When things fall apart and when they come together: Tracing the processes of a task-shared intervention for perinatal depression in South Africa

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With acknowledgement to Chinua Achebe, who wrote "Things Fall Apart" (1958).

Declarations

I, Thandi Davies, present this thesis in fulfilment of the requirements for the degree of Doctor of Philosophy in the Department of Psychiatry and Mental Health, Faculty of Health Sciences, University of Cape Town. I hereby declare that this thesis is based on my original work and that neither the whole work nor any part of it has been, is being, or will be submitted for another degree in this or any other university. Ethical approval was obtained from Ethics Research Committee of the Faculty of Health Sciences at the University of Cape Town (HREC REF: 790/2015) (See Appendix A).

I confirm that I have been granted permission by the University of Cape Town's Doctoral Degrees Board to include the following publication in my PhD thesis, and that my co-authors have agreed that I may include the publication:

Davies, T., Schneider, M., Nyatsanza, M., & Lund, C. (2016). "The sun has set even though it is morning": Experiences and explanations of perinatal depression in an urban township, Cape Town. Transcultural Psychiatry, 53(3), 286-312.

I conceptualised the article, conducted the data collection and analysis, and drafted the manuscript. Marguerite Schneider was the Project Manager on the AFFIRM project, Memory Munodawafa (nee Nyatsanza) was the clinical counselling supervisor, and Crick Lund was the Principal Investigator. All three co-authors reviewed and commented on the draft manuscript.

See Appendix B for the letter of approval confirming permission to include this publication.

Signature: Signed by candidate Date: 7 November 2020

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Abstract

Depression in the perinatal period carries a significant burden of disease and can have negative impacts on foetuses and infants of mothers suffering from the illness. Risk factors for perinatal depression are particularly high in Low- and Middle-Income Countries (LMICs), and include partner abuse, economic insecurity, HIV, unwanted pregnancy, and food insecurity. Despite the substantial burden, there is a considerable 'treatment gap' between the need for treatment and the provision of services for perinatal depression in LMICs. Task sharing using non-specialist health workers has been recommended as a cost-effective means to address this treatment gap and reduce the burden on mental health specialists in public health services. Evidence has shown moderate effects of task-shared treatments on the reduction of perinatal depression, but little is known about the processes, mechanisms and elements that lead these treatments to be effective.

This thesis is nested within the Africa Focus on Intervention Research for Mental Health - South Africa (AFFIRM-SA) randomised controlled trial (RCT), which aimed to test a task-shared psychological treatment for perinatal depression in Khayelitsha, a low-income township outside of Cape Town in South Africa. The aim of this thesis was to explore the mechanisms of implementation and change of this intervention through a process evaluation.

Before implementation of the intervention, qualitative research was employed to explore the idioms, symptoms and perceived causes of depression particular to perinatal women living in Khayelitsha, using semi-structured interviews and a framework analysis approach. This was conducted with 12 depressed and nine non-depressed pregnant women and mothers of young babies, and 13 health care providers. These idioms and symptoms were also compared with the ICD 10 and DSM-5 criteria for major depression. The research found that local idioms used to describe depression included 'stress', 'thinking too much', being sad or unhappy, and being scared. Some of the common symptoms of depression were expressed as withdrawal and not wanting to talk, crying or sadness, poor concentration, thinking too much, fear and anxiety, stress, sleep problems, headaches, and body pain. The primary causes that women attributed to these depressive symptoms were lack of support, having an unwanted pregnancy, death of a loved one, poverty, unemployment, thinking too much, coping with a new baby, and stress. These were exacerbated by the extreme risk factors the women faced in Khayelitsha such as low income levels, poverty, partner abuse, low education levels, poor housing and living conditions, and poor health care. The findings from this research were recommended for inclusion in the development of the counselling intervention manual for the RCT.

Following implementation of the AFFIRM-SA RCT counselling intervention, the trial outcome assessments found non-significant effects in the reduction of depressive symptoms on the Hamilton Depression Rating scale (HDRS) at three and 12 months post-partum, but also found significant improvements on the Edinburgh Postnatal Depression Scale (EPDS) at both time points for the intervention group, compared to the control group. The process evaluation for this thesis subsequently examined mechanisms and contextual factors that may have influenced the intervention outcome. This involved reviewing the counselling manual and conducting a grounded theory analysis of a sample of the counselling session transcripts from the intervention.

The review of the counselling manual found that the structure, layout, instructions and grammar in the manual may have led to some difficulties in its interpretation and use for counsellors and participants. The grounded theory analysis included 39 participants who had completed all six sessions of the intervention (totalling 234 sessions). The use of grounded theory allowed for findings to emerge which had not been pre-specified before analysis. This process began with the identification of 'open codes', which was anything that 'stood out' from the data. Following this, a secondary 'axial coding' of the data then identified four themes that encompassed all of the open codes. The themes were: therapeutic breakdowns in the counselling sessions, the adverse influence of socio-economic context on therapeutic effectiveness, reported positive outcomes, and attributes given for the reported changes. In turn, these themes could be represented by one of two 'core concepts' that characterised the processes that occurred during the counselling sessions. These were deviations from the intended counselling protocol (*when things fall apart*), and effectiveness of the counselling sessions (*when things come together*).

The third level of coding, termed 'selective coding', examined the potential reasons for the deviations from protocol and the mechanisms or elements behind the attributions of the reported outcomes. Possible reasons for deviations include the original context of the development of the intervention, not fully incorporating the formative research and pilot findings, the limited skill base of the counsellors, limited training and supervision, the structure and design of the intervention, ownership by the counsellors of the intervention, the role of advice in this context, and contextually related need from the participants. This also explained potential reasons for the non-significant effects of the intervention on the HDRS. In terms of the attributions that the participants gave for their outcomes of change, many of these acted as 'mechanisms' or therapeutic elements of the counselling, and these elements were similar to previous research on common or 'non-specific' elements in the therapeutic space. These elements played an important role in participants' feelings of connection and reduction of distress, despite evidence of deviations from the counselling protocol. This was in keeping with the significant effects of the intervention on the EPDS outcomes.

The thesis presents two models of processes that occurred in the intervention. The first posits that the intervention did not sufficiently disrupt the mechanisms or context that creates and perpetuates depression to enable long term shifts or significant changes in clinical depressive symptoms. The second suggests that the intervention provided a sense of connection and a subsequent 'buffer' of resilience to handle every-day stressors, but that this buffer was short-term and could not provide longer-term resilience against the extreme context of poverty, unemployment, abuse and trauma. Through a process evaluation of the design and implementation of the AFFIRM-SA intervention, this thesis presents a wide range of contextual considerations and therapeutic elements relevant to designing and implementing more acceptable and responsive public mental health interventions that aim to bring about real and sustainable change for perinatal depression in South Africa and other LMICs.

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In addition, I hope that this thesis gives some voice to the participants in this study, who go unheard in their struggles not only with mental health but also in negotiating day-to-day survival in their lives.

I would like to thank my supervisors who have inspired and guided me through this journey. Marguerite Schneider, you have been a consistent source of support and encouragement for me. I have always known that I could ask you for help and be vulnerable with you when it is so difficult to do so in an academic environment. I want to thank you for your care and support that went beyond our academic relationship, and for believing in me throughout all of the ups and downs of the last five years. Thank you. "Resist everything except temptation" will remain one of my mottos for a long time!

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List of Abbreviations

AFFIRM: Africa Focus on Intervention Research for Mental Health

APA: American Psychiatric Association

CBT: Cognitive Behavioural Therapy

CES-D: Centre for Epidemiological Studies-Depression scale

CHWs: Community Health Workers

CI: Confidence Intervals

CMDs: Common Mental Disorders

DALY: Disability Adjusted Life Years

DOH: Department of Health

DSMB: Data Safety and Monitoring Board

DSM-5: Diagnostic and Statistical Manual of Mental Disorders

EPDS: Edinburgh Postnatal Depression Rating Scale

HDRS: Hamilton Depression Rating Scale

HICs: High Income Countries

HIV: Human Immunodeficiency Virus

HREC: Human Research Ethics Committee

ICD-10: International Classification of Diseases

IPT: Interpersonal Therapy

IPV: Intimate Partner Violence

LMICs: Low- and Middle-Income Countries

MNS: Mental, Neurological and Substance use disorders

MOU: Midwife and Obstetrics Unit

NCD: Non-Communicable Diseases

NIMH: National Institute for Mental Health

NGO: Non-Governmental Organisation

NIDS: National Income Dynamics Study

PCMD: Perinatal Common Mental Disorders

PHC: Primary Health Care

PHQ9: Patient Health Questionnaire

PST: Problem Solving Therapy

RCT: Randomised Controlled Trial

SASH: South African Stress and Health Study

SCID: Structured Clinical Interview for Depression

SD: Standard Deviation

SMD: Standardised mean difference

SSA: Sub-Saharan Africa

THP: Thinking Healthy Programme

UCT: University of Cape Town

WHO: World Health Organisation

YLD: Years Lived with disability

Chapter 1. Background, aims and objectives

1.1 Introduction

Perinatal depression creates significant levels of disability for women and their infants. Yet there is a major 'gap' between the need for, and the provision of, mental health care for this and other mental disorders in Low- and Middle- Income Countries (LMICs) (Saxena, Thornicroft et al., 2007). Task sharing has been recommended to increase coverage of care for mental disorders at primary care levels and to address this gap in LMICs (World Health Organisation (WHO), (2008b). This involves non-specialist health care workers delivering mental health care through routine delivery systems, supervised by mental health specialists (Singla, Kohrt et al., 2017). Testing of task-shared interventions and treatments for mental illnesses using randomised controlled trials (RCTs) over the last two decades has contributed valuable evidence to the field of global mental health, with many of these interventions showing significant positive effects on perinatal depression and other common mental disorders (CMDs) (Barbui, Purgato et al., 2020; Singla et al., 2017).

However, there are numerous challenges to the successful implementation of these interventions using non-specialist workers. These include how to make them more acceptable and appropriate to the populations they serve, and identifying what particular elements are therapeutically effective within the interventions (Barnett, Lau et al., 2018; Singla and Hollon, 2020). There is therefore a need to move beyond testing the effectiveness of psychological interventions toward a) testing the mechanisms that lead to the effectiveness or non-effectiveness of interventions and b) designing interventions in response to the contextual need expressed by participants themselves (Burgess, Jain et al., 2020). Process evaluations are one such means to do so.

This thesis is nested in the 'Africa Focus on Intervention Research for Mental Health - South Africa (AFFIRM-SA)' RCT, that was conducted between 2011 and 2016 (Lund, Schneider et al., 2020). The RCT aimed to test a task-shared treatment for perinatal depression in Khayelitsha, Cape Town, that was provided by community health workers (CHWs). The following section describes the background and methodology of the AFFIRM-SA RCT in order to frame the thesis. The chapter concludes with the aims, objectives, and outline of the thesis.

1.2 The AFFIRM-SA Randomised Controlled Trial

Given the significant treatment gap of professionals and resources to deal with the burden of mental disorders, a call was put out for researchers to test methods of task sharing to address this (Collins, Patel et al., 2011). At the time, there had been a few examples of effective task-shared treatments in LMICs, including problem solving therapy interventions for CMDs in Zimbabwe and South Africa (Chibanda, Mesu et al., 2011; van't Hof, Stein et al., 2011), group interpersonal therapy for depression in Uganda (Bolton, Bass et al., 2003), and cognitive behavioural techniques to treat perinatal depression in Pakistan (Rahman, Malik et al., 2008). There was also growing acknowledgement in the research field that mental disorders and socio-economic deprivation interact in a negative cycle, and that mental health interventions may provide potential economic benefits to individuals and families (Lund, De Silva et al., 2011; Patel, Lund et al., 2010).

A group of investigators responded to this call to test methods of task sharing, in South Africa. The South African Government had already produced policy guidelines that aimed to integrate mental health into primary health care (PHC) through task sharing of treatment using CHWs in primary health clinics (Department of Health, 1997). In the Western Cape, there was a policy-driven opportunity to address the high rates of maternal mortality and perinatal depression, which were higher than the global average (Cooper, Tomlinson et al., 1999; Rochat, Richter et al., 2006). The investigators thus designed an individual-level RCT to test task sharing of mental health services for women with perinatal depression in Khayelitsha, Cape Town.

Khayelitsha is a township similar to many low-income settlements around the world, where unemployment is high, at 32% (Western Cape Government, 2017), and education levels are low, with only 38% of adults having completed secondary school (Statistics South Africa, 2011). The legacy of the separation policies of the apartheid government is still strongly influential, with approximately 90% of the population being black African people, most of whom speak isiXhosa. More than two thirds (68.4%) of households in Khayelitsha reported being severely food insecure in 2017 (Manyise, 2017). Infrastructure is poor, with many residents living in tin shacks, and only 35% of houses having piped water to the dwellings (Statistics South Africa, 2011). A study in 2007 found a 12-month prevalence of 34.9% of CMDs in adults in this population (Havenaar, Geerlings et al., 2007). There are fourteen PHC facilities in Khayelitsha which serve the majority of the population of well over 400 000 people (Engelbrecht, Summerton et al., 2003; Statistics South Africa, 2011). In the last decade a district hospital has been built, but there are still dire staff shortages across these facilities (Medical Brief, 2018).

1.2.1 Design and methods

The project was funded by the National Institute for Mental Health (NIMH) in the USA. For a full description of the research protocol, see Lund, Schneider, et al. (2014). The RCT, named AFFIRM-SA, was designed against the backdrop of available knowledge of task-shared interventions around this period. It aimed to test the cost effectiveness of task sharing in this population and setting, through the use of local CHWs to deliver a counselling intervention to depressed pregnant women in Khayelitsha. The research was conducted at Midwife and Obstetrics Units (MOUs) in two PHC clinics in Khayelitsha. CHWs were trained to provide a six-session manualised counselling intervention to all women allocated to the intervention arm in the study. Control arm participants received monthly phone calls for three months which involved separate CHWs asking standardised health questions to the participants each month.

Before the RCT began, formative qualitative research was conducted, some of which by the current author. This involved in-depth semi-structured interviews with midwives at MOUs, CHWs, and depressed and non-depressed pregnant women in Khayelitsha. Meetings were also held with stakeholders such as PHC facility managers and local non-governmental organisation (NGO) directors to ascertain feasibility of an intervention in this context. The interviews were conducted with two main objectives: to determine the local descriptions, symptoms and causes of perinatal depression in Khayelitsha; and to determine the feasibility, acceptability and content of a potential counselling intervention using CHWs at local clinics, for this population. It was intended that these interviews would inform the development of a contextually appropriate intervention to address perinatal depression in this population. Methods and results of the formative component are described in Chapter Four of this thesis.

Development of the counselling manual

Following the formative research, a workshop was conducted with an expert panel consisting of public mental health specialists and interventionists who had previously designed psychotherapy manuals in South Africa, to inform the design and development of the counselling manual. This was used in conjunction with data from the formative research, and the skills of the clinical social worker employed on the trial. The manual included four sections. The first two sections provided information on depression and basic counselling skills, training activities, vignettes and self-reflection exercises for the CHWs. The third section contained a step–by-step guide for conducting the sessions, and the fourth had a workbook that was given to participants for homework, and which included details of local counselling NGOs for their reference if they needed it.

Section Three, the actual intervention, included six different session topics. These were: 1) psychoeducation, 2) problem solving, 3) behavioural activation, 4) healthy thinking, 5) birth preparation, and 6) termination and evaluation. Development of the intervention itself is reported in detail by Munodawafa (2018).

The aim of the sessions was for counsellors to inform participants about depression in pregnancy, prepare them for birth, teach them psychological skills such as problem solving, behaviour activation and cognitive restructuring, and encourage them to practice these in homework activities. The idea was for the participants to be able to apply these skills in their everyday lives, thereby reducing depressive symptoms and increasing their coping strategies. The use of basic counselling techniques and client-centred counselling were to underlie the modalities in each session.

Recruitment

A sample size of 420 women (with 210 in each arm) was calculated to be adequate to demonstrate intervention effects (Lund, Schneider, et al., 2014). Women were recruited by fieldworkers into the study at the two PHC clinics if they met the following inclusion criteria:

- 18 years or older
- Attending one of two antenatal PHC clinics (Michael Mapongwana or Site B) in Khayelitsha
- Presenting for their first antenatal visit, at no later than 28 weeks gestation
- Being a resident in Khayelitsha
- Speaking isiXhosa as a first language (or competently as a second language)
- Able to give informed consent
- Not requiring urgent medical attention or have severe mental health problems noted by fieldworkers or recorded on their clinic cards.
- Screening positive for depression with a cut-off of 13 or above on the Edinburgh Postnatal Depression Scale (EPDS)

Outcome measures

Once the women had met the above criteria, they were invited to participate in the study, and if they agreed, they completed a full baseline assessment. After completion of the assessment, they were randomised into the intervention or control arm. The assessment battery included a number of measures. Some of these included the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden et al., 1987); The Major Depressive Episode and Suicidality modules of the Mini International Neuropsychiatric Interview 6.0.0 (MINI) (Sheehan, Lecrubier et al., 1998); the Household Food Insecurity Access scale (HFIAS) (Coates, Swindale et al., 2006); the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem et al., 1988); the Alcohol Use

Disorders Identification Test (AUDIT) (Saunders, Aasland et al., 1993); and brief drug, interpersonal abuse, and HIV questions.

The 17-item Hamilton Depression Rating Scale (HDRS) (Hamilton, 1986), was used as the primary outcome measure. This was adapted and validated for use in isiXhosa by non-clinicians (Davies, Garman et al., 2019). The adapted HDRS had excellent inter-rater reliability (intra-class correlation coefficient: 0.97-0.98) and acceptable internal reliability (Cronbach's Alpha =0.76). The primary outcome for the RCT, termed as 'response', was defined as at least 40% reduction in score at 3 months postpartum compared to baseline, and 'recovery' was defined as a score below eight at both three-month and 12-month postpartum assessments.

The assessments were conducted at recruitment, eight months gestation, and three and 12 months postpartum. The data were collected on cellular telephones and uploaded and stored electronically by a data capture system named Mobenzi (www.mobenzi.com).

Following recruitment by the fieldworkers, participants were randomised by the Mobenzi electronic system into either the intervention or control arm using a computer-generated random number sequence, stratified by clinic of recruitment. The electronic system then allocated intervention participants to one of the six counselling CHWs, and control participants to one of two non-intervention, or control CHWs, on a rotational basis. Counselling CHWs and control CHWs would receive an SMS text message when a new participant was allocated to them.

Intervention condition

The intended duration of the intervention sessions was 45-60 minutes long. Sessions were to be initiated within two weeks of recruitment and occur weekly. The aim was to complete all six sessions before birth, but this did not always occur, and 27.7% of the intervention participants received some or all of their sessions post birth. Sessions were held either at the clinic, often aligned to their check-up appointments, or at their homes, if they expressed that they would feel more comfortable there. In every session the counsellors also asked the participants 14 standard questions on a checklist about their physical and mental health, intimate partner abuse, any major life changes, and whether any external mental health support had been received.

Control condition

Participants allocated to the control condition received one phone call, monthly, for three months. The phone calls were conducted by two CHWs trained in following a specific phone call protocol and checklist, which included the same 14-item checklist that intervention participants were asked. The participants received no

counselling and if they expressed distress, suicidal ideation, or the need for counselling, they were referred to either the PHC clinic mental health nurse, or a counselling NGO in Khayelitsha. Phone calls lasted approximately 10 minutes.

CHW Counsellors

Twelve CHWs who worked at the Philani Nutrition Project in Khayelitsha were selected by the organisation to participate in counselling training. These CHWs had been conducting health promotion and education household visits. The CHWs participated in five days of training. The training was conducted by the RCT Clinical Social Worker, and covered basic counselling techniques, the modules of the intervention, and using the counselling manual. Following the week of training, the clinical social worker selected the six most promising CHWs from the original 12, to be employed in the study and deliver the intervention. Following initiation of the intervention, the counsellors received weekly group supervision and 30 minutes of individual supervision every month if requested. Group supervision included reviewing participant progress, discussion and feedback from cases, follow up on referrals to other organisations. The clinical social worker sat in on some initial sessions, and listened to audio recordings of the sessions on a weekly basis (Munodawafa, 2018).

Control CHWs

Two isiXhosa-speaking CHWs were employed to conduct phone calls for the control arm. They were trained in conducting the phone calls through following a set protocol, were not trained in any counselling techniques and did not have any experience of providing any form of counselling.

The supervisor for the intervention and control CHWs was the trial clinical social worker who supervised and trained all of the CHWs and monitored the counselling and phone sessions.

Fieldworkers

Four fieldworkers conducted the assessments at the two different clinics in Khayelitsha. They were residents of Khayelitsha, had school matric certifications (12 years of schooling), and had been working previously in data collection. All instruments were translated by the fieldworkers themselves, and then independently back translated. This allowed for a deeper understanding of these measures, played an important role in their training, and ensured a translation that would be easily understood by the participants from the same area. Fieldworkers were blinded to participants' allocation arm and were managed by myself.

My role in the AFFIRM-SA RCT

I was employed as the Research Officer on the AFFIRM-SA trial. My duties included training and managing the fieldworkers, translating and adapting the assessment tools, conducting the adaptation of the HDRS, conducting the formative research, contributing towards development of the counselling intervention, coordinating data collection, and conducting data quality assessment. I was not involved in the implementation of counselling sessions or control phone calls.

1.2.2 Ethical approval

Ethical approval for the AFFIRM-SA RCT was obtained, and renewed annually, from the UCT Human Research Ethics Committee (HREC) (Reference number: 226/2011), and from the Data Safety and Monitoring Board (DSMB) appointed by the funders, the National Institute for Mental Health in the USA. Ethical approval for the current PhD study was granted from the University of Cape Town Health Sciences Human Research Ethics Committee, reference number: 790/2015 (See Appendix A for the approval). The study also received clearance from the Department of Health (DoH) to conduct research in the two PHC clinics in Khayelitsha. See Appendix C and D for ethical approval for the AFFIRM-SA RCT and permission from the DoH. The study complied with the Declaration of Helsinki (2013), The Department of Health Ethics in Health Research: Principles Structures and Processes, 2004, and the Guidelines for Good Clinical Practice in the Conduct of Clinical Trials in Human Participants in South Africa (Second Edition, 2006).

All participants provided written informed consent to participate and have their counselling sessions audio recorded for analysis and quality supervision (see Appendix E for consent forms for the RCT). Consenting procedures for the formative study are described in Chapter Four (see Appendix F for the consent form), and Chapters Five to Seven involve secondary analysis of data from the AFFIRM-SA main trial.

In both the RCT and formative research, if participants scored 17 or above on the MINI Suicidality module or mentioned suicidal ideation during interviews, they were immediately referred to the mental health nurse in the corresponding community health centre.

1.2.3 AFFIRM-SA RCT outcomes

Full results for the RCT are reported in the primary outcome paper (Lund, Schneider, et al., 2020). For the purpose of this thesis, the main results are summarised below.

Participant flow

A total of 5061 women were approached at the MOUs for screening. 2187 of these women met initial inclusion criteria and were screened with the EPDS. 425 women (19.4%) screened positive on the EPDS and were enrolled in the study (209 in the intervention arm and 216 in the control arm). Following six exclusions and 35 suspensions, a total of 384 participants were included in the final analysis (184 intervention and 200 control). Of the 184 women in the intervention arm, 98 (53.3%) completed all six counselling sessions, and 187 (93.5%) of the 200 control arm participants received all three phone calls.

Results

As reported in Lund, Schneider et al. (2020), the analysis indicated "no significant difference in the proportion of participants who showed a response on the HDRS at three months postpartum between the intervention (n=82, 55.4%) and the control arm (n=89, 47.6%; RR=1.16; 95% Confidence Interval (CI) 0.94, 1.43). Response at 12 months postpartum was also not different between the two arms" (p.1). However, there was an improvement in mean EPDS scores from baseline to three months postpartum, which was significantly greater in the intervention arm (mean= 7.6, SD: 5.2) compared to the control arm (mean=9.5, SD 5.7; RR=0.78, 95% CI: 0.67-0.91, p=0.001). This was similarly observed at 12 months postpartum (intervention: mean=8.0, SD 5.28; control: mean= 9.8, SD 5.94; RR=0.79, 95% CI: 0.68 to 0.92, p=0.003) (Lund, Schneider, et al., 2020).

It is important to note that participants were recruited using the EPDS, which is a screening tool that indicates perinatal distress. It is not a diagnostic tool that is able to make a clinical diagnosis of depression, which the HDRS is. The proportion of women who were clinically depressed at baseline on the HDRS was only 40% of those identified as distressed using the EPDS (Lund, Schneider, et al., 2020), but the HDRS was used as the primary outcome measure at follow-up time points. This may in part explain the lack of effects on clinical depression found on the HDRS, but the significant effects on a reduction in distress on the EPDS, at follow-up assessments. The HDRS and EPDS are included in Appendix G and H for reference purposes.

1.2.4 Previous qualitative evaluation of the AFFIRM-SA RCT

As part of her PhD thesis, Munodawafa (2018) conducted an evaluation of counsellor and participant perspectives on the barriers and facilitators to the delivery of the AFFIRM-SA intervention, using post-intervention interviews with the six counsellors and 34 participants. Findings from the interviews with the six counsellors were that intervention delivery was facilitated by "the content of the intervention, ongoing training and supervision, using a counselling manual, conducting counselling sessions in the local language, fidelity to the manual, and counsellors' confidence and motivation to conduct the sessions". Barriers to implementing the intervention as planned included "contextual factors such as poverty, crime and lack of space to conduct

counselling sessions, and participant factors such as the nature of the participant's problem, young age, and avoidance of contact with counsellors" (p.62).

Interviews with participants who had partially or fully completed all six counselling sessions identified factors that acted as barriers or facilitators in receiving the intervention. Contextual barriers included "unplanned pregnancy, interpersonal difficulties and location of the counselling" (p. 84). Mechanisms of the intervention included "participants' willingness to learn new skills and change their behaviour, counsellor's motivation and empathy towards participants, and the content of the intervention, and implementation factors included the perception of the use or inability to use material such as the counselling manual, homework book and relaxation CD" (p. xiv). The majority of the participants found that psychoeducation, problem solving and healthy thinking were the most useful sessions (Munodawafa, 2018).

The evaluation also assessed counsellor fidelity to the manual, using a rating scale developed from the counselling manual, and analysing counselling transcripts of one participant from each counsellor against this scale. Fidelity to the manual varied between counsellors, ranging in percentage from 55%-70%; the lower levels of which is not optimal fidelity (Breitenstein, Gross et al., 2010).

1.2.5 Current evaluation

The current thesis adopts a process evaluation framework for investigating data from the RCT and complements the previous research in distinct ways. First, it reports on the element of the AFFIRM-SA formative research that examined the localised ways of describing perinatal depression – the idioms of distress – and the experiences and attributed aetiology of perinatal depression in the context of Khayelitsha. This research assisted in the development of the task-shared intervention and sets the context of the women's lives in which the intervention was situated. This is presented in the form of a published paper in Chapter Four.

Second, following implementation of the RCT, this thesis analyses counselling session transcripts of participants who completed the intervention, through a grounded theory approach (Corbin and Strauss, 2014). This provides valuable insight into processes occurring in the moment of therapy between counsellor and participant. This method avoids the potential for re-interpretation of information or feedback presented differently to a researcher in an interview context after completion of the intervention, and supplements the findings from the formative interviews.

The thesis adds a unique perspective in the current research field into the processes that occur within actual counselling sessions and fills an important gap in implementation analysis, and in reporting mechanisms of

change of task-shared interventions. This had not been conducted in the AFFIRM-SA RCT, and to my knowledge, does not appear to have been conducted in other task shared interventions for perinatal depression in LMICs. The objectives for this evaluation are presented below.

1.3 Aims and objectives

The overall aim of this thesis is to explore the mechanisms of implementation and change of the AFFIRM-SA task-shared counselling intervention for perinatal depression in Khayelitsha through a process evaluation. This will be answered by addressing the following objectives:

Before implementation of the AFFIRM-SA RCT,

1) To examine local pregnant women, mothers, and health workers' idioms of distress and understandings of the symptoms and perceived causes of perinatal depression in Khayelitsha, to inform development of the counselling intervention, and to provide contextual information for the intervention.

Following implementation of the intervention,

2) To describe and critique the AFFIRM-SA counselling manual, to explore potential influences it may have had on the RCT results, and
3) To examine the processes that occurred in the implementation of the counselling sessions.

1.4 Thesis outline

The thesis is structured as follows: Chapter Two presents a review of literature that broadly centres around task sharing for perinatal depression and CMDs in LMICs, and challenges thereof. Chapter Three introduces the methods and conceptual frameworks for the thesis. Chapter Four presents research on the formative study that was conducted for the AFFIRM-SA RCT in 2015. This chapter is in the form of an article that was published in the journal *Transcultural Psychiatry* in 2016. The research examines local idioms of distress and understandings of the symptoms and causes of perinatal depression in Khayelitsha, and compares these symptoms to international classification systems for major depression.

Following implementation of the AFFIRM-SA RCT, the subsequent chapters unpack the mechanisms underlying the implementation of the RCT. Chapter Five summarises and describes the counselling manual to provide a background for the thesis, and then conducts a retrospective review to explore potential influences it may

have had on the RCT results. Chapter Six presents 'deviations' from intended theory and protocol that occurred in the implementation of the counselling sessions, and Chapter Seven, the outcomes and attributions of change reported by participants during the sessions.

Chapter Eight, the thesis discussion, explores the potential reasons for the deviations from protocol that occurred, as well as the possible mechanisms or therapeutically effective elements that led to the reported outcomes and attributions of the sessions from the participants. Two models of implementation processes that may have occurred in the trial are then presented. This provides insights into the challenges of implementing a psychological intervention using CHWs in LMICs, but also into the mechanisms and therapeutic elements that participants themselves found beneficial in the counselling process. Lessons from the thesis are presented as recommendations for design and implementation of future task-shared research interventions in mental health. Prior to the conclusion, the strengths and limitations of the thesis are discussed, including a section on researcher reflexivity.

Chapter 2. Review of literature

The following literature review presents various factors related to the prevalence, burden, and treatment gap for CMDs and perinatal depression in LMICs, with specific reference to South Africa. It examines the risk factors for perinatal depression, specifically the influence of poverty, food insecurity, low education levels, intimate partner violence, unwanted pregnancies, and lack of social support, and HIV. Task sharing is discussed as the current treatment solution to address some of the burden of CMDs and perinatal depression in LMICs. There are a multitude of factors needing to be considered when implementing task sharing, not least of these being the need to develop a deeper local understanding of depression and its related causes, in order to address this burden.

The various therapeutic elements that can and have been included in task-shared interventions are then presented, followed by research methodologies for task sharing, with a focus on the importance of process evaluations and of implementation science frameworks in intervention research. The review concludes with a brief presentation of potential future content and methods required for more accessible and acceptable task-shared mental health service provision in LMICs. The specific focus of the review is on perinatal depression but research on other common mental disorders is included where relevant for task sharing and treatment of perinatal depression.

2.1 Depression in LMICs

Depression is characterised by a sad, empty, or hopeless mood, with diminished interest in most activities, and can include fatigue, poor concentration, worthlessness, guilt, insomnia and suicidality (WHO, 2010). It can have significant impacts on social and economic functioning, and is strongly influenced by surrounding social determinants (Lund, Brooke-Sumner et al., 2018). Within the larger cluster of mental, neurological and substance use (MNS) disorders, depression is the third leading cause of years lived with disability (YLD) globally (The Lancet, 2018), and is attributable to 2.3% of disability-adjusted life years (DALYs) for women (GBD 2017 and HALE Collaborators, 2018). It places significant burden on individuals, their families, and the health care system supporting them. This results in an economic impact on society through costs of care, but also through lost earning potential through disability and care requirements of the family (Lund, Myer et al., 2013). This burden on countries' economies draws attention to the consequences of depression, and the need to prioritise, develop and adapt treatment plans for mental disorders in public health service planning. The

following sections discuss depression prevalence in LMICs, its implications, risk factors and social determinants, and the significant gap in the provision of services for those with this condition.

2.1.1 Prevalence of depression

In sub-Saharan Africa (SSA), major depressive disorder has increased in prevalence by 112% since 1990, and mental health conditions are predicted to cause 45 million YLDs by the year 2050 (Charlson, Diminic et al., 2014). This has significant implications for treatment coverage in SSA. In South Africa specifically, depressive disorders are now the fifth highest cause of YLD (Institute for Health Metrics and Evaluation, 2017). The South African Stress and Health (SASH) Study is the only nationally representative study that has been conducted on anxiety, mood and substance use disorders, and this was conducted in 2002 - nearly two decades ago. This study found a lifetime prevalence for CMDs of 30.3%, and prevalence in the 12 months prior to the survey of 16.5% (Stein, Seedat et al., 2008). The Western Cape had the highest 12-month and lifetime prevalence of CMDs in South Africa, at 39.4% (Herman, Stein et al., 2009). The prevalence of major depression specifically was 9.7% lifetime prevalence and 4.9% prevalence in the past 12 months (Tomlinson, Grimsrud et al., 2009).

In 2015, the South African National Income Dynamics Study (NIDS), which collects nationally representative data every two years found that the proportion of the population who screened positive for depression on the Centre for Epidemiological Studies-Depression scale (CES-D) was 13% (Pengpid and Peltzer, 2018). This is significantly higher than the prevalence found by the SASH study in 2002 (at 4.9%), but the data needs to be used with caution as the CES-D had not yet been validated in South Africa at the time.

There have been other prevalence studies of depression and other CMDs conducted in South Africa, but these usually focus either on relatively small geographical areas, or on comorbidity with other illnesses. Many of these studies are now dated and there is a need for more recent research on prevalence of CMDs in South Africa. To note, many of these studies, as with the current study, have been conducted in Khayelitsha, Cape Town, because it is the largest township in South Africa, and is located near two universities and university hospitals in the city. Prevalence studies in Khayelitsha have found symptoms of CMDs in 34.9% of adults in 2007 (Havenaar et al., 2007), and specifically of depression in 37% of adults at a primary care clinic in 2003 (Carey, Stein et al., 2003). Three studies provide rural prevalence data of CMDs in general adult populations, with a 27.1% prevalence in a village in the Western Cape (Rumble, Swartz et al., 1996), 27% in a rural community in Limpopo (Havenaar et al., 2007), and 23.9% in rural KwaZulu Natal (Bhagwanjee, Parekh et al., 1998). Other studies have been conducted that assess the prevalence of mental disorders comorbid with factors such as Human Immunodeficiency Virus (HIV) (Joska, Fincham et al., 2010; Myer, Smit et al., 2008) hypertension (Grimsrud, Stein et al., 2009), tuberculosis (Peltzer, Naidoo et al., 2012), in youth (Liang, Flisher

et al., 2002), elderly people (Peltzer and Phaswana-Mafuya, 2013), and perinatal depression (see below). These studies have demonstrated significant associations of common mental disorders with the above factors in South Africa.

2.1.2 Prevalence of perinatal depression

Women in the perinatal period, defined for this study as the phase from conception until one year post birth, are particularly vulnerable to mental disorders and depression. The burden of perinatal depression may be even larger than for other mental disorders, not least because of the intergenerational impact it has on infants (Surkan, Kennedy et al., 2011). Globally, there is a pooled prevalence of perinatal depression of 11.9% (Woody, Ferrari et al., 2017). In LMICs, estimates show a pooled prevalence of antenatal depression at 19.2%, and 18.7% postnatally, which is almost double that of high-income countries, with estimates of 9.2% antenatally and 9.5% postnatally (Woody et al., 2017).

A recent systematic review of studies from ten countries in Africa found an even higher pooled prevalence of antenatal depression of 26.3% (Dadi, Wolde et al., 2020), and a similar review found a pooled prevalence of postnatal depression of 16.84% (Dadi, Akalu et al., 2020). In South Africa specifically, the prevalence of antenatal and postnatal depression has been found to be particularly high. In this country, most published studies of antenatal depression have been conducted in Khayelitsha, where prevalence ranges from 19.4% (Lund, Schneider, et al., 2020) to 48.9% (Vythilingum, Roos et al., 2012). These studies largely used the Edinburgh Postnatal Depression Scale (EPDS) for screening. In rural KwaZulu Natal, a 41% point prevalence of antenatal depression was found in 2006, and 47% in 2011, using the Structured Clinical Interview for Depression (SCID) (Rochat et al., 2006; Rochat, Tomlinson et al., 2011). Last, one study in Mpumalanga found 26.5% antenatal prevalence on the Kessler-10 scale (Peltzer and Phaswana-Mafuya, 2013). There are fewer studies of postnatal depression in South Africa. One study in Khayelitsha found prevalence of 15.5% to 34.7% (using the SCID) (Cooper et al., 1999), and another from Gauteng found a prevalence of 16.4% using the Pitt Depression Questionnaire (Ramchandani, Richter et al., 2009).

2.1.3 Implications of perinatal depression

Perinatal depression impacts not only the women suffering from it, but also foetuses, infants, and children of mothers who experience more severe symptoms in the perinatal period. If antenatal depression is not treated or does not improve, it increases the risk of mothers developing postnatal depression (Meintjes, Field et al., 2015; Rahman and Creed, 2007; Robertson, Grace et al., 2004), thus continuing the disability for mothers after birth. Antenatal depression can also lead to behaviour traits and negative health-related behaviours that affect

the unborn baby, including neglecting antenatal care and check-ups, inappropriate diet and poor weight gain, the use of harmful substances, and self-harm and suicide, and can lead to preeclampsia, preterm delivery, low birth weight (Hollins, 2007; Kurki, Hiilesmaa et al., 2000; Stewart, 2011; Wachs, Black et al., 2009). These have obvious consequences for future growth of children. Antenatal stress has also been found to be significantly associated with an increased risk of both autism spectrum disorder and attention-deficit hyperactivity disorder (Manzari, Matvienko-Sikar et al., 2019).

Following birth, postnatal depression has been shown to have numerous and serious negative impacts on infant and child development outcomes (Patel, DeSouza et al., 2003; Rahman, Harrington et al., 2002; Rahman, Iqbal et al., 2004; Surkan et al., 2011). Postnatal depression has been found to predict poor mother-infant relationships and child growth, affect child temperament, and impair behavioural and cognitive development (Cooper, Tomlinson et al., 2009; Field, Diego et al., 2006; Grote, Swartz et al., 2009; Surkan et al., 2011). It can also affect appropriate attachment and bonding in infants and children, and can lead to social difficulties later on (Murray, Fiori-Cowley et al., 1996). Even at a very early age, infants are able to observe and interpret their mothers' affect and interaction and modify their responses accordingly (Cohn, Matias et al., 1986). A detached mother who is unresponsive to cues put from the infant can lead to withdrawal and discontent for the infant (Murray, Cooper et al., 1991), with appreciable difficulties for children later in life.

Postnatal depression may also delay mothers from caring for their children's illnesses (WHO, 2008a), and inhibit investments in children such as with learning materials or the physical environment (Baranov, Bhalotra et al., 2020). A meta-analysis by Goodman et al. found that maternal depression was significantly related to higher levels of internalising and externalising behaviours amongst children growing up. If depression persists in mothers, it has been shown to increase mood disorders and emotional difficulties for children of these mothers (Goodman, Rouse et al., 2011).

The above research demonstrates the clear need to develop appropriate interventions to address the high levels of perinatal depression and stress that women face in LMICs, and to prevent the intergenerational effects of mental disorders on their children. Indeed, Patel et al. (2018) wrote that screening at risk women and providing interventions to promote recovery are important interventions to prevent mental disorders in offspring.

2.1.4 Risk factors for perinatal depression

Women suffering from depression cannot be considered in isolation from the social conditions that affect their condition. A number of risk factors affect perinatal depression and other CMDs. These include being of female

gender, having low education levels, food insecurity, being the victim of abuse, having an unwanted pregnancy, lack of social support, HIV, and the conditions of poverty. Risk factors have common features in the majority of populations in LMICs, where there is inadequate health service provision, high levels of crime and violence, a high prevalence of communicable diseases, poor sanitation and access to basic services, and overcrowded living conditions, all of which have been shown to increase risk of developing or experiencing depression (Lund, Breen et al., 2010; Patel, Lund, et al., 2010). All of these factors may be viewed as prognostic indicators of psychopathology (Wampold and Budge, 2012).

Simply being of female gender is a risk factor for depression and CMDs, particularly in LMICs (Patel, Araya et al., 1999; Patel, Lund, et al., 2010; Rahman, Fisher et al., 2013; Stein et al., 2008). Patel and Kleinman (2003) point out that "women bear the brunt of the adversities associated with poverty: less access to school, physical abuse from husbands, forced marriages, sexual trafficking, fewer job opportunities and, in some societies, limitation of their participation in activities outside the home" (p.612).

Poor education provision is also a common feature in LMICs, with women facing additional cultural and familial barriers to accessing education. A systematic evidence mapping by Coast et al. (2012) found that lower levels of education were associated with a higher risk of postnatal depression. Other authors have found a consistent relationship between depression and low education amongst adults in LMICs (Araya, Lewis et al., 2003; Patel and Kleinman, 2003; Saxena et al., 2007). It has been argued that the single most effective means to improve life circumstances for women is to improve access to and provision of education (Sommer and Fallon, 2020).

Food insecurity has been found to have a strong correlation with CMDs in LMICs (Lund, Kleintjes et al., 2010). Studies conducted in Zambia, Ethiopia, Tanzania and Uganda have demonstrated the associations between food insecurity and poor mental health (Cole and Tembo, 2011; Hadley and Patil, 2006; Tsai, Bangsberg et al., 2012; Weaver and Hadley, 2009). Pregnancy and the presence of a new-born can add another level of stress for women who are already food insecure. Tsai et al. (2012) found that social support played a moderating role on the effects of food insecurity on depression in women in Uganda.

Intimate partner violence (IPV), or being the victim of physical, sexual, psychological or economic abuse, is highly prevalent in LMICs (Gelaye, Rondon et al., 2016), and has been shown to be associated with depression (Fisher, Cabral de Mello et al., 2012; Howard, Oram et al., 2013; Spedding, 2017) and perinatal depression (Connelly, Hazen et al., 2013; Dadi, Akalu, et al., 2020; Mitchell, Wight et al., 2016). This is of particular cause for concern in LMICs where levels of violence against women are particularly high. In South Africa, these have been found to often be related to financial stress amongst men (Jewkes, 2002).

Economic abuse is a significant aspect of IPV. This can be defined as controlling a woman's ability to acquire, use, and maintain economic resources (Adams, 2011). This abuse can range from partners prohibiting or disrupting women's employment, to engaging in 'economically destructive behaviour' (Goodman, Smyth et al., 2009), such as accumulating debt, spending household income, using women's assets for personal benefit, and withholding or spending their own personal income without contributing to household needs (Howard and Skipp, 2015). Economic abuse of women has been found to have significant effects and long term associations with maternal depression (Postmus, Huang et al., 2012) and psychological distress and suicide (Antai, Oke et al., 2014; Stylianou, 2018).

Having an unplanned or unwanted pregnancy has been found to be associated with symptoms of depression (Fisher et al., 2012; Hartley, Tomlinson et al., 2011; Rochat et al., 2006), particularly when this is as a result of partner abuse or rape. Unwanted pregnancies can accentuate tenuous ties of current or expected emotional support, which is also associated with perinatal depression in a number of countries (Cooper et al., 2009; Dadi, Akalu, et al., 2020; Rahman, Iqbal et al., 2003; Smyth, Siriwardhana et al., 2015). Poor support from relatives was found to correlate with antenatal depression in one systematic review (Dadi, Wolde, et al., 2020), and from partners, in other studies (Fisher et al., 2012; Hartley et al., 2011; Rochat et al., 2006).

HIV/AIDS is a significant risk factor for depression in South Africa (Berger-Greenstein, Cuevas et al., 2007; Kagee and Martin, 2010), and disproportionately affects women (at 62.7% of all infections) (UNAIDS, 2018). HIV status also impacts social, relational and economic participation throughout women's lives, and is thus an underlying factor inhibiting full or permanent recovery from depression (Taraphdar, Guha et al., 2011). Conversely, people living with HIV/AIDS are more likely to experience depression and other MNS disorders (Andersen, Kagee et al., 2015; Chibanda, Benjamin et al., 2014). This is an important issue in public health service provision given that there is an HIV prevalence of 20.4 % in South Africa (UNAIDS, 2018). HIV prevalence in pregnant women specifically was found to be 37.3% in one study in rural KwaZulu Natal (Kharsany, Hancock et al., 2010).

In addition, there are significant associations between CMDs and a wide range of poverty measures such as unemployment, housing difficulties, crime and income shocks (Baranov et al., 2020; Patel and Kleinman, 2003). Poverty-related risk factors for perinatal depression specifically include low or irregular income levels or low socio-economic status, inadequate housing, overcrowding, and lack of privacy (Dadi, Akalu, et al., 2020; Fisher et al., 2012; Gelaye et al., 2016; Patel, Lund, et al., 2010). In the postnatal period, women are also often excluded from economic productivity which has further impacts on depression and agency in this period (Hanlon, Whitley et al., 2009).

Factors associated with poverty, such as insecurity and hopelessness, social change, violence and physical ill-health, can add further layers of stress, and can reduce women's ability to cope with the insecurity of day-to-day living (Coast et al., 2012). Women in LMICs face limited access to family planning services, skilled birth attendants, birthing facilities, and basic and emergency obstetric care (Fisher, Rahman et al., 2010). In these adverse circumstances, the associated psychosocial demands of pregnancy and caring for an infant can increase perinatal women's vulnerability to mental health problems (Fisher, Cabral de Mello et al., 2011).

It has been proposed that mental illness and poverty interact in a vicious cycle (Patel and Kleinman, 2003; Patel, Lund, et al., 2010), which interacts in two mutually re-enforcing pathways: through either 'social causation' or 'social drift'. The social causation theory postulates that the conditions of poverty bring about or maintain mental illness "through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence, and trauma" (Lund et al., 2011, p. 1502). The social drift theory proposes that people who already have a mental illness may drift into poverty through the various consequences of their illnesses, such as "increased health expenditure, reduced productivity, stigma, and loss of employment and associated earnings" (*ibid,* p. 1502).

South Africa has a certain form of poverty that relates to the history of colonialization and apartheid, leading to racial discrimination, political violence, economic instability, and inequality (Philip, Tsedu et al., 2014). This is a particularly insidious and persistent form of poverty and leads to greater levels of violence and crime within society. South Africans who were previously disadvantaged have fewer assets and skills, earn lower wages, and are less likely to be employed than the majority of the previously 'advantaged' white population (Sulla and Zikhali, 2018). This has psychological implications, particularly for women, such as hopelessness, powerlessness, social isolation, and disempowerment (Patel and Kleinman, 2003), resulting in potentially more 'invisible' effects and complex needs for perinatal interventions (Goodman, Smyth et al., 2010).

It is clear that social and environmental determinants are integral in shaping mental health within a population (Patel et al., 2018), and this is particularly pertinent for pregnant women, largely because of the insecure social, political and economic conditions that are ubiquitous in LMICs. It is thus very important to take cognisance of the above risk factors in treatment goals for perinatal depression. While this may not always be possible, designing a treatment package without taking these factors into consideration would disregard the factors causing the distress in the first place.

2.1.5 Treatment gap

Despite the high prevalence of perinatal depression, it is still largely unrecognized in health policy in LMICs (Rahman et al., 2013), and does not receive the research attention, treatment and service personnel it deserves (Gelaye et al., 2016). This leads to a significant 'treatment gap', that is, the gap between the number of people who require, and those who receive treatment (Saxena et al., 2007). In the lowest income countries, this gap translates to up to 93% of the people who require mental health services not receiving treatment (Patel, Maj et al., 2010). The consequences of the extreme lack of service provision for mental illness amounts to enormous disability, human suffering, and economic loss (Saxena et al., 2007).

The poor provision of care is largely due to the poor availability of treatment personnel or service providers trained in mental health care in LMICs. Where services are provided in LMICs, they are usually led by nongovernmental organizations or research institutions (Davies, Rahman et al., 2019). The 2017 WHO Mental Health Atlas reported that there are 0.1 psychiatrists and 0.3 mental health nurses per 100 000 people in low income countries. In Africa, there are only 0.9 mental health workers per 100 000 people (WHO, 2018). The Atlas estimates that high income countries (HICs) have approximately 120 times more psychiatrists than low income countries.

A recent study revealed that there is an average of 0.31 psychiatrists per 100 000 uninsured population in South Africa, and these are largely concentrated in the urban centres (Docrat, Besada et al., 2019). Additionally, there are only 0.97 public sector psychologists per 100 000 uninsured population, and 1.83 social workers per 100 000 uninsured population. Although these numbers are slightly higher than estimates for LMICs generally and Africa specifically, they demonstrate a massive treatment gap of approximately 92% for mental disorders, epilepsy and intellectual disability (Docrat et al., 2019).

Unfortunately, there are no available figures on the treatment gap for perinatal depression specifically, in LMICs or South Africa. However, given the stigma around this condition (Moore, Drey et al., 2017), and that it has low rates of recognition in LMICs (Gelaye et al., 2016), it is likely the treatment gap is as high or higher than that for other mental disorders.

2.2 Treatments for mental disorders through task sharing

Given the disturbing treatment gap for depression and CMDs and, by extension, perinatal depression, there have been calls to scale up treatment for mental disorders through 'task sharing' (WHO, 2008b). This was initiated through the landmark series in *The Lancet* in 2007, which called for the integration of mental health into general health care (Lancet Global Mental Health Group, 2007). Subsequently Collins et al. (2011) published a call for researchers to address this gap and evaluate whether task sharing using evidence-based psychological techniques would work for various mental disorders.

2.2.1 Task sharing using non-specialist workers

The World Health Organisation (WHO) defines task sharing as transferring specific tasks to health workers with shorter training and fewer qualifications, in order to make more efficient use of human resources (WHO, 2008b). Task sharing aims to utilise local, affordable personnel and resources, to provide services based at primary care platforms (Fairburn and Patel, 2014). This is essential as the majority of populations in LMICs seek health care only at primary levels (Singla et al., 2017).

Task sharing in mental health care involves using non-specialist health care workers, or those who have not had professional training in mental health, such as community health workers (CHWs), peer counsellors, or teachers. Other terms used for community based non-specialists include non-specialist providers and lay health workers. This thesis will use the term 'CHWs' as the generic term to describe non-specialists throughout, but where necessary will refer to the specific terms. This description does not include more specialised cadres such as nurses and doctors.

Task sharing aims to deliver mental health care through routine delivery systems under supervision from mental health specialists (Singla et al., 2017). The CHWs used for task sharing are usually members of communities who have no formal experience in delivering mental health treatments, and are subsequently trained in these particular projects to provide these services (Singla and Hollon, 2020). They then work with mild to moderate cases of mental illnesses, using specific techniques they have been trained in, and only refer more serious or suicidal cases to mental health specialists where available. This aims to reduce the burden on specialists and provide a basic level of mental health care for more of the population.

Recent recommendations in this field are that counsellors working in task-shared mental health interventions should come from the same community and background as the participants (Barnett et al., 2018; Verhey, Ryan

et al., 2020), so that they have an authentic understanding of the struggles of their participants, particularly if they are from situations of poverty or gender inequity (Pugach and Goodman, 2015; Thompson, Cole et al., 2012).

Importantly, Thomson (2016) warns that using CHWs is not a 'cheap option' in providing universal access to health care. Task-shared interventions that use CHWs need to invest time into understanding the social, political and economic context of the intervention and appropriately develop the skills of the CHW to meet these needs. Nevertheless, accumulating evidence suggests that CHWs can be trained to deliver evidence-based therapies effectively in LMICs, thereby increasing the number of providers who can provide these complex, multicomponent psychosocial treatments (Barnett et al., 2018).

2.2.2 Treatment modalities in task sharing

The treatment modalities most commonly used in task sharing for CMDs in adults and perinatal depression are psychoeducation, cognitive behavioural therapy (CBT), interpersonal therapy (IPT), behavioural activation, and problem solving therapy (PST). For more information on each modality see Davies et al. (2019). These were all developed in HIC (Verhey et al., 2020) and have been adapted to varying degrees for use in LMICs (Section 2.3.7 discusses this further).

The most frequently used treatment for adult depression in LMICs is CBT (Cuijpers, Karyotaki et al., 2018). In brief, CBT assists in identifying maladaptive cognitive patterns and aims to replace them with reality-based interpretations and behaviours. A few systematic reviews have analysed the effectiveness of various treatment classes, although it is difficult to compare these modalities against each other in different contexts and populations. Despite this, authors have found CBT to consistently be the most effective method in improving mental health outcomes across LMICs (Barbui et al., 2020; Cuijpers et al., 2018; Dennis, 2007; Singla et al., 2017; van't Hof, Cuijpers et al., 2011). The cognitive component of CBT may be quite complex for non-specialists and participants to grasp (Chibanda, Verhey et al., 2016), which may be a hinderance to conducting it effectively in LMICs. However, Papas et al. (2010) argue that the highly structured format of manualised CBT may in fact make it more feasible for non-specialists to conduct.

For treatment of perinatal common mental disorders (PCMDs) in LMICs, psychoeducation is the most predominant (at 33.3% of interventions), followed by problem solving (23.1%), CBT (17.9%), and behavioural activation or IPT (12.8%) (Singla et al., 2017). Psychoeducation, which involves the provision of information about the mental illness and providing basic strategies to manage and cope with it, is useful for task sharing because it is easy for CHWs to implement and requires less training and supervision.

In a review of interventions for PCMDs, Clarke et al. (2013) found that CBT or IPT treatments reported much larger effect sizes for PCMD symptoms than 'health promotion' interventions. In this review, health promotion interventions involved sharing of information on perinatal health (including psychoeducation), developing skills, and increasing social support. Still, these were found to have beneficial effects on PCMDs, and may have a wider reach of women than pure psychological interventions, and have the added benefit that they tend to address some of the determinants of PCMDs, such as poor maternal health, infant mortality, and lack of social support. They can also provide women an opportunity to share concerns and feelings, and receive social support from a group, which they may not do in individualised therapy (Clarke et al., 2013).

2.2.3 Treatment for CMDs using task sharing

A number of systematic reviews and meta-analyses have examined the effectiveness of task-shared interventions for CMDs in LMICs over the years. A meta-analysis by de Silva et al. (2013) found that psychosocial interventions targeting depression in LMICs had a moderate positive effect on social functioning (standardised mean difference (SMD): 0.46, 95% CI 0.24–0.69); and another by van Ginneken et al. (2013) found that task-shared interventions may improve depression and anxiety (risk ratio (RR): 0.30, 95% CI: 0.14 to 0.64).

More recently, Singla et al. (2017) found moderate to strong evidence for task sharing in reducing the burden of common mental disorders. This review of 27 studies found stronger evidence of effectiveness of task sharing, with a pooled effect size for all CMD outcomes of 0.49 (SMD) (95%, CI: 0.36–0.62), favouring intervention conditions. A meta-analysis by Cuijpers et al. (2018) found that the overall effect of task-shared psychotherapies in LMICs was high compared to HICs, with Hedges' g = 0.73 (95%, CI: 0.51-0.96) after adjustment for publication bias, but that these results may have been influenced by comparing the intervention to treatment as usual control conditions (which usually comprises no treatment), and of lower quality interventions. The authors also state that even if these interventions are not necessarily *more* effective than those in Western countries, they are not less effective, and therefore conclude that treatment for depression in LMICs through psychotherapeutic techniques is effective.

The latest review of evidence in LMICs, an umbrella review of systematic reviews and meta-analyses of interventions treating various mental health outcomes, reported similar evidence to the previous reviews (Barbui et al., 2020). They found the most robust evidence of efficacy of psychosocial interventions to be for adults with depression in humanitarian settings (standardised mean difference (SMD): 0.87, 95% CI 0.67–1.07), and for adults with CMDs in all settings (SMD: 0.49, 0.36–0.62). They endorse the findings of the previous

studies in that “psychosocial interventions might have a clinically relevant effect” (p. 168). They go on to emphasise that “none of these effect sizes from the systematic reviews reached the maximum of the ratings in terms of strength of association and evidence of credibility” (Barbui et al., 2020, p. 168).

There is thus evidence that suggests that CHWs *can* deliver evidence-based treatments for CMDs with positive effects. However, the reviews all state that many studies are of low quality, and it is therefore hard to make assumptions about which interventions are more effective (Van Ginneken et al., 2013), and *how* they should be implemented or replicated (Barnett et al., 2018).

2.2.4 Treatment for perinatal depression using task sharing

There have been a relatively high number of task-shared interventions specifically focused on perinatal depression in LMICs. This may be due to the fact that pharmaceutical treatments for women in the perinatal period are not always safe for the foetus or for breastfeeding infants, and psychotherapies are seen as preferable (Davies, Rahman, et al., 2019). Two thirds of the trials included in the review by Singla et al. (2017) described above targeted only women, and many of these focused on perinatal depression. Three systematic reviews examining the effectiveness of interventions for perinatal mental health specifically were published in 2013, all of which found effect sizes favouring the interventions.

Rahman and colleagues (2013) identified 13 RCTs that aimed to improve mental health of women in the perinatal period in LMICs. They found a pooled effect size of the interventions on maternal depressive symptoms of −0.38 (95% CI: –0.56 to −0.21; $I2$ = 79.9%), with additional effects for children such as improved mother-infant interaction, better cognitive development and growth, reduced diarrhoeal episodes and increased immunization rates.

Clarke et al. (2013) identified 10 RCTs in LMICs using lay health workers in interventions for PCMDs, and found an overall reduction in PCMDs compared to usual care when using continuous data for PCMD symptomatology (effect size: -0.34, 95% CI: -0.53 to -0.16). Last, van Ginneken et al. (2013) also found that task-shared interventions may ‘slightly’ reduce symptoms for mothers with perinatal depression (SMD: -0.42, 95% CI: -0.58 to -0.26). As with the reviews of interventions addressing CMDs, these reviews suggest that task sharing for perinatal mental health using non-specialist workers may be effective in reducing symptoms of depression in LMICs, and in benefitting infants and children, but that the quality of this evidence remains relatively poor.

The above findings leave room for some doubt about the efficacy and replicability of findings from most task-shared interventions. However, as there is currently so little provision of treatment for mental disorders in

LMICs, and since it is unlikely that there will ever be sufficient professionals to deliver mental health care to all who require it (Singla et al., 2017), task sharing is currently the most viable approach to improving *access* to treatment for perinatal depression and CMDs (Bolton, 2019). In other words, given the fact that there is currently *minimal* treatment, some form of treatment through task sharing is better than nothing at all. In addition, there is currently no research demonstrating deleterious effects of task sharing for CMDs in LMICs. This indicates that more effort needs to be put into examining exactly *how* treatments work, so that they can more adequately address the needs of underserved communities and ultimately improve treatment outcomes (Barnett et al., 2018; Cuijpers, 2019).

2.3 Requirements for implementing task sharing

The above evidence demonstrates that task sharing can be effective and feasible for perinatal and other mental illnesses, but that it is not an outright solution for the provision of mental health services in LMICs. A number of factors need to be considered to increase acceptability and feasibility of such interventions (Padmanathan and De Silva, 2013). Some of these factors include the provision of financial resources for service provision and training, selecting CHWs who have adequate competence for counselling, training, supervision, adequately assessing and addressing need for services, adapting the intervention, considering the broader context, and looking at sustainability and scale up potential of interventions. These are applicable for perinatal depression and other CMDs and are discussed below.

2.3.1 Financial resources and remuneration

The overarching requirement for implementation of mental health services through task sharing is that of resources and financial remuneration for providers (Petersen, Baillie et al., 2012). One of the key findings from Padmanathan and De Silva's (2013) review was that a shortage of funds for hiring, training and infrastructure provision for CHWs hinders adequate service provision as planned. Many research trials have used volunteers or people who have been paid only a small stipend. Others have been paid adequately, through the research study, but are then left without job security after the research has been completed.

The lack of formal recognition, job security, or adequate remuneration means that lay health workers may not be fully committed or attracted to the work, which hinders sustainability of the service provision and completion of intervention delivery (Bolton, 2019; Padmanathan and De Silva, 2013; Petersen, Baillie, et al., 2012). In evaluating the CBT-based 'Thinking healthy programme' (THP) in Pakistan and India five years since its initiation, Atif et al. (2019) found implementation and sustainability challenges to include demotivation of

CHWs due to lack of certainty about the programme's future, and their increased requirements for financial compensation (CHWs only receive $10 a month as an incentive in these programmes).

Despite this, the THP programme is an example of the successful retention of CHWs in the intervention. Both this programme and the Friendship Bench programme in Zimbabwe (Chibanda, Cowan et al., 2017) are examples of research that has continued and transformed into integrated and continual service provision, where, in the THP for instance, 70% of the CHWs have stayed in the programme since its inception. This implies that these programmes are providing aspects that go beyond remuneration to retain their CHWs. Esponda et al. (2020) emphasise that mental health programmes in primary care need to strengthen health systems through improved financing, increasing human resources, and ensuring continuous capacity building.

2.3.2 Competence

Therapist competence is another important factor in the effectiveness and outcomes of treatment studies. This relates to "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" (Fairburn and Cooper, 2011, p. 373). It is very difficult to measure competence *before* implementing an intervention and until recently there were few standardised means to measure competence in the provision of interventions (Kohrt, Schafer et al., 2020).

Kohrt et al. (2015) acknowledged the lack of competence assessment tools in research trials and responded by developing a tool to assess therapist competence. This tool, the 'ENhancing Assessment of Common Therapeutic factors rating scale' (ENACT), can be used in training and supervision of CHWs across various settings. The authors recommend that non-specialists need to become competent in 'common factors' of therapy, before they can learn treatment specific skills.

In order to address the lack of competency assessment tools, the WHO is developing the 'Ensuring Quality in Psychological Support' (EQUIP) platform as an online resource for competency assessments to evaluate and modify trainings and curricula. This platform will also offer training modules on the common factors discussed above, in acknowledgement that these are vital ingredients for effective interventions (Kohrt et al., 2020). Kohrt et al. write that using standardised competency assessments such as the one being developed for EQUIP will aid in selection of CHWs, inform training duration and content, and provide opportunity for certification for CHWs on various skill targets (2020). This may assist recognition of competencies and capabilities of CHWs in task sharing as interventions for mental health move into an era of scaling up treatment for mental illnesses.

Having a reliable and valid competency measure will assist in better interpreting outcomes of studies, evaluating training and supervision models, and scaling up and disseminating interventions into broader contexts (Kohrt et al., 2015). Ideally, there should therefore be some form of competence assessment at the point of selection, after training, *and* during implementation, in order to maintain high levels of competency in conducting psychological counselling. These assessments should involve basic counselling skills *as well as* treatment specific factors (Pedersen, Lakshmin et al., 2020).

2.3.3 Training

Following basic competence of CHWs is the matter of training non-specialists in the provision of often complex psychological treatments. As mentioned, there is evidence of interventions that are effective, using CHWs with minimal training and supervision. However, due to financial constraints, there are usually minimal financial, time and human resources that are allocated to training of CHWs. Training quality and duration can have wide reaching implications for the effectiveness and adequate provision of services of an intervention, and effective training is a key component of successful trial implementation (Verhey et al., 2020).

Studies reporting on trials rarely provide information sufficient for replication of the training and supervision approach. In the absence of adequate training guidelines, interventions provide 'train and hope' approaches that involve brief or once-off training with limited post-training support, in the hope that it will be sufficient (Murray, Dorsey et al., 2011). Training periods for CHWs are extremely variable in RCTs for perinatal depression. Reported training periods range from three days to one month, with an average of 10 days of face-to-face training for task sharing interventions (Singla et al., 2017). Myers et al. (2019), who provided three days of training in their pilot study, found that their CHWs requested additional training to feel more confident in providing psychological counselling. The CHWs stated that they had concerns about whether the training protocols adequately prepared them for intervention delivery.

Murray and colleagues (2011) wrote an important paper proposing an apprenticeship model for lay counsellor training and supervision in mental health treatments in LMICs. The authors recommend that, following the selection of lay counsellors with a basic aptitude or interest in mental health, training should provide the foundation of basic knowledge and skills, through active, experiential learning, with the incorporation of skill practice such as behavioural rehearsal, with coaching and feedback, and small group work. They also emphasise the importance of attending to contextual factors such as identifying and utilising organisational support. They recommend that a training apprenticeship for continuous services (beyond RCTs) could last up to a year (Murray et al., 2011).

2.3.4 Supervision

Following training as the foundation for building skills, supervision is one of the most valuable elements and critical factors for effective implementation of interventions, as well as predictor of behavioural change (Murray et al., 2011; Rahman, 2007). Indeed, many of the more successful task-shared approaches in LMICs have been those with high-intensity implementation support (Barnett et al., 2018), and one study found that the inclusion of ongoing supervision was critical in influencing counsellor adherence and skill (Beidas, Edmunds et al., 2012). In South Africa, Petersen et al. (2014) found that across studies, lay-counsellors had low fidelity to counselling models, which indicated the need for increased supervision and support. They recommend using psychosocially oriented specialists to play this supervisory role.

Adequate and appropriate supervision has impacts not only on the performance of the interventions themselves, but also on CHWs sense of "belonging, morale, productivity, retention, respect and credibility with other stakeholders" (Assegaai and Schneider, 2019, p. 2). Myers et al. (2019) write that weekly supervision that includes regular re-training opportunities would encourage increased confidence and competence amongst the CHWs.

Supervision is equally critical to monitor and relieve emotional burnout and secondary trauma that the CHWs may experience in their counselling (Barnett et al., 2018). CHWs usually originate from the same communities that they serve, and therefore experience the same stressors, traumas and poverty that their clients do. This may put CHWs at risk for experiencing secondary trauma and becoming emotionally exhausted in this process. Adequate training, supervision and monitoring may assist in preventing and reducing this distress among CHWs.

Within the context of research trials, supervision is often under-prioritised because of time and financial resource scarcity, but with proper planning and budgeting this can be improved. There are more barriers to providing adequate supervision for CHWs in integrating interventions into public health service provision, and these include negative attitudes towards supervision on the part of supervisors, lack of space for supervision meetings, and not prioritising supervision amongst other clinic demands (Myers et al., 2019). The availability of a suitably qualified supervisor, particularly in rural areas, may also be a challenge.

2.3.5 Considerations of context

Intervention context can influence how counsellors are able to perform and how an intervention is received by participants (Kok, Kane et al., 2015). It is therefore essential that interventions take into consideration the broader context within which they are implemented, such as social, cultural and gender norms, values and

belief systems, education and health provision systems, and political and economic context and history. Mayston et al. (2020) examined explanatory models of depression in SSA, and found that participants identified depression symptoms as only one problem among many, and that these were consistently ranked below the economic problems that they faced. They found that depression was attributed largely to social adversity, economic and relationship problems, and HIV-related issues.

Much intervention research using CHWs to treat mental disorders in LMICs does not discuss the context within which interventions are situated, or the implications of context for CHWs and implementation (Kok et al., 2015). Frymus et al. (2013) endorse that most studies do not incorporate or report on factors of context, even though it has important implications for the performance and motivation of CHWs. In South Africa, Colvin and Swartz (2015) wrote that in order to properly understand and support CHWs, we need to begin by conducting a much broader analysis of the health system and political context. Thus, a deeper understanding of community structure, history and services, is integral to implementing services in a community (Thompson et al., 2012).

2.3.6 Addressing need

The review by Padmanathan and De Silva (2013) highlighted that often, interventions did not adequately respond to the problems that participants face or satisfy the need that they really had. This is directly related to the consideration of context mentioned above, but with the focus on participants themselves *within* their contexts. The consideration thereof would have impacts on adherence to interventions, as well as improved 'usefulness' to target populations, and would likely impact their effectiveness. Padmanathan and De Silva relate that interventions that have been locally adapted or developed have a greater level of satisfaction for participants, such as those conducted by Balaji et al. (2012) and Rahman (2007).

One means of addressing this need is by gaining an understanding of local experiences of depression: how depression is defined, experienced, and treated. Research that takes into account local understandings and responses to mental illnesses may encourage agency of participants, and improve the acceptability and uptake of interventions (Campbell and Burgess, 2012; Mayston et al., 2020). An example of this identified need is of a study conducted with San communities in South Africa (den Hertog, Maassen et al., 2020), where the interviews with participants relayed that depression should be understood "beyond individual suffering" and taken into the greater social and political environment. The authors recommend that interventions should therefore take into account multiple levels of need within this context, that addresses "socioeconomic conditions, strengthens local resources, and fosters collaboration among locally appropriate informal and formal support structures" (den Hertog et al., 2020, p. 10). Thus an exploration of local needs and what

treatments and resources are acceptable for mental illnesses is essential for intervention acceptability (Bolton, 2019; Mayston et al., 2020)

The identification of local forms of treatment may be a more difficult task, because the general population, especially an untreated one, may not know what form treatment *could* take (Bolton 2019). It would therefore be important to delve deeply into cultural and historical practices of healing and recovery from trauma, in order to access some of these methods and more acceptable forms of treatment. This links with a possible issue of using 'talk therapy' in societies that are not accustomed to traditional forms of psychotherapy and may use more embodied methods such as community rituals, dancing, drumming and singing (Moodley and West, 2005).

2.3.7 Cultural adaptation

Another key issue that remains to be resolved for task sharing is the adequate adaptation of interventions for local culture and context, while still achieving intervention fidelity (Healy, Kaiser et al., 2018). Most psychotherapies for depression were developed in high-income Western cultures (Verhey et al., 2020), and initially, task sharing in LMICs largely involved testing the effectiveness of these psychotherapies (Bolton, 2019). Murray and Jordans (2016) point out that "mimicking mental health care delivery approaches from HICs may not be sustainable in LMICs because there are such great differences in funding, personnel and infrastructure" (p.5).

Research has shown that adjustments or adaptations to Western developed psychological interventions increase acceptability, feasibility and effectiveness for non-Western settings (Bolton, 2019; Naeem, Waheed et al., 2010). Adaptation can include language translation, culturally acceptable forms of healing, and involving cultural rituals (Wampold, 2015). A fully adapted treatment should explain material in a way that is understandable to both counsellors and clients (Bolton, 2019).

Chibanda and colleagues (2017) demonstrated a thorough adaptation and integration of the Friendship Bench problem solving therapy (PST) intervention in Zimbabwe through a four year long iterative adaptation process. The authors used peer interaction and sharing of personal experiences to incorporate locally generated indigenous terms to re-frame concepts of PST, while still maintaining fidelity to the aims of the Friendship Bench programme (Chibanda et al., 2017). Through conducting this type of adaptation, an ownership of the intervention was created, along with a deeper understanding of the concepts of the therapeutic intention.

In recognition of the need for localised adaptation of interventions, Bolton (2019) recommended following seven steps for adaptation:

1) Preliminary understanding of local priority mental problems
2) Selection of treatment approach
3) Conversion of manual and training materials into simple language
4) Translation of the manual and training materials into local language
5) On-site provider training
6) Piloting
7) On-going adaptation

Following these steps may be extremely helpful for interventions to be more responsive to need, address the need correctly, experience less attrition, attain better outcomes, and be more sustainable for scale up into the greater community.

In conclusion, there are many elements that need to be considered for task sharing to be appropriate and acceptable to local populations, as well as feasible for scale-up and long-term sustainability. It is increasingly acknowledged that in-depth consultation and co-development of interventions with CHWs and service users is essential. This would consider the socio-political context in which the population is situated and assist in responding to identified needs, ultimately leading to improved treatment outcomes.

2.4 Mechanisms of change in task-shared interventions

In addition to the practical elements that contribute to the effectiveness of counselling interventions, there is increasing awareness of the importance of the mechanisms of change or therapeutic elements within counselling sessions. Until recently, there has been little research on the mechanisms of change within task-shared counselling sessions in LMICs, with most of the research having been conducted in HICs with professional psychologists (Norcross and Lambert, 2018). There is thus a movement to start identifying what elements are effective in therapy using CHWs, rather than simply testing whether a particular treatment modality works. Authors who have begun to conduct this research within task sharing include Jordans et al. (2012), Singla et al. (2017), Cuijpers (2019), and Mayston et al. (2020).

2.4.1 Therapeutic elements

Singla et al. (2017) conducted a pivotal review of the implementation processes and effectiveness of psychological treatments for adult CMDs and PCMDs in task-shared interventions in LMICs. In the review they analysed not only the most commonly endorsed elements of treatment but also the elements with the

strongest associations with treatment outcome. This analysis heads in the valuable direction of identifying the actual elements or mechanisms of effective treatment. The review included 27 task-shared interventions in LMICs. They found that the strongest associations were with the following therapeutic elements:

1) interpersonal elements (β = 0.442, p = 0.029). These were: identifying or eliciting social support, communication skills, assessing relationships

2) emotional elements (β = 0.415, p = 0.046): identifying/eliciting affect, linking affect to events, emotional regulation, emotional processing, and

3) nonspecific (engagement) elements (β = 0.409, p = 0.052): collaboration, empathy, active listening, normalisation, involvement of significant other.

Research conducted by Jordans et al. (2012) with children in Burundi found that it was the use of particular treatment mechanisms by the counsellors that predicted positive changes in depression and anxiety, rather than through a specific treatment modality. The authors identified five treatment mechanisms associated with outcome trajectories, being client centeredness, therapeutic alliance, active problem solving, trauma focused exposure, and family involvement. Interestingly, although there were issues with translating Western-oriented psychotherapeutic concepts into a culturally different context, there were still therapeutic elements or 'working mechanisms' that lead to the reported therapeutic effects.

Although North America-based, Norcross and Lambert (2018) identified the most 'demonstrably effective' elements in therapy through their 'Task Force on Evidence-Based Relationships and Responsiveness'. These elements were collaboration, goal consensus, cohesion in group therapy, empathy, therapeutic alliance, positive regard and affirmation, and collecting and delivering client feedback. These endorse those found by Singla et al. (2017), even though they were not from task-shared situations.

2.4.2 Therapeutic alliance

As a therapeutic element, the therapeutic alliance may be the most important factor for treatment effectiveness, and is a necessary target of therapy (Cuijpers, 2019, p. 281). This alliance involves the bond between the therapist and client, agreement about the goals of therapy, and agreement about the tasks of therapy (Wampold, 2015), or the "collaborative nature of the patient-therapist interaction, their agreement on goals, and the personal bond that emerges in treatment" (Kazdin, 2009, p. 420).

Many authors further confirm that the therapeutic alliance contributes to treatment outcome independent of the type or modality of therapy (Barth, Lee et al., 2012; Norcross and Lambert, 2018; Timulak and Keogh, 2017).

Indeed, two of the three key effective elements identified by Singla et al. (2017) were interpersonal elements and engagement elements, both of which are core to the therapeutic relationship.

Wampold and Budge (2012) wrote that the alliance with a therapist is therapeutic because it involves a significant other who is genuinely invested in the clients' wellbeing. Wampold later wrote that psychotherapy should provide a client with a human connection, which, if appropriate, will be health promoting and healing *in itself*, particularly in contexts of social isolation and insecurity. This connection could be described as attachment, belongingness, social support, or the lack of loneliness (Wampold, 2015). Within task-shared interventions in LMICs, Mayston et al. (2020) reported that many studies emphasised the therapeutic effects of connection with others, and that through being able to share problems, participants were able to heal and experience the preventative effects of social interaction.

2.4.3 Common elements

Researchers are now acknowledging that many of these therapeutic elements span across most forms of treatment or therapeutic modality and refer to them as common elements or common factors. These are described differently by different scholars, but in the main, relate to the therapeutic relationship established between client and counsellor. Warmth, empathy, genuineness, trust and rapport-building are common threads, along with other skills such as incorporating client's expectations, using culturally appropriate concepts for distress, and promoting hope and expectations for recovery through procedures or rituals acceptable to the client (Barth et al., 2012; Cuijpers, Reijnders et al., 2019; Laska, Gurman et al., 2014; Pedersen et al., 2020).

Wampold (2015) developed the 'Contextual Model' of common factors, based on a large body of previous research. In this model, therapy is hypothesized to work through three pathways, following the initial establishment of a therapeutic relationship. The first pathway is the creation of the 'real' and personal relationship between client and therapist through connection to a caring and empathic person. This is marked by genuineness in interactions with each other. The second pathway is the creation of expectations and hope, through explanation of the disorder and its causes, what the treatment will involve, and a means to cope with problems. Wampold writes that the therapy should give clients hope that they are capable of completing the therapeutic tasks, and that when the tasks are completed, they will be able to cope with their problems. The third pathway involves the ingredients of specific therapies or health promoting actions, which would differ depending on the type of therapeutic modality. An explanation of the particular therapeutic ingredients that the client finds acceptable, should again create expectations from the client that the therapy will be helpful,

leading to subsequent actions toward greater mental health. In sum, Wampold argued that if the treatment elicits healthy client actions, it will be effective, no matter the treatment type.

2.4.4 Acknowledgement of clients' background

There is also evidence of the value of acknowledging clients' backgrounds and economic situation in low income settings, and the subsequent incorporation of practical methods to deal with problems related to this, in therapy. Two studies conducted with low-income women in the USA suggest that participants found therapy to be effective when their therapists were aware of the nature of poverty and poverty-related stressors, and had some direct exposure to poverty themselves (Pugach and Goodman, 2015; Thompson et al., 2012). In addition, both studies identified instrumental support as a key factor that participants found meaningful and which was in fact identified as an essential element of therapy. This included instances of identifying resources for food or financial support, acts of advocacy or alliance with the participant, practical support (such as searching for housing resources, provision of material items, assistance with paperwork) or referrals. Interestingly, when therapists did not offer this kind of support, "some participants felt that the therapy seemed irrelevant to their real lives" (Pugach and Goodman, 2015, p. 413).

An example of the above was demonstrated through the process evaluation conducted by Rahman (2007), that unpacked the implementation of the THP trial in Pakistan. The study reported that because the CHWs were from the same communities as the participants and were aware of community resources, the CHWs were able to help participants in valuable practical ways. For example, one CHW motivated a participant to take out a small loan to buy a buffalo to produce milk to sell, which ultimately led to a marked improvement in self-worth, confidence, finances, and in depressive symptoms. Another CHWs set up a neighbour support group which significantly helped a socially withdrawn mother. A third CHW intervened in a participant's experiences of IPV by speaking to the participant's husband's spiritual mentor who then counselled the husband, leading to a marked improvement in his behaviour (Rahman, 2007).

This example is included in full to demonstrate the relevance and value of CHWs coming from the same community as the participants. Because of their understanding of the context and insight into the available resources and support within communities, they were able to help participants practically, going beyond basic psychosocial counselling. This is a strength for task-shared interventions, and highlights that in low-income situations particularly, therapists need to treat the 'whole person' in their contextual system, rather than focusing exclusively on symptoms of mental illness (Thompson et al., 2012).

There are thus a variety of therapeutic mechanisms that can be used in task-shared interventions for perinatal and general CMDs that span across different treatment modalities. In combination with responding to contextual need and the other requirements for task sharing discussed above, these mechanisms need to be incorporated into future treatment programmes, with a prioritisation of training and competency in these elements (Jordans et al., 2012; Singla et al., 2017).

2.5 Research in task sharing

The implementation of mental health research interventions is growing rapidly, with 70% of studies conducted globally having been undertaken since 2010 (Barnett et al., 2018). Conventionally, this has taken the form of relatively brief formative and feasibility research, and a subsequent randomised controlled trial to test the effectiveness of a specific treatment modality against a control or treatment as usual condition. More recently, process evaluations are being implemented to assess more intricate elements of RCTs and interventions in the move to understand the processes and mechanisms behind effectiveness of RCTs. This section documents research methods commonly used in the development and adaptation of task-shared mental health interventions in LMICs.

2.5.1 Formative research

In task-shared interventions, formative research is conducted before RCTs are implemented, to assess the 'feasibility and acceptability' of an intervention before it happens. To a large degree, formative studies assess the practicalities of implementing a chosen intervention (e.g. CBT) to a chosen population (e.g. perinatal depression), usually with pre-chosen implementers (e.g. CHWs). The studies examine aspects such as language required, locality or place of counselling, group or individual preference, demographic of CHW preferred, number and duration of sessions, and training or resources required to implement the intervention. Some feasibility studies include a pilot of the intervention too.

Myers et al. (2019) provide a useful example of a study where a brief counselling intervention was piloted with patients who had diabetes or HIV comorbid with depression or substance abuse problems. Interviews were conducted with CHWs to assess feasibility and acceptability of the intervention in Cape Town, South Africa. The intervention was deemed feasible and acceptable to CHWs but uncovered some needs which led to alterations to the recruitment protocol, content of the intervention, training duration, and supervision content for CHWs. Rahman (2007) also wrote about how he and others developed their psychological intervention for depressed mothers in Pakistan in their formative research, through the exploration of CHWs' current experiences of providing health care, local health beliefs, and day-to-day activities. This was done so that

interventions could be appropriately integrated into their normal and routine work. This depth of the feasibility assessment may have contributed to the success of the later intervention (Rahman et al., 2008).

Formative and feasibility research are vital in the development and implementation of interventions. In this, they should go beyond assessing how to address the practical elements of an already selected intervention, to investigate true contextual need, and the type of response required to match this need (Bolton, Lee et al., 2014). This can be done through a consultation with all stakeholders involved, to obtain opinions on true need, treatment type, delivery and sustainability, and adequacy of training and supervision (Padmanathan and De Silva, 2013). This type of research can then lead to a 'co-production', or 'co-development' of interventions (Burgess et al., 2020), that may be more relevant and appropriate for specific target populations.

One method of co-producing interventions may be through conducting participatory research, which can assist in gaining insights into the roles of the health system and the individuals involved, as well as giving a voice to CHWs and those with mental illness (Frymus et al., 2013). Participatory evaluation methods can assist in building the understanding between social determinants, mental health, and other outcomes going forward (Burgess et al., 2020).

Petersen and colleagues (2012) provide an example of using a 'participatory implementation framework' with local communities to inform the design and development of their manualised group-based interpersonal therapy (IPT) for depression. This process allowed for the involvement of community members in the development and creation of the manualised intervention. This foregrounded local knowledge from community members themselves on interventions to mediate pathways to health, as well as how to manage problems within the cultural and contextual constraints of lived realities. Through this participatory research, the authors were able to develop a more 'culturally competent' intervention than one simply imposed on the community, encouraging personal empowerment of those receiving care, as well as a cognisance of the social determinants of mental illness (Petersen, Baillie, et al., 2012). The subsequent intervention demonstrated significant improvements in depression scores on the Patient Health Questionnaire (PHQ9) for the intervention group at three month follow up (Petersen, Hancock et al., 2014).

A similar participatory process was followed by Chibanda and colleagues (2017) in the development and adaptation of the Friendship Bench problem solving therapy intervention for CMDs in Zimbabwe, which also demonstrated significant effects in this population (Chibanda, Weiss et al., 2016). This process was described in the section on adaptation above.

2.5.2 Reporting of feasibility studies

Reporting of feasibility studies is essential for sharing findings and learning from other research (Damschroder, Aron et al., 2009; Hoddinott, 2015). Yet, there may be a risk in reporting that task-shared interventions are feasible and acceptable to certain populations before intervention results are assessed. If the trials are not successful or effective, these statements may provide misinformation about the appropriateness of an intervention to a specific context.

For example, one systematic review of 13 mental health interventions for PCMDs conducted by CHWs in LMICs stated that "studies provide evidence of the feasibility of training such workers to deliver mental health interventions effectively in a relatively short time" (Rahman et al., 2013, p. 598). However, this type of evidence provides little mention of the competencies, training and supervision of the counsellors themselves, or other mechanisms at play, in reaching the effective trial results that were found in the review.

More recently, a systematic review of RCTs and qualitative studies was conducted to examine the implementation outcomes of 18 CBT interventions for CMDs delivered by non-specialists in LMICs (Verhey et al., 2020). The authors stated that "findings suggest that delivery of CBT-based interventions by [non-specialist health workers] NSHWs can be acceptable, appropriate and feasible in LMICs settings" (p.1). In this review, there are publications that state the 'feasibility and acceptability' of their interventions before they were implemented, without consideration of the final outcome results of these interventions. Indeed, some of the interventions included in the review did not in fact show significant effects from their interventions in their outcome assessments.

Statements from feasibility research should potentially, therefore, be reviewed on an ongoing basis and at completion of trials, and should be reported and published *with* outcome results in order to demonstrate true feasibility or acceptability of an intervention (Hoddinott, 2015). Selohilwe et al. (2019) provide an example of this in their paper that reports outcome data *and* process evaluation findings of their depression counselling intervention for chronic care service users. This paper describes the intervention effects, while also exploring the qualitative benefits of counselling that participants experienced, and the real-life barriers to session attendance for participants that had an impact on retention to the counselling. This enables a far deeper understanding of the processes that occurred during implementation of the intervention, and leads to a much fuller understanding of how and why the intervention had the impacts that it did, and subsequently, how this could be scaled up and replicated.

2.5.3 Randomised controlled trials

Randomised controlled trials have traditionally been viewed as the most scientifically rigorous method for assessing change over timepoints in psychological, behavioural or medical interventions. RCTs use one or more intervention groups and compare these to a control group – which receives either no treatment, a placebo, or another form of 'standard care' within the current care system. Treatment is standardised as far as possible so that the 'dose' remains consistent across participants.

RCTs were originally designed to test biomedical interventions, often using specific drugs and placebos. They may not be optimal for testing real-world psychosocial interventions, especially in LMICs. Criticisms of RCTs, particularly in task-shared situations, include that they prioritise internal validity over external validity, and are specific to the context they are provided in, meaning that the findings may not be generalisable across differing cultures or populations (Kaplan, Giesbrecht et al., 2011; Mulder, Murray et al., 2017). In behavioural interventions, particularly task-shared ones in LMICs, outcomes are likely to be influenced by multiple factors that cannot be controlled for, such as personality types of counsellors, learning and counselling abilities of CHWs, and socio-cultural and economic factors affecting counsellors and participants.

Research to investigate the effectiveness of task-shared interventions for mental health thus needs to build upon the traditional format of testing a clinical intervention against a control, in the acknowledgment that information more relevant to contextual influences and responses needs to be collected and analysed, with the ultimate goal of increasing and improving service provision to those most at risk.

2.5.4 Process evaluations

RCTs may demonstrate that a particular modality is effective in treating a mental illness against a control, but as Kazdin (2009) argued, we still "cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change" (p.426). Mulder (2017) confirmed this by writing that psychotherapy research has historically paid "disproportionate attention to treatment outcome, with relatively little attention to the mechanism of action of psychotherapies" (p.953).

Process evaluations may be one means of complementing RCTs to include the assessment of mechanisms of change within interventions. Moore et al. (2015) describe the purpose and function of process evaluations as being to gain understandings of the pathways that link the theory underlying an intervention and its causal assumptions, to the outcomes produced. This can be done through examining contextual factors,

implementation factors, and mechanisms of impact, and the links between these. The framework created by the authors is reproduced below to demonstrate these key functions (Figure 1).

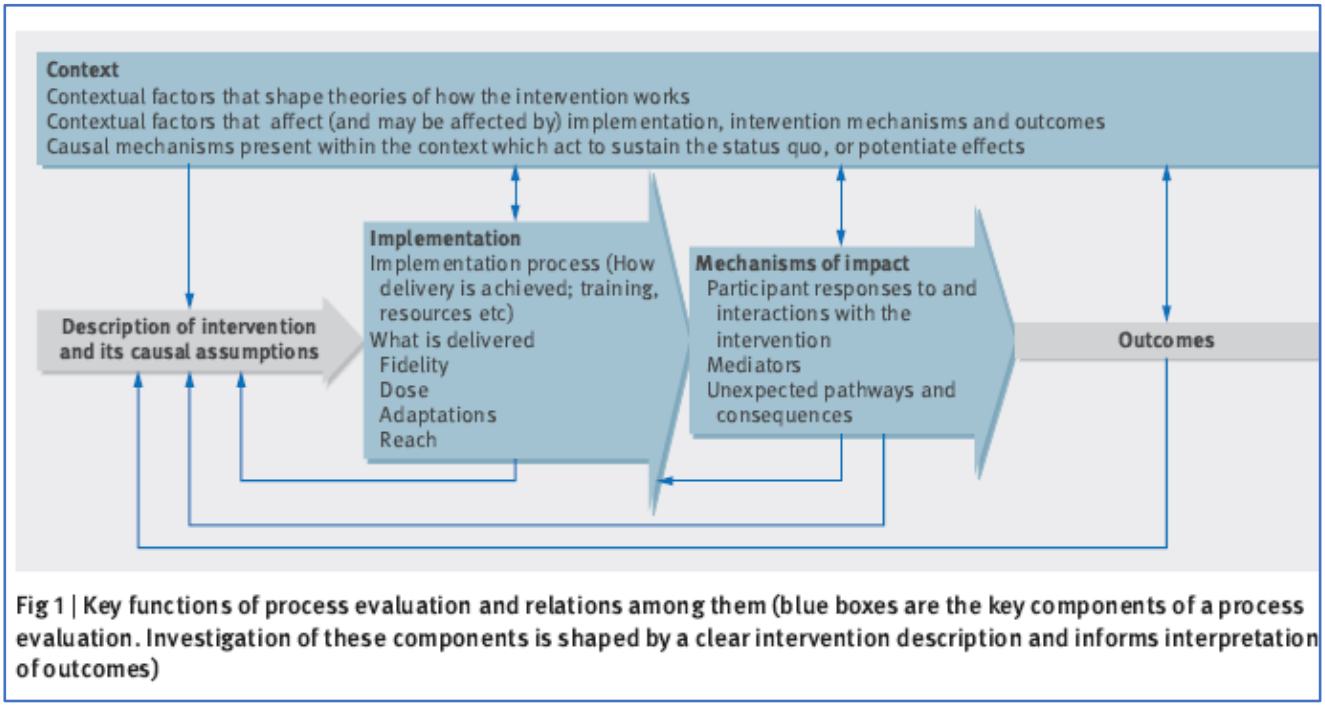

Figure 1: Key functions of process evaluations and relations among them (Moore et al., 2015)

Process evaluations are a fundamental necessity for research trials. As Cuijpers et al. (2019) point out, we need to examine not just *whether* an intervention works (through RCTs and statistical outcomes), but *how* it works, in order to start improving the effects of therapies. Transference from one successful trial to another context would not be appropriate or feasible unless the mechanisms of effectiveness are understood, and subsequently reported for others to learn from (Hoddinott, 2015).

Equally important, when a trial shows non-significant results, is to investigate what happened in the implementation process, to find out what got 'lost' between the theory, implementation, and actual reception by participants. These evaluations need to be done in order to make recommendations and contribute to improving intervention effects in similar low- and middle-income settings where context (largely poverty-related) plays an integral role in the effectiveness of interventions. Unfortunately, evidence reporting the implementation processes of mental health programmes in LMICs is still scarce (Esponda et al., 2020).

Ideally, process evaluations should be conducted throughout an intervention to access information from CHWs about what challenges they and the participants are facing and what needs they have (Frymus et al., 2013), and to evaluate whether the intervention is being received as intended. There are a few process evaluations

that have been conducted of task-shared interventions for CMDs in LMICs that provide useful insights into the processes, facilitators and barriers that arose in conducting these trials. Each evaluation focuses on different aspects that they aimed to discover from the evaluation, and thus results are relatively study specific. They range from identifying barriers and facilitators to implementation, uptake and retention in sessions, to identifying treatment mechanisms and optimal factors of therapy for participants.

Four key process evaluations have examined interventions for CMDs in LMICs. Two concentrate on identifying the mechanisms that led to effective or non-effective treatment in the interventions. These were evaluations of group IPT for depression in KwaZulu-Natal, South Africa (Petersen, Bhana et al., 2012), and of psychosocial counselling for children in Burundi (Jordans et al., 2012). Petersen et al. found that improved social support, individual coping skills and improved personal agency assisted in the reduction of depressive symptoms, and Jordans et al. found specific treatment mechanisms to be client centeredness, therapeutic alliance, active problem solving, trauma focused exposure, and family involvement.

The other two evaluations examined the barriers and facilitators to session attendance, uptake of practices and content, and training and supervision. These were evaluations of group-based counselling for depression comorbid with chronic conditions in KwaZulu-Natal (Selohilwe et al., 2019), and of an integrated mother child parenting intervention in Uganda (Singla and Kumbakumba, 2015). Selohilwe et al. found that session attendance was hindered by women's caregiving burden, poor counsellor attributes and poor referral processes, and Singla and Kumbakumba found that detailed manual and structured monitoring forms helped to facilitate training, supervision and delivery.

A few process evaluations have been conducted for perinatal depression specifically, in LMICs. Rath et al. (2010) evaluated a women's group-led community mobilisation intervention on maternal and new-born health outcomes and found that six broad factors positively influenced the intervention's impact. These were: acceptability of the intervention to the population, a participatory approach to the development of knowledge, skills and 'critical consciousness', community involvement beyond the groups, a focus on marginalized communities, the active recruitment of newly pregnant women into groups, and a high population coverage (p.11).

In a process evaluation of the THP programme for perinatally depressed women, Rahman (2007) reported a number of factors that influenced impact and evaluation. These included having a flexible approach to implementing and providing the intervention, the importance of the CHWs position and resourcefulness in the community, the importance of understanding that women's depression can often be traced to social and

economic circumstances in their lives, and the importance of generating indigenous solutions to problems. The success of the intervention also depended on the supervisors' experience of CBT and the motivation and interest of CHWs, which can be enhanced by regular supervision and monitoring.

Munodawafa (2018) conducted an evaluation of the barriers and facilitators to the delivery of the AFFIRM-SA intervention. Findings were reported in Section 1.2.4. In summary, barriers to conducting and receiving counselling sessions included "poverty, crime, and lack of space to conduct counselling sessions", "the nature of the participant's problem, young age of participants, avoidance of contact with counsellors" (p.62), and "unplanned pregnancy, interpersonal difficulties and location of the counselling" (p. 84). Facilitating factors for counsellors included "the content of the intervention, ongoing training and supervision, using a counselling manual, conducting counselling sessions in the local language, fidelity to the manual, and counsellors' confidence and motivation to conduct the sessions" (p.62). Participant facilitators included "willingness to learn new skills and change behaviour, counsellor's motivation and empathy towards participants, and the content of the intervention" (p 84).

The above evaluations are helpful in recommending contextual considerations but are relatively study specific. A systematic review of the identified processes, mechanisms, and facilitators to intervention implementation, uptake and efficacy would be helpful in consolidating these findings so that they are more readily accessible for researchers conducting similar interventions.

2.5.5 Implementation science

In addition to process evaluations, 'implementation science' is gaining recognition in research on task-shared interventions for mental health in LMICs, including perinatal depression. Implementation science has been defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles and Mittman, 2006, p. 1). Implementation science research attempts to gain a deeper understanding of why or how treatments work or do not work, through the assessment of factors such as therapist competence, treatment quality and mediating variables (Singla and Hollon, 2020). It evaluates the extent to which interventions benefit the participants, prolong sustainability, and include dissemination of findings to other contexts (Damschroder et al., 2009).

Damschroder et al. recommend that implementation science incorporate the assessment of progress and barriers and facilitators *during* implementation in order to identify and rectify these if needed (2009). Following this, they recommend building on traditional outcome assessments at post-intervention, to include exploration

into what factors influenced the intervention, and how the implementation itself influenced actual performance of the intervention. Last, they emphasise the process of organising and promoting the research findings, which is important in developing theory, and sharing knowledge and information across research studies (Damschroder et al., 2009).

More recently, Singla and Hollon (2020) set out three important criteria for implementation research and the examination of *how* treatments can be effective. These are: 1) an ongoing examination of relevant implementation factors related to the therapist and treatment; 2) moderation, mediation and cost-effectiveness analyses to assess strengths and challenges of interventions; and 3) linking therapist competence with treatment outcomes, using digital methods to ensure acceptable training and supervision. The authors recommend using implementation science to study client, therapist and treatment factors that complement traditional treatment effectiveness analyses. Conducting these examinations is necessary to help scale up psychological treatments and subsequently, to better address the burden of CMDs globally.

In summary, research into task-shared interventions therefore needs to undergo a shift from the current focus of RCTs on 'effectiveness outcomes', towards an inclusion of formative research for co-development of interventions and the use of process evaluations and implementation science research. This research needs to include the analysis of empirically validated working mechanisms, to identify the exact mechanisms of treatment outcome and how best to utilise non-specialist workers in mental health interventions (Cuijpers et al., 2019; Singla and Hollon, 2020).

2.6 Looking ahead for task-shared interventions

There is growing recognition that many of the current solutions to mental illnesses may not be optimal in improving mental health, and there are still many questions around how to scale-up the use of non-specialists in the provision of mental health care (Barnett et al., 2018). There are a few potential areas for improving the responsiveness, appropriateness and effectiveness of task-shared interventions for mental health in LMICs. These are covered briefly.

The first is that of addressing social determinants and the risk factors that can trigger the presence of mental disorders (Patel et al., 2018). Burgess et al. (2020) wrote an important commentary articulating the difficulty for psychosocial interventions to improve mental health and wellbeing against the backdrop of 'intractable' social and environmental determinants of ill health, many of which are an every-day reality of the lives of people in LMICs living in poverty. They acknowledge the impacts that social, economic, and political factors

play on mental health, and that psychosocial interventions in the past have been ill-equipped to deal with these broad determinants. This is endorsed by a recent United Nations report on mental health (UNHRC, 2019) and the Lancet Commission on global mental health and sustainable development (Patel et al., 2018).

Burgess et al. (2020) propose that psychosocial prevention, promotion, and treatment interventions begin to expand the 'social elements' of interventions through a commitment of five key elements. These are:

1) Hold community empowerment as the key factor in the development of mental health interventions and mental health promotion
2) Provide further evidence to demonstrate the benefits of community led interventions such as social programming and social interventions as mechanisms for improvement in mental health
3) Prioritise service user, community knowledge, and ownership in the process of intervention design, from inception to implementation and delivery
4) Transition to people-centred health systems and services, to include responses to socio-structural issues, to enable combined action on social and health challenges
5) Further develop the understanding of the relationship between interventions that address social determinants (such as cash transfers or gender empowerment programmes), with mental health outcomes and other social, economic, and health trajectories, especially among young people.

The authors stress that implementing the above will require the buy-in of "a range of policy partners, funders and, most importantly, local communities" (p. 2). The use of participatory research will be crucial for this endeavour (Mayston et al., 2020).

Second, stepped care is another element that can be employed in resource-poor environments (Hanlon, Fekadu et al., 2014). This can involve a number of elements, beginning with, for example, psychoeducation for any at-risk individuals, and then group psychosocial interventions for anyone identified with moderate to severe mental disorders, with referral to specialists only for suicidality or severe and unmanageable disorders (Davies, Rahman, et al., 2019). This mode can improve efficiency and capacity to treat more people in LMICs (Hanlon et al., 2014). One method of using stepped care for perinatal depression is described by Atif et al. (2019). The authors recommend a system of risk assessment, psychosocial treatment, and referral and specialist support where necessary, in a programme that acknowledges the complicated factors of IPV and poverty that usually accompany perinatal depression.

Third, in recognition of the growing need for responses to multiple and comorbid mental illnesses in LMICs, Murray and other researchers have proposed a 'common elements intervention approach' (CETA). This uses

evidenced-based common elements that are adaptable for different symptoms and severity levels of various mental illnesses (Murray and Jordans, 2016). A few interventions have tested the effectiveness of CETA in Iraq, Thailand, Ethiopia and Zambia, and have shown significant effects in all four studies (Bolton et al., 2014; Murray, Hall et al., 2018; Murray, Kane et al., 2020; Weiss, Murray et al., 2015). The researchers acknowledge that although more studies are required, the results suggest that it is possible for non-specialist workers to learn a simplified common elements approach, and that the elements in CETA are "collectively as effective or more for comorbid presentations in comparison to single disorder treatments or control conditions" (Murray and Jordans, 2016, p. 3).

There is also a growing impetus to use and test the effectiveness of mobile and internet-based forms of therapy. For example, Epping-Jordan et al. (2016) have designed a 'Self Help plus' stress management course to assist people (particularly in humanitarian crises) with stress, anxiety and adversity, using a guided self-help format and delivered through pre-recorded audio courses, complemented with bibliotherapy. Other interventions include video teleconferencing, text messaging, smartphone-based applications and social media platforms. These have started to prove helpful and increase response rate and individual resilience, particularly in war and disaster settings (Ruzek, Kuhn et al., 2016). In addition, mobile-based technology can be used to assist with training and supervision of non-specialists through programmes such as the 'Technology Assisted Cascaded Training and Supervision System' (TACTS), currently being tested by Rahman and colleagues in Pakistan (Rahman, Akhtar et al., 2019).

It can be seen that there are growing options for the creation of task-shared interventions that are more responsive and appropriate to contextual need and local capacity. Many of these lend themselves to being scaled up in order to provide mental health care for the great number of people who are in need of it.

2.7 Conclusion

The above review has examined the literature around factors related to the treatment of perinatal depression and CMDs in LMICs in general and South Africa specifically. The significant gap in the availability of services to address these illnesses has serious implications for women with perinatal depression and their foetuses and infants. Various risk factors and social determinants typical of LMICs are strongly associated with the presence of perinatal depression, specifically poverty, poor education, food insecurity, intimate partner violence, an unwanted pregnancy, and HIV/AIDS.

Task sharing has been proposed as a means to address the treatment gap through the use of non-specialists and community health workers, under supervision from mental health specialists. While there is evidence of effectiveness of task-shared interventions for CMDs and perinatal depression, there remain many challenges in implementing these interventions in a manner that is feasible, acceptable and contextually appropriate both to the participants receiving them and to the CHWs who are implementing them.

Research is beginning to examine elements that have been found to be effective within therapeutic contexts, although this is still limited for task-shared interventions and for perinatal depression. Those that have been noted include identifying or eliciting social support, communication skills, assessing relationships, identifying/eliciting affect, linking affect to events, emotional regulation, emotional processing, collaboration, empathy, active listening, normalisation, involvement of significant other, therapeutic alliance, and connection (Cuijpers et al., 2019; Singla et al., 2017; Wampold, 2015). Developing a deeper understanding of depression and its locally related causes is also essential in creating contextually relevant interventions.

The review also presented various challenges in developing and assessing task-shared interventions. The inclusion of participatory formative research, process evaluations and implementation science may assist in developing more relevant, responsive and acceptable interventions for improving mental health in LMICs. Many examples from the review demonstrate the significant and far-reaching impact that social determinants and risk factors have on perinatal depression in LMICs. It appears that as yet there is no knowledge of how interventions that are psychosocially oriented may be able to address some of these risk factors which would ultimately break the 'vicious cycle' of poverty and mental illness. Elements such as addressing social determinants, eliciting community involvement in treatment, using a stepped care model or a common elements model, and using mobile and internet-based forms of therapy, are proposed as methods to scale up service provision and improve the responsiveness, appropriateness and effectiveness of task-shared interventions for mental health in LMICs.

2.8 Rationale for the thesis

There are several gaps in research highlighted in the above literature review that this study aims to address. First, despite the high burden of perinatal depression in LMICs, including South Africa, and the implications this has for offspring of women with perinatal depression, there is still limited research on local understandings and idioms of perinatal depression in LMICs. There is a small research base now building around identified causes of perinatal depression, but more research is required into perspectives from women themselves on

their explanatory models and what modes of interventions or elements of therapy they might appreciate during the perinatal period.

Second, research into task-shared interventions for mental illnesses has increased considerably in the last decade, and there is growing evidence of their effectiveness. Yet, little known about which interventions are optimal for which contexts, and more importantly, *how* these interventions work or don't work (Barnett et al., 2018). Knowledge on what elements are therapeutically effective within *task-shared* interventions is also still limited, particularly for interventions for perinatal depression. Singla et al. (2017) provide a good base from which to conduct additional research on what elements are optimal for use in task-shared interventions for PCMDs.

Third, there is limited research on *how* non-specialists or CHWs implement task-shared interventions, as well as how participants receive these interventions. With the exception of Jordans et al. (2012) who used counsellor session notes, process evaluations of the implementation of task-shared interventions conventionally elicit participant perspectives on an intervention through the use of semi-structured interviews and focus groups either before, during or after interventions (e.g. Rath et al. (2010), Rahman (2007), Munodawafa et al. (2018) and Petersen et al. (2012)). It appears that there have not been any large-scale evaluations of task-shared interventions that examine actual intervention implementation, such as through an analysis of the session transcripts themselves.

Fourth, there are very few process evaluations of task-shared interventions for perinatal depression as yet. Those that have been conducted provide relatively study-specific findings. As the body of reporting grows, it is hoped that findings can be collated to create and inform more responsive interventions that are relevant to perinatal distress and task sharing. Linked to this is the assessment of capability and capacity of CHWs to conduct psychological interventions. This is an integral element of the success of task sharing but is not commonly examined in relation to the overall effectiveness outcomes of interventions.

Last, being a relatively new field, there is limited reporting and documentation of interventions that have not shown significant effects, or an examination of the factors that may have led to the non-significant or negative effects. Given the amount of time and financial resources invested in RCTs, it is an ethical obligation to investigate the mechanisms and processes behind significant and non-significant outcomes of an intervention, and share these lessons and recommendations to inform the development of future interventions (Cuijpers et al., 2019; Singla and Hollon, 2020). As described in Chapter One, the AFFIRM-SA RCT did not show significant effects in reducing depressive symptoms for the intervention arm on the Hamilton Depression Rating scale

(HDRS). However, there *were* significant effects shown on the Edinburgh Postnatal Depression Scale (EPDS) tool. A process evaluation provides an opportunity to examine the mechanisms that led to both the reported significant and non-significant outcomes, which will then contribute important knowledge to the field of task sharing for common mental disorders.

Chapter 3. Thesis methods

As stated in Chapter Two, a process evaluation of an RCT allows one to 'mine' for the intricate details that may be missed in quantitative analyses of outcomes. These details enable a deeper understanding of how an intervention worked or why it didn't work, and what mechanisms occurred in the process. This is particularly relevant with regard to the outcome results of the RCT: that no significant effects were shown on the Hamilton Depression Rating Scale (HDRS) at three and 12 months postpartum, but that there were significant effects on the Edinburgh Postnatal Depression Scale (EPDS) at both time points. This chapter describes the methods for each objective.

3.1 Methods: Objective One

Objective One aimed to examine local pregnant women, mothers, and health workers' idioms of distress and understandings of the symptoms and perceived causes of perinatal depression in Khayelitsha, to inform development of the counselling intervention, and to provide contextual information for the intervention. As a published paper, the sample and methods used in Objective One are described in full in Chapter Four. In brief, the research was conducted at a Community Health Centre Midwife Obstetric Unit (MOU) in Khayelitsha, Cape Town. Semi-structured interviews were used to interview 12 depressed and nine non-depressed pregnant women and mothers of young babies. The women were screened for depression using the EPDS and the MINI. Thirteen health care providers were also interviewed, which included six registered nurse midwives and three HIV Counsellors who worked at the MOU, and four Community Health Workers who serviced the area.

A framework analysis approach (Lacey and Luff, 2001; Ritchie and Spencer, 2002) was employed to explore the idioms, symptoms and perceived causes of depression particular to the participants, and these were compared with the published diagnostic criteria for an episode of major depression in the International Classification of Diseases (ICD-10) diagnostic system (WHO, 2010) and the Diagnostic and Statistical Manual of Mental Disorders system (DSM-5) (American Psychiatric Association (APA), (2013).

3.2 Methods: Objective Two

The purpose of Objective Two was to describe and critique the AFFIRM-SA counselling manual, to explore potential influences it may have had on the RCT results. This was conducted in two phases. First, in order to provide a background to the analysis of the counselling sessions, the structure of the manual was described, and then each session topic was presented and explained.

Second, in conjunction with the grounded theory analysis (described below), the manual was read from a viewpoint of discovering elements that may have impacted the counsellors' ability to use and implement the manual in a manner that was easy and understandable for them. It was also checked for issues of grammar and sentence structure for the same reasons. Various issues started to emerge that were consistent across the different session topics, and these fell under four overarching categories. These are described in Chapter Five.

3.3 Methods: Objective Three

Objective Three aimed to examine the processes that occurred in the implementation of the counselling sessions.

3.3.1 Sample

Participants were selected from the AFFIRM-SA RCT participants using random sampling (Patton, 1990). The recruitment procedures and characteristics of the AFFIRM-SA RCT sampling are described in Chapter One. Of the 184 women in the intervention arm, 97 participants completed all six counselling sessions in the RCT. From these 97, a random selection of seven participants per counsellor (42 participants) were selected for transcription. Of these participants, three had incomplete transcriptions due to problems with the audio recordings identified by the transcriber. This resulted in a total of 39 participants for analysis in this thesis, which amounted to an analysis of 234 transcribed sessions (six transcripts per participant). Table 1 below illustrates this process.

Table 1: Numbers of participants analysed per counsellor

Counsellor	Participants who completed all 6 sessions (n)	Randomly selected participants for analysis	Incomplete transcripts	Number of participants analysed (n)	Number of transcribed sessions
Csr A	24	7	0	7	42
Csr B	16	7	1	6	36
Csr C	18	7	1	6	36
Csr D	10	7	0	7	42
Csr E	20	7	0	7	42
Csr F	9	7	1	6	36
TOTAL	**97**	**42**	**3**	**39**	**234**

Table 2 below provides some basic characteristics of the counsellors. The table also provides the proportion of participants who completed all six sessions per counsellor. As the table shows, the proportion of participants varied substantially, with particularly low numbers for counsellors D and F. This may have been related to individual counsellor motivation, technique and style, but it is not possible to determine this in the current analysis.

*Table 2: Basic counsellor characteristics and proportion of participants who completed sessions**

Counsellor	Age	Marital Status	Education	Health promotion experience before AFFIRM training	Proportion of participants who completed all sessions per counsellor (%)
Csr A	46	Widow	Grade 9	2.5 years	65,7
Csr B	44	Single	Grade 12	5 years	52,9
Csr C	40	Widow	Grade 12	11 years	52,9
Csr D	32	Single	Grade 11	2 years	30,3
Csr E	28	Married	Grade 12	4 years	69,6
Csr F	33	Single	Grade 12	2 years	25,7

*Adapted from Munodawafa (2018)

Table 3 below provides a comparison of mean data from the sample randomly selected for this thesis (n=39), those not selected for the sample (n=58), all participants who completed sessions (n=97), the intervention arm full sample (n=209), and the 425 participants who completed the baseline assessment for the RCT as a whole. Scores are very similar for the baseline characteristics across samples, other than that the randomly selected thesis sample had a higher percentage of women who were employed at baseline compared to those not selected for the sample. This difference is not significant (p=0.146), and the sample is otherwise representative of the 97 completing participants and the 209 intervention arm participants.

Table 3: Participant characteristics

Characteristics	Thesis sample (n=39)	Not selected for thesis (n=58)	P value (sample vs not selected) [a]	Completed all sessions (n=97)	RCT intervention arm sample (n=209)	RCT total sample (n=425)
Mean Age (SD)	27.7 (5.97)	27.9 (5.59)	0.977	27.8 (5.71)	27.59 (5.94)	27.31 (5.71)
School level completed* (Mean, SD)	10.9 (1.47)	11.0 (1.28)	0.702	10.9 (1.35)	10,92 (1,65)	11.00 (1.43)
Percentage employed (n, %)	22 (56.4)	23 (39.7)	0.146[b]	45 (46.4)	98 (46.9)	193 (45.4)
EPDS score Baseline (Mean, SD)	17.2 (2.92)	18.0 (3.75)	0.371	17.7 (3.45)	17.57 (3.73)	17.36 (3.64)
HDRS score baseline (Mean, SD)	15.9 (5.27)	14.8 (4.33)	0.426	15.2 (4.74)	15.53 (4.88)	15.49 (4.76)
EPDS score 3 Months postnatal (Mean, SD)	7.7 (5.45)	7.2 (4.98)	0.699	7.4 (5.15)	7.61 (5.18)	8.65 (5.55)
HDRS score 3 Months postnatal (Mean, SD)	8.5 (4.63)	8.6 (3.77)	0.712	8.5 (4.10)	9.11 (4.56)	9.68 (4.81)

* South African schooling grades are from grade 0-12. 13 represents post-school study.

[a] Mann-Whitney U test

[b] Fisher's Exact test

It is important to keep in mind that all 39 participants for whom data was analysed had completed all six counselling sessions. The data collected is thus a representation of the views of the 53% of participants who *did* complete the sessions, rather than the 47% who did not complete them. This is discussed further in the limitations section of this thesis. An analysis of transcripts of participants who did not complete the sessions is beyond the scope of this thesis.

Participant and counsellor labelling

In this chapter, counsellors are anonymised and labelled as Csr A, Csr B, Csr C, Csr D, Csr E, and Csr F. Similarly, participants are anonymised using alphabetical lettering according to their counsellor. For example, the seven participants counselled by Counsellor A are labelled AA, AB, AC, AD, AE, AF, and AG. Session numbers are abbreviated as S1-6.

3.3.2 Data collection and management

All RCT counselling sessions were audio recorded, and 42 were randomly selected for transcription. Transcripts and data were managed using NVivo 12 Qualitative data analysis software (QSR International Pty Ltd, 2018).

3.3.3 Data analysis

A grounded theory approach was used to analyse the data for Objective Three (Corbin and Strauss, 2014; Glaser and Strauss, 1967; Strauss and Corbin, 1998). This involves examining the data with the aim of uncovering an 'emergent grounded theory' (Mills, Bonner et al., 2006) around what occurred in the actual implementation of the trial: the real life interactions that happened between counsellor and participant that are not reported in any quantitative analysis of the trial effects. Grounded theory was initially developed by Glaser and Strauss (1967). The two researchers subsequently diverged in their opinions of the methods of analysis, although they both offer guidelines using three forms of coding. Glaser (1992) recommended using 'open', 'theoretical' and then 'constant comparative' coding to analyse the data and arrive at a theory. Following this, one or two central or core categories are identified which represent the main themes of the research.

Corbin and Strauss (2014; 1998) similarly recommend a process of 'constant comparison' of the findings until the researcher can formulate a theory. This process ensures that "only the concepts and statements that stand up to a rigorous comparison process become part of the theory" (p.212). This process involves comparing 'incident to incident', when data is self-explanatory, and using 'theoretical comparisons' when data is not as easy to interpret. Using theoretical comparisons roughly refers to the process of interpreting data through the lens by which we make sense of the world, or drawing on what we know, "to help us understand what we do not know" (1998, p.79). This makes use of the properties of comparative instances or incidents to examine and interpret one's own data. Later authors refer to this as building new insights on preconceived 'sensitizing concepts' that originate from ideas from the literature (Charmaz, 2008).

Importantly, in describing this kind of coding and interpretation of data, the above authors are not negating our own terms of reference and experiences in how we interpret data, but are instead explaining that we can use this to unpack those parts of the data that we do not understand. Thus, in order to create grounded and 'dense' theory, sensitivity to the data is required, while also maintaining sensitivity to our own biases. This allows for an acknowledgement of the influence of our own unconscious and cultural inheritances, and a subsequent examination of ways to move through or beyond these.

The issue of objectivity in qualitative research and particularly in grounded theory has often come into question (Madill, Jordan et al., 2000). The evolution of grounded theory and subsequent developments in the field suggest that 'objectivity' in qualitative research can represent a willingness to 'give voice' to participants (Mills et al., 2006), rather than controlling certain variables such as in statistical analysis. 'Objectivity' in qualitative research would require representing the voices of participants as accurately as possible, through 'listening' to what has been said, while constantly keeping in mind the difference in values, culture and experiences between researcher and participant (Ponterotto, 2002).

In relation to this type of 'objectivity', Mills et al. (2006) wrote that grounded theory depends on a clarification of the nature of the relationship between the researcher and participant, and on an understanding or statement of what can actually be known from the data. In this vein, the current analysis would be termed 'constructivist grounded theory', through the acknowledgement that the development of theory from a qualitative analysis is 'co-constructed' by participant and researcher (Mills et al., 2006). Similarly, Charmaz (2008) wrote that qualitative data, specifically grounded theory data, should be understood as "constructions of experience", whereby the researcher is actively interpreting meaning from the data.

There are three core processes used in constant comparative coding for grounded theory. First, open coding involves the initial reading of the data and identifying codes and categories that emerge from this process. Properties and dimensions of these codes and categories are also explored. In this process, data is broken down into parts and examined for similarities and differences. Data such as events, actions or interactions that are found to be conceptually similar are then grouped into categories. Examining the data for differences and similarities allows for differentiation among categories (Strauss and Corbin, 1998). Second, axial coding involves identifying sub-categories and discovering relationships between and around concepts – that is – coding around the 'axis' of a category identified in the open coding. It is in these two steps that theoretical saturation has to be reached, whereby "no new properties, dimensions, or relationships emerge during analysis" (Strauss and Corbin, 1998, p. 143).

Finally, selective coding involves developing a narrative of the findings by integrating the concepts and connections, to create a 'grounded' theory from the narrative. Selective coding is the process of integrating and refining categories, to form a larger theoretical scheme organized around a central explanatory concept. Strauss and Corbin write that in the third step, "data are reassembled through statements about the nature of relationships among the various categories and their subcategories. These statements of relationship are commonly referred to as 'hypotheses'. The theoretical structure that ensues enables us to form new explanations about the nature of phenomena" (1998, p. 103).

Being a grounded theory analysis, it is difficult to have a second coder create codes for the same data, to assess coding or rating reliability. For assessment of reliability and acceptability of the coding, the themes and codes, with coded data, were therefore presented to an expert panel. The specialist group comprised my two PhD supervisors and two registered counsellors with experience in qualitative data analysis, intervention design and implementation of task-shared psychological interventions. The panel was consulted on the reliability and acceptability of the codes themselves, as well as the acceptability of the data that had been categorised into the codes. The panel endorsed the acceptability and trustworthiness of the coding and of the distinctions between codes, as well as the rationale for the way the data had been coded.

Coding process

Under a broad conceptual framework of process evaluations for complex health services research (described in Section 3.3.4 below), the method of 'constant comparison' (Strauss and Corbin, 1998) was employed for coding the data. The first step entailed 'open coding', which involved reading all of the transcripts with an open mind, and coding anything that 'stood out' from the counselling sessions. After analysis of a few participants, these codes started to correlate with and endorse each other, and these were allocated to various categories that grouped codes that were similar to each other. In total, 42 open codes were identified. These are presented in the two figures below.

After careful examination of all of the codes, it could be seen that all of them corresponded with one of two 'core concepts'. These were: deviations from the intended counselling protocol, and descriptions by participants of effectiveness of the counselling sessions. These concepts are reported in Chapters Six and Seven respectively.

With the two overarching concepts in mind, the open codes were further analysed for each category in terms of what Corbin and Strauss (2014) refer to as 'axial coding'. This involved identifying sub-categories and relationships between concepts. Under the concept of 'deviations from protocol', two main themes emerged. These were therapeutic breakdowns in the counselling sessions and the adverse influence of socio-economic context on therapeutic effectiveness. Under the concept of 'effectiveness of the counselling sessions', the two main themes were 'reported positive outcomes', and 'attributions for outcomes of change'.

While conducting this second level of analysis, it emerged that there were some key themes that might explain the reasons for the codes identified, which can be termed 'selective coding'. These started to form the narratives of potential reasons why the processes that transpired in the counselling sessions, occurred. This

related to possibilities around why this particular task sharing intervention was not implemented strictly according to counselling protocol, and a larger narrative started to emerge around the possible mechanisms or therapeutic elements that occurred in the counselling sessions.

Theoretical and data saturation was clearly reached from the available transcripts (Fusch and Ness, 2015). Theoretical saturation in this case refers to there being no new or relevant data emerging for categories, that the categories are well developed in property and dimension, and the relationships among categories are well established (Strauss and Corbin, 1998).

Figure 2 and 3 below illustrate the coding and categorising process that occurred through the grounded theory analysis.

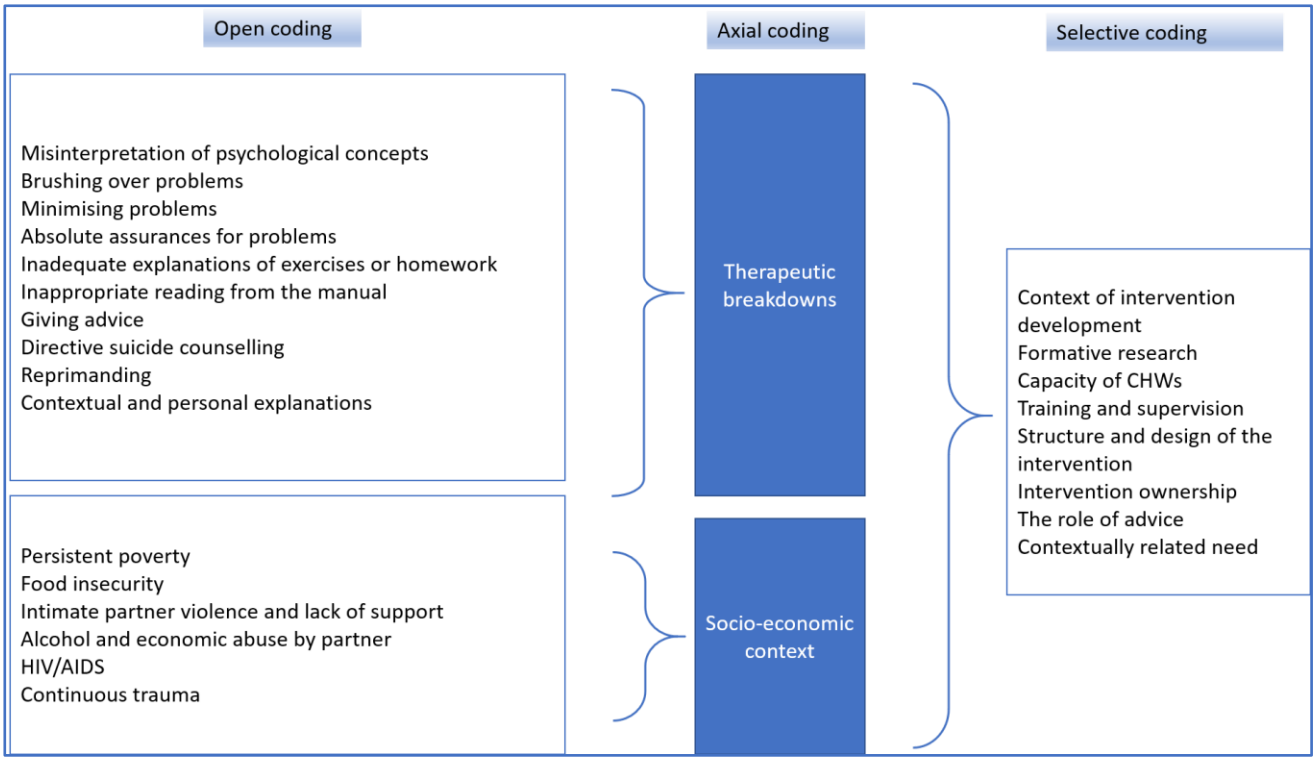

Figure 2: Deviations from intended counselling protocol

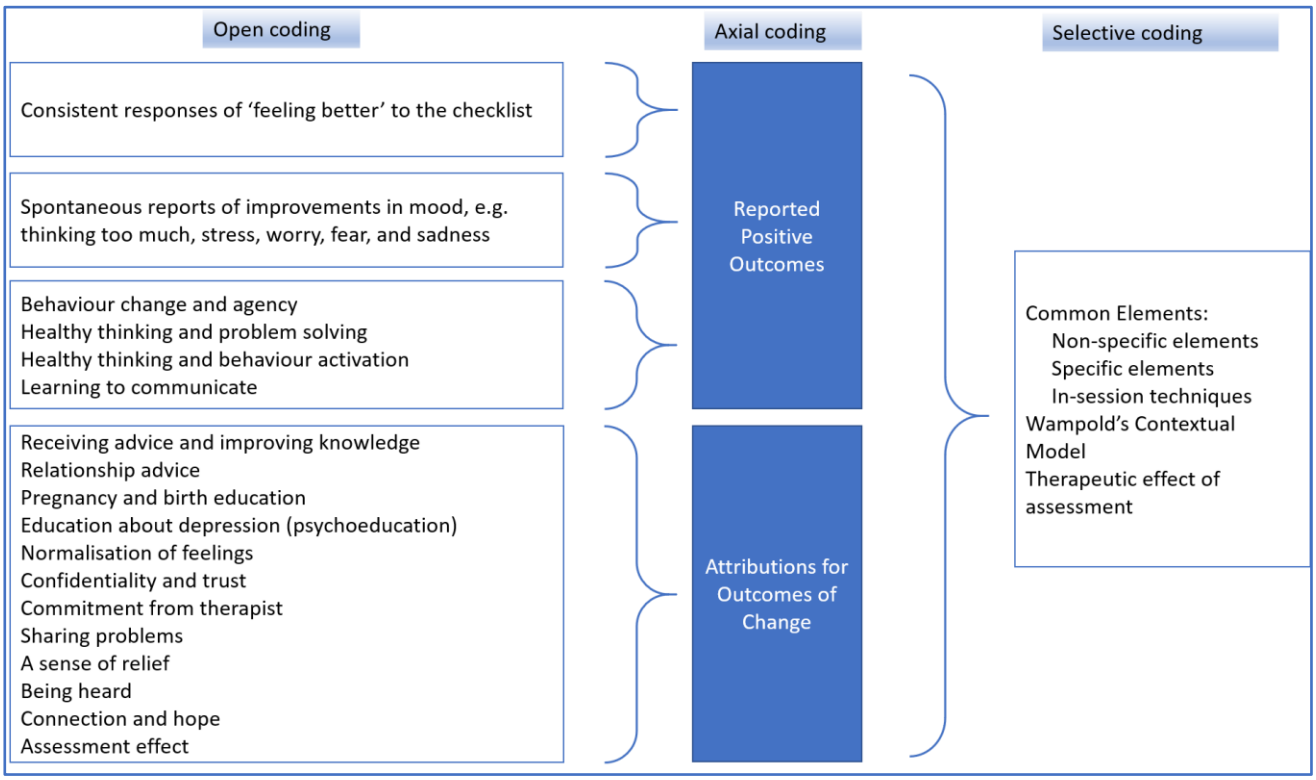

Figure 3: Effectiveness of the counselling sessions

3.3.4 Conceptual frameworks

Conceptual frameworks provide a structure from which to examine and explain the phenomenon being studied (Camp, 2001) to guide and systemise the results in a contextually appropriate manner. While acknowledging that grounded theory ultimately creates its own theory, the thesis is guided by broad frameworks of process evaluations for complex health services research (Moore et al., 2015; Moore and Evans, 2017; Murdoch, 2016, 2019), which take into consideration how trial protocols are distributed and enacted at multiple contextual levels. These frameworks encourage questions about the processes that occur between the initial theory of an intervention and the eventual receiving of it (Murdoch, 2019).

In order to do this, Murdoch writes that we need to understand how a system functions, how the problem was created, and how it is sustained in context. This is enabled through a set of guidelines for investigating health service interventions in context. These ask the following questions: What intervention is acually delivered? Is it the one intended by the researchers? How does the theory underpinning the intervention play out in practice? How does the target population behave in response to the intervention? How is the intervention sustained (or not) over time? (Murdoch, 2019). Murdoch recommends that we target where disruptions are likely to occur between different contextual features, and search for disruptions in targeted activities to expose

social structure of intervention delivery. This involves considering the implications of social structure in implementing and sustaining interventions over time and in different spaces (Murdoch, 2019).

This research is also guided by the commentary by Moore and Evans (2017), who recommend bringing context more prominently into consideration, reaching across disciplines, and moving away from viewing interventions as “discrete packages of components which can be described in isolation from their contexts” (p. 132), toward a better understanding of systems in which interventions are placed.

The current examination will therefore take into consideration the various levels of context at play in implementation of the intervention. It will use the above perspectives on process evaluations to guide the examination of the implementation of the AFFIRM-SA counselling intervention from a contextual positionality. In this way, the evaluation aims to contribute toward a qualitative evidence base that explores mechanisms and elements of change within therapeutic task sharing, ultimately toward more optimal implementation of task-shared psychological treatments in LMICs.

Chapter 4. Formative research for the counselling intervention

This Chapter is presented in the form of a previously published article (Davies, 2016). It addresses Objective One, which is to examine local pregnant women, mothers, and health workers' idioms of distress and understandings of the symptoms and perceived causes of perinatal depression in Khayelitsha, to inform development of the counselling intervention, and to provide contextual information for the intervention.

Title: 'The sun has set even though it is morning': Experiences and explanations of perinatal depression in an urban township, Cape Town.

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4.1 Background and Rationale

There is substantial debate regarding the experience of depression in diverse cultural contexts globally. While there is an urgent need to focus on the rapidly rising mental health burdens on the public health systems, through task sharing to address the treatment gap, many interventions are developed in Western countries and potentially not culturally sensitive enough, or adequately aware of the impact of social determinants on mental health, specifically in low and middle-income countries (LMICs) (Kirmayer and Swartz, 2014; Patel, Minas et al., 2013; Summerfield, 2012; Swartz, 2012).

The impact of social determinants on mental health is especially pertinent for women in LMICs, where risk factors for depression are particularly high (Lund, Stansfeld et al., 2014; Patel, Lund, et al., 2010). These include low socio-economic status, poverty, financial stress, social and economic inequalities (Aneshensel, 2009; Lund, Breen, et al., 2010; Patel and Kleinman, 2003), low education levels (Saxena et al., 2007), pregnancy (Cooper et al., 1999; Hartley et al., 2011), HIV status (Berger-Greenstein et al., 2007; Kagee and Martin, 2010), food insecurity (Lund, Breen, et al., 2010; Lund et al., 2011), non-communicable diseases (Collins, Insel et al., 2013), substance abuse, and exposure to violence and abuse (WHO, 2012).

Theoretical models for understanding the relationships between these risk factors have drawn attention to the notion of 'life stressors', or 'severe events' (defined as exposure to chronic and persistent stressors) being associated with risk for depression and poor health outcomes (Broadhead and Abas, 1998; Muhwezi, Agren et al., 2008; Patel, Lund, et al., 2010). For example, in the late 1990s, Broadhead and Abas found that the onset of depression in Harare, Zimbabwe, was most frequently preceded by a 'severe event' (Broadhead and Abas, 1998).

This links with the work of Aneshensel (2009), who used the 'stress process model' developed by Pearlin and colleagues (1981) to advance theories on the effects of social inequalities, social stress, income, social status, and support, on depression. The model demonstrates how disadvantaged people experience more traumatic events than those from advantaged backgrounds, but have fewer resources to cope with these events (Aneshensel, 2009; Pearlin, Menaghan et al., 1981). Broadhead and Abas's work endorses this theory through the presence of severe events and major difficulties in the women's social worlds, which puts them at an elevated risk for depression (Broadhead and Abas, 1998).

In low resource settings in South Africa, high rates of antenatal and postnatal depression have been reported. For example, in a peri-urban settlement in Cape Town, the prevalence of antenatal depression was found to be 39% (Hartley et al., 2011), and postnatal depression 34.7% (Cooper et al., 1999). In rural KwaZulu Natal, a 41% prevalence of antenatal depression was found in 2006 (Rochat et al., 2006), and 47% in 2013 (Rochat, Tomlinson et al., 2013). These rates are high compared to the rest of Africa, where prevalence rates of antenatal depression are between 4.3% and 17.4% (Sawyer, Ayers et al., 2010), and in LMICs worldwide, where antenatal depression is estimated at 15.6%, and postnatal depression at 19.8% (Fisher et al., 2012). In South Africa, typical pregnancy-related stressors include low and irregular income levels, lack of partner and family support, partner violence, and unplanned pregnancies (Hartley et al., 2011; Rochat et al., 2006).

Maternal mental health is recognised as a key factor in determining infant and child development (Surkan et al., 2011). Both antenatal and postnatal depression have been shown to have negative impacts on child health and growth outcomes (Patel et al., 2003; Rahman et al., 2002; Rahman et al., 2004; Surkan et al., 2011). Behaviour traits associated with depression in pregnant mothers affecting the unborn baby include: neglecting antenatal care and check-ups, inappropriate diet and poor weight gain, the use of harmful substances, and the risk of self harm and suicide (Stewart, 2011; Wachs et al., 2009). Postnatal depression also predicts poor mother-infant relationships, child growth, temperament, and behavioural and cognitive development (Cooper et al., 2009; Field et al., 2006; Grote et al., 2009; Rahman et al., 2004; Tsai and Tomlinson, 2012). Postnatal depression may also delay mothers from caring for their children's illnesses (WHO, 2008a). It is thus important

for both mothers and their children that maternal mental health is improved through addressing perinatal depression.

Given the high prevalence of perinatal depression, its particular relationship with maternal and child health, and its elevated occurrence in LMICs, effective intervention strategies need to be researched and developed. Within the global discourse, it is important to develop localised understandings of depression in order to provide context-specific, acceptable and effective interventions. Campbell and Burgess (2012) emphasise the importance of dialogue between communities, researchers, and service providers, regarding how best to integrate 'local' and 'global' perspectives in optimising opportunities for well-being (Campbell and Burgess, 2012). They write that the research base needs to take into account local understandings and responses to mental illnesses in order to encourage agency of people who suffer from such conditions, and improve the acceptability and uptake of interventions. Mental health interventions thus need to resonate with communities' own understandings, worldviews, and needs, in order to build their own internal capacities (Summerfield, 2012). Interventions should also be "driven by local knowledge and that such knowledge should flow in both directions between the global south and the global north" (Patel, in Bemme and D'souza, 2012, p. 2).

In order to involve local perspectives in this debate, the concepts of the 'everyday rhetoric' and 'idioms of distress' for mental illness are used as a theoretical framework from which to explore the data. Everyday rhetoric can be seen as a manner of talking about depression in response to specific circumstances (Shotter, 1993; Symon, 2000). 'Idioms of distress' are defined as "socially and culturally resonant means of experiencing and expressing distress in local worlds" (Nichter, 2010, p. 405). These are brought about through the presence of past or present stressors, including anger, social insecurity, anxiety and loss (Nichter, 2010). De Jong and Reis argue that particular idioms invite action within their context of local meaning, and will continue to be present until their aetiology is exposed (de Jong and Reis, 2010), such as systemic or particular problems within the social, political, or economic environment. In this way they differ from the 'symptoms' of an illness, which are used to more directly describe the features or indicators of an illness. Symptoms report on a condition; idioms often include "symbols, behaviors, language, or meanings" (Hollan, 2004, p. 63) that are used to express distress or suffering.

This paper therefore seeks to develop deep and localised understandings of the idioms of distress, symptoms and perceived causes of perinatal depression, so that these may be used to inform a localised and culturally relevant intervention for perinatal depression in this area (Collins et al., 2013), and to inform health care providers of the idioms used to understand this common but often unidentified illness.

While investigating these understandings of depression, we also seek to conduct research that is relevant for global mental health. This is achieved by examining the relation between local idioms and symptoms, and the international criteria for depression. We thereby combine the local and global viewpoints in order to develop an understanding of a worldwide illness, which has similar symptoms but is described using differing 'indigenous idioms' of distress (Patel, 1995).

4.2 Methods

The study was conducted in the peri-urban township of Khayelitsha on the outskirts of Cape Town, South Africa. The settlement comprises approximately 400 000 black African people, most of whom live in overcrowded, poor living conditions, with high levels of unemployment, poverty and crime, and low levels of education (Statistics South Africa, 2011). Many houses or shacks are without electricity, running water, or an indoor sewerage system. Many residents have moved to Cape Town from rural areas across South Africa, and the predominant language is isiXhosa.

The study used a qualitative exploratory design. Participants were recruited from a Community Health Centre Midwife Obstetric Unit (MOU) in Khayelitsha. An average of 15 women attend their first antenatal booking appointments at the MOU every day, and these women were approached and asked to participate in the screening on the designated study days. Likewise, mothers attending the baby clinic (with babies up to one year old) were also approached and asked to participate in the study. Only women who were 18 years or older, could speak English or isiXhosa, lived in the area, and had the capacity to consent were asked to participate.

In total, 84 women agreed to participate, and were screened with the Edinburgh Postnatal Depression Screen (EPDS) (Cox et al., 1987), which has been validated for use in South Africa (De Bruin, Swartz et al., 2004). This tool screened for depression, and if the women scored 13 or higher, they were further assessed and diagnosed using the Major depression module of the Mini Neuropsychiatric Interview (MINI) version 6.0 (Sheehan et al., 1998). The women who were diagnosed with a major episode of depression on the MINI were then interviewed about their descriptions and experiences of depression. Along with the depressed women, nine women who had low EPDS scores (under 10) were also interviewed in order to obtain the views and experiences of depression from women who did not meet diagnostic criteria for depression. This was purposefully done in order to avoid a possible circular argument that might contend that women who were screened with the screening tools would describe symptoms identified in those screening tools.

Along with these women, thirteen health care providers were interviewed using purposive sampling. They included six registered nurse midwives and three HIV Counsellors who worked at the MOU, and four

Community Health Workers who service the area. The rationale for including health care providers was to gain a broader description of the perception of depression amongst the community, including from those who care for and are expected to help women with depression.

Data were collected using semi-structured interviews to elicit descriptions of the participants' indigenous idioms and explanations of maternal depression. The interviews covered a range of factors relating to maternal mental health, service utilisation and service need in the study area. Interview schedules were reviewed by research partners, translated into isiXhosa and then back translated to check for accuracy. The interviews with participants were audio recorded and then transcribed verbatim in isiXhosa, after which they were translated into English by the transcriber. Box 1 summarises topics covered in the interviews. The interviews were part of the formative research for the South African section of the Africa Focus on Intervention Research for Mental health (AFFIRM-SA) study. This is an individual-level randomised controlled trial (RCT) to determine the effectiveness and cost-effectiveness of a task-sharing counselling intervention for perinatal depression in a low resource context in Cape Town (Lund, Schneider, et al., 2014).

Box 1: Data collection topics

1. Demographics and pregnancy details
2. Understandings and causes of maternal depression
3. Depression and pregnancy
4. Depression and stigma
5. Pathways of care for depression
6. Attitudes to task shifting
7. Attitudes to interventions for depression

A framework analysis was employed for the data analysis. This approach is particularly useful in applied policy related research (Lacey and Luff, 2001; Ritchie and Spencer, 2002). The data were indexed and initial codes were guided to a certain degree by the semi-structured interview topics, following the Framework Analysis approach. The analysis focused specifically on discovering themes related to symptoms and causes of depression. Further themes not captured by the initial coding were identified through extensive reading of the transcripts. Transcripts and data were managed using NVivo 8 Qualitative data analysis software (QSR International Pty Ltd, 2014). Given the similarities between ante-natal and post-natal women's descriptions noted during the data collection phase, we decided to analyse these data together as one group.

The local symptoms were then compared with the published diagnostic criteria for an episode of major depression in the International Classification of Diseases (ICD-10) diagnostic system (WHO, 2010) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) system (APA, 2013). The symptoms reported by participants were identified in the framework analysis prior and without reference to the diagnostic criteria from the DSM-5 and ICD-10.

Ethical approval was received from the University of Cape Town Health Sciences Human Research Ethics Committee (HREC Reference no: 226/2011). All participants received and signed informed consent forms for the study and were assured of confidentiality. Every participant screened (positive or negative) was given a pamphlet with information on maternal depression and the available mental health services in the area (after their interviews if they were interviewed). The fieldworker and counsellor referred a number of women with high EPDS scores to counselling and support NGOs in the area or to the psychiatric nurses at the clinic when participants demonstrated suicidal ideation.

In this small study of 84 consenting women at their first antenatal booking, 29 screened positive for depression with the EPDS, and 12 were diagnosed with a current or past episode of major depression on the MINI 6.0. These 12 depressed women were interviewed, and nine non-depressed women were also interviewed. Of the 21 women in total, 15 were pregnant, and six were mothers of young babies. Their ages ranged between 21 and 41 years, and all women chose to be interviewed in isiXhosa. Among women included in the study, EPDS scores ranged between two and 21. The midwives, HIV counsellors and CHWs were all isiXhosa speaking women and worked in and around the study site.

4.3 Results and Discussion

4.3.1 Local idioms of distress

In order to discover local idioms of distress, the following question was asked: *"The [EPDS] questions we just asked you mentioned things like blaming yourself, being anxious or worried or stressed, feeling scared, having difficulty sleeping, being sad, or feeling like harming yourself. [Depending on the symptoms the participant had identified.] What word or words would you use to describe the feelings I have just mentioned?"* Health workers were asked; *"What word or words would you use to describe depression?"*

Some idioms of distress were similar to the symptoms identified by the participants, but others were distinct. The most common idioms link with the most common descriptions of symptoms, specifically by the depressed women; including stress (i-stress/unxungu phalo), thinking too much (ucingakakhulu), being sad or unhappy (ukudakumba), and being scared (ukoyika). This may relate to the fact that there is no specific word in isiXhosa

for ‘depression’; and thus identification of the illness may be linked more directly with the symptoms experienced.

In the interviews, ‘i-stress’ is both a word used to describe the illness (e.g. “*You end up with stress and sickness”* (Pregnant Woman (PW) 15)), and a reaction to socio-economic factors that may have induced the ‘stress/depression’, such as economic and social insecurity, particularly related to an unwanted pregnancy and a lack of support.

‘Being sad or unhappy’ and ‘thinking too much’ is also a direct description of the impact/effect of depression. Thus, being asked to name the word(s) you would use for depression, the most accessible “word” (idiom) might be one describing or expressing the feelings or meanings related to the un-named illness or distress.

Along with these direct answers to the above questions, other idioms were identified. Two women used the depiction of the sun setting on them, when describing their depression*: “It is bad; you feel the sun has set even though it’s morning. You don’t feel like yourself even when you are walking”* (Mother (M) 3). Another said, *“It is bad; even the sun you will see it has set. I don’t know how I would compare it. When I had these thoughts, they’d tell me the sun has set. I would just not sleep”* (PW 8). These descriptions are a localised means of expressing distress (Nichter, 2010), emphasising that this illness, represented as darkness, is constantly present for these women: the sun has set and it is dark, “even though it is morning”.

A non-depressed woman brought many idioms into her description of depression, saying: *“It’s when your brain is, is cramped… It’s not focused on who I’m talking to, the brain is busy, it’s under suffocation, and everything can just blow up right now”* (ND 3).

Other less commonly mentioned idioms included ‘suppression of the brain’, ‘the brain is tired’, ‘heart palpitations’, ‘mental disturbance’ ‘having pain’, and ‘you are like the weather’. These all demonstrate a ‘reaching out’ for meaning amongst the women through developing an ‘everyday rhetoric’, using symbols or language (Hollan, 2004) that may not directly identify the illness but does indicate the suffering involved.

On the whole, idioms and symptoms identified by depressed and non-depressed women and health workers were similar, but some differences should be noted: the women specifically identified the idioms of thinking too much, being unhappy/sad, the brain is tired, being scared, and having pain, while only the health workers mentioned (once for each example): fatigue/burnout, mental disturbance, and being crazy/ possessed by witchcraft. These differences may demonstrate the distinction between the presentation and appearance of depression to the health workers, combined with a possible lack of understanding of the illness; with the actual ‘feeling’ and experience of it, by the women. This underscores the importance of understanding the idioms

experienced by the depressed women, in order to include them in interventions, and inform health workers of these experiences.

In the case of this research, the idioms have been included in the development of the counselling intervention manual for the RCT, through various means such as: the use of the words identified by the women to describe depression; the use of experiences described by the women as vignettes for examples of problem solving; and a response to the needs identified by the women using theoretical approaches to address these needs such as 'problem solving' and cognitive restructuring or "healthy thinking" (Rahman, 2007). The idioms were also included in a local adaptation and validation of the primary outcome measure for the RCT, the Hamilton Rating Scale for Depression.

4.3.2 Symptoms of depression

The analysis identified 14 categories of symptoms and descriptions of depression from the participants' interviews. These were: withdrawal and not wanting to talk, crying or sadness, poor concentration, thinking too much, fear and anxiety, stress, sleep problems, headaches and body pain, not 'caring', suicidal thoughts, loss of appetite, anger, hopelessness, and self-blame/guilt.

These are summarised in Table 4 below. In order to provide a global comparison, the table also displays all of the key DSM-5 and ICD 10 symptoms required for classification of an episode of major depression. All nine DSM-5 requirements (labelled 1-9) and all 10 ICD-10 requirements (labelled 1-3 and a-g) were mentioned by the women, through differing descriptions.

One consideration relating to this descriptive study is that the depressed women were diagnosed using an international diagnostic system, thus meaning that the symptoms they describe have already been identified by the scale. However, the top four symptoms the *non-depressed* women used to describe depression also align with the principal requirements for the ICD10 and DSM-5 scales to diagnose depression. All other symptoms mentioned by the depressed women were also mentioned by non-depressed women and health workers, including one more: that of self-blame or guilt. This demonstrates, with respect to this particular sample, that women diagnosed by the scales and those not diagnosed on the scales both identify symptoms that align with the international scales for depression.

Table 4: Symptoms of depression listed by frequency of mention, compared to DSM-5 and ICD10 symptoms

Symptoms of described depression	Depressed Women	Health Workers	Non-Depressed Women	Total	DSM-5 Symptom	ICD-10 Symptom
Withdrawal & not wanting to talk	9	7	5	21	(2)* Markedly diminished interest or pleasure in all, or almost all, activities (6)Fatigue or loss of energy nearly every day	(2)Loss of interest & enjoyment (3)Reduced energy, increased fatigability & diminished activity
Crying or Sadness	7	3	3	13	(1)Depressed mood most of the day, nearly every day (e.g. feels sad, empty, hopeless)	(1)Depressed mood (2)Loss of interest & enjoyment
Poor concentration	6	3	4	13	(8)Diminished ability to think or concentrate, or indecisiveness, nearly every day (5)Psychomotor agitation or retardation nearly every day	(a)Reduced concentration & attention
Thinking too much	6	1	2	9	(7)Feelings of worthlessness or excessive inappropriate guilt nearly every day. [The sense of guilt or worthlessness associated with a major depressive episode may include guilty preoccupations or *ruminations over minor past failings*.]	
Fear&Anxiety**	5	0	1	6		
Stress**	4	3	4	11		
Sleep problems	4	1	0	5	(4)Insomnia or hypersomnia nearly every day	(f)Disturbed sleep
Headaches & body pain**	4	0	2	6		
Don't care	3	4	0	7	(2)Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day	(2)Loss of interest & enjoyment
Suicidal thoughts	2	1	1	4	(9)Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or suicide attempt or specific plan for committing suicide.	(e)Ideas or acts of self-harm or suicide
Loss of Appetite	2	1	0	3	(3)Significant weight loss when not dieting or weight gain	(g)Diminished appetite
Anger**	2	6	2	10		
Hopelessness	1	0	0	1	(1)Depressed mood most of the day, nearly every day (e.g. feels sad, empty, hopeless) (7)Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).	(1)Depressed mood (c)Ideas of guilt & unworthiness (d)Bleak & pessimistic views of the future (b)Reduced self-esteem & self-confidence
Blame/guilt	0	0	2	2	(7)Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day.	(c)Ideas of guilt & unworthiness

* Number/letter on the DSM-5 or ICD 10 Scales

** Symptoms not listed as key identifiers on the DSM-5 or ICD 10 Scales. (However, they are included in the DSM-5 'Associated Features Supporting Diagnosis': "Individuals frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain (e.g., headaches; joint, abdominal, or other pains). … And MDE with anxious distress: Anxious distress is defined as the presence of at least two of the following symptoms during the majority of days of a major depressive episode or persistent depressive disorder (dysthymia): 1. Feeling keyed up or tense. 2. Feeling unusually restless. 3. Difficulty concentrating because of worry. 4. Fear that something awful may happen.") (APA, 2013).

Symptoms were retrieved from quotations such as the following, which typify experiences of depressed women like this mother, and demonstrate the complex nature and symptomology of depression:

> *"They are angry, and when they talk about their problems they cry. Some lose weight when they are stressed. Some gain weight; you will find that they are not happy but they still gain weight. Some lose appetite. When they are with people they are always thinking"* (M 60).

The most common symptom identified by the women was of *withdrawal* from social and familial activities, including looking after babies and children. Health workers similarly spoke of depressed women '*not wanting to talk'*.

One midwife described her experience of the withdrawal of a depressed woman as follows:

> *"After delivery, the patient wasn't talking to anybody… just quiet and staring, as if she is just looking at you - not turning the eyes. Just open her eyes like this. So that is when someone is depressed"* (Midwife (MW) 3).

Likewise, women illustrated symptoms of withdrawal in the following examples:

> *"I like being alone… I don't want to interact with other people. I have this thing, like always wanting to be alone [and] not being happy… You feel alone you don't care about anything, anything because you are not at it, there's nothing you can do… I would say it changes you how you see yourself like a nobody in front of other people. You don't care about much. You keep thinking about this thing… If there is something that is being done, I am not in a mood to do that thing and be places with children or people"* (PW 4).

> *"I just see when it's dark... I don't even go out; I stay at home all day in bed. When people call me I don't feel like giving them attention. When they knock I don't answer… I tell my children to lock me inside"* (PW 6).

"I can say for example it's someone who is always sitting alone, like someone who doesn't like to sit with people… But the things she is doing it's… it's like she is a child that grew up without parents" (Non-depressed woman (ND) 4).

These quotations demonstrate that the women are aware that their behaviour is different when they have these feelings; it is not healthy or 'normal' to withdraw, ignore children's needs, or feel worthless or hopeless in this community. Withdrawal as a result of their feelings has a major impact on their immediate day-to-day interactions. This extends to caring for children's healthy development, as well as job seeking behaviour, which have implications for their own and their children's educational, social and economic development.

Crying or sadness was the other most common symptom mentioned by the participants. This was identified through statements such as: *"I feel sad and down, I am not who I'm used to be*" (M 57), *"I am thinking and crying"* (PW 15), and *"I was sad, all the time crying"* (PW 8). A non-depressed mother said that her friend who had depression *"was always crying, and I would say 'friend, don't cry …I understand that your heart is hurting… It is hurting a lot by small things that are not supposed to make you cry"* (ND 3). These too demonstrate the identifiable 'abnormal' patterns of behaviour such as 'being affected by small things' and not being who you used to be.

Rochat and colleagues found in their study of women in rural KwaZulu-Natal, that feelings of 'sadness' were also the most frequently reported symptoms when describing depression (Rochat et al., 2011). These women presented with disturbance of mood, loss of interest, suicidal ideation and concentration difficulties (Rochat et al., 2011), as in the current study. The word 'stress', as a symptom, was examined carefully for its meaning in the different transcripts. It appears that this is used as a word to denote 'worry'; generally about 'life stressors' that the women are facing, but also carries an affective component, indicating anxiety or discomfort. Thus 'stress' is a symptom of depression, but simultaneously a reflection of the hardships and adversities in the women's lives.

The symptom *thinking too much* was usually mentioned concurrently with *stress* by participants. These two phrases form part of the everyday rhetoric of the illness, through the manner in which it is spoken and the response it provides in seeking definitions of these feelings. It is understandable that the stress/worry frequently leads to excessive rumination about the problems *causing* the stress/worry. This is endorsed by the fact that these two phrases were also the most frequently used idioms by the women for depression *and* were identified as causes too. This can be seen in the following examples:

> *"I would say depression is a stress more than others or bigger, maybe thinking too much, it's made by something you have, or problems, then you think about that thing… I could have it in the stress that I have with problems. I am sitting thinking about them"* (PW 4).

Here, the 'stress' is about specific problems in the woman's life. However, this 'stress' encourages thinking too much, which in turn induces more stress/depression.

One woman said:

> *"It's someone who is stressed to the point that the stress is too much. Thinking too much, and when she is thinking, it's like she is going to go mad, and lose control. For example, when she thinks, she can even scream thinking about committing suicide"* (M 60).

These phrases are mentioned so closely together that they combine to form the same 'rhetoric' in describing depression. They are also related to an anxiety around the problems she has. The two in combination become so severe that it might drive the woman to suicide.

Furthermore, another woman said:

> *"I would say it's someone who thinks and does not have anyone to talk to and ends up doing things they are not supposed to and ends up with stress and sickness because of thinking because of that thing you can't talk about"* (PW 15).

In this description, 'stress and sickness' are the idioms used for depression, brought about by 'thinking', and having no one to talk to, about the thing you can't talk about. This also highlights the largely unrecognised and stigmatised nature of mental illness in this area, and the related lack of care for those with the illness.

Interestingly, the phrase 'thinking too much' (or "kufungisisa") was identified as both a cause and a symptom of depression by the Shona people in Zimbabwe (Abas and Broadhead, 1997; Patel, Simunyu et al., 1995). Similar descriptions have been used in Nigeria of "were ironu" (Odejide, Olatawura et al., 1977) and 'nervios' in Mexico (Salgado de Snyder, de Jesus Diaz-Perez et al., 2000). The English phrase or Western description for 'thinking too much' is 'rumination', which is a common inclusion in many other assessments of depression or anxiety (Nolen-Hoeksema, 2000).

One mother said that she knew she was depressed because she thinks until her "brain is tired" (M 75). This links with the other most commonly mentioned theme in the women's narratives of depression**;** that of *poor concentration or confusion*. Participants described this as follows: *"[Depressed women] don't talk straight or*

whatever they talk about they forget it" (ND 2), *"There are times I even forget - I don't know what is happening"* (PW 20), and

> *"[Depression is] when the brain is tired… They send you to do something but you are unable to that thing because you are thinking and forgetful, and then after ten to fifteen minutes you realise what you were sent to do"* (PW 30).

A non-depressed woman stated that she doesn't *"have the disease of forgetting*" (ND 3). Here stigma of 'disease' and the ramifications of forgetfulness and poor concentration on daily life functioning and child care are clear.

Another local feature of depression was that of *not caring,* which links to the symptom of withdrawal from activities. Lack of motivation to take care of oneself affects the mother and her whole household; expressed through these comments: *"It's difficult to wash, even to clean the house. It's difficult to do anything"* (M 75), and *"You don't look after yourself, you don't care about yourself"* (PW 22).

The implications of not caring and withdrawal on the baby's health and wellbeing are demonstrated by a mother who struggled to accept her baby initially, but is now 'interested in him' and loves him more:

> *"In the beginning it [being stressed] was affecting me. I had days that I was tired of him, and had a feeling of giving him up for adoption. But I did not have the courage to do it. If something comes up I can't go, I am stuck, I don't have money to go there. Had to stay with the baby, so having regrets about him. I didn't care about him, getting annoyed with him. If he cried I ignore him, it still happens but I don't want to make that a habit. I continue with what I am doing and finish it, and then I will give him my attention… I did not want him really"* (M 60).

A pregnant woman also spoke of her feelings:

> *"You feel alone [and] you don't care about anything… I won't have time for the baby or take care of it or support it, I am always thinking, even what I am thinking, I think because I am going to have a baby, the baby is not the first thing in my life… I don't want to interact with other people… You don't care about much"* (PW 4).

This quotation brings to our attention the relevance of and need for specifically designed counselling interventions that focus on the symptoms identified by the women themselves. This woman is identifying many needs in her statement: that of needing support ('you feel alone'), of her lack of preparation and desire for a baby, her state of 'thinking too much', her dissociation from others, as well as her lack of care, for herself

or her baby. An intervention that therefore focuses on the identified needs of this woman is very important in her particular situation.

All the symptoms the women experience have consequences for women's daily functioning and attention to infant growth, nutrition and emotional development. Withdrawal, poor concentration, stress, and 'not caring' all have the potential to negatively affect the care of infants, and in turn affect emotional bonding, psychological development, and physical health of the infant, as illustrated by several studies from LMICs (Cooper et al., 2009; Patel et al., 2003; Rahman et al., 2004).

The above symptoms and experiences were compared with the international diagnostic criteria of the DSM-5 and ICD-10 scales. The comparison revealed that the principal requirements for a diagnosis of depression by both nosological systems were met by the descriptions and idioms from the women. These requirements on both scales are: depressed mood, loss of interest and enjoyment/pleasure, and reduced energy leading to increased fatigability and diminished activity (APA, 2013; WHO, 2010).

The results suggest that in this township, amongst isiXhosa women, experiences or symptoms of depression are similar to those listed in the DSM-5 and ICD-10 scales, but that women use different words or idioms to describe these symptoms. These findings corroborate those of Patel (1995) and Broadhead and Abas (1998), who found similarities in the manifestation and expression of depression in Zimbabwe when compared to international criteria. Rochat and colleagues also found that Zulu women in KwaZulu Natal used 'psychological language' to describe symptoms of depression, and they concluded that the standardised diagnostic tools they used were culturally sensitive (Rochat et al., 2011).

Of the 14 symptoms identified by the participants, four are not listed in the main identifying criteria on the DSM-5 or the ICD-10 scales. These were: *fear and anxiety*, *stress, headaches and body pain,* and *anger*. However, f*ear and anxiety* and *headaches and body pain* are mentioned in the 'coding procedures' and 'associated features' of major depression in the DSM-5 scale (APA, 2013), and *anger* is included in other scales commonly used to diagnose depression, such as the Hamilton Rating Scale for Depression (Hamilton, 1986). The above experiences or symptoms have also been frequently shown to have high levels of comorbidity with depression in other international studies (Gorman, 1996), and are associated with a range of other polymorphous expressions of distress and social dysfunction.

4.3.3 Perceived causes of maternal depression

Study participants attributed a number of causes to depression in their community. The most frequent of these were: lack of support, unwanted pregnancy, death of a loved one, poverty and unemployment, thinking too much, coping with a new baby, and stress. It is notable that when women describe the causes they are more

likely to provide external or tangible explanations for depression as opposed to 'internalised' ones, such as biological or genetic aetiologies. The causes identified by the participants are summarised in Table 5.

Table 5: Perceived causes of depression

Cause of depression	Depressed women	Health Workers	Non-depressed women	Total
Lack of support or partner desertion	8	8	2	18
Unwanted pregnancy	6	6	2	14
Death of a loved one	5	0	1	6
Poverty and Unemployment	4	8	2	14
Thinking too much	4	2	1	7
Coping with a new baby	3	3	0	6
Stress	2	6	1	9
Abuse or rape	2	4	2	8
HIV status	1	4	0	5
Witchcraft or beliefs	0	1	0	1
The situation they are in	0	0	2	2

It is overwhelmingly clear that there is a desperate need for support – both emotionally and financially – amongst pregnant women and mothers in this township; many of whom cite lack of support and/or desertion by a partner as the primary cause of their depression. One pregnant woman said that the cause of her depression was "*not having someone to tell me what to do so I can get help"* (PW 8). This is not unexpected, as noted in the findings of Fisher and colleagues (2012), who found difficulties in the intimate partner relationship to be closely associated with perinatal mental health in LMICs (Fisher et al., 2012).

An earlier study in the same township found similar evidence that the strongest predictors of depressed mood in pregnancy were lack of emotional support from women's partners, relationship violence, a household income below R2000 (approximately $200) per month, and young age (Hartley et al., 2011). These findings also corroborate what Petersen and colleagues (2013) found in KwaZulu-Natal, with lack of social support being a key factor attributed to cause of depression amongst women with HIV (Petersen, Hancock et al., 2013).

The pregnant women interviewed were those at their first antenatal bookings. Many of them had only recently discovered that they were pregnant, and there was a lot of attribution of an *unwanted or unintended pregnancy* as the cause of their depression. The anxieties around these unwanted pregnancies were related to being unemployed and thus having no money to care for the baby, partners discovering the pregnancy and deserting them, family members rejecting them, and the added burden for some of being HIV positive and

having a child to look after. This correlates with evidence from other resource constrained countries (Fisher et al., 2011). One woman said her depression was "only caused because I am pregnant" (PW 22). Another mother described the effects of an unwanted pregnancy as an added financial stress and having an impact on caring for other children:

> *"Sometimes I feel like not having the baby. There is nothing I can do. It's already here. If the baby was not here, there would not be so much stress. But now the problem is this I have to think about the baby then my life. So again I had that dumb brain to let myself get pregnant again... For example, I have my first born [but] he is not as important when I have this baby. Most of the time, I am spending my money on the baby. The [first born] in the Eastern Cape, I am not taking care of him ever. Since I gave birth I haven't sent money at all"* (M 40).

The results contrast with those found by Hartley and colleagues that depressed mood was not associated with an unplanned pregnancy (Hartley et al., 2011). This may be attributed to the small sample size of the current study or the presence of multiple risk factors for these women.

Pain, related to the *death of a loved one* compounds the lack of support for women, especially in the perinatal period when this is more desperately needed than at other times. Two quotations demonstrate the effect of this loss on the women:

> *"[My friend's] sister died …So [she] was not working and had kids. She was helped by her sister. Her children were fed by her sister, but then her sister died. While she used to be the bread winner. She was never right afterwards"* (M 75).

> *"It was not nice and then my brother had died. Then everything was upside down. Nothing was going right…It was the first thing to disturb my life. Then my mother died last year December"* (PW 8).

This cause, predominantly identified by depressed women and not health care providers, is something identified by women who are already vulnerable and feeling unable to cope with everyday stress as capably as other women might. The added pain of the loss compounds this vulnerability. This shows again why it is important to hear from the depressed women themselves about what *they* think are the causes of their own depression, in order to improve our understandings of depression in this area.

There are multiple examples of the effect of poverty and unemployment on mood state in the interviews. One woman said that depression is caused *"because a person can need money, or need work, or even food to eat"* (ND 5), and another said:

"It is caused by not respecting other people and poverty. Having too much load on my shoulders… If I could get a job I'd be fine. [It is] the one thing that is discouraging me the most. I am sitting, I don't have money" (M 60).

Another mother said her depression was caused by *"unemployment; not working and always being at that house"* (M 52). Thus a woman, sitting alone in her shack, desperate for help and demobilised by her condition, without the stimulus of employment, or the reward of receiving money from a job, becomes overwhelmed by 'stress'; and she has all day and all night to 'think too much' about how she will feed, clothe and care for herself and her baby. Patel and colleagues (2009) speak of this link where poverty, unemployment, and poor social relationships are both risk factors for mental illness and outcomes of the illness (Patel, Lund et al., 2009). This qualitative research also demonstrates the inter-linked and cyclical nature of the poverty-depression relationship, however further research is needed to more specifically test these causal pathways.

Thinking too much, an idiom for depression, was identified as a cause of depression. Stress, another idiom in turn, was also identified as a cause of depression. This demonstrates the cyclical connection between the descriptions, symptoms and causes. The participants identify external stressors as the cause of stress/worry/depression, which brings about the internal stress of thinking too much/depression.

Notably, it was mostly the health workers who attributed depression to stress. This may be related to the fact that they are not experiencing the stress themselves, but are interpreting the cause through the multitude of factors that they witness the women having to cope with, on a daily basis. The health workers said that depression *"is caused by stress"* (CHW 2), *"when a person has too much going on"* (HIV 1), and that depression *"is an illness …from too much stress. For example around pregnancy, and with regarding being a mother, and worrying about money, and miscarriages etcetera. So stress causes depression"* (HIV 2). A midwife also related stress and depression thus: *"You are stressed and then you think too much and then you get depression and then you don't see the way things are; you are confused. At that time you are not orientated"* (MW 5).

As shown in this discussion, stress (and thinking too much) can be brought about by the presence of extreme stress and daily 'life stressors' for the women. Traumatic situations, multiple risk factors, and a lack of support for the pregnant mothers in this township greatly increases the likelihood of depression amongst these women. Causes of depression (or stress) in this respect can be explored using Aneshensel's 'Structural origins of mental health disparities' (Aneshensel, 2009). These origins involve:

(1) *Differential exposure to stressors:* This is identified through poor living conditions (housing and sanitation), unemployment, overpopulation, poor education, gender violence and rape, and high HIV rates. (2) *Differential access to psychosocial resources:* This comes out strongly in the interviews through the

identification of the lack of support from partners and families, as well as through joblessness (and therefore poor financial support), and stress relating to insecure tenure of homes.
(3) *Differential effectiveness of psychosocial resources, or moderation*: This can be identified through the poor system of referral pathways for depression (no systems for identification, no clear referral pathways, and poor follow-up). There is also minimal communication between midwives at the MOU and the psychiatric nurses at the clinic, with a very low number of psychologists in the area.

The risk factors that the women face in this situation correlate with many of those from international studies, such as low income levels, poverty, partner abuse, low education levels, poor housing and living conditions, poor health care, unwanted pregnancies, and HIV status (Brandt, 2009; Coast et al., 2012; Dunkle, Jewkes et al., 2004; Lund, Breen, et al., 2010; Rochat et al., 2011). The current study provides further evidence to corroborate already documented associations between depression and stressful life events (Aneshensel, 2009; Patel, Lund, et al., 2010).

In summary, the local descriptions and causes of depression in this township setting appear to be highly interconnected, and they draw attention to the impact of multiple risk factors and social determinants on the mental health of women in the study. The risk factors identified are correspondingly highly conducive to stress; the most commonly used phrase to explain depression in the study. A task-shared basic counselling intervention could provide these women with a platform for talking about and reflecting on these feelings. The understanding gained from the analysis of women's descriptions and experiences of depression provide a clear framework for both psychotherapeutic techniques and terminology to be included in such an intervention to meet local needs.

4.4 Limitations of the study

We are aware that the depressed women who were interviewed were diagnosed using the MINI 6.0 and the EPDS, and thus might provide symptoms of depression that might have already been identified by the scales. However, we attempted to control for this by interviewing women who were not diagnosed as depressed on these same scales, as well as getting perspectives from health care providers in the area. In addition, the terminology used in the descriptions of symptoms was not the same as that used in the assessment tools, suggesting that the women were describing their own thoughts and feelings and not just repeating the terms in the EPDS or MINI.

The analysis focused specifically on discovering themes related to symptoms and causes of depression, and a distinction was not made between ante-natal and post-natal women's descriptions, or between unintended

and unwanted pregnancies. Also, in our focus on depression, we are nonetheless aware that other 'persecutory' symptoms may be experienced by women, and may not have been reported on, for example, paranoia, phobia, panic states and anger.

4.5 Conclusion

This study has found, through examining the localised idioms, descriptions and perceived causes of perinatal depression in an urban township in Cape Town, that descriptions are particular to the local setting, but that symptoms are similar to those identified by international diagnostic systems. Comparison with the ICD-10 and DSM-5 criteria shows that these diagnostic systems are relevant for identification of depression in this situation, providing that they are translated correctly and thorough training is conducted.

There is thus value in both local and global perspectives on depression. International diagnostic systems may not capture all the specific aspects of women's experience of distress, but they are useful (albeit crude) markers of needs for care and support. At the same time, it is vital that psychosocial interventions draw on the local idioms of distress and experiences of women, in both their design and delivery. The sharing of these experiences is important for drawing attention to what is local and what is global in the mental health of mothers.

Additionally, most of the symptoms the women experience are attributed to external 'life stressors', or risk factors that they face in their everyday lives; the most notable of these being poverty, unwanted pregnancies, death of loved ones, and lack of social and economic support. The 'stressors' identified by these women corroborate with reports from studies in other LMICs, which validates the concept of a 'vicious cycle' between the effect of low socio-economic conditions and depression (Patel and Kleinman, 2003).

The study also highlights the effect of the larger social system that the participants are involved in. The risk factors they face, most of them far out of their control, are all too often a consequence of decades of discriminatory politics and policies that favour the wealthy in South Africa. This underlines the importance of the integration of mental health research into policy development and local development initiatives.

Also notable in this study is the role of pregnancy in women's mental health. This is a period of vulnerability to depression and stress, and all participants identified or agreed with the need for counselling to help them during this time. Assistance at this vulnerable time could have positive impacts on both mothers and infant development (Rahman et al., 2013). Local counselling interventions specifically designed for the lived experiences of women in these vulnerable situations are sorely required. The findings of this study help to

inform the intervention arm of the RCT, through the inclusion of these idioms, narratives and understandings in the counselling intervention manual, and a contribution to the local adaptation and validation of the Hamilton Rating Scale for Depression. This in turn will be fed back to the local primary health care facilities, non-governmental organisations and Department of Health, as part of the dissemination of findings from the RCT.

Finally, the study contributes to an evidence base at a local level, through exploring idioms and descriptions of depression. This provides information for health providers and policy makers to create context-specific and relevant assessments and interventions for maternal depression in this area. It also informs practitioners from different cultural backgrounds to be sensitive to the meanings of the particular idioms and symptoms in this setting. Understanding the social aetiology of depression subsequently encourages opportunities for interventions at a population level (Lund et al., 2011). It is also hoped that this will contribute to further research in the field, such as conducting similar qualitative exploratory research in other cultural settings; using local cultural idioms and symptoms to inform future developments of international instruments and nosological symptoms, and designing and evaluating appropriate psychosocial interventions for maternal depression.

Chapter 5. Review of the AFFIRM-SA counselling manual

This chapter firstly describes the structure and content of the counselling manual. The manual was translated into isiXhosa and used by counsellors in isiXhosa, but the English version was reviewed. Second, a limited critique of the manual is presented.

5.1 Manual structure and topics

The development of the counselling intervention and manual was described briefly in Chapter One and is reported in detail by Munodawafa (2018). As mentioned, the intervention comprised six sessions, structured to be approximately 45-60 minutes in length, and ideally occurring every week or two weeks over two-to-four months before birth. In reality, due to the practicalities of participants' lives, not all participants completed all sessions before birth, leading to 51/184 participants receiving some or all sessions after birth.

5.1.1 Manual structure

All six sessions followed a basic structure that involved a welcome and introduction, administering a standardised 14-item checklist, discussion of the purpose of the session, introducing and practicing activities, explanation of homework, agreeing on the next session date, and termination of the session. In addition to the basic structure, each session had a topic that was based on a specific therapeutic modality. This was explained to the participants, and then was demonstrated through participatory activities that the counsellor led the participant through.

5.1.2 Session topics

Each session followed one of the following topics: 1) psychoeducation, 2) problem solving, 3) behavioural activation, 4) healthy thinking, 5) birth preparation, and 6) termination and evaluation. Table 6 provides a summary of these sessions.

Table 6: Counselling intervention topic description

Session topic	Description
1. Psychoeducation	Providing information on the symptoms and causes of depression specific to the local context; provision of a relaxation CD
2. Problem solving	Work according to a step-by-step method to identify, prioritise, make plans, and manage problems
3. Behaviour activation	Identify activities mothers were no longer doing due to their symptoms of depression and encourage re-activation of these
4. Healthy thinking	Identify 'unhealthy' thoughts, find positive and more realistic thoughts to replace the unhealthy ones, and then practice this
5. Preparation for birth	Provide information on nutrition, birth, and preparing for life with a baby
6. Termination and evaluation	Summarise all past sessions, elicit feedback on the sessions, and assess whether the participant requires further mental health assistance

The following section describes the sessions in more detail:

1) Session 1, "Psychoeducation", involved provision of information on the symptoms and causes of depression specific to the local context, exploring the participants own depression, and building rapport with the counsellor. Participants were also given a CD which had a relaxation exercise recorded in isiXhosa.

2) Session 2, "Problem solving", used a step-by-step method to: identify problems that participants were facing, prioritise the most important one(s), discuss ways of managing the problem, choose the best possible solution, make a plan for action, and check in on whether the solution worked in the next session.

3) Session 3, "Behaviour activation", required mothers to use the previous week's homework to list activities that she used to enjoy doing but doesn't do any more. In the session the counsellor was then to discuss when and why the mother stopped doing these activities, identify what activities they would like to do again that might make them feel better, and then make a plan for the best time to take action on these activities.

4) Session 4, "Healthy thinking", focused on the link between 'unhealthy thinking' and 'unhealthy behaviour'. It described steps for changing unhealthy thinking into healthy thoughts, through learning to identify unhealthy thoughts, find positive and more realistic thoughts to replace the unhealthy ones, and then practice this. The session used a locally contextualised vignette to practice identifying unhealthy thoughts and replacing them with healthy thoughts (based on the 'Thinking Healthy' manual that Rahman et al. created (2008)).

5) Session 5, "Preparation for birth", used the session to provide information on nutrition, birth, and preparing for life with a baby, to assist in decreasing anxiety and fear about birth and a new baby. The mother was provided with an opportunity to ask questions she was unsure about.

6) Session 6, "Termination and evaluation", was a shorter session, that summarised the past five weeks and asked for feedback from the mother about what she enjoyed or did not enjoy in each session, what she thought

could have been done better, and whether she felt she needed further help, in which case she was referred to a local counselling organisation.

The manual also included a section on suicidal ideation management. When participants expressed suicidal ideation, the manual instructed counsellors to acknowledge and reflect feelings, normalise, educate, and refer participants to the mental health nurse at the clinic (this was described in more depth in the manual itself).

Therapeutic relationship and basic counselling skills

The counsellors were required to follow the instructions and activities in the manual, while also maintaining an empathic and open attitude to participants, using basic counselling skills. These were based on the principles of client-centred counselling (Rogers, 2012), and included: Confidentiality, trust, respect, empathy, non-judgemental attitude, warmth, genuineness, open-ended questioning, active listening, normalising thoughts and feelings, clarification, confrontation, reflection and summarising. These basic counselling skills were described in the first two sections of the manual that provided information and training activities for the counsellors, and were included in the initial five-day training course. Counsellors were initially trained, and later reminded in supervision, not to give advice to participants or provide their own opinions on their problems. They were instead asked to encourage solutions and perspectives from participants themselves.

The three above capacities (following the manual, using the therapeutic topics, and establishing a genuine therapeutic relationship and basic counselling skills) were all taught to the CHWs in the initial five-day training course.

In addition to the counselling, in every session the counsellors asked the participants 14 standard questions on a checklist about their physical and mental health, and about intimate partner abuse. This was included to allow for a systematic, regular, and comparable assessment of basic emotional state and level of threat that participants were experiencing in every session, and with every phone call that the control participants received as well, which allowed for measurement across sessions if necessary. See Appendix I for the questions.

The aim of the intervention was for the counsellors to use the six sessions to teach participants certain psychological skills such as problem solving, behaviour activation and cognitive restructuring, as well as to educate them about depression, pregnancy, birth and baby health. It was intended that the participants would practice the skills through homework activities and then provide feedback on the use of the skills in the following session. It was theorised that this would assist participants in applying these skills and improved

knowledge in their everyday lives, thereby reducing depressive symptoms and increasing resilience, going forward.

5.2 Manual critique

An analysis of the manual revealed that the wording and instructions for counsellors might not have always been optimal. The following issues arose from the analysis of the manual: alternating grammar, unclear instructions in the sessions, unclear homework activities, and an inflexible design. These are presented below.

5.2.1 Alternating grammar

The manual contained different 'styles' of grammar, which were used interchangeably, and sometimes, but not always, put in italics. In a real-time session with participants, it is unlikely that CHWs would distinguish between italics and normal text in the instructions. Additionally, there were many editing errors in the writing. The styles are termed, for this analysis, as 'instructional', 'direct reading', or 'third person' style. Examples of these are demonstrated below:

Instructional style: *"Write down the date of the next appointment, tell the mother that she can write down her thoughts, feelings or questions to be discussed with the counsellor in the following session"* (Session 1).

Direct reading style: *"In the next session we will focus on problem solving can you write down some of the problems you have been facing then we can discuss them in our next session"* (Session 2).

Third person style: *"The counsellor helps the mother to look at different ways of acting out the solutions"* (Session 2).

The following sentences in Session 2 demonstrate the way these styles were used interchangeably:

> *"Choose the best solution together, and then make a plan on how you will act on this solution. Encourage the mother to make her own decisions and plans. The counsellor helps the mother to look at different ways of acting out the solutions. Ask the mother to write down her plan in her activity book and then to take action on her plan in the coming week, and then give you feedback on how it went in the next session. If the plan has not worked then the counsellor could help the mother to look at other possible actions."*

Unless the counsellor knew exactly what to do and what the instructions were saying, it would be hard to move from 'direct reading style' to then reading instructions that were meant only for themselves, immediately following this.

5.2.2 Unclear instructions in the sessions

Reading through the manual and comparing it to what the counsellors actually did in the sessions revealed that the instructions on how to do exercises within the sessions were neither clear nor concise. This was a combined result of changing grammatical styles, as well as not having very clear steps for the counsellors to follow on how to do activities.

To begin with, all of the sessions had a description about the purpose of the session for the counsellor. However, these were in a 'descriptive' format and were not repeated as instructions to explain the purpose of the session to the participant. Perhaps it had been assumed that the counsellors would read the descriptions and then paraphrase them for the participants, as there were no other opportunities where the topic was concretely explained to the participant. It was therefore left up to the counsellor to interpret and explain it in her own way (if she did that at all), or for her to read the description itself, which a few counsellors did.

An example of the description at the beginning of Session 2 is:

> *"Different people have different views on what a problem is. Problem solving looks at how to manage problems as well as how to develop an action plan to solve the problems. Problem solving can empower a mother to think of different ways of tackling her problems. Aim of the session: To help the mother to use steps of problem solving skills in her everyday life."*

Secondly, following the descriptions of the topics, all sessions began with an abstract instruction to the counsellor which said: *"Follow up on last week's issues from the session; take note of any issues that the mother would like to discuss and address them."*

Unfortunately, this was rarely done by counsellors. This instruction may have been too general or abstract for the counsellors to read and take action on. An implication of not following this instruction was the loss of an opportunity to reinforce discussions and activities from the previous session. In addition it provides room for misinterpretation or self-interpretation by the counsellor. A more direct instruction such as, "*Ask the mother if there is anything she would like to discuss from last session", "Go over last session's activities and homework",* or even a direct style of *"Is there anything you would like to talk about following last week's session?"* might have been more helpful in this case.

The sentences below demonstrate the confusing nature of some of the instructions themselves.

> *"In this session we will be focusing on healthy thinking and I would like to discuss steps to healthy thinking with you. After discussing the steps I would like you to listen to a story first and then I will have*

some questions on unhealthy thoughts that the woman in the story has after. Remember when we spoke about changing how we can look at problems in order to cope? That is part of healthy thinking" (Session 4).

The ambiguity of this sentence was initially detected through the analysis of the counselling sessions. When the manual was examined, it could be seen that the counsellors *were* actually following the manual, but that the manual itself was not clear. There were similar instances of this occurring in other sections of the manual.

5.2.3 Unclear homework instructions

Similarly, the homework activity instructions were not clear either. For example, the instruction for homework for Session 3 was:

> *"Unhealthy thoughts include any negative thoughts that the mother has had or has. Encourage the mother to think of and list any unhealthy thoughts that she might have had in the past or that she has on a daily basis for example self-blame – 'I am not a good mother, it is my fault that the baby is ill'."*

Most counsellors simply read this to the participants. There are similar instructions for Session 4 homework that were not explicit:

> *"Encourage the mother to continue writing her activities and her mood while she is doing these activities. Remind the mother to include unhealthy thoughts and healthy replacement thoughts which can be discussed in the following week as feedback."*

5.2.4 Inflexible design

Session 5 involved education on preparing for birth. Although the intention of the intervention was to conduct all of the sessions before birth, some women gave birth before completing Session 5. The manual did not make provision for this possibility and thus some women did not receive this session before giving birth, and instead received it afterwards, negating its value. The counsellors (and supervisor) might have felt restricted by the inflexible nature of the research, and the manual itself, that prescribed that sessions should be followed in a set order so that external influences on results could be reduced. This was a project-related problem that should have been dealt with by the project as soon as the issue arose. This is considered further in the discussion.

Secondly, the 14-item checklist often provided an opportunity for participants to identify and talk about their problems, but because of the set list of questions that counsellors had been instructed to follow, there was no

space for any follow up or exploration of these expressed concerns, which was another missed opportunity to follow up on these issues.

The above evidence demonstrates that the structure, layout, instructions and grammar in the manual may have led to some difficulties in its interpretation and use. These flaws did not encourage understanding by counsellors nor support the flow in the sessions.

Chapter 6. When things fall apart: deviations from intended counselling protocol

The 'core concept' identified in the axial coding process, of 'deviations from counselling protocol', are presented in this chapter. These are categorised into two main themes that group the type of deviations that occurred, being: 1) therapeutic breakdowns in the counselling sessions and 2) the influence of socio-economic context on therapeutic effectiveness. Potential reasons and mechanisms behind the above themes are discussed in Chapter Eight.

6.1 Therapeutic breakdowns in the counselling sessions

The first broad theme identified involves examples of what can largely be referred to as therapeutic breakdowns in the implementation of the counselling sessions. As will be seen, this is intricately linked with an inconsistent use of 'basic counselling skills' that were meant to underlie the whole intervention. There were many examples where counsellors did not demonstrate 'client-centred counselling', by not validating what participants had said, or demonstrating a seeming lack of empathy, and instead giving participants their own advice.

The codes under this theme are presented below. They include: a misinterpretation of psychological concepts, brushing over problems, minimising problems, absolute assurances for problems, inadequate explanations of exercises or homework, inappropriate reading from the manual, providing advice, directive suicide counselling, reprimanding participants, and contextual and personal explanations. It is important to note that these 'breakdowns' or 'deviations' may not have been inappropriate for the participants themselves, but they were not included in the manual, training, or intended counselling process.

6.1.1 Misinterpretation of psychological concepts

There was substantial evidence of misinterpretation of the psychological concepts or skills that counsellors were supposed to teach to participants. This was largely demonstrated through the misinterpretation of words or concepts such as 'psychoeducation' or 'behaviour activation'. It must be noted that this theme may be influenced by the translation from isiXhosa into English, and so the words themselves need to be viewed with this in mind.

The first example of this is of Csr A, who read an instructional sentence from the manual to the participant, and then went on to explain in her own way:

"Psychoeducation: the advisor teaches the mother about mental problems by explaining to them, the cause, what to expect and what the solution is. Psychoeducation helps to reduce being looked down upon due to depression. Did you hear? Psychoeducation is depression. Do not be confused when I use them interchangeably" (AD, S1).

This shows quite clearly a misinterpretation or re-interpretation of 'psychoeducation' to explain it in the way she understands it (which is not how it is intended in the manual).

The concept of Behavioural activation seemed to be misinterpreted quite often by counsellors too. The instruction in the manual for Behaviour activation writes:

"*Today we are going to talk about the effect that depression has on your behaviour and how we can reduce your depression by doing more positive activities. This is called behaviour activation."*

This concept was instead explained to participants by some counsellors as if it was an 'action' in itself, not a technique to be learnt. Csr A explained it as:

"Behaviour activation is the way you used to behave when you were depressed. Maybe you used to sleep a lot and be angry, so now we are going to change those things" (AF, S3).

Csr D also seemed to interpret the concept as an action or activity in itself, rather than a skill to be learnt, to decrease symptoms of depression. One of her many interpretations of the above instruction was:

"*Today we are doing our third session. The purpose of this session is about how to carry yourself. I will explain to you how you should carry yourself when facing problems. Some people tend to change when they have problems and start drinking or others become promiscuous thinking that it is a way of releasing stress. Today I will teach you how to carry yourself when facing problems"* (DA, S3).

Csr E described the Behaviour activation session using her own words, saying:

"The aim of our session is to help the mother to realise that the way she feels spiritually is in line with the things she loves and how she carries herself" (EG, S3).

In this example, the counsellor is explaining the concept of activating positive behaviour in her own words, but bringing in her own personal and contextual relevance, using 'spirituality' as a demonstration of alignment to a positive sense of self.

The above quotations show that the counsellors understood the *idea* that depression can change behaviour, and that changing behaviour patterns can decrease depressive feelings, but they interpreted the instructions of 'positive activities' and behaviour activation differently to the manual. This may have made subsequent the activities or instructions difficult for participants to understand.

To explain 'healthy thinking' with a different participant, Csr E used an example of abortion, even though the participant had not mentioned abortion in her session:

> *"Remember we spoke about changing the thoughts in order to be a part of positive thoughts. To turn negative thoughts into the positive one includes discernment of destructive thoughts and it will not help me; it is not right. You see! Abortion could damage you. So that is a destructive thought. Maybe it is your only child and you will never have a child again. You see in your lifetime you will be hurting and thinking that 'I should not have aborted'. You see! …That is a really bad thought. Get factual positive thoughts which you can use to replace the negative ones. It is crucial to get factual thoughts and know that it is something that has happened or have seen. So that you can also use it. Learn about positive thoughts and use them. So something you have learnt and know that it is constructive, you see!"* (EF, S4).

Here the counsellor interpreted the 'thought' of abortion (using her own example) as a negative thought, rather than it being a practical option that a woman may need to think about if she cannot cope with having a baby. The counsellor did two things here: she imposed her own belief system of abortion being 'bad' into the session, and interpreted this for the participant as 'negative thoughts', rather than using examples from the manual that are more related to cognitive processes.

Another example of 'healthy thinking' being interpreted as practical advice was from Csr C who said, *"Healthy thoughts are for instance if you get paid R300 at work and decide to save R100 and use the R200. That is how you save*" (CD, S4).

It thus appears that the counsellors used the words themselves without a full understanding of what the concept actually meant, as it was intended.

It is important to note that there were other instances where counsellors did explain this concept adequately, which had positive implications for participants. These are explored in Chapter Seven.

6.1.2 Brushing over problems

It also became clear that there were many examples of 'brushing over' what participants had said, or of issues they had raised, without following the client-centred techniques of acknowledgement and reflection, and thereby validating the issues that they were going through. This may have been employed by counsellors because they did not feel equipped or capable of responding to or dealing with the problems raised by participants, or that the manual did not allow for space to explore these.

One example of this was when a participant was reading what she wrote in her homework book to the counsellor, relating many things that had been going on in her life. The counsellor immediately moved onto introducing problem solving without even acknowledging the participant's homework or the factors that she spoke about:

> *BC: I wrote, 'I was afraid to tell my mother about my pregnancy, but she has no problem with that. How do I feel about my problems? I feel to be alone and I am blaming myself. I decided to listen to music at my place. I can write more about my aunt's status because that was stressing me but now, I am fine. I am sharing with my boyfriend and aunt when I have a problem and I am feeling much better now. I can sleep very well, and I am not getting tired anymore because I can do my house work.'*
> *Csr B: Ok this session is about problem solving and you have to list all your problems, what is causing your problems and you have to identify the main problem.*
> *BC: Ok.*
> *Csr B: Now I am going to ask you the 14 questions about how you feel since last week.*
> *BC: Ok"* (Csr B, BC, S2).

The above is an example of how a counsellor felt the need to stick to the manual and not deviate from its instructions. This could have devalued or invalidated what the participant had said.

Csr E did a similar thing with one of her participants, using her own example of the cause of depression and not acknowledging the participants' question or personal example:

> *Csr E: What you think is making you depressed?*
> *EA: I think about my children.*
> *Csr E: Maybe your pregnancy is making an argument between you and your husband.*
> *EA: Even if from the first time, that did not happen [to me]? [an argument did not happen]*
> *Csr E: Yes. This CD is yours; you can play it when you feel angry. It is going to tell you what to do so instead of getting angry you can play it* (EA, S1).

Csr D similarly did not acknowledge a suicidal revelation, but instead moved onto a practical question:

> *DB: I couldn't accept that I was pregnant, I had a problem, I have a child and my boyfriend, and I ate things to kill myself, twice*
>
> *Csr D - How old is your child*
>
> *DB - My child is... the other one is 16 and the other is 9, 12.* (DB, S1)

Csr A did not acknowledge or follow up the below participant's revelation of pain and lack of recognition of her illness at her church:

> *AF: They know at church that I always sing even though I don't know how to sing. They would ask me why I am not singing. I would be thinking they have no idea how much pain I am in.*
>
> *Csr A: Okay so you say you like going to groups and singing. You can write your activities in your book. We will talk about them next week. You write things you like* (AF, S3).

In the following quotation, Csr A did not acknowledge what the participant had written in her homework, and instead asked her to 'write everything we ask':

> *Csr A: You answered this question, 'how do you feel'? You wrote that "I feel much better because I have someone now. It is better than before but I need to do something because I am single parent and we have no food".*
>
> *Next time please write everything we ask here please. …You can also list the things you like to do, maybe you like to do hair and to travel to Eastern Cape to see your family.*
>
> *AB: Yes I like to do hair.*
>
> *Csr A: Ok that is my example, so you can list your favourite things.*
>
> *AB: Ok* (S3, AB).

This response may have been that the problem the participant wrote about – that she had no food to eat – was an entirely circumstantial, poverty-related problem, and that the counsellor was not equipped to deal with it. This is discussed further in Chapter Eight. Her response additionally demonstrates the impracticality of a 'therapeutic' manual being able to deal with the socio-economic realities of the participants: encouraging the participant in 'behaviour activation' such as 'travelling to the Eastern Cape' does not address the real problem of poverty and desperation of having no food to eat.

This also leads to missed opportunities within the therapeutic space. For example, Csr E did not follow up *how* EB had improved:

> *Csr E: Is there any improved difference in your life after we met? If yes, can you tell me?*

EB: After we met, you gave me advice not to take problems too seriously

Csr E: Ok. After we met, did you get help from anyone such as the advisor from Philani? (EB, S4)

Finally, Csr B did not acknowledge or follow up the revelation of 'shame' around pregnancy:

Csr B: How do you feel since you are not attending the church?

BC: My church has no problem about attending but I feel ashamed since I am having a second baby and not working or married.

Csr B: Why you think like that?

BC: I just feel ashamed about my pregnancy.

Csr B: Ok you can list all things you want to do even if you do not like them example drinking alcohol, sleeping during the day. You said that you are drinking because of your boyfriend.

BC: Yes I am going out because I want also to keep myself busy.

Csr B: So where you leave your child?

BC: At my cousin's house (BC, S3).

It must be noted that the counsellors came from traumatised backgrounds themselves and would have experienced trauma and abuse in their own lives. The apparent lack of empathy within the therapeutic relationship suggests that that the counsellors may not have wanted to address these experiences because it might have brought up their own pain and trauma.

6.1.3 Minimising problems

Similarly, the counsellors sometimes seemed to trivialise the problems that participants presented, demonstrating what appeared on the surface to be a lack of empathy within the therapeutic relationship. This was a particular trait of Csr A but was shown by other counsellors too.

The following disturbing quotation illustrates this point; showing how the counsellor used her own strategy of minimising the revelation of rape, rather than following up on the trauma of the experience itself:

Csr A: Do you have anything else you want us to discuss before we continue?

AC: Yes - when I was looking after someone's baby in 2009; I left in that place late and I took a taxi with only a few people, and they left me with a driver. The driver raped me and I did not tell anyone.

Csr A: He was old?

AC: Not that old or young.

Csr A: Hmm… what did he say to you?

AC: He asked me if I am going to [place name].

Csr A: Hmm.

AC: He raped me.

Csr A: What happened after?
AC: I told him that he can take me back where he took me.
Csr A: You did not tell anyone?
AC: No.
Csr A: How do you feel since you are talking now about it?
AC: Mmm.
Csr A: Did you test? [For HIV]
AC: Yes, I did again just now.
Csr A: Ok you are still fine?
AC: Yes sister.
Csr A: You are very lucky, AC.
AC: Hmm.
Csr A: Do not mention it because they can laugh at you.
AC: Hmm.
Csr A: You can't talk with a social worker either.
AC: No.
Csr A: You feel fine?
AC: Yes sister.
Csr A: At least you are not pregnant or HIV infected and you must be glad.
AC: Yes sister.
Csr A: Thank you for sharing this.
AC: Ok sister.
Csr A: We are going to continue now.
AC: Ok sister (AC, S4).

This quotation also demonstrates the social context that both the counsellor and participant come from: it is indeed a reality that other people and social workers might 'laugh' at a woman or stigmatise her for her experience in this community. It can additionally be speculated that it could have been culturally difficult to delve deeply into disturbing experiences, or it might have raised uncomfortable feelings for the counsellor if she too had experienced rape at some point.

Last, Csr E demonstrated an attempt to make a participant feel better about HIV/AIDS, again through the reality that so many other people have it, rather than focusing on what the participant was actually experiencing:

ED: What gets me is being on treatment. I do not know how it will work
Csr E: Just make sure that you take treatment correctly. Do not worry, be happy. No problem. There is nothing that will happen.
ED: It gets to me sometimes
Csr E: You just have to ensure that you take the treatment as told. There are lots of them [who have HIV], and your child will be fine if you do as told… Nothing will be wrong with the child – he/she will

grow up to be a healthy child and will find it by himself. Is there any improved difference in your life after our meeting? If yes, can you tell me?

ED: Yes there is. I do not think a lot and no longer [get] easily angered. Since we started talking (Csr E, ED, S4).

The examples above demonstrate what appear to be strategies adopted by counsellors to make participants feel better, while also demonstrating a failure to adhere to the intended protocol of basic counselling skills, by trivialising their problems or comparing them to others, through their own form of 'normalisation'. Although these stem from good intentions, they do not align with the designed therapeutic approach of the intervention.

6.1.4 Absolute assurances for problems

Another strategy that the counsellors used quite often was that of making assurances that after the six counselling sessions, the mothers would feel fully better and that all their problems would be solved. It appears that there was an attitude, or belief, that simply by reading through and completing the manual, the participant would almost magically feel better.

The passage below demonstrates this belief, as well as a possible lack of confidence in using the manual:

Csr A: What do you think causes the signs of depression? The signs we talked about.

AE: Stress

Csr A: Stress, okay thank you for your answer. If I hear you correctly you say that what causes depression is things that happen when a person is pregnant and then the person gets stressed. The second question is, 'what do you think causes signs of depression', and you say it is stress. Thank you. I welcome your answer. You look angry and down. We will solve everything that happens in your life. You are here today; I am here today calling you so we can talk and you can become that 'AE' again [chuckle] (Csr A, AE, S1).

Csr E seemed to have an absolute belief in the power of counselling when a participant asked whether 'feeling sad' was going to affect her baby. She answered:

"No, you have had counselling, so you are not going to have a problem. It can affect a baby if you are depressed until you give birth. If you talk about your feelings, nothing is going to happen" (Csr E, EA, S4).

Csr B told a participant in Session 1, that in their second session, they would do 'problem solving', and that

"*each and every problem is going to be solved. [Then] the last session we check if that you managed to solve your problems and you will be able to assist other people*" (Csr B, BC, S1).

Finally, Csr D assured her participant in Session 1, that:

"You will be just fine my dear. The good thing is that you have a good relationship with God. I am also here for you. We will work together. When we finish here I can assure you that you will see a lot difference in your life" (Csr D, DE, S1).

6.1.5 Inadequate explanations of exercises or homework

Very often, the counsellors did not explain the session exercises and the homework activities well or clearly to the participants. Often the concept of the session was summarised or explained to the women, but it was not practiced in the session itself. Participants were then told to do the exercise(s) for their homework, and to report back in the next session. Unfortunately, these exercises were not often discussed in the following session. This would have impacted greatly on whether the participants actually learnt the techniques themselves and were able to retain the skills for use in future situations.

This is demonstrated with an example from Csr B and a participant in the 'Healthy thinking' session, where she did not pursue the 'negative thoughts' that the participant spoke of. Instead she provided a one-sentence instruction for the homework activity, and then read the instructions for *counsellor*s to the participant:

Csr B: Let us discuss other thoughts. Do you have negative thoughts about yourself?

BC: I was thinking that since I am pregnant, now my boyfriend is not serious about me. He used to be at home always but since I am pregnant, he is going out.

Csr B: How you can handle that situation?

BC: I would ask him what he thinks about being a father.

Csr B: Ok can you think about positive thoughts instead of negative thoughts?

BC: Yes I can.

Csr B: This says that I must encourage you about thinking about positive thoughts and you can write them on your homework. We can discuss them in our next session.

BC: Yes.

Csr B: Our next session is on the 19th

BC: Yes.

Csr B: Step 3 says I must summarise our session and encourage you to do your work. Please go to your aunt and watch the DVD and make the children watch as well.

BC: Ok (Csr B, BC S4).

This quotation clearly demonstrated that 'healthy thinking' was not taught fully; nor was the homework exercise explained well. Similar examples were found from all of the counsellors. They also often did not follow the instructions in the manual. This might well have been due to the design of the actual manual, and not necessarily the fault of the counsellors.

6.1.6 Inappropriate reading from the manual

There were many examples of the counsellors reading from the manual. While this may not be problematic if it is a direct instruction from the manual, the counsellors would sometimes read out loud the instructions that were meant for themselves. In one instance, a counsellor even read part of the training manual to a participant. This hints at a lack of confidence with the content of the manual and understanding of the concepts; while also showing the intention to 'follow' the manual as they have been instructed. The act of reading a manual rather than speaking directly to a participant has important implications on therapeutic effect. Counsellors reading the instructions intended for themselves to the participants caused some visible confusion. There are numerous examples of this from all counsellors. Two are presented below.

> *Csr B: How you can look your situation, you can have the positive thoughts instead of negative thoughts.*
>
> *BD: Can you [repeat that]?*
>
> *Csr B: You can have the positive thoughts instead of negative thoughts, for example I am a good woman or a better person. Encourage the mother to write the next appointment and the positive thoughts instead of negative thoughts. Remind the mother about the session and what are you going to discuss in the next session. The third step is about to finish, we talked about your negative thoughts.*
>
> *BD: In this session?* (Csr B, BD, S4)

Similarly, Csr D read to her participant:

> *"Here it reads, helping a mother understand that the way she feels is related to the things she loves and how she carries herself. I need to encourage you to do things that will make you feel better. Like I said previously, the things that make you happy when you do… It reads here that I need to encourage you to continue to do those things and leave the negative things. …Here it says that we must help you and make you believe that everything will be alright and you will be better.*
>
> *DA: The way you feel?*
>
> *Csr D: Yes, the way you feel now* (Csr D, DA, S3).

6.1.7 Giving advice

A common technique used by the counsellors was to give advice to participants. Even though they were trained not to do so, they would often be in situations where giving advice was a default response. The following examples demonstrate how the counsellors gave advice rather than teaching participants to explore answers to their own problems, as intended in the protocol. This response may also have been due to a social and cultural norm in a traditional 'help-seeking' situation. These issues will be unpacked further, below.

The first example is of Csr E, who was asked a direct question by a participant. She gave her own advice, which was 'to pretend' not to be angry and to be strong in front of her children:

> *Csr E: What do you want us to discuss today because you have no questions here?*
>
> *EA: I want to know what I can do when I feel angry and lonely.*
>
> *Csr E: Ok when you feel lonely you can play with your children if your partner is not around.*
>
> *EA: He is going far now and I am getting angry with my children.*
>
> *Csr E: You are angry with your children?*
>
> *EA: Yes.*
>
> *Csr E: You need to pretend and you should not cry in front of your children. You need to be strong for your children. When you play with your children you need not to shout at them. Your problems are angry and feeling lonely. I am going to ask my colleagues as well for you, but now I can say play with your children and leave them when you feel angry* (Csr E, EA, S2).

The intention of the intervention and manual was to teach participants how to explore the answers to their own problems. But it appears that the counsellors lost sight of this and felt they needed to find solutions to the participants' problems or questions.

Csr E provided her own advice in response to the participant 'presenting' her problem in the first session. The participant said that her husband used to love her and her children but does not anymore. The counsellor responded with a series of opinions on how to cope:

> *"It is not the end of the life when you are pregnant, and you need to be strong for your children. If your husband is not supporting them now, it is not your fault. You can continue your business and support your children because even their father is not supporting them. Men are not supporting their children anymore and it might not be good to be looked after by their father. As a woman you know how to raise your children properly and you can be a good role model. The second thing you need to look after yourself as a pregnant woman. You can affect your baby if you stress a lot… The baby is a blessing and do not worry about the children. You need to follow your heart and do the best for your children. Men*

are all the same now, you need to apply for the [social assistance] grant for them. Now let us go back to our session" (Csr E, EA, S1).

Some counsellors offered practical advice or solutions to try to help participants cope or deal with problems that they were facing, largely because many of their problems were contextually based (as will be explored further, below).

Csr A gave advice to one of her participants, relating to the socio-economic situation that they found themselves in, emphasising the need for education and employment. This response may have stemmed from her own experiences. This advice was not easy to fulfil however, especially because the participant had no money herself:

"Look after your brother as a parent to him. There is no one else who can look after him... You must take him to school, he must study. The one that works educates the one who does not work, do you hear? Look after him, when he is in high school education look for a place and go fetch him so he can study. Make sure you provide for his studies, so that he will never struggle as you did. Do you hear?" (Csr A, AE, S2)

Similarly, advice about what to do with boyfriends or men was very common in the sessions. This is probably directly linked with the context the counsellors come from, where there is pervasive gender violence, partner abuse and gender stereotypes that are held in this community and in South Africa as a whole. The counsellors themselves would have been through relationships with men who had betrayed them; and being in a physically close community they would have observed many other relationships and behaviours of men. The advice they give about men is very clear, directive and unequivocal. It appears they have formed their own opinions about men and do not leave these behind at the 'counselling door'.

The following examples are included to demonstrate the strong influence of context on the opinions that the counsellors held about various aspects within their communities. These also highlight how difficult it is to conduct 'standardised' counselling within influential contexts.

The first example is of Csr D, who did not hesitate to offer advice. Her beliefs about the lack of agency that women have in relationships was clear, when she stated:

"[DE], let me give you a piece of advice about men. When you get angry that he spends time or drinks with his friends, the first thing in his mind is that his girlfriend or wife is controlling him. Do you understand? The right medicine for them is [for you] to keep quiet and not ask anything, even if you want to talk" (Csr D, DE, S6).

Csr E demonstrated her feelings about men through stating that all men cheat. She responded to a participant by saying:

> *"Now you think that he is cheating when he goes out. I can advise you that if he is buying food at home [for you], just keep quiet. All men are cheating so you need to look after your children"* (Csr E, EA, S2).

Similarly, Csr E unwittingly demonstrated her perceptions of abuse, coming from a society where emotional, physical and sexual abuse is highly common and severely under-reported. When she asked whether the participant had experienced abuse, the participant said that he '*talks to me'*. Csr E responded that "*that is not abusive. It is abuse when you keep quiet and you are scared to respond to him*" (Csr E, EA, S1).

It is not known whether the counsellors' advice had a positive or negative effect on women's feelings of depression. They were however receiving advice about intimate aspects of their lives that would have had an impact on them in one way or another. The intervention had not intended to focus on men and relationships, nor was it highlighted in the manual. Nevertheless, because of the problems that participants brought to the sessions and the opinions of the counsellors, the subject was visible in most of the sessions that the counsellors undertook. This points once again to the contextual nature of interventions and the influence of particular local situations on the development of broad interventions within these nuanced contexts.

6.1.8 Directive suicide counselling

Although there are theoretical guidelines in the training manual on how to manage suicidal ideation in participants, such as acknowledging and normalising feelings, these were not followed in practice. As the following quotations demonstrate, when suicidal ideation was mentioned, the counsellors slipped straight into giving the participants advice. Importantly though, it appears that sometimes this is what the women needed. This is one of many examples of the clash between possible socio-cultural expectations and more Westernised client-centred counselling strategies.

In the examples below, when suicide is discussed, both Csr A and Csr D start giving advice straight away. They do this without asking any follow up questions or an acknowledgement of the feelings (as the manual and training required):

> *Csr A: You still want to commit suicide?*
>
> *AC: Yes sometimes when life is difficult.*
>
> *Csr A: You have to think for your children and people around you. You need to be strong in life and think about your children* (Csr A, AC, S3).

Csr D gave advice straight after a participant said she has a 'big problem' with suicidal thoughts, in the 14-item checklist. However, this advice seemed to have an important impact:

> *Csr D: I want to encourage you; you want to kill yourself because you think you don't have another way to solve this problem that you're in. Firstly, you have two children… For you to sit and think that you should kill yourself and to take actions as well, to eat what you ate and wake up in hospital… When you come back you see your children, that they are affected right… How much more if you were no longer around, do you ever think that? Because they love you and want you…*
>
> *DB: I never thought about it*
>
> *Csr D: And you have a family, you have a sister, you have a mother, all these people need you, in their lives. All these people love you, you are important in many people's lives, for you to want to kill yourself just for one person, that just made you pregnant, when you didn't want to be pregnant. Do you understand what I am saying?*
>
> *DB: Yes*
>
> *Csr D: Did you not think of it like that?*
>
> *DB: No.*

Further into the session, Csr D continued:

> *"Even the person you are killing yourself for [father of her child], loves you and cares about you. Do you understand that, so when those thoughts come, take out your CD and listen to it, if it does not help, send me a call-back, I'll talk to you. I will not like it the next time I meet you, telling me you have been to the hospital again. You must know I am here for you, you can call me anytime even at night"* (Csr D, DB, S1).

Whether they follow the directions in the training manual or not, dealing with suicidal ideation is never easy. There are other examples of counsellors giving their numbers to participants or inviting them to phone them at any time if they are in need. Although this is visibly supportive of the participants, it places a huge burden on the counsellors themselves, and may be a strategy that helps the participant feel better, but which is not sustainable as a counselling strategy or on the counsellors themselves in the long run.

6.1.9 Reprimanding

Linked to giving advice was another theme of scolding or reprimanding participants. Although this does not align with traditional client-centred counselling techniques, it is possibly a cultural or social norm, in the form

of a motherly or elderly figure making known what is right and wrong. The following examples about pregnancy and having children is a demonstration of this:

Session 1:

Csr A: When did you last do your family planning?

AC: In December.

Csr A: You were pregnant already?

AC: Yes but I did not know.

Csr A: In future you must plan your future properly because you are not married but you are pregnant again.

AC: Yes.

Csr A: Ok. A condom is also important; you know why condom is important?

AC: Yes to prevent HIV and other diseases.

Csr A: Ok yes a condom is also preventing pregnancy and I do not want us to discuss pregnancy anymore. You have to take care of yourself instead of getting pregnant. (Csr A, AC, S1)

Session 5:

Csr A: Ok you mentioned that you see yourself as someone useless. We are going to discuss that problem today

AC: Yes.

Csr A: Why do you say so?

AC: I have two children already and I am still very young.

Csr A: You are the one who is making children. You are 22 years old and you stay with your boyfriend since you were 18 years. You need to look after yourself even although you are staying with your boyfriend (Csr A, AC, S5).

This kind of scolding may lead to further guilt or burden on the participants. There is obvious frustration on the part of the counsellor, but this is combined with her ability and tendency to give health and reproductive advice to a young woman who appears not to have agency over her reproductive decisions.

Another example of frustration and blatant scolding was from Csr F, who was talking about homework. She said:

"The last session you spoke about your likes and dislikes right? Where is your book? You do not write [your exercises]. I gave an example for you and you did not write. You see? I even said choose here all the way to this side. You see?... I gave an example and even made brackets for you… You did not write. Write! Write! At all. Are you getting old? I said here you must write activities that you do on a daily

basis… You chose not to write them, but you will still write them. Do not think you have escaped because you still have the book. I want that book and this one full for Session 5. Do you understand?" (Csr F, FA, S4)

It must be noted that all of the counsellors were employed previously as "mentor mothers", where their role was to give health advice to pregnant women. This is another explanation as to why this may have been the most comfortable 'mode' for them to operate in, within the client-counsellor relationship.

6.1.10 Contextual and personal explanations

This final section provides evidence of strategies that the counsellors employed that were related to their own contexts and therapeutic styles. Although this is not a breakdown in therapeutic effectiveness as such, it demonstrates diversions from the manual and intended protocol. Unlike traditional psychotherapy, the counsellors often brought their personal background, stories, and advice into the sessions, or examples of the local context to explain depression or the exercises.

In a problem solving session, one counsellor used what the participant had told her to create a narrative about how to review and evaluate her problems to find practical solutions in line with their urgency. This quotation is included in full because it demonstrates the dire nature of the problems that some of the participants are facing, and how difficult problem solving in this situation might be. As a result, the counsellor seemed to do the example *for* the participant through listing the issues she had gathered from the participant so far, rather than encourage the participant to do it herself. This is an example of a counsellor creating her own strategy or reinterpreting the exercise into a method that she feels comfortable with *and* to deal with the contextual reality. Interestingly, the participant seems to respond to her strategy:

Csr F: So you need to understand that you have a problem and this thing is a problem in your life. And then the next step is to list all your problems according to their weight. As you have many problems, like using drugs, drinking alcohol, being unemployed, sleeping around and having no place to stay. The reason I am sleeping around is because I have no place to stay and I do not have a job. Then from your problems, which one drives you to sleeping around? Because sleeping around is the biggest problem. Because when you sleep around, you will be infected by diseases. It will get you killed. The reason why you did all these things is because you have no place to live and no job. So you know that the only way to get a place to sleep is by going to a tavern. Where you will meet a man who will take you with him and then by so doing you have a place to sleep for the night. Then you wake up the following day; you do the same thing because you have to eat. So why are you doing all of this?

FC: I am doing all of this because I have no income.

Csr F: So from all these problems which one is your number one priority?

FC: Having no income.

Csr F: Having no place of residence?

FC: Second priority.

Csr F: Alcohol and drug use?

FC: Third priority.

Csr F: Now that you have listed them, you write down in your book priority 1, 2 and priority 3 because problems differ. Then as you have listed them, you will then know which one of these problems is major. So as soon as I get an income I will be able to buy a shack and then I will not sleep around and my stress levels will drop. Then once all that is done, there will be no need for me to go to a tavern. You can then work through the drug issue because drugs and alcohol are two different things. If you work through these things then you can go to a rehab [centre] because you will have income now. Let's come to the book now on page 62. This is how you solve problems. They have made an example for you, if your partner does not communicate with you (Csr F, FC, S2).

The same counsellor (Csr F) also demonstrated her personal beliefs and views on gender and the powerlessness of women, as well as about women's agency in getting pregnant (this particular counsellor used a lot of her own life stories in her counselling). She said, "*Sister, you cannot plan pregnancy. There are things that you can control, and there are those that you cannot control at all*" (FC, S2). The participant went on to tell her that her partner intentionally 'burst' a condom, and as a result she fell pregnant with their third child. Csr F responded, saying, "*Men do that; these things are part of the life we live. Okay let's move on*" (S2).

In another example, Csr E brought in her cultural assumptions and views about pregnancy before marriage and advised the participant to tell her father about her pregnancy, because she had 'disappointed' him by not being married:

"Maybe he was expecting you to get married and leave your home in a white wedding. And now you just got pregnant. A pregnant person cannot be married in a white wedding because that person is no longer a girl. You see! So, it is important for you to tell him so that he does not feel disappointed" (Csr E, EF, S1).

Last, Csr A brought in her own personal trauma in one session to demonstrate a point about suicide. She disclosed to AF that she herself had almost committed suicide by jumping in a river, when her husband died. She said that: *"I was not thinking about my children. I thought I should also die, but God saved me and now I am telling other people that it is not right to do that"* (Csr A, AF, S2).

These examples demonstrate the influence of personal context on counselling styles and techniques, and how difficult it may be to regulate or standardise counselling in different contexts. This could be particularly hard when there are already socio-cultural techniques in practice (such as giving advice), or when the counsellors come from highly traumatised backgrounds themselves.

6.2 Influence of socio-economic context on therapeutic effectiveness

The second source of deviation from the intended counselling protocol was that of the influence of the participants' own contexts. This had a direct impact on the potential effectiveness of counselling on depressive symptoms. In almost every counselling session it was clear that women faced persistent poverty in their lives. This condition exists in a self-perpetuating cycle of other factors such as food insecurity, IPV, economic abuse, alcohol abuse by partners, lack of support from partners, HIV/AIDS and continuously occurring traumatic events.

This may also be referred to as 'persistent distress', whereby the women experience stress and distress throughout and after the counselling process, which interferes with the effectiveness of the counselling. This is also evidenced in the formative data, reported in Chapter Four, in which women report socio-economic circumstances as the primary cause of their depression. The core themes of the influence of socio-economic context that came out from the transcripts are described below. The following section is described largely from the perspective of the participants.

6.2.1 Persistent poverty

In the following instances, participants demonstrate the limitations and constraints they experience on a daily basis due to poverty. They are constrained from accessing health and education services, from seeing family and accessing social support, and experience relationship problems because of a lack of money:

When Csr A asked AC whether she had managed to see a social worker yet because her boyfriend had been abusing her, she said that she hadn't, because she was "*struggling to have transport money*" (AC, S2). Although social workers are placed at every primary clinic in Khayelitsha, the participant was not within walking distance of the clinic, and the cost of R12 (less than $1) was more than she could afford to seek help for the domestic violence she was experiencing.

AA reported that she could not return regularly to the children's hospital for physiotherapy for her disabled child because she could not afford the transport money to get there. She stated that the cause of her depression was "*not seeing eye-to-eye*" with her husband (S2). Csr A asked her what it was that he did, to hurt her, and she said, "[*Sigh], the truth is, he is not doing something bad like having an affair. The devil is the money*" (AA, S2).

AB could not afford to send her child to crèche, because that would use up all of the social grant money they receive and they required this money to buy food (Csr A, S3). More distressing, DB was almost driven to suicide because she was unable to buy things for the children during winter: "*Children must get clothes, do you see, that is stress. Why would someone not want to kill himself or herself?*" (Csr D, DB, S2).

In attempting to explore the social support networks that BE may have, Csr B asked:

> *You do not like to visit friends or visit family members? Do you have a family in Cape Town?*
>
> *BE: Yes, I do, In Philippi*
>
> *Csr B: In Philippi? But you do not visit them?*
>
> *BE: No*
>
> *Csr B: Why?*
>
> *BE: It is money*
>
> *Csr B: So, because of the money, you do not visit them?*
>
> *BE: Maybe I would go to them to relieve my stress* (Csr B, BE, S1).

6.2.2 Food insecurity

"What made me sad? It is hunger. Hunger is killing us" (BE, S1)

In the discourses in the counselling sessions, food is sometimes an expression of the need for money, when money is such a transient and temporary 'substance'. When women fall pregnant and have children, there is often a sharp increase in stress and depression related to the consequence that they will have to feed more people than themselves.

AB said that she experienced depression after the birth of her baby, when she found out that she was HIV positive. She said that she felt like crying too, when her children were crying. She went on to say that:

> *"The worst thing that is stressing me is when we do not have food. Children asked for food at that time because they do not understand. My child, if he slept without food but at 5am in the morning he wants food and the other one is screaming when he wants food. He is saying where is food? Where is food? I*

leave them and go away because that moment is stressing me and I come back late, but they are still going to ask for food. If I bought a loaf of bread my children are singing, saying 'mother, mother'" (AB, S1, Csr A).

AC attributed her depression symptoms to having "*no Pampers [diapers] or food for my child*" (S1), and AF struggled to take her ARV medication because you need to eat food with the pills. The need to feed her children takes priority over the necessity of taking her own ARV medication:

"I chew the food and when I am about to swallow, I pop the tablet and swallow. That works fine and when I have money or maybe a Rand… but you know there are children in the house so… [sigh]. It is fine though…" (S3).

BE said that she used not to have an appetite for certain foods, but now she will eat anything, **"***due to the lack of food availability*" (Csr B, BE, S1).

Last, DA expressed the need for a food parcels to help them. She said:

"We commonly feel bad when we are pregnant and end up not giving birth because of problems. It would be great if you visited us more often and food parcels would help because we do not work. You wake up not knowing what to eat and yet have this baby you are carrying and the father has left you" (Csr D, DA, S6).

6.2.3 Intimate partner violence and lack of support

Physical and sexual abuse, often linked to substance abuse by partners, were frequently reported by participants. Other aspects around a lack of support from partners were also commonly described. These factors were all prominent in the participants' discourses and endorse the findings from Chapter Four. Some examples of these are presented below.

AG reported that since she was pregnant, she and her boyfriend started fighting 'physically':

"Yhoo we are fighting physically now since I am pregnant. It never happened before but since I am pregnant we are fighting physically… My boyfriend does not want me to socialise on my cell phone with my friends, but he is socialising with his friends; so we had a physical fight about that… He says that he is the only man in the house so I have to listen to him" (Csr A, AG, S1).

AC disclosed that she had taken her boyfriend to court because "*he wanted to sleep with me without my permission and he was beating me*" (AC, S2), and BD said that "*The father of my baby is cheating, and beating me a lot and he uses the stones to beat me"* (BD S4).

The following quotation demonstrates the issue of abuse and the impact it has on persistent distress, directly affecting the potential impact of the counselling sessions. In the 14-item checklist in Session 6, the participant admitted that she had been feeling better, until she was abused by her partner over the weekend.

> *Csr E: Being abused by your partner?*
>
> *ED: All that has never happened and now it is happening this weekend*
>
> *Csr E: So it is a problem currently*
>
> *ED: As for now*
>
> *Csr E: Ok. Is there anything else problematic in your life?*
>
> *ED: No, except this one*
>
> *Csr E: Is there any improved difference in your life after our meeting? If yes, can you tell me?*
>
> *ED: Er… there was, but now…*
>
> *Csr E: It has decreased. Now you feel no energy*
>
> *ED: I am feeling weak now* (Csr E, ED, S6).

Regarding a lack of support from partners, EA related her problems since falling pregnant: *"My husband said he loves me and my children but now he is not doing that. Now [I am] pregnant again, he is worse"* (Csr E, EA, S1).

NM said that her partner had now moved to Johannesburg and does not pay maintenance for them. *"He does not even want to hear. [So] I just let him off the hook"* (BE, Csr B. S1).

6.2.4 Alcohol and economic abuse by partners

Closely linked with intimate partner violence was multiple reports of the abuse of alcohol by women's partners. This had a hugely negative impact on women's mental health, the support they received from their partners and their financial situations. They often reported that their partners spent any available money on alcohol, and not on food or rent.

BC said that her partner 'drank' all the money that they had:

"I have asked my boyfriend to stop drinking and he said he will stop. He is still drinking and I need support for the child….He brings money home but he drinks it and now we do not have money to even pay for rent. He used to bring R100 at home but now he is not bringing anything" (Csr B, BC, S3).

FC had a similar situation, as she said:

"He withdrew R3000 [from the bank] then came back home and he did not even know his name. I asked him why he withdrew the money. He said I must not ask him. He made a mistake by saying that. I told him that he takes me for a fool. We haven't even bought the groceries or anything. He only had R50 in his pocket left. Out of R3000. He said he gave it to his brother. His brother asked him to loan him some money then they spent the rest on alcohol" (Csr F, FC, S6).

DA attributed her depression to her boyfriend ignoring her pleas for him not to drink, and the many implications this had on her anxiety and worry for the future:

"The reason I feel down is because I am sometimes not happy at home. My boyfriend drinks and does not want to listen to me. I am sick and he is also sick [with HIV/AIDS]. When I advise him not to drink, he does not listen. He recently went to get tested and his CD4 count was 94. He has gone back to drinking heavily. I am pregnant and feel like he will not be around and my child will not have a father. He is not home at night and that hurts me. When he comes back he wants food. I sit and think of many things. Must I dump him or what? …I tried to speak to him yesterday also because this is the problem that happens when he is drinking. When he gets paid, he goes straight and comes home drunk. When I talk to him, he does not listen and says I am judging him" (Csr D, DA, S1).

DE explained her situation by saying:

"It started with alcohol, there is nothing else. He values alcohol more than me and the baby. He doesn't know that he is a father. All he cares about is alcohol all the way. I don't understand what kind of person he is. Last week there was a fight but it was light because it`s always there when he is drunk and I would shout at him. I would tell him to just go to sleep when he is drunk" (Csr D, DE, S1).

The above examples provide clear evidence of the distress and anxiety that the pregnant women face through their partners' abuse of alcohol. Both the abuse of alcohol and the lack of partner support for women during pregnancy demonstrate degrees of economic abuse by partners, whose behaviour and decisions about the use or mis-use of money lead to significant distress for the participants in this study.

6.2.5 HIV/AIDS

The diagnosis of HIV is certainly one of the catalysts of depression for pregnant women and is often mentioned as a cause of the participants' depression (see Chapter Four). The diagnosis of HIV is a traumatic event in itself. Following this is the stress of disclosure to loved ones, and then learning how to live with the illness and having to continually take ARVs.

AA stated that the reason for her depression was "*knowing that I am HIV positive*" (S1), and AB said that "*I had a problem when I was diagnosed with HIV because I took time to accept my status*" (S1, Csr A). AF explained the cause of her depression and demonstrated the ongoing stigma around HIV in the community too:

> *"[My thoughts of not wanting to be alive] started when I found out that I was HIV positive. People in the community were laughing at me… They concluded that I was positive before the doctor tested me and found me HIV positive… Neighbours and friends came to my house and checked my medication. They kept coming to my house. When I went to the shop they would look at me through the window and laugh at me. I told myself that I am sick and I don't know what is wrong with me. The doctors had not diagnosed my illness yet"* (Csr A, AF, S1).

HIV status impacts on social, relational and economic participation throughout the women's lives, and is thus an underlying factor inhibiting full or permanent recovery from depression.

6.2.6 Continuous trauma

Instances of trauma shared by the women in the transcripts include murder, family death, and physical abuse, to name a few. The following are devastating examples of the reality that women face in Khayelitsha. One participant's brother committed suicide (Csr A, AE), and another's boyfriend was murdered: "*His younger brother found a job and he was using alcohol and drugs. On that night my boyfriend was sleeping already and his brother attacked him with an axe*" (AB, S1).

Another participant had experienced the death of three family members in her life: her mother at age 12, her older sister, and most recently her brother, who she used to stay with after her mother died, until he "*shot himself to death*" (BB, S1). BB's multiple traumas had a direct implication on her finishing school:

> *"My aunt decided that [my brother] must leave [home] and he left. That was before the other one shot himself. After he left I stopped going to school because I was studying in town. My aunt didn't have enough money for me to go to town. Then I started studying in [L-School]. I failed isiXhosa only. Then I was like, it doesn't help to repeat a class only because I failed one subject. So I ended up dropping out from school"* (Csr B, BB, S1).

The horrifying instances of death and trauma are so relentless and real in many of the women's lives. The persistent effects of context and life stressors was explained by CB in her last session. She said that she would like to be able to continue having counselling sessions, because:

> *"Stresses are not only limited to pregnancy, even when [you are] not pregnant, there are things you encounter and wish to talk to someone you have spoken to and get along with… Even after giving birth because there is stress, and maybe you don't get them now but after birth, and you need someone to share with"* (Csr C, CB, S6).

Similarly, BC demonstrated the transient availability of money and its impact on depression, when she said, "*I have no more things that are stressing me now, since I am working, because I can buy clothes and food for my children. I used to stress a lot before but now I am fine*" (Csr B, BC, S1).

In Session 3, AB said, *"I feel much better because I have someone [counsellor] now. It is better than before, but I need to do something because I am a single parent and we have no food"* (Csr A). This quotation demonstrates well the effect of the (temporary) emotional relief provided by the counselling sessions, but the inevitability of circumstance that is far more difficult to escape, without education, skills or a support system that provides a base from which to grow economically. The above quotations paint a picture of the nature and complexity of the problems that participants faced. It also demonstrates that the design of the manual may not adequately help the counsellors cope with such deep-seated issues. This is unpacked below.

6.3 Summary

The above section has presented examples of instances where there were deviations from the intended counselling protocol that arose from the data. These were demonstrated through various counselling techniques and strategies that were used in the sessions, and where the intention of the protocol was negated or disturbed due to local context or a possible misunderstanding of the manual. Chapter Eight addresses the possible reasons for these deviations from protocol and from this, generate recommendations for future interventions.

Chapter 7. When things come together: effectiveness of the counselling sessions

Despite the clear demonstrations of therapeutic breakdowns occurring in the counselling sessions, and the non-significant findings from the Hamilton Depression Rating Scale (HDRS), there was abundant evidence from the transcripts that women felt that their depressive symptoms were lessening. This occurrence was endorsed by the significant differences in the Edinburgh Postnatal Depression Scale (EPDS) scores.

The grounded theory analysis uncovered some unexpected elements that were not always explicit, but that provide deeper, more qualitative evidence of how and why the counselling sessions helped the women to feel better. This is an important distinction from the RCT outcomes, which were reported retrospectively to the fieldworkers through verbal assessments using standardised instruments. This chapter presents the concept of 'effectiveness of the counselling sessions' expressed by the participants during the sessions. The two main themes under this concept are: 'reported positive outcomes', and 'attributions for outcomes of change'.

7.1 Reported positive outcomes

The following section describes the outcomes that participants spoke about throughout the counselling sessions, despite evidence in the previous section of suboptimal implementation of the counselling protocol. It is categorised into three main sections. The first category is of participants' responses to the standard checklist that they were asked every week. The second category describes spontaneous reports of improvement in mood and affect, and the third describes the reported changes in behaviour, agency, cognition and communication. As will be shown, there were robust positive reports and responses to the impacts of the sessions.

7.1.1 Consistent responses of 'feeling better' on the checklist

As mentioned above, in every counselling session the counsellors asked the participants to complete a checklist of 14 questions about their physical and mental health and abuse. This was included as a mechanism for measuring change across sessions. (See Appendix I for the questions). These were rated on a Likert-type scale with four answer options of: "not a problem, a small problem, a medium problem, or a big problem". Following this, the manual instructed counsellors to ask: *"Have there been any big changes in your life since you last spoke to someone from AFFIRM (positive or negative)? If yes, please describe these for me?"* This question was included as a means to assess whether there had been any major life events since the last session, that may

have affected the participants' depression (and ultimately, had an impact on their assessment scores in the outcome assessment).

In practice, however, counsellors often asked the participants a version of whether there had been any *positive changes* in their lives, in a question form such as: *"Have there been any positive changes since you saw someone from AFFIRM?", "Do you see any differences in your life since we met?"* or*, "Is there a better difference in your life after our meeting?".*

Although there is a strong possibility that participants' responses to this question were in part due to a 'desirability bias', in the desire to please the counsellors, participants consistently responded with concrete examples of positive feelings or behaviours since they had met with the counsellors. In addition, they elaborated on reasons *why* they were feeling better, going beyond simply reporting that they 'felt better'. There were numerous examples of this. One example per counsellor is presented below. The issue of desirability bias is discussed further in the limitations section in Chapter Eight.

As an example, an interaction between Csr F and FC in Session 4 went as follows:

> *Csr F: Is there a better or worse difference in your life after our meeting?*
> *FC: There is a lot of difference because as we meet and talk about things, I am learning new things and different ways to deal with problems.*
> And then in Session 6 Csr F asked: *Is there a better difference in your life after our sessions?*
> *FC: There is a big difference. At the beginning as I was depressed. I saw everything differently. Do you understand? Sometimes I would ignore some issues and choose not think about them… Ever since our session, understanding the problems that cause depression helped me a lot.*

In the second session, Csr D asked DB, *"is there a better difference in your life after meeting me, and having these sessions? If yes can you tell me?"* DB responded saying, *"Yes there is a difference now, because I am able to sit with people and talk, and there would be no problem".* In the third session she responded to the question by saying, *"the work I was not doing I am able to do… and I am free, I can be around people now…I don't have that much anger now"* (DB, S3).

EA responded to Csr E's question asking whether she "had any differences since we have met?" in Session 4, by saying, *"Yes now I can control myself if I am hurt and I am not thinking about killing myself. I cry if I feel sad and talk with someone"* (EA, S4).

In Session 5, Csr B asked, *"Is there any improved difference after you met me? If there is, would you mind telling me?"* BA responded*: There is… It taught me to share things… And not keep them inside when dealing with problems. To try to find a solution to the problem"* (BA, S5). Csr B also asked BC whether she saw *"any difference in her life",* and she responded, *"Yes a lot sister, I am very happy now and I am not blaming myself anymore. I can communicate with my boyfriend and he is supporting me"* (BC, S5).

All of the counsellors received positive responses to their questions not withstanding their different ways of interacting with participants. In the last session, Csr A asked AB, *"Do you experience any difference since we met last time?" S*he responded, *"Yes a lot sister. Now I do not get angry anymore and spend with my kids and friends. I go out to my neighbour's house. I do not take everything seriously now like before so I am doing things better now"* (AB, S6).

Through the 'personal interpretation' or misinterpretation of the question in the manual, a great number of responses were elicited that allow us to interrogate the nuances of some of the healing elements of counselling sessions that were not assessed in the formal quantitative assessments. These are extremely important in helping identify what does work in counselling and what aspects of counselling the women appreciated (even if only temporarily).

7.1.2 Spontaneous reports of improvements in mood

The second category of subjectively reported positive outcomes from the participants was spontaneous accounts of improvement in mood and a decrease in depressive symptoms, that were not prompted by the above-mentioned question. Many of these reported improvements aligned with the localised symptoms described in Chapter Four, such as thinking too much, stress, worry, fear, and sadness**.** In addition to these, women reported reductions in anger and irritability, and sleeping problems.

A reduction in feelings of sadness were described in reports such as:

> *"The things I had, like being irritated, and sadness, have been reduced… I am not depressed any more"* (Csr C, CE, S3)
>
> *"I feel a happiness that I am not used to"* (Csr A, AD, S4)
>
> *"I am not feeling upset anymore"* (Csr B, BD, S3)

Many women mentioned a reduction in rumination which was a commonly described idiom of depression. This was reported in examples such as:

> *"I don't think too much… I am now sleeping at night* (Csr A, AE, S3)

"I no longer over-think" (Csr E, ED, S5)

"There is nothing I am thinking, I no longer cry" (Csr C, CB, S4)

"I am alright now, unlike when I was over-thinking" (Csr E, EF, S6)

Women also reported a reduction in anger and irritability, demonstrated below:

"Yes, I used to be angry and thinking negatively but now I can control myself" (Csr E, EA, S5)

"Now I do not get angry anymore and spend time with my kids and friends. I go out to my neighbour's house. I do not take everything seriously now like before, so I am doing things better now" (Csr A, AB, S6)

And,

"I would say that I had the anger before my pregnancy because I used to keep quiet when I am hurt. I think now I have a time to speak out and express how I feel. I used to blame everyone when I am hurt but now I see that I am changing… If I am getting angry sometimes I speak with myself and the sessions taught me how to handle my anger. (Csr A, AG, S3)

Linked with improvements in mood were many examples of a reduction in suicidality, with increased realisations of the implications thereof. AE reported in her last session, that:

"I am always hopeful that there is always a solution to every problem. That is what I learnt after I met with you. I don't think about committing suicide no matter what the problem is. Know that all problems have a solution. The worry is less now. I am stress free" (Csr A, AE, S6).

EA identified already in Session 2, that *"Now I am not thinking about killing myself",* and confirmed this in Session 4, saying *"Now I can control myself if I am hurt and I am not thinking about killing myself"* (Csr E, EA, S4).

On reflecting on the six sessions, DB said,

"What I liked [about the sessions] is when I have a problem again I will not think of killing myself… I will use my brain and think about my children… Then think what I will do, but never think of killing myself" (Csr D, DB, S6).

Finally, in Session 4, DE reflected on her process:

"One thing I pick up now as we talk is [that] wanting short cuts to solve your problems when you are stressed is not a right thing to do. I realise that more and more as we continue with sessions. I never

saw it this way before because someone would interrupt me. Now I realise that it is not wise to think of taking your life and leaving your children behind" (Csr D, DE, S4).

In Section 6.1.8 in Chapter Six, examples were given of the style of 'suicide counselling' that counsellors used, which was largely directive and instructional (and not necessarily empathic). The counsellor who had the most examples of this was Csr D. The two quotes above, powerful examples of change, are both from her participants, who obviously responded to this type of 'advice' around suicide.

7.1.3 Change in behaviour and thinking

Along with an improvement in mood, women reported changes in behaviour and thought patterns. This is despite evidence in the previous section of counsellors not doing the exercises in the sessions and not always explaining concepts or exercises according to protocol and intention. Even so, most of these changes were related to either the concepts from the manual or from the advice that the participants had received from the counsellors. It was clear that some of the skills or elements of the intervention had been learnt.

The reports of change fitted into four main themes of behaviour change and agency, healthy thinking and problem solving, healthy thinking and behaviour activation, and learning to communicate. They are explained and developed below. As will be seen, healthy thinking was usually described in relation to solving problems or behaviour activation, and it is thus reported separately as such.

Note too, that 'behaviour activation' is different to 'behaviour change'. These are separate concepts because behaviour activation is a demonstration of active change directly related to the concept and modality that was used in Session 3. It demonstrates an attempt to make an active change due to a direct lesson learned. 'Behaviour change' on the other hand is a demonstration of a shift in general behaviour as a result of any content or experience from any counselling session. These two concepts are presented separately.

i. Behaviour change and agency

The first category was behaviour change, with examples of women who report actual changes in their lives as a direct outcome of the counselling.

An example of this is of a participant who, in the termination session, related the changes in her life through the sessions and of whom she had become through the process. Her explanation included a shift towards becoming more responsible for her own behaviour and claiming a sense of agency. When the counsellor asked her what she had learnt in the sessions, she said:

"I am not learning anything right now, but I saw something. I realised that if a person wants to change, they can change. Change is really possible. I have really changed. I am humble now, but before I was not. I used to stay with my boyfriend for two weeks without going home. The boyfriend robbed people. I was not eating healthy foods for my baby. I ate vetkoek and intestines. What is that? That is not good food. I realised that I should use my brain and so I started working" (Csr C, CD, S6).

Secondly, AF had defaulted from her HIV ARVs, and had stopped taking them. In the first session, her counsellor advised her resolutely that she had to start taking ARVs again (this was something she was used to dealing with as a community health worker). There follows an interesting reflection on this in their second session together where AF reports that she has started taking her medication again, acknowledges that she wants to be 'encouraged' to do so, to be told to do so by someone, but also demonstrating an increased agency in doing this herself:

"I should do it naturally without needing to be told. Yes, I can be told, but I should also encourage myself... My decision is to take my treatment. I have started to take it… It still makes me feel sick, but I will hang in there" (Csr A, AF, S2).

Similarly, BB described her changes as follows:

"I have now realised that I have done some things because of being selfish. Not wanting to clean myself, not eating, not bathing and also staying alone. Not wanting to be around people was a torture for my baby. Yes, I visited my [young son] and talked to him but then I leave him. My affection for him is only for that moment. As I was talking with you about the solutions, I realised that I was pushing some people away. I realised that I am not giving my child enough love, because I am pushing him away. I only see him when it suits me because I am lazy. It is not fair [on him]" (Csr B, BB, S6).

ii. Healthy thinking and problem solving

Many women reported instances where they had improved in their thinking styles or cognitive patterns, usually in order to solve their problems. The concepts of healthy thinking and problem solving were, in the main, mentioned together in women's descriptions of shifts and changes. This implies that for many women, an improvement in thought patterns led to an improvement in ability to solve problems. It thus appears that the 'technique' of problem solving is actually a healthy thought pattern in itself. In terms of a cognitive reframing of the thought process of being able to solve one's own problems, the two work well together. This is clear in the following quotations:

"I feel free to face problems no matter where they come from and that is something I could not do before. Previously I would think, 'Oh my God! What happened?' But now I can face problems. I can

share with other people, be around them and laugh. Before I would laugh for five minutes and be grouchy and leave. Or I would leave and go to friends to do something wrong [take drugs/alcohol]" (Csr A, AF, S3).

Showing a similar linking between concepts, DA said in Session 6,

"I liked the session about Positive Thoughts because when you think and carry the load of everything you may end up doing something wrong like committing suicide or neglecting your children because of carrying that burden. You believe that you are the cause, whereas that is not true. I loved that session a lot because now I can deal with my problems" (Csr D, DA, S6).

In the following two quotations, similar language is used around solving problems and having hope (healthy thinking), even though they are examples from different participants and counsellors. BD said:

"I see a difference because of the thing you taught me - how to solve a problem, you see! [When I have a problem], I give myself hope that it is going to be alright" (Csr B, BD, S5).

And DE said:

"I realised that I am depressed, and have hope especially when reading the [homework] book as it explains well what we shall deal with step by step. I have hope that I will be able to solve the problem" (Csr D, DE, S2). In Session 3 she then said*: "With other problems I know how to find a solution after the second session. Before I would just sit and not know what to do. Now there are things that I know how I can handle them"* (Csr D, DE, S3).

iii. Healthy thinking and behaviour activation

In the same way, healthy thinking was used interchangeably with examples of behaviour activation to describe the changes the participants were making or going through. This is shown in the following example where CD described what she was doing (behaviour activation), but by describing them as healthy thoughts. She said,

"Healthy thoughts are dealing with your problem. If you cannot handle your temper go outside and jog or do something else… Maybe if you are being scolded, you can go outside and not pay attention to that" (Csr C, CD, S4).

In Session 5, AD read out the changes that she was experiencing, from her homework book:

"My work – I wash my dishes, cook, wash my kids, talk to my friends go to the mall, cook for the baby and watch funny stories. I will be laughing all by myself and an observer would think that I am with people even though I am alone. My spirit is happy beyond words. I sing my nice songs; I have no

negative thoughts. I am imaginative and dreaming. I am a loving person and smile alone" (Csr A, AD, S5).

DE said that since she started the sessions, *"I am able to identify a good way of behaving and a bad way of behaving, unhealthy thoughts and healthy thoughts"* (Csr D, DE, S4).

Last, AB described over a few sessions how she keeps busy and now does all that is required of her at her home:

> *"I do everything at home now, I am not lying. I feel less stress; now I do my bed, dishes and I change my mat [bed]… I can do the things I like now, I prepare [things] for my child to [go to] school, cooking and doing dishes. I bath myself, read my bible and make myself a coffee when I feel tired… Now I can cook for my children and spend time at home instead of going around… so I am doing things better now"* (Csr A, AB, S4).

These quotations provide examples of reported changes in activity that demonstrate a shift from previous 'withdrawal' behaviour, a typical symptom of depression, which might be attributed to the counselling effects. These are descriptions of activation of behaviours, often due to a shift in thinking style, that had previously been avoided.

iv. Learning to communicate

There was also a strong thread of women reporting that they were starting to communicate, whether it be with their counsellor, their family, and/or their partners.

This was demonstrated in an example from BB, who related that she now talks about her problem before it becomes too much of a stress for her. She said, in Session 6, that:

> *"I talk now when I have a problem. I don't keep quiet. I used to stress about something before talking about it. Now I first talk, look at it, and do what I need to do, before I stress about it and before I think about how it will go if I didn't do it. So now I first come up with a solution before I make it a problem… There is nothing more important than talking, instead of keeping it inside. When you keep it to yourself it does not sit well with you. That can lead to you getting sick. That is what I learnt"* (Csr B, BB, S6).

BA demonstrated her learnings about communication when she read out what she had written in her homework book:

"I met [Csr B] and we spoke. I was in a very good mood. It is a nice thing to meet her because I learnt that when you have something bothering you, do not sit with it or keep it. Seek help or try to solve the problem you have. She made a big difference to me" (BA, S3). She later also said, *"Counselling taught me to share things, and not keep them inside, when dealing with problems, try to find a solution to the problem"* (Csr B, BA, S5).

AF reflected about her learnings about communication in Session 5:

"I learnt that I should not hold on to things that are bothering me. If something is bothering me, I should share it with another person. I mostly talk to my sister in Drift Sands. We chat on WhatsApp. We talk and have a good time… [Before], I could not share about my problems, but now I don't keep things to myself. I can speak to my mother when I have a problem" (Csr A, AF, S5).

Within these learnings, women also reported being able to communicate better with their partners, which would have had an important impact on their mood state, acceptance of pregnancy, and a feeling of being supported. For instance, in Session 3, AA related that before, *"I would hold on what he says and not say anything. So I decided to quickly address it and ask him not to speak like that".* Csr A responded with an affirmation, saying, *"That is good. You have used a skill there. Well done*" (AA, S3).

Below is another example of a participant reporting an improvement in communication with her partner, which is sustained over time. Examples are given from Session 3,4 and 6:

S3: "I can communicate with my boyfriend and he is supporting me. He is respecting me and I do not need friends because I am always at home. We talked as well about his feelings and I understand about what he is saying. When we have a problem, he is going out because I am getting angry so he is avoiding that".

S4: "When I have a problem I write down or talk about it. I am not stressing anymore since I met you. I can communicate with my boyfriend if we have a problem".

S6: "[In the sessions] I learned that it is very important to communicate with your partner and do not hold everything to yourself. It is important not to take things on yourself and you can harm a baby… I am able to communicate with my boyfriend I can speak out how I feel. My boyfriend expressed his feelings as well [about] how I treat him" (Csr B, BC, S6).

Learning to communicate again and receiving positive reinforcement for doing so is an important outcome from the counselling. This additionally encourages further social support for women when they need it.

7.2 Attributions for outcomes of change

The following section unpacks the attributions that the participants were giving as reasons for their feeling better and experiencing behavioural and cognitive changes. The identified attributions include: improving knowledge through receiving advice on relationships, pregnancy, birth, and depression, a normalisation of feelings of depression, the experience of confidentiality and trust, commitment from the therapist, sharing problems, a sense of relief, empathy and being heard, experiencing a sense of connection and hope, and the effect of the baseline assessment. These are presented below.

7.2.1 Receiving advice and improving knowledge

As much as giving advice may have been a deviation from protocol, the advice and education that the participants were given by the counsellors seems to be one of the mechanisms attributable to their change in behaviour and improvements in mood. In addition to counsellors providing unrequested advice, there were many instances when participants asked outright for advice from their counsellors.

This is demonstrated in an example from a participant who still needed assistance at the end of the six sessions. She asked*, "If you could advise me about what to do in marriage, with my husband, kids and my entire family so that my family will not fall apart in my presence?"* (Csr A, AA, S6). One can sense the desperation in this appeal, at the end of the six counselling sessions, on issues that the psychological counselling had not been able to address. This explicit request for what to do to save her 'entire family' expressed an expectation that her counsellor would have all the answers.

The expectation of the 'all knowing' counsellor was confirmed in a more positive example, when a counsellor read what a participant had written in her homework book. She said, *"When you have a problem, do not stay and let it eat you while you have people who can advise and give you a solution to the problem bothering you of any sort"* (Csr B, BA, S3).

The mechanisms of advice were visible through three key themes: that of advice about relationships, pregnancy and birth, and depression. These are presented below.

i. Relationship advice

Many participants acknowledged the advice that the counsellors had given them about relationship or family issues, and some attributed their shifts in relationships and communication to this advice. It appears that they

valued the presence of someone they could trust and whom they looked up to, who could give them guidance on what to do in their life situations.

The relationship advice that counsellors gave participants was largely associated with their partners and their families. In the following example, DA read out from her homework book that she had been fighting with her boyfriend for a long time and wanted to find out from Csr D *"If it is a solution to leave him. Will I be able to find the right person?"*

In her fifth session, DF said to her counsellor that there was a "*better difference in my life because you advised me on how I should behave. Not to shout at the person I live with… he [ended up] asking for forgiveness"* (Csr D, DF, S5).

Some participants needed encouragement for things they knew they needed to do but didn't know how. In many instances this is related to the disclosure of pregnancy to boyfriends or parents, which was one of the factors causing their distress in the first place. Even if the advice was short or inadequate for their exact situation, it seems that it provided them with courage or agency to act towards positive change. The following two examples demonstrate an attribution of a shift in their lives to the advice they received from their counsellors. Both participants had not told their fathers about their pregnancies, and knew they needed to but were too afraid to do so.

EF told Csr E that after their first session, she spoke to her father, "*thanks to your advice you gave me on what to do".* She said, once she did it, *"I had that hurting thing, I disappointed him… I cried, I cried. He scolded me… He scolded me but he did not do so the way I thought he would".* Csr E responded by saying, *"I am happy when you managed to speak to your father. This is a good thing. So this is one of the problems you have resolved by yourself. It is very important to face your problems"* (Csr E, EF, S2).

In Session 4, AD reported that she *"Got the power to stand up to my father*". Csr A asked, *"Where did you get the power from?",* and AD responded, *"From you!"* (Csr A, AD, S4).

Last, the following example is of a participant relating what she had learnt from the counselling in Session 5. This quotation was surprising to read and has been included to demonstrate the value of receiving advice, because in all four of the preceding sessions with this participant the counsellor brushed over the participant's problems, read from the manual, and gave her own advice. In spite of this, at the start of Session 5, the participant read the following from her homework book:

"We spoke about the positive and negative thoughts, so I wrote here about my negative thoughts. I am controlling my partner since I am pregnant, and I am fat now. I think he is not satisfied by me anymore. I am also too dark [skinned]… The right [healthy] thoughts are that [it is] not a bad thing to communicate with a partner. It is important to express your feelings to your partner. The communication is also important in order to have a good relationship. The baby needs both the parents to be supportive all of the time. Alcohol is not a solution, it can make more problems. It is important to communicate, when a baby is born, and a woman should not blame herself about her pregnancy" (Csr B, BC, S5).

The above quotation encapsulates the essence of this theme: that even though a counsellor may have used a directive counselling style for the majority of the sessions, the participant attributed her positive shifts to this advice, and this served as a mechanism for positive change.

ii. Pregnancy and birth education

The second category of advice was oriented around health, pregnancy and giving birth. Due to the counsellors' previous employment as 'mentor mothers', they were knowledgeable about pregnancy and women's health, and were used to providing this kind of advice. Session 5 in the manual specifically focused on this but counsellors also provided information in other sessions. The need for knowledge around pregnancy and birth is demonstrated below:

"I think you should advise all the pregnant mothers in Khayelitsha because everyone who is pregnant gets stressed. Especially we people who are not married. It would be great if everyone that is pregnant gets help and advice about what she should do" (Csr A, AE, S6).

BC expressed similar feelings:

"This [counselling] is very important for pregnant women because it educates us on how to raise our children. I am educated about how to handle things. Most women need help from outside, to take care of their children".

She then related what she had learned from the sessions, which included *"To be able to communicate and express my feelings to my partner. I learned how to raise my baby"* (Csr B, BC, S6).

AG reported that: *I learnt a lot about opening up, speaking about my problems, and especially advising and being advised. I learnt to look after my child, to speak and the way to… love. I learnt to communicate with my child and love him "* (Csr A, AG, S6).

The above examples of improved knowledge through education from the counsellors demonstrates the value they attributed to the advice they received in these areas.

iii. Education about depression

The therapeutic topic of Session 1 was 'psychoeducation'. The information on depression in this session was often read to the participants from the manual. Despite this, there are many examples of how helpful this information had been for participants in learning about the symptoms of depression and about the various causes of depression. This indicates low levels of mental health literacy in this context and the need for education and assistance in this area.

Some examples of these reports are provided below:

CB said, *"I felt that my depression went away after we spoke about that first session on depression… When we met and you advised me on what causes depression"* (Csr C, CB, S6).

Other participants expressed the following:

> *"I know how to make decisions now since I met you. My life is easier now because I am aware about depression and symptoms"* (Csr B, BC, S3).
>
> *"I feel very good because this is educational… I have a lot of information that I did not know before… It changes me a lot and helps me"* (Csr C, CC, S3).
>
> *"I learned how to treat my children even if I am not well, because I used to abuse my children when I was depressed" (Csr A, AB, S6).*
>
> *"Understanding the problems that cause depression helped me a lot"* (Csr F, FC, S6).

These examples provide an interesting commentary on the value of psychoeducation as a therapeutic tool and mechanism for change in itself. Through providing information and knowledge on the condition, symptoms and causes, women are empowered and the feelings that they experience are normalised.

7.2.2 Normalisation of feelings

The sense of recovery that women describe, having learnt about depression and its causes, appears to lead directly to a subsequent feeling of relief and release of self-blame, guilt and internalisation of feelings. Through the normalisation of these feelings by the counsellors, there is better understanding of depression, and a subsequent acceptance and recovery. Again, this points to the lack of mental health literacy in the community and clinics they attended.

Participants reflecting on the process of counselling in Session 6, expressed the following:

> *"I learned to express my feelings and trust myself*" (Csr B, BD, S6)
>
> *"I learned how to solve problems and not blame myself"* (Csr C, CA, S6)
>
> *"I am happy and satisfied about your education from AFFIRM. Since I spoke with you I am free and I am not blaming myself anymore"* (Csr B, BC, S6)
>
> And, *"I know now about the depression and how to behave; I learned that depression is a healing process, but you need to speak out about your feelings*" (Csr A, AG, S6)

Similarly, in other sessions, participants mentioned learning not to blame themselves or internalise their problems, such as AE who used to *"Tell myself that I am the problem. But now I feel stress free and alright"* (Csr A, AE, S3). CB also expressed that *"I felt like sort of forgiving myself a bit now"* (Csr C, CB, S2), and BA who said that she "*Learnt not [to] internalise something when you have a problem"* (Csr B, BA, S4).

The feeling of 'blame' is mentioned often; whether this be for being depressed or for being pregnant. It appears that sharing problems with their counsellor assists in reprieve from this blame, and often, a subsequent ability to address problems in their lives. One can imagine the positive impact this would have on women's sense of acceptance of self and being in the world, in the knowledge that they are not alone or unique in having these feelings.

A few women mentioned stigma around counselling and depression, and how difficult it was to seek help. NG related that *"The problem is that the people who are now surrounding us can laugh about your problem, so it was hard for me to talk about all my problems to people before. But now I felt good. As long as there is someone I can talk to. Someone like you"* (Csr A, AE, S6).

BB talked about the stigma of counselling, saying**, "***We, as black people, have that belief that when you are going for counselling you are either crazy or HIV positive. But counselling is not about that"* (Csr B, BB, S2).

The normalisation of depressive feelings and symptoms therefore appears to be assisted by the normalisation of asking for help as well.

7.2.3 Confidentiality and trust

Within the therapeutic space, the participants often mentioned how much it meant to them that they could trust their counsellor with their confidential problems and life stories. This allowed for an expression of their needs and a release of stress and the strain from internalising these stresses. It also allowed for expression of

problems that could not be discussed with family or friends, particularly in an environment where there is a lot of stigma. In this environment, women expressed that they couldn't trust that there wouldn't be gossip around what they have shared. This was demonstrated by BD in a few different sessions when she said:

> ***"****I like it because I feel free. I expressed my feelings because I trust this person is not going to judge me"* (S2). *"Now I feel free because I was scared to share my problems. I was feeling that if I share, then they can discuss my problems. I am not crying now and I think positive about my problems"* (S5). *"I like that I am sharing my problems with another woman. You told me that our discussion is confidential so that made me to feel free"* (Csr B, BD, S6).

The following example shows fittingly the value of trust and confidentiality within the therapeutic relationship, as well as the expectation of receiving advice: *"Now I have someone to talk to, someone I trust, and someone I know will advise me, someone I know that won't talk about what I tell her and it will be between us"* (Csr D, DE, S5).

AG endorsed this in Session 6 when she said:

> *"Sometimes in your family you cannot talk to a family member. You have to talk to someone you do not know, in order to say all that you want to say. So what I liked is coming here to talk to you in the sessions, because I have no one to talk to in the house. You remember that my mother was cross so I do not feel comfortable to share the problem I have in relation to the child. So I just wait for the sessions in order to come to you so that all could stop*" (Csr A, AG, S6).

The therapeutic aspect of confidentiality and subsequent trust between participant and counsellor is a compelling mechanism for positive behaviour change. This is supported through reinforced acceptance and normalisation of behaviour and feelings, a lack of judgement of these, and subsequent opportunity for participants to share, discuss problems, and possibly even work out solutions, thanks to the space they have been given to do so.

7.2.4 Commitment from therapist

Another aspect that appears to have had an impact on positive outcomes and improved mood for participants was the assurance and commitment from the counsellors that they would have six sessions together (acknowledging that this was a research requirement). In some instances, this was a challenge for the counsellors as some participants were difficult to reach and did not always come for their sessions when they came to the clinic for check-ups. As a result, counsellors would often have to go to participant's houses to hold

the sessions. This persistence seemed to pay off for many of the women, as demonstrated in the examples below.

AE said that she couldn't always afford to come to the clinic for her sessions, so she was very appreciative that Csr A came to see her, *"Even if I do not have money"* (Csr A, AE, S6).

AC described the support from her counsellor as the reason why she no longer had 'wrong thoughts'. Csr A asked, *"Why do you not have [the wrong thoughts] anymore?"* And she responded, *"Because I have the supporters like you"* (Csr A, AC, S4).

The following humorous comment describes the developing relationship between a participant and her counsellor. It exposes her initial resistance to counselling, but what a considerable influence it had had on her life:

> *"I was thinking about the difference in my life [since we met]… I was thinking that I wanted to dump you! [both laughing]. [But] I thought that if I had dumped you, I was going to remain like this my whole life. So I say I thank you because you kept on calling me"* (Csr A, AD, S6).

It is interesting to note that all of these examples are from Csr A. She was the oldest counsellor, who had the highest retention of participants. This may hint at the value placed on an older counsellor, who was possibly more worldly wise and stable in her own person, and therefore more dependable as a counsellor in this context.

7.2.5 Sharing problems

Although women live cheek by jowl in Khayelitsha township, they often experience social isolation, particularly when a potentially stigmatising event has occurred (such as rape, sexual abuse, having no money, an unwanted pregnancy, HIV diagnosis, or losing a partner). These multiple instances of trauma are often suppressed by women who do not have supportive family or friends to talk to, or who are too ashamed to speak to those they know. The police system is notoriously callous, unwelcoming and gender biased against women for them to want to report trauma and abuse (no social workers present, few women police, disbelief from police).

The counselling sessions provided a space for the participants to have someone to talk to and with whom to share their problems. This appears to be another significant factor that women attribute to feeling better. There were many examples of participants relating that they were increasingly able to express their problems and face them in their normal lives. Thanks to having someone to talk to, many experienced a sense of relief.

For instance, CB said,

> *"There is a lot [of difference] because initially I was depressed. My heart was broken and could not share my problems with someone. I would keep my problems inside but now I can share, and now I am no longer depressed nor sad. I just have stress about giving birth but not the kind of stress that would affect me. It is stress about giving birth. I feel a lot better. I can at least answer back when someone says something to me because I no longer internalise that. What made me tense was keeping everything inside. It made me cry all the time and feel hopeless"* (Csr C, CB, S5).

Other participants expressed similar feelings:

> *"There is a difference [in how I feel now] after I talked to you about things"* (Csr F, FC, S2)
>
> *"Now I am not thinking about killing myself because I can share my problems"* (Csr E, EA, S2)
>
> And, *"Ever since I came into this programme I am now able to talk and empty my chest. I can face my problems now. I just put it behind me".* (Csr A, AF, S6)

CA expressed this over a number of sessions:

> *"Because I spoke out, now I feel much better… Since I met AFFIRM people I am able to express my problems. I am not thinking like before, I am better now"* (S2)*, "Because I have shared my problems with you from the first session, now I am feeling much better* (S5) *… I am not stressing like before. I learned how to solve problems and not blaming yourself. You need to find a person to share your problem with*" (Csr C, CA, S6).

The sessions with the counsellors seem to have helped women to share and express their problems, and in doing so, often assisted them in solving their problem. Both of these factors demonstrate an increased feeling of support from an 'other' in the women's lives. This feeds directly into addressing one of the causes of depression that women identified in Chapter Four, around a lack of support during the insecure time of pregnancy.

7.2.6 A sense of relief

The counselling provided a platform for many women to talk about trauma they had experienced in their lives, an opportunity that many of them had not had before. The following quotations demonstrate examples of the sense of relief that women felt through the disclosure of traumatic instances and their feelings of depression and sadness. This was clearly shown by BD when she said: *"Since I spoke out about my problems and I feel*

differently. I am not stressing about my problems anymore. I am relieved, now I am not stressing anymore" (Csr B, BD, S3).

AG read from her homework book that:

> *"I am thankful for the first session. [It] helped me to relieve the load I had on my shoulders. It minimised the thoughts that could have hurt me and my child. I also feel like loving my child even more. I felt better and I don't want to run away from people who are close to me any more… The session helped me to open up and to also cry. I felt better thereafter and was in the mood to carry on with the session… I opened up and cried and felt relieved"* (Csr A, AG, S2).

In Session 3, CB said that her change in mood came *"Through talking and getting rid of something bothering you. This helps a lot [rather] than bottling it up with no one you trust to discuss it with. Because if we were not meeting maybe I could have done something to myself"* (Csr C, CB, S3). Both of the above women intimated self-harm or suicide due to the lack of opportunity they had had to talk to about their problems.

Another participant said to her counsellor: *"I realised that when I talk about certain things I get healed. Talking to you made me feel better. I managed to see how I get hurt by some things, and what I am supposed to do to achieve certain things"* (Csr B, BB, S2).

FC expressed about her first session that: *"the session was helpful to me because there was no one that I could talk to, in order to get help about things that… like things that are bad things and good things… there is a difference [in how I feel after] I talked to you about things"* (Csr F, FC, S2).

The feeling of relief after being able to talk about an internalised traumatic experience thus seemed to be an important mechanism in improving affect amongst the participants.

7.2.7 Empathy and being heard

Following the experience of sharing problems and feeling a sense of relief, a third therapeutic 'level' is the subsequent feeling of 'being heard' or experiencing empathy. Section 6.1.2 reported many instances of counsellors simply brushing over participants' problems. Yet there are still reports from participants about how it felt to share their problems and have someone really listen to them. This demonstrates that when the counsellors did do this, even if briefly, that it was healing for the women.

AB described the feeling of being heard, similar to that of the concept of 'Ubuntu'. This is a widely used South African concept. It can be explained in the sense that we become more authentic versions of ourselves through the presence and influence of others in our lives. AB read from her homework book:

> ***"****Since I met [Csr A] my life changed and she is the parent to me. She educates me about everything. [Csr A] is always in a good mood and listens to you. I do not feel depressed anymore, a person is a person because of others, and I thank you"* (Csr A, AB, S6).

The following participant said that she appreciated being heard, and liked to be helped with her problems:

> *"I don't think the same way I used to before… Because there is someone I talk to who listens to me. Someone who doesn't judge me. Because I also don't know why I am that way… And not just listen, but try to help me solve the problem"* (Csr D, DE, S4).

This interesting quotation demonstrates so well the appreciation of a collaboration in the therapeutic relationship, in that the participant feels heard and not judged, but then is also hopeful that her counsellor will help her to try and 'solve the problem' together.

Contrastingly, BB described the process of being heard in the context of a therapeutic situation, but was one example of a participant who did not want advice from her counsellor:

> *"There is a big difference [in me] compared to before, [and] the difference is getting bigger. Lately, I feel like… Do you know that feeling when you feel like someone has to listen to you? Now I feel that… when there is a person who listens to you… Besides not wanting to be judged. Sometimes you don't want advice. You just want someone who to listen to you. That gives hope"* (Csr B, BB, S4).

7.2.8 Connection and hope

One of the more subtle findings from the data was that participants were experiencing an increased sense of *connection* between themselves and their counsellors, and consequently, were encouraged to improve and re-establish their own social support in their lives. The following quotations provide some examples of the improved sense of connection that participants felt through the process of counselling.

> CB said, *"When I talk to my boyfriend, he does not want to be involved. So, at least by meeting you, through talking to you, it is better…Because sharing is important"* (S3)*; [The sessions also] removed my stress. Through listening, I discovered that this way helps [better] than staying by myself and not having someone to solve problems with"* (Csr C, CB, S6)

In concluding Session 6, AF expressed her gratitude for the connection she felt:

> "*There is nothing [else] except for saying thank you. I did not think that I would be like this, [being] able to talk about a problem. I am like the only child. I talk, but I cannot talk too much… If I don't want to I don't want to and you won't force me. I learnt a lot of things here and I am grateful"* (Csr A, AF, S6).

CD said that what she liked best from the sessions was *"The care; because I would be sad and you would always ask, 'what made you sad in the past two weeks?' You help me feel comfortable to share my pain"* (Csr C, CD, S6). Even though the counsellor was likely asking the survey questions, CD experienced this as consistent care and felt a sense of connection through this consistency.

The feeling of recovery and reminder of how to communicate and make contact seemed to help women reconnect with neighbours and friends and feel the benefit of this. AD demonstrated the increased sense of connection she had with her family, when she said, *"Now I want to do good things; I hated my family members… But I want them now!"* (Csr A, AD, S4). Other examples are provided below:

> *"Now I can socialise with people even though I had no relationship with them before… [I share with] my friend next door. We just share our things"* (Csr A, AC, S3).
>
> *"I am free and I now socialise to reduce my problems"* (Csr A, AE, S5)
>
> *"It was nice to see the neighbours, rather than being alone and being locked up… To be out with friends was nice"* (Csr B, BE, S3).

Another element of connection seems to be the provision of hope and motivation by the counsellors. The increase in hope was mentioned by participants on numerous occasions. As it has been included in a number of the categories above, it has not been allocated a category of its own. One example of this is when AA described in Session 6 that what meant the most to her in the sessions was *"Being comforted and given hope, even through life's ups and downs… So, I liked being comforted, and being given hope"* (Csr A, AA, S6).

The discussion in Chapter Eight will elaborate further on the role that connection plays as an element that encompasses all other attributions within the therapeutic relationship.

7.2.9 Assessment effect

One other factor that had a visible role to play in assisting participants to feel better or more connected, was the impact of participating in the baseline survey assessment for the RCT with the fieldworkers. Of the 39 participants, 30 reported in Session 1 that they felt better after participating in the baseline assessment with the assessor. These reports were all prompted by counsellors asking participants whether they had

experienced changes or differences since meeting with 'someone from AFFIRM' in the 14-item checklist, as described in Section 7.1.1. Since this was asked in Session 1, the participants justifiably understood this as the assessment with a fieldworker. It provided important information on the isolation that participants had been feeling, how unrecognised their situation was, and how desperately they needed to talk to someone, when they participated in the baseline assessment. It also highlights that simply being listened to was, in itself, a healing process. There are numerous examples in the data that demonstrate this interesting phenomenon. A few of these are included below.

Firstly, feelings of increased hope and motivation were mentioned:

Csr A asked both AA and AE whether there was *"A difference after you met with someone from the AFFIRM project – that lady you spoke with at the beginning?"*

AA responded, saying,

> *"Yes there was… The difference I experienced [after I spoke to the fieldworker] is that I got to have hope… She gave me hope as we were talking… She encouraged me… She encouraged me not to underestimate myself after this situation… To be the [person] I was before"* (Csr A, AA, S1).

AE responded to the question saying, "*There was a difference [after I met with the fieldworker]; I had hope that this will pass"* (Csr A, AE, S1).

Csr D also asked this question and DE responded by saying:

> *"Yes there is a change. I have more hope now and I don't think all the time as I used to. I feel that my stress level is lower than before I came here. I stopped wanting to be all alone and not wanting to talk to anyone compared to before. I did not trust anyone and think I could speak to anyone. It is better now after I spoke to her. When I spoke to her, when I came to book, I was very stressed and I could not sleep at night nor eat. When I met with her I was really sad and she saw that. She gave me hope… After I spoke to her I felt better"* (Csr D, DE, S1).

Secondly, participants mentioned that they appreciated having someone to speak to:

> *"I am not going to lie, talking about my problems really helped me because I felt better than I was. I realised that there was a change… Because I looked at things with a different perspective. Like I said, having someone to talk to really helped me"* (Csr F, FC, S1).
>
> *"Things are better because I spoke about it; at least there was someone who listened"* (Csr F, FF, S1)
>
> *"I felt much better after we met… I felt like I found someone I can speak with about my problems. Yes, I feel sorry for those who refused to go there because they missed an important session"* (Csr A, AB, S1)

"I felt good because after I spoke to her I was thinking until I got home. I thought, 'wow there are such things, people that are able to talk to people like this!' I did not know that there were such things" (Csr A, AE, S1).

Through having someone to talk to, participants felt a sense of relief:

"It felt like something was removed from my body. It felt like other things got easier" (Csr A, AF, S1).

"I am fine now, because of speaking to the sister I spoke to. Talking about what I felt made me feel a lot better. Telling someone something like that made me feel like something has been taken from my shoulders. I cannot say my life is 100% right, but I am happy now" (Csr F, FB, S1).

"[When I met the fieldworker] I was nervous and angry. I spoke with her and I was relieved after" (Csr A, AC, S1).

Last, some participants appreciated the advice they received from the fieldworkers:
EF said, *"The questions that young lady asked me and the pieces of advice she gave me, they made a big difference"* (Csr E, EF, S1).

The following two examples demonstrate extremely influential impacts on behaviour change. One participant stopped smoking 'tik' (crystal methamphetamine) and 'dagga' (marijuana) after her baseline assessment, which had a significant influence on the health of her baby and of her friends:

"[After I met with [the fieldworker] I did not smoke tik or dagga. I just smoke a cigarette". (Csr C, CD, S1). And at the end of the six counselling sessions*, "I see a difference because I was just starting to use drugs and stopped. My baby was born healthy… My friends were also getting into this bad habit of smoking tik. They saw me smoking tik. I would not want to spend a lot of time with them because I was smoking tik. They would talk…. They thought that for them to be close to me they must also smoke what I was smoking. I smoked and stopped. They also smoked and stopped because I also stopped. Clearly they were following my lead*" (Csr C, CD, S6).

Secondly, AG said that she had tried to commit suicide four times already, but had not thought about going to counselling. *"But I have no problem now. When I met the AFFIRM people I felt better. I am not thinking about killing myself"* (Csr A, AG, S1).

7.3 Summary

This chapter presented evidence of reported positive outcomes, and attributions of these outcomes, that the participants spoke about throughout their counselling sessions. These included changes in mood, affect, behaviour and communication. The attributed mechanisms included receiving advice, a normalisation of feelings of depression, the experience of confidentiality and trust, commitment from the therapist, a sense of relief, sharing problems, empathy and being heard, experiencing a sense of connection and hope, and last, the effect of the baseline assessment.

These results are set starkly against evidence from the previous chapter, which demonstrated the multiple counselling strategies and deviations from the counselling protocol that occurred. This provides commentary around the deep need for connection and support amongst this population of women, and the sense that the counselling sessions were appreciated, for the above reasons. The following chapter discusses what role these factors have as therapeutic elements in task sharing interventions.

Chapter 8: Discussion, recommendations, and conclusion

The previous chapters reported on findings that focused on the three broad objectives. In summary, these objectives were:

Before implementation of the AFFIRM-SA RCT,

1) To examine local pregnant women, mothers, and health workers' idioms of distress and understandings of the symptoms and perceived causes of perinatal depression in Khayelitsha, to inform development of the counselling intervention, and to provide contextual information for the intervention.

Following implementation of the intervention,

2) To describe and critique the AFFIRM-SA counselling manual, to explore potential influences it may have had on the RCT results, and
3) To examine the processes that occurred in the implementation of the counselling sessions.

This chapter unpacks the possible reasons and mechanisms for the findings that were identified in the three objectives. The structure of this chapter is as follows. In relation to relevant literature, Section 8.1 presents a brief discussion of the findings from Objective One. Sections 8.2 and 8.3 discuss potential reasons for the deviations from protocol – 'when things fell apart' – and the possible mechanisms or elements behind the attributions of the reported outcomes – 'when they come together'. This includes findings from the review of the manual and the 'selective codes' that were identified from the grounded theory. It highlights many factors that are relevant for the design and implementation of task sharing for alleviating depression in LMICs. Section 8.4 presents two models that were created to understand what may have occurred in the implementation process. Recommendations for research in task-shared mental health interventions are then presented, followed by the strengths and limitations of the thesis, a reflection on reflexivity as the researcher, and finally, the thesis conclusions.

As stated previously, the outcome assessments of the Hamilton Depression Rating Scale (HDRS) and the Edinburgh Postnatal Depression Scale (EPDS) differed, despite overlap in the construct of depression that they seek to assess. Reductions in clinical depression on the HDRS at three and 12 months postpartum were not significantly different between the intervention and control group (RR=1.16; 95%; CI 0.94, 1.43). There were no notable differences in the mean change in HDRS scores from baseline to three or 12 months postpartum (Lund, Schneider, et al., 2020). However, EPDS outcome scores in the intervention group demonstrated significant reductions in distress compared to the control group at both of these time points (3 months: RR=0.78, 95% CI: 0.67-0.91, p=0.001; 12 months: RR=0.79, 95% CI: 0.68 to 0.92, p=0.003). Through qualitative

methods, the process evaluation was able to interrogate the factors that could have contributed to both sets of outcomes on the HDRS and EPDS. The results show clear deviations from protocol that might have led to non-significant effects on the HDRS, but simultaneously, compelling evidence of improvement in mood, behaviour and cognition reported by participants, which may have been reflected in the EPDS scores.

The conceptual frameworks for process evaluations put forward by Moore et al. (2015) and Murdoch (2016) helped to examine where 'disruptions' occurred in the intervention delivery. They framed the analysis through emphasis on the influence of contextual factors, implementation factors, and mechanisms of impact, on the counselling sessions (see Figure 1 in Chapter Two for a demonstration of these factors). The analysis of counselling sessions themselves provided an important method of assessing implementation processes within a trial, that goes beyond quantitative data analysis and even beyond interviews with participants themselves. It provides an opportunity to 'see in' to the sessions as they were happening, rather than elicit responses from participants or counsellors after the process had been completed. This uncovered many important therapeutic and contextual aspects of the intervention that were not recognised or identified through the outcome assessments for the RCT. These findings therefore provide important information for understanding aspects that occur within RCT implementation that can and should be used to inform future research and intervention development.

8.1 Local descriptions of depression

Chapter Four comprised an analysis of one component of data from the AFFIRM-SA formative research before the intervention was designed. Coordination of the interviews was conducted by the current author. The chapter examined the idioms of distress and ways of describing depression amongst pregnant women, CHWs and midwives in Khayelitsha, and looked at the locally understood causes of depression in this context. It also compared these symptoms to international classification systems for major depression.

The study found that idioms used to describe depression in Khayelitsha included 'stress', 'thinking too much', being sad or unhappy, and being scared. Symptoms of depression identified by the participants themselves were as follows: withdrawal and not wanting to talk, crying or sadness, poor concentration, thinking too much, fear and anxiety, stress, sleep problems, headaches and body pain, not 'caring', suicidal thoughts, loss of appetite, anger, hopelessness, and self-blame/guilt. The results found that lack of support, unwanted pregnancy, death of a loved one, poverty and unemployment, thinking too much, coping with a new baby, and stress were the primary causes that women attributed for these depressive symptoms. These were

exacerbated by extreme risk factors the women faced in Khayelitsha such as low income levels, poverty, partner abuse, low education levels, poor housing and living conditions, and poor health care.

In their qualitative review of explanatory models of distress, Mayston et al. (2020) found that expressions of depression in LMICs are often attributed to economic stress and social adversity, along with relationship problems and HIV-related issues. This corroborates the findings of the report from the Lancet commission on global mental health and sustainable development, which stated that social and environmental determinants play a crucial part in shaping population-level mental health (Patel et al., 2018). Fisher et al. (2011) also found that perinatal mental disorders in particular in LMICs appear to have social rather than biological determinants.

A qualitative study of common mental disorders (CMDs) in adults in rural Kwa-Zulu Natal found very similar findings to the current study, in that the triggers or causes of depression that participants identified were largely interpersonal and contextual, such as HIV/AIDS, grief, multiple losses, interpersonal conflict and abuse of women, and financial stress and worry, particularly around not having the economic capability to provide basic necessities (Bana, Cambanis et al., 2009).

Another study with women from India identified similar findings that mental illness was attributed to stress. The most common stressors were interpersonal conflict, domestic violence, and poverty (Kermode, Herrman et al., 2007). A study from the Northern Cape in South Africa with San participants endorsed the view that depression is a condition that is a 'mirror' of life stressors and sociocultural context, and that solutions lie in addressing the underlying circumstances and socioeconomic conditions present (den Hertog et al., 2020).

In addition, the findings from Chapter Four endorse previous research that women require specific support and counselling during pregnancy and for a period after birth (Rahman et al., 2008). The provision of counselling or even mother and child support groups during this time has been found to have significant effects on maternal mental health and on infant development outcomes (Clarke et al., 2013; Rahman et al., 2013).

The data demonstrated that women in the study experienced similar symptoms of depression to those experienced globally, but that they spoke about these symptoms in locally resonant ways. This endorses the movement for a global understanding of mental health and the treatment thereof, while drawing on local idioms of distress and experiences of women to inform, design and evaluate appropriate psychosocial interventions for maternal depression. This could assist in the development of more appropriate and acceptable interventions (Bolton, 2019).

The findings from this chapter highlight the need for support during pregnancy, and the influence of context and multiple risk factors on the occurrence, experiences, and descriptions of perinatal depression. Importantly, the findings correspond with the results from the grounded theory in that perinatal depression in this context stems largely from contextual factors, which are common and persistent in this population. This again highlights the role of social determinants in experiencing symptoms of perinatal depression. Findings from this chapter suggest the inclusion of contextual factors and idioms in the development of the AFFIRM-SA intervention.

8.2 Disruptions affecting intervention delivery

Following completion of the counselling intervention, the subsequent grounded theory analysis and review of the manual identified many factors that could have contributed to deviations from intended counselling protocol, broadly employing the frameworks from Murdoch (2016) and Moore et al. (2015; 2017). First, there were some elements in the counselling manual that may not have been optimal for counsellors to follow, which could have had an impact on the implementation of the sessions. Second, there were many instances relating to 'therapeutic breakdowns' in counselling implementation, such as misinterpretation of psychological concepts, brushing over problems, absolute assurances for problems, inadequate explanations of exercises or homework, inappropriate reading from the manual, giving advice to participants, and including personal opinions on participants' situations.

Third, the harsh and difficult context that both the counsellors and participants lived in affected and influenced the implementation of the intervention. This context caused a situation of 'persistent distress' for the participants, which had clear implications for the implementation of the counselling sessions and on their effectiveness. The dominant features spoken of by the participants in the sessions were persistent poverty, food insecurity, intimate partner violence and abuse, abuse of alcohol by partners, economic abuse, lack of support from partners, HIV/AIDS, and continuous trauma.

This thesis found that, within the context of an RCT testing a manualised psychological intervention for perinatally depressed women in Khayelitsha, the intervention was not delivered optimally. There are a number of factors that may account for why this occurred, and which might have led to the non-significant effects on the HDRS. These include the original context of the development of the intervention, not fully incorporating the formative research and pilot findings, the limited skill base of the counsellors, limited training and supervision, the structure and design of the intervention, ownership by the counsellors of the intervention,

the role of advice, and contextually related need from the participants. These aspects may be useful for other task-shared interventions to consider in the future, and are discussed below.

8.2.1 Context of intervention development

The context of intervention development played a fundamental role in many of the possible factors contributing to protocol deviations. The AFFIRM-SA RCT was initially conceived in 2010 and was developed between 2011 and 2013. In these years, there was less information available than there is currently, on designing, developing and implementing task-shared interventions to address mental disorders in general and depression in particular. In addition, implementation science and pragmatic trials were only starting to become more evident. The approach selected was to test a psychological intervention, which used evidence-based Western-oriented psychological techniques, through a standardised and highly structured behavioural model.

At the time, there had not been much focus on the actual therapeutic elements within *task-shared* interventions. This is noticeably absent in comparison to such studies from individual psychotherapy in high income countries (Norcross and Lambert, 2018). This is now beginning to take hold, driven by studies such as that conducted by Singla et al. (2017). The intervention was also constrained by budget and time frame requirements, which in turn had implications for the resources committed to the formative research, training, intervention development, piloting and supervision.

It is notable that a few other task-shared interventions developed over the same time period and also funded through the NIMH Collaborative Hubs similarly did not show significant results on their primary outcome measures, such as the peer-delivered 'thinking healthy' programmes in Pakistan (Sikander, Ahmad et al., 2019) and India (Fuhr, Weobong et al., 2019). Non-significant differences were also reported between high- versus low-intensity psychological intervention for perinatally depressed women in Nigeria (Gureje, Oladeji et al., 2019). Again, a focus on actual elements and mechanisms that are therapeutically effective may play a role in improving outcomes of task-shared interventions.

8.2.2 Formative research

There were two aspects involved in the formative research for the intervention. The first was to identify how women experienced and described perinatal depression in the context of Khayelitsha. This was presented in Chapter Four. The second examined the feasibility and potential content of a counselling intervention for these women in this context, and was reported by Nyatsanza et al. (2016).

Following this research, some of the local idioms were incorporated into the manual, and experiences described by women were used in the vignette in the 'Healthy thinking' module. Theoretical approaches such as problem solving and healthy thinking were also included to address some of the needs identified by the women. The grounded theory findings suggest that this might not however have been sufficient to develop a contextually relevant intervention. In addition, the intervention responded to the experiences of depression largely with psychotherapeutic techniques. In this context, these techniques may not have been able to address the context-related causes and mechanisms that were creating and perpetuating experiences of depression.

Although the interviews included CHWs and nurses around their perceptions of a counselling intervention and their thoughts about the need for an intervention, there is a possibility that the feasibility study concentrated more on the practicalities of implementing the intervention, rather than exploring *how* to respond to the more circumstantial causes or attributions of depression or socio-economic need that women were experiencing. The feasibility study found that "respondents preferred a female counsellor and felt that clinic based individual sessions should be provided at least once a month by an experienced Xhosa speaking counsellor from the community" (Nyatsanza et al., 2016, p. 9). Perhaps a more protracted process involving the *selected* counsellors in planning and developing the intervention may have enabled the development of an intervention that was more responsive to contextual need and practices, as well as what kind of capacities the CHWs realistically had, and what their training needs were.

Following a review of the knowledge gaps in planning, developing and delivering programmes using CHWs, Frymus et al. (2013) recommend conducting participatory research with CHWs before implementing trials. This could assist in accessing information about particular challenges that might be faced, and subsequently what might help CHWs to perform better. As mentioned in Chapter Two, Petersen et al. (2012) conducted participatory research with community members to inform the development of their manualised group-based IPT. This provides a good example of the beneficial effects on implementation of initial participatory research when adequate time and funding is allocated to it. Participatory methods can also lead to a 'co-development' of interventions, which may result in a more appropriate intervention for both CHWs and participants (Burgess et al., 2020).

Furthermore, there is the possibility that insufficient feedback on the actual *content* of the intervention was obtained from those who spoke isiXhosa and from the CHWs from Khayelitsha. Although psychological experts were consulted in developing the intervention, there were no isiXhosa speaking experts on the panel, and at the time the CHW counsellors had not been selected. This may have led to a discordancy between the

psychological modalities or skills in the intervention, and what might be culturally, linguistically and contextually acceptable in this particular context. Additionally, although the intervention was piloted with six participants, a space was not provided to receive feedback from the counsellors or participants on the actual content of the intervention, and adaptations focused instead on the practicalities of implementation and refining of CHW training.

In Zimbabwe, Chibanda et al. (2017) provided an example of using formative research with CHWs to adapt the content of a PST intervention to be suitable to local participants (see Section 2.3.7 in Chapter Two). The research demonstrated the value of a much longer iterative adaptation process and could be used as a framework for formative research. Bolton (2019) also provides detailed steps on training, piloting and ongoing adaptation of interventions so that they can be culturally and contextually relevant and appropriate for both counsellors and participants.

8.2.3 Capacity of CHWs

Another factor that might have led to inadequate delivery of the intervention is that it was possibly unrealistic to expect that CHWs, most of whom had 12 years of schooling and some basic health training, would be able to conduct psychological counselling and teach psychological skills to women. The counsellors had only five days of intensive training, while most professionals who do this have at least a four year university degree or diploma.

The educational level of the counsellors may have hindered their full capacity to grasp and internalise the psychological modalities or concepts in the intervention. This would have on impacted their ability to teach these concepts to the participants themselves, which would in turn have had important implications for participants' sustained skill retention and symptom reduction. Counsellors' education level may also have had a role in their ability to read instructions correctly and in understanding how to follow the manual, while being able to maintain a consistent therapeutic relationship with the participant at the same time.

In AFFIRM-SA, six counsellors were chosen out of 12 that had been trained in the week-long training, through role plays and demonstration of basic counselling skills. Beyond this training, actual counselling competence was not measured further. The ENACT rating scale for counsellors (Kohrt et al., 2015) was only being developed at the time of the AFFIRM-SA trial. A selection of sessions was listened to by the supervisor, but this might have been inadequate to measure full counselling competence. A formal fidelity assessment on a limited sample was only conducted after completion of the trial (Munodawafa, 2018).

Two studies in the Western Cape examined CHW proficiency in motivational interviewing, and both found that the CHWs did not achieve optimal proficiency in the technique (Mash, 2008, Evangeli 2009). This raises questions around abilities of CHWs to understand psychological concepts, but also could be related to training and supervision of CHWs implementing task sharing interventions.

In examining CHW competence and the measurement thereof, Kohrt et al. (2015) discuss Miller's (1990) hierarchy of clinical skills, which involves the measurement of four levels of skill, being "knows, knows how, shows, and does". Level one, 'knows', assesses conceptual knowledge of a therapy, and level two, 'knows how', refers to knowledge of how to apply theory. The ability to apply skills ('shows') is one of the least examined skill domains, and is particularly lacking in training and research conducted in LMICs (Kohrt et al., 2015). Level four, 'does', refers to how counsellors apply skills in practice. It follows that only when a counsellor is able to 'show' therapeutic competence should they conduct interventions. This aspect would be vital in both training and continued supervision, in order for supervisors to assess adequate competence of the CHWs.

The recently established 'EQUIP' initiative may assist in facilitating competency-based training (Kohrt et al., 2020). As mentioned in Chapter Two, this platform could help to provide competency assessments and evaluate therapeutic training for CHWs. This aims to aid the selection of CHWs, create certain skill targets for them, and contribute toward training design and content, which this thesis has identified as necessary and which will be useful in future interventions.

There is limited literature on selection criteria and assessment of *initial competency* of CHWs to be able to conduct psychological interventions before training and supervision is conducted (Frymus et al., 2013). At a basic level, CHWs should hold some basic interest or inclination in mental health and counselling and have a desire to help those with mental illnesses, as well as have at least a high school education, and strong interpersonal skills (Kohrt et al., 2015; Murray et al., 2011; Spedding, 2017).

As discussed in Chapter Two, studies reporting task-shared effectiveness do not often describe competency, training, and other elements of context in their trial outcome papers. This may lead to potentially inaccurate assumptions about the abilities of CHWs to conduct these treatments across different contexts, because mechanisms of therapeutic effectiveness are largely unmeasured and unreported. Mulder et al. (2017) remind us that evidence of efficacy and effectiveness is not equivalent to evidence of validity. Competency therefore needs to be recognised as an important factor contributing to intervention effectiveness and contextual validity.

8.2.4 Training and supervision

It became clear through the analysis of data that many of the strategies employed by the counsellors may have been prevented or improved by a greater depth of initial training and continuing supervision. These are discussed below.

i. Training

Training for counsellors was conducted over five days. While acknowledging the budgetary constraints and requirements of running a time-tight and schedule-bound RCT, it can be deduced from the results that the training, in this instance, was not long or thorough enough to teach complex psychological concepts to the CHWs and how to follow and use the manual. The core implication of insufficient training and supervision of CHWs is that the psychological modalities in the manual, and basic counselling techniques, were not deeply understood or internalised by the CHWs. This was evidenced by factors such as the misinterpretation of the psychological concepts such as psychoeducation and behaviour activation, and by strategies counsellors used such as brushing over and minimising problems, giving advice, and reprimanding participants (as shown in Chapter Six).

The lack of understanding by the CHWs would in turn have impacted on whether or how the participants themselves were able to learn the psychological skills intended in the protocol, and subsequently maintain them over a longer period of time. Similarly, it leads to the question of whether the counsellors had internalised that the intention of the intervention was to *teach* participants practical *skills* to assist them in problems that would inevitably occur again, after the intervention was completed.

It is important that CHWs are not 'blamed' for these deviations. Rather, the deviations can be understood as coping methods that they used because they were not sufficiently equipped or supported through training, supervision, and the acquisition of knowledge. Much of the research on task sharing does not report the training that researchers conducted with their CHWs (Barnett et al., 2018), making it difficult to compare the AFFIRM-SA training with others. The effective 'Thinking Healthy' trial (THP) in Pakistan had only a three-day training period and monthly half day supervision throughout the intervention, but the same modality was used throughout the 16-session intervention (Rahman et al., 2008). This may have made training and comprehension of concepts easier. This contrasts to the eclectic AFFIRM-SA intervention where there were numerous concepts for CHWs to understand. The five-day training was largely didactic, with limited time for role play activities.

Recent iterations of the THP trial using peer counsellors in Pakistan and India (Fuhr et al., 2019; Sikander et al., 2019) included lengthier classroom trainings (25-40 hours long), field supervision and internships, and competency assessments using the ENACT scale (Kohrt et al., 2015). However, neither of them achieved significant results on their primary outcome measures. Another trial that conducted a manualised psychological intervention for perinatally depressed women in Nigeria provided a three-day training with a two-day top-up one month later, also found no significant differences between intervention and control arms (Gureje et al., 2019). These findings reiterate that task-shared interventions are not always effective in reducing symptoms of depression and bring into question what the actual mechanisms or elements are that lead to effectiveness in one trial but not another.

In terms of recommendations for training, Barnett et al. (2018) write that training outcomes improve when there are opportunities to practice and receive feedback on skill use, as opposed to didactic presentations or discussion. This links to the recommendation above that the demonstration of competency ('shows') is an essential one in training (Kohrt et al., 2015).

ii. Supervision

Supervision has been found to be vital for effective implementation of interventions (Rahman, 2007), counsellor adherence and skill development (Beidas et al., 2012), and as a predictor of behavioural change (Murray et al., 2011). Following commencement of the AFFIRM-SA trial, weekly group supervision was provided to the counsellors in the form of group discussions. This supervision largely involved obtaining updates on participant progress in sessions, discussion of difficult cases, follow-up on previous referrals and feedback on session notes. Individual supervision was offered to counsellors once a month, but this was seldom taken up. Supervision format did not use a specific supervision tool but rather a general discussion of how the sessions were being conducted.

Given the evidence of the many therapeutic breakdowns in the sessions, including misinterpretation of concepts, not explaining exercises and homework adequately, and not practising exercises in the sessions, there is a possibility that the group supervision did not follow a style that scrutinised the CHWs' basic understandings of the psychological concepts, and therefore did not appreciate whether these had been fully grasped.

It also possible that monitoring of the counselling sessions themselves during the early stages of the trial may have focused on fidelity to the manual and case management, rather than assessment of counselling capabilities. Sitting in on counselling sessions and listening to recorded sessions in the beginning of the trial

might have assisted in identifying where counselling skills and understandings of psychological concepts were lacking, and may have resolved some issues early in the trial.

Group supervision allows supervisors to include more CHWs at a lower cost, thereby using time and resources more efficiently (Hill, Dumbaugh et al., 2014). However, this may lead to the tendency to discuss case studies and debrief from the sessions, rather than interrogating the counselling skills themselves. Petersen et al. (2014) found in their review of 29 interventions in South Africa that there was often little distinction between supervision and "debriefing" across studies. The authors found that support and supervision of lay counsellors was generally poor, with a lack of standardised training across studies and organisations.

There are a variety of monitoring strategies that are feasible in LMICs, that include counsellor self-report, live observation of sessions, and role-play behavioural rehearsal (Murray et al., 2011). These authors recommend that at a minimum, counsellors should complete a self-report form for every session that includes the components delivered, assignments that were practiced, and safety monitoring. Peer-supervision, using a structured scale, also has potential for enhancing supervision capacities (Singla, Ratjen et al., 2020).

Evidence of personal disclosure from the section on 'contextual and personal explanations' in Section 6.1.10 demonstrates that the counsellors come from the same traumatic backgrounds as the participants and experience similar stressors and trauma histories. Supervision thus needs to address experiences of secondary trauma and emotional exhaustion that the CHWs will inevitably face in conducting mental health interventions in their own communities (Barnett et al., 2018; Kemp, Petersen et al., 2019). In AFFIRM, the counsellors were *offered* free counselling sessions by an agency unrelated to the trial implementation, but the offer was not taken up, for reasons unknown to the supervisor.

The results also point to the importance of training for supervisors. This is endorsed by literature from high income countries (Scott, Ingram et al., 2000), but little is yet known or even published about the ideal amount or method of supervisor training for task-shared mental health care (Hill et al., 2014). Supervisors are typically mental health specialists, but competencies in clinical skills do not necessarily translate into supervisory competence. This may be particularly pertinent when a supervisor is not from the same background as the CHWs. In a task-shared research context, there are often substantial expectations placed on the supervisor to work with minimally-educated counsellors and participants, under management from highly educated, academic supervisors.

In the current trial, the supervisor was expected to be both a translator between English and isiXhosa, and also a broker between the academic, Western psychological culture, and local beliefs and practices of the CHWs on the ground, in a culturally meaningful way. This may have placed great pressure on this role and was possibly unrealistic to expect culturally acceptable 'translations' of all of the intervention requirements to the CHWs. In addition, as with all RCTs, there were multiple expectations from many different parties, such as the funders, ethical boards, monitoring and safety boards, psychological experts, academic supervisors, peer researchers, and local isiXhosa-speaking counsellors and participants.

Task-shared psychological interventions therefore require a great deal of time dedicated to training in skills development and ensuring that concepts are grasped, as well as adequate and appropriate supervision. Similarly, supervisors themselves need support and training, not only in how to successfully supervise minimally trained CHWs, but also in their roles as 'cultural brokers' in trials.

8.2.5 Structure and design of the intervention

There are three main factors related to the design of the intervention that might have led to the deviations from the protocol and therapeutic breakdowns: i) the manual design and presentation, ii) the number of different therapeutic modalities in the AFFIRM-SA intervention, and iii) the limitations of the evaluation design.

i. Manual design and presentation

The review of the counselling manual in Chapter Five suggested that the structure of the manual may not have been optimal for counsellors to follow. It contained a variety of styles and tenses in the instructions, was sometimes confusingly phrased, and required counsellors to switch between reading certain sections to participants and conducting actual activities in others.

The requirement of having to follow and read a manual, combined with the manual itself being poorly structured, may have undermined the creation of a fully empathic relationship or rapport with participants. This could have created what Murdoch (2016) refers to as an 'interactional dilemma' in the counselling space, repetitions therefore possibly detracting from the true essence or nature of counselling. In using a manual, the counsellors' attention is split between reading the instructions to themselves and to participants and remembering the requirements of the session, while also developing and maintaining an empathetic interaction with participants. This may have had a deleterious effect on a full therapeutic connection which assists in reducing depressive symptoms and feelings. Indeed, in Munodawafa's (2018) study that involved different AFFIRM-SA participants, the perception of counsellors' ability to use the counselling manual and homework book was identified as a factor influencing effective implementation

For the AFFIRM-SA trial, the CHWs were not professionally trained in therapy nor necessarily highly literate. The manual could therefore have been more simply and clearly worded, with better distinctions between what is supposed to be read aloud and what instructions were specifically for counsellors. These lessons are very important for future development of manuals for task sharing.

The manual was reviewed by a number of counselling professionals who deemed it appropriate before translation. However, the above evidence suggests a discordance in the process of reviewers 'reading' through a manual, what gets lost or changed in translation, and the active and practical use by the counsellors. For the development of psychological manuals, Bolton (2019) recommends writing materials in a form that uses simplified language, translated by local translators, and preferably a group of them. Interestingly, he recommends that the translators should not be mental health professionals, so that questions or comments they may have about the materials would be similar to those of the CHWs and participants.

ii. Therapeutic modalities

Second, the counselling intervention was developed in consultation with psychological experts, through a workshop conducted in 2012. The experts came from different theoretical psychological backgrounds, and each recommended different evidence-based modalities such as behaviour activation, healthy thinking, cognitive behavioural therapy (CBT) and problem solving, which have been shown to work independently in different contexts. The intervention therefore included all of these elements in an eclectic approach. This may have involved too many psychological modalities for the counsellors and the participants to grasp, and attempted to cover too much in six sessions. It might have been more practical to have chosen one modality and repeated it over a number of sessions, so that both the counsellors and participants would have been able to learn these skills more confidently. All the same, this eclectic approach was deemed the most appropriate at the time. Examples of successful interventions using single modalities include the CBT-based 'Thinking Healthy' trial in Pakistan (Rahman et al., 2008) and the problem solving 'Friendship Bench' trial in Zimbabwe (Chibanda, Weiss, et al., 2016)

Using more than one modality is not uncommon, as Singla et al. (2017) found in their review of 27 studies in LMICs. Sixty-three percent of studies in their review used more than one treatment modality, with 2.26 modalities being the average across studies. Singla et al. (2017) subsequently recommend using 'simpler' treatments that instead include empirically supported psychological common elements that they identified in their study (these are described further, below). The shift away from more complex interventions such as CBT also assists in reducing costs, training and maintenance of quality among lay health workers (Bolton, 2019). A

few trials are currently testing simplified versions of interventions, such as Problem Management (Dawson, Bryant et al., 2015; Hamdani, Ahmed et al., 2017) and behavioural activation interventions (Patel, Weobong et al., 2017).

iii. Limitations of the evaluation design

Last, the inflexibility of the research and intervention design may have hindered any opportunity for change in content and design once the intervention was established and counselling sessions were underway. The RCT design may have deterred any opportunity for CHWs to give feedback about what was not working for them in the manual design or content, or the intervention itself. There were no opportunities for the CHWs to respond more appropriately to contextual need of the participants. One means of being able to do this would be to use a more iterative and responsive approach to intervention design and implementation. This might be achieved through a 'continuous process evaluation approach' (Murdoch, 2016; Padmanathan and De Silva, 2013), whereby interventions are assessed before, during *and* after the intervention.

An example of an intervention with an iterative responsive design is a study by Michelson et al. (2020), who report on two stages of piloting a transdiagnostic, low-intensity intervention for CMD for adolescents in schools in India. Through the two stages of piloting, the authors integrated their pilot feedback into a more deeply evolved and adapted intervention that was more appropriate to the adolescents' personal and situational needs. The authors report that using an 'iterative approach' enabled modifications to be planned *and* evaluated in a timely manner.

Responsive research would involve some degree of flexibility within an intervention, which would allow for creatively adapting to the population or individual receiving counselling, while still delivering essential components. Murray et al. (2011) describe this as balancing flexibility with fidelity to an intervention. An example of flexibility within a trial was the THP intervention conducted by Rahman and colleagues (2007; 2008), where counsellors were flexible in adapting to the needs expressed by the participants themselves. Counsellors in this study reported that some participants required empathic listening, others needed help with infant care, some required physical and health care, and yet others needed assistance with interpersonal relationships. The value of flexibility and responding to individual needs within a structured intervention creates a particularly positive response from participants and engenders a belief that counsellors really want to help them (Pugach and Goodman, 2015; Thompson et al., 2012). The AFFIRM-SA intervention may therefore have been more responsive to both participant and counsellor needs if the intervention had involved a more iterative and responsive design.

8.2.6 Intervention ownership

There appears to have been a lack of ownership of the counselling intervention by the counsellors. Often, it appeared as though there was an almost 'magical' belief that the manual *itself* would help the participants, rather than there being any agency from the counsellor, through her own strategies or effort. This was revealed through aspects such as counsellors not addressing traumatic events disclosed during the 14-item checklist, counsellors giving participants 'absolute assurances' about the efficacy of the intervention to help them, and inappropriate reading from the manual. In addition, the counsellors often provided inadequate explanations of homework and in-session exercises, through a summary of the exercise but not practicing it in the session itself.

It is almost as if the counsellors believed that the manual, which was designed by academics from a university with authority and 'knowledge', held a power that would help participants in itself, without any therapeutic input or agency from the counsellors themselves, or, for that matter, from the participants. This highlights issues in designing and implementing manualised interventions with non-professionally trained counsellors who, through lack of professional knowledge, may not deeply understand the therapeutic intention of the manual or the intervention, and instead rely on the manual itself to do the actual therapeutic work. Again, adjustments in competency assessment, training and supervision, as well as improving communication between CHWs and the supervisor, and the supervisor and her academic supervisors, might have assisted in improving this situation.

The historical complexities of racial and gender discrimination in South Africa provides reflection that as local black women with only twelve-year school qualifications, the CHWs may not have felt empowered to give any feedback on what they felt about the intervention, or what they did not understand. They might have felt that they did not have any space to give essential feedback on something that had been developed by those in a position of power. Jordans et al. (2012) refer to this as the "cultural distance between the context of development of psychotherapeutic concepts and context of implementation" (p.346).

To mention again, the adaptation process employed by Chibanda et al. (2017) in the Friendship Bench programme encouraged a sense of ownership and empowerment in the CHW counsellors, which in turn created an acceptance of the counselling intervention in the community, thus increasing sustainability in the longer term. This thesis thus suggests that CHW views and voices need to be encouraged and incorporated in the development and continued implementation of interventions as they are the ones who are implementing it on the ground.

8.2.7 The role of advice

Chapter Six provided abundant evidence of counsellors giving advice to participants, throughout the sessions and across all counsellors. This suggests that this might have been a social norm within this context, as suggested by Chibanda et al. (2017) for the African context and Kohrt et al. (2015) for a Nepalese context. Although the Western client-centred model encourages counsellors not to give any advice and rather elicit responses from participants, perhaps advice was what was actually needed or expected in this context. Perhaps the CHWs, seen as elders or more educated people, were expected to provide advice to younger or less experienced women, who listen to and respect the advice being delivered. This may have unwittingly negated a possible counselling norm in this population and caused an interactional dilemma or 'cultural clash' for the counsellors.

In addition, as demonstrated in Section 7.2.1, some women explicitly requested advice from their counsellors. This may relate to the severity of the women's circumstances and the lack of educational and personal capacity they had to deal with their situations. They may also have expected it through their perceptions of what counselling entails. Perhaps this should therefore be incorporated into context-specific interventions rather than negated and discouraged. The role of advice in counselling is acknowledged in some other studies that use non-specialist providers (Dewing, Mathews et al., 2013; Jordans et al., 2012; Kohrt et al., 2015), and is explored further, in Section 8.3.1 below.

There is also counter-evidence that client-centred therapy and refraining from giving advice is effective. Referring to their successful problem solving therapy interventions in Zimbabwe, Chibanda et al. (2017) noted that the clients in their study appreciated and were empowered by being encouraged to find their own solutions. The authors emphasised the importance of allowing clients to drive the therapeutic process. The Friendship Bench manual even instructs counsellors to 'avoid advising the patient to stay strong or not cry, because it is good to express emotions' (Pedersen et al., 2020).

It is thus not possible to speculate or generalise on the most appropriate approach for localised mental health services. The evidence serves instead to reinforce that every context is different and that we need to be highly attuned to the cultural nuances and requirements of each context that mental health interventions are provided in. It is also vital to ensure that adequate formative research is conducted to establish the true needs of a population and to adequately and appropriately respond to those needs.

8.2.8 Contextually related need

The context within which the participants lived in, in Khayelitsha, is a combination of poor physical conditions (such as health service, sanitation, roads, electricity, housing, high cost of nutritious food) and highly stressed social conditions (such as unemployment, family not present, partners having multiple girlfriends, relationship insecurity, and financial insecurity). The majority of the women expressed need for monetary help, economic skills, improved food security, and safety from violence and abuse, rather than relief from depression. These problems often seem to be spoken of as locally accepted, generalised problems, that are embedded in everyday discourse, and that may seem untenable to address through psychologically oriented therapeutic sessions.

It is therefore a possibility that even when the counsellors *did* follow the manual or demonstrate basic counselling skills, the nature of the context and the mechanisms of poverty were often too powerful for therapeutic strategies to have any lasting effect. With the exception of problem solving, the sessions were designed to focus on psychological techniques and skills. They were not designed to specifically address the causes that had been identified by participants in the formative research, such as poverty and unemployment, abuse and intimate partner violence (IPV), unwanted pregnancies, grief and crime. AFFIRM-SA was not alone in this: the review of acceptability and feasibility of task-shared psychological interventions by Padmanathan and De Silva (2013) found that other mental health interventions had also not adequately responded to local problems or satisfied the participants' circumstantial needs.

The limitations of psychological therapy interventions in this context raises the possibility of adding elements to these interventions that address some of the social determinants of mental health, either alone, or in combination. Some examples might include poverty reduction, addressing intimate partner violence and multi-component interventions. These are discussed below.

i. Adding an economic component

There is emerging evidence that interventions that involve both economic and mental health aspects can improve mental health *and* economic status (Lund et al., 2011; Lund, Orkin et al., 2020). A qualitative study examining the impact of a comprehensive rural health project in India, which included income generating projects, found that women stated that their mental health was enhanced when they increased their capacity to earn income separately from their husbands. Some of the strategies for income generating projects were promoting literacy and numeracy, the formation of self-help (micro-credit) groups, training women in marketable skills, and providing seed funding/loans for businesses (Kermode et al., 2007). Given the evidence

emerging from the thesis, and that income inequality and lower household income are significantly associated with depression in South Africa (Burns, Tomita et al., 2017), it seems important that mental health interventions should include economic enhancement components that would complement psychological elements.

ii. Tackling intimate partner violence

Intimate partner violence has a clear impact on women's mental health. This was also confirmed in a previous study using AFFIRM-SA trial quantitative data (Schneider, Baron et al., 2018). The causes and impacts of partner abuse, whether it be verbal, physical, sexual or economic, thus also need to be addressed in psychological interventions, particularly for pregnant women.

In this study, partner abuse was often preceded by the abuse of alcohol by women's partners, and this is therefore another important factor for consideration when designing interventions. The relationship between partner alcohol abuse and IPV was acknowledged and addressed in a recent intervention in Zambia by Murray and colleagues (2020), using the 'common elements treatment approach' (CETA). The authors found significant effects on alcohol use reduction in women's partners, and on instances of IPV. Future interventions could well consider using this approach.

There is scant evidence of mental health interventions that include IPV reduction strategies as part of their interventions (Tol, Murray et al., 2019), or even of evidence-based approaches dedicated purely to the reduction of IPV (Joyner and Mash, 2011). Reducing levels of IPV is difficult, especially in contexts of poverty where perpetrators are disempowered and poverty and challenging living conditions are more likely to drive IPV perpetration (Gibbs, Dunkle et al., 2020). As with mental health interventions, IPV reduction interventions are less likely to be effective if underlying drivers like poverty, food insecurity and issues of masculinity within these contexts are not addressed (Closson, Hatcher et al., 2020).

iii. Multi-component interventions

Despite mixed evidence in the literature but driven by evidence from the data in grounded theory analysis, this thesis supports the inclusion of multi-component interventions. In addition to a mental health component, these would include strategies to deal with intimate partner abuse and an economic skill-building component. The data from this thesis also supports the notion that the provision of a basic income for women who have nothing at all, would reduce their levels of anxiety around not being able to provide for their new-born infants and other children. A grant would enable them to buy basic food which is essential for their physical and mental

survival. This would assist in addressing both the economic determinants of depression *and* mitigate the economic impact of depression (Lund and Cois, 2018).

In summary, the evidence from Chapter Six suggests that the intervention was not able to sufficiently address or mitigate the social or economic issues that were placing extreme psychological strain on the women in the study. In this regard, Bolton candidly wrote that it might be 'naïve' to believe that task sharing for mental health can assist under the multiple problems that people in LMICs face, such as conflict, instability, and poverty (2019). As far as possible, this should therefore be kept in mind when designing and implementing mental health interventions in LMIC.

8.2.9 Summary of deviations from protocol

This section discussed factors that might have led to the various deviations from counselling protocol that occurred in the AFFIRM-SA intervention. Fundamental to the processes of the intervention appears to have been that training and supervision of the CHWs may have been suboptimal, leading, amongst other things, to an inadequate understanding of skills that needed to be taught to and internalised by participants. Similarly, the supervisor may have been placed in a difficult role as a 'cultural broker' between academic expectations and local needs. Training and supervision of CHWs in task-shared interventions therefore needs to be thorough, intensive and continuous. Within the context of task sharing, we also need to gain a deeper understanding of the expectations placed on these CHWs in their ability to learn skills and understand psychological concepts, when they themselves have limited education.

There also appear to have been issues with the design of the intervention itself. These range from not including local or isiXhosa-speaking experts in designing the manual and getting feedback from the pilot study, unclear instructions, styling and format of the manual, and including too many psychological modalities in the intervention. There may have been a lack of cultural or contextual consideration in the intervention, through imposing more Western psychological methods on a more community-orientated culture, where advice might be a socially accepted norm in counselling situations. Thus the manual-based intervention, focusing on psychological skills and techniques, may not have adequately addressed the 'real' contextual need of the participants such as economic skills and improved food security. Likewise, it was unable to help ameliorate situations of IPV and abuse in any significant way, or help women deal with the consistent trauma and crime that they face in Khayelitsha. This intervention may therefore have benefitted from an extended period of formative research and piloting in order to create an iterative intervention that was more responsive to the needs of both CHWs and participants.

In conclusion, there are multiple and complex layers of context at play within the implementation of task-shared interventions for mental health. The above discussion demonstrates that it is vital that the specific context of each intervention is taken into account when developing and implementing interventions. This context must be fully acknowledged, through an understanding of culture, history, political background, language, expectations, individual need, and socio-economic positioning, to name a few. This commentary provides important points of consideration for the design and implementation of task-shared interventions in the future. These are discussed in the recommendations in Section 8.6 below.

8.3 Therapeutically effective elements

Chapter Seven presented the subjectively reported positive outcomes of change from the sessions by the participants, and their attributions for these reported outcomes. The analysis employed a grounded theory approach which aimed to ensure that themes and results were driven by the data from the counselling session transcripts themselves. The outcomes narrated by women during the sessions included consistent reports of 'feeling better', an improvement in mood and affect, a reduction in suicidality, a shift in thinking patterns and subsequent behaviour, actions, or activities (such as identifying negative thought patterns, solving problems, and increased agency), and learning to communicate.

These reports provide evidence that speaks to the findings of significant improvements in EPDS scores for the intervention group in the RCT outcome assessments. The EPDS could have been picking up levels of distress or anxiety that were not necessarily clinical symptoms of depression but that were more relevant to women's experiences of depression and distress in this context. The intervention may thus have led to reductions in psychological distress or mild depression, but wasn't able to address more severe depression symptoms, as measured by the HDRS.

Furthermore, although the data points to many deviations from protocol by the counsellors, these may not necessarily have been inappropriate for the participants themselves. This encourages two reflections: first, that in this context this might actually have been appropriate and needed by the women in this particular culture (see Section 8.2.7 and 8.2.8 on advice and contextually related need), and second, that my viewing and interpretation of the data comes from the positioning as a 'Western' researcher with a psychological background. I reflect on this further in Section 8.8 on Reflexivity.

Following the reports of positive outcomes, the data were examined for the attributions by the participants for their reported improvements and changes. Not only did this elucidate the elements or mechanisms behind the improvements but it also assisted in confirming that women were not reporting these positive outcomes due to desirability bias. The quantity and range of the explanations, unprompted by the counsellors, alluded that women were reporting these attributions as indicating their subjective experience of improvement and not simply to please their counsellors. These attributions were the elements that assisted them to feel better and experience improvements in mood: elements that were perceived by them to be therapeutically effective. These elements were consistently reported by all participants included in the analysis, across counsellors and across the different modalities of the therapy sessions.

The attributions were grouped into various categories that aligned with what the women reported, and were as follows: receiving advice around relationships, pregnancy and birth, psychoeducation, normalisation of feelings, the experience of confidentiality and trust, commitment from the therapist, sharing problems, a sense of relief, empathy and being heard, and experiencing a sense of connection and hope.

Previous authors have examined effective elements of therapy and have referred to them as 'working mechanisms', 'engagement elements', 'non-specific elements', or 'common' elements in therapy (Cuijpers et al., 2019; Jordans et al., 2012; Murray and Jordans, 2016; Singla et al., 2017). Barth et al. (2012) explain these therapeutic elements as being parts of the therapeutic exchange that are universal across experiences of therapy, are not related to specific modalities, and are elemental in determining the outcomes of treatment. These could be factors such as the personal qualities of the therapist, the therapeutic alliance, and the client's hopes and expectations (Barth et al., 2012).

Two frameworks are used to interpret the reported therapeutic elements in this study. The first is the taxonomy of treatment components and techniques, referred to as common elements, developed by Singla et al. (2017). This is presented in Section 8.3.1 below. The second is a 'Contextual model' of therapeutic effectiveness developed by Wampold (2015), presented in Section 8.3.2. A brief discussion about the role of assessment as a therapeutic element then follows.

8.3.1 Common elements

In their seminal review of task-shared psychological treatments in LMICs, Singla et al. (2017) developed a taxonomy of treatment components and techniques that goes beyond specific treatment modalities or packages, referred to as common elements. They identified three categories of therapeutic elements, being: 1) "Nonspecific elements", also referred to as engagement elements, which are reflective of the approach used by the therapist to engage a client, 2) "Specific elements", which refer more to psychological mechanisms, and encompass four broad domains of emotional, behavioural, cognitive, and interpersonal elements, and 3),'in-session techniques'. This is defined as the skills that the therapist implements during a session to deliver an element (Singla et al., 2017). The above categories can be used to make sense of the data and outcomes identified in the counselling sessions from the participants in this study.

i. Non-specific elements

First, many of the attributions and reasons for positive outcomes reported by participants can be attributed to non-specific or engagement elements in the therapeutic space, or, what many authors identify as the

therapeutic alliance between counsellor and participant. A therapeutic alliance can be defined as the "collaborative nature of the patient-therapist interaction, their agreement on goals, and the personal bond that emerges in treatment" (Kazdin, 2009, p. 420). It can include empathy, therapist positive regard, and therapist genuineness, all of which have been found to be robust predictors of psychotherapeutic outcome (Wampold and Budge, 2012). Therapeutic alliance is an essential factor cutting across treatment modalities that contributes to the effectiveness of treatment (Cuijpers et al., 2019; Norcross and Wampold, 2011; Timulak and Keogh, 2017).

The non-specific elements that participants in this study spoke about in the counselling sessions that were related to therapeutic alliance included sharing problems, normalisation of feelings, experiencing trust in their counsellor, experiencing confidentiality, feeling empathy and being heard, valuing the commitment from the therapist, experiencing a sense of connection, and a feeling of hope. The non-specific elements identified by Singla et al. (2017) that had the strongest associations with treatment outcome were: collaboration, empathy, active listening, normalisation, involvement of significant other. Empathy from counsellors was also mentioned by different AFFIRM-SA participants in Munodawafa's (2018) study as a factor that facilitated their retention in the RCT.

In a recent commentary, Cuijpers (2019) noted that hope and the expectation that problems will be solved, are fundamental and necessary targets of therapy. In this study, being given hope was mentioned frequently as a catalyst for change by participants. Pedersen et al. (2020) found in their review of psychological treatment manuals that 94% of manuals included instructions for CHWs to promote hope or optimism for change. Even though this was not explicit in the AFFIRM-SA manual, the participants identified hope and optimism as one of the effective therapeutic styles used by the counsellors.

A review of clients' perspectives on psychotherapy by Timulak and Keogh (2017) found that while clients valued therapist techniques and expertise, what was more important for them was the sense of warmth, authenticity, honesty, and dedication within the therapeutic relationship. Another study with low-income women in the USA confirmed that, similar to the current study, participants identified the importance of feeling heard in the relationship (Pugach and Goodman, 2015), and also being listened to without judgement. Women in the current study spoke of the impact this feeling of being heard had, on their mood and feeing of connection with their counsellors.

Sharing problems and social interaction was found to be integral to healing of depression in a review of studies in Sub-Saharan Africa (Mayston et al., 2020). Lambert and Ogles (2004) also endorse that the mitigation of isolation is imperative for treatment effectiveness. This is clearly relevant to the women in Khayelitsha in the

current study, particularly where women feel isolated from social networks and trauma is deep and widespread.

The exact nature of the therapeutic alliance in this study might be slightly different to that reported in the literature. This was demonstrated through the prescriptive advice and reprimanding interactions that the AFFIRM-SA counsellors used in many of their sessions, often framed from the position of counsellor authority over participants. Despite this, the alliance or relationship that was created in the AFFIRM-SA counselling sessions was noticeably helpful to participants. This style therefore may have been more appropriate, relevant or acceptable to this particular context.

Therapeutic alliance can also be understood as a sense of *connection* between counsellor and participant. Timulak et al. (2013) found in a meta-analysis that the human connection within a supportive safe relationship was one of the key features found to aid client process in therapy. The study data emphasises the deep need amongst participants for increased connectedness and trusting relationships. The provision of counselling may well be the place where this can be achieved and then modelled for further interactions. In a task-shared context, there is often the added benefit that CHWs have multiple connections of their own in the communities in which they live and work, and may thus be able to suggest and encourage increased further connection for their participants in their own communities.

An improved sense of connection can foster and encourage further connection (Jordan, 2008). This is demonstrated in the current study through women improving their communication skills, experiencing connection, increasing personal agency, and then reaping the rewards of these improved skills through enhanced impacts on social networks and support. Ideally, this creates a reinforcing cycle of improved communication and subsequent connection to others in their lives.

ii. Specific elements

Second, in addition to the non-specific elements and therapeutic alliance, there are other 'specific' elements identified by Singla et al. (2017) that relate to psychological mechanisms within treatment, but that are still not related to any particular modality or treatment type. The specific elements with the strongest associations with treatment outcome in their review were: identifying or eliciting social support, communication skills, assessing relationships (interpersonal elements), identifying/eliciting affect, linking affect to events, emotional regulation, and emotional processing (emotional elements). The elements within the AFFIRM-SA counselling sessions that align with these more specific elements were receiving advice around relationships, pregnancy, birth and depression (psychoeducation), and experiencing a sense of relief. Learning to communicate was

widely reported as an outcome of the sessions and this may also have played a role as a reason or attribute for improvement in mood.

Additionally, there were descriptions of women experiencing more agency and subsequent behaviour change in their lives (reported in the section on 'change in behaviour and thinking' in Section 7.1.3). This could well have been linked to improved knowledge of depression and its causes and learning about methods to deal with this. It seems that psychoeducation played a therapeutic role through the provision of information, and was greatly appreciated in a context where there is very low mental health literacy (Spedding, 2017).

Perhaps fittingly, psychoeducation was identified as the most commonly used element in Singla et al.'s review of task sharing interventions for CMD in LMICs (2017) and was included in 88% of manuals reviewed by Pedersen et al. (2020). Psychoeducation is an interesting element as it is used both as a specific treatment in itself, as well as an engagement element of therapy.

In an examination of elements that predict efficacy and effectiveness of therapy, Lambert and Ogles (2004) found that catharsis, identification with therapist, mitigation of isolation, and advice are some of the essential elements for therapeutic effectiveness. The elements in the current study all align with these findings. The positive role of advice is recognised in a number of other international studies (Dewing et al., 2013; Jordans et al., 2012; Kohrt et al., 2015; Lambert and Ogles, 2004). Linked with a sense of relief, catharsis was identified in a qualitative meta-analysis of insight events in psychotherapy (Timulak and McElvaney, 2013). In a South African study with a similar perinatal population, 'disclosure' and release of stress was also cited as a significant factor for improvement in mood (Marsay, Manderson et al., 2018). In the current study, the sense of relief and release of self-blame and guilt was often as a result of the normalisation of feelings by counsellors (see Section 7.2.6).

iii. In-session techniques

Last, Singla et al. (2017) identified in-session techniques which are more specific to particular treatments but still play an essential role in therapeutic effectiveness. In their study, these were identified as: psychoeducation, assigning homework, giving praise, interpersonal focus, behavioural experiments, motivational interviewing, direct suggestions, reviewing homework, goal-setting, and role-playing.

Within the current study, these techniques could be seen as the strategies that were employed by the counsellors as per protocol and guided by the manual, and would have included the topics or skills the counsellors taught the participants, being psychoeducation, problem solving, behaviour activation and healthy

thinking. Evidence of these strategies being used is visible in some of the sessions, and these skills, when used appropriately, may have assisted in the improvements in mood, cognition, and behaviour amongst some of the participants.

8.3.2 Wampold's contextual model

Along with Singla et al.'s (2017) review, the contextual model created by Wampold (2015) provides a useful way of organising and making sense of the participants' outcomes and attributions, in relation to their context. As stated in the literature review, this model hypothesizes that therapy works through three pathways, following the initial establishment of a therapeutic relationship. The first pathway is the 'real' and personal relationship between client and therapist. In the current study, this would involve the elements trust and confidentiality, commitment from the therapist, sharing problems, a sense of relief, empathy and being heard, feeling a sense of connection, and the positive impact of the baseline assessment.

The second pathway is the creation of expectations and hope, through an explanation of the disorder and its causes, and a means to cope with problems (the treatment involved). This affects clients' expectations of outcome and subsequent treatment effectiveness, and would involve receiving advice about pregnancy, birth and relationships, psychoeducation, normalisation, and experiencing hope and motivation.

The third pathway involves the ingredients of specific therapies or health promoting actions, which would differ depending on the type of therapeutic modality. In the current study, these factors would have been the same as the 'in-session techniques' mentioned above, being psychoeducation, problem solving, behaviour activation and healthy thinking.

Using this model provides opportunity for reflection on the process of counselling as a whole, whereby the intervention may have fulfilled the first two pathways: that of creating a personal relationship between participant and counsellor, and of the creation of expectations and hope. However, counsellors may not have grasped the 'ingredients of specific therapies' fully enough to have sufficiently fulfilled the third pathway, which would have impacted the HDRS outcome. This would clearly link with the insufficient provision of optimal training and supervision to develop these more specific psychological skills, and it provides reflection on the contrasting results between the HDRS and the EPDS outcomes.

8.3.3 Therapeutic effect of assessment

Last, the participants reported marked positive effects from the experience of participating in the baseline assessment alone. Although the attribution is not related to the counselling sessions themselves, this finding is included to highlight the need for and value of connection and empathy this context. To repeat from Chapter Seven, the reasons given by women for the helpfulness of the baseline assessment were that of being given hope and motivation, having someone to talk to, a sense of relief, and receiving advice. This was experienced simply from one hour of dedicated questioning from a fieldworker, but this hour involved personal and focused attention and care expressed to a vulnerable woman in a time of deep need. It is notable how similar these four elements are to the therapeutic elements that participants identified from the counselling sessions. This emphasises both the therapeutic effectiveness of these elements *and* how healing the women found the baseline assessment.

Interestingly, research was conducted into this phenomenon with a similar sample to the current study, in Johannesburg, South Africa. The authors specifically examined changes in mood following a screening assessment with pregnant women, and identified that the women experienced 'measurement reactivity', whereby the assessment itself resulted in changes in mood (Marsay et al., 2018). The study assessed potential mechanisms for these changes and found very similar results to this study, being the process of disclosure, gaining self-knowledge, validation of experiences, a sense of personal agency, and seeking out support from others (Marsay et al., 2018). The mechanisms were attributed to both the content of the questions and the quality of interaction with the interviewer.

The authors endorse the importance of the quality of the encounter, which involved non-specific therapeutic elements such as a sense of connection with the assessor, engagement, warmth, empathy and active listening. Their participants identified that the interviewers they spoke to were warm and empathetic, and that they felt supported and cared for, which allowed for an improvement in mood and anxiety following a single screening event (Marsay et al., 2018). This is particularly interesting because the fieldworkers in this thesis were skilled and empathic female interviewers and were the first point of contact and opportunity for 'relief' that the participants would have had. The fieldworkers would thus have needed to be able to listen empathically, contain the women's emotions, and refer them for clinical services should these be needed. This again underscores the role of connection, alliance and support as therapeutic factors in reducing distress in this perinatal population.

8.3.4 Summary of therapeutically effective elements

This section discussed the various elements that the women themselves identified as being therapeutically effective in their counselling sessions, and related them to the relevant literature in the field. The data serves to confirm that, despite the evidence that counsellors did not always follow the manual optimally, there were many 'non-specific' and 'specific' therapeutic elements, not related to a type of therapeutic modality, that contributed toward positive outcomes. Although no assumptions can be made about causality, this study adds to the growing body of research on common elements of therapy, where all of the therapeutic elements mentioned by the participants themselves corroborate elements already identified in the international literature. It is interesting that although common elements were not formally included in the AFFIRM-SA intervention, the nature of the unfolding therapeutic relationship appears to have enabled some of these anyway.

These findings endorse what various authors are now proposing: that the use of a limited number of common elements or factors can assist in addressing the large treatment gaps in LMICs, through incorporating them as key therapeutic factors in the implementation of mental health interventions (Kohrt et al., 2015; Murray and Jordans, 2016; Singla et al., 2017). The authors recommend that competency and training in common elements should be prioritised, and only once these are adequately learnt, should training in specific therapeutic modalities be executed (Jordans et al., 2012; Singla et al., 2017). These elements then need to be tested to identify which factors are most predictive of treatment outcomes in task-shared interventions in LMICs (Ottman, Kohrt et al., 2020; Pedersen et al., 2020).

Last, against the context of social isolation and economic exclusion that is widespread across LMICs, one of the essential elements identified by participants was the establishment of a sense of connection between counsellor and client. The sense of connection the participants describe in this study endorses the idea that it is not necessarily the therapeutic modalities themselves that are effective, but more the fact that there is a 'real' relationship (Wampold, 2015) and feeling of connection in a context where this is rare and difficult to attain. The sense of connection can assist in encouraging growth, change, clarity, productivity, increased self-worth, and the desire to foster further social connections (Jordan, 2008). This desire in particular could then create a positive feedback loop of connections, which would go beyond the therapeutic relationship, and start to reinforce the benefits and value of increased connection and communication, and subsequent positive impacts on mental health (as the participants in this study stated was happening for them). These connections may form a buffer, although limited in capability, against the impacts of the socio-economic traumas that participants face on a daily basis.

8.4 Models of implementation processes and outcomes

Two models have been developed to understand what has been discovered through this process evaluation of the AFFIRM-SA RCT counselling sessions. These models enable reflection on the contrasts that have been highlighted in this thesis and that are demonstrated in the contrasting findings of the HDRS and EPDS: that there were many visible deviations from protocol and therapeutic breakdowns in the counselling, but that there were also obvious elements that were therapeutically effective within the sessions.

8.4.1 Model 1: The intervention did not disrupt the mechanisms that perpetuate perinatal depression

Guided by the work of Murdoch (2016), the first model unpacks the various aspects of the intervention, from theory, to conceptualisation of the intervention, to implementation, bordered by contextual need. The model, based on the data around deviations from protocol, is that in general, the intervention as it was, did not meet or fit the contextual needs of either the counsellors or the participants, and subsequently did not disrupt the 'mechanisms' that create or perpetuate perinatal depression (Hawe, 2015; Moore and Evans, 2017). It posits that in the formative work, the need that was (rightly) identified was *depression,* and that the theory and manual to address this need was based on evidence from the time (2011), which relied heavily on psychological techniques to address depressive symptoms.

In addition, due to inadequate training and supervision, the intended manual and protocol was not administered as intended, and psychological skills were not taught or learnt adequately by counsellors and participants alike, thus not encouraging a permanent ability to use these skills in the inevitably repeated instances of trauma in the participants' lives.

The counselling sessions did provide certain benefits for participants, such as a sense of relief, support, advice, and a sense of connection. However, due to the above factors, 1) the 'contextual need' of the participants was not met by the intervention, and 2) the intended psychological skills were not learnt or internalised to be able to effectively address context. This resulted in a feedback loop where neither the intended protocol nor the actual implementation were able to address the continued trauma and context that the women faced in their daily lives, which were core factors that lead to the development of depression in the first place.

In the AFFIRM-SA trial, the intention of the theory, protocol and manual was to teach participants psychological skills to improve their life circumstance and feelings of depression. Yet these would not have been able to

address the mechanisms that perpetuate or sustain perinatal depression (Hawe, 2015; Moore and Evans, 2017), which are mostly poverty related. Therefore, going forward with task-shared interventions for mental health, there needs to be an inclusion of contextually relevant responses that potentially include an economic skill building component, and strategies to deal with IPV to realistically address the context that women living in Khayelitsha (and many other low resource settings) face.

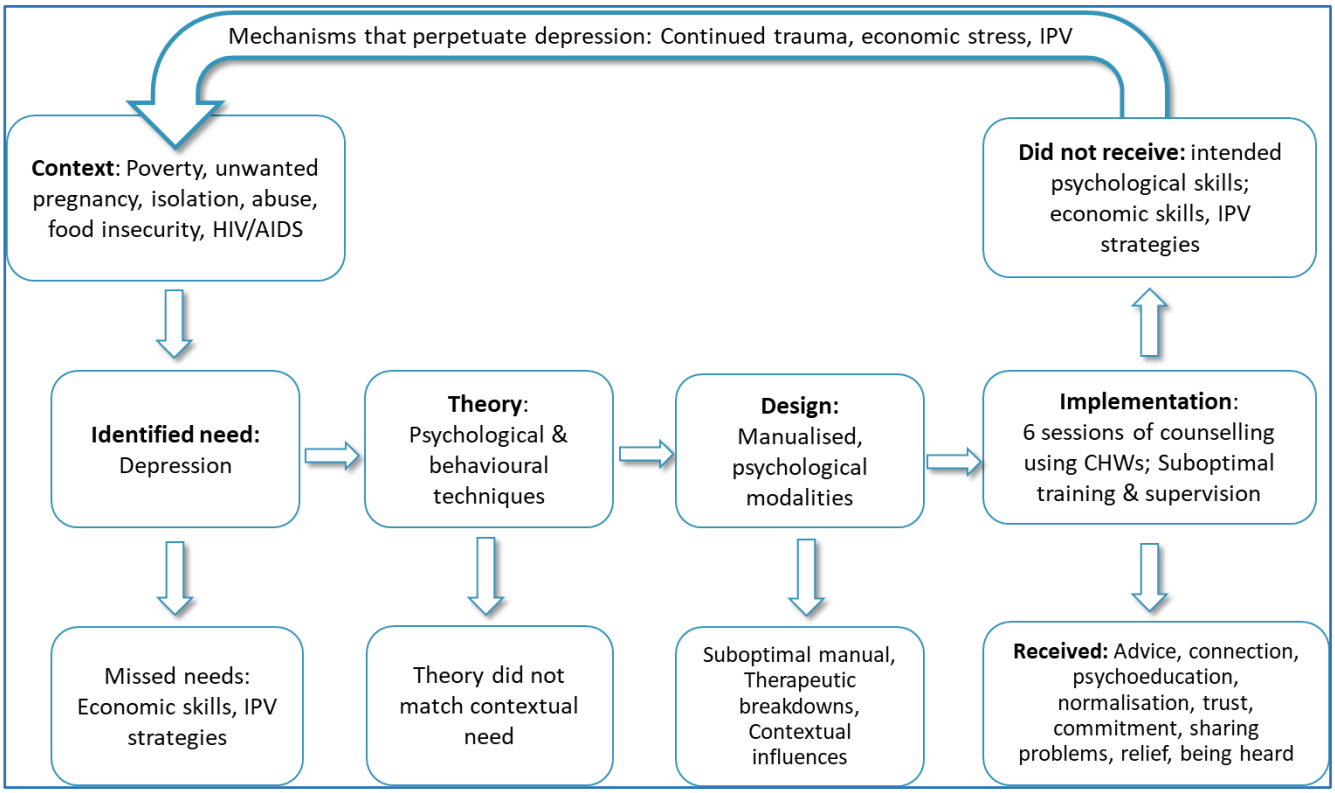

Figure 4: Model 1. The intervention did not disrupt the mechanisms that perpetuate perinatal depression

8.4.2 Model 2: The intervention provided connection and short-term resilience

A second way of looking at the data, guided by the reports of session outcomes, is through the lens of connection and resilience. This model posits that against the highly stressed and traumatic contextual background in which the participants live, the act of talking to a counsellor and having the commitment from a counsellor of six sessions together, may have provided a sense of connection, support, and ease of isolation that was able to act as a buffer to keep distress at bay, and provide a reprieve – albeit brief – of their everyday stress.

This sense of connection could have assisted in relieving immediate symptoms of distress, stress and trauma, created a sense of hope that problems could be solved, built some form of psychological resilience, improved the ability to communicate, and increased feelings of support. This would have encouraged a desire to foster

further social connections, which is an essential element in the reduction of feelings of isolation, and led to a subsequent improvement in mood and symptoms of depression.

Unfortunately, although the counselling sessions were obviously helpful to the participants for the duration *of* the sessions, these changes were probably of a temporary nature that existed because of and within the therapeutic time frame where the women felt that they had some form of support through the connection with the counsellors. Unfortunately, this sense of connection and support was short-term, and therefore could not reduce clinical symptoms of depression or provide longer-term resilience against the context of extreme poverty.

Model Two (see Figure 5) is a graphic representation of this theory, whereby the sense of connection felt through the sessions created a small buffer of resilience that helped to reduce distress and deal with everyday stress (which is possibly what the EPDS picked up), but that this buffer was temporary in nature, and was not robust enough to reduce clinical symptoms of severe depression (on the HDRS) or to ward off the impacts of poverty such as unemployment, abuse, food insecurity and trauma.

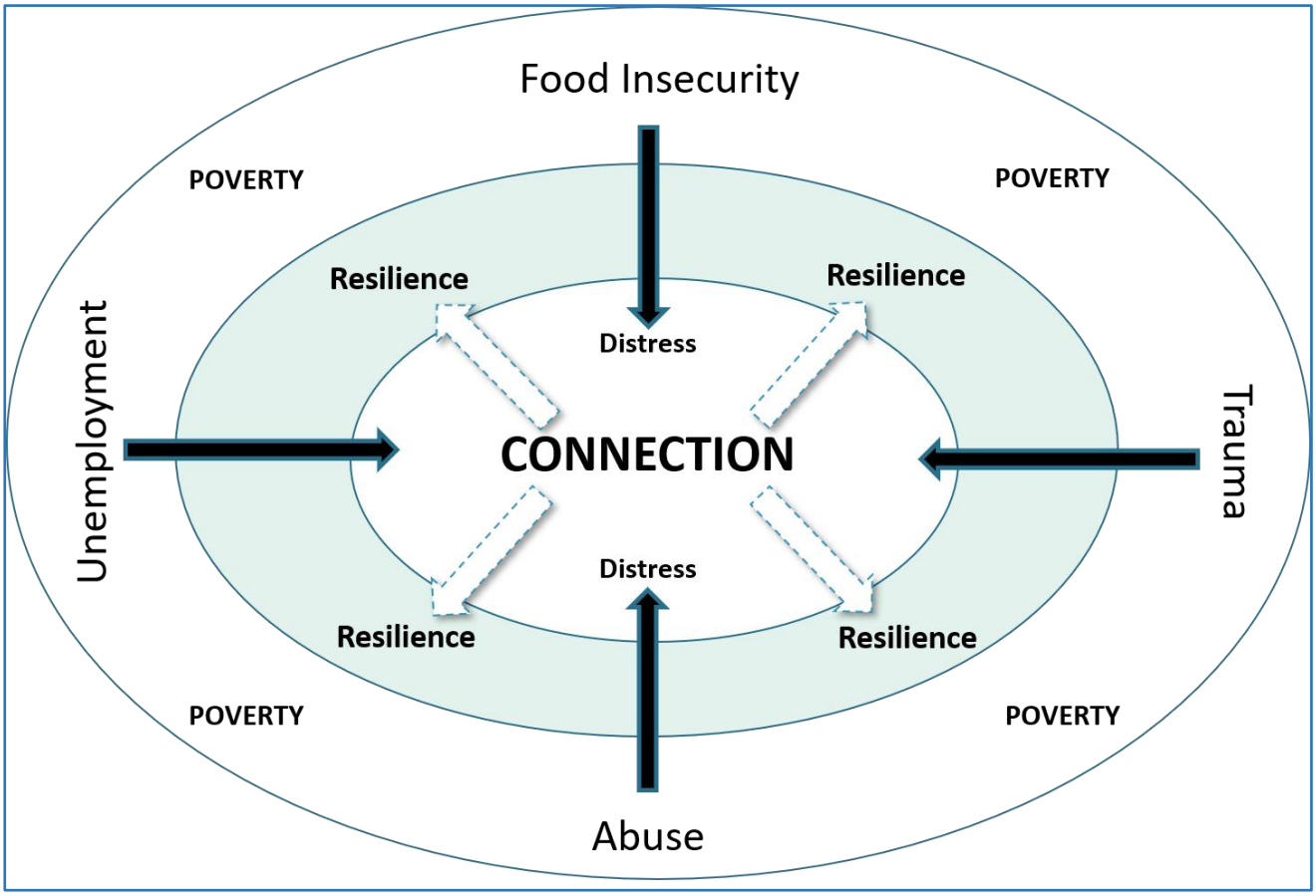

Figure 5: Model 2. The intervention provided connection and short-term resilience

8.5 Discussion summary

The findings from this thesis demonstrate that there is visible distress and depression within this perinatal population, but that a large part of this distress may be driven by contextual circumstances. It thus appears that the AFFIRM-SA intervention did not adequately or appropriately respond to the socio-cultural need of CHWs *or* participants. Additionally, it appears that the training and supervision of the CHWs and the design of the manual hindered the implementation of the psychological protocol as it was intended. It is therefore not known whether, if the psycho-behavioural theories had been appropriately implemented, participants would have learnt and internalised the skills necessary to cope with their current and future psychological distress. It is also not known whether these skills would have been sufficient to attenuate the impact of IPV and economic distress.

At the same time, the findings show that the counselling *did* provide helpful and therapeutic elements for a number of participants, and that these therapeutic elements align with many of the common elements identified by a number of other researchers in the field of psychotherapy and task sharing. These elements, combined with the therapeutic alliance experienced in the counselling sessions, provided a sense of connectedness that acted as a buffer of resilience for women while in the therapeutic programme, but one that was likely to be short-lived once the programme ended, as they were not supported by an effective transfer of psychological skills.

As mentioned previously, it is an ethical obligation to investigate the mechanisms and processes behind significant and non-significant outcomes of an intervention given the amount of time and resources that were invested in it, to be able to share lessons and recommendations that can inform the development of future interventions (Cuijpers et al., 2019; Singla and Hollon, 2020). Conducting a process evaluation of the AFFIRM-SA intervention through analysing the counselling sessions themselves provides invaluable insight into what was happening in the intervention and in the interactions between counsellors and participants. Other process evaluations of perinatal mental health interventions that used interviews with participants (Rahman, 2007; Rath et al., 2010) confirmed the necessity of including local CHW and participant views, needs and preferences in the design and implementation of interventions, so that they are more acceptable and appropriate for the communities they are designed for. They also noted that adequate training and supervision during implementation is vital for success of an intervention.

Using the findings from the current thesis, Box 2 below provides reflections on how the AFFIRM-SA RCT may have been conducted differently in hindsight. These are useful considerations for conducting further task-shared interventions in the future and complement the recommendations that follow.

Box 2. Re-designing AFFIRM-SA

Intervention design
Use responsive research and an iterative design, with an embedded 'continuous process evaluation' throughout the research
Check in regularly with the CHWs about how they find using the manual, how participants are responding to the content, what they think participant needs are, what their needs are
Adapt appropriately
Build in ownership of the intervention so that CHWs feel that they can be flexible when they need to respond to individual needs

Formative research
Use a participatory process, including giving feedback and assessing response to this feedback
Assess what women need, and what kind of intervention would suit them best
Assess what capacities the CHWs actually have, and what level of training they would subsequently need
Create an intervention in collaboration with CHWs who have some counselling experience in this context
Empower CHWs to be part of the design of the intervention to create a sense of ownership of the intervention
Propose a combination of the chosen modality (e.g. problem solving) with locally used counselling or healing techniques
Adapt the proposed modality/technique (e.g. problem solving) to the phrases and terminology, through workshopping this with the CHWs

Training
Conduct training over at least three weeks and include refresher training every six months
Train CHWs in basic counselling skills and common elements
Ensure CHWs develop basic psychological competencies and skills, with a thorough understanding of the psychological concepts being used
Assess competency using role plays, group work and competency assessments (e.g. ENACT, EQUIP)

Pilot
Pilot the intervention with CHWs and participants and then get feedback from both parties on structure *and* content of the manual and intervention, using an iterative research design

Intervention
Include training for supervisors in how to supervise CHWs
Build in that the supervisor sits in on sessions in the beginning to assess competency
Include individual supervision, after listening to audio recordings of sessions with counsellors
Encourage group feedback from counsellors on participant problems
Use only one therapeutic modality, such as problem solving
Remove the 'evaluation' module as the last session
Ensure that free counselling of counsellors by an external agency that is not linked to supervision is made mandatory

Manual
Formulate the manual in one grammatical style (i.e. either the counsellor reads all the instructions out loud to the participant, or none of them, and the instructions are only for the counsellor).

Assessment
Include more regular and locally relevant assessments of change, using outcomes identified by participants, such as those reported in this study.

8.6 Recommendations

The AFFIRM-SA RCT was conducted as a task-shared mental health intervention for women with perinatal depression in Khayelitsha. It was planned in 2010/2011 and implemented in 2013. While the findings from the process evaluation in this thesis are specific to the counselling sessions and qualitative data from the RCT, the lessons can be generalised. They have implications for future task-shared research interventions for mental illness in similar low- and middle-income settings, where poverty and inequality are some of the key and common driving factors for mental illness across these contexts. Once research is conducted that is responsive to local context, it is hoped that interventions can be more efficiently and effectively scaled up across public domains. The recommendations arising from this thesis are presented below.

Formative research

To begin with, extra time and budget needs to be built into conducting fully comprehensive feasibility studies before an intervention begins. These should go beyond the practicalities of research, toward asking the right questions and paying attention to what participants in each particular context might require (Bolton, 2019). It would also entail a review of the traditional and cultural strategies that are already being used, or have historically been used, in working with mental illness and mitigating isolation, in order to incorporate these into a culturally relevant intervention (Wampold, 2015). A comprehensive feasibility study could involve community-level participatory research, which would provide insight into the roles of both the community and the health system (Petersen, Baillie, et al., 2012).

Address contextual need

Thus, driven by the learnings from this study, in addition to working out the practicalities of implementing a trial, a feasibility study should include a deep examination of the localised understandings and causes of depression and mental illness (Chibanda et al., 2017). These should then be integrated into the intervention so that it is created in a format and design that is responsive to the needs of the population and is conducted in a culturally congruent manner (Wampold, 2015).

Throughout the intervention development and implementation, contextual influences need to be kept in mind, such as those described by Moore et al. (2015). These would include those that “affect (and may be affected by) implementation, intervention mechanisms and outcomes, and causal mechanisms present within the context which act to sustain the status quo, or enhance effects” (p.24). These contextual factors need to be used and acknowledged when designing the theory of change model for the intervention. An understanding

of the structural systems in which the women are located should therefore be developed (Burgess et al., 2020). Then, in collaboration with the women themselves, mechanisms should be identified that would help them to cope with the symptoms of depression, as well as with the adversities that they face.

If interventions are using previous evidence-based modalities, it is vital to adapt them to local needs. Bolton (2019) recommended various steps in the adaptation process that involve: preliminary understanding of local priority mental problems, selection of treatment approach, conversion of manual and training materials into simple language, translation of the manual and training materials into local the language, on-site provider training, piloting, and on-going adaptation.

Responsive research

The above points emphasise the importance of developing manuals, materials and processes in collaboration with all stakeholders. This should be done through initial participatory research, piloting, and testing manuals and interventions, and finally retrieving feedback from counsellors and participants so that it is better embedded and appropriate and integrated into the context and community.

This can be done through an adaptive and iterative approach, conducting continuous process evaluations and involving constant feedback even during the implementation of research trials (Michelson et al., 2020). Importantly, these evaluations need to be budgeted for and included right from the beginning stages of research proposals and grant writing, with funders building in expectations of this process.

Therapeutic elements in the intervention

Following intensive feasibility research, the design of the intervention should include the use of common factors or non-specific elements that have been identified in international literature and in local studies, if these are available (Cuijpers et al., 2019; Murray and Jordans, 2016; Singla et al., 2017). Examples from AFFIRM-SA include establishing a sense of trust, creating an environment that fosters problem sharing and a willingness to talk openly to someone, experiencing a sense of relief, increased awareness and education, normalisation, social support, and a feeling of connection. Others identified by Singla et al. (2017) include eliciting social support, communication skills, emotional regulation, emotional processing, collaboration, empathy, active listening, normalisation, and involvement of a significant other. CHWs and counsellors need to be trained in these 'common therapeutic factors' that should then serve as the basis or foundation for all psychological treatments, regardless of modality (Singla et al., 2017).

Following this, the intervention could then include elements of mental health promotion through evidence-based modalities such as problem solving or CBT, IPV reduction, *and* economic skill-building components and/or cash transfers. The mental health component should involve only one therapeutic modality (for example, as used by Rahman et al. (2008) and Patel et al. (2017)). In this study, the problem solving modality seemed to be most appreciated, and this came second to the therapeutic elements in the sessions such as the connection with the counsellor and a feeling of alliance and support. Using only one therapeutic modality would allow counsellors to become more familiar with this approach, thus growing their confidence and competence. Based on AFFIRM-SA feedback, there should also be the provision or opportunity for more than six sessions of counselling.

Design of the manual

For CHWs who are not professionally trained in therapy nor necessarily highly literate, manuals need to be clear and simply worded, with obvious distinctions between what is supposed to be read out loud and the instructions meant to guide the counsellors (Bolton, 2019). Ideally, the manual should only be written in one grammatical style. It should either be extremely explicit with decisive instructions guiding counsellors to follow every step, or a great deal more open, with only a few key pointers about the topic of the sessions. The latter approach would be more reliant on counsellors having learnt the basic counselling techniques, skills and content required for each session (as used by Rahman et al. (2008) for example).

Piloting

Once an intervention is initially developed, it should be fully piloted, and feedback on content *and* implementation should be elicited from CHWs and participants alike. The design of the trial should be open and use an iterative process so that feedback can be incorporated and then tested again, once it has been incorporated. This would involve the inclusion of constant process evaluations to assess mechanisms of impact, such as participant and counsellor responses to the intervention, potential mediators, and unanticipated pathways and consequences (Moore et al., 2015). By conducting thorough feasibility and piloting, the assumptions created in the intervention theory of change model can also be tested and modified. The trial design needs to be flexible enough that implementation processes can be shifted should this be necessary.

Training

Given that the AFFIRM-SA trial had only one week of training, and that other interventions have provided training for up to one month (Singla et al., 2017), a key recommendation from this study is that training for CHWs is conducted over *at least* three weeks, and that refresher training sessions are conducted throughout the intervention. Training for CHWs to become mental health counsellors needs firstly to embed the

knowledge, understanding and practice of common therapeutic elements (Kohrt et al., 2015; Singla et al., 2017). Once these are internalised, training can continue around understanding the psychological concepts behind the chosen modality, and then how to follow and use a manual. Petersen et al. (2014) recommend using standardised training models with simple counselling guidelines for both behaviour change and psychosocial problems. Budgeting for this extended period of training needs to be encouraged and expected by funders and should be included in all funding proposals.

Competency

CHW's therapeutic competence and ability to follow a manual needs to be assessed before they are employed on a project requiring them to conduct counselling. Standardised role plays may be used to assess this such as the ENACT and EQUIP tools (Kohrt et al., 2015; Kohrt et al., 2020). In addition, CHWs should ideally hold some basic interest or inclination in mental health and counselling and have a desire to help those with mental illnesses (Spedding, 2017).

Supervision

Intricately linked with training is the provision of regular and thorough supervision for CHWs. This would involve not only case management but also an in-depth examination of counselling style, rapport with participants, and understanding of psychological concepts (Barnett et al., 2018; Myers et al., 2019). Supervision needs to ensure that the CHWs can apply the psychological concepts they are using consistently across different participants (Barnett et al., 2018). AFFIRM-SA data shows that this should also involve the supervisor sitting in on initial sessions and at regular intervals throughout the intervention, as well as consistently listen to audio recordings of the sessions.

Supervision may be enhanced through the use of peer supervision, objective counsellor self-report forms, live observation of sessions, and role-play behavioural rehearsal (Murray et al., 2011). Throughout the process, CHWs need to be empowered so that they feel able to give feedback and suggestions on content and implementation of the intervention to ensure that it is congruent with local expectations, context and capabilities (Chibanda et al., 2017).

Last, given the potential for burnout and drop in efficiency of CHWs who work continually with psychosocially disadvantaged people, external support and monitoring mechanisms should be mandatory for them (Barnett et al., 2018).

Support for the supervisor

Similarly, the clinical supervisor needs to be provided with training in supervision skills and receive regular supervision and support (Barnett et al., 2018). This should include the awareness and support around the fact that the supervisor often has to play the role of 'cultural broker' between CHWs and investigators. Employing more than one supervisor in an intervention may be a means to prevent burnout and overload for supervisors (Myers et al., 2019).

Assess mechanisms of change

Process evaluations should be conducted throughout an intervention (Murdoch, 2016). Feedback on these evaluations should become a requirement for trials (Bauer, Damschroder et al., 2015), in order to increase the amount and flow of information around what works and why it works, rather than simply *whether* it works (Cuijpers, 2019). It is only through consistent and ongoing assessment and reporting of these mechanisms across trials that we can start to learn what elements are essential in improving mental health, how these elements can be replicated, and what can be improved (Cuijpers et al., 2019).

Where possible, interventions should set up systems that are able to assess causal links between therapeutic elements and treatment outcomes (Cuijpers et al., 2019), and to analyse moderators, mediators and cost effectiveness to identify the variables that contribute to the most effective changes and outcomes in task-shared psychological treatments (Singla and Hollon, 2020).

Funding and compensation for CHWs

Interventions to address mental illness need to be sufficiently funded so that appropriate training, supervision and compensation may be provided for CHWs, in the recognition that they are the key players as the core providers of mental health services (Esponda et al., 2020). In this regard, task sharing should be viewed from the perspective of increasing coverage of care rather than of saving money.

Reporting

Last, it is vital that all stages and processes of task-shared research be reported, including the training, supervision, and intervention development processes (Damschroder et al., 2009). Feasibility studies should be reported alongside trial outcomes, so that feasibility and acceptability is more fully realised than only through a pilot study (Hoddinott, 2015). For randomised controlled trials and their pilots, the Consolidated Standards of Reporting Trials (CONSORT) guidelines should be used (Schulz, Altman et al., 2010).

In conclusion, the AFFIRM-SA RCT has shown that task-shared interventions for mental health in LMICs need to be more responsive to the contextual drivers of depression. They should include a limited number of therapeutic elements or mechanisms of change that are locally feasible and acceptable. Adequate training and supervision are essential for success. Once these interventions are tested in pilot studies, they may be evaluated in fully powered RCTs.

8.7 Limitations and strengths

8.7.1 Limitations

There are several limitations to this thesis that should be noted. First, the results may be unique to women in the perinatal period in Khayelitsha. However, the implications for task sharing are generalisable.. Second, the data for the grounded theory analysis was retrieved from counselling session transcripts rather than in-depth interviews which ask more particular or specific questions. This allows for a possibility of over- or misinterpretation of the data. Nevertheless, the use of grounded theory, rather than another method of qualitative analysis such as framework analysis, allowed the coding and categories to emerge from the data itself rather than be imposed on it, which to a certain extent should have negated this possibility. The benefit of this is discussed below.

Third, there is the possibility that participants were consistently reporting positive outcomes to their counsellors in the sessions due to a 'desirability bias'. Desirability bias refers to the "tendency of research subjects to give socially desirable responses instead of choosing responses that are reflective of their true feelings" (Grimm, 2010, p. 1). It must be acknowledged that the participants might have wanted to please the counsellor in their responses, and this may have been the case some of the time. Despite this, there are factors that point to it not only being due to a desirability bias. For example, when participants reported positive changes, they usually went beyond simply responding that they were 'feeling better', by elaborating on the reasons *why* they felt better, and giving examples of what had changed. Furthermore, there were spontaneous reports and discussions *throughout* the sessions that demonstrated positive change; so it was not only in response to the survey question asked directly by the counsellors. The responses were also positive across all six of the counsellors.

Fourth, it must be noted that the transcriptions were transcribed verbatim from audio recordings in isiXhosa to written English, and there may have been incongruities around what was actually said and done in the counselling sessions that were not adequately 'translated' into the written transcripts. This could have led to

the loss of some non-verbal nuances that occurred in the sessions, as well as there being potential mis-translations of particular words into English.

Fifth, due to the nature of grounded theory, the data were rated and analysed only by one rater. Thus inter-rater reliability of the identified codes and themes could not be assessed. This limitation was compensated for by conducting a workshop with an expert panel that was consulted on the reliability and acceptability of the codes themselves, as well as the acceptability of the data that had been categorised into the codes. The panel endorsed the acceptability and trustworthiness of the coding and of the distinctions between codes, as well as the rationale for coding the data the way it had been done.

Sixth, an analysis of counselling transcripts from participants who did not complete all six sessions may have contributed to further data on 'deviations' from the counselling protocol. The data might have identified possible reasons for participants not completing sessions that related to counselling style and participant response. In addition, those who received fewer than six sessions may have reported fewer benefits or positive outcomes from the sessions This could have been a reason for non-completion. An analysis of counselling session transcripts of participants who did not complete all sessions was beyond the scope of the current thesis.

Relatedly, the 39 participants in this study may have completed all six counselling sessions because they were 'getting' something out of them, leading to inflated responses of the positive outcomes of the sessions. Nevertheless, these responses were still helpful to retrieve effective therapeutic elements and did not hinder the availability of data demonstrating deviations from protocol.

An in-depth analysis of the styles particular to each counsellor was not conducted as it would have required a more specific focus on each counsellor and would have diverted attention from the more generalised research questions about the intervention. Counsellor change over time was also not analysed as this was not within the scope of the thesis.

There are also limitations that relate to the sole use of qualitative methods in this thesis. This study design did not allow for an analysis of causal relationships between therapeutic elements and treatment outcome, nor could it conduct an analysis of potential mediating and moderating variables such as food insecurity, economic status, and time taken to complete sessions, on treatment outcome. These would make for valuable contributions for mental health interventions in the future.

Last, the common therapeutic elements that were identified through the grounded theory are correlational reports applicable only to this study. However, the identified elements do add to the growing body of evidence of component studies contributing evidence that appears to be corroborating across interventions and different therapeutic modalities.

8.7.2 Strengths

The thesis also has many strengths. The use of qualitative analysis afforded an in-depth examination of data that accessed a deep and contextual view of the realities of the implementation of the trial. A grounded theory methodology allowed coding and categories to emerge from the data itself rather than being imposed on it. In opposition to the concern of possible desirability bias, this provided more of an 'unmediated' perspective, in which participants were not 'observed' or questioned by a researcher. This uncovered elements from the RCT that researchers had not been aware of at any stage in the trial.

The analysis of counselling sessions themselves provided insight into strategies that counsellors employed in sessions that cannot easily be assessed through retrospective feedback from counsellors themselves. It also accessed reflections from participants in the immediacy of the therapeutic moment. Interviews conducted after completion of the intervention deliver different data than that collected during sessions, as responses from participants can be mediated through time, reflection, and potential desirability bias. This contributes a different form of data than that retrieved from the standardised instruments for the outcome assessments conducted by the fieldworkers.

To my knowledge, this thesis is the first large-scale study of processes and mechanisms occurring within actual counselling sessions, across a number of counsellors and participants, in a task-shared intervention for perinatal depression, or even for CMDs, in an LMIC. This approach has traditionally only been conducted in Western contexts within therapeutic interactions between one client and one therapist, largely to examine the nature of the therapeutic relationship between the two (Norcross and Lambert, 2018). This process highlighted many contextual and therapeutic challenges that are faced in task-shared psychosocial interventions. It also provided a unique perspective on the therapeutic elements that participants themselves found valuable, and adds to the relatively small database of common elements appropriate for task-sharing.

8.8 Reflexivity

It is important to acknowledge my role and influence as the author on the interpretation and presentation of the data in this thesis. I am a South African born, white, first-language English speaker with a university education. These factors alone place me in a position of privilege and particular perspective within the socio-political history of South Africa. My culture also stems from an individualistic, Western orientation, and I accordingly cannot make any assumptions about socio-cultural norms in another culture. I am trained in counselling theory, and thus view the counselling sessions through this lens, bringing a particular academic or therapeutic judgement onto the therapeutic quality of the sessions. I was also employed as a research officer on the AFFIRM-SA RCT and was thus intricately involved in its development and coordination. I was not however involved in the implementation of the intervention and control group protocols. This helped me to interpret the counselling sessions but may in turn have biased me in judging what 'should' and 'shouldn't' have been done.

Guided by recommendations from Murdoch (2016), I attempted to adopt an attitude of not 'blaming the counsellor' and instead tried to incorporate the influence of all contextual factors that may have had an impact on the counselling sessions. I found that this was a helpful method to avoid 'individualising' the problem and instead acknowledge the multiple factors of context that play a role in influencing individual behaviour within the implementation of an intervention.

In addition, as much as I followed the guidelines and tenets of grounded theory, I could not escape from imposing my own meaning in reading the transcripts, which is subjective and dependent on the viewpoints, culture and background that I personally bring to the analysis. Corbin and Strauss (1998) write that experience and knowledge sensitise a researcher to problems and issues in the data, and that this can be drawn on to identify properties and dimensions of emergent concepts. I believe that my theoretical counselling background, and employment as the Research Officer, were two such 'experiences' that were drawn upon to interpret the concepts.

In an attempt to mitigate against potential bias in analysing the data, the data analysis coding process and subsequent codes were presented to a panel of experts for feedback on the relevance and reliability of these codes, as described earlier.

I also acknowledge that I can never assume to know the lived experiences of the participants in the study, and it was therefore important for me to represent the voices of the participants as accurately as possible, while

still acknowledging that the development of theories and hypotheses from the data is 'co-constructed' by both participants and the researcher (Mills et al., 2006). I thus acknowledge that the findings and discussion presented in this thesis will have a thread of my own socio-cultural influences and background running through them.

8.9 Conclusion

Perinatal depression is a particularly significant mental illness because of the double burden it carries, not only for the women experiencing it, but also for their infants and children that are affected by it in numerous ways. The prevalence of perinatal depression is particularly high in South African township contexts such as Khayelitsha. The AFFIRM-SA RCT tested an intervention to address the treatment gap for perinatal depression through designing and implementing a randomised controlled trial that employed a six-session task-shared treatment, using psychological techniques demonstrated to be effective in previous interventions.

This thesis conducted a process evaluation of this RCT. Following evaluation of the formative research, grounded theory analysis of data from counselling session transcripts proved to be invaluable in exploring the processes, mechanisms, and factors at play in the implementation of the intervention by CHWs as counsellors. This method allowed for an in-depth understanding of how counsellors implemented the sessions, as well as how participants experienced the sessions, what needs they expressed, and what outcomes they were reporting. The narrating of these processes aligns with reporting recommendations for interventions articulated by authors such as Singla and Hollon (2020), Moore and Evans (2017), and Damschroder et al. (2009).

This method also assisted in revealing potential explanations behind the differing results from the RCT primary outcome assessments: that of non-significant effects on the HDRS, and significant effects on the EPDS. It provided an important differentiation from the trial outcomes that were reported to the fieldworkers retrospectively at three- and 12-months post-partum. Evidence from the process evaluation highlighted factors that may have hindered full clinical recovery from perinatal depression on the HDRS, but also demonstrated many positive outcomes of change and reductions in distress, which was reflected in improved scores on the EPDS.

Critically, the findings emphasise and endorse the importance of adequate training and supervision (Barnett et al., 2018; Verhey et al., 2020). This is essential to support minimally educated CHWs to provide psychological therapy to participants who face multiple poverty-related traumas on an ongoing basis.

The influential role of risk factors in experiencing depression was clearly highlighted by participants from both the formative research and in the counselling sessions in this study. This corroborates with current research that acknowledges risk factors and social determinants as predictors of mental illness, particularly in low income settings (Patel et al., 2018). The participants expressed that their depression symptoms were, to a large degree, attributed to the experience of social, economic and environmental distress in their lives, and that an amelioration of these stressors would contribute significantly to their experiences of depression. This thesis therefore confirms that these broader determinants of mental illness need to be addressed if symptoms are to be improved (Burgess et al., 2020). This could involve designing multi-component interventions to address mental illness at multiple levels, implementing social assistance programmes and holistic approaches to community development that attend to a range of poverty related factors such as unemployment, deprivation, disempowerment and food insecurity. The results indicate that this may be achieved through conducting participatory action research in the formative phase of intervention development. This would help to better incorporate the voices and needs of all stakeholders (Burgess et al., 2020).

Participants in this study corroborated other research around the effectiveness of common elements in therapeutic settings (Singla et al., 2017), such as the experience of empathy, trust, being heard, and feeling supported. In particular, this research identified the value that participants held of receiving helpful advice from counsellors, and of experiencing a sense of connection with their therapist. This adds to the growing evidence proposing the use of these common engagement elements in training and implementing task-shared therapy, regardless of the type of modality used.

There are multiple challenges that interventions face in implementing task sharing; particularly in the directive that they should be cost effective while also increasing coverage of mental health services at a primary care level. This thesis presents a wide range of contextual considerations and therapeutic elements relevant to designing and implementing more acceptable and responsive public mental health interventions that aim to effect real and sustainable change.

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Appendices

Appendix A. UCT ethics approval for this thesis

UNIVERSITY OF CAPE TOWN

HUMAN RESEARCH ETHICS COMMITTEE
FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) **This serves as notification of annual approval, including any documentation described below.**			
☐ Approved	Annual progress report	Approved until/next renewal date	25.02.2021
☐ Not approved	See attached comments		
Signature Chairperson of the HREC		Date Signed	12/2/20

Comments to PI from the HREC
Thank you for the deviation document

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	9 March 2020		
HREC REF Number	790/2015	Current Ethics Approval was granted until	28/02/2020
Protocol title	Perinatal depression: local definitions, measurement and relationships to poverty, food insecurity and social support.		
Protocol number (if applicable)	1		
Are there any sub-studies linked to this study?	☐ Yes ☒ No		
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	A/Prof. Marguerite Schneider, for PhD student Thandi Davies		
Department / Office Internal Mail Address	Psychiatry and Mental Health		

1.1 Does this protocol receive US Federal funding?	☐ Yes	☒ No

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

To note, the title of the thesis was changed, and was accepted by the Doctoral Degrees Board in July 2020.

Appendix B. Letter of approval confirming permission to include a publication in the thesis

From: DOCTORAL DEGREES BOARD
To: thandi.davies@gmail.com; Thandi Davies
Cc: Adri Winckler; Marguerite Schneider
Subject: Permission to include publications in your PhD thesis: Claire Thandiwe Davies DVSCLA004
Date: Tuesday, 18 August 2020 12:48:21
Attachments: Outlook-sxtx0441.png
Outlook-5mz2dowd.png
Declaration - Inclusion of publications.docx
Importance: High

Dear Claire Davies

I hereby confirm that the Deputy Chair of the Doctoral Degrees Board has **approved** your request to include the specified publication in your PhD thesis.

In your thesis (after your declaration that it is your own work) please include the following separate signed statement listing the publications that you were given permission to include:
"I confirm that I have been granted permission by the University of Cape Town's Doctoral Degrees Board to include the following publication(s) in my PhD thesis, and where co-authorships are involved, my co-authors have agreed that I may include the publication(s): "

This declaration serves to notify examiners that the Doctoral Degrees Board has granted you permission to include publications in your thesis.

Kind Regards

JANINE ISAACS
Doctoral Degrees Board Officer

UNIVERSITY OF CAPE TOWN
Room 5.04 | Masingene Building | Cross Campus Road |
| Middle Campus | Rondebosch | South Africa | 7700
Doctoral Candidates Webpage
+27 (0) 21 650 2202

From: Thandi Davies <thandi.davies@gmail.com>
Sent: Wednesday, 29 July 2020 12:43
To: DOCTORAL DEGREES BOARD <ddb@uct.ac.za>; Janine Isaacs <janine.isaacs@uct.ac.za>
Cc: Marguerite Schneider <marguerite.schneider@uct.ac.za>
Subject: Request for Permission to Include a Publication in my PhD Thesis: Thandi Davies, DVSCLA004

Dear Janine
I hope this email finds you well.
I am writing to request permission from the Doctoral Degrees Board to include a publication in my PhD thesis, which I am hoping to submit by October 2020.
Herewith, please find attached (as one PDF file):
1. My own letter requesting permission to include publications in my PhD thesis.
2. A letter of support from my primary supervisor, A/Prof Marguerite Schneider
3. Copies of email correspondence with each co-author, indicating their support.
I would be very grateful for the approval of the board to include this publication in my thesis.
Best wishes,
Thandi Davies

Appendix C. UCT ethics approval for the AFFIRM-SA randomised controlled trial

HUMAN RESEARCH ETHICS COMMITTEE
18 MAY 2015
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938)			
This serves as notification of annual approval, including any documentation described below.			
☑ Approved	Annual progress report	Approved until/next renewal date	28.4.2016
☐ Not approved	See attached comments		
Signature Chairperson of the HREC	pp TJBurgess	Date Signed	20/05/2015

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	12 May 2015		
HREC REF Number	226/2011	Current Ethics Approval was granted until	17 May 2015
Protocol title	COLLABORATIVE HUBS FOR INTERNATIONAL RESEARCH ON MENTAL HEALTH (U19): AFRICA FOCUS ON INTERVENTION RESEARCH FOR MENTAL HEALTH (AFFIRM) **AFFIRM-SA trial (South Africa) and TaSCS trial (Ethiopia)**		
Protocol number (if applicable)	12161949		
Are there any sub-studies linked to this study?		☐ Yes X No	
If yes, could you please provide the HREC Ref's for all sub-studies? **Note:** A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	Prof Crick Lund		
Department / Office Internal Mail Address	Psychiatry and Mental Health		

1.1 Does this protocol receive US Federal funding?	X Yes	☐ No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	☐ Yes	X No
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget.	☐ Yes	X No

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Appendix D. Permission letters from the Department of Health to conduct research at the two Primary Health Care Clinics in Khayelitsha

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
healthres@pgwc.gov.za
Tel: +27 21 483 9907: fax: +27 21 483 9895
1st Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: RP 79/2012
ENQUIRIES: Dr Sikhumbuzo Mabunda

46 Sawkins Road,
Rondebosch,
7700

For attention: Associate Professor Crick Lund

Re: Africa Focus on Intervention Research for Mental Health (AFFIRM)

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries.

Michael Mapongwana **Ms Matiyela** **(021) 363 1080**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 18/7/2012

CC **DR G PEREZ** **DIRECTOR: EASTERN/KHAYELITSHA**

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
healthres@pgwc.gov.za
tel: +27 21 483 9907; fax: +27 21 483 9895
1st Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 79/2012
ENQUIRIES: Charlene Roderick

46 Sawkins Road,
Rondebosch,
7700

For attention: Associate Professor Crick Lund

Re: Africa Focus on Intervention Research for Mental Health (AFFIRM)

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries.

Khayelitsha Site B **Mr David Binza** **Contact No. 021 361 4835**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR N Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 10/01/2014

CC **DR A HAWKRIDGE** **DIRECTOR: EASTERN/KHAYELITSHA**

Appendix E. Consent form for the AFFIRM-SA RCT

AFFIRM RANDOMIZED CONTROLLED TRIAL

INFORMED CONSENT FORM FOR PARTICIPANTS

The Research Study

We are asking you to participate in this research study. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

The University of Cape Town is doing this project to research maternal mental health in Khayelitsha. The project is called AFFIRM (**AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental health), which is a collaboration between the University of Cape Town, University of Addis Ababa, Columbia University, Johns Hopkins University, Kings College University, Makerere University, and the Department of Health. It is funded by the National Institutes of Health, USA.

Why is it important?

The study is important because one out of every three women in Khayelitsha experience depression or anxiety when they are pregnant or after having a baby.

What is it for?

This study is looking at ways to provide counselling services and mental health assistance to depressed pregnant women, so that they can learn to manage and cope with maternal distress.

We want to find out how best to use a "task-shifting" approach, which means using community health workers instead of psychologists and psychiatrists, to provide counselling services for depression. We want to develop appropriate and cost effective mental health services for these women, and we hope that the information obtained will help to improve mental health services in South Africa and other countries in sub-Saharan Africa.

Who will be involved?

1. 420 pregnant women at their first antenatal booking at Michael Mapongwana Community Health Centre MOU and Site B Community Health Centre MOU, who show symptoms of depression when assessed on the EPDS.
2. Community Health workers who work in the catchment area of Michael Mapongwana Community Health Centre and Site B Community Health Centre.
3. Registered Nurse Midwives based at Michael Mapongwana Community Health Centre and Site B Community Health Centre, who work with perinatal mothers and/or mental health in Khayelitsha.
4. Service managers at Michael Mapongwana Community Health Centre and Site B Community Health Centre.

How long will it last? The study will run from July 2012 to July 2016.

What will it mean if you participate in the study?

If you agree to participate in this study you will be asked a few screening questions about depression with the EPDS. If you are distressed according to the EPDS, we will continue with an interview which will take approximately one hour. The interviews will ask some sensitive questions and all information you give us will be kept strictly confidential. You can refuse to answer any questions that you feel uncomfortable answering. The information you give us will be used to help us design a cost effective counseling intervention to help mothers who are suffering from depression.

After this, you will EITHER receive 6 counseling sessions when you come for your pregnancy checkups, OR monthly telephone calls from a community health worker to discuss your depression and ways to help to improve it. The sessions will be audio recorded to ensure the quality of the counseling. You will then be asked to participate in three more interviews at: one month before birth, three months after birth, and twelve months after birth. We intend to conduct the interviews and counseling sessions on the same days you come for your pregnancy and baby check-ups at the clinic so that you will not incur any additional costs. In the interviews after your baby is born we will also ask some questions about your baby. We will inform you if any new findings arise during the duration of the study that may affect your participation.

Is there any disadvantage from participating in this study?

There is the possibility that you may have a mental health problem or that participating in the study may remind you of a time that you had such a problem. The risks associated with worsening of your depression are present whether or not you participate in this study. If you get distressed by a mental health problem or feel suicidal, we will refer you for psychological help. If you have a serious substance abuse problem or psychiatric illness that was not initially picked up at the interview, we will refer you for external assistance and you will no longer be able to participate in the study.

If you receive counseling from us, there a small risk that counselors may breech confidentiality and/or disclose personal information to you or others. We will minimize this risk by careful evaluation of the counselors and through weekly group supervision and monthly individual supervision for them. If you report or the counselors observe any child abuse, we are obliged by law to report this to the Department of Social Development. This means that we will need to give information about your child to the social worker.

Is there any advantage to the study?

We hope that the counselling will improve your mental health and help you to build better ways of coping with depression in the future. We also hope that the information obtained will help to improve mental health services in South Africa and other countries in sub-Saharan Africa.

What alternatives do I have if I don't participate in the study?

If you think you are depressed but you do not want to participate in the study, you can contact one of the organisations listed in the pamphlet we give you, and they can help you.

What if I change my mind later?

You are free to withdraw at any stage from participating in the study and your decision will not disadvantage you in any way. You will need to inform a member of the project if you wish to withdraw, and if you require, we can refer you to relevant local mental and social health services.

Who will see the information that we collected?

All records will be kept completely confidential, and stored electronically at UCT. Your identity will be anonymous and your information will be combined with that of all the other participating women. After the information is analysed, the recordings and transcripts will be destroyed. This information will only be seen by the researchers and investigators.

When we have finished the study, the information that you provide to us could be used by researchers outside of this study. However, your name and personal details will never be given to any of these researchers. They will never be able to identify who you are.

Who to contact if you want to know more, or if you have a problem at any time?

If you want more information on the study before deciding whether or not to participate, or if you participate and later need help or have questions, please contact:

Prof C. Lund, Department of Psychiatry and Mental Health, University of Cape Town,

Tel: 021 685 0120

If you have any questions about your rights and welfare in the research, please contact: The Human Research Ethics Committee, Groote Schuur Hospital. Tel: 021 406 6626

Consent to Enrol **Research ID #**

I, _____ agree to participate in the research study on maternal mental health in Khayelitsha, to help to develop relevant and cost effective ways of helping mothers with depression.

I have received and understood the study information sheet. I have discussed the advantages and disadvantages of participating in the study and I agree to participate in the interviews as stated in the information sheet.

I know I can leave the research study at any time without prejudice and be referred for psychological help if need be.

Signature: _____

Date: _____

Witness

Name: _____

Signature: _____

Date: _____

You may keep the information sheet. The signed consent form will remain in our study files.

Appendix F. Consent form for the formative research for the AFFIRM-SA RCT

AFFIRM RANDOMIZED CONTROL TRIAL
INFORMED CONSENT FORM FOR PARTICIPANTS ("Adult subjects")

The Research Study

We are asking you to participate in this research study. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. The University of Cape Town is doing this project to research maternal mental health in mothers in Khayelitsha. The project is called AFFIRM, (**AF**rica **F**ocus on **I**ntervention **R**esearch for **M**ental health), which is a collaboration between the University of Cape Town, Addis Ababa University, Columbia University, Johns Hopkins University, Kings College London, Makerere University, and the Department of Health, and funded by the National Institute of Mental Health.

Why is it important?

The study is important because one out of every three women in Khayelitsha experience depression or anxiety when they are pregnant or after having a baby.

What is it for?

We are studying counselling services and mental health assistance to depressed mothers and pregnant women, so that mothers can be helped to cope with maternal depression. 420 women will be participating in this study.

We want to find out how best to use a "task-shifting" approach, which means using lay counselors, or community health workers, instead of psychologists and psychiatrists, to provide counselling services for mental illnesses. We want to develop appropriate and cost effective mental health services for these mothers, and we hope that the information obtained will help to improve mental health services in South Africa and other countries in sub-Saharan Africa.

Who will be involved?

1. Pregnant women who are diagnosed with a DSM-IV Diagnosis of major depressive disorder on the MINI, who are attending the Michael Mapongwana Community Health Centre.
2. Community Health workers who work in the catchment area of Michael Mapongwana Community Health Centre.

As the pregnant women will be seen by the CHWs most likely at the clinic it means that the clinic is also involved in the project, and more specifically:

3. Registered Nurse Midwives based at the Michael Mapongwana Community Health Centre, who work with perinatal mothers and/or mental health in Khayelitsha.
4. Service managers at the Michael Mapongwana Community Health Centre.

How long will it last? The study will run from July 2012 to July 2015.

What will it mean if I participate in the study?

If you agree to participate in this study you will receive either a number of counselling sessions or monthly telephone calls from your community health worker to discuss your depression and ways to help to improve it. You will be assigned to either the counseling sessions or the monthly telephone calls by a computer, using a random choice, similar to flipping a coin. After you have received either the counseling sessions or the telephone calls, we will contact you again when your baby is 3 months old, and then again when your baby is 12 months old, to do follow-up interviews.

If you receive the counseling sessions, these will be recorded to help us understand what works best in the counseling sessions. The only person who will listen to these recordings will be the counselor's supervisor, who will then remove any identifying information from the recording.

Is there any disadvantage from participating in this study?

There is the possibility that you may have a mental health problem yourself or that participation in the study may remind you of a time that you had such a problem. If you get distressed by this, we will refer you for psychological help.

Is there any advantage to the study?

We hope that the information obtained will help to improve mental health services, especially for pregnant women and mothers of young babies in South Africa and other countries in sub-Saharan Africa. We also help that you will feel better yourself as a result of the contact that you support or information that you receive from staff on the project. This service will be provided for free.

What if I change my mind later?

You are free to withdraw at any stage from participating in the study and your decision will not disadvantage you in any way.

Who will see the information that we collected?

All records will be kept completely confidential. Your identity will be anonymous and following analysis of the data, the tapes and transcripts will be destroyed. The data will only be seen by the researchers and investigators.

Who to contact if you want to know more, or if you have a problem at any time?

If you want more information on the study before deciding whether or not to participate, or if you participate and later need help or have questions, please contact:
Prof C. Lund, Department of Psychiatry and Mental Health, University of Cape Town,
Tel: 021 685 0120
If you have any questions about your rights and welfare in the research, please contact: The Human Research Ethics Committee, Groote Schuur Hospital.
Tel: 021 406 6626

Consent to Enrol **Research ID # _____**

I, _____ agree to participate in the research study on maternal mental health in Khayelitsha, to help to develop relevant and cost effective ways of helping mothers with depression. I have received and understood the study information sheet. I have discussed the advantages and disadvantages of

participating in the study and I agree to participate in the interviews as stated in the information sheet. I know I can leave the research study at any time without prejudice and be referred for psychological help if need be.

Signature: _____
Date: _____
Witness 1
Name: _____
Signature: _____
Date: _____
You may keep the information sheet. The signed consent form will remain in our study files.

Appendix G. The AFFIRM-HDRS assessment tool

These questions relate to your feelings over the past month.

1 WORK AND ACTIVITIES

During the past month, have you been less able than usual to work or do your usual activities? Do your activities make you feel tired, or have you lost interest in your activities or house work?

0 - No decrease in productivity or time spent at work and/or doing usual activities
1 - Activities make you feel tired
2 - Lost interest in work or activities or house work
3 - Decrease in productivity of work or activities or house work
4 - Spending less time at work or doing activities

2 WEIGHT LOSS

Have you lost any weight during the past month?

0 - No
1 - Possibly
2 - Yes, definite change in weight (not on diet)

3 APPETITE

During the past month, have you experienced a loss of appetite?

0 - No loss of appetite
1 - Some loss of appetite but you are still eating
2 - At least some loss of interest in food and you require encouragement to eat

4 LIBIDO

During the past month, have you had an interest in sex?

0 - Yes, normal interest in sex (or is not sexually active)
1 - Somewhat less interest
2 - A lot less interest than usual or no interest at all

INSOMNIA: The following 3 questions will ask you about different aspects of sleep: going to sleep at night, waking up in the middle of the night, and waking up early or sleeping late in the morning.

5 EARLY INSOMNIA

Firstly, during the past month, have you had troubles or difficulties falling asleep?

0 - No
1 - Sometimes
2 - Yes, almost every night

6 MIDDLE INSMONIA

During the past month, have you been waking up during the night?

0 - No
1 - Sometimes
2 - Yes, almost every night and you get out of bed (other than for urinating/peeing)

7 LATE INSOMNIA

During the past month, have you either been waking up earlier in the morning than you wanted to, or sleeping too much?

0 - No
1 - Sometimes
2 - Yes, most of the time

8 GENERAL SOMATIC SYMPTOMS

During the past month, have you experienced fatigue or had less energy than usual? Or have you had headaches, backaches, or aches in specific parts of your body?

0 - None
1 - Some
2 - Yes, a lot

9 GUILT

During the past month, have you been feeling guilty or bad about something you have done? Do you feel you have let people down or that you are evil? Do you think your illness is punishment for something?

0 - No feelings of guilt
1 - You feel you have let people down OR you feel evil or bad
2 - You feel you have let people down AND you feel evil or bad
3 - You think that your illness is a punishment
4 - You feel like you are hearing voices in your head, or you feel you are so bad that you will hurt other people, or it will lead to your own death

10 PSYCHIC ANXIETY

During the past month, have you been feeling nervous, anxious, worried or frightened?

0 - Never
1 - Sometimes
2 - Quite often
3 - Most of the time
4 - Yes, signs or problems are very bad all of the time

11 SOMATIC ANXIETY

Now I am going to read you a list of physical symptoms. Tell me if you have experienced any of these in the last month and how severe they are:

A. Stomach or digestive problems or pains
B. Heart palpitations
C. Breathing very fast or trouble breathing
D. Urinating often
E. Muscle aches, body aches
F. Unusual sensations like trembling or ringing in your ears
G. Flushing, feeling faint, or sweating

Code for the most severe symptom:

0 - Absent
1 - A little bit
2 - Some
3 - A lot
4 - Severe, and you can't do anything because of it

12 HYPOCHONDRIASIS

During the past month, have you been worrying more than usual about your health and how your body is working? (Apart from normal fears about your pregnancy). [Don't read the options to the participant. Make the assessment yourself.]

0 - No unnecessary worries about her health
1 - Some unnecessary worry about her health
2 - A lot of unnecessary worries about her health
3 - Strong beliefs she has a physical problem and doctors won't believe her

4 - Delusional, e.g. she thinks that her body is rotting

13 SUICIDE

During the past month, have you had thoughts that life is not worth living, or that you would rather be dead? Have you had thoughts of hurting or killing yourself? If yes, how often?

0 - No
1 - Sometimes
2 - Often
3 - Most of the time
4 - Suicide attempt

14 INSIGHT

Do you think that you have a psychological problem, such as depression? [Don't read the options to the participant. Make the assessment yourself.]

0 - Acknowledges being depressed or having a psychological problem (OR is not currently depressed)
1 - Acknowledges illness but blames it on something else
2 - Denies any illness but is currently depressed in your opinion

15 DEPRESSED MOOD

During the past month, have you been feeling sad, depressed, helpless, hopeless, or worthless? If yes, how often do you feel this way?

0 - No, not at all
1 - Occasionally
2 - Quite often
3 - Very often
4 - Yes, almost all the time

16 RETARDATION

Observe and rate slowness of thought, speech, concentration, and physical movement [Don't read the options to the participant. Make the assessment yourself.]

0 - Normal speech and thought
1 - A bit of slowness in thinking or speaking (Slight retardation)
2 - A lot of slowness in thinking or speaking (Obvious retardation)
3 - A lot of very long pauses (Interview difficult)
4 - Interview impossible

17 AGITATION

Observe and rate restlessness, fidgetiness and physical activity [Don't read the options to the participant. Make the assessment yourself.]

0 - None
1 - Fidgetiness
2 - Playing with hands, hair, obvious restlessness
3 - Restless, moving about; can't sit still
4 - Hand wringing, nail biting, hair pulling, biting of lips, person is moving about a lot

TOTAL SCORE_____

Appendix H. The Edinburgh Postnatal Depression Scale (EPDS)

In this next section, we will READ you STATEMENTS about how you have been feeling recently. Please provide the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

IN THE PAST 7 DAYS:

1. I have been able to laugh and see the funny side of things

- ☐ As much as I always could [0]
- ☐ Not quite so much now [1]
- ☐ Definitely not so much now [2]
- ☐ Not at all [3]

2. I have looked forward with enjoyment to things

- ☐ As much as I always did [0]
- ☐ Rather less than I used to [1]
- ☐ Definitely less than I used to [2]
- ☐ Hardly at all [3]

3. I have blamed myself unnecessarily when things went wrong

- ☐ Yes, most of the time [3]
- ☐ Yes, some of the time [2]
- ☐ Not very often [1]
- ☐ No, never [0]

4. I have been anxious or worried for no good reason

- ☐ No, not at all [0]
- ☐ Hardly ever [1]
- ☐ Yes, sometimes [2]
- ☐ Yes, very often [3]

5. I have felt scared or panicky for no good reason

- ☐ Yes, quite a lot [3]
- ☐ Yes, sometimes [2]
- ☐ No, not much [1]
- ☐ No, not at all [0]

6. Things have been getting on top of me

- ☐ Yes, most of the time I haven't been able to cope at all [3]
- ☐ Yes, sometimes I haven't been coping as well as usual [2]
- ☐ No, most of the time I have coped quite well [1]
- ☐ No, I have been coping as well as ever [0]

7. I have been so unhappy that I have had difficulty sleeping

- ☐ Yes, most of the time [3]
- ☐ Yes, sometimes [2]
- ☐ Not very often [1]
- ☐ No, not at all [0]

EPDS continued:

8. I have felt sad and miserable

- Yes, most of the time [3]
- Yes, quite often [2]
- Not very often [1]
- No, not at all [0]

9. I have been so unhappy that I have been crying

- Yes, most of the time [3]
- Yes, quite often [2]
- Only occasionally [1]
- No, never [0]

10. The thought of harming myself has occurred to me

- Yes, quite often [3]
- Sometimes [2]
- Hardly ever [1]
- Never [0]

SCORE_____

Appendix I. 14-Item checklist

	Not a problem	A small problem	A medium problem	A very big problem
1. Sadness				
2. Lack of interest				
3. Hopelessness				
4. Irritability				
5. Anxiety				
6. Weight loss or gain				
7. Appetite problem loss or gain				
8. Sleep problems				
9. Tired or lack of energy				
10. Use of drugs				
11. Use of alcohol				
12. Suicidal thoughts or actions				
13. Partner Abuse (Verbal, physical or sexual e.g. shoving, biting, hitting, threatening with a weapon)				
14. Other: Specify (_____)				

☐ Have there been any big changes in your life since you last spoke to someone from AFFIRM (positive or negative)? If yes please describe these for me?

☐ Since the last interview or phone call, have you been visited by anyone or have you gone to see anyone to get assistance or support with a problem? E.g.

Philani Mentor Mother
Community Health worker
Counsellor from the parent centre
Spiritual healer or church member?
Other: Specify ---------