Perinatal Mental Health Project

ANNUAL REPORT

2011

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Caring for mothers.
Caring for the future.

Recognising the enormous need for public maternal mental health services, the Perinatal Mental Health Project (PMHP) envisions universal access to quality mental health care, routinely integrated into maternity services, for all women.

To achieve this aim, the PMHP partners with the Department of Health and works with vulnerable women, civil society, international organisations and academic institutions to implement 4 inter-related programmes. These programmes develop an innovative model for integrated mental health services and include: a pragmatic mental health service, responsive teaching and training, research and advocacy.

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Acronyms

AIDS  Acquired Immunodeficiency Syndrome
CPMH  Alan J Flisher Centre for Public Mental Health
HHCC  Hope House Counselling Centre
HIV   Human Immunodeficiency Virus
MMH   Mowbray Maternity Hospital
MOU   Midwife Obstetric Unit
NGO   Non-governmental Organisation
PMHP  Perinatal Mental Health Project
PMNS  Peninsula Maternal and Neonatal Service
UCT   University of Cape Town
WHO   World Health Organisation

• All photos by PMHP unless acknowledged.
1. Message from Dr Simone Honikman, PMHP Director

The PMHP has faced increasing demands on its staff and activities in 2011.

We have needed to provide more services, to more women, who have more severe life difficulties. There have been more requests to address the training needs of a range of health workers and community carers.

At the same time, we have been offered partnerships with two prestigious international research consortia undertaking global mental health work in low resource settings. Local, national and international stakeholders have sought our contributions to public debate and policy development.

In order to respond to the increased need, the PMHP has been fortunate to be able to expand its staff component and activities. This growth has been managed within the framework of a carefully-developed strategic plan which incorporates human and financial sustainability as critical underlying principles.

It still remains however, a challenge for us to balance our passion for caring for mothers with the limits of our financial and organisational capacity. Our partnership with the Department of Health is strengthening and it is through this mutually supportive avenue that we anticipate more women will be reached.

Until that happens, we are learning that health staff are increasingly stressed and mothers are increasingly vulnerable to a multiplicity of hardships. It is commonplace for our counsellors to be addressing in one woman, a combination of four or five factors such as poverty, on-going gender-based violence, HIV, bereavement and childhood sexual abuse. We have had to adapt. We have needed to invest more in the supervision and support of our counselling team; we have had to fine-tune screening procedures to ensure that those with the highest risk profiles are engaged in care; we have included in our care package substantial community referral and networking, telephonic sessions and follow-up procedures. Through our research, we continue to develop smarter ways to deliver quality care to more women.

Despite all the challenges, the PMHP team has been able to achieve much in 2011. In addition to our staff, the team includes our partners, donors, colleagues. I hope that this report will reflect adequately what has been done and that it will honour the value of this work.
2. Who benefits?

The PMHP was founded to address mental illness among pregnant women and girls from some of the most disadvantaged communities affected by poverty, HIV/AIDS, violence, abuse, social exclusion and refugee status. In 2011, the demographic profile of our beneficiaries was 70% black, 28% coloured and 2% white.

Addressing maternal mental illness requires supportive, empathic care for women during and after pregnancy. Through its training and advocacy programmes, and in partnership with the Department of Health and civil society, the PMHP builds capacity among the following sectors:

- health workers, maternity nurses and midwives in the public sector
- undergraduate and post-graduate students in the health-related fields
- community care workers engaged with vulnerable women and girls
- health ministries in other low-income countries

The average cost for private mental health care is R750 per hour in South Africa. The PMHP cost for mental health care in 2011 was R185 per woman reached. This cost includes as many one-on-one sessions as required – the current average is 3 sessions per client. In addition, it includes liaison work by the counsellor for specialist referrals and social support as well as postnatal follow-up care and evaluation. This calculation is based on the full cost of the PMHP service project, including personnel and programme administration.
3. Programmes

3.1 Clinical Services

The PMHP has been operating an integrated maternal mental health service at Mowbray Maternity Hospital (MMH) since 2002. In 2011, the Project launched 2 new pilot sites. Through our partnership with Hope House Counselling Centre (HHCC), maternal mental health services were offered at False Bay Hospital and Retreat Midwife Obstetric Unit.

Through this joint initiative, HHCC carries the cost of 2 lay counsellors, one each at False Bay Hospital and Retreat Midwife Obstetric Unit, while PMHP provides training, service development, technical and clinical supervision, as well as monitoring and evaluation. By sharing costs and responsibilities, the PMHP is able to explore the cost effectiveness and sustainability of its model. In addition, operating in diverse contexts tests the flexibility and scalability of a national maternal mental health service model.

Summary Indicators, Targets & Outputs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Annual Target</th>
<th>Annual Outputs</th>
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<tbody>
<tr>
<td><strong>MOWBRAY MATERNITY HOSPITAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% women screened</td>
<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td># women screened</td>
<td>1400</td>
<td>1708</td>
</tr>
<tr>
<td># women counselled</td>
<td>220</td>
<td>291</td>
</tr>
<tr>
<td># women referred to psychiatry</td>
<td>N/A</td>
<td>7</td>
</tr>
<tr>
<td><strong>FALSE BAY HOSPITAL</strong></td>
<td></td>
<td></td>
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<tr>
<td>% women screened</td>
<td>50%</td>
<td>97%</td>
</tr>
<tr>
<td># women screened</td>
<td>840</td>
<td>929</td>
</tr>
<tr>
<td># women counselled</td>
<td>120</td>
<td>354</td>
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Presenting problems among clients counselled

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<tr>
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<tbody>
<tr>
<td>A – Primary support</td>
<td>84%</td>
<td>74%</td>
<td>64%</td>
<td>63%</td>
<td>74%</td>
</tr>
<tr>
<td>B – Social environment</td>
<td>41%</td>
<td>33%</td>
<td>23%</td>
<td>17%</td>
<td>27%</td>
</tr>
<tr>
<td>C – Health / medical</td>
<td>29%</td>
<td>21%</td>
<td>17%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>D – Lifestyle transition</td>
<td>57%</td>
<td>46%</td>
<td>40%</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>E – Psychiatric conditions</td>
<td>30%</td>
<td>43%</td>
<td>56%</td>
<td>48%</td>
<td>18%</td>
</tr>
<tr>
<td>Included in 2 or more categories</td>
<td>76%</td>
<td>78%</td>
<td>76%</td>
<td>66%</td>
<td>55%</td>
</tr>
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Diagnoses among clients referred for psychiatry

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</thead>
<tbody>
<tr>
<td>Major Depressive Episode</td>
<td>100%</td>
<td>75%</td>
<td>80%</td>
<td>77%</td>
<td>86%</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Features of anxiety</td>
<td>43%</td>
<td>13%</td>
<td>0</td>
<td>46%</td>
<td>0</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>14%</td>
<td>13%</td>
<td>60%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15%</td>
<td>0</td>
</tr>
<tr>
<td>Sleep Disorder</td>
<td>29%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>29%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>More than one diagnosis</td>
<td>86%</td>
<td>38%</td>
<td>40%</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>Medication prescribed</td>
<td>86%</td>
<td>88%</td>
<td>60%</td>
<td>77%</td>
<td>64%</td>
</tr>
</tbody>
</table>
What does this data mean?

Screening: The PMHP model strives to identify need among all women attending antenatal care at its service sites. When women attend for maternity care, mental health screening is offered routinely. Women have the option to decline screening. Overall, the PMHP is able to ensure over 80% screening coverage.

Qualify: Of women who are screened, a significant proportion will present risk factors for psychological distress, or will currently be experiencing symptoms of depression, anxiety or other forms of psychological distress. Research has shown high levels of common mental disorders during and after pregnancy, which our monitoring data corroborates. We have found that pregnant women and girls at our new community-based service sites experience significantly higher rates of distress than at our primary facility at MMH.

Women qualify for counselling based on their screening scores. If they meet cut-off criteria, they are referred to the on-site PMHP counsellor for individual, therapeutic counselling. Wherever possible, counselling sessions are booked to coincide with the client’s antenatal appointments. This increases women’s opportunity to access services by reducing costs in terms of transport, childcare and extra time off work – significant factors determining whether or not women will take up mental health care.

Optimising uptake: Screening and counselling is provider-initiated but voluntary. The PMHP maintains an ‘open-door’ policy for women and girls who may not take up the offer of counselling at the time of qualifying. Most women do take up the opportunity to see a counsellor, and on average attend for 2-3 sessions.

Lost to follow-up: This term refers to women who may accept an appointment for counselling but who do not attend any of the counselling appointments made with the PMHP counsellor. A client is only considered ‘lost to follow-up’ after the counsellor has attempted to re-schedule the appointment 3 times, and has included an invitation letter in the client’s file to alert the attending nurse to the client’s situation. The PMHP continues its ‘open-door’ policy in all cases.

Trends

Increased reach The PMHP continues to increase its reach through screening and counselling. The counsellors have exceeded targets at both Mowbray Maternity and False Bay hospitals. The large case load at our new sites, however, has raised concerns about the sustainability of our counselling service in these settings. Responses, such as improved supervision, support, and self-care, are being integrated into service design. The red curve in the chart below illustrates the PMHP’s steady increase in reach.
Mowbray Maternity Hospital  At MMH, about a third of women who qualify declined appointments. About two-thirds of qualifying women take up our service. As our longest-operating service site, proven systems are in place, ensuring excellent client tracking and no loss to follow-up.

Stigma  The PMHP has identified stigma as a major challenge to service uptake. PMHP’s new counsellor, Ziyanda Mabuto, gives weekly talks in the antenatal waiting room to inform women and girls about mental wellness, to explain what counselling is, and to re-assure women. In addition, PMHP has increased the output of information brochures considerably, translating mothers’, adolescent and fathers’ brochures into the 4 primary languages spoken at this facility: English, Afrikaans, isiXhosa and French.

Implementing partners

With the support of the DG Murray Trust, the PMHP has been able to explore methods to support adaptable and sustainable service delivery. One such measure is through establishing an implementation partnership with Hope House Counselling Centre (HHCC). This has been a mutually beneficial partnership in that the PMHP has contributed to HHCC’s capacity through strategic and practical support. The PMHP has, in turn, been able to test the adaptability of its model in a cost-effective way.

False Bay Hospital  While the case load at False Bay Hospital has been considerable, the counsellor, Antoinette Devasahayam, who has been operating at this site for a year, has achieved a more than three-quarter counselling uptake. In addition, she has minimised the number of clients who decline significantly. This is due to her ability to adapt the PMHP model to suit the clinical environment, and conduct screening herself. This early interface with the client diminishes stigma and allows the client to feel at ease about attending future counselling sessions.

What about our Retreat site?  Our second pilot partnership with HHCC was established at Retreat Midwife Obstetric Unit (MOU) in March 2011. Similar to the False Bay site, PMHP provided service development and oversight, while a counsellor was provided by HHCC. However, Retreat proved to be a challenging site.

Women attending this facility face extreme adversity. Clients experience a multiplicity of risk factors, resulting in more suicide risk management, traumatic cases, extreme poverty, domestic violence and abuse, problematic social environments, and more primary support problems. The clinical case load was severe, with increased pathology in a greater proportion of clients. The counsellor appointed was unable to cope with challenges related to load and severity of cases, and administration, despite support provided by the PMHP team. Our challenge was exacerbated when the second counsellor recruited gave notice due to unforeseen emigration plans.

The challenges faced at the Retreat site are indicative of many low-income communities, and this is a very important learning opportunity for the PMHP. We have been working with HHCC and MOU staff to develop more manageable systems. PMHP has provided continued care for existing clients, but has not been able to provide new services since August. Recruitment of a new counsellor is anticipated by early 2012. Together with MOU staff and HHCC, we will develop an adapted service model to meet the women’s mental health needs at this site.
Outcomes & Impact

Preliminary analyses conducted in 2011 show that PMHP counselling has a beneficial impact on clients, in terms of mood, coping, and general functioning. We have also shown that our intervention builds the clients’ assertiveness and resilience to face the challenges of motherhood in difficult social and economic conditions.

PMHP outcomes evaluation data show that women experiencing significant distress prior to the PMHP intervention report the following positive outcomes:

- 86% report that their situation is ‘much improved’ or ‘resolved’ after the PMHP intervention
- 95% report successful bonding with their baby
- 88% report being able to cope with parenting and life circumstances

Team update

In 2010, the PMHP was able to employ Charlotte Mande-Ilunga on a part-time basis to provide dedicated support to the increasing number of refugee women attending the MMH facility. In 2011, Charlotte was able to become a full-time staff member, and Ziyanda Mabuto joined the team, providing additional services in isiXhosa.

The Mowbray site now enjoys the dedicated counselling support of 2 full-time counsellors, freeing the Clinical Services Coordinator, Bronwyn Evans, to take on a more supervisory role across the 3 service sites. As the Project’s Clinical Psychologist, this means that Bronwyn now focuses on: providing clinical supervision and debriefing for the counselling team at all sites, training counsellors and maternity staff in maternal mental health screening, as well as overseeing and adapting the PMHP model to suit new clinical environments. Bronwyn’s counselling focuses on women with more severe needs. In this way, the PMHP model continues to evolve toward being more sustainable and cost effective: the main client interface work is increasingly provided by primary level mental health counsellors, while more scarce skills, such as qualified clinical psychologists, are maximised through a stepped-care model.

"Every week, I give a talk in the waiting room. I introduce the PMHP, I talk about what we do. I talk about pregnancy, and how some women may need a little extra support during this time. I let them know that is what we offer. They think counselling is for mad people, they think it means they are ‘crazy’. But many women have come to my office after my talk, and said ‘I think this is something I need’. It also presents an opportunity to include dads. They really like our literature for fathers, it helps them feel involved."

Ziyanda Mabuto
PMHP Counsellor

After qualifying as a counsellor, Ziyanda Mabuto completed her community service on the Phelophepa Train. ‘This was a difficult learning experience,’ says Ziyanda. ‘With only five days in a community, clients could only have one session with me, which would just open the can of worms without providing adequate therapeutic support. Therapy is not like dentistry,’ she says. In addition, as a counsellor, Ziyanda realised the need for a supportive environment, especially to debrief. ‘The biggest lesson,’ notes Ziyanda, ‘was how huge the need is for counselling services. The queues were so long. I saw one client after the other. It didn’t stop. People wanted counselling.’

Ziyanda is therefore very interested in service development which focuses on supportive and containing therapeutic interventions. ‘Even when it is brief, it can be supportive, like here at PMHP,’ says Ziyanda. ‘I have found that most of my clients need a solution-focused intervention,’ which, she says, points to the lack of social support faced by many pregnant women and girls. ‘We empower the woman. Together, we focus on practical, supportive solutions.’
3.2 Teaching & Training

Addressing maternal mental illness requires the public health service to be an active partner in service provision. The PMHP partners with the Department of Health, and trains health workers in the maternity setting to provide mental health screening and to refer women to appropriate services. We also train community care workers engaged with vulnerable women.

Building capacity among health workers, medical students and community-based practitioners equates to an increasing awareness of maternal mental health issues, recognition of common mental disorders such as depression and anxiety, skills for compassionate engagement, and the ability to refer appropriately.

The PMHP added ‘train-the-trainer’ modules to its existing training menu. In collaboration with the Foundation for Professional Development and the Department of Health, the Project provided training to 50 Master Trainers for the first National Primary Health Care Re-engineering Programme trainings in Pretoria.

PMHP Training Menu

- Basic counselling skills
- The ‘Secret History’ method
- Integrating maternal mental health into routine service delivery
- Maternal mental health case management workshop
- Morning workshop on experiences of motherhood, maternal mental health and self-care
- Train-the-Trainers: maternal mental health

The interactive method developed by the PMHP is a uniquely applicable resource which can be used to convey sophisticated concepts in simple digestible terms.

- By helping practitioners to become more aware of their own reactive feelings, the exercise raises compassion for the other’s hidden feelings.
- It increases the capacity for ‘mentalisation’ – helping practitioners to think about feelings.
- By having to process their own thoughts, beliefs and motivations and through these, to try and ‘read’ the other’s mind, the exercise encourages practitioners to reflect on their own potential misinterpretation of the others’ hidden anxieties, desires, needs and intentions when merely responding to manifest behaviour.

In the space of an hour, the ‘Secret History’ hones culturally-sensitive emotional understanding. It has been used successfully in training primary health care practitioners in high and low-income societies. I myself find it a very useful exercise when training practitioners who work with teenage parents, in the UK or elsewhere in Europe and the USA.

Professor Joan Raphael-Leff, University College London/Anna Freud Centre. June, 2011

The ‘Secret History’ training method aims to equip health workers with a greater understanding of the mental health of clients, co-workers and themselves. This workshop describes a fictional narrative of a client and health worker interacting over time. The group is divided into two – half play the role of the “client” and half play the “health worker”. Mid-way through the workshop, the groups physically swap roles. The private background of each character is revealed in stages. The groups are encouraged to respond to each other directly, in an expressive and confrontational style. At each stage, the participants identify their feelings and needs. New information and skills about compassionate engagement with clients are more easily acquired when training is participatory, infused with humour, and draws on health workers’ own intuition and insights.

We expected you to be a teacher. But you showed us that the solutions lie within ourselves.

Health worker,
Kenya
PATA Master Class
Activities & Outputs

The PMHP Teaching and Training programme has been in operation since 2003. Since 2008, the PMHP has provided teaching or training to 1466 health providers or health students. A new strategic initiative was identified: train-the-trainer programmes allow the PMHP to maximise its limited capacity while increasing the sustainability of mental health service integration broadly. It serves PMHP’s long-term vision of building a critical mass of empowered service providers. With a dedicated programme coordinator on board, the PMHP hopes to increase its annual reach to 700 beneficiaries.

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<tr>
<th>Indicator</th>
<th>Annual Target</th>
<th>Annual Outputs</th>
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<tbody>
<tr>
<td></td>
<td>2011</td>
<td>2010</td>
</tr>
<tr>
<td>Maternity nurses</td>
<td>60</td>
<td>237</td>
</tr>
<tr>
<td>Psychiatry nurses</td>
<td>N/A*</td>
<td>0</td>
</tr>
<tr>
<td>Medical students</td>
<td>100</td>
<td>180</td>
</tr>
<tr>
<td>Post-graduate students</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Advanced midwifery students</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Non-health sector students</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Community-based practitioners</td>
<td>40</td>
<td>94</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>641</strong></td>
<td><strong>400</strong></td>
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* A scaled-up programme is in development with the University of Stellenbosch.

Other outputs include distributing updated versions of the following PMHP documents:

- Service Development Guidelines for facilities providing maternal mental health care
- Basic Counselling Skills Guide
- Resource Directory for the Cape Town Metro region

These are available for download on the website.

Outcomes & Impact

Health workers participating in PMHP teaching and training programmes report:

- increased morale
- being able to understand ‘difficult patients’ better
- feeling empowered by being able to identify and take action to address maternal mental health problems
- improved ability to handle personal crises
- increased skills for compassionate care of mothers

Above left: Local training recipients: Hanover Park staff.
Above right: Beyond our borders - pan-African PATA training recipients: greeting and affirming using non-verbal compassionate engagement skills.
Kevashini Govender-Naidoo, a UCT-trained Clinical Psychologist, joined the team in October 2011 as part-time Teaching and Training Coordinator. Each of PMHP’s four programmes now enjoys a dedicated manager. Kevashini will take the train-the-trainer programme to scale, explore income generating opportunities and integrate maternal mental health sensitisation and training into accredited curricula of various healthcare professions.

From her days as a SHAWCO (Students Health and Welfare Centres Organisation) volunteer at UCT, to training counsellors in support services in the United Kingdom, Kevashini has had a special affinity for training. She has focused on train-the-trainer programmes to maximise resources where mental health services are limited. Her community service within the correctional services in Pietermaritzburg was especially formative. ‘There was just one of me, and thousands of inmates in 5 prisons. I had to make a plan.’ And group work was an effective plan. Kevashini held group sessions for inmates, not only helping them deal with their own problems, but training them to support each other, an important intervention in a setting where no other support was available. Having very little clinical supervision herself, Kevashini knows the necessity of effective support for the sustainability of counsellors. ‘Group work also allows the opportunity to train counsellors how to support each other, practice self-care and to be reflective in their work. Supervision and proper support is so important, but under-prioritised.’

The Hanover Park site development
3.3 Research

The PMHP conducts implementation research to refine clinical services, training, advocacy, and policy development. In this way, our research is reflexive and pragmatic: findings inform practise, and practical experience within the programme areas guide research.

A research priority is the development and validation of a brief screening tool for maternal mental disorders that can be utilised in busy, low-resource, primary care settings. The current screening tools have been developed in Europe and the U.S., and have been found too cumbersome to use in South African clinical settings. For example, the current screening questionnaire:

• is too long for busy nurses to incorporate into their routine procedures
• is not user-friendly (the multiple-choice scales are time-consuming for health workers to score)
• does not take into account the impact of learning HIV-status at time of booking

In November 2011 the PMHP officially launched its maternal mental health screening tool study to address this gap. We completed construction of a building at the Hanover Park community health centre, employed research and counselling staff, conducted a pilot study and commenced recruiting women from the community into the study.

Truworths Community Foundation Trust generously partnered with the PMHP for the erection of a building and the establishment of the garden at Hanover Park MOU.

The PMHP aims to scale-up integrated mental health services by providing the health sector with a brief, context-sensitive mental health screening tool.

During the study, 1 in 3 women attending the maternity service are screened, undergo a diagnostic interview, are offered counselling if required and are referred to social support services where appropriate.

Why Hanover Park?

Hanover Park is a low-income community in which the social and demographic hardships faced by women and girls increase their vulnerability to mental illness, especially around pregnancy. Around 6600 women or girls attend the MOU every year, yet no dedicated mental health support service is currently provided. By locating a service in Hanover Park, we are also able to serve a broader range of beneficiaries from the greater Klipfontein Sub-district who access this site for maternity care. These communities are among the most disadvantaged of the Cape Flats. The prevalence of mental illness was expected to be high.

The Hanover Park team

The PMHP Research Coordinator, Thandi van Heyningen, has provided leadership and scrupulous supervision of research procedures. In addition, Thandi and the PMHP team have worked closely with the Hanover Park community and the MOU facility staff to ensure buy-in and stakeholder support for our work. PMHP now works in partnership with the Community Health Clinic infrastructure and has joined forces with the ‘Greening of Hanover Park Project’ and have planted a garden at the facility. Facility staff have expressed great appreciation for the opportunity to enjoy a calming, therapeutic garden in what is an often challenging working environment.

We experience a lot of problems at Hanover Park. There is a high amount of stress in the patient population, but we don’t know where to send women. We need your service here. More women need access to your services.

Midwife, Hanover Park MOU
What have we learned? During the initial data collection phase, preliminary analysis shows a 45% prevalence of maternal mental disorders in this population, based on a diagnostic interview. This is higher than expected. Women’s emotional well-being is especially affected by:

- extreme poverty
- community-based violence such as gang conflicts and the continuous state of trauma which many women experience
- intimate partner violence, rape and child abuse
- high rates of substance and alcohol abuse
- high rates of adolescent pregnancy

Prevalence data will inform our service development at this site once the study is complete.

Shirley Ndwanynana graduated with her Honours degree in Psychology from the Nelson Mandela Metropolitan University in 2005. She has been a Psychology tutor and facilitated HIV training in the Eastern Cape, and in 2008 became involved in clinical research, such as a bio-behavioural study with the Medical Research Council. Shirley has a particular interest in maternal mental health, as an intervention for the improved well-being of mothers and their infants. Shirley hails from Port Elizabeth in the Eastern Cape, and is the eldest of 3 sisters. She is married and the proud mother of a baby girl.

Liesl Hermanus completed her psychology internship at Parkfields Primary School in Hanover Park in 2007, and knows the community well. She received her Honours degree in Psychology from the University of the Western Cape in 2007 and is an HPCSA registered counsellor. From 2007 to 2010, Liesl worked as a counsellor at the National Responsible Gambling Programme providing support to people with gambling problems and their family members. She was a school counsellor at St Anthony’s Primary School before joining the PMHP. Liesl is mother of a 4-year-old son.

It is interesting to note the correlation between our data and findings in other areas of the country. For example, Rochat et al (2011) found 47% diagnostic prevalence for depression in Hlabisa in rural KwaZulu-Natal.

Activities & Outputs

While the Hanover Park research site has been a primary objective in 2011, the PMHP has produced a range of research outputs. The additional support provided by Research Assistant, Emily Baron, has contributed to improved data collection, management, reporting, and research uptake.

Emily Baron joined the PMHP in February 2011 as an intern. After 6 months as a volunteer, the PMHP was able to offer her an additional 6-month post as Research Assistant, acknowledging her substantial contributions to the Project’s research and advocacy outputs. Emily holds an MSc in Developmental Psychopathology, obtained from Durham University in England. Her experience in a range of non-profit organisations has focused on providing counselling and support to disadvantaged populations. Emily also gained international public mental health experience in the Mental Health and Substance Abuse Department at the World Health Organisation (WHO) in Geneva, Switzerland. This is where she first learned about the PMHP. Her expertise in quantitative data analysis has enriched the development of PMHP’s research agenda, as well as enabled skills-sharing with our research and service personnel.

Research translation The PMHP uses programme data to inform and produce a range of materials for academic, professional and clinical audiences, as well as service beneficiaries and the general public.

These include:
• policy briefs
• academic presentations
• peer-reviewed academic journal articles
• issue briefs on maternal mental health and HIV/AIDS, violence and abuse, adolescent pregnancy, child outcomes, refugees and the cost of mental illness

The PMHP team is completing a range of research papers for submission to academic journals. These papers will cover the following:
• an analysis of the PMHP’s stepped care model
• an appraisal of the utility of screening for risk factors as well as psychological symptoms to enhance service uptake
• a case study demonstrating the role of social support in maternal mental health care
• evidence-based recommendations for rationalising referral to psychiatric care
• the development of a brief risk factor screen for low-resource settings
• an evaluation of the PMHP’s ‘Secret History’ training method for health workers as an intervention to improve maternity care

Specific tools which have been developed include:
• a short mental health screening tool: currently being validated at Hanover Park MOU
• a contribution to the PALSA Plus PHC 101 Guidelines: a symptom-based document using clinical algorithms and key messages to guide primary care practitioners to diagnose and manage clients appropriately
Research for improved service delivery

How do we know our counselling intervention works? The Project conducts postnatal follow-up assessments with all clients counselled. This is done telephonically, usually 6 to 10 weeks after birth. In this way the PMHP is able to assess the impact of its service by comparing the mother’s emotional well-being at the initial screening and counselling session to the postnatal call. This also allows for improved monitoring and follow-up of clients.

An MA Psychology student from the University of Stellenbosch commenced research with the PMHP to explore barriers to accessing maternal mental health care. This data will allow the PMHP service design to adapt to ensure maximum uptake for those most vulnerable.

A research focus in 2011 was to assess how women fare after PMHP counselling. This included:

- analysing women’s well-being in relation to the problems they presented at screening and at the first counselling session
- evaluating the quality of PMHP counselling with a focus on clients’ experience of the counselling service
- developing a scientifically rigorous research protocol for an independent evaluation of PMHP’s postnatal assessment process. This will commence early in 2012. The PMHP’s internal processes have been useful for responding to clients’ needs, however, an external evaluation will provide an independent assessment of PMHP’s effectiveness

Outcomes & Impact

Research uptake

The PMHP collaborates on global mental health research consortia as a research partner and cross-country, maternal mental health consultant. The focus of these research partnerships is on strengthening mental health systems at primary care level, and developing capacity for up-scaling mental health interventions in low and middle income countries. PMHP provides a specific focus on maternal mental disorders.

The PMHP is a founding member and partner of the Alan J Flisher Centre for Public Mental Health (CPMH). Within the Centre, the PMHP is a cross-country partner of the Programme for Improving Mental Health Care (PRIME) funded by a 6-year DFID (UK Department for International Development) grant which aims to ensure uptake of world-class research on policy implementation and service scale-up in Ethiopia, Uganda, India, Nepal and South Africa.

The PMHP is also contributing to the development of a randomised controlled trial of a community health worker intervention for maternal mental health through the Africa Focus on Intervention Research for Mental Health (AFFIRM). This project is funded by the National Institute of Mental Health (USA) and aims to capacitate health ministries toward improved service delivery in Ethiopia, Zimbabwe, Malawi, Ghana, Uganda and South Africa.
The Second Summit of the Movement for Global Mental Health was a unique one-day meeting bringing together international experts, practitioners and persons affected by mental disorders. The Summit was also the occasion for the launch of the Second Lancet Series on Global Mental Health. PMHP Director, Dr Simone Honikman, was invited to present the PMHP experience. Her talk, ‘Maternal mental health care: a model for integration’, was well received. In a panel discussion, Simone shared the stage with leaders in the field such as Dr Shekhar Saxena (Director of the Department of Mental Health and Substance Abuse at World Health Organization) and others.

Members of the PMHP team delivered the following oral presentations:

- Activating social support through a maternal mental health intervention: The case of Asanda
- ‘Health workers go to the movies.’ Health worker perceptions of the PMHP film ‘Caring for Mothers’ as advocacy strategy
- Maternal mental health: Addressing key vulnerabilities
- Maternal mental health: An upstream intervention for improving child outcomes
- Structural violence and mental health: The case of pregnant refugee women
- ‘If you have not slept in that house, you will not know that the roof is leaking.’ The PMHP refugee counsellor intervention
3.4 Advocacy & Policy Development

The PMHP aims to amplify lobbying and advocacy efforts to address the unmet mental health needs of pregnant women and girls who experience extreme adversity. The Project hopes to act as a catalyst for broader engagement among civil society, health managers and policy makers to leverage support for universal maternal mental health care.

Through various campaigns, presentations and collaborations, the PMHP’s reputation as an expert in maternal mental health continued to grow in 2011. We have been able to scale up our effort to partner with policy developers and implementers considerably. The PMHP Director presented at the 2011 Western Cape Premier’s Health Summit where she successfully initiated the development of a mental health working group for the Provincial Department of Health. The Director was invited to participate in the National Department of Health’s training and capacity building programme for the National Primary Health Care Re-engineering Programme. This was followed-up with direct engagement with the Minister of Health, who has facilitated our meeting with key health leaders to discuss the maternal mental health gap.

Activities & Outputs

Beneficiary outreach The PMHP produced a range of client information brochures available at PMHP service sites and other clinical settings in English, Afrikaans, isiXhosa and French.

The South African Department of Health developed a Primary Healthcare Re-engineering Plan to respond to the lack of progress around key health indicators. These include indicators related to the Millennium Development Goals (MDGs). The PMHP recommends that mental illness not be thought of as an isolated health problem. A focus on maternal mental health promotion provides an efficient, cross-cutting solution to many of the challenges highlighted in the Minister’s Re-engineering Plan.
Other outreach work included collaborations with:
- Ikhaya Lethemba Preschool (Imizama Yethu, Hout Bay): Community outreach training for staff and parents
- The Ububele Educational and Psychotherapy Trust (Soweto, Gauteng): Skills sharing and advocacy programme development
- The HEDUZA Project (Health Education South Africa): contribution of maternal mental health content and materials to computer-based education platform for use in clinics by pregnant women, health workers and doctors

**Policy development** Our lobbying efforts bore fruit in 2011 as PMHP was invited to contribute to policy development through a range of fora across the women’s, children’s and HIV/AIDS sectors:
- Submission to the South African National AIDS Council (SANAC) addressing the gap in maternal mental health in the new National Strategic Plan on HIV/AIDS (2012-2016)
- Western Cape Premier’s Health Summit
- Proposal to the National Minister of Health on integrating maternal mental health into the community-based specialist teams responsible for maternal and child health

**Issue briefs** The PMHP developed 4 new topics for issue briefs: adolescent pregnancy, child outcomes, the cost of maternal mental illness and the rationale for the Hanover Park research project.
Media The PMHP grew its media profile with several opinion pieces in local newspapers, such as the Cape Times and the New Age, the Mail & Guardian and the University of Cape Town Monday Paper.

- Op-ed: Cape Times (19 April 2011) Why do we always blame the girls? by Diane Cooper, Simone Honikman and Ingrid Meintjes.
- Op-ed: Cape Times (9 September 2011) Nurses are stressed, ill-treated, burdened by Simone Honikman and Ingrid Meintjes.
- UCT Monday Paper (11 February 2011) New project to PRIME mental health services.
- UCT Monday Paper 12 July 2011) PRIME time for new project.
- New Age (8 August 2011) Mothers suffer in silence by Rhoda Kadalie.
Organisational recognition

The PMHP enjoys the support of the University of Cape Town, and the Department of Health at local, provincial and national levels. The Project collaborates with a range of partners to build momentum for the integration of maternal mental health care for vulnerable women at scale. We work with a range of international, academic, government and non-governmental agencies. As a founding partner of the Alan J Flisher Centre for Public Mental Health, the PMHP contributes substantively to developing research capacity, teaching, consulting and advocacy to promote mental health in Africa and other low-resource settings.

The PMHP maintains relationships with a range of social support organisations. Central to our strategy is linking fragmented social support services together to provide a continuum of complementary services for women. In many instances, the PMHP has developed training programmes for these organisations to equip them to deal with maternal mental health issues. PMHP clients are referred regularly to external support services such as social workers, shelters, domestic violence support services and refugee centres. The PMHP maintains and updates a resource directory, which it disseminates to all maternity facilities and partners.

Some of PMHP’s collaborations in 2011 include:

- Groote Schuur Hospital HIV/AIDS Mental Health Group: collaborated on mental health policy development
- The Sr Lilian Centre: presented at the Sensitive Midwifery Symposium and contributed article to the Sensitive Midwifery Magazine
- Treatment Action Campaign (TAC): collaborated on mental health policy development and knowledge sharing on issues related to HIV/AIDS and maternal mental health
- National Advocates for Pregnant Women (New York, United States): invited to share expertise on the impacts of mental illness during pregnancy

Midwives at the Sensitive Midwifery Symposium in Nelspruit. The Advocacy & Communications Coordinator was invited to the Sensitive Midwifery Symposium hosted by the Sr Lilian Centre to raise awareness about maternal mental health among midwives at the Nelspruit, Mpumalanga and Somerset West, Western Cape symposia. Some of the comments from midwives:

‘It was really inspiring to know what we can do to help those affected by mental illness.’

‘I wish there was more time for this important information. It was an eye-opener.’

Advocacy & Communications Coordinator Ingrid Meintjes with TAC Deputy Chairperson Victor Lakay

‘Today we have learned about the critical gap in understanding how mental health affects this epidemic. This gap explains the difficulties in our work, especially during the important time of pregnancy, and especially with respect to the challenges around ARV adherence.’

TAC activist; TAC and People Living with HIV Consultation on the National Strategic Plan on HIV/AIDS
The PMHP has employed the services of **Kariema Lowe**, of the Barefoot Teacher, to develop the PMHP’s fundraising strategy. In addition to mentoring the Advocacy and Communications Coordinator, Ingrid Meintjes, Kariema compiled a fundraising assessment of the organisation and developed a donor database. This will allow for a more systematised approach to fundraising and communicating with our donors. We have incorporated key learnings from her assessment into our strategic plan. For example, the PMHP has begun to develop a long-term sustainability plan and a value statement which will guide our engagement with implementation and donor partners.

The tables below depict the PMHP’s income and expenses for 2011.

### 2011 INCOME

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<tr>
<th>Organisation Name</th>
<th>Amount</th>
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<td>Mary Slack &amp; Daughters Foundation</td>
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<td>Truworths Community Foundation Trust</td>
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<td>The Stella &amp; Paul Loewenstein Educational Trust</td>
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<td>Medical Research Council</td>
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<td><strong>Total income</strong></td>
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### 2011 EXPENSES

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<td>Infrastructure Levy</td>
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<tr>
<td><strong>Total expenses</strong></td>
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</tr>
</tbody>
</table>

Kariema is a fundraising consultant and trainer. She runs the fundraising and capacity-building arm of Barefoot Teacher, an unusual communications company that specialises in assisting non-profit organisations and government entities with a range of publishing and communication services. Before freelancing, Kariema worked at a number of institutions, including alumni relations at UCT and the former Peninsula Technikon. She has raised funds for organisations working in areas as diverse as teacher training, early childhood development, tertiary education, mental health, youth life skills, intellectual disability, community counselling, children’s centres and after school care. Visit the Barefoot Teacher website for more information: www.barefootteacher.co.za

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Barefoot Teacher works with innovative organisations whose work is likely to have the greatest impact on a particular sector. We are assisting the PMHP to help realise its vision of universal access to maternal mental health services.

**Kariema Lowe**
The PMHP needs to raise ZAR 800,000 (20%) to meet its budget for 2012. This is a significant improvement on our financial forecast of last year.
5. Sustainability

The Project’s sustainability has improved considerably with four staff members at management level, including the Director, being appointed to permanent positions with the University of Cape Town. Financial sustainability is focused on securing long-term donor support while exploring mechanisms to improve PMHP’s self-sufficiency, such as generating income through the PMHP’s training programme. Employing a dedicated, full-time fundraiser and an administrator have been identified as imperatives for our ongoing sustainability, and funding is currently being sought for these posts.

The Project collaborates with a range of partners – international, academic, government and non-governmental - to build momentum for the integration of maternal mental health care for vulnerable women at scale. Partnerships also allow the PMHP to test its model in a variety of settings while sharing the cost of services.

Broad engagement within its sector, and across complementary sectors, ensures buy-in and ongoing commitment to compassionate, comprehensive health care for women in distress. Strategic innovations such as our new train-the-trainer programme aim to build a ‘critical mass’ of enabled service providers, which is key to sustainability.

6. Organisational development

2010-2011 was a period of rapid growth: the team doubled from 5 to 10 employed members and operations expanded from 1 to 4 service sites. We also welcomed Ms Thabisa Xhalisa onto our Board of Advisors, representing the interests of our service beneficiaries.

The graph below provides a schematic representation of expenditure in the Project, which correlates with increasing activities, staff and outputs. The highlighted areas of increased spend reflect periods of notable growth.

At the beginning of 2011, the PMHP embarked on an independently facilitated strategic planning process. This was necessary to ensure that expansion is strategically sound, and that the risk and uncertainty which accompanies growth, is well managed. The Project completed human resources, capacity and financial forecasting. It reviewed its operations and identified gaps and areas requiring additional capacity and has implemented strategies to address key challenges.

We are confident that the Project is growing in a sustainable and responsive manner, and that its organisational procedures have been appropriately improved to manage the complex and dynamic institutional, political, social and economic environment in which it operates.
Since attending the PMHP counselling service, Thabisa has gone on to graduate from the University of Cape Town, and in 2011, received her Master’s degree in Education. Having grown up in poverty, Thabisa left her home in the townships of Knysna in 2002 with only R50 in her pocket, two skirts and two T-shirts in her bag - determined to find a better life in Cape Town. Today, Thabisa is a mother of 2, a lecturer at UCT and currently working on her PhD.

**Thabisa Xhalisa** It’s hard to be depressed when your culture doesn’t believe in it. We don’t have a word for it. Within an African tradition, there is no such thing as depression. I have been told that I am looking for attention. And that I must pull up my socks.

My depression started when I lost my twin brother in 1997 but I did not know what I had because I had never heard of depression. After his death, I was overwhelmed by a cloud of sadness, which resulted in feelings of loneliness. I could not talk about this because I was scared of being seen as a weaker vessel. I also wanted to be strong for my mother because this was her fifth child she had lost. In 2003 my condition got worse – my mother died of cancer. But I told myself that I have my son and my studies to focus on, rather than feeling sorry for myself. I ignored the symptoms. But by the time I was pregnant with my second child in 2006, things were much much worse.

At this stage, I had no control of my mental illness. I was suddenly overwhelmed by suicidal thoughts, feelings of guilt and panic attacks. That is when I met the counsellor at the Perinatal Mental Health Project.

The PMHP counsellor helped me realise that it is normal to have these feelings, and that it doesn’t mean I’m a bad mother. As I was attending therapeutic sessions, I stopped casting myself with stones and regained a love of myself. I started appreciating the gift of being a mother and I developed a strong bond with my second child, my daughter - which was only lukewarm before.

My mother used to say that ‘an elephant does not find its trunk heavy’ but I now realise that at times motherhood brings exhaustion, tiredness and feelings of inadequacy. This is the reason why mothers need support. I had help to develop a good sense of self, that is what I received from the PMHP. A good sense of self means not blaming yourself, and asking for support when you need it. There is no shame in depression. I am a Xhosa woman but I am not ashamed. This is a sickness like any other.

The PMHP team enjoys a range of professional development opportunities, from regular attendance at academic symposia and meetings hosted by the UCT Faculty of Health Sciences as well as the following development opportunities:

- Director and Clinical Services Coordinator: attended conference at the Institute of Psychiatry at Kings College, London entitled ‘Perinatal Psychiatry in the 21st Century’.
- Communications & Advocacy Coordinator:
  - Digital philanthropy and fundraising (Digital4Good hosted by Women in Philanthropy)
  - Online communication course (UCT Information & Communication Technology Services)
  - Introductory isiXhosa (UCT Professional Development)
- Research Coordinator:
  - Clinical Research Methods Course (UCT Professional Development)
  - Introductory isiXhosa (UCT Professional Development)
- French-speaking counsellor: Trauma Counselling (South African College of Applied Psychology)
7. Looking ahead

2012 promises to be an equally busy year with training and research work to be conducted in several African countries, the completion of data collection for our screening tool development study and the finalisation of academic papers for journal submission. We will be involved in a randomised controlled trial of a community health worker intervention for mothers in distress. We have been invited to consult to a rural health facility in the Eastern Cape, to several community based organisations and to present our lessons learnt to national and international conferences. There are substantive opportunities for contributions to provincial and national health strategies.

However, the Project will not continue to expand services. Rather, it strives to support and capacitate the Department of Health to provide maternal mental health services to scale. We envision our role as an incubator, supporter and advocate for the development of good practice and scalable maternal mental health interventions for low-resource settings.

Our 4 diverse service sites will continue to generate lessons for our models, while providing quality maternal mental health care to thousands of mothers.

The PMHP Team

*FROM LEFT TO RIGHT, BACK ROW:* Kevashini Govender-Naidoo, Kariema Lowe, Thandi van Heyningen, Shirley Ndvananyana, Charlotte Mande-Ilunga, Simone Honikman, Liesl Hermanus

*MIDDLE ROW:* Ziyanda Mabuto, Emily Baron, Antoinette Devasahayam

*FRONT ROW:* Bronwyn Evans, Ingrid Meintjes, Sally Field

*ABSENT:* Zuhayr Kafaar, Justine Evans, Sarah Howard
Acknowledgements

Our Donors

- The Stella & Paul Loewenstein Educational Trust
- Welton Foundation
- Mary Stack and Daughters Foundation
Our Partners

The PMHP has received commendation from the World Health Organisation, an Impumelelo Award for Innovation and Poverty Alleviation, and the highest award for ‘good and promising practice’ by the USAID AIDSTAR-One Project in 2010. The PMHP is the only project of its kind in South Africa, and only one of a handful in the developing world.