women in the postnatal period midwives should assess the mother–infant interaction.

- If any significant difficulties are apparent pertaining to the mother–infant interaction with concern on the mother's mental health, a risk of harm to the infant should be done.
- When a woman experiences significant mental health challenges with difficulties interacting with her infant, there is need of addressing both problems, whilst the wellbeing of the infant is given priority at all times.

- Where there is noticeable variations in affect, opinions, discernments and conducts in the early stages after childbirth, the midwife should ensure that comprehensive mental health assessment are done.
- Those women who are recognized as being in danger of potential suicide during clinical evaluations with or without use of a validated tool need some specific assessment. Following this, identified immediate risk should be managed, as well as offering backup services and therapeutic choices. The security of the offspring must also be upheld.
- Comprehensive mental health assessments by midwives and other health professionals should be well linked to identified referral options and active support systems for women.
- Community midwives should pursue an ongoing role in provision of psychosocial attention to women, as well as the babies plus their families in the perinatal epoch for continued support then refer to mental health expertise as necessary in singled out cases.

8.5.11 Partnership in mental health care

- Midwives should create a woman-centred climate which should include shared governance, vision and commitment of leaders.

- Partnership can be achieved through involvement of women, family and community, provision of feedback and measurement, as well as availability of the midwife and constant respectful communication.

- Relationship between the midwife and the woman should be based on an open, collaborative process, where there is setting of mutually agreed goals and tasks and regular support, as well as empowerment and support in cases where referral becomes necessary.

8.6. SECTION 3: ORGANISATIONAL FACTORS THAT PROMOTE MATERNAL MENTAL HEALTH

8.6.1 Organisational factors that promote maternal mental health

For effective implementation of maternal mental health, there has to be commitment from leadership, top management, midwifery management and heads of departments. A combination of factors has to be put together, despite the technical guidelines being at the fore. The is need to have a midwife equipped with mental health skills, well informed and involved woman and her family, as well as workforce mental health capacity building programmes. The following are some of the proposed means to attend to these concerns.

8.6.1.1 Leadership

Headship by the executive team, midwifery administration, departmental and unit heads, midwives, obstetricians and any maternity senior health personnel, should submit to dedicated commitment which is dominant towards the success of the mental health approaches and should walk the talk as suggested here.

The following are proposed ways of spearheading maternal mental health:

- A clear maternal mental health strategic vision and promotion of an environment which is conducive for therapeutic communication.
- Midwifery administration should review organisational policies and rules in order to specifically skew them towards facilitation of the implementation of the principles maternal mental health.
- Conducting health facility readiness assessment as a strategic means of identifying aspects to focus on during implementation could be done proactively.
- The already existing quality assurance team or committee may just take up the task with co-option of identified specialties instead of establishing another structure for implementation.

- Institutional focal persons should assist by precipitating interest and formation of positive attitudes towards mental health, which implies calling for behavioural change. These persons will function as a dynamic connection to high-ranking administration, information sharing, influencing subordinates and strengthening synergy with broader organisational goals.
- Leadership should, therefore take it upon themselves to take strides to catch up with world class maternal mental health initiatives and assessments by displaying of clear commitment and acting as role models.

8.6.1.2 Staffing

An undisputable aspect of achieving optimal maternal mental health is adequate staffing which caters for balanced workload. It is essential to ensure availability of an ideal number of midwives, other health professionals and requisite skills mix per shift with clear and available referral protocol.

8.6.1.3 Education, training and staff development

The need for midwives who are competent in provision of ideal maternal mental health cannot be underscored; this would result in women achieving optimal mental health. The education and training of midwives is imperative as already elucidated by literature and findings from this study. Clearly key aspects of maternal mental health education, especially the skills acquisition and mentoring ones are not addressed holistically, which makes the drive toward education and training of midwives, in particular, imperative. Proposed capacitation initiatives are as follows:

- All midwifery training curricula and programmes should incorporate the mental health and emotional wellbeing components. This calls for curriculum review.
- Regular in-service training on maternal mental health interventions and psychosocial assessments in maternity institutions should be mandatory.
- Supportive supervision, which encompasses on-the-job teachings should be invigorated.

- Preceptorship and mentorship programmes on maternal mental wellbeing initiatives should be a fundamental section of the education and training.
- There may be need to harness all the possible ways of improving maternal mental health care into midwifery education and practice, including co-opting the mental health guidelines developed in this study.
- Using a validated tool such as the Q-LES-SF for psychosocial and mental risk assessment should also be mandatory.
- There is need to utilize all adult instruction and knowledge acquisition strategies that stimulate interest in learning about maternal mental wellbeing.
- Empowering midwives to be active participants within the clusters that champion promotion of maternal mental wellbeing could boost their enthusiasm on the subject.
- Recognising and rewarding midwives that excel by exhibiting distinguished theoretical and practical mental health output could also act as a motivator.

8.6.1.3 Enabling Environment

The guidelines can only be effectively implemented within an enabling or conducive environment which has the necessary infrastructure, addresses staffing issues, partakes in re-organisation of the services as well as having clear monitoring and feedback mechanisms.

8.6.1.3..1 Infrastructure and environment

Infrastructural design should attempt to provide psychological stability for both women and midwives through provision of sufficient space to match the amount work and facilitation of the confidentiality, luxury and self-respect of women. Lin et al. (2013:4) impressed on respecting the woman's space, through staff lowering their voice tone when discussing with women, and preventing conversations about women's issues in therapy areas or exposed work spaces where unintended audience becomes privy to uncalled for information. The following are provided as guides:

- Availing private rooms for women in order to proffer varied options for labour, partner support and individualised care.
- Strengthening of maternity systems such as referral channels in order to avoid unnecessary crowding of the tertiary levels of care.

8.6.1.3.2 Adequate resources

Resources are essential for not only easing difficulties that midwives have to put up with when proffering services but spill to making women realise better contentedness with services in the perinatal period. Guides aimed at guaranteeing accessibility of resources are as follows:

- Midwifery administration needs to conduct inventories of the equipment and provisions status for onward action.
- Key implementation strategies should emphasise forecasting of economic and material resource needs to ensure that optimal services are provided.

8.6.1.3.3 Staffing Issues

Midwives should have a superior awareness of perinatal mental wellbeing to enable them to make available the ideal backing and data provision to women and significant others and to recognize when specialist mediation is required (Carroll et al., 2018:19). Instruction and other organisational backings, for example care conduits and recordings which are essential for strengthening midwives' mental health care, collaboration interventions, and suitable, well timed mental health care. The following are proposals to improve staff aptitudes towards mental health care as well as the staff welfare. Key implementation strategies should emphasise:

- Estimating staff capacitation demands, fiscal and personnel requirements suitable for provision of these services.
- Addressing background and discrete workforce influences including staff deficiencies, pitiable working circumstances, and diminished work fulfilment.

8.6.1.3.4 Re-organisation of maternal mental health services

Re-organisation of maternal mental health services entails developing vigilance in utilising the four pillars of the BC's framework; education, screening, management as well as support networks. The vehicle for delivering such intervention should be based on culturally sensitive, family-centred approach. Beyondblue Clinical Practice Guidelines (2011:33) asserts that the model involves asking the woman whom they might want to be associated with their care and, with the woman's assent, look for this inclusion early and also being aware of the emotive welfare of family members and offering backup services if necessary. McCauley-Elsom (2009:66) concurs with development of a careful plan with the concurrence of the woman and her mate as this would facilitate avoidance of many mental and other problems with such management and care of women. Reorganisation for optimal maternal mental health services can be done through:

- Planning in collaboration with involvement of the midwives, wellbeing experts, the lady, her accomplice and additionally her family. Intercessions that draw in the family can moderate some significant hazard factors for mental illness in women: a reduced sense of personal assistance, derogatory and constraining sexual orientation generalizations, absence of money related independence and abuse and violence from intimate companion (Rahman et al., 2013:593).
- Hands-on and imaginative psychosocial services should be incorporated into everyday perinatal care in order to give across the board access to psychosocial assets for moms and address the unique needs of women in the perinatal period.
- The mental and emotional wellbeing needs to be completely incorporated into maternal health services through routinely screening women during the prenatal and postpartum periods with the goal that proper and opportune mediations can be established (WHO, 2018:2).
- All women, during pregnancy, labour and post childbirth, should have individualised care plans reflecting interventions aimed at achieving their identified goals.

- Mandatory use of validated screening tools for early detection of mental challenges and timely interventions and solution--focused brief psychological therapies.

- Psycho-educational mediations that join data with mental and emotional backing.
- Ensuring improved access to education and vocational training for women.
- Enhancement of mother and offspring relationship by improving mother's affectability and improved responsiveness to newborn developmental requirements for incitement.
- Enforcing accomplice connections through the advancement of partner involvement at every phase of the perinatal journey and general improvement in family and social support for womenfolk.
- Major implementation systems should emphasise constructing the evidence base, making models for maternal mental emotional wellness care and building up a legal and policy structure

8.6.1.3.5 Monitoring and feedback

There ought to be a system of ceaselessly monitoring the effects of psychosocial intercessions on maternal mental health outcomes. The worthiness of such estimation and appraisal inputs lies in utilising them to structure and execute explicit mediations or procedures to improve the experience of women. The proposed strategies are:

- To design systems for regular monitoring and feedback on maternal mental health so as to consistently request women' discernments about the mental health mediation services.
- Implementation of the initial antenatal screening provides a baseline and subsequent interval evaluations on further encounters indicate the changes in the mental status of women.

- An important recommendation is conducting satisfaction surveys on women, companions and other family members in order to elicit feedback and improve on mental health care.
- Information from data sources, procedures and results ought to be followed, benchmarked and used to improve nature of care.
- At the individual level, the midwives ought to connect with women and their families in evaluating care and outcomes. This has to be consistent and be done at every visit to the maternity facility.

8.7 CONCLUSION

Current trends ascend to the accelerated need to improve clinical approaches and design future approaches to support women during childbirth, intrapartum and aftercare, towards attainment of positive birth experiences (Tehari et al., 2018:73). The Health Action Plan (2013-2020:25) reiterates the need to execute systems for advancement of psychological wellness and anticipation of psychopathology through inclusion of mental health emotional appropriateness as a feature of home and wellbeing institution based prenatal and postpartum services consideration for new moms and newborns, including training on child rearing abilities. This guidelines document was developed to fulfill such motives, through inputs from research studies within the country and extensive literature search. It was also subjected to reviews by senior midwifery administration and other senior health professionals. The document does not only offer practical directions to action but in addition also proffers methods for addressing country specific organisational influences vital for effective execution. This guideline which is particularly for maternal mental and emotional wellness health care in the perinatal period could be applied to other situations of health care delivery.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS OF THE STUDY

9.1 INTRODUCTION

The reason for this research study was to investigate the adequacy of the mental wellness mediations offered by midwives as well as to measure and analyse the extent to which the levels of the psychosocial markers reflect viability of the psychological well-being intercessions. An exploration and description of the encounters of women, midwives and key informants on the viability of the mental health interventions ensued. Finally the mental health guidelines that would direct mental health interventions to be followed throughout the perinatal period in Zimbabwe were developed. The study encompassed midwives, key informants, as well as women who are the consumers of the mental wellbeing intercessions, in order to have a complete perspective on encounters. Both quantitative and subjective techniques were utilized to gather data. Chapters 5 to 7 indicated the numerical statistics and the conversations of the two phases of the study, quantitative with two instruments and qualitative with in-depth interviews on three different participant groups. Chapter 8 summarized the findings and proffered the protocols to direct mental health interventions. This section exhibits the conclusions of the investigation, the impediments and recommendations.

9.2 CONCLUSIONS

This investigation tried to analyze the degree of usage interventions for mental and emotional wellness care in women during the perinatal period with the point of developing guidelines to be followed throughout the perinatal period. The discoveries showed that woman definitely had psychosocial challenges but documents indicated a lack of mental health interventions to ameliorate these challenges.

The quantitative study using the psychosocial scale (the Q-LES-Q-SF assessment tool) unveiled that the psychosocial scores were generally poor which indicated that perinatal interventions are lacking or are not making much influence on the mental status and

social welfare of women by the third trimester of pregnancy. Apparently, all the demographic variables are not necessarily linked to the superiority of life enjoyment and gratification of the expectant women. It became apparent that the need for scaling up or monitoring psychosocial assessments and interventions, particularly with the utilisation of the Q-LES-Q-SF, tool cannot be overemphasized.

Analysis of the documents revealed deficient recording of the mental health attributes of midwifery care, a situation which reveals a serious gap in implementation of psychological interventions by midwives. It was disturbing to note that the documentation showed either no recording or deficient recording throughout the different phases of midwifery care, namely, antenatal, during labour, postnatal care and also on discharge planning. Other studies have alluded to reporting flaws whilst emphasising the importance of documentation of interventions and other structural supports. Carroll et al. (2018:19) highlighted the need for capacitation and other infrastructural support, like documentation and care conduits, as necessary for training and supporting midwives in their mental health care and collaboration interventions.

The women's perspectives culminated in several themes emerging under the categories; meeting mental health needs, relationships with midwives, women's expectations, women's role, hindrances to mental wellness provision and enhancement of mental health. Women alarmed at the absence of information on mental health. They expressed that the largest portion of client information is given at the antenatal phase through group educational sessions and input is pre-determined by the midwives. They would prefer reinforcement through one-on-one education sessions by personal midwives which they deemed to be erratic. It was apparent that midwives did not provide the ideal emotional and psychosocial support. The women indicated that midwives did not relate appropriately with women since they lacked continuity of care, respect, courtesy, attentiveness with poor communication and had a tendency to promote stigma. Women's expectations were to have pleasurable experience, partnership in care, respectful communication and attentiveness by midwives as well as receiving mental health education and counseling. The women identified aspects which hinder provision of mental health as having too many women versus inadequate staff,

incompetent midwives, unacceptable attitudes by midwives and poor communication. Women's recommendations for enhancing mental health were to increase staff, enforce partner involvement, maintain standards, respect women and finally to re-educate and supervise midwives on the aspect of mediation of mental health in women.

The perspectives from midwives and key informants generally evoked themes generally found in the scientific writings on perinatal mental wellbeing. According to the category on information and frames of mind about women's mental and emotional wellness, three themes emerged; midwives lack knowledge on mental health, poor coverage of mental Health in the midwifery curriculum and varied attitudes towards provision of maternal mental health, with heavier inclination towards negative attitudes. In terms of the category on competency, it was apparent that midwives were incompetent and there was nonexistence of standardised mental examination procedures and ladies indicated the fact that midwives generally expose women to stigma. Under the category of meeting mental health needs, two themes were identified; gaps in maternal mental health care and empowering women. Midwives and key informants clearly exposed that there were gaps in provision of perinatal maternal mental health services and expressed disempowerment which threads through to women's lack of communicative ability. Factors hindering mental health care were identified as a lack of knowledge and skills, negative attitudes and heavy workloads. Suggestions on ways of improving mental health were: educating midwives on mental health, mentorship and preceptorship, utilization of mental health protocols which are inclusive of validated screening tools and review of the mental health component of the midwifery curricula. Nevertheless, it is important to take cognisance of the limitations as the conclusions are being drawn.

9.3 RECOMMENDATIONS

The ensuing recommendations emanated from the study:

9.3.1 Leadership and spearheading of perinatal mental health

Successful implementation of the provision of optimal maternal mental health is dependent on leadership commitment, effort and workable organisational systems. A clear policy should guide the strategic direction which harnesses mental health as an overarching attribute of care for women, their partners and households. Leadership from the executive team, midwifery administration, departmental and divisional leaders, midwives, obstetricians and any maternity high-ranking wellbeing personnel, should submit to dedicated commitment, which is fundamental for the success of mental and emotional wellness approaches and should walk the talk. The Ministry of Health and child care, Zimbabwe should concentrate on the mental health part of maternal care, adopt these guidelines, and construct more accord on it through more extensive meetings and encouragement of its execution. Leadership should, therefore, serve as role models by demonstrating open commitment to catch up with world class maternal mental health initiatives and assessments, through proactive identification of areas to focus on during implementation and by conducting a maternity facility readiness assessment. The already existing quality assurance teams or committees should be assigned this responsibility. Institutional focal persons will also help by precipitating interest and positive attitudes towards mental health, resulting in behavioural change. The persons, therefore, become a vital linkage between senior management and subordinates, whilst influencing information sharing and strengthening synergy with broader organisational goals.

9.3.2 Education, training and staff development

Education and training of midwives is imperative as an on-going learning initiative in order to satisfy the need for midwives who are competent to deliver the ideal mental health mediation to women. These trainings should imbibe key attributes of maternal mental health education; especially acquisition of skills and mentoring that will improve their attitudes. This may necessitate conducting of a methodical assessment of midwives' competences, capacitation needs then preceptorship and mentorship aptitude. Reviews and adjustments of the maternal mental health component in

midwifery curricula should be a mandatory exercise. It is prudent that the trainings be guided by intermittent appraisals in the loopholes in service provision. It ought to be mandatory for all midwives and other professionals in maternity settings to have regular in-service and hands on trainings regarding the matter. Incessant evaluation of the appropriateness of the educational plans material on maternal mental health mediation and efficacy of screening tools with possible updating should be at the fore.

9.3.3 Staffing

Inadequate staffing with increased workload with a heavy impact on the capacity to fulfill women's mental and emotional wellness requirements was eminent in the investigation. Governance should address the severe depletion of manpower with the earnestness that it deserves based on guidance from the ideal staffing norms. Undisputed allowance for estimating developing staff, monetary and human asset essentials to afford attainment of optimal maternal health should be an integral part of strategic planning. Mechanisms for addressing context specific and discrete workforce issues inclusive of staff deficiencies, poor working circumstances, low occupation fulfillment should always be proactively planned for.

9.3.4 Increased sensitivity and attentiveness

The study noted discrepancies in provision of the ideal sensitive care and attention to women, yet good woman-midwife interaction and the woman's involvement in her care are fundamental. Gaps in intercessions for mental health instruction, commitment and interaction patterns in general. Women's information needs and preferences vary such that besides the initial group education, one-on-one educational sessions should be a must for every woman. At the antenatal period where most education is done, midwives should explore the preferences and market the available options, including those for childbirth and pain relief. Women should be introduced to a midwife who shall be with them throughout labour and in case of unavoidable disruption there should be a smooth handover-takeover.

9.3.5 Enabling Environment

The guidelines can only be effectively implemented within an enabling or conducive environment. Besides addressing staff issues, the necessary infrastructure and resources should be made available, as well as re-organising the services. Infrastructure should avail private space to satisfy varied options for labour, partner support and individualised care, as well as strengthening of the referral channel policy to avoid unnecessary overcrowding of the tertiary maternity levels of care. Resources are essential for offering ideal services and ensuring the psychosocial comfort of ladies during the perinatal period. Midwifery administration ought to audit the status of the implements and provisions for further action and key implementation strategies should be attached to financial estimates and material resource needs. Re-organisation for optimal maternal mental health services can be done through collaborative planning, integration of psychosocial services, and routine perinatal care through routinely screening women during the prenatal and postpartum periods and mandatory development and implementation of individualised care plans. Enforcing partner involvement, enhancement of mother-child relations and emphasis on building a strong evidence base are other important aspects of re-organisation of services.

9.3.6 Monitoring and evaluation

A system of continuously monitoring the influence of psychosocial intercessions on maternal mental wellbeing outcomes is deemed essential quality improvement attribute since substantiation is fundamental to enlightening and backing up service excellence. The study highlights several gaps in provision of maternal mental health care, thereby expressing the need for continuous checking and administration of work activities. Collecting reference point data through the initial antenatal screening provides a baseline for subsequent interval mental health interaction with the woman. An important recommendation is conducting satisfaction surveys on women and their households so as to elicit feedback and improve on mental health care. At the individual level, Information on data sources, procedures and result ought to be followed, benchmarked and used to improve nature of care. At the individual level, the midwives ought to

connect with women and their families in assessing care and outcomes. Formalised frameworks to consistently get regular input, from the lady as well as from the birthing assistants ought to be set up. Maternal mental health should form part of the discussion at formalised ordinary joint meetings of the entire workforce to evaluate improvement of patients. Other ways of evaluating maternal mental health are: integration of pointers to maternal mental health in other integrated monitoring systems such as the Health Information Management System (HMIS), annual peer reviews, discussions at conferences and seminars.

9.4 FURTHER RESEARCH

Several opportunities for future research are exposed by the results from this study. Further research could explore maternal mental health interventions in other regions to give a more profound comprehension of the issue as well as data for comparison. Besides the heavy inclination on subjective data in this study, different investigations could investigate gathering extra target estimations through observations and through use of other psychosocial tools besides the Q-LES-SF scale. Future studies that focus on mental health care could benefit midwifery services through dwelling on these not so encouraging findings in this study. Going forward, implementation of the mental health guidelines and the probable adaptation of the Q-LES-SF psychosocial scale should be bolstered with focused operations investigations.

9.5 CONTRIBUTION OF THE STUDY

The results from this study may seem to give a relatively gloomy picture of the phenomenon under study, however their value cannot be underrated. Studies on this area of research, especially focusing on mental health in the perinatal setting, seem very limited within the Zimbabwean context, such that this results in paucity in local research evidence in common interventions which are done in pregnancy, during childbirth and after childbirth. This study is even unique in the way it afforded a sequential explanatory approach which started quantitatively with assessing the psychosocial adjustment of women and also analysis of the documentation of the mental health interventions, followed by exploration of the various perceptions. These

were explored on women who are the custodians of care, the midwives themselves and the key informants who are a rich source of information. The comprehensive combination of quantitative and qualitative revealed the nonexistence of country specific research proof backing up numerous midwifery intercessions done during expectancy and childbirth. The study then gave rise to crafting of the first guidelines and also to defining the first framework for provision of optimal mental health care in Zimbabwe.

9.6 LIMITATIONS

The following are limitations of the study:

Usually there is general criticism of qualitative research regarding small samples, interpretation and bias. The researcher in this study opines that the comprehensive depiction of the respondent group was spelt out, point of saturation was clearly elucidated and the information assortment strategies and the procedure of investigation demonstrated the straightforward idea of the exploration in phase 2

The use of a psychosocial scale and document analysis during quantitative data collection, as well just as the utilisation of top to bottom conversations could have been enhanced by direct observations of the midwife-woman interactions at the different phases of the perinatal period. However, the participants voluntarily participated, were very open and clearly articulated details of their experiences. However the views of those who did not participate may be different.

Conclusions may not be generalisable since the study was conducted in a catchment area which is for half of the provinces, rendering them to be transferable to other locations of comparable characteristics. Of special note is the fact that most of the themes which came up were backed up by the country specific and global literature. Thus, the findings could be quite valuable to midwifery practice and maternity institutions that desire to improve provision of maternal mental health services and may also guide future research.

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Weerasinghe, I. 2019. Supporting Mothers of Color with Culturally Relevant Mental Health Services. CLASP | 1200 18th Street NW | Suite 200 | Washington, D.C. 20036 | (202) 906-8000.Copyright © 2019 by the Center for Law and Social Policy, Inc. All Rights Reserve

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APPENDICES

Appendix 1: Quality of Life Enjoyment and Satisfaction questionnaire (Q-LES-Q)

Instructions

Taking everything into consideration, I would like to know how satisfied you have been with your life during the past four weeks. Please indicate which of the following comes closest to how you have felt, not just how you feel today. Please TICK IN ONE BOX under each response for each question, which is the closest to how you have felt

		Very poor	Poor	Fair	Good	Very good
		1	2	3	4	5
1	Physical health					
2	Mood					
3	Work					
4	Household activities					
5	Social relationships					

6	Family relationships					
7	Leisure time activities					
8	Ability to function in daily life					
9	Sexual drive, interest and/or performance					
10	Economic status					
11	Living/housing situation					
12	Ability to get around physically without feeling dizzy or unsteady or falling					
13	Your vision in terms of ability to do work or hobbies					
14	Overall sense of well being					

Appendix 2: Document analysis checklist

Period	Attribute	No recording 1	Minimal recording 2	Fair recording 3	Good recording 4	Very good recording 5
Antenatal period	1. Full history of the woman's personal mental health at the booking appointment					
	2. Full mental risk assessment or MSE.					
	3. Referal for identified high risk of mental illness					
	4. Individual management plans depending on the severity of the mental health disorder					
	5. Counselling services provided according to identified need					
	6. Clients' current mental health each antenatal clinic visit					
	7. Assessment for social care involvement to support parenting and the welfare demands.					
	8. Use of mental					

	health assessment tools					
	9. Management of identified mental challenges such as self-help strategies, psychosocial support, appropriateness of referral.					
Care during labour	10. Documented mental health plan and assessment during delivery					
	11. Written plans for pain relief in labour					
Post-partum period	12. Postnatal assessment and documentation of the client's mental health and emotional wellbeing as part of every postnatal check.					
	13. Prompt records of changes in the mental status.					
Discharge planning	14. Clear lines of communication between services that are crucial for quality care.					
	15. Community Referral Pathway for ongoing care; to					

	counselors, psychologist, social services, specialist Mental Health Team/Psychiatric services					

Appendix 3: Interview Guide for women

1. Do midwives meet the mental health needs of women in perinatal period?
2. Are the midwives raising adequate awareness?
3. Do the midwives build a trusting relationship?
4. How supportive are midwives to the mental health of women during the perinatal period?
5. Do the midwives facilitate reduction of stigma around mental health issues?
6. What factors hinder appropriate mental health care delivery for women and their families?
7. How can midwives improve the mental health of women?

Demographic Data

1. How old are you?
2. What is your highest level of education?
3. How many children do you have?
4. What is your marital status?
5. How many times have you delivered in this hospital?
6. Where is the location of your urban residence?
7. Have you attended antenatal reviews**?**

Appendix 4: Key Informant and midwives Interview Guide

1. How is the knowledge and attitude towards mental health during the perinatal period?
2. Are midwives competent in dealing with mental health issues?
3. How protected are the woman with mental illness from being ‘stigmatized’ and or labeled?
4. Are the mental health needs of women in midwifery practice met?
5. What are the factors that hinder appropriate mental health care delivery in midwifery practice?
6. What are the ways of improving mental health competencies in midwifery?

Demographic Data

1. How old are you?
2. How many years have you worked as a midwife?
3. What is your sex?
4. Which department are you working in?

Appendix 5: Sample Consent form

Dear participant

You are invited to participate in this study on analyzing the adequacy of current perinatal interventions on mental health. This information leaflet will help you to decide if you would like to participate. Before you agree to take part, you should fully understand what is involved. You should not agree to take part in the study unless you are completely satisfied with all aspects of the study. Please familiarize yourself with the purpose of the study and your responsibility and rights before you agree to give permission to participate.

The purpose of this study is to analyse the adequacy of the current perinatal interventions on mental health. The assumption is that meeting mental health needs brings mental stability to all expectant women. A scale will be used where responses are then analysed in order to assess the psychosocial of women in the third trimester of pregnancy. The thinking behind this is that by this phase of pregnancy midwives would have implemented interventions which would result in mental stability among most of the women. This study would facilitate review of mental health approaches with the aim of improving clients coping with mental health challenges.

Should you agree to participate, you will be required to complete the questions on the psychosocial scale as honestly as possible without any adverse feelings or thoughts. The study involves no foreseeable physical or psychological discomfort. However, should you feel uncomfortable or unwilling to continue you are free to withdraw at any given time of the study with absolutely no punishment nor future disadvantages whatsoever. You do not have to give reasons for your decision.

Your participation in this study is totally voluntary with no forms of compensation. All information obtained is strictly confidential and the study data will be stored in a secure place and coded for analysis. No information will be linked to your name since no identity will be revealed during and after the research. Ethical approval for the study is ascertained from UNISA and from Zimbabwe Research Ethics Committee. All stages of the research will be conducted according to the internationally accepted principles.

I declare that there is no conflict of interest that may influence the study procedures, data collection, data analysis and publication of results. You are free to contact me on any of my contacts: +263773635347 or +2639203336/8 or email at cgwatiringa@gmail.com.

Your cooperation and participation in the study will be greatly appreciated. Please sign the informed consent if you agree to participate in the study.

Calleta Gwatiringa
Researcher

Appendix 6: Mpilo Hospital Request letter

NATIONAL UNIVERSITY OF SCIENCE AND TECHNOLOGY

FACULTY OF MEDICINE

NUST Complex, Mpilo Hospital
Vera Road
Mzilikazi, Bulawayo, Zimbabwe

P.O. Box AC 939, Ascot, Bulawayo, Zimbabwe
Telephone 263-9-203336/8
Fax: 263-9-203309

15 March 2017

The Clinical Director
Mpilo Central Hospital
P O Box 2096
Bulawayo. Zimbabwe

RE: REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY AT MPILO CENTRAL HOSPITAL

Study title: Development of mental health guidelines to be followed throughout the perinatal period in Zimbabwe

I am requesting permission to conduct a study at your institution. My name is Calleta Gwatiringa and I am a PHD student on the DPhil Nursing programme at the University of South Africa (UNISA). As part of my studies, I am conducting a study to investigate the adequacy of current perinatal interventions on mental wellbeing in Zimbabwe in order to develop mental health guidelines to be used throughout the perinatal period.

The study entails a retrospective review of the clients' documents, completing a psychosocial scale to assess mental health status and semi-structured interviews explore clients, midwives and key informants' perceptions on the extent to which mental health needs are met. This will be followed by development of mental health guidelines. I have attached the proposal and the ethical clearance certificate from UNISA.

My contact details are cgwatiringa@gmail.com or calleta.gwatiringa@nust.ac.zw, and mobile number 0773635347.

Your faithfully,

Calleta Gwatiringa (Lecturer, Nursing and Midwifery, Faculty of Medicine, NUST)

Appendix 7: Medical Research Council Clearance letter

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL LETTER

REF: MRCZ/A/2333 **31 August, 2018**

Calleta Gwatiringa
National University of Science and Technology
Department of Nursing and Midwifery Sciences
Faculty of Medicine
Box AC 939 Ascot
Bulawayo

RE: DEVELOPMENT OF MENTAL HEALTH GUIDELINES TO BE FOLLOWED THROUGHOUT THE PERINATAL PERIOD IN ZIMBABWE.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

a) Study proposal
b) Consent Forms (Ndebele, Shona, & English)

APPROVAL NUMBER : MRCZ/A/2333

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE : 31 August, 2018**
- **TYPE OF MEETING : Expedited**
- **EXPIRATION DATE : 30 August, 2019**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw.

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

.....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2018 -08- 31
APPROVED
P.M. BAG 39 FOR CHAIRPERSON, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix 8: UNISA Ethical Clearance

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

7 December 2016

HSHDC/577/2016
Mrs C Gwatiringa
Student: 5855-624-9

Supervisor: Prof LM Modiba
Qualification: D Cur
Joint Supervisor:

Dear Mrs C Gwatiringa

Decision: Ethics Approval

Name: Mrs C Gwatiringa

Proposal: Development of mental health guidelines for perinatal care in Zimbabwe.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 7 December 2016.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

Open Rubric

THIS IS TRUE COPY OF THE ORIGINAL
M.O. SIBANDA B.Sc. CSCLS LONDON
IPM CED DIPLOMA
COMMISSIONER OF OATHS
92 J. M. NKOMO STREET BYO

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PO Box 392 UNISA 0003 South Africa
Telephone +27 12 429 3111 Facsimile +27 12 429 4150
www.unisa.ac.za

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2016 -06- 07
RECEIVED

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication (e.g. Webmail, E-mail messages, letters) with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON

Approval template 2014

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone +27 12 429 3111 Facsimile +27 12 429 4150

Appendix 9: Editor's Report

NATIONAL UNIVERSITY OF SCIENCE AND TECHNOLOGY

P. O. Box AC 939 – Ascot – Bulawayo, Zimbabwe
Cnr. Gwanda Road/Cecil Avenue

Telephone: 263-9-282842/289413
Fax: 263-9-286803

DEPARTMENT OF PUBLISHING STUDIES

EDITORIAL HUB

28 December 2019

To: The supervisor
University of South Africa
PO Box 392, Pretoria 0003

Dear Sir/Madam

Editorial report for Calleta Gwatiringa's thesis

In my capacity as editor of the thesis, I have the pleasure to report that in an effort to assist this well written presentation, I went through the thesis and ensured the following:

1. **Headings, sections and pages**
   a. Checked all chapter headings against content for errors.
   b. Checked chapter headings for consistency or use of capitals.
   c. Checked subheadings within chapters for consistency.
   d. Checked for consistency in spaces above and below headings and subheadings of same weight.
   e. In-text content was aligned where necessary and citation errors were highlighted.
   f. Searched for widows and orphans.
   g. Checked for consistency in use of italics, bold font and bullet numbering throughout the thesis.
   h. Punctuation and grammatical errors were highlighted.

2. **References**
   a. All references that had been omitted from the list of references were highlighted.
   b. Checked consistency in in-text citation.
   c. Omissions of dates of publication and page numbers for quotations were highlighted.
   d. Checked consistency in citation of references.

Contents page, Figures, Tables, Abbreviations and Acronyms, Appendices
   a. Created the Contents page.
   b. Checked consistency in presentation of headings and page number alignment.
   c. Created List of Tables and List of Figures pages.
   d. Checked consistency in presentation of Tables and Figures within the chapters.

e. Checked consistency in placement of captions.
f. Checked spacing of captions
g. In some tables/figures she did not indicate the source or page from which the figure was extracted.
h. Generated the list of abbreviations and acronyms used in the thesis.
i. Added appendices to the thesis document.

I therefore, recommend that the candidate attends to the issues raised before submission. Comments and areas to be attended to were highlighted in the edited copy.

Kind regards

Dr Mass M. Tapfuma

Appendix 10: Turnitin Report