Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective.

By

Palesa Leshaba

Dissertation submitted in fulfilment of the requirements for the

Master of Health Systems Studies

at the

Centre for Health Systems Research & Development

Faculty of the Humanities

University of the Free State

Bloemfontein

Supervisor: Prof. Gladys Kigozi-Male

Co-supervisor: Dr. Ngwi Nnam Thecla Mulu

July 2025

Declaration

I, Palesa Leshaba, declare that the Master's Degree research dissertation that I herewith submit for the Master of Health Systems Studies degree at the University of the Free State is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.

23 July 2025

Student Signature Date

Centre for Health Systems Research & Development

Abstract

Background

Postpartum mental health (PPMH) remains a neglected aspect of maternal care within South Africa's primary health care system. This neglect is especially evident in peri-urban areas where overburdened community health centres (CHCs) often lack the capacity to offer mental health support. Although national policy acknowledges the importance of maternal mental health , postpartum women continue to face significant barriers in accessing care. These challenges extend beyond resource limitations, and include stigma, inconsistent screening practices, and sociocultural norms that minimise emotional distress. As a result, symptoms of depression, anxiety, or trauma frequently go undetected in settings that prioritise physical health. Existing research has largely overlooked the complex multilevel factors shaping access to PPMH care. This study addresses this gap by examining the determinants of access to postpartum mental health services (PPMHS) at a peri-urban CHC in Gauteng Province in South Africa.

Methodology

The study employed a qualitative exploratory case study design grounded in a constructivist paradigm. The socio ecological model (SEM) provided a guiding framework to explore the multi-level determinants of access to PPMHS at the CHC across five levels: individual, interpersonal, organisational, community, and societal. Semi structured interviews were conducted with ten postpartum women (within six months of delivery) attending postnatal care at the CHC, as well as eight healthcare providers directly involved in maternal care. Participants were selected through purposive sampling to ensure depth and relevance of insights. Data were transcribed verbatim and analysed using abductive thematic analysis (ATA), which allowed for the integration of both data-driven themes and SEM-informed theoretical constructs. Ethical approval was obtained with all participants providing informed consent. Confidentiality and respectful engagement were upheld throughout the research process.

Findings

The study identified a range of interrelated barriers and facilitators to accessing PPMHS across all five levels of the SEM. At the individual level, limited awareness of PPMH and internalised stigma discouraged help-seeking. In contrast, exposure to mental health education and trauma-informed care provided by healthcare providers facilitated service use. At the interpersonal level, emotional support from family members and partners played an instrumental role in enabling access to care. Conversely, the absence of such support posed a significant barrier. At the organisational level, systemic issues such as inconsistent screening practices, staff shortages, a lack of provider training in mental health, and the absence of mental health integration into routine postnatal care hindered access to PPHM services. However, access was supported by the availability of trained mental health professionals and proactive referral efforts by some healthcare providers. At the community level, entrenched cultural stigma, by rigid gender roles, and religious belief surrounding emotional distress inhibited disclosure and care seeking, yet respectful treatment and the use of culturally sensitive practices by healthcare providers improved acceptability of mental health services. At the societal level, limited involvement of frontline providers in policymaking and the absence of structured PPMH monitoring mechanisms weakened implementation of PPMHS at the CHC.

Conclusion

The study highlights the complex, layered factors that shape access to PPMH care at the CHC. Addressing these challenges requires a coordinated, multilevel response. Priorities should include strengthening mental health literacy among women and families, enabling family support, augmenting provider capacity through training, and incorporating culturally responsive care into routine care services at the CHC. It is also important to have meaningful involvement of frontline healthcare providers in policy development and the establishment of quantifiable implementation strategies. A context-sensitive and integrated approach to implementing PPMHs has the potential to strengthen maternal mental health outcomes and ensure that primary healthcare services are more responsive to the needs of postpartum women.
Key Words: Postpartum Mental Health, Socio-Ecological Model, Community Health Centre, Postpartum Period, Postpartum women, Healthcare Provider.

Acknowledgements

I would like to express my sincere gratitude to my supervisor, Professor Kigozi-Male, for your unwavering support and guidance throughout this research project. Your insightful suggestions, constructive feedback, and expertise have played a vital role in shaping and refining this work. I am deeply grateful for the time and encouragement you have generously provided. To my co-supervisor, Dr Ngwi Mulu, I am equally grateful for your thoughtful input and clear guidance. Your comments have helped me to simplify my approach, clarify my thinking, and strengthen this paper. Both of your contributions have been invaluable to my academic and personal growth.

I am especially grateful to my family, in loving remembrance of my father, Vusimuzi Leshoedi, whose support and faith in my potential still motivate me. To my mother, Selina Leshoedi, your presence and care have been a source of strength. To my partner, Makgale, and our children, thank you for your understanding, patience, and encouragement. I am deeply grateful because you provided me with the emotional and practical support necessary to complete this work.

I would like to extend my sincere gratitude to postpartum women and healthcare providers who generously provided their time and shared their experiences.

This dissertation is a result of the collective support, encouragement, and inspiration I have received from all of you.

Thank you.

Khotso e ke e be le lona, bophelo bo le katise, lesedi le le bonesetse tseleng, mme katleho e le latele kamehla.

Table of Contents

List of Tables

List of Figures

Abbreviations and Acronyms

ATA	Abductive Thematic Analysis
CHC	Community Health Centre
CHWs	Community Health Workers
CMHS	Community Mental Health Services
DoH	Department of Health
EPDS	Edinburgh Postnatal Depression Scale
GBV	Gender-Based Violence
HICs	High-Income Countries
HPA	hypothalamic-pituitary-adrenal
IPV	Intimate Partner Violence
LMICs	Low- and Middle-Income Countries
PP	Postpartum Psychosis
PPD	Postpartum Depression
PPMD	Postpartum Mental Disorder
PPMH	Postpartum Mental Health
PPMHS	Postpartum Mental Healthcare Services
PPPs	Public-Private Partnerships
PPTSD	Postpartum Post-Traumatic Stress Disorder
SA	South Africa
SEM	Socio-Ecological Model
SEMMW	Socio-ecological Model of Mental Health and Well-Being
SNPs	Single-Nucleotide Polymorphisms
WHO	World Health Organization

Definitions of Key Concepts

Mental Health Disorder:

A Mental disorder refers to a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour (American Psychiatric Association, 2013). Such disturbances reflect a substantial impairment in the psychological, biological, or developmental processes underlying mental functioning (World Health Organization (WHO, 2022). These disorders are usually associated with significant distress or disability in social, occupational, or other critical areas of functioning (American Psychiatric Association, 2013; WHO, 2022)

Peri-Urban:

A peri-urban area is located on the outskirts of urban centres and represents a mix of urban and rural characteristics (Harrison, 2017). In South Africa, these areas frequently include townships and informal settlements, shaped historically by apartheid spatial planning (Turok, 2012; Marutlulle, 2022).

Community Health Centre (CHC):

A primary health care facility that receives government funding and provides various services, including maternal, child, and mental health care (Nteta et al., 2010). CHCs are intended to serve the local community and serve as the first point of entry into the public health system.

Health Care Providers:

Healthcare providers are personnel involved in delivering health care services to patients (WHO, 2016). They comprise doctors, nurses, community health workers, counsellors, psychologists, psychiatrists, and social workers (WHO, 2016). Healthcare providers conduct assessment, treatment, referral and ongoing care for postpartum women with a mental health disorders (O'Hara & McCabe, 2013).

Mental Health Literacy:

Mental health literacy refers to knowledge and understanding of mental health disorders, including the ability to recognise symptoms, take appropriate steps to seek help, and understand treatment and management options (Jorm, 2012). Higher mental health literacy enables early identification of PPMDs and promotes appropriate help-seeking behaviour.

Stigma:

In the context of PPMH, stigma refers to negative attitudes, beliefs, and behaviours directed at mothers experiencing PPMDs (Corrigan et al., 2014). Stigma can result in social exclusion, shame, and reluctance to seek professional care (Thornicroft et al., 2016).

Barriers to Care:

Barriers to care are challenges that prevent individuals from accessing necessary health services (Penchansky & Thomas, 1981). These challenges may be physical, such as distance and lack of transport; financial, including the cost of travel or treatment; social, including lack of support; or psychological, including fear, stigma, or low awareness of mental health disorders (Syed et al., 2013; Field et al., 2020).

Facilitators of Care:

Facilitators of care are factors that encourage or enable access to health services, such as supportive family relationships, positive cultural attitudes toward care, availability of skilled healthcare providers, and sufficient health system resources (Andersen, 1995). These facilitators help promote timely recognition, help-seeking, and management of postpartum mental health disorders (O'Hara & McCabe, 2013).

CHAPTER 1 :
INTRODUCTION

1.1 Introduction

Over the past decade, South Africa has made notable progress in improving maternal health outcomes through targeted policies and interventions to reduce maternal mortality and expand access to skilled obstetric care (Bhardwaj et al., 2018; Moodley et al., 2018). National frameworks such as the *South African Maternal, Perinatal and Neonatal Health Policy* (Department of Health [DoH], 2021) and the *Guidelines for Maternity Care in South Africa* (DoH, 2016) underscore the role of primary healthcare in ensuring accessible and high-quality antenatal, intrapartum, and postnatal care services. These services have yielded positive physical health outcomes for women during and after pregnancy.

However, maternal mental health – particularly in the postpartum period – remains a significantly under-prioritised component of comprehensive maternal care in South Africa (Awini et al., 2023; Brown & Sprague, 2021; Lovero et al., 2019; Field et al., 2014; Kathree et al., 2014). This gap is especially evident in peri-urban areas, where historic inequities, persistent poverty (Sigamoney & Singh, 2023), limited public service delivery (Chiwaranana, 2024; Phillip, 2014; Jürgens et al., 2013), and over-stretched, poorly resourced healthcare facilities (Sigamoney & Singh, 2023; Mataboge et al., 2016) constrain access to appropriate mental support services. Community Healthcare Centres (CHCs) in these areas are often the first point of maternal care and are mandated to provide antenatal, obstetric, and postnatal services, including mental health screening and basic psychological support (DoH, 2024; 2023).

While these responsibilities are clearly outlined in policies, CHCs and other public facilities often lack the funding and resources to implement them effectively, particularly in the context of postpartum mental health [PPMH] (Brown and Sprague, 2021; Kathree et al., 2014). As a result, services remain insufficient for the screening, diagnosis, and treatment of postpartum mental disorders [PPMDs] (Brown and Sprague, 2021; Mokwena and Masike, 2020; Kathree et al., 2014). In contrast, the private sector offers greater access to specialist mental healthcare, perpetuating the country's two-tiered healthcare system where access to quality PPMH is primarily determined by socioeconomic status (Willie et al., 2024; Brown & Sprague, 2021).

Given these challenges, this study explores postpartum women and healthcare providers' perspectives on the provision and uptake of postpartum mental healthcare Services (PPMHS) at a CHC in the Gauteng Province. It explores the barriers and facilitators at the individual, interpersonal, community, and society levels. Chapter 1 introduces the postpartum period and associated mental health concerns, and outlines relevant policies. The chapter then presents the theoretical framework underpinning the study, followed by the problem statement, rationale of the study, and significance of the study. A summary of the research methodology follows this and concludes with an overview of the dissertation structure.

1.2 Background to the Study

1.2.1 Conceptualising the Postpartum Period

The postpartum period is commonly described in biomedical literature as the first six weeks following childbirth during which the woman experiences significant physiological recovery and hormonal adjustment (Kumarasinghe et al., 2024; Kamel et al., 2014; World Health Organization [WHO], 2022; Romano et al, 2010). This limited timeframe may not fully capture early motherhood's psychological shifts and social challenges. In contrast, the broader perinatal period typically defined as the beginning at 28 weeks (154 days) of gestation and ending one week following childbirth (Tiruneh et al., 2021), has been expanded in mental health literature to encompass the period up to 12 months following childbirth (Palfreyman & Gazeley 2022; Sambrook Smith et al., 2022; Garcia & Yim, 2017). Evidence suggests that both mental and physical health issues often continue beyond the initial six weeks post-delivery, influenced by a range of lifestyle changes and complex roles that come with motherhood (Carroll et al., 2016; Fahey & Shenassa, 2013; Mottola, 2002). Dagher et al. (2021) assert that pregnancy and the first year after childbirth are important times to screen and treat depression, with depressive and stress symptoms often peaking during the first year after birth (Hannon et al., 2022). In light of such findings, the terms "postpartum" and "perinatal" are increasingly used in broader overlapping ways (Vogel et al., 2024; Isobel, 2023; Garcia & Yim, 2017). This study defines the postpartum period as extending from birth to six months post-delivery. This definition allows for a more inclusive understanding of maternal mental health care experiences in peri-urban locations in South Africa, which aligns with the conceptual framework developed by Romano et al. (2010).

Romano et al. (2010) emphasise the significance of the postpartum period and its relationship with various psychological and physiological adaptations and difficulties experienced by women. They propose that the postpartum period can be meaningfully subdivided into three distinct phases: the immediate postpartum phase (0-12 hours), the subacute phase (2-6 weeks), and the delayed phase (up to 6 months) (Chauhan & Tadi, 2022; Romano et al., 2010). The immediate postpartum phase involves the initial adaptations after childbirth. The subacute phase is characterised by physical recovery and emotional adjustments, including personal identity shifts, and forming a bond with the baby (Hwang et al., 2022). This phase also includes adaptation to new social and parental roles, where maternal self-efficacy is crucial (Hwang et al., 2022). The delayed phase continues this process of adaptation and recovery, during which women remain vulnerable to PPMDs (Garapati et al., 2023; Modak et al., 2023; Meltzer-Brody et al., 2018;). Understanding these stages provides important context for examining mothers' mental health care experiences during the first six months postpartum. Given the vulnerability to psychological distress during the postpartum phases, it is crucial to understand the spectrum of mental health disorders, PPMDs, that may emerge in this period.

1.2.2 Understanding the Spectrum of PPMDs

PPMDs encompass a wide range of psychological conditions that may affect mothers during and after childbirth. These include but are not limited to depression, anxiety, eating disorders, and psychosis (Garapati et al., 2023; Modak et al., 2023; Meltzer-Brody et al., 2018). While these disorders are not individually classified in the standard diagnostic manuals such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-10), mental health professionals commonly refer to postpartum depression (PPD) and postpartum psychosis (PP) as key clinical entities (Mughal & Siddiqui, 2018; Doyle et al., 2015).

Historically, postpartum mental disturbances were recognised as far back as the 19th century by Louis Victor Marcé, who offered one of the first clinical descriptions of PP (Osborne, 2018; Doyle et al., 2015). These disorders pose significant risks to maternal and infant well-being, making them a priority for research and clinical intervention (Modak et al., 2023; Saharoy et al., 2023; Turner & Honikman, 2016). It is crucial to distinguish PPMDs from "baby blues," a common transient mood disturbance that affects approximately 40% to 85% of women worldwide within the first week after delivery. The "baby blues" usually resolve within 10-14

days without intervention (Gruszczynska-Sinczak et al., 2023; McKelvey & Espelin, 2018; Rai et al., 2015). While usually mild, prolonged symptoms can have serious ramifications for maternal mental health, underscoring the need for early monitoring (Rai et al., 2015).

Among PPMDs, PPD is the most prevalent and typically emerges within 12 months of giving birth (Liu et al., 2022; Batt et al., 2020). PPD is characterised by pervasive sadness, hopelessness, guilt, and diminished interest in daily activities (Dennis et al., 2024). Mothers may also struggle with bonding with an infant (Saharoy et al., 2023; Mughal & Siddiqui, 2018) and experience somatic symptoms such as appetite or sleep changes (either increased or decreased), fatigue, difficulty concentrating, headaches or stomach aches, and in severe cases, thoughts of self-harm or harm to the baby (Urizar & Munoz, 2022; Anjum, 2019; Mughal & Siddiqui, 2018). Another primary concern in PPMH is anxiety disorders, which often co-occur with PPD (Petty, 2022; Phoebe et al., 2022). Symptoms may include excessive worry, restlessness, feeling agitated, sleep disturbance, intrusive thoughts and physical symptoms like muscle tension (Bandelow et al., 2023; Mishra et al., 2023; Chand & Marwaha, 2022; Petty, 2022; Phoebe et al., 2022). Unlike general anxiety, postpartum anxiety may centre on fears related to infant health, parenting or the mother's ability to care for the child (Anniverno et al., 2013).

In some cases, mothers may experience Postpartum Post-Traumatic Stress Disorder (PPTSD), often triggered by traumatic childbirth experiences (Horsch et al., 2024; Milosavljevic et al., 2024; Ahsan et al., 2023). Key symptoms include intrusive memories, emotional numbing, avoidance of childbirth-related reminders, and heightened arousal (Thiel et al., 2018; Schwab et al., 2012). This condition may surface abruptly within a few days or weeks after giving birth (Rai et al., 2015). Furthermore, postpartum psychosis (PP) is a more severe and rare form of PPMD with onset usually occurring within the first two weeks postpartum (Reilly et al., 2023; VanderKruik et al., 2017; Rai et al., 2015). The condition is characterised by symptoms including paranoia, delusions of grandeur, rapid mood swings, cognitive disruption, and disorganised behaviour (Lavanya et al., 2019; Doyle et al., 2015). Taken together, these conditions illustrate the diversity and complexity of maternal mental health challenges during the postpartum period. Crucially, they also contribute to the growing global burden of mental health problems as PPMDs are frequently under-detected and inadequately managed, particularly in low- and middle-income countries (Freeman, 2022; Mascayano et al., 2015). The following section explores the magnitude of this burden, focusing on global prevalence estimates and disparities, with particular attention to low- and middle-income (LMIC) contexts.

1.2.3 The Burden of Mental Health Problems and PPMDs

Mental disorders constitute a significant global health burden, with rising prevalence rates and significant geographical disparities (GBD 2019 Mental Disorders Collaborators, 2022;). In 2019, an estimated 970 million individuals – equivalent to 12.5% of the world's population – were affected by a mental disorder, with depression and anxiety disorders being the most prominent conditions (WHO, 2022). The global burden of mental disorders continues to increase, with depressive disorders ranking among the leading causes of disability-adjusted life years (DALYs) (GBD 2019 Mental Disorders Collaborators, 2022). PPMDs account for a substantial portion of this burden (Hahn-Holbrook et al., 2018). Globally, approximately 17.7% of women experience postpartum depression, with prevalence rates varying across regions (Hahn-Holbrook et al., 2018). Despite the magnitude of this problem, PPMDs remain significantly underdiagnosed and undertreated in most regions of the world (Wilson et al., 2024; Priyadarshini et al., 2023).

The burden of mental health disorders is disproportionately concentrated in LMICs, where mental disorders account for 19.1% of DALYs (Rathod et al., 2017). Contributing factors include fragile healthcare infrastructure, economic volatility, and sociocultural factors that hinder access to care (Nadkarni et al., 2024; Rathod et al., 2017). Alarmingly, over 75% of individuals in LMICs who require mental healthcare do not receive it, perpetuating the escalating mental health crisis (Freeman, 2022; Mascayano et al., 2015). Mental healthcare remains inaccessible mainly in many LMICs due to a severe shortage of mental health professionals, weak integration of mental services into primary care, and cultural stigma surrounding mental illness (Patel et al., 2018). For example, Nigeria faces a critical shortage with only 250 psychiatrists serving a population of 200 million people (Fadele et al., 2024). The shortage of healthcare providers and widespread societal stigma worsen the already compromised access to care for those who have severe mental illness (Fadele et al., 2024). Similarly, Bangladesh, home to more than 160 million people, has just 500 psychiatrists and 270 psychologists, most of whom are concentrated in urban centres, leaving a large part of the population without adequate mental health services (Hasan et al., 2022).

With rates of at least 17%, prevalence of PPMDs is significantly higher in LMICs compared to high-income countries, where reported prevalence is 13% (Wang et al., 2021). In Ethiopia, for instance, PPD affects 22.08% of women, with key risk factors including food insecurity,

intimate partner violence (IPV), and a lack of antenatal mental health screening (Zeleke et al., 2021). In Brazil, 40% of women reported experiencing their first depressive episode postpartum, with low socio-economic status, low educational attainment, and pregnancy-related behaviours such as smoking identified as significant contributors (Santana et al., 2021). These disparities underscore the intersectionality of socio-economic, cultural, and health system determinants in shaping PPMDs in LMICs.

Despite these challenges, some countries have made notable progress. Rwanda, for instance, has improved access to mental health care services through decentralising services to rural districts and integrating mental health services into primary health care systems (Nsanzabaganwa et al., 2024). Furthermore, the use of trained community health workers (CHWs) in screening mental illness and electronic health technology has also helped to reduce stigma and expand service coverage in under-resourced areas (Nsanzabaganwa et al., 2024). These advances highlight the value of contextually tailored approaches and the importance of ongoing region-specific research to address structural determinants of PPMH.

In Sub-Saharan Africa, mental health disorders contribute to approximately 10% of the total disease burden (Fekadu et al., 2017). However, accurate estimation of the full magnitude of this burden is still a challenge, due to limited epidemiological data, inconsistent diagnostic tools and a lack of standardised mental health assessments (Gbadamosi et al., 2022; Duthé et al., 2016). This issue is compounded in South Africa by a complex interplay of socioeconomic inequality, historical injustices, and structural barriers (Jack et al., 2014). Nearly one in every three South Africans experiences a mental disorder at some point during their lifetime, yet access to mental health services is severely limited (Meyer et al., 2019; Jack et al., 2014). Docrat et al. (2019) estimated a treatment gap of 92% in the public mental health system, with 86% of the mental health budget allocated to inpatient care and only 8% to primary mental healthcare.

PPMDs are particularly relevant in the broader mental health context in South Africa. National estimates suggest between 35% and 47% of women experience some form of PPMD, well above global averages of 10% and 19.8% (Brown et al., 2020; Hung et al., 2014). In peri-urban settlements, PPD affects between 16.4% and 39% of women (Kathree et al., 2014). The high prevalence rates demand specialised interventions and robust support systems. Left untreated, PPMDs carry significant implications for maternal well-being, infant development, maternal-infant bonding, and overall stability of the family. The following section examines the multifaceted outcomes associated with untreated PPMDs.

1.2.4 Outcomes of Untreated PPMDs

The effects of untreated PPMDs profoundly impact short-term and long-term health outcomes (Mokwena, 2021; Slomian et al., 2019). Among mothers, having untreated PPMDs is associated with significant functional impairments, including self-neglect, sleep and appetite disturbances, and a decline in executive function. These deficits compromise a mother's ability to care for herself and her infant (Stewart & Vigod, 2019; Slomian et al., 2019; DeBattista, 2005). Furthermore, cognitive deficits associated with PPMDs, such as decision-making and attention, can compromise maternal sensitivity, exacerbating difficulties in infant care (McNab et al., 2022; Stewart & Vigod, 2019). Also, suicidal thoughts and tendencies toward self-harm signal the severity of untreated PPMDs, with suicide being a documented cause of maternal death in some settings (De Backer et al., 2024; Bright et al., 2022; Shi et al., 2018).

The repercussions of untreated PPMDs also extend to infant health and development. These disorders can disrupt early mother-infant bonding and the formation of secure attachment relationships (Goodman, 2019; Murray et al., 2014). Infants exposed to maternal depression or anxiety may experience changes in stress response, reduced social interaction, and impaired emotional regulation (Aktar et al., 2019; Bernard-Bonnin, 2004). Longitudinal research suggests that these early disturbances heighten vulnerability to later psychological disorders, such as depression, anxiety, and attention disorders (Slomian et al., 2019). Moreover, a strong link exists between maternal mental health and infant nutritional outcomes. PPMDs affect both the initiation and continuation of lactation, increasing the risk of malnutrition and stunting (Saharoy et al., 2023; Anato et al., 2020). While some evidence indicates that pharmacological treatments for PPMDs may impact breastfeeding, the potential harm to infant health from untreated PPMDs is far greater. Therefore, a balanced, evidence-based treatment approach is essential (Saharoy et al., 2023).

Untreated PPMDs can also affect family relationships. They may contribute to interpersonal conflict and emotional distance between partners (Battle et al., 2021; Slomian et al., 2019). Fathers may feel incompetent and powerless in fulfilling their caregiving needs and supporting their partners (Battle et al., 2021). Over time, these tensions may erode intimacy and trust, highlighting the broader relational impact of PPMDs (Slomian et al., 2019).

Beyond health and relational effects, PPMDs also carry significant economic implications. Bauer et al. (2022) emphasise that alleviating the burden of PPMDs in South Africa requires substantial financial investment, both in terms of expanding mental health services and

addressing the cost associated with untreated PPMDs. Loss of productivity arises from both maternal absenteeism and the long-term developmental impacts on children, which may perpetuate cycles of disadvantage (Bauer et al., 2022). These economic costs are especially acute in low-income communities, where poor access to healthcare exacerbates existing disparities (Meyer et al., 2019). Addressing these challenges calls for context-specific policies that integrate specific maternal mental health needs into primary healthcare services. Both international and national frameworks have been introduced to support this agenda, emphasising early detection and comprehensive care for affected mothers.

1.2.5 Overview of Global and Local Policies and Frameworks Linked to Maternal Mental Health

Sustainable Development Goals (SDGs) – a set of 17 global objectives adopted by the United Nations as part of the 2030 Agenda for Sustainable Development – offer a comprehensive framework for promoting equity, health, environmental sustainability, and peace (Arora & Mishra, 2019; Colglazier, 2015). Among the priorities of the SDGs is the commitment to improving the health and well-being of all people (Mahlatsi, 2021; Boldosser-Boesch et al., 2017; Chapman, 2016). Maternal health, mental health, and gender equality are explicitly recognised within this agenda (Lund et al., 2018; Manandhar et al., 2018).

SDG 3 seeks to decrease maternal mortality and improve mental health, directly linking with PPMH concerns (Handa et al., 2024; Vlassoff, 2019). Similarly, SDG 5 addresses gender inequality by targeting the root causes of discrimination and violence against women, factors strongly associated with poor maternal mental health (Sharma, 2023; Vlassoff, 2019). Additionally, SDG 10 encourages including marginalised communities to reduce health disparities (Bhandari, 2024). Socio-economic and gender-related factors continue to limit women's access to mental health care, particularly in low-resource settings (Bhandari, 2024). In this regard, the SDGs call for health systems to be reoriented to address all people's physical and mental health needs, with particular attention to the well-being of vulnerable women (Lund et al., 2018; Manandhar et al., 2018).

Universal Health Coverage (UHC) is aligned to the SDGs, which seek to ensure equitable access to quality health services – including mental health care – without financial hardship (Kiendrébéogo et al., 2020; Fusheini & Eyles, 2016). As a fundamental component of the 2030 SDG agenda, UHC emphasises reducing financial and systemic barriers to care, especially for

under-resourced mental health care services (Rahman et al., 2022; Hanlon et al., 2019). While countries like Ghana and South Africa have made strides toward implementing UHC, persistent challenges remain. These include limited population coverage, unaffordable out-of-pocket payments, and fragmented service delivery (Mukwena & Manyisa, 2022; Fusheini & Eyles, 2016; van den Heever, 2016). Thus, despite progress, there are still significant gaps that have to be addressed to provide equitable access to mental health care.

To specifically address PPMH challenges, the World Health Organization (WHO) introduced the *Guide for Integrating Perinatal Mental Health into Maternal and Child Health Services* (Akkineni et al., 2023). This initiative seeks to embed mental health care into postnatal care frameworks by training maternal and child health professionals to identify and manage perinatal mental illness (Akkineni et al., 2023; Manolova et al., 2023). Complementing this effort is the *WHO's Mental Health Gap Action Programme (mhGAP),* which provides evidence-based guidelines to help non-mental health specialist providers deliver mental health services in low-resource settings (Brohan et al., 2024; WHO, 2023). The mhGAP promotes mental health equity and aims to strengthen primary care systems in LMICs through task-sharing approaches and simplified protocols (WHO, 2023).

Nevertheless, healthcare policy alone cannot cater to the multifaceted requirements of postpartum women. Labour policy, particularly regarding maternity leave, is critical in supporting PPMH. The International Labour Organization (ILO) recommends at least 14 weeks of paid maternity leave, highlighting its benefits for maternal recovery, infant bonding, breastfeeding, and well-being (Hidalgo-Padilla et al., 2023; Addati et al., 2022). More extended maternity leave has been associated with lower PPD, anxiety, and stress and improved mother-infant interactions (Hidalgo-Padilla et al., 2023; Brito et al., 2022; Van Niel et al., 2020; Avendaño et al., 2015). Despite these benefits, implementing effective labour policies remains challenging in LMICs, where informal employment is widespread and social protection is often limited (Pereira-Kotze et al., 2023; Horwood et al., 2021). As a result, many women in LMICs do not receive the full protective benefits of formal maternity leave, thereby increasing the risk of psychological distress in the postpartum period. Addressing these policy gaps requires policy innovation, a shift in social norms prioritising postpartum women's well-being across all employment sectors (Pereira-Kotze et al., 2023).

1.2.5.1 South African policy context

South Africa has made significant strides in advancing mental health care through legislative and policy reforms. *The Mental Health Care Act (No. 17 of 2002)* marked a turning point in promoting the rights of individuals with mental illness, endorsing a community-based and decentralised model of mental health care across service levels (Burns, 2008; DoH, 2004). This Act provided the foundation for the *National Mental Health Policy Framework and Strategic Plan (2013–2020)*, which sought to integrate promotion, prevention, treatment, and rehabilitation within a rights-based framework (DoH, 2013). The policy aligns with the *WHO Mental Health Action Plan* by emphasising human rights protection, prioritising vulnerable groups and developing district-level service infrastructure (Kleintjes & Schneider, 2023; Marais & Petersen, 2015).

Building on this foundation, South Africa's *National Mental Health Strategic Plan (2023–2030)* was developed in collaboration with stakeholders, including government departments, NGOs, professional associations, and individuals with lived experience (Sorsdahl et al., 2023). The Plan envisions universal access to integrated mental health services by covering promotive, preventative, curative, rehabilitative, and palliative care (Sorsdahl et al., 2023). While the core intervention pyramid model from the earlier policy is retained, the new Plan strengthens community-based approaches and seeks to reduce dependence on psychiatric hospitals (Morar et al., 2024). Notably, women are explicitly identified as a priority group, with interventions tailored to address their unique psychosocial vulnerabilities, especially during pregnancy and the postpartum period (DoH, 2023). These services are embedded in standard antenatal and postnatal care, with district-level specialist teams supporting routine screening and management of common mental disorders in postnatal care (DoH, 2023).

Complementing this effort is the *National Health Insurance (NHI)* Act, which aims to ensure universal health care through centrally managed public funding (Mkhwanazi, 2024). The NHI is positioned to strengthen the integration of mental health into primary health care, enhance the coordination between public and private sectors, and reduce funding inequities (Shisana et al., 2024). It envisions financing services through Primary Health Care Contracting Units, improving access to care for underserved and vulnerable populations, including postpartum women. According to Meyer et al. (2019), the NHI presents a strategic opportunity to formalise the role of general practitioners in screening and managing mental illness health conditions, particularly within community-based care models.

Despite these progressive developments, substantial challenges remain in the effective integration of mental health services into primary health care, particularly in the context of postpartum care. Jack et al. (2014) highlight persistent gaps in the assessment of mental, neurological, and substance use disorders (MNS), inadequate integration of traditional healing practices, and a lack of cost-effectiveness analyses to guide resource allocation. To ensure meaningful integration, policy implementation must be bolstered by adequate resources, capacity development and responsiveness to the specific needs of postpartum women, particularly in underserved communities. The effectiveness of policy frameworks in addressing PPMH challenges depends not only on their implementation but also on a nuanced understanding of the various factors influencing mental health across different levels of society. To unpack these complex interactions and understand barriers and facilitators to accessing PPMHS, this study adopts a multi-level lens, the Social Ecological Model (SEM).

1.3 Theoretical Framework

The SEM provides a valuable perspective for examining various levels of influence, such as individual, interpersonal, community, organisational, and societal, that shape health and well-being (Caperon et al., 2022; Golden et al., 2015). By highlighting the dynamic interplay between the individuals and their environments, the model draws attention to the broader structural and contextual determinants of health (Golden et al., 2015; Golden & Earp, 2012).

Guided by the SEM, this study explores how different levels of influence impact PPMH (Michaels et al., 2022; Reupert, 2017). At the individual level, factors such as beliefs, education, and physical or health status may affect a woman's susceptibility to postpartum mental illness (Michaels et al., 2022; McLeroy et al., 1988). The interpersonal level considers the role of family relationships in providing emotional and practical support throughout the postpartum period (Reupert, 2017; McLeroy et al., 1988). At the organisational level, workplace practices and the structures of health services may affect access to PPMH (McLeroy et al., 1988). The community level encompasses the general local environment, such as availability of local resources and norms and values (McLeroy et al., 1988). Societally, national policies and broader systematic factors significantly shape women's PPMH (Michaels et al., 2022; Golden & Earp, 2012). Although McLeroy et al. (1988) conceptualised the above outermost level as the policy level, the present study follows the adaptation by Chopak-Foss et al. (2020) and Golden and Earp (2012), who employ the phrase societal level to describe not only policy but

also systemic concerns such as funding allocation, infrastructure, and systematic inequalities all of which are determinants of access to PPMHS. The SEM thus provides a multidimensional framework for identifying and analysing the barriers and enablers to accessing PPMHS. Given the complex nature of maternal mental health outcomes, a multi-level analytical approach is essential for understanding the interplay of personal, institutional, and policy factors (Wold & Mittelmark, 2018). Chapter 2 presents an in-depth review of the SEM and its application to this study.

1.4 Problem Statement

South Africa's limited research on PPMH hinders the advancement of mental health service improvement (Ng'oma et al., 2020). According to Kaminer et al. (2018), high-quality, context-driven research that would be used to develop therapeutic interventions based on the specific conditions prevailing in South Africa is needed. They further argue that existing strategies must be adapted to address local requirements to be effective in treating common mental health disorders. In line with this, Brown and Sprague (2021) identify a significant gap in the availability of detailed data and qualitative insights into PPMH, pointing out that much of the current research fails to capture the complex realities of PPMDs. They stress the importance of including diverse communities, particularly postpartum women, in research and using local languages to gain a deeper understanding of these mental health challenges, so that responses can be appropriately aligned with the specific social context.

Additionally, Abrahams and Stellenberg (2015) mention the need for qualitative research to develop further insights into community attitudes towards mental distress and mental health needs. They emphasise that it is crucial to recognise the factors contributing to mental health challenges in such studies. The use of inclusive and culturally responsive research methodologies holds prospects for better accessibility and cultural appropriateness of mental health care to advance the effectiveness and equity of care (Truter, 2023; Sorsdahl et al., 2021; Brown et al., 2020). Addressing these research gaps is essential in enhancing access to PPMH services and informing more effective and contextually appropriate policy implementation (Brown & Sprague, 2021; McKenna et al., 2017).

1.5 Rationale for the Study

In response to the gaps identified above, this study employs a qualitative approach to explore facilitators and barriers to PPMH care in a peri-urban setting in South Africa. By capturing the perspectives of both postpartum women and healthcare providers, the study aims to understand the systemic obstacles and contextual issues influencing access to PPMH care (Brown & Sprague, 2021; Stellenberg & Abrahams, 2015).

Following Brown and Sprague's (2021) call for data triangulation in PPMH research, the study collected data through in-depth semi-structured interviews with both postpartum women and healthcare providers. This multi-perspective approach enhances the credibility and richness of the findings and enables a nuanced exploration of how PPMHS are perceived, accessed, and navigated. Ultimately, the study aims to offer recommendations to support more responsive and equitable service development.

In addition to methodological triangulation, the research addressed a common limitation in PPMH studies by incorporating linguistic and cultural considerations. Kirmayer (2021) and Van den Berg (2016) argue that language plays a critical role in mental health research, as linguistic mismatches can result in inadequate or inaccurate representations of psychological distress. To address this challenge, participants were given the option of being interviewed in Sesotho, the most spoken language in the study setting (Statistics SA, n.d.). This enabled participants to articulate their experiences more fully and authentically, contributing to richer, culturally grounded data and more contextually valid conclusions (Brown & Sprague, 2021).

Furthermore, applying the SEM provided a structured lens to examine the multiple, interacting influences on PPMH care. The study explored how intrapersonal, interpersonal, community, and policy factors shape access to PPMHS, echoing Stellenberg and Abrahams' (2015) call for deeper qualitative enquiry into these contextual determinants. It also mapped the complex interplay between social, economic, and healthcare-related barriers and enablers, producing locally grounded insights potentially transferable to similar contexts.

This research contributes meaningful, actionable recommendations for improving postpartum mental health care in under-resourced settings by combining qualitative enquiry with linguistic inclusivity and multi-level analysis. These findings are intended to inform future research, guide the development of interventions, and support the creation of policies that promote equitable access to mental health care for postpartum women in peri-urban communities.

1.6 Scope of Study

This research examines the barriers and facilitators to accessing PPMHS at a peri-urban CHC in Gauteng province. Ten postpartum women within six months of delivery and eight healthcare providers involved in providing postnatal and mental health services were part of the study. The participants were selected based on age (19 years or older), residing within the catchment area of the CHC, and regular utilisation or provision of maternal health services. The research investigates the factors that affect service access at multiple levels of influence.

Limitations: The study is limited to women within six months of childbirth and healthcare providers of a specific peri urban CHC only. It does not include postpartum women after six months, long-term maternal and child health outcomes, or healthcare providers of other facilities. The results are context-specific which are not extendable to rural or urban or private healthcare settings.

1.7 Research Aim and Objectives

1.7.1 Research Aim

To utilise a socio-ecological framework to examine the barriers to and facilitators of accessing PPMHS at a peri-urban CHC in Gauteng province, from the perspectives of healthcare service providers and postpartum women within the first six months of giving birth.

1.7.2 Research Question

What are the key barriers and facilitators influencing access to PPMH services at the CHC as identified within a SEM?

1.7.3 Secondary Objectives

- Individual level: To examine the knowledge, beliefs, and attitudes of both postpartum women and healthcare providers in the CHC towards PPMDs and their impact on postpartum women's mental health-seeking behaviour.
- Interpersonal level: To investigate the effect of social support, encompassing familial and peer support, on the uptake of PPMHS as perceived by postpartum women and healthcare providers at the CHC.

- Organisational Level: To explore the perception of postpartum women and healthcare providers on resource adequacy for mental health services at the CHC. Additionally, it sought to examine the perception of postpartum women on transportation availability, operational hours, and staff attitudes when accessing PPMHS at the CHC.
- Community level: To explore the perspectives of postpartum women and healthcare providers regarding how community attitudes, beliefs, and norms may have impacted access to PPMHS for postpartum women at the CHC.
- Societal level: To assess healthcare providers' perceptions of the effectiveness and implementation of relevant PPMH policies at the CHC.

1.8 Research Design and Methodology Overview

This study was conducted using a qualitative research approach. A case study design was used, and this design aimed to explore and describe the barriers and facilitators of accessing PPMHS at a CHC in Gauteng Province. The case study design allows for an in-depth exploration of complex concepts within their real-life context, which is needed to gain insight into the specific difficulties and resources in this context (Yin, 2018). The methodology will be further elaborated on in Chapter 3.

1.8.1 Research Paradigm

The study employed a constructivist paradigm because it focused on understanding how participants actively construct their reality of accessing or providing PPMHS (Adom et al., 2016). According to this paradigm, individuals construct their own perceptions and behaviour through their knowledge, beliefs and social interactions (Adom et al., 2016). In addition, this paradigm was used because the main objective of this research is to explore and get an in-depth understanding of the meanings and experiences of participants based on their own perspectives in the specific context of the CHC (Creswell & Creswell, 2018).

1.8.2 Case Study Design and Setting

A case study design was deemed suitable for the research. This particular design enables detailed examination of complex issues in real-life settings, which is required to understand the problems and opportunities in this specific context (Simons, 2020; Schoch, 2020). A case study

design is especially helpful when the goal is to develop detailed understandings of the attitudes and perspectives of research participants (Yin, 2018). This study specifically sought to do so with postpartum women and healthcare providers by exploring the dynamics that impact access to postpartum mental health services. The CHC in the Sedibeng district was selected based on key maternal health indicators like low coverage of antenatal first visit and high maternal mortality ratio. These factors reflect the possible barriers and opportunities influencing maternal and neonatal mental health (Massyn et al., 2020); a comprehensive description of these indicators will be discussed in Chapter 3.

1.8.3 Sampling

The research employed a purposive sampling method. Purposive sampling is a technique where the researcher selects samples based on certain predetermined criteria and with a set of characteristics that were directly aligned to answer the research questions (Palinkas et al., 2015; Babbie & Mouton, 2010). Ten women between the ages of 19 and older who had recently experienced the postpartum period within the last six months attended antenatal care, were delivered, and were currently attending postnatal check-ups at the CHC. They participated in the study. Eight healthcare providers providing PPMHS and working at the centre also participated in the study. Qualitative research often employs small samples for in-depth, case-centred analysis that reflects the richness and complexity of participants' experiences. Boddy (2016) noted that meaningful findings can be developed from small samples since depth is prioritised rather than generalisability. Sandelowski (1995) also argues that sufficiency in sampling is a function of data richness, which is best achieved through intense immersion with a limited number of participants.

1.8.4 Participant Recruitment

The researcher collaborated closely with the CHC facility manager and nurses who had direct access to potential participants during postnatal visits. Confidentiality agreements were established with the staff involved in recruitment, ensuring privacy. Informed consent management was a priority, with clear guidelines provided to the CHC staff, emphasising voluntary participation, study procedures, and participant rights. The interviews took place at locations convenient to the participants. When selecting the interview location, utmost consideration was given to maintaining privacy and confidentiality. The interviews with

healthcare providers were conducted outside working hours to prevent service delivery disruption and honour the participants' professional commitments.

1.8.5 Data Collection

The study utilised semi-structured interviews for an in-depth analysis of participants' experiences and perceptions, allowing flexibility in questioning whilst maintaining a focus on key themes of the study. This flexibility shows the exploratory aspect of the interviews, allowing the participants to freely discuss issues and provide a descriptive account (DiCicco-Bloom & Crabtree, 2006).

Two separate interview schedules were developed; one for the postpartum women, which requested information on emotional well-being and mental health, social support and access to services, and another schedule for the healthcare providers which requested information on service delivery, availability of resources, and patients' needs in postpartum or perinatal care. The interviews from postpartum women were carried out using Sesotho or English (76.4% of the local population speak Sesotho; Stats SA, n.d) based on the language selection of the participant, whilst all healthcare providers were interviewed in English. Each interview lasted between 30-45 minutes, and were audio-recorded with participants' consent.

1.8.6 Data Analysis

Thematic analysis was the analytical approach applied to interview data. The study used an Abductive Thematic Analysis (ATA) method. Abduction thematic analysis combines empirical data and theory to generate logical and useful interpretations for a phenomenon to avoid useless explanations (Thompson, 2022). It sets initial parameters based on theory rather than fitting data into established frameworks or seeking a single objective truth (Thompson, 2022).

1.8.7 Ethics Statement

Several necessary steps were taken to ensure that ethical guidelines were adhered to. Permission to conduct the research and ethical clearance was first sought from the General/Human Research Ethics Committee. Required permissions were also obtained from relevant authorities such as the Gauteng Department of Health and the chosen CHC before data collection commenced. Participants were provided with information regarding the purpose,

nature and anticipated limitations of the study; possible associated risks and benefits; and their right to withdraw from the study at any point in time without any adverse consequences (Charmaz, 2014). They were explicitly told there were no advantages to participating in the study. Confidentiality was maintained by the researcher throughout the interviewing process by using pseudonyms and signed confidentiality agreements (Patton, 2015). Data was stored on password-protected files and secured in a locked filing cabinet. The researcher prioritised establishing a safe and respectful space to avoid harming participants (Patton, 2015). Participants who needed mental healthcare were immediately referred to mental healthcare facilities within or outside of the institution if needed (Patton, 2015). Interviews were conducted in private spaces.

1.8.8 Conflict of Interest Statement

The researcher declares that they have no personal or financial relationships with individuals, organisations or funding sources that might introduce bias or undermine the integrity of the outputs. As a social worker, the researcher used self-reflexivity to minimise data collection bias, meaning the researcher consciously noted their biases during the research process to maintain objectivity (Olmos-Vega et al., 2023).

1.9 Overview of the Chapters

Chapter 1: Introduction

Chapter one starts with the study background, the problem statement and the study rationale. It also concisely describes the study methodology and design, stating the research objectives. In addition, it states the research questions, thus providing a basis for the rest of the study.

Chapter 2: Literature Review

Chapter 2 first discusses disparities in access to PPMHS in LMICs and then examines global biopsychosocial risk factors affecting PPMH. It describes how the same factors operate in South Africa. The chapter then describes measures to enhance the provision of PPMH care in South Africa, such as decentralisation and public-private partnerships. Finally, it introduces the socioecological model, a theoretical framework used in this study to understand the barriers and facilitators to PPMHS.

Chapter 3: Methodology

The methodology chapter describes the procedures followed in the study. The chapter explains the research paradigm, approach, and design. It also details how data was collected, analysed, and how participants were sampled. The chapter also addresses ethical considerations such as the process of consent acquisition and protection of privacy to uphold the ethical standards of the study.

Chapter 4: Findings and Discussions

The findings are presented and discussed in this chapter, using the SEM, with themes identified from the data categorised according to the various levels of the model. Relevant literature is drawn upon to provide context and allow for a discussion of the findings.

Chapter 5: Conclusion and Recommendations

The conclusion chapter summarises the study's main findings and reflects on their significance. In the chapter, the research goals shall be reiterated, and final thoughts concerning the study's implications on future research and practice shall be given. This chapter concludes the study by recapping its contributions to the field concerning opportunities for further research.

1.10 Conclusion

This chapter introduced the study by providing background information and outlining the problem, specifically the challenges of accessing PPMHS in South Africa’s peri-urban areas. It also presented the research aim and highlighted the study’s design and ethical considerations. The following chapter presents a comprehensive literature review, examining key determinants of access to PPHM services and elaborating on the theoretical framework.

CHAPTER 2 :
LITERATURE REVIEW

2.1 Introduction

"Mmago ngwana o swara thipa ka bogaleng" [A mother holds the knife by its cutting edge]
— Sesotho proverb.

This proverb conveys the stoic tolerance demanded of mothers but also suggests the typically concealed suffering behind such self-denial. This invisible strength, though culturally idealised, can mask profound emotional suffering, particularly in the postpartum period, when mothers must adapt to the new demands of motherhood (Tikka et al., 2022; Romano et al., 2010). This chapter begins by presenting the SEM as a framework to guide the analysis of barriers and facilitators to care at the individual, community, institutional, and societal levels. This is followed by a critical review of the literature on PPMH within the general context of LMICs, with emphasis on how economic and historical factors influence maternal mental health outcomes. Furthermore, the chapter discusses the complex interaction of biopsychosocial risk factors for the challenges associated with PPMH. The chapter continues to review the current provision of PPMHS in South Africa, acknowledging the remaining progress and challenges. Finally, the chapter reviews the barriers and facilitators to PPMHS within the South African context, presented using the SEM framework.

2.2 The Socioecological Model: Its History and Development

The initial theories of health behaviour concentrated mainly on micro-level determinants with minimal attention to the broader environmental and social forces (Scarneo et al., 2019; Golden & Earp, 2012). The SEM was developed to bridge this gap with an overarching theory synthesising individual behaviour within environmental determinants (Uchendu et al., 2020). Unlike reductionist theories, SEM explains human-environment interactions as bidirectional, with individuals affecting and being affected by their environment (Manfredo et al., 2014; Salihu, 2014).

The theoretical foundations of SEM lie in Urie Bronfenbrenner's ecological systems theory, outlined in the 1970s to explain human development (Kilanowski, 2017; Tudge et al., 2016). Bronfenbrenner's theory describes how individuals are situated within a set of environmental

systems in a hierarchical arrangement, from immediate family influences (microsystem) to large societal systems (macrosystem) (Mary & Antony, 2022; Eriksson et al., 2018). This theoretical framework was later applied in public health practice to examine multifaceted determinants of health behaviour (El Zaatari & Maalouf, 2022; Ettekal & Mahoney, 2017; Perron, 2017). McLeroy and colleagues used Bronfenbrenner's framework in their seminal work of 1988 in the field of public health by identifying five levels of influence: intrapersonal, interpersonal, institutional, community, and public policy levels (Golden & Earp, 2012). Stokols (1992) took the work a step further by presenting a more integrated social ecological approach that focused on the relationship between the individual and the various environmental settings to which they belong. Stokols and colleagues posited that the environment's social, physical, and cultural dimensions have a profound and cumulative effect on health outcomes, for which they must be included in the design of health interventions (Sallis et al., 2015; Stokols, 1992). This revised framework enabled public health intervention to move from individual level interventions to context-based, laying the foundation for modern ecological models in health behaviour (Glanz et al., 2015).

The SEM theoretically emphasises the necessity of a multi-level model in describing health behaviour that entails individual, interpersonal, organisational, community, and societal levels (Scarneo et al., 2019; Salihu, 2014). Firstly, the individual level describes how demographics, knowledge, attitudes, and beliefs influence health-related decisions (Scarneo et al., 2019). Secondly, the interpersonal level considers how relationships and social networks affect health behaviour's improvement or deterioration (Place et al., 2024). Thirdly, at a level higher than interpersonal relationships, the organisational level considers institutional policies and structural arrangements that affect health practices in formal organisations (Scarneo et al., 2019). Fourthly, the community level highlights cultural norms and the availability of local resources as significant determinants of population health (Place et al., 2024; Caperon et al., 2022). Finally, the societal level focuses on economic structures, social norms, and policies, and how they shape the overall environment within which health behaviour occurs (Ngwenya et al., 2020; Scarneo et al., 2019). By considering interactions at various levels, the SEM provides a more complex explanation of health behaviour than micro-level models, which may not assess the impact of the broader environmental determinants (Salihu, 2014). Empirical evidence has supported SEM as a practical framework for understanding the complexity of health issues and ensuring equitable access to health care (Nonyel et al., 2021; Mehtälä et al., 2014). Public health applications of SEM entail identifying risk and protective factors (Scharpf

et al., 2021), guiding multi-level intervention design (Schölmerich & Kawachi, 2016; Mehtälä et al., 2014), and examining intervention effects in multilevel contexts (Cholley-Gomez et al., 2023).

Furthermore, SEM also plays a role in health disparity research and reducing inequities (Caperon et al., 2022; Ma et al., 2017; Shortt et al., 2014). Through examinations of interactions among individual, interpersonal, community, and societal level variables, SEM works to uncover structural processes driving disparities in health outcomes (Hawkins et al., 2021; Centre for Disease Control and Prevention, 2015). The model highlights the importance of social determinants like education, income, and distribution of resources as key drivers of health inequities (Braveman & Gottlieb, 2014; Salihu, 2014).

SEM has garnered significant attention in maternal mental health studies, particularly in the period of the COVID-19 pandemic, where socio-ecological determinants were demonstrated to have a substantial contribution to maternal distress (Keleynikov et al., 2024). For example, studies in Burkina Faso and Malawi employed SEM to examine the determinants of depression among pregnant and parenting adolescent females, thereby calling for integrative screening and multi-level interventions (Ajayi et al., 2023). Fischer et al. (2021) also employed SEM to examine the sleep health of rural-residing mothers in the United States. They recognised limitations such as geographical isolation and less availability of health services, which further validated the feasibility of using the model in analysing multi-level determinants.

2.2.1 Application of the Socio-Ecological Model to Postpartum Mental Health and Well-Being

This research draws on the work of Chopak-Foss et al. (2020), as indicated in Figure 2.1, who applied the PPMH to explore barriers and facilitators to PPMHS. Their multi-level analysis reveals how policy, community, organisational, interpersonal, and individual factors collectively shape the accessibility and quality of PPMH care. At the policy level, national strategies are increasingly emphasising the need for maternal mental health. However, the translation of these strategies into effective action is typically hindered by limited resources, a lack of robust accountability mechanisms, and inefficient budgetary allocation. At the community level, advocacy, awareness-raising campaigns, and mobilisation of CHWs can potentially broaden mental health literacy and encourage help-seeking behaviour. However, the extent of such activity varies widely. At the organisational level, screening procedure

inefficiencies, healthcare provider training, and fragmented referral procedures are some of the key determinants of delay in mental illness diagnosis and treatment. On an interpersonal level, family members and peers are significant sources of support; however, a lack of familiarity with mental illness within the family could foster dismissive attitudes and, hence, discourage women from seeking the required treatment. At an individual level, the social stigma, cultural beliefs, and insufficient knowledge regarding PPMDs deter women from accessing available services.

Building on Chopak-Foss et al.'s (2020) work, this study also used the Socio-ecological model of mental health and well-being (SEMMW) as a theoretical framework to examine how various factors influence various dimensions of PPMH (Michaels et al., 2022; Reupert, 2017). It emphasises the influence between the environment and mental wellbeing, especially significant for new mothers balancing caregiving responsibilities with their own recovery (Reupert, 2017). The model suggests a shift in how mental health is viewed, emphasising the importance of society in shaping mental health outcomes. It also offers strategies for promoting healthy development, managing stress, and fostering social connections (Michaels et al., 2022). Through this model, practices contributing to PPMH can be systematically identified, along with areas where services may be deficient (Devooght et al., 2023; Chopak-Foss et al., 2020).

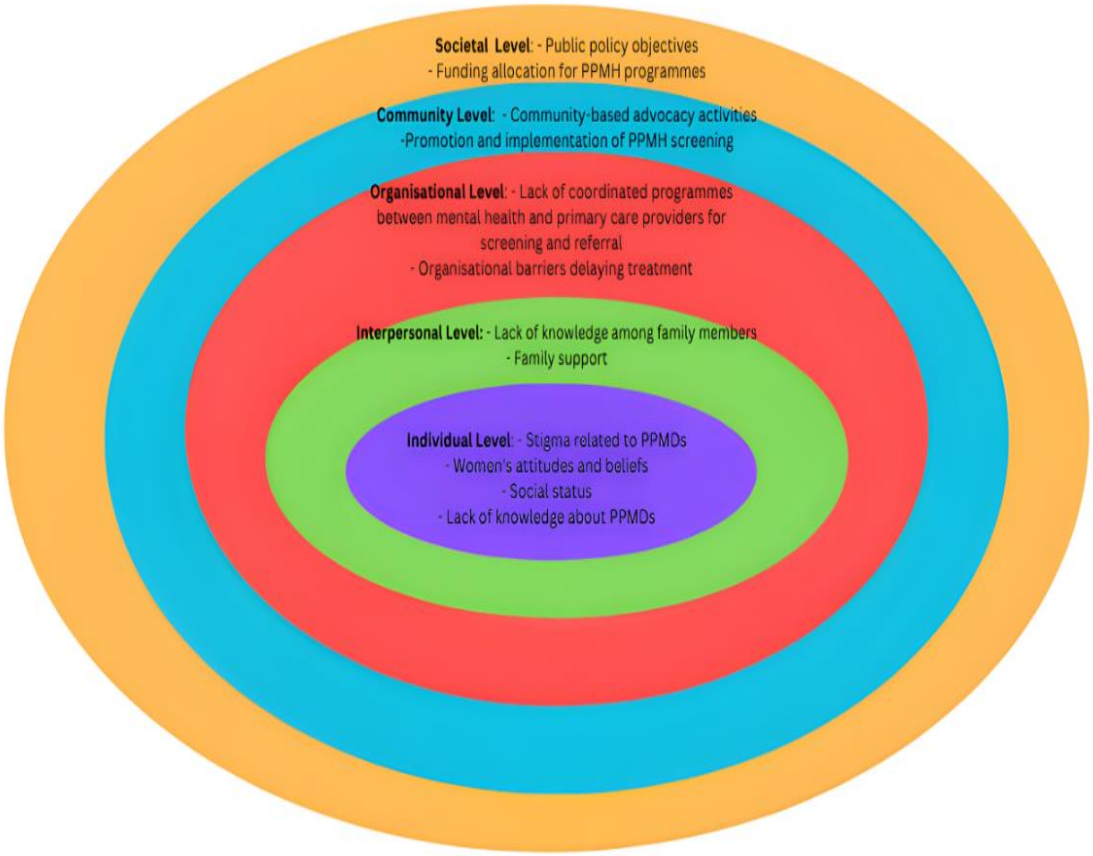


Figure 2.1: Factors Influencing Postpartum Mental Healthcare Access within the SEMMW (Adapted from Chopak-Foss et al. (2020)

2.2.2 Limitations of the Socio-Ecological Model in Postpartum Mental Healthcare

While the SEM is useful for understanding the multiple layers of influence on health outcomes, it's application in peri-urban SA contexts exposes key conceptual and practical limitations. A key critique is that the SEM tends to see the relationships among the various levels as largely linear and additive, thus oversimplifying the complex, adaptive and reciprocal nature of real-world health systems (Kilanowski, 2017). This limitation can cause fragmented or reductionist understandings of PPMH challenges, where responses are narrowly defined and sectors focus on discrete factors rather than on wider ranges or the dynamic interconnections between them (Kilanowski, 2017). Another limitation of the SEM is that its integration demands a methodological shift that can be resource-intensive, particularly in under-resourced peri-urban CHCs. According to McLeroy et al. (1988), one of the major challenges with ecological models is that they often lack sufficient specificity to guide the conceptualisation of problems or the identification of appropriate interventions. This limitation makes it difficult to operationalise

multi-level strategies or to design interventions that effectively link interacting levels (Elder et al., 2007; McLeroy et al., 1988).

Introducing systems thinking into the SEM can help to address these limitations. According to Meadows (2018) and Peters (2014), systems thinking views health outcomes as the product of interdependent, evolving systems rather than as a simple cause and effect. In doing so, systems thinking looks at feedback loops, unintended consequences and emergent behaviour (Meadows, 2018; Peters, 2014; De Savigny & Adam, 2009). Systems thinking can help PPMH researchers and practitioners understand how social support, resource allocation, staff attitude and community stigma continuously interact with one another, thus encouraging socially-driven interventions that are adaptive to the complexity of postpartum women's lived experiences (Meadows, 2018; Peters, 2014; De Savigny & Adam, 2009).

2.3 Contextualising PPMH Care in LMICs

Although many LMICs have adopted policies advocating for the integration of mental healthcare into maternal health services, the implementation of these policies remains inconsistent and largely ineffective (McNab et al., 2022; Garman et al., 2019). Integration efforts are hindered by persistent structural barriers, including inadequate healthcare infrastructure, chronic shortages in the health workforce, and weak policy implementation at the primary healthcare level (McCartney et al., 2021; Weinstein et al., 2017). These challenges are not only contemporary but are also rooted in historical, geopolitical, gender norms and cultural contexts that have shaped the trajectory of mental health service delivery in LMICs.

2.3.1 Historical and Geopolitical Influences on PPMH in LMICs

The provision of mental health care in many LMICs has been profoundly shaped by the legacies of colonialism and institutionalised oppression, which have created enduring disparities in healthcare infrastructure access and governance (Kleintjes & Schneider, 2023; Kirmayer & Pedersen, 2014; Mills, 2014). Post-colonial states often inherited fragmented and exclusionary health systems that prioritised the needs of elite or settler populations while neglecting the broader populace. These systems entrenched structural deficiencies that continue to undermine the delivery of equitable mental health services (Michalopoulos & Papaioannou, 2016; Bayeh, 2015; Kirmayer & Pedersen, 2014).

Despite gaining political independence, many LMICs experience weak health governance and economic instability, both limiting sustained investment in mental health programmes (Harriman et al., 2022; Naher et al., 2020). In Kenya, for instance, Di Pierdomenico et al. (2024) highlight the continued influence of colonial-era legislation that permits involuntary detention and substitute decision-making for individuals with mental health conditions. This legal framework reinforces a narrow biomedical approach and impedes the adoption of rights-based, community-focused models of care that address broader social and structural determinants of mental distress. South Africa similarly grapples with enduring effects of colonialism and apartheid-era policies, which have shaped a mental health system that remains insufficiently responsive to the cultural and psychological needs of postpartum women, especially those from historically marginalised communities (Harriman et al., 2022; Sukeri et al., 2014).

Geopolitical instability further compounds these structural challenges. Women in conflict-affected settings are at heightened risk of developing mental illnesses due to exposure to violence, forced displacement, and collapse of health systems (Bendavid et al., 2021; Langlois et al., 2015). Migrant and refugee women, especially those from conflict zones, often face intersecting vulnerabilities, including cultural dislocation, economic hardship, and institutional barriers to accessing specialised PPMHS (Jolof et al., 2022; Seidi et al., 2022; Haque & Malebranche, 2020). Beyond infrastructural and policy-related obstacles, discriminatory health practices, language barriers, and lack of documentation often lead to delayed, insufficient, or denied care for migrant women (Garapati et al., 2023; Heslehurst et al., 2018). The intersection of cultural displacement and postpartum expectations can intensify psychological distress, particularly when customary familial support systems are disrupted in host countries (Wittkowski, 2017). For instance, Hunter-Adams (2016) found that migrant women living in Cape Town, South Africa, often lacked access to support from unemployed and older women within their communities. These figures traditionally provide crucial postpartum support. This absence was associated with increased stress and difficulties in infant care. The study underscores the need for culturally sensitive and context-specific mental health interventions tailored to the unique experiences of displaced postpartum women.

2.3.2 Cultural and Sex-Based Expectations Influencing PPMH in LMICs

It is also essential to examine the cultural and sex-based demensions that shape the delivery and experience of PPMH in LMICs. Biological sex is a critical determinant of health that mediates inequalities in healthcare access, utilisation and outcomes through both entrenched cultural expectations, norms and institutional structures (Miani et al., 2021; Carmel, 2019;

Manandhar et al., 2018). In many LMICs, dominant sex-based expectations frame women as primary caregivers and men as economic providers (McNab et al., 2021). This division often results in unequal power dynamics that limit women's autonomy, including the ability to seek PPMHS (Cislaghi & Heise, 2020; McNab et al., 2021; Hay et al., 2019). These norms increase women's caregiving burden and restrict their decision-making power, particularly in households where men control financial and health-related choices (Thomas et al., 2024; Nishimwe-Niyambanira & Sabela, 2019). Empirical studies illustrate the far-reaching consequences of such norms. In Tanzania, a study found that couples who perceived childbearing and maternal care as the exclusive domain of women were significantly less likely to utilise skilled attendant antenatal services, reflecting how sex-based roles and beliefs can constrain healthcare access (Garrison-Desany et al., 2021). In South Africa, these patterns are intensified by the legacies of Apartheid and labour migration, which have historically fragmented family structures and placed the burden of caregiving squarely on women (Hatch & Posel, 2018). As a result, some postpartum women face inadequate partner support, exacerbating their vulnerability to mental distress. Moreover, economic dependence on male partners can deter women from seeking mental health support for fear of retaliation, emotional withdrawal, or financial instability (Mutahi et al., 2022).

These historical, geopolitical and sex-based dynamics are central to understanding the broader socio-structural context affecting PPMH in LMICs. It is at the intersection of historical, cultural, and economic constraints that the structural vulnerabilities of postpartum women become more pronounced. These contextual factors intensify the effects of biopsychosocial risk factors – issues that are explored in the subsequent sections.

2.4 Bio-Psychosocial Risk Factors affecting PPMH

While PPMH conditions are universally acknowledged as a significant public health concern, they are shaped by a complex interplay of biopsychosocial factors that are context-specific. Awareness and identification of PPMH risk factors are critical for improving access to care and health outcomes (Garapati et al., 2023; Žuti, 2023). The following section discusses the global literature on these risk factors and evaluates their relevance to South Africa.

2.4.1 Biological Factors Affecting PPMH

2.4.1.1 Genetic factors

Biological factors, particularly genetic vulnerability, increasingly contribute to developing PPMDs (Luo et al., 2023; Kjeldsen et al., 2022; Payne & Maguire, 2019). According to Kjeldsen et al. (2022), individuals with a family history of psychiatric illness face more than double the risk of developing PPD compared to those without such a history. This may be due to shared genetic vulnerability or common environmental factors across generations (Luo et al., 2023; Guintivano et al., 2018).

A family history of major depression or bipolar disorder is especially significant, with studies demonstrating a strong correlation between such histories and the onset of PPMDs (Garapati et al., 2023; Bauer et al., 2018). Neurobiological processes – such as dysregulation of neurotransmitter systems and the hypothalamic-pituitary-adrenal (HPA) axis – appear to underlie such risks. Evidence also points to the role of epigenetics in the onset of PPMDs. Specific single-nucleotide polymorphisms (SNPs) in protein kinase C – a key regulator of neurotransmission and neuroplasticity – have been linked to depressive symptoms during the first 32 weeks after childbirth. Other SNPs near the transcription start site of the kininogen 1 gene, which is involved in inflammatory processes, have been engaged in depressive symptoms measured using the Edinburgh Postnatal Depression Scale (EPDS) (Parasian, 2021), suggesting that inflammatory and endocrine pathways may mediate genetic vulnerability. Despite these insights, genetic research on PPMDs in South Africa remains limited. Onu et al. (2023) highlight a significant gap in genetic epidemiological studies of severe mental disorders across sub-Saharan Africa, underlining the need for further studies to inform culturally and regionally relevant prevention and care practices.

2.4.1.2 Endocrine factors

The hormonal fluctuations that accompany pregnancy, childbirth, and lactation have a profound impact on maternal mental health (Parasian, 2021; Furtado et al., 2019). Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, a key stress response system, is strongly linked to PPD. While elevated cortisol is common during pregnancy, abnormally low cortisol levels upon waking have been associated with major depressive disorder during pregnancy (Rathi et al., 2022). In addition to direct endocrine effects, pregnancy-related hormonal shifts may trigger changes in gene expression, thereby increasing susceptibility to

PPD (Parasian, 2021; Furtado et al., 2019). Alterations in thyroid hormone may also lead to mood instability, sleep disturbances, and other symptoms associated with PPDs (Ghaedrahmati et al., 2017). Oxytocin, a hormone that is crucial for maternal behaviours like parturition and lactation, has been investigated for its potential protective effects against PPD. Evidence suggests that oxytocin helps to buffer stress and enhance maternal attachment. However, empirical research in this area remains scarce, particularly in low-resource settings. Psychological stressors such as anxiety, life events, and low self-esteem may disrupt hormonal equilibrium, compounding susceptibility to PPD (Zhang et al., 2023).

In South Africa, the integration of endocrine factors into maternal mental health assessments is limited. Hoare and Vythilingum (2023) underscore the importance of considering both biological and psychosocial influences on PPD. Their review identifies hormonal dysregulation and inflammation as key biological risk factors and advocates for integrated care systems that combine pharmacological and psychosocial interventions. Recognising the biological underpinnings of PPMDs is essential to developing effective, multidimensional treatment strategies.

2.4.2 Psychological Factors Affecting PPMH

2.4.2.1 History of depression or anxiety

A prior history of anxiety or depression is among the most consistent predictors of PPMDs, as reported across both high-income and LMIC countries (Guintivano et al., 2018; Ghaedrahmati et al., 2017). Individuals with pre-existing mood disorders are especially susceptible to perinatal hormonal fluctuations during pregnancy and the postpartum period, which exacerbate underlying psychopathology (van der Zee-van den Berg et al., 2021). Moreover, residual symptoms from previous episodes may obscure the onset of new mental health conditions, complicating early diagnosis and delaying access to appropriate care (O'Hara & McCabe, 2013).

In South Africa, inconsistent mental health screening in primary health care settings results in many women entering pregnancy with undiagnosed or untreated mental illness (Docrat et al., 2019; Marais & Petersen, 2015). This situation is compounded by the broader mental health crisis in the country, where one in every three individuals is likely to experience a mental health disorder at some point in their lifetime. Yet only 27% of those individuals with severe mental illness receive adequate treatment (Craig et al., 2022; Ruffieux et al., 2021). The existing

treatment gap reflects a systemic imbalance between mental health needs and service capacity, as a significant proportion of the mental health budget is directed toward inpatient care at the expense of community-based interventions (Docrat et al., 2019; Marais & Petersen, 2015).

The lack of standardised screening protocols for mental illness before and during pregnancy constitutes a critical systems-level shortfall that elevates risk in the postpartum period, particularly among women with a history of undiagnosed mental health challenges (Docrat et al., 2019; Marais & Petersen, 2015).

2.4.2.2 Perceived stress

Perceived stress, arising from socioeconomic challenges, interpersonal conflict, or caregiving burden, is a significant predictor of PPMH (Leonard et al., 2020; Payne & Maguire, 2019). A systematic review revealed that postpartum women who report higher levels of perceived stress are considerably more likely to experience depressive symptoms (Lewis et al., 2021). Chronic stress disrupts the HPA axis, increasing the risk for depressive and anxiety disorders (Bieleninik et al., 2021). Stress has also been associated with impaired maternal-infant bonding and negative development in children, creating transgenerational cycles of risk (Nolvi et al., 2023; Oyetunji & Chandra, 2020).

In South Africa, research on perceived stress and PPMH is limited, yet structural disadvantage likely intensifies the stress experienced by many postpartum women. High rates of unemployment, limited access to mental health services, and persistent gender disparities in caregiving responsibilities intensify women's experience of stress (Modjadji & Mokwena, 2020). Yet, stress perception is inherently subjective – women in similar circumstances may report varying levels of distress depending on available coping resources and the support available through their social networks (Shields et al., 2023). This interplay between structural stressors and individual experiences of stress complicates mental health vulnerabilities, gradually undermining resilience and coping capacity.

2.4.2.3 Personality traits

Personality traits such as neuroticism and perfectionism have been associated with increased susceptibility to PPMDs (Puyané et al., 2022; Gelabert et al., 2020). Neuroticism is characterised by heightened emotional reactivity, anxiety, and irritability, which predispose

individuals to mood and anxiety disorders during the postpartum period (Puyané et al., 2022; Pereira-Morales et al., 2019; Eckerdal, 2018; Udoviić, 2014). Perfectionism, which is marked by unrealistically high personal standards and chronic self-criticism, has been identified as a significant risk factor for PPMDs. Women who score high on measures of perfectionism often set unrealistic expectations for themselves, especially in their roles as mothers. When these expectations are unmet, they experience intense emotional distress, including symptoms of depression and anxiety. (Bull et al., 2022; Price et al., 2020). Perfectionism is also frequently associated with low self-esteem, which further heightens the risk for PPMDs (Han & Kim, 2020; Gelabert et al., 2012; Maia et al., 2012). These interconnected traits can perpetuate a cycle of self-criticism, dissatisfaction, and psychological strain that undermines maternal mental health.

Although South African literature exploring the relationship between personality traits and PPMH is limited, there is reason to believe that cultural factors may intensify the effects of perfectionism. Frizelle and Kell (2010) illustrate how South African mothers often compare themselves to idealised social norms of 'good mothering,' leading to increased self-scrutiny and internalised feelings of inadequacy. This dynamic mirrors perfectionist tendencies, as women view themselves as deficient when unable to meet these culturally prescribed standards.

2.4.3 Social Factors Affecting PPMH

2.4.3.1 Socioeconomic stressors

Financial hardship is one of the most consistently documented risk factors for PPMDs, particularly depression and anxiety in new mothers (Smith & Mazure, 2021; Wang et al., 2021). Economic insecurity, stemming from difficulty affording basic necessities such as food, shelter, and healthcare, contributes significantly to maternal stress and undermines family wellbeing (Kelly et al., 2023; Bassuk & Beardslee, 2014). In South Africa, these financial stressors are compounded by high levels of unemployment and a rising cost of living (Brown et al., 2020). Many postpartum women face considerable anxiety related to meeting their family's basic needs, especially in contexts where social safety nets are fragile or absent (Horwood et al., 2021; Qobadi et al., 2016). Food insecurity, affecting more than 20% of South African households, exacerbates the physical and emotional demands of the postpartum period (Zielińska et al., 2023; Abrahams & Lund, 2022; Madeghe et al., 2020) with implications for both maternal and infant health. Beyond food insecurity, housing instability is another

significant source of distress, globally and locally. Frequent relocations, overcrowded living conditions, and homelessness not only undermine a sense of safety but also intensify psychological strain (Kelly et al., 2023; Bassuk & Beardslee, 2014). In South Africa, many families live in informal settlements due to housing unaffordability, further reinforcing intergenerational cycles of poverty and vulnerability to poor mental health (De Schutter et al., 2023; Silverman et al., 2022; Marutlulle, 2021; Chakwizira, 2019; Stellenberg & Abrahams, 2015).

2.4.3.2 Substance abuse

Substance use is also a well-documented risk factor for PPMDs, often co-occurring with socioeconomic disadvantage and structural inequities (Reitan, 2019; Chapman & Wu, 2013). Among pregnant and postpartum women, substance use elevates the risk for depression, anxiety, and other psychiatric disorders, through both neurochemical disruptions and the effects of stigma and social marginalisation (Akunna, 2024; Corr et al., 2020; Uhl et al., 2019; Erickson, 2018; Cleveland et al., 2016; Kuo et al., 2013; Coleman-Cowger, 2012). In South Africa, substances such as alcohol, methamphetamine (tik), and cannabis are mainly used as coping mechanisms by women grappling with chronic poverty and psychosocial stressors (Browne et al., 2023; Masiko & Xinwa, 2017). Postpartum women who use substances frequently report guilt and shame, which intensify emotional distress and contribute to isolation (Adams et al., 2021; Cleveland et al., 2016). Access to addiction and mental health services remains limited due to punitive health policies, stigma, and fear of legal consequences (Scheibe et al., 2017; Myers et al., 2016; Sorsdahl et al., 2012). These issues cumulatively result in delayed help-seeking and worsen negative mental health consequences. Harm-reduction approaches – emphasising non-punitive, integrated care – are urgently needed to support maternal recovery and mental health (Puccio, 2023).

2.4.3.3 Unintended pregnancy

Unintended pregnancy – particularly among adolescents – is consistently associated with increased risk for PPD and anxiety (Muskens et al., 2022; Qiu et al., 2020). The psychological burden of unplanned motherhood is often compounded by limited support systems, lack of preparedness, and social stigma (Gebrekristos et al., 2023; Eslaminia et al., 2022; Roberts et al., 2021). The strain of an unplanned pregnancy may intensify existing vulnerabilities,

particularly in settings where mental health and maternal care services are scarce (Bahk et al., 2015; Watt et al., 2014). In South Africa, unplanned pregnancies are linked to elevated depressive symptoms, including suicidal ideation, particularly among teenage and unmarried mothers (Moganedi & Mudau, 2023; Rochat et al., 2013). Social stigma, familial rejection, and disrupted education are among the key stressors affecting these young women, many of whom drop out of school and face ongoing precarity. In education settings, unmarried pregnant students report significant stress due to social judgment, relationship instability, financial constraints, and academic pressure. These concurrent stresses contribute to PPMH deterioration and delayed care-seeking (Phiri et al., 2021). Beyond the immediate postpartum period, the long-term consequences of unplanned pregnancy include increased developmental issues, risks for children, and continued maternal psychological strain (Beumer et al., 2024; Su, 2017). This cycle of disadvantage often results in reduced economic and emotional support for both the mother and child, thereby perpetuating intergenerational mental illness and socioeconomic disparity (Govender et al., 2020; Herd et al., 2016).

2.4.3.4 Exposure to violence

Gender-based violence (GBV), including intimate partner violence (IPV), is a significant public health crisis, with devastating effects on maternal mental health (Tappis et al., 2016; Sanjel, 2013). IPV during pregnancy is strongly associated with PPTSD, anxiety, and depression, with women exposed to IPV being nearly three times likely to develop postpartum depressive symptoms (Wei et al., 2024; Dawson et al., 2021; García-Moreno & Riecher-Rössler, 2013).

South Africa has one of the highest rates of GBV globally, with a femicide rate five times the global average, and approximately 51% of women reporting lifetime exposure to IPV (Govender, 2023; Luvo & Saunders 2022). While physical violence is often the focus of discourse, psychological abuse, marked by coercion, humiliation, and emotional manipulation, can have equally or more severe mental health consequences due to its chronic and insidious nature (Saito et al., 2012). When experienced during pregnancy, such psychological trauma frequently persists into the postpartum period, manifesting as chronic anxiety, social withdrawal, and impaired mother-infant bonding (Groves et al., 2011).

Despite the severity of these impacts, most South African women encounter significant challenges when seeking help for IPV. Many women encounter victim-blaming from

authorities, fear retribution, or lack the financial means to leave abusive relationships, and face resistance to prosecuting domestic violence cases (Mmamabolo et al., 2020; Groves et al., 2014). Stigma further isolates survivors and exacerbates their mental health struggles (Groves et al., 2014). Compounding these challenges are barriers in accessing confidential, trauma-informed mental healthcare, especially in under-resourced areas (Govender, 2023; Luvo & Saunders 2022). A multi-faceted response involving legal reform, mental health service expansion, and efforts to dismantle harmful gender norms is essential.

2.4.3.5 Social support and social isolation

The absence of social support has constantly been linked to increased risk for PPMDs, while social support acts as a protective factor (Ekpenyong & Munshitha, 2023; Feinberg et al., 2022; Inekwe & Lee, 2022). Women who experience social isolation, especially during the perinatal period, are more likely to suffer from PPD and prolonged emotional distress (Adlington et al., 2023; Kent-Marvick et al., 2022; Taylor et al., 2022; Seymour-Smith et al., 2021).

South Africa's legacy of apartheid continues to undermine social cohesion, particularly through historical displacement and familial fragmentation (Shiba 2021; Roos et al., 2019). Rural-to-urban migration, driven by economic necessity, often severs traditional support networks and increases isolation among new mothers (Nyoni & Kollamparambil, 2022; Mulcahy & Kollamparambil, 2016). For postpartum women without strong support structures, feelings of loneliness are exacerbated, undermining maternal-infant bonding and impeding emotional recovery.

2.4.4 HIV as a Biopsychosocial Risk Factor

Medical comorbidities, especially HIV, pose substantial biopsychosocial risks to PPMH. Globally, women living with HIV (WLWH) show significantly higher rates of PPD compared to HIV-negative women. A meta-analysis, Zhu et al. (2019) estimated that 21% of WLWH experienced postpartum depressive symptoms, although prevalence varies by setting. Biologically, HIV contributes to mental health disorders through chronic immune activation and inflammation, and damage to the central nervous system – mechanisms linked to depression (Remien et al., 2019). HIV also affects neurotransmitter pathways through oxidative stress and blood-brain barrier disruption (Remien et al., 2019). Psychologically, the stress of an HIV diagnosis during or after pregnancy, concerns about vertical transmission, and long-

term disease management can severely impact maternal mental well-being (Ashaba et al., 2017). Concerns regarding disease progression, mother-to-child transmission, and long-term effects of living with HIV enhance emotional stress (Ashaba et al., 2017; Kapetanovic et al., 2014). Socially, HIV-related stigma often leads to isolation, reduced access to support, and further increases the risk of psychiatric morbidity (Yato et al., 2023; Ashaba et al., 2017).

These dynamics are particularly evident in South African peri-urban areas, where HIV prevalence is greater than the national average (Leung Soo et al., 2023). Despite widespread availability of HIV services, social inequities and gender norms continue to shape poor outcomes. Antenatal HIV testing, which often coincides with a woman's first diagnosis, can exacerbate psychological distress and heighten vulnerability to PPMDs (Turner & Honikman, 2016). Mental health disorders among people living with HIV (PLWH) in South Africa is estimated at 43.7%, far above that of 30.3% for the general population, underscoring the need for integrated care addressing biological, psychological, and structural stressors for postpartum women (Turner & Honikman, 2016).

2.5 Strategies for PPMH Service Delivery in South Africa

In recent years, South Africa has progressively acknowledged the necessity for incorporating mental health care into maternal care models, specifically within primary health care (Honikman & Field, 2019; Field et al., 2014). Initiatives to restructure service delivery models have called for innovations into new models for bridging service gaps and extending services to vulnerable groups (Abrahams et al., 2022; Brown & Sprague, 2021; Maphumulo & Bhengu, 2019). This section discusses strategies such as decentralisation of mental health services, public-private partnerships, and other interventions that have been used to strengthen the delivery of PPMH services.

2.5.1 Decentralisation of PPMH Care in South Africa

Decentralisation involves the systematic transfer of power from central to local government institutions to develop healthcare systems that are more sensitive to local needs and better placed to respond to inequalities in service delivery (Hendricks et al., 2014). This practice aligns with global health governance practices and guidelines, including those by the WHO promoting decentralisation of healthcare as a policy for improved accessibility, efficiency, and equity of services, particularly in resource-constrained environments (Maphumulo & Bhengu, 2019; Winchester & King, 2018).

In South Africa, decentralisation is part of the broader de-institutionalisation agenda aimed at moving mental health care from psychiatric hospitals to community- and primary care-based facilities (Lund et al., 2010; Petersen et al., 2009). Based on this model, primary healthcare (PHC) facilities such as CHC serve as the initial contact for mental health services, such as the identification and treatment of common PPMDs like postpartum depression (Docrat et al., 2019; Sibiya & Hlongwa, 2019). The Adult Primary Care (APC) 2023 clinical tool serves as a comprehensive guide for healthcare providers in PHC settings, facilitating the identification, management, and referral of common mental disorders, including postpartum mental disorders (DoH, 2023). The tool consolidates national guidelines to provide a structured approach for mental health care at the primary healthcare level (Mokwena & Masike, 2020). Registered Nurses (RNs) with a Basic Psychiatric Nursing Qualification are formally trained to provide mental health services, including screening, counselling, and referral (SANC, 2019). Their qualification ensures they possess the competencies required to identify and manage PPMH conditions effectively, consistent with the guidance provided in the APC 2023 tool (DoH, 2023; Petersen et al., 2012). Advanced Mental Health Professionals, including psychiatrists, clinical psychologists, and psychiatric/mental health nurse specialists, possess postgraduate qualifications and specialised training in mental health (Petersen et al., 2012). They are capable of conducting comprehensive assessments, providing specialised interventions, and managing complex or severe cases of PPMDs, ensuring appropriate care for high-risk postpartum women (Lund et al., 2010; Egbe et al., 2014). District hospitals provide more specialised evaluation and short inpatient care as intermediaries between community-based care and tertiary-level psychiatric facilities (Lund et al., 2012).

Despite enabling policy contexts for integrating mental health into PHC, implementation remains challenging (Docrat et al., 2019; Lund et al., 2011). A considerable percentage of PHC facilities face chronic systemic problems, such as low staffing levels, minimal mental health training, and intermittent availability of specialist personnel. These individually and collectively undermine service integration and reduce access to quality mental health services at the community level (Docrat et al., 2019; Kramers-Olen et al., 2014; Lund et al., 2010). Moreover, screening-related behaviours are not consistent due to a lack of standardised procedures and fragmented follow-up systems, each of which compromises continuity of care (Lovero et al., 2019). To counter these challenges, South Africa has increasingly turned to public-private partnerships to expand the coverage of services and the continuity and quality of mental health care.

2.5.2 Public-Private Mix in PPMH Care in South Africa

South Africa has officially integrated PPMHS into primary and postnatal care systems for continuity of care (Brown & Sprague, 2021). However, access is greatly hampered by structural barriers, especially in resource-poor settings. The general shortage of mental health professionals, mainly in rural areas, exacerbates existing disparities, as a large proportion of postpartum women are not offered adequate care (Sorsdahl et al., 2023; Moodley et al., 2022). Although the prevalence of PPMDs is estimated to be similar in urban and rural settings, significant economic, geographical, and sociocultural barriers hamper equal access to services, especially for vulnerable populations (Mokwena & Modjadji, 2022).

Inequities in access to mental health interventions continue to be exacerbated by the existing inequality between the private and public sectors. The private sector, which serves a minority of the population, is relatively over-resourced when compared to the public sector, which serves the majority but is significantly under-resourced (Abrahams et al., 2022; Hlafa et al., 2019; Kula & Fryatt, 2014). An estimated 70 to 92 % of those who have a mental health disorders in South Africa are not treated formally, a situation aggravated by the overwhelming maldistribution of mental health professionals, as over 80% of psychiatrists work in the private sector (van Rensburg et al., 2021; Docrat et al., 2019; Egbe et al., 2014). Public mental health professionals are significantly under-resourced in South Africa, with merely 0.31 psychiatrists, 0.97 psychologists, 1.53 occupational therapists, 1.07 speech therapists, and 1.83 social workers available per 100,000 individuals (Docrat et al., 2019). Even with the increased rate of PPMDs, the percentage of public health expenditure devoted to mental health is low, equating to a mere 5% of total public health spending (Docrat et al., 2019).

Public-Private Partnerships (PPPs) have been suggested as a strategic approach to addressing resource shortages by leveraging the expertise and funds of the private sector towards the renovation and strengthening of public mental healthcare facilities (Walwyn & Nkolele, 2018; Kula & Fryatt, 2014). One example is the partnership between Sanofi South Africa and the University of the Witwatersrand, which aimed to enhance mental health leadership within the South African public health system by offering a course to build competencies in patient advocacy and integrated mental health care (Szabo et al., 2017).

Despite their potential, PPPs are not fully exploited within the South African health sector, including mental health, mainly due to systemic inefficiencies, policy fragmentation, and fiscal

austerity (Fombad, 2019). Strengthening the role of PPPs in mental health will require regulatory reform and increased intersectoral trust, coordinated governance, and more equitable resource allocation across all levels of care (Mbaka & Mwange**,** 2023; Mugwagwa & Banda, 2020).

The National Health Insurance (NHI) policy framework seeks to bridge the divide between the public and private sectors and promote access to quality health care. However, its implementation has faced scrutiny, particularly regarding financial sustainability, accountability mechanisms, and service delivery (Naidoo et al., 2023; Fusheini & Eyles, 2016). In this complex and evolving policy landscape, targeted interventions for PPMH have emerged within South Africa's public health system, although their reach and sustainability remain uneven.

2.6 Current PPMH Care Interventions in South Africa's Public Health System

2.6.1 Evaluation and Diagnosis of PPMH Conditions

Routine PPMH screening has become more incorporated into postnatal and antenatal care, per the *Mental Health Policy Framework and Strategic Plan for South Africa 2013–2020* (Abrahams et al., 2022; Brown et al., 2020). Though policy guidelines exist, their implementation is not consistent. Most healthcare providers do not carry out screenings due to discomfort in managing mental health issues, insufficient training, and uncertainty regarding the referral processes (Abrahams et al., 2022; Mokwena & Masike, 2020). This indicates that there is still a discrepancy between policy and practice that hinders early detection and intervention of PPMDs. Task-shifting is one of the strategies implemented to address the problem of inadequate mental health professionals in the public health sector.

2.6.2 Task-Shifting in Primary Care

Task-shifting has been employed extensively to deal with South Africa's shortage of mental health experts, with non-specialist practitioners such as nurses and CHWs assuming responsibilities in mental health service provision (Yankam et al., 2023; Brown & Sprague, 2021). Literature indicates that this approach has widened access to mental health services, particularly in resource-poor settings (Spedding et al., 2015; Petersen et al., 2012). Yet, studies have highlighted serious concerns, including excessive workloads, poor supervision, and

inequitable training, that may undermine service quality and sustainability (Petersen et al., 2012). The success of task-shifting in bridging service gaps would thus depend on structural and operational determinants inherent in the health sector.

2.6.3 The Stepped Care Approach

The Stepped Care Model is another fundamental component of PPMH care in South Africa. It is a stratified model, which facilitates the implementation of low-intensity interventions before more costly interventions are provided (McNab et al., 2022). This model is helpful in the optimisation of PPMH outcomes, particularly in low-resource environments (Abrahams et al., 2022). Despite its advantages, there is evidence that organisational factors, such as staff shortages and lack of coordination with Community Mental Health Services (CMHS), can impede the implementation of the stepped care model (Abrahams et al., 2022). The degree to which the model can be effectively executed in South Africa's current healthcare systems continues to be the focus of ongoing research.

2.6.4 Community-Based Interventions

Complementing facility-based strategies, community-level approaches have emerged as integral components of PPMH care. Through community-based interventions, CHWs play a significant role in providing PPMH care through the delivery of services such as screening, primary counselling, and home visits (Myers et al., 2019; White et al., 2017; Nxumalo et al., 2016). Community-based interventions have been linked with improved access to mental healthcare alongside treatment adherence in resource-poor settings (Morar et al., 2024). Furthermore, culturally competent care often aligns with community practice and belief, lessening stigma and enhancing service uptake (Morar et al., 2024). Evidence also emphasises certain significant limitations, such as inconsistent remuneration, improper training, and high levels of attrition that undermine the sustainability of such initiatives (Truter, 2023). As complex as PPMH care and applying interventions are in South Africa, theoretical models that understand individual and contextual considerations have become requisite for the guidance of health studies (Davidoff, 2019).

2.7 Barriers to PPMH Care Access

At each level of the SEM, some challenges are accountable for the issues postpartum women encounter in accessing care (Devooght et al., 2023; Chopak-Foss et al., 2020). These barriers are particularly of concern in the South African context, where cultural, economic, and systematic determinants intersect to create challenges (Brown & Sprague, 2021; Brown et al., 2020; Kathree et al., 2014). These barriers will be elaborated in the following sections, detailing how each factor affects access to PPMHS.

2.7.1 Individual Barriers to PPMH Care Access

2.7.1.1 Knowledge barriers

Limited knowledge and awareness of PPMH conditions constitute a significant barrier to care seeking (Daehn et al., 2023). Most women do not identify the symptoms of PPMH because of low mental health literacy, thus resulting in delays or complete avoidance of help-seeking (Daehn et al., 2023; Steeves-Reece et al., 2019). This disparity is also driven by widespread myths and misconceptions that cloud accurate information and blur everyday postpartum phenomena with clinically relevant disorders. Daehn et al. (2022) argue that the interplay of physiological changes, including mood swings, appetite shifts, and fatigue levels, creates ambiguity in symptom interpretation, thereby promoting confusion and a lack of active responses.

Aside from clinical oversight, socio-cultural narratives perpetuate barriers to knowledge acquisition. Legere et al. (2017) observe that women in the postpartum period tend to attribute their psychological distress to customary postpartum adjustment rather than diagnosable mental disorders. This misattribution creates a core gap in care-seeking, perpetuating the cycle of undiagnosed and untreated mental disorders. The widely held and deeply rooted societal expectation of maternal resilience also exacerbates the issue. The "stoic mother" model, as developed by de Sousa Machado et al. (2020), encourages internalised stigma whereby help-seeking is aligned with personal inadequacy and facilitates silence and self-management instead of professional engagement.

In South Africa, Kometsi et al. (2019) note that knowledge barriers extend beyond individual knowledge and include broader cultural conceptions of mental health. The use of inaccurate and non-clinical language to explain psychological distress among African participants indicates a gap between Western biomedical constructs of mental illness and local conceptions.

This divergence in language and knowledge systems hinders healthcare professionals' capacity to make themselves understood and hence delays diagnosis and intervention. In a study conducted in Cape Town, Spedding et al. (2018) describe alarmingly low PPMH literacy, with just 26% of participants accurately identifying mental disorders according to DSM-5 criteria. More concerning, 77.4% of the respondents did not identify symptom descriptions as representing a mental health disorder, with many instead attributing psychological distress to factors such as stress or personal weakness. In their study conducted in Cape Town, Field et al. (2020) support these results, observing that such gaps in knowledge are especially evident in economically disadvantaged areas, where access to education and healthcare is substantially restricted.

2.7.1.2 Fear of stigmatisation

Stigma is also a barrier to accessing PPMH, influencing both individual and community attitudes toward seeking help for mental health disorders. Many new mothers avoid admitting that they have axpossible PPMD or seeking professional help because of the fear of being labelled as “crazy” or “weak”(Eylem et al., 2020; Thompson et al., 2004). The pervasive social expectation that motherhood is inherently fulfilling and manageable intensifies this reluctance, as women internalise feelings of failure for experiencing mental health challenges (Thorsteinsson et al., 2018).

Both internalised and societal stigma are present in South Africa. Egbe et al. (2014) point out that psychiatric stigma (internalised stigma) promotes self-devaluation, the development of negative self-concepts, and avoidance of mental health care services. From their research conducted in a district located in the North West province of South Africa, women commonly experience fear of stigmatisation by their communities or judgment by health care providers, and this discourages them from seeking care. Social rejection, teasing, and the anticipation of prejudice constitute a hostile environment whereby postpartum women would rather endure their distress in silence rather than expose themselves to the risk of stigmatisation.

2.7.2 Interpersonal Barriers to PPMH Care Access

2.7.2.1 Interpersonal stigma

The process of mental health disorder stigma extends beyond the individual, permeating interpersonal relationships and internal community dynamics. Rössler (2016) describes stigma as a multifaceted phenomenon with cognitive, emotional, and behavioural dimensions, negatively influencing individuals' help-seeking. Stigma in South Africa is found in family, community, and clinical settings through discriminatory attitudes and social exclusion (Egbe et al., 2014). A study conducted in the North West province of South Africa by Monnapula-Mazabane and Petersen (2023) demonstrated that women who access mental healthcare are often openly discriminated against by their social support systems, which serves to perpetuate implicit bias and undermine the effectiveness of their support systems.

2.7.3 Organisational Barriers to PPMH Care Access

2.7.3.1 Organisational resource constraints

In addition to the interpersonal barriers that women face, organisational barriers like systemic resource limitations remain significant in the delivery of PPMHS in South Africa (Brown & Sprague, 2021). The inadequate mental health financing in the nation's national healthcare budget has led to a lack of skilled personnel (Mokgaola et al., 2022). The comparative scarcity of mental healthcare in primary care settings further undermines the effectiveness of integrated mental health care, thus denying many postpartum women the necessary care (Strümpher et al., 2014).

The gap in treatment is also increased through the absence of universal mental health screening. According to Mokwena and Masike (2020), a study conducted in the Tshwane sub-district of Gauteng Province, most of the postpartum women who have signs of depression go unrecognised and untreated because of structural inefficiencies within service provision and screening policy. The absence of standardised screening protocols reduces the likelihood of early identification as well as intervention, thereby increasing the risks of prolonged PPMDs.

2.7.3.2 Distrust of healthcare professionals

This treatment gap is further deepened by entrenched institutional distrust, a significant barrier within the South African health system (Thela et al., 2022). The post-apartheid climate has

created a deep-seated distrust of state institutions, which, when compounded with generalised mismanagement and corruption, has eroded confidence in the provision of healthcare (Rispel, 2016). Adverse patient reports of care experiences marked by fragmented care, cultural insensitivity, and perceptions of healthcare providers' insensitivity fuel this distrust (Chuma & Sibiya, 2022). Disrespectful maternity care disproportionately affects marginalised women, thus perpetuating their unwillingness to access PPMH care (Brown & Sprague, 2021; Honikman et al., 2015).

2.7.4 Community-Level Barriers to PPMH Care Access

2.7.4.1 Cultural and religious barriers

Apart from institutional determinants, cultural and religious beliefs substantially impact attitudes toward mental health in South Africa, consequently affecting responses towards care and treatment (Galvin et al., 2023; Shange & Ross, 2022). A considerable percentage of the population still considers mental health disorders from a supernatural perspective, thereby consulting traditional healers rather than pursuing professional medical intervention (Galvin et al., 2023; Shange & Ross, 2022). Spedding et al. (2018), in their research conducted in Cape Town, emphasised that some regarded religious and spiritual counselling as only slightly less helpful than consultations with mental health professionals, such as psychologists or social workers, and therefore indicated the possible role of religious and spiritual leaders in facilitating access to mental health care.

The convergence of various cultural and religious perspectives renders the understanding and handling of mental illness more complex. These perspectives influence the conceptualisation of mental health and the coping strategies individuals adopt towards it (Sikrweqe et al., 2024). Researchers argue that conventional mental health practice is monocultural, rooted in Western paradigms unlikely to address the specific cultural contexts of South African communities (Leichsenring et al., 2018). Healthcare providers must engage with these cultural processes, comprehending the value of culturally responsive intervention to deliver relevant and effective services. However, cultural stereotypes can potentially negatively influence attitudes and treatment behaviour (Sikrweqe et al., 2024; Ogundare, 2020). Therefore, while traditional and spiritual systems can be valuable sources of information, they must be critically evaluated within the context of informing the development of evidence-based mental healthcare practices.

2.7.5 Societal Barriers to PPMH Care Access

2.7.5.1 Political trauma

Societal factors, including the historical legacy of apartheid and ongoing political trauma, further complicate access to PPMH care (Brown et al., 2020). Apartheid has left a legacy of a stark disparity in standards of living, particularly in the townships, where citizens endure unhealthy environments, under-resourced healthcare facilities, and heightened exposure to stressors that worsen mental illness (Maphumulo & Bhengu, 2019). The trauma caused by historical and ongoing systemic racism takes a heavy toll, especially among ethnic minority postpartum women, as they bear a disproportionate burden of mental illness due to these multi-dimensional stressors (Hankerson et al., 2022; Kozhimannil et al., 2011).

Furthermore, the persistent impact of the social and spatial segregation under apartheid has undermined social support networks within townships, further increasing psychological distress. Dispersed communities are both geographically cut off and socially disconnected, further entrenching difficulty in gaining access to physical and mental health care (Strauss, 2019; Abel, 2015). The socioeconomic inequalities and educational disparities created by apartheid persist in creating patterns of stress and mental illness among South Africans (Harriman et al., 2022; Abel, 2015). These structural inequalities, therefore, demand multi-pronged interventions, which require extensive health care reform that explicitly addresses the social, economic, and infrastructural barriers to mental health care among underserved populations (Ndebele et al., 2021; Maphumulo & Bhengu, 2019).

2.7.5.2 Policy limitations

The policy environment in South Africa impacts the delivery of integrated PPMH care, especially early PPMD screening (Brown & Sprague, 2021). One challenge is the gap between national-level policies and their translation into sub-national, regional, and local levels. This fragmentation results in significant disparities, thus limiting the ability of healthcare providers to detect, refer, educate, and treat PPMDs, especially in resource-scarce settings such as rural and township communities (Brown & Sprague, 2021; Kathree et al., 2014). Although national policies have been developed to address these disparities, various challenges hinder the successful integration of mental health services into primary healthcare systems, specifically affecting women in the postpartum period. This is further exacerbated by inadequate funding

and the significant workload placed on publicly funded mental health care (Marias & Petersen, 2015; Petersen et al., 2011).

2.8 Facilitators to PPMH Care Access

While the preceding section outlined the barriers constraining access to PPMHS, growing evidence also highlights a range of facilitators that can enhance service utilisation and engagement (Honikman et al., 2015; Brown & Sprague, 2021). Understanding these facilitators is essential for identifying how health systems can strengthen supportive mechanisms, empower women, and improve service responsiveness, particularly within low- and middle-income settings such as South Africa (Honikman et al., 2015; Brown & Sprague, 2021). Their discussion in the following sections provides insight into how integrated, context-sensitive strategies can promote equitable access to care (Hanlon et al., 2019).

2.8.1 Individual Facilitators to PPMH Care Access

2.8.1.1 Knowledge and Awareness

Increasing mental health literacy among postpartum women enhances recognition of symptoms, reduces misconceptions, and improves health-seeking behaviour. In Ethiopia, group-based psycho-education significantly increased PPMH literacy by empowering women with the knowledge to identify possible PPMDs and navigate care pathways (Tessema et al., 2024). Although there are currently limited studies specifically assessing PPMH literacy in South Africa, improving knowledge and understanding of mental health is widely recognised as a key facilitator for engagement with services.

2.8.1.2 Self-efficacy and confidence

Interventions that build women's self-efficacy strengthen their perceived control over their health and encourage proactive engagement with services (Davies, 2022; Honiman et al., 2012). In South Africa, specifically in Cape Town, the Perinatal Mental Health Project (PMHP) implemented skills-based programmes that build women's self-efficacy, enhancing their confidence and perceived control over mental health (Honikman et al., 2012; Perinatal Mental Health Project, 2015). A task-shared psychosocial intervention for perinatal depression in Cape Town further demonstrated that integrating mental health support into routine maternal care encourages proactive engagement with services (Davies, 2022). By enhancing self-efficacy and

confidence, these interventions help bridge the gap between awareness of postpartum mental health issues and actual service utilization.

2.8.2 Interpersonal Facilitators to PPMH Care Access

2.8.2.1 Supportive Relationships

In South Africa, cultural practices and family support significantly influence postpartum care, offering both emotional and practical assistance to new mothers (Drigo, 2021). In rural areas like Mpumalanga, women often adhere to traditional customs, such as using herbal remedies and following specific dietary practices during pregnancy, which are deeply rooted in cultural beliefs and passed down through generations (Drigo, 2021). These practices foster a sense of connection to ancestry and community, which is crucial for maternal well-being (Drigo, 2021). Additionally, A study by Nyasulu et al. (2025) conducted in uMgungundlovu District, KwaZulu-Natal, explored family-centred postnatal care. It highlighted the crucial role of family members in providing practical and emotional support to mothers and newborns, improving engagement with postnatal services.

2.8.3 Organisational Facilitators to PPMH Care Access

2.8.3.1 Adequate Resources and Infrastructure

Adequate human resources, stable medication supply, and functional referral systems are fundamental enablers of access. Facilities with well-trained staff and sufficient space for privacy during consultations promote patient trust and reduce drop-out rates (Strümpher et al., 2014; Mokwena & Masike, 2020). In practice, some CHCs have adopted screening tools, routine follow-up, and flexible scheduling as part of collaborative care or stepped-care models, although implementation remains inconsistent across settings (Lovero et al., 2019; Petersen et al., 2023). Well-resourced facilities make services physically and psychologically accessible, thereby translating policy into practical availability.

2.8.3.2 Availability of Skilled Healthcare Providers

Provider competence in maternal mental health screening is directly linked to service uptake. Trained healthcare providers foster positive experiences that build trust in the system. Evidence from Cape Town shows that when screening and referral systems were strengthened through the Perinatal Mental Health Project (Honikman et al., 2012), about 90% of antenatal women

were offered screening (95% uptake), 32% qualified for counselling referrals, and a majority of those accepted referral and attended sessions. Skilled providers thus act as both enablers and advocates for sustained engagement.

2.8.4 Community Facilitators to PPMH Care Access

2.8.4.1 Community-Based Mental Health Initiatives

Community-based non-governmental organisations (NGOs) play a vital role in addressing PPMH challenges in South Africa, particularly in peri-urban and underserved areas. NGOs often bridge gaps between formal healthcare services and communities by offering counselling, psychosocial support, parenting programmes, and outreach initiatives, which improve access and reduce stigma (Pillay, 2022; Davies et al., 2022; Honikman et al., 2012). Organisations such as Family and Marriage Society of South Africa (FAMSA) and Lifeline South Africa provide counselling and trauma support services that complement facility-based care and increase help-seeking options for postpartum women (FAMSA, n.d.; Lifeline South Africa, n.d.). By engaging communities and raising awareness about mental health, these NGOs help overcome socio-cultural barriers, support early identification of PPMDs, and contribute to the normalisation of seeking mental health care (Davies et al., 2022; Honikman et al., 2012).

2.8.5 Societal Facilitators to PPMH Care Access

2.8.5.1 Advocacy and Equity-Driven Reform

Persistent advocacy by civil society and women's health organisations has elevated PPMH within South Africa's policy discourse. The PMHP and the South African Federation for Mental Health have influenced policy recognition of maternal mental health as a human rights issue, aligning with constitutional commitments to equity and access (PMHP, 2010; South African Federation for Mental Health, 2025). Advocacy translates into resource allocation, training, and implementation frameworks that expand service availability and affordability (PMHP, 2010). Moreover, national dialogues on gender equity and social justice have reframed maternal well-being as a public health priority, encouraging inclusive service design that reaches marginalised women (Udenigwe & Kåks, 2022).

2.9 Conclusion

The literature review began by exploring the SEM used to frame individual, interpersonal, organisational, community, and societal issues within this study. The socio-cultural, historical,

and economic basis of the disparities in PPMH care in LMICs was discussed. The review further elaborated on the complexities of PPMH and its intersection with various biopsychosocial determinants. In South Africa, significant efforts are underway to scale up PPMHS through decentralisation, public-private partnership and community-level interventions. Yet, they remain incomplete without a coordinated framework to address service delivery and systemic inequities. key barriers to PPMH care in South Africa were identified, including stigma, resource scarcity, religious and cultural beliefs, political trauma, and policy gaps. Conversely, several facilitators have been highlighted, such as social support, community engagement, integrated service delivery, and the availability of skilled healthcare providers, which can enhance utilisation and the effectiveness of PPMHS. The research methodology utilised in this research will be presented in the next chapter.

CHAPTER 3 :
RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology used to explore the facilitators and barriers of access to PPMHS at a peri-urban Gauteng CHC in South Africa. Guided by a social constructivist paradigm, the study explores postpartum women's and healthcare providers' perceptions and perspectives regarding the accessibility of mental healthcare services. A qualitative approach was chosen for its potential to facilitate in-depth insight into the subjective realities of participants within their social and healthcare contexts. A case study design was selected to investigate the context of the CHC, and purposive sampling was employed to recruit participants with direct experience and knowledge of the study's objectives. Data were collected through semi-structured interviews. Thematic analysis was conducted through an abductive approach to generate themes at various levels of the SEM. Furthermore, key ethical guidelines, such as seeking consent, ensuring confidentiality, and endeavouring not to cause harm, were rigorously followed in the study. These decisions ensured that the determinants of access to PPMHS in this setting were investigated ethically.

3.2 Establishing a Research Paradigm for the Study

To establish a firm foundation for the research paradigm relevant to this study, it is necessary to achieve an in-depth understanding of the concept "paradigm." An academic research paradigm is a set of interconnected assumptions and presumptions that direct the researcher throughout the research process (Rahman, 2023; Creswell & Creswell, 2018). The paradigm is key to establishing the research question, methodology, and ensuing interpretation (Baker, 2022; Creswell & Creswell, 2018). Mackenzie and Knipe (2006) describe a paradigm as a set of ideas, assumptions, or beliefs that form the intellectual underpinning of a study, and state that it is crucial to select a paradigm that suits the purpose and context of the inquiry. The choice of a research paradigm is guided by the researcher’s ontological and epistemological assumptions, which determine the methodology and shape the researcher’s worldview (Mann & Stewart, 2021; Creswell & Poth, 2018). Ontology concerns the nature of reality, questioning whether it is fixed and objective or dynamic and subjective (Nieuwenhuis, 2016; Morgan,

2014). These views impact researchers considerably in framing research topics, interacting with the participants, and handling the interpretation of results and implications (Mann & Stewart, 2021; Al-Ababneh, 2020). Epistemology is focused on the researcher-subject dyad and attempts to establish what can be known and how knowledge is achieved (Sol & Heng, 2022; Kivunja & Kuyini, 2017). It is necessary to comprehend the epistemological foundations, especially while working with sensitive issues such as mental health, where lived experiences inform the knowledge landscape (Scotland, 2012). Methodology, another fundamental aspect of a research paradigm, is the methods and ways of collecting and analysing data. It provides a structured guide for achieving the study's objectives (Creswell & Creswell, 2018; Kivunja & Kuyini, 2017; Rehman & Alharthi, 2016).

Table 3.1, informed by Turin et al. (2024), highlights the key aspects of five major research paradigms, reflecting their unique and complementary roles in social science research. While Blaikie and Priest (2017) identify various paradigms, the selected paradigms provide a foundational overview of philosophical stances for understanding and interpreting social phenomena.

Table 3.1: Summary of Key Aspects of Major Research Paradigms (Modified from Turin et al., 2024)

Paradigm	Ontology (Nature of Reality)	Epistemology (Nature of Knowledge)	Methodology (Research Methods)
Positivism	Objective, singular reality independent of perception	Knowledge derived from empirical observation and experience	Quantitative methods (e.g., experiments, surveys)
Interpretivism	Subjective, socially constructed realities	Knowledge gained through understanding individuals' perspectives	Qualitative methods (e.g., interviews, focus groups)
Constructivism	Multiple, socially constructed realities	Knowledge is constructed through interactions and experiences	Qualitative methods (e.g., case studies, narratives)
Pragmatism	Practical realities that depend on context	Knowledge is what works in practice; a blend of subjective and objective elements	Mixed methods (both qualitative and quantitative)
Critical Theory	Reality shaped by power structures and social injustices	Knowledge aimed at social change, challenging existing power structures	Qualitative and quantitative methods (e.g., participatory research, critical discourse analysis)

Before presenting the research paradigm, it is crucial to consider the factors that inform its selection. Herbert and Higgs (2004) state that a research paradigm must mirror the nature of the study and the socio-cultural processes that shape the participants' realities. This study, which investigated access to PPMH care in a peri-urban CHC from a socio-ecological perspective, needed a paradigm to capture the multifaceted influences that occur at individual, interpersonal, organisational, community, and societal levels. Herbert and Higgs (2004) also comment that ensuring congruence between study setting and research paradigm guarantees methodological fit with the research questions and flexibility to respond to evolving contextual determinants.

3.2.1 Constructivism

The current study is situated within the social constructivist worldview, which critiques traditional notions of objective reality and emphasises the subjective construction of knowledge (Boyland, 2019). Originating from various philosophical traditions, constructivism has significantly influenced fields such as psychology, education, and the social sciences, shifting paradigms of knowledge construction (Fosnot, 2013; Ültanır, 2012). Key philosophers like Immanuel Kant, Jean Piaget, and John Dewey have contributed foundational to this tradition. Kant argued that knowledge is actively constructed from sensory data, emphasising the observer's role in shaping reality (Danielyan, 2023; Hendrix, 2019). Focusing on cognitive development, Piaget highlighted the importance of active, experiential engagement with the world as central to knowledge acquisition (Martí, 2023; Amineh & Asl, 2015). Dewey, in turn, emphasised the precedence of experiential learning and lived experience in the process of knowledge building (Kolb, 2014).

In contrast to positivism, which regards knowledge as objective and external, constructivism asserts that knowledge is socially constructed and shaped by subjective interpretations and social interactions (Aliyu et al., 2014; Creswell, 2013). These early philosophical foundations paved the way for theorists like Vygotsky, who extended constructivism to social constructivism, emphasising the role of social interaction and cultural context in cognitive development (Chand, 2023; Liu & Matthews, 2005). Vygotsky’s theory of the Zone of Proximal Development (1978) stresses that knowledge development is facilitated through social interaction with more experienced individuals, a concept directly applicable to postpartum women’s interactions with healthcare providers (Vygotsky, 1978). These

interactions with the guidance of more knowledgeable individuals, such as healthcare providers, family members, and peers, help women construct meanings and beliefs about their mental health, influencing their experiences and perceptions of care.

Social constructivism further evolved with the work of Berger and Luckmann (1991), who proposed that social reality is co-constructed through everyday interactions, and Kukla (2000), who argued that conscious actions and individual beliefs influence social facts. Knowledge, therefore, is not fixed or universal but context-dependent, shaped by individual, social, and cultural factors (Andrews, 2012; Lincoln & Guba, 2000). This approach aligns with the SEM, providing a theoretical foundation for exploring how social contexts and interactions influence postpartum women's mental health experiences.

3.2.1.1 Ontological assumptions

Social constructivism challenges deterministic paradigms like positivism by positing that reality is not an objective, static entity to be discovered, but a dynamic construction shaped by social interactions (Burr & Dick, 2017). According to Crotty (1998), the social world must be understood as a construct rather than a discovery, highlighting the fluidity of knowledge and its co-construction through ongoing interpretation and social engagement. Reality, in this view, is not universal but is continually reshaped through interactions and interpretations, making it subjective and context-dependent (Creswell, 2013).

This ontological stance is particularly relevant to the current study, which seeks to understand how individual and social factors influence postpartum women's experiences with mental health care in the context of a CHC in a peri-urban setting in Gauteng Province, South Africa. By acknowledging that these experiences are deeply contextual, shaped by social norms, familial relationships, and cultural attitudes, the study embraces the idea that multiple, situationally dependent realities exist. Thus, the study does not attempt to uncover universal truths but instead explores the varying, co-constructed realities of postpartum women.

3.2.1.2 Epistemological assumptions

Social constructivism posits that knowledge is co-constructed through continuous dialogue between individuals and their social environments (Boyland, 2019). It rejects the idea of knowledge as an objective, observable truth, instead suggesting that understanding emerges

from the shared interpretations of experiences, with meaning constructed through individual perceptions and social interactions (Boyland, 2019). This aligns with Vygotsky's (1978) emphasis on the social nature of knowledge development, where learning is embedded within social encounters and cultural practices.

Furthermore, social constructivism acknowledges that knowledge cannot be separated from the knower, meaning that a researcher's experiences, worldview, and biases shape the knowledge produced (Guba & Lincoln, 2013). Reflexivity is crucial in this epistemology, encouraging researchers to examine how their perspectives influence the research process (Finlay& Gough, 2008). In qualitative research, this reflexive stance fosters a more empathetic and participatory relationship between the researcher and participants, encouraging open dialogue and shared meaning-making (Bourke, 2014; Liamputtong, 2007).

In the context of PPMH, this epistemological stance is critical, as it positions both the researcher and participants as co-creators of knowledge. Women's perceptions of mental health are shaped through interactions with family, healthcare providers, and social norms, making their understanding of PPMH fluid and influenced by their lived experiences. By embracing a constructivist epistemology, this study explores the complexity of these perceptions and their influence on women's help-seeking behaviours and engagement with mental health services.

3.2.1.3 Addressing the limitations of social constructivism

Social constructivism, although helpful in examining the subjective nature of knowledge, has several criticisms. There is a particular concern with its possibility of leading towards relativism, where any interpretation is regarded as equal and objective research is dismissed (Guba & Lincoln, 2013). The emphasis on the presence of multiple realities is challenging because it renders research findings harder to interpret and lowers the prospects for deriving conclusive or actionable recommendations (Boyland, 2019). Several measures were taken in this study to overcome these drawbacks and ensure that the ensuing results and conclusions provided actionable recommendations.

Analytic bracketing was employed to systematically put aside the researcher's biases in data collection and analysis procedures, thus facilitating interpretation of results through each level of the SEM instead of only from the researcher's perspective (Boyland, 2019). Secondly, having a critical stance during the research process required scrutinising assumptions and

power relations at all levels of the SEM (Boyland, 2019). This reflexive stance guarantees that the study does not accept the prevailing discourses on face value.

Constructivism's ontological and epistemological assumptions offer extensive insights for characterising qualitative research more profoundly, enabling further examination of human behaviours and societal phenomena. Nevertheless, researchers must critically consider their limitations so that the knowledge generated remains pertinent and valuable in the given context.

3.3 Qualitative Research Approach

Qualitative research approach comprises a variety of philosophical paradigms and methodologies related to the inquiry, analysis, and interpretation of social phenomena (Vaismoradi & Snelgrove, 2019). Qualitative methods have developed from colonial ethnographies to pluralistic and interpretive traditions, which indicate changes in philosophical thought and research paradigms (Pant, 2023). Based on subjectivist ontology and relativist epistemology, qualitative research values subjective realities of human understanding and views the interdependent relationship between researcher and participant (Wicks & Whiteford, 2003). It has allowed for the analysis of experiences through the eyes of those who experience them (Urcia, 2021). Qualitative methods have been used in health services research for variable identification, instrument development, and theory refinement (Tripp–Reimer & Doebbeling, 2004).

This study employed a qualitative approach in examining complex and individual postpartum women's and healthcare providers' experiences in everyday contexts. Relative to quantitative research that aims for numerical information, qualitative approaches enable the collection of rich explanatory descriptions (Tracy, 2024; Bergin, 2018). This approach is appropriate to the aims of this study since it provides rich data regarding the determinants of access to PPMH care (Creswell & Poth, 2018). Due to its emphasis on subjective experience and meaning, qualitative research enables a more profound comprehension of healthcare providers' and postpartum women's perceptions (Creswell & Creswell, 2018; Babbie, 2016).

3.3.1 Justification for Qualitative Research

3.3.1.1 Exploring phenomena in natural settings

Qualitative research is particularly suited for exploring phenomena within their natural settings (Lim, 2024; Austin & Sutton, 2014). It contributes to an understanding of individual

experiences and helps investigate the meanings that participants assign to such experiences (Lim, 2024; Austin & Sutton, 2014). In this study, interviews happened in real-life settings of participants, whether at work, home, or other settings where participants felt at ease. This type of research also permitted observation and discussion within a comfortable environment for the participants, enabling further insight. Authenticity is critical in qualitative research in that it could substantially influence the credibility of results. Conducting interviews with relaxed respondents can restrict social desirability bias, an effect where respondents alter responses to fit presumed norms (Harrison et al., 2001).

Furthermore, the researcher plays a central role in qualitative studies, acting as both the data collector and interpreter. According to Yin (2016), the researcher's emotional intelligence, observational skills, and interviewing expertise are critical in shaping the data collection process. Throughout this study, the researcher actively conducted interviews, using a semi-structured interview protocol to guide conversations; this allowed the researcher to probe deeper into participants' responses, clarifying ambiguous statements and exploring emerging themes, which enriched the overall data quality.

3.3.1.2 Faithfulness to participants' voices

A fundamental principle of qualitative studies is a commitment to preserving participants' authentic voice (Rana et al., 2023; Lyons et al., 2013). The researcher focused on documenting participants' words, expressions, and meanings, and on representing them faithfully and truthfully (Nieuwenhuis, 2016). Realising that perfect objectivity cannot be achieved, authenticity was sustained through an attempt to minimise bias.

3.3.1.3 Flexibility in data collection

Qualitative research is also characterised by inherent flexibility, whereby the researcher can modify their strategy in response to unfolding data (Lim, 2024; Hennink et al., 2020). Flexibility was critical in this research in that it allowed the researcher to adjust follow-up questions and discussion areas depending on the answers provided by the participants. With the aid of a semi-structured interview guide, the researcher facilitated an interactive dialogue in which the participants could articulate themselves without being limited by structured questions. Fouché et al. (2021) observe that such an approach promotes a natural flow of interaction, vital for developing more insight into the participants' experiences.

The researcher's adaptability also facilitated the establishment of rapport with the participants, thereby building a safe and protective environment in which they felt at ease sharing sensitive details regarding their mental health and interactions with healthcare (DeJonckheere & Vaughn, 2019; DiCicco-Bloom & Crabtree, 2006). This element of qualitative research is especially crucial when dealing with vulnerable populations, such as postpartum women, as it promotes information sharing.

3.3.2 The Role of the Qualitative Exploratory Approach

This study adopted a qualitative exploratory research approach. As Denzin and Lincoln (2000) highlight, exploratory research is invaluable for examining phenomena that are comparatively new or less explored. Exploratory research is most appropriate in identifying emergent concerns, formulating new hypotheses, and making initial interpretations that can be utilised to guide subsequent research studies (Kurzhals, 2021). Apart from that, this type of research facilitates subsequent research by promoting new ideas, theories, and models (Reiter, 2017; Stebbins, 2001).

The exploratory approach aligns closely with the constructivist paradigm underpinning this study. When a phenomenon is underexplored, such as the experiences of women in peri-urban areas seeking PPMHcare, there are few established data and frameworks to explain it. The constructivist stance complements the exploratory design by allowing meaning to be constructed from participants' narratives. Together, they support a contextually grounded understanding that reflects how individuals interpret and make sense of their experiences within their specific social and cultural environments.

3.4 Research Design: Case Study

Research design is the crucial link between study implementation and research questions, merging research purpose, theoretical background, setting, and data collection methods into a logical structure for enabling systematic inquiry (Nieuwenhuis, 2016). The structure is particularly crucial in qualitative research, which examines phenomena rooted in tangible contexts and firmly influenced by socio-cultural factors. Qualitative research can employ a range of designs (see below Figure 3.1), including narrative research, phenomenology, grounded theory, ethnography, and case study research (Creswell & Creswell, 2018).

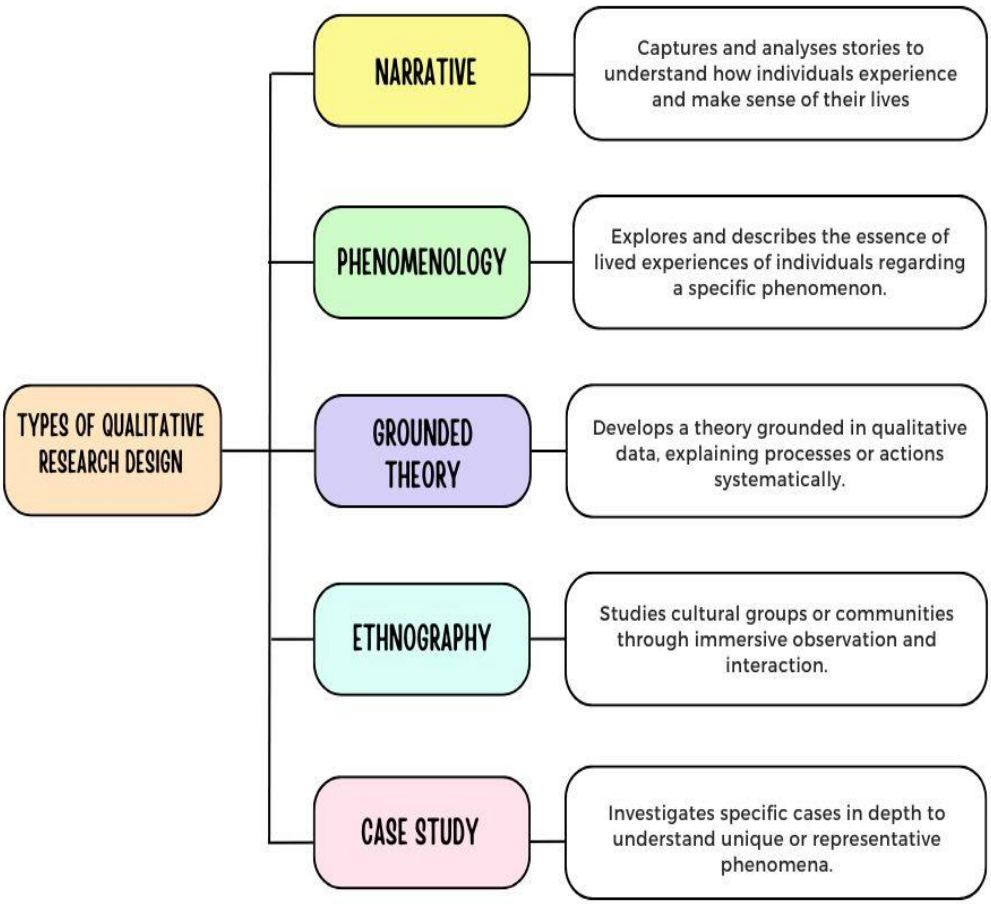


Figure 3.1: Summary of Qualitative Research Designs and Their Primary Focus Areas (Modified from Creswell & Creswell, 2018)

Within qualitative research design, case study design has been selected as it can offer an in-depth analysis of access to PPMH care within the participants' natural environment (Campbell-Clarke, 2023; Crowe et al., 2011). Yin (2016) notes that a case study is a qualitative method that enables detailed examination of a phenomenon in its real-world context, particularly if it is not feasible to separate it from its environment. The case study design is often chosen when the researcher is focused on addressing "how," "why," and "what" questions (Yin, 2018). The design aims to investigate complicated phenomena in their naturalistic settings (Gustafsson, 2017; Baškarada, 2014; Creswell, 2007). It has been widely used in health research to study interventions, barriers to service delivery, and policy implementation, offering practical knowledge to enhance health outcomes (Campbell-Clarke, 2023).

Case studies can be utilised to investigate phenomena that are challenging to measure since they provide detailed explanations of individual circumstances (Morse & McEvoy, 2014). Case studies concentrate on the interaction between variables affecting specific phenomena (Lucas et al., 2018) and allow theoretical frameworks to be established and implemented, as in the SEM implemented in the current study (Ebneyamini & Moghadam, 2018). In this study, the "case" is the peri-urban CHC in South Africa, a bounded context within which the availability and accessibility of PPMH care are being investigated (VanWynsberghe & Khan, 2007). Figure 3.2, adapted from Kass et al. (2024), illustrates several kinds of case study designs, including intensive single case studies, multiple case studies, in-depth, extensive multiple case studies, mini multiple case studies (MMCSS), and marginal case studies. It gives a brief overview of each design's distinct features and usage, facilitating the determination of this study's most suitable case study design.

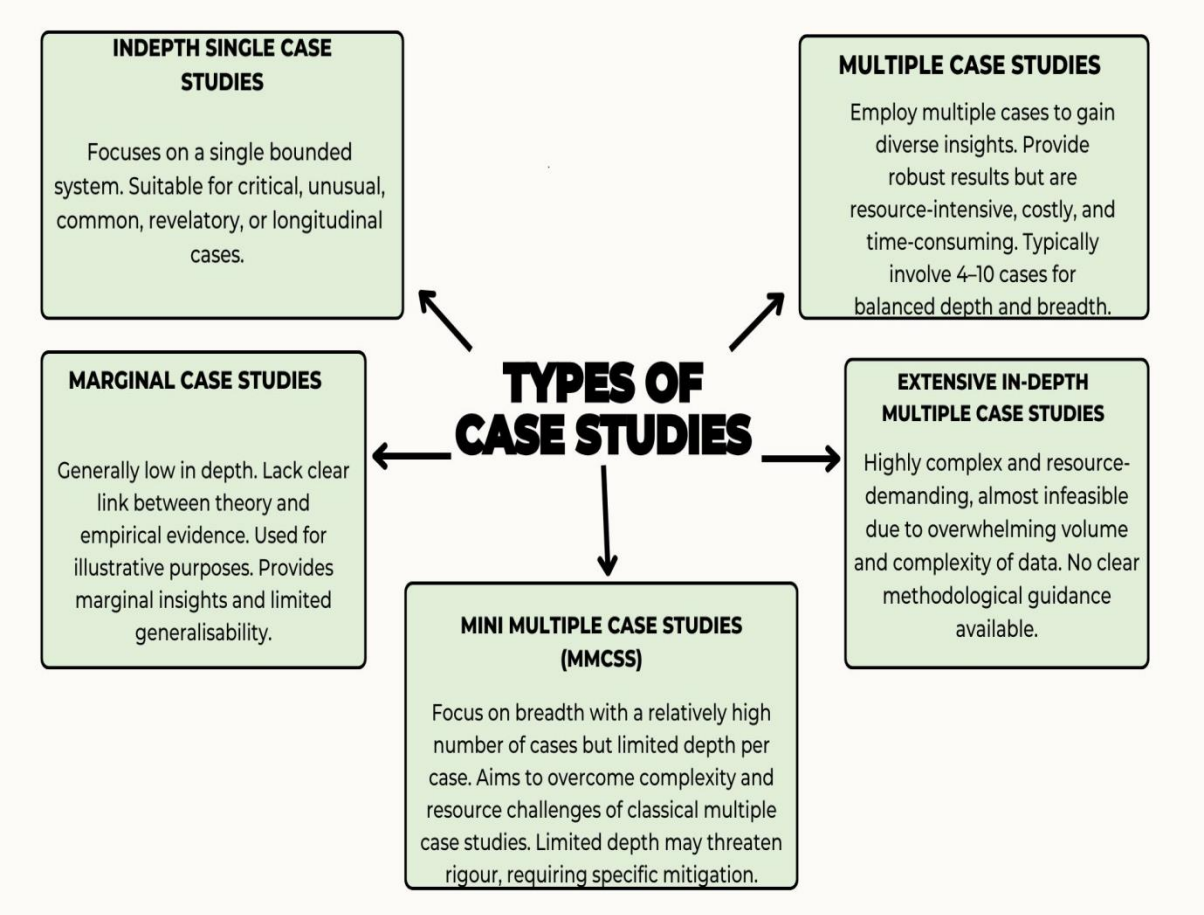


Figure 3.2: Overview of Case Study Designs (Modified from Käss et al., 2024)

This study used a single-case study research design to explore access to PPMH care at a CHC. A single-case study, as outlined in Figure 3.2, is particularly suitable when the case is critical,

unusual, common, revelatory, or longitudinal (Kass et al., 2024). The chosen CHC is a crucial case because of its strategic importance in understanding systemic facilitators and barriers to PPMH access in a peri-urban South African setting. Additionally, it is a revelatory case because it provides insight into a population and setting that have been comparatively under-researched in the literature. This strategy enables detailed, context-specific analysis while reconciling time and resource limitations. (Lobo et al., 2017). The study setting aligns with Yin's (2016) assertion that case studies are most appropriately used for analysing phenomena in their natural setting, where the researcher exercises minimal control over the events but may potentially gather rich, contextual data.

Case studies can have various purposes, and researchers commonly classify them into different types depending on their research aims. Yin (2018) distinguishes descriptive, exploratory, explanatory, and illustrative case studies. Descriptive case studies provide detailed accounts of phenomena within their real-life contexts, focusing on portraying events, processes, and experiences as they occur rather than examining causal links (Yin, 2018). In contrast, explanatory case studies examine cause-and-effect relationships to understand why or how a phenomenon occurs (Yin, 2018). An exploratory case study design is employed in the current study. An exploratory case study design is an initial phase that lays the groundwork for theory development and subsequent studies (Yin, 2018). Exploratory case studies are beneficial in reducing uncertainty about different elements of an intervention, deciding how to measure outcomes, identifying implementation issues, and informing public health programme development and its evaluation (Nallala et al., 2023; Moore et al., 2018). In line with this, the present study contributed to understanding implementation issues in service delivery, aligning with its research objectives and addressing a critical knowledge gap in peri-urban healthcare access.

3.4.1 Limitations in Case Study Research Design

Case studies, as one of the qualitative research designs, share certain limitations that are peculiar to them compared to other research designs. These are based on the character of single case studies, which concentrate on an in-depth examination of some phenomena in their real-life setting. Among the common limitations reported in case study research is generalisability (Tight, 2017; Miles, 2015). Yet, Polit and Beck (2010) contend that one of the defining features of exploratory, single case studies is that they are not typically designed to yield generalisable

findings. Its purpose is not the universal application of findings across different settings or populations; rather, it is to achieve a rich understanding and interpretation. Since generalisation is not the goal, the emphasis moves from generalisability to transferability. Transferability is the degree to which conclusions reached in a single case could be judged to be applicable or relevant to similar settings or contexts (Lincoln & Guba, 1985). This will be further elaborated later in the chapter.

Another limitation of case study design is the potential for researcher bias. The researcher's views and interpretation could significantly influence the analysis and conclusions drawn from the data (Acar-Ciftci, 2020). To mitigate researcher bias, data triangulation was employed by collecting information from two distinct sources – interviews with healthcare providers and postpartum women – cross-referencing these findings with relevant literature to enhance the credibility of the results (Bans-Akutey & Tiimub, 2021; Carter et al., 2014). Reflexivity was also maintained throughout the research process by reflecting on the researcher's positionality and acknowledging potential biases that could affect interpretation (Holmes, 2020; Creswell, 2013). Furthermore, an audit trail was established to systematically document the rationale behind data selection and theme development, thereby increasing transparency of the analysis process and reinforcing the credibility of the findings (Carcary, 2020; Wolf, 2003).

Furthermore, case studies are also time- and resource-intensive. Case studies' complexity requires in-depth data collection and analysis, often taking significant time and resources (Hancock et al., 2021; Paddock et al., 2018). To prevent the case study from being resource-demanding, its scope was deliberately limited to highlight important themes relevant to the research question and objectives instead of encompassing all case elements (Hartley, 2004). This strategic move served to facilitate the use of resources in a more effective and concentrated way. The challenges created by time and resource constraints were mitigated by employing these changes.

3.5 Research Setting and Case Selection

The research area was a township within the Sedibeng District Municipality in the Gauteng province, which comprises three municipalities: Emfuleni, Midvaal, and Lesedi. The area was purposefully selected because of its peculiar socioeconomic and health challenges, including governance. According to Massyn et al. (2020), aggregated district-level data for Sedibeng indicate that a large proportion of households are female-headed (34.7%–37%), with high

unemployment rates (26.4%–31.9%) and a high proportion of the population without matriculation certificates (42.5%–66.1%). These socioeconomic disparities are key social determinants of health with far-reaching effects on overall health outcomes, including mental health (Elwell-Sutton et al., 2019; Omotoso & Koch, 2018).

Maternal and child health statistics from Sedibeng District Municipality underscore the significant challenges the local community faces. Although antenatal care utilisation is relatively high, with 71% of the women attending their first antenatal visit before 20 weeks of pregnancy, postnatal care utilisation remains notably poor. Only 55.6% of the mothers received postnatal care within six days of delivery, the lowest rate among Gauteng's five municipalities, and well below the national average of 70.9% (Massyn et al., 2020). This disparity raises concerns about the accessibility and quality of postpartum care services in the district. Infant and neonatal mortality rates are also high in the district, with the under-five mortality rate at 11.3% as opposed to the nation's 4.7% (Massyn et al., 2020). The rates reflect the need to correct systemic issues in paediatric healthcare services.

Compounding the maternal health challenges in Sedibeng are systemic gaps in the provision of mental health care. Robertson and Szabo (2017) highlighted critical shortcomings in the district's mental health system, including a shortage of specialist personnel, such as psychiatric nurses and social workers. These deficits are further exacerbated by chronic under-funding and poor integration between general practice and CMHS, resulting in fragmented care and limited accessibility. Inadequate numbers of case managers and a scarcity of residential facilities contribute to the inability of CMHS to meet community needs effectively. These challenges underscore the urgent demand for increased resource allocation and stronger service integration across the Sedibeng District Municipality.

Against this backdrop, selecting a CHC within the Sedibeng district for this study was strategic, given its unique combination of systemic challenges and service delivery strengths. The CHC offers an integrated continuum of maternal health care services, including screening and support for PPMH, which makes it an ideal site for examining both barriers and enablers of PPMH care in a peri-urban context. Prior research has identified high rates of postpartum depression in similar South African communities, where mental health outcomes are significantly shaped by social determinants (Kathree et al., 2014).

3.6 Data Collection Methods

3.6.1 Semi-Structured Interviews

This study's primary data collection method involved semi-structured interviews, which involved two distinct semi-structured interview guides: one for healthcare postpartum women (see Appendix 1) and the other for healthcare providers (see Appendix 2). Semi-structured interviews are a widely used qualitative data collection technique that combines the consistency of structured interviews with the flexibility of unstructured ones (Karatsareas, 2022; Roulston & Choi, 2018). Structured interviews follow a fixed set of questions asked in the same order across all participants, typically comprising pre-established questions in binary yes/no or multiple-choice questions (Karatsareas, 2022). Alternatively, unstructured interviews are interactive in nature, with no predetermined questions, thus allowing the participants to provide lengthy and detailed responses (Zhang & Wildemuth, 2009). Thus, semi-structured interviews allow the researcher to explore specific topics while remaining open to emergent issues through probing (Karatsareas, 2022).

This approach was specifically suitable for the current research because it enabled rich, in-depth data on participants' experiences and perceptions of PPMH to be collected. Using an interview guide with open-ended questions, the researcher encouraged the respondents to share their subjective experiences and perceptions in their own words (DeJonckheere & Vaughn, 2019; Guest et al., 2017). The flexible nature of semi-structured interviews allowed for follow-up and clarifying questions, facilitating a more in-depth exploration of themes that emerged during the conversation. (DeJonckheere & Vaughn, 2019; Guest et al., 2017). This method proved particularly appropriate for discussing sensitive topics such as PPMH, where participants may feel more comfortable disclosing their experiences in a non-judgmental, empathetic environment (Adams, 2015).

3.6.1.1 Limitations of semi-structured interviews

Semi-structured interviews have the advantage of combining the flexibility of unstructured interviews with the systematic approach of more structured methods. Nevertheless, several limitations must be acknowledged and addressed to enhance the reliability and validity of data collected.

One of the key concerns is the potential of interviewer bias, which may arise through leading questions or even subtle verbal or non-verbal cues that influence participants' responses (Diab

& Al-Azzeh, 2024; Kühne, 2023; Cairns-Lee et al., 2022). To circumvent this issue, interviewers must be trained to be neutral and not share their own opinions. In addition, employing a well-designed interview guide with aptly worded questions can reduce bias by ensuring that all the respondents answer the same questions in the same manner, thus reducing the room for external influence.

Another limitation is the susceptibility of self-reported data to social desirability bias, especially when discussing sensitive topics such as mental health. Participants may tailor their responses to align with perceived social norms rather than expressing their true feelings or experiences (Irvine et al., 2013; Bispo Júnior, 2022). Ensuring confidentiality and fostering a secure environment are necessary actions to mitigate this type of bias (Bergen & Labonté, 2020).

Lastly, while the open-ended nature of semi-structured interviews allows for deeper exploration, it can sometimes produce disorganised and difficult-to-analyse data (Kallio et al., 2016). To avert this challenge, it is recommended to use a structured interview guide initially, with pre-established questions as well as space for themes to arise that can be probed. The continuous refinement and modification of the guide according to formative results improve its effectiveness (Kallio et al., 2016).

3.6.2 Development of Semi-Structured Interview Guides and Pretesting Phase

The two semi-structured interview guides (see Appendix 1 and Appendix 2) were based on a comprehensive review of the relevant literature, which facilitated the identification of key themes and commonly explored questions aligned with the research objectives (Boraie & Gebril, 2015). Academic supervisors subsequently reviewed initial drafts of the guides to assess the clarity, coherence, and relevance to the research aims.

Following the development of the initial draft, the semi-structured interview guides were pretested with three participants representing the two target populations: one healthcare provider and two postpartum women, who shared characteristics similar to those of the intended study population. The pretest aimed to evaluate the interview guides' effectiveness in eliciting meaningful and relevant responses and identify any issues related to ambiguity or lack of relevance in the questions (Bhalla et al., 2023; Hurst et al., 2015). The pretest scripts were not included in the main analysis. Guided by input from pretest participants, a number of changes were made to the guide. Questions were rewritten to ensure that respondents would

understand them as originally intended, and changes were made to prevent leading questions while encouraging openness rather than closed answers. Prompts were included in some questions to elicit more complete answers, and the sequence of questions was adjusted to improve the logical flow of the interview. These adjustments ensured that questions were unambiguous and capable of obtaining data consistent with aims of the research.

3.6.2.1 Interview duration

The duration of the interviews was estimated to be between 30 and 45 minutes, allowing sufficient time for the researcher to nurture the relationship with the participants to enable the participants to share their experiences and provide detailed insights (Young et al., 2021; Ortiz, 2015). This standardised timeframe ensured that all participants were given an equal opportunity to contribute while respecting their time constraints.

3.6.2.2 Language considerations

The interviews with the postpartum women were conducted in either Sesotho or English to facilitate effective communication and accommodate the language preferences of the participants. This approach aligns with Stats SA (n.d.), which reported 76. 4% of the residents in the study area are Sesotho speakers. Conducting interviews in a language most familiar to participants was intended to foster a more natural expression, reduce the risk of misinterpretation, and enhance the accuracy of the data collected. Given that South Africa has 11 official languages, with English not being the most spoken, Brown and Sprague (2021) proposed that future studies in perinatal mental health should increasingly incorporate indigenous languages to capture culturally embedded expressions of distress better. This is also supported by van den Berg (2016), who notes that current research tends to focus on a limited number of languages and regions, suggesting a need for more linguistically inclusive studies to address persistent communication problems.

3.6.3 Sampling Strategy

3.6.3.1 Purposive sampling

For this research, purposive sampling was employed to select individuals who possessed certain qualities or attributes relevant to this study's objectives (Palinkas et al., 2015; Tongco,

2007). Purposive sampling or judgmental sampling is a type of non-probability sampling that allows the researcher to deliberately select participants who are particularly knowledgeable about or experienced with the phenomenon of interest (Ahmed, 2024; Palinkas et al., 2015).

3.6.3.2 Justification for purposive sampling

To justify the use of purposive sampling, it is important to contrast it with other sampling methods.

Random sampling is a form of probability sampling where every member of the population has an equal opportunity to be selected (Bhardwaj, 2019; Acharya et al., 2013). It is well suited for studies that generalise findings to the broader population (Noor et al, 2022). However, in the context of this qualitative study, random sampling would likely result in the inclusion of individuals without specific postpartum experiences or healthcare perspectives needed to explore the research issues in depth.

Stratified sampling involves dividing the population into homogeneous subgroups (strata) and selecting a random sample from each subgroup (Sharma, 2017; Acharya et al., 2013). While this approach allows for representativeness across key subgroups (Schreier, 2018; Tipton, 2013), this case study prioritised in-depth understanding over representativeness. Stratified sampling was inappropriate for capturing postpartum women's and healthcare providers' nuanced experiences in the selected CHC context.

Convenience sampling involves selecting participants based on ease of access, availability, or willingness to participate (Lopez & Whitehead, 2016; Sedgwick, 2013). While this sampling method is inexpensive and time-efficient, it may not yield participants who are best positioned to provide relevant and insightful information. Thus, convenience sampling lacks the methodological rigour required for in-depth qualitative inquiry (Etikan, 2016).

Purposive sampling was utilised because it enabled the researcher to select participants most likely to yield rich, relevant, and diverse data (Campbell et al., 2020; Palinkas et al., 2015). This method ensured the inclusion of individuals who had direct and relevant experiences (Etikan, 2016). As a well-established strategy in qualitative research, purposive sampling enables the researcher to reduce irrelevant variation and focus on information-rich cases that align closely with the research objectives (Palinkas et al., 2015; Smith & Noble, 2014). The study captured current insights and reflected on contemporary experiences and challenges by selecting women who had recently gone through the postpartum phase. Additionally, including

healthcare providers directly involved in postpartum care allowed for a more comprehensive understanding of the care environment, integrating both the perspectives of the service recipients and those delivering the services.

3.6.3.3 Inclusion criteria for participant selection

For the research to elicit relevant information, participants needed to meet the inclusion and exclusion criteria indicated in Table 3.2:

Table 3.2: Inclusion and Exclusion Criteria for Postpartum Women

Inclusion Criteria	Exclusion Criteria
Must be a resident of the township served by the CHC.	-
Effort made to enrol women within the common reproductive years (19 and older).	Excluded if younger than 19 years.
Must be within six months postpartum to align with the defined postpartum period.	Excluded if more than six months postpartum at the time of the interview.
Should have received antenatal care, delivered the baby, and attended postnatal check-ups at the CHC.	Excluded if they did not receive antenatal care.
Must have given informed consent to participate in the study.	-
Must be proficient in either Sesotho or English to ensure effective communication during the interview.	-
Well enough to participate in interviews	Excluded if suffering from severe conditions that impair communication or informed consent.

Table 3.3: Inclusion and Exclusion Criteria for Healthcare Providers

Inclusion Criteria	Exclusion Criteria
Must be currently working at the CHC in the township.	-
Should have had direct contact with postpartum women during postnatal care or providing mental healthcare.	Excluded if not involved in service provision for postpartum women.
Must be willing to provide views and be able to communicate in English or Sesotho.	-

The inclusion and exclusion criteria were designed to recruit participants who would be capable of providing information relevant to the study's objectives. Ten postpartum women were selected based on having recent postpartum status, residence within the catchment area of the CHC, use of maternal healthcare services, and language capacity, to enable their experiences to align with the research context. Similarly, eight healthcare providers were included based on their active involvement in postpartum care, guaranteeing their perspectives were directly related to the barriers and facilitators in PPMH service delivery. These criteria facilitated the elicitation of focused, contextually relevant data while excluding individuals whose circumstances might impede effective participation or detract from the study's scope.

3.6.4 Participant Selection and Recruitment

Effective recruitment of participants played a crucial role in ensuring the reliability and quality of data collected (Bonisteel et al., 2021). In the current case study, the researcher implemented a participant recruitment approach developed in consultation with the staff members at the CHC, who had direct access to potential participants during postnatal consultations. These included postnatal nursing staff and mental health professionals. The recruitment process was designed with privacy and confidentiality in mind (Gyure et al., 2014). To ensure these standards were met, the researcher implemented confidentiality agreements with the staff responsible for recruiting postpartum women. These agreements specified how the participants' personal information would be handled, ensuring that it was kept confidential and used for the study. Furthermore, clear protocols were established to protect the participants' privacy throughout the research process.

Informed consent was a principal aspect of the recruitment process of the study participants (Hoverd et al., 2021; Robinson, 2014). The researcher requested that the CHC staff facilitate an open, ethical, informed process. The staff provided the prospective participants with a study brief, explaining the study's purpose and the voluntary nature of their participation. Subsequently, the researcher provided a comprehensive description of the study, clarifying the participants' concerns or questions. The process also highlighted the right of the participants to refuse or withdraw from participating in the study at any moment without any adverse consequences. Only after participants fully understood the aims, procedures, and potential risks and benefits of the study was informed consent formally obtained from them.

3.6.5 Data Collection and Saturation

Because of the inherent nature of qualitative research and case study design, data saturation was the primary determinant of sample size. Data saturation to the point where no new themes or insights emerge from the data (Naeem et al., 2024; Saunders et al., 2018). The researcher continued recruiting participants until data saturation was realised, ensuring that the data collected were sufficiently rich, comprehensive, and reflective of all the key themes relevant to the research objectives.In this study, a total of 10 postpartum women and 8 healthcare providers were interviewed. Using saturation as a guiding principle strengthened the study's rigour and ensured that the study was robust and exhaustively explored the phenomenon under investigation.

3.7 Data Analysis

3.7.1 Thematic Analysis

Thematic analysis was employed in data analysis. It is one of the most widely used techniques in qualitative data analysis as it enables the researcher to systematically identify, organise, and interpret meaningful patterns or themes within the data (Naeem et al., 2023; Clarke & Braun, 2017). It provides a rigorous yet flexible framework for making sense of complex qualitative information (Terry et al., 2017; Crowe et al., 2015). This research specifically used the ATA approach, which integrates empirical data with theoretical insights to derive plausible and meaningful interpretations of the phenomena under investigation (Thompson, 2022). Abductive analysis values both data-driven and theoretical perspectives, ensuring that

interpretations are grounded in the participants' experiences and informed by relevant conceptual frameworks (Thompson, 2022).

3.7.1.1 Application of Abductive Thematic Analysis

ATA (Thompson, 2022) was utilised in the current study. This iterative and flexible methodology integrates inductive findings from the participants' experiences with theoretical insights to inform the interpretation of the findings.

(a) Step 1: Transcription and Familiarisation

All the interviews with postpartum women and providers were transcribed. Then the researcher familiarised herself with the data by thoroughly reading the transcripts and noting recurring patterns related to barriers to and facilitators of accessing mental healthcare. Early observations included patterns of cultural norms and provider attitudes.

(b) Step 2: Coding

Descriptive codes such as "Support," "Awareness," and "Stigma" were assigned to relevant segments of the data. An iterative coding approach was then employed to review and refine these preliminary codes, allowing for categorising related codes into broader categories. For example, codes like "awareness" and "support" were grouped under a higher order theme, such as "knowledge and awareness", which was identified as critical for understanding socio-ecological factors influencing access to PPMH care. This process allowed the researcher to move from descriptive to more analytical coding aligned with the SEM.

(c) Step 3: Codebook Development

A codebook was developed to ensure consistency and rigour in the coding process. Each code was defined and accompanied by drawing from the data to illustrate its application, helping to standardise the interpretation of complex themes such as "relational support" from both the perspectives of postpartum women and healthcare providers (see Appendix 3).

(d) Step 4: Development of Themes

Relationships between codes were examined to construct more abstract and generalisable themes. For example, “lack of awareness” and “lack of knowledge” were grouped under the broader theme “Knowledge and Awareness Barriers,” reflecting an individual-level factor influencing healthcare-seeking behaviour. This categorisation was closely aligned with the overall research focus on barriers to and facilitators of access to PPMH care.

(e) Step 5: Theorising

The themes were mapped onto the SEM, enabling analysis across multiple levels – individual, interpersonal, organisational, community, and societal. This step provided a theoretical lens for interpreting how structural and personal factors collectively shape access to PPMHS during the postpartum period.

(f) Step 6: Comparison of Datasets

Themes were compared across participant groups to explore similarities and differences in perspectives. For example, postpartum women frequently cited tangible challenges such as transportation difficulties, whereas healthcare providers emphasised the systemic issues, like the need for additional mental health training and resource constraints.

(g) Step 7: Data Display

The thematic network analysis, as explained by Thompson, was used to illustrate the relationships between the themes identified. The process enabled an understanding of how significant themes connect to healthcare accessibility. The relationships between the themes were analysed to understand the thematic structure of the data, as well as the SEM of PPMH.

(h) Step 8: Writing Up

The findings were organised according to the major themes, each supported by illustrative quotations from participants. The final write-up emphasised how the themes collectively contribute to a better understanding of the multifaceted barriers to and facilitators of access to PPMH care.

3.8 Ensuring Trustworthiness in Qualitative Research

Qualitative research needs thorough consideration of the complexities involved in data collection, analysis, and interpretation, since it is subjective and contextual (Morse, 2015). A successful approach to addressing such complexities necessitates using measures that boost credibility, reliability, transferability, and confirmability, guaranteeing qualitative research's quality and trustworthiness (Lincoln & Guba, 1985).

Credibility is defined as how well the findings truly represent participants' experiences and views (Stahl & King, 2020). A key strategy used to enhance credibility was data triangulation, which employed two diverse data sources: postpartum women and healthcare providers, to verify the findings (Carter et al., 2014). Reflexivity was also key to establishing credibility, prompting constant critical scrutiny of researcher biases, so that they would not unduly influence the analysis (Peddle, 2022). Data triangulation and reflexivity are discussed in detail later in this chapter.

Dependability refers to the consistency and reliability within and across different study contexts (Rose & Johnson, 2020). This was attained by systematically documenting the research process, including detailed descriptions of data collection and analysis (Nowell et al., 2017). Using an audit trail enhanced transparency by providing a clear record of the researcher's decisions and analytical reasoning, enabling others to assess the study's methodological rigour (Carcary, 2020).

Transferability refers to the degree to which research findings can be transferred to other contexts (Rose & Johnson, 2020). This aspect was ensured through thick descriptions concerning the research setting, the characteristics of the participants, and contextual matters (Stahl & King, 2020; Shenton, 2004). By offering elaborate descriptions, readers can assess the relevance and significance of findings to their case (Drisko, 2024). Transferability provides pertinent information applicable in corresponding contexts (Drisko, 2024). As an example, the findings of this research have potential transferability to other Free State or Gauteng peri-urban CHCs with predominantly Sesotho-speaking clients and similar socioeconomic and structural issues.

Confirmability reduces the researcher's bias and ensures that the study's conclusions are grounded in participants' data rather than personal assumptions or interpretations (Lim, 2024). To this end, the researcher employed data triangulation, alongside a reflexive approach.

Reflexivity enabled the researcher to critically interrogate her positionality and the possible influence of personal biases on the research process, thereby contributing to the transparency and validity of the findings (Muthanna & Alduais, 2023; Olmos-Vega et al., 2023). A detailed account of the researcher's positionality is presented later in this chapter. The integration of these strategies supported the production of findings that are not only confirmable but also credible, dependable, and transferable.

3.8.1 Triangulation of Data

Triangulation is a key research strategy in qualitative research used to enhance the credibility and trustworthiness of findings by cross-checking and comparing data from at least two independent sources or methods (Aguilar Solano, 2020; Carter et al., 2014). Triangulation strengthens validity by reducing bias and increasing the robustness of conclusions (Aguilar Solano, 2020; Johnson et al., 2020). Denzin (1978) identified four kinds of triangulation:

1) Data triangulation involves comparing data across different participants, times, and settings.
2) Investigator triangulation, wherein multiple researchers contribute to data interpretation to minimise individual biases.
3) Theory triangulation, which entails analysing data through multiple theoretical lenses.
4) Methodological triangulation involves using multiple data-collection methods.

Data source triangulation was employed in this study by collecting information from postpartum women and healthcare providers. This allowed the researcher to cross-check perspectives, identify consistencies or discrepancies, and develop a more comprehensive understanding of the factors influencing access to PPMH care (Flick, 2018; Carter et al., 2014). By drawing on multiple sources, the study reduced reliance on any single viewpoint and enhanced the findings' overall trustworthiness and contextual richness.

3.8.2 Reflexivity

Reflexivity is a key element in establishing credibility in qualitative research. It involves scrutinising the researcher's role, position, and impact throughout the study (Palaganas et al., 2017; Kingdon, 2005). It involves critical self-reflection on how assumptions, bias, values, and positionality may affect both the research process and its outcomes (Olmos-Vega et al., 2023;

Palaganas et al., 2017; Mao et al., 2016). Reflexivity promotes validity and integrity by continuously examining these elements (Palaganas et al., 2017; Mao et al., 2016).

In this research, reflexivity was central to the insight that knowledge is socially constructed through collaborative work between the researcher and the participants, founded on mutual experience, meaning, and understanding (Rodriguez & Ridgway, 2023; Arvay, 2003). The researcher actively attempted to exercise reflexivity of their position and how their worldview shaped the research process (Olmos-Vega et al., 2023; Patnaik, 2013). A lack of reflexivity would decrease the face validity of a study; therefore, its presence is necessary to provide rigorous findings (Thurairajah, 2018; Probst, 2015).

Olmos-Vega et al. (2023) propose four kinds of reflexivity that assist in comprehensive research:

- Personal reflexivity, where researchers consider their expectations, assumptions, and reactions and understand how these might shape the research process.
- Interpersonal reflexivity considers relationships and relative power between the researcher and the research participants.
- Methodological reflexivity entails critically examining the methodological decisions taken and how these reflect the research paradigm.
- Contextual reflexivity pertains to the importance of being aware of the cultural and historical context of the research and how this affects the study.

All three types of reflexivity highlight the importance of ongoing reflection and ethical issues to ensure that the study is conducted accurately and yields credible findings.

3.8.2.1 Strategies to enhance reflexivity

To enhance reflexivity, researchers use a range of strategies to increase self-awareness, critically examine assumptions, and reduce the influences of personal biases during the research process (Olmos-Vega et al., 2023; Patnaik, 2013). These include ongoing self-reflection, peer debriefing, maintaining a reflexive diary, conducting member checks with participants to validate interpretations, and engaging in multiple viewpoints through interdisciplinary or interagency collaboration with stakeholders in the communities (Olmos-Vega et al., 2023; Smith et al., 2014).

3.8.2.2 Reflexive journaling

Reflexive writing through memos, field notes, and journaling enables systematic documentation of evolving insights, decisions, power dynamics, and contextual influences in research. The researcher utilised journaling as the key reflective strategy to manage emotional responses, monitor and address personal biases, maintain objectivity, and refine interviewing techniques across data collection phases (Mishra & Gupta, 2024). This practice fostered transparency and intention in the research process, supporting both analytical depth and researcher well-being (Olmos-Vega et al., 2023).

3.8.2.3 Applying the positionality framework

Positionality is critical to qualitative research, particularly for new postgraduate researchers who must engage in reflexive practice to articulate their evolving positionality. This includes recognising their multiple insider-outsider positions and understanding how these identities influence data collection and interpretation (Holmes, 2020). The positionality framework proposed by Patnaik (2013) guided the reflective engagement throughout the research process. It explores how the researcher's personal and professional background shaped various aspects of the research. The application of this framework is detailed below.

(a) Self-awareness

As a black woman who grew up in a peri-urban township in post-apartheid South Africa, I witnessed firsthand the long-term psychological impacts of political violence and social inequality. My father's loss of family members during the apartheid era and the intergenerational trauma that followed deeply influenced my understanding of mental health and its social determinants. These lived experiences, coupled with my familiarity with the harsh socio-economic conditions many vulnerable groups face, shaped both my commitment to mental health advocacy and my research interest in the well-being of vulnerable populations.

This research topic emerged from these personal experiences and was further refined by my supervisors. They helped me narrow my broad interest into a focused, academically viable inquiry with real-world relevance. My values of empathy, social justice and a strengths-based approach to mental health, rooted in both personal and professional domains, informed how I conceptualised the study and engaged with participants.

(b) Reflexivity

My identity as a black woman and mother from a similar peri-urban cultural and linguistic background significantly shaped how I approached the research. These shared aspects foster rapport and trust, particularly when exploring sensitive experiences such as PPMH.

Being a mother, researching the postpartum experiences of other mothers allowed me to connect deeply with participants' joys, anxieties and challenges. However, this shared identity also required critical reflexivity to avoid projecting my own experiences onto the participants. I remained conscious of the need to distinguish between shared empathy and over-identification, ensuring that participants' individual stories remained central.

My professional background as a social worker and mental health practitioner gave me a systemic lens to interpret the narratives. While this training enabled a compassionate and informed approach, I remained vigilant against inadvertently reinforcing power imbalances or allowing professional knowledge to overshadow the lived experiences shared with me. Throughout the research, I aimed to balance professional insight with openness to participant meaning-making.

(c) Insider/outsider roles

My familiarity with the community's language, values and socio-economic challenges positioned me as both an insider and an outsider. I held an insider identity that helped me to build rapport, trust, and mutual understanding. However, my role as a researcher and mental health professional also positioned me as an outsider. I maintained boundaries and was an outsider to the community and its challenges. In managing these dual roles, I was intentional about setting boundaries. While participants saw me as an ally or confidant, I maintained professional distance, avoided influencing responses, and did not conflate the research role with a counsellor or advisor. Where appropriate, I provided referrals to relevant services while safeguarding the integrity of the research process.

(d) Impact on research

As a Black African trained in biomedical models of mental health but also grounded in indigenous worldviews, I navigated a complex research identity. Initially, my biomedical background inclined me toward understanding mental health through a Western lens. However,

my commitment to decolonial and contextually relevant approaches led me to reflect critically and challenge this bias. Through this reflection, I realised that some postpartum practices initially perceived as "unscientific" were culturally grounded support mechanisms. This dual awareness enabled a more holistic analysis that respected both scientific and cultural paradigms.

I used member checks to ensure the accuracy and validity of the findings and triangulated across various data sources. My participant-centred approach, an extension of my professional training, ensured that participants' voices remained at the heart of the research.

(e) Dynamic nature of positionality

My understanding of the barriers and facilitators of postpartum mental health service access evolved throughout the study. Initially, I viewed the different levels of the SEM – individual, interpersonal, organisational, community and societal as distinct. However, as I collected and analysed the data, I realised the complexity and interplay between the levels.

A key realisation was the influence of cultural norms across multiple levels. Practices I initially saw as community-level factors were also deeply embedded in interpersonal relationships, particularly in shaping support systems. This made me view the socio-ecological framework not as a hierarchy of separate levels, but as an interconnected web of influences on PPMH. I also recognised that the same factor could be a barrier and a facilitator depending on the context and personal experience.

In the early stages of the research, I became aware of a paternalistic tendency stemming from my professional background as a social worker. Despite my training in collaborative, person-centred approaches, I occasionally found myself interpreting the research through a lens of what I thought would be best for the participants. Acknowledging this bias prompted a shift. I re-centred participants' narratives and ensured that their perspectives, not my professional assumptions, guided the research findings. This reflexive stance was vital to maintaining ethical integrity and responsiveness in the study.

3.9 Ethical Considerations

In the present research, several ethical principles were maintained to safeguard the participants' rights, welfare, and confidentiality. Ethical principles in research are regulations and guidelines that seek to promote the treatment of participants with respect, fairness, and integrity (Ketefian, 2015; Vanclay et al., 2013). These regulations follow the basic principles outlined in the

Belmont Report (1979), highlighting the importance of respect for persons, beneficence, and justice.

3.9.1 Ethical Clearance

Before the study began, ethics clearance was obtained from the University of the Free State General/Human Research Ethics Committee (see Appendix 4). Ethics clearance is necessary as it protects the rights and well-being of the research participants and guarantees that the research is conducted ethically. It also makes the research more credible and trustworthy (Yesuf, 2024). The ethics clearance was done by submitting a full research proposal that was screened to determine any prevailing ethical concerns to ensure protection of the participants' rights and welfare, aligning with what is stipulated in the Belmont Report (1979), which articulates the need for ethical review of research to minimise undue risks to subjects and ensure that the research is conducted ethically.

3.9.2 Gate Keeper Approvals

The concerned authorities acquired all the required permissions, including the Gauteng DoH and the CHC (see Appendix 5). All these approvals were needed to ensure compliance with institutional and regulatory standards and to gain access to the research site and its members. Obtaining approval entailed assuring the gatekeepers that the research objectives aligned with institutional policies and local regulations.

3.9.3 Informed Consent

The researcher conducted a written informed consent process, ensuring that the participants were adequately informed before the interviews. The healthcare provider presented a brief overview of the study, stating its purpose and voluntary participation during postnatal consultation with the mothers. Mothers willing to participate were referred to the researcher in a different room. There, the researcher provided detailed information about the study's objectives, procedures, risks, and benefits. The participants were also provided with the consent forms (see Appendix 6) and were allowed sufficient time to consider their participation before signing. Informed consent was sought for participation in the study and audio recording of the interviews. Interviews were conducted in a private room at the facility to ensure confidentiality.

For participants who preferred to be interviewed elsewhere, the researcher made follow-up arrangements to conduct the interviews at a time and location convenient for each participant and in a private and secure environment.

Participants were informed of their right to terminate their participation in the study at any point in time without penalty, and their attention was repeatedly drawn to this right. Participants were made aware that no benefit would result from participation and that they were at liberty to decline participation. Participants were reassured that their decision to participate would not impact the services they received in the CHC. This preparatory plan attempted to set expectations and avoid misunderstanding about the study. Following the ethical principles articulated in the Belmont Report (1979), particularly the principle of respect for persons, the study maintained the participants as independent individuals with the freedom to make independent decisions on their involvement, devoid of coercive pressure.

3.9.4 Confidentiality and Privacy

Bos (2020) defines confidentiality as the agreement between the researcher and participant that sensitive or private information will be treated with the utmost care, emphasising the importance of trust in this relationship. Confidentiality protects individuals' privacy and fosters participant trust (Kaiser, 2009). Participants' privacy and confidentiality were maintained during the research process.

As outlined in the Belmont Report (1979), respect for individuals emphasises the importance of safeguarding participants' privacy and autonomy. This principle was upheld through measures designed to protect sensitive information and maintain participants' dignity and privacy. The researcher implemented strategies to prevent disclosure of identifiable personal information, thereby mitigating potential risks of harm such as embarrassment or discrimination. Pseudonyms were used in all research documents and reports, with the exception of consent forms, to ensure participants' identities remained confidential. While pseudonyms were not feasible for signed consent forms, these forms were kept in a secure location separate from the research data, eliminating any direct link between participants' identities and their responses.

Confidentiality agreements (see Appendix 7) were signed by the researcher and the healthcare providers who assisted with participant recruitment, ensuring compliance with established ethical standards. All electronic files were stored on a password-protected computer to

safeguard participant data. Hard copies containing identifiable information were securely stored in lockable cabinets within the researcher's home. Access to both physical and electronic data was restricted exclusively to the researcher.

3.9.5 Non-Maleficence

Researchers have an ethical responsibility to safeguard participants' emotional well-being and to avoid actions that may lead to feelings of betrayal or distress during the research (Jelsma & Clow, 2005), requiring clearly defined roles, ongoing self-reflection regarding objectivity, and regular debriefing with colleagues. It is imperative in studies involving marginalised communities, where the risk of harm may be heightened. Researchers must also be prepared to make appropriate referrals to support services when necessary, and in certain situations, such as child abuse, to prioritise reporting of essential concerns over participant autonomy. These limitations must be communicated during the informed consent process (Jelsma & Clow, 2005).

The principle of beneficence, as outlined in the Belmont Report (1979), entails minimising harm and maximising benefits for the research participants. In this study, particular attention was given to the potential emotional or psychological distress that could result from discussing PPMH experiences. To reduce this risk, interviews were conducted in a secure, respectful environment that enabled open and safe disclosure. Participants who required mental health support were promptly referred to the mental health unit of the CHC. Furthermore, Lifeline Vaal was engaged and agreed to provide free counselling services to participants (see Appendix 8). Information about these services was communicated during the consent process and again during debriefing. Walk-ins were welcome at their facilities in the community, for those who preferred alternative methods, a 24-hour telephonic counselling service was also available. The researcher provided a direct referral form (see Appendix 9) to Lifeline Vaal, ensuring that the participants could receive immediate post-study support, if needed. Participants were encouraged to express any emotional discomfort during the interviews and were assured they could pause or terminate the interview at any stage. Their well-being was continuously monitored during the research process. These proactive measures exemplify the application of beneficence, ensuring that participants' emotional and psychological needs were prioritised.

According to Evrin (2021), risk assessment involves evaluating the likelihood, consequences, and acceptability of potential risks and forms part of a broader risk management strategy to implement appropriate control measures. Prior to data collection, a comprehensive risk analysis

was conducted to identify potential challenges and establish mitigation strategies to ensure the safety and integrity of the study.

Discussing sensitive topics such as PPMH can also strain researchers emotionally and psychologically. To uphold the ethical principle of beneficence, the researcher implemented protective measures for her own well-being. These included professional supervision and self-care practices like journaling, as Dickson-Swift et al. (2008) recommended. This attention to the researcher's mental health ensured that the study was conducted ethically and sustainably.

3.9.6 Participant Debriefing

In line with best practices, participant debriefing was conducted to safeguard participants' emotional, psychological, and physical well-being. The aim was to ensure that individuals left the research setting in a state at least equal to, if not better than, their condition prior to participation (McNally, 2017). After the interviews, participants were debriefed to provide further clarification about the study, respond to outstanding questions, and offer reassurance. During this session, the researcher provided further clarification about the study, addressed any outstanding questions, invited feedback on the interview process, and offered reassurance regarding confidentiality, the value of their contributions, and the availability of support should any distress arise from participation. Participants were also provided with information about available resources, including referrals to appropriate mental health services if needed.

3.10 Conclusion

This chapter described the research methodology used to explore the barriers to and facilitators of utilisation of PPMHS among postpartum women in a peri-urban CHC. The inquiry was framed in a social constructivist paradigm premised on the understanding that social interactions and contextual realities shape knowledge. A qualitative approach, employing an exploratory case study design, was used to capture the richness and complexity of participants' experiences. Data were collected through semi-structured interviews, which balanced structure with flexibility, allowing in-depth exploration of key issues. Thematic analysis was conducted within an abductive analytical framework informed by the SEM. This approach enabled the integration of theoretical insights and participants' perspectives, offering a nuanced understanding of PPMHS utilisation.

Methodological decisions were closely aligned with the objectives and research question and were well-suited to the broader health systems context. Strategies such as reflexivity and adherence to ethical study protocols enhanced the study's trustworthiness. The next chapter presents the study's findings, offering thematic data analysis and highlighting key barriers to and facilitators of accessing PPMHS.

CHAPTER 4 :
FINDINGS

4.1 Introduction

This chapter presents and discusses the study's findings regarding the availability of PPMHS in a peri-urban CHC in the Gauteng province. Data was collected from 5 December 2023 to 23 April 2024. The chapter first gives an overview of the participant demographics to contextualise the data collected. This is followed by the presentation of themes using the SEM, which discusses the barriers to and facilitators of accessing PPMHS at the individual, interpersonal, organisational, community, and societal levels. Each level comprises themes describing barriers to and facilitators of access to PPMHS. At an individual level, the findings highlight factors relating to knowledge, awareness, and personal beliefs. Interpersonal level findings refer to the importance of supportive familial relationships. Organisational themes refer to access to resources and logistical concerns. Community-level themes include prevailing attitudes and beliefs, both cultural and religious, and existing support mechanisms. Lastly, at the societal level, themes emphasise the importance of effective policy implementation coupled with extensive public health campaigns. The chapter concludes by summarising the main findings and emphasising key insights related to the CHC case study.

4.2 Presentation of Key Findings

4.2.1 Demographics of Participants

This section summarises the demographic characteristics of the postpartum women and healthcare providers participating in this study. These details offer important contextual information to frame the findings and discussions on PPMHS delivery. A total of 18 semi-structured interviews were utilised in this study, comprising ten (10) postpartum women and eight (8) healthcare providers.

4.2.1.1 Demographics of Postpartum Women

Table 4.1 summarises the demographics of postpartum women who participated in the study.

Table 4.1: Demographics of Postpartum Women

Characteristic	Category	Frequency (n)
Age (years)	20–25	2
	26–30	3
	31–35	2
	36–40	3
Education	Grade 12 or higher	7
	Diploma	1
	Short courses/certifications	2
Employment	Unemployed	4
	Self-employed	3
	Formally employed	3
Marital Status	Married	6
	Single	3
	Divorced	1
Number of Children	1	3
	2	3
	3	2
	4	2

4.2.1.2 Demographics of Healthcare Providers

Table 4.2 summarises the demographics of healthcare providers involved in PPMHS at the CHC and the identifiers used in participant quotes throughout the study.

Table 4.2: Demographics of Healthcare Providers (n = 8)

Qualification Type	Mental Health Training	Frequency (n)	Relevance to PPMHS	Identifier
Primary-level mental health qualification [Registered counsellors or Social workers (SW)]	Academic training in mental health and psychosocial support	1	Can provide basic mental health assessment, counselling, and referral within primary care (Health Professions Council of South Africa, 2024; Social Service Professions Act 110, 1978).	C
Nursing qualification with mental health component	Academic modules including mental health	3	Able to identify and respond to PPMH symptoms, perform basic screening, and provide education (SANC, 2019).	RN+MH
Nursing qualification without mental health training	None	1	Limited ability to identify or respond to PPMH issues; may refer cases to other providers (Phungula et al., 2024)	RN
No formal healthcare qualification (e.g., CHWs)	None	3	Supports PPMHS indirectly through health education, community engagement, or administrative tasks Roux et al., 2020).	CHW

4.2.2 Summary of Themes and Sub-themes

The analysis of interviews with postpartum women and healthcare providers identified several barriers and facilitators to accessing PPMHS. These themes are categorised accordingly to the SEM framework of individual, interpersonal, organisational, community, and societal levels. Table 4.3 outlines identified themes and sub-themes of the current study to give an overview prior to the presentation of findings.

Table 4.3: Summary of Themes and Sub-themes

Level	Themes	Sub-themes	
Level	**Themes**	**Barriers**	**Facilitators**
Individual	Knowledge and Awareness	Lack of understanding of PPMDs	Healthcare provider knowledge and clinical observation; Raising awareness of available PPMHS
Individual	Personal Beliefs and Attitudes	Internalised stigma and misconceptions surrounding PPMDs	Addressing self-stigma and myths surrounding PPMDs
Interpersonal	Relational Support	Lack of spousal/partner support; Extended family influence limiting help-seeking	Partner involvement encouraged by healthcare providers; Supportive role of family in promoting help-seeking
Organisational	Resource Adequacy	Inadequate availability of mental health professionals; Inadequate routine screening for PPMH; Insufficient mental health training among maternal healthcare providers	On-site availability as a facilitator; Proactive and integrated screening practices
Organisational	Logistical Factors	Transportation challenges affecting access	–
Community	Community Attitudes	Negative influence of norms and public perceptions	–
Community	Religious and Cultural Beliefs	Cultural, religious, and linguistic factors hindering access	Cultural, religious, and linguistic practices enhancing engagement
Community	Community Support Structures	Limited access to community resources	Recommended community engagement strategies

Societal	Policy and Systemic Issues	Challenges in policy implementation and effectiveness	Recommendations for improving policy implementation and effectiveness
Societal	Public Health Interventions	–	Proposed national initiatives to enhance access and service delivery

4.2.3 Individual Level Findings

4.2.3.1 Knowledge and Awareness

(a) Lack of understanding of PPMDs

Limited understanding of PPMDs among postpartum women at the CHC was identified as a barrier. Participants commonly reported uncertainty about the signs of mental health issues and whether professional support was needed. Emotional distress was often normalised as part of motherhood, and the lack of educational information made postpartum women unable to recognise when help was needed.

Illustrative quotes:

> *"I guess I haven't really thought about it... thinking about my own mental health support isn't something I usually do, I think I don't even know what to look out for, like the line between normal worries and depression and stuff."* (P-208_PPW [postpartum woman])

> *"I have to admit that I don't know much about mental health. I find myself just trying to manage everything and make things work without really thinking about whether my feelings are normal or maybe if I might need help, like just to know. Sometimes, I feel stressed or sad due to my circumstances, and while I always believed these thoughts were just about being a mom, I now see that understanding mental health better could help me to know when I need support or when someone else needs it."* (P-206_PPW)

> *"When I had my first baby, I didn't even know that feeling sad or overwhelmed could be something more than just being tired. I thought it was normal to feel alone, and scared sometimes."* (P-210_PPW)

Women's limited knowledge of PPMDs reflects gaps in individual-level PPMH literacy, contributing to delayed recognition and help-seeking.

(b) Healthcare provider knowledge and clinical observation

Healthcare providers reported that mental health education, observational skills, and trauma-informed care enabled them to recognise postpartum women experiencing PPMDs, including those who did not actively seek help. Awareness of subtle signs, such as self-neglect or neglect of childcare, allowed timely identification and support. Trauma-informed approaches were also emphasised as crucial for addressing overlapping stressors, including substance use and histories of violence, which complicate clinical presentations and affect psychosocial functioning.

Illustrative quotes:

> *"So, for you to be able to pick up, maybe to screen the patient for postpartum, let's say it's postpartum depression or whatever, you need to have the basics of mental health... at least it gives you the whole understanding of mental health, not only postpartum. Mental health is key."* (P-101_RN+MH)

> *"We are able to see that there is a problem... Such behaviour indicates a problem. We then analyse or observe their physical appearance. We are able to identify women who neglect themselves and their children."* (P-104_RN+MH)

> *"If a mother comes in with a problem of substance abuse, we always know that there's an underlying problem that we will try to tackle... Every day is a challenge just to survive... all these things really compound into anxiety and depression. Mothers don't know how to deal with all these issues. A lot of women who come here also have a history of violence emitted on them, sexual abuse, domestic violence, even at home, and so all these things compound into very serious psychological traumas and problems with these women."* (P-105_C)

Healthcare providers' knowledge and observation skills support a holistic, sensitive approach to PPMH care, ensuring that high-risk women are identified and supported.

(c) Raising awareness of available PPMHS

Healthcare providers reported that clear and simple communication was an essential facilitator for promoting access. They emphasised not only providing women with information about available services, but also supporting them to make their own decisions about whether and how to seek help. CHWs were identified as playing a critical role in this process, providing

health education, guidance, and follow-up support from the time of birth through the postpartum period, helping to bridge the gap between awareness and actual service use.

Illustrative quotes:

> *"You know everything can be improved. You know you need to go back to the basics. Explaining to the patient. There is improvement in that. You know, we think of big things. But if you inform the patient and arm them with information, so that they can be aware of these services. What are they doing, and what is mental health about, and how can they be helped?"* (P-101_RN+MH)
>
> *"So, what you find is that we try to support them. We try to teach them on issues related to mental health. However, it is up to them to decide to take the next step whether they will seek help because they are the ones who will now be the ones who need to make the initiative."* (P-104_RN+MH)
>
> *"We then offer health talk and offer advice on where they can find mental health assistance."* (P-107_CHW)

Raising awareness through education and guidance supports postpartum women in making their own decisions while promoting uptake of PPMHS, highlighting the dual role of healthcare providers in informing and guiding service users.

4.2.3.2 Personal Beliefs and Attitudes

(a) Internalised stigma and misconceptions surrounding PPMDs

Internalised stigma and misconceptions regarding PPMDs among postpartum women at the CHC were identified as key barriers to accessing mental healthcare. Participants commonly reported fear of seeking mental health support due to concerns about negative consequences, such as losing custody of their children, and pressure to appear emotionally strong. Societal and cultural expectations often led women to suppress their mental health needs to avoid appearing vulnerable or inadequate.

Illustrative quotes:

> *"If I knew that talking doesn't mean that I am, I mean like the baby is at risk or may be taken from me, then it would be easier…I feel like I'm supposed to be this superhero*

who never gets tired... it's hard when things don't go as planned. I feel like I'm failing." (P-207_PPW)

"So, they think that by going to the mental health department, it means you are mentally ill… You need to explain… it just means you will see our psychologist, there is a psychiatrist, and a social worker. They can assist you." (P-101_RN+MH)

"When they ask for help… they do not want others to know that they're seeking help because they feel that they automatically will not be living up to the cultural expectation of what a woman ought to be, which is a stronghold of the family." (P-102_RN+MH)

These findings demonstrate the pervasive influence of internalised stigma and cultural misconceptions on postpartum women's engagement with PPMHS.

(b) Addressing internalised-stigma and myths surrounding PPMDs

A strategy to reduce internalised-stigma and misconceptions about PPMDs is identified as a facilitator. A Healthcare provider reported that education clarifies that seeking mental health support does not indicate being "mentally ill" and that framing care as a proactive step toward wellness encourages openness.

Illustrative quote:

"So, they think that by going to the mental health department, it means you are mentally ill. So, you need to explain and say, no, me taking you there, it just means you will see our psychologist, there is a psychiatrist and a social worker. So, all of them can help you. They do different things and can also assist you by referring you so that you are ok. So, you need to explain to them because the very fact that you are going to say mental health, we are now dealing with stigma" (P-101_RN+MH)

This educational and reframing strategy support women in recognising the value of PPMHS, thereby facilitating timely help-seeking and engagement despite prevailing stigma and cultural misconceptions.

Figure 4.1 Illustrates how individual-level factors such as knowledge, beliefs, and attitudes toward PPMDS play a critical role in shaping engagement with PPMHS, highlighting how they can act both as barriers and enablers to seeking care in this case study.

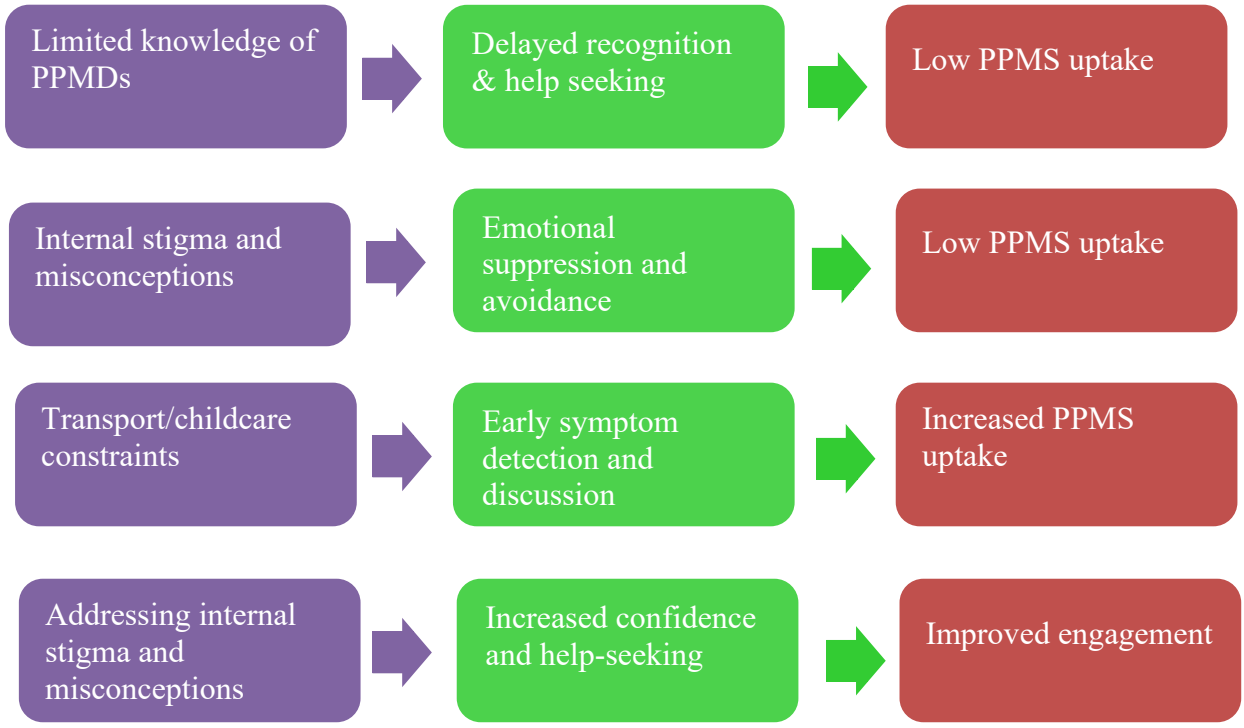


Figure 4.1: Illustration of how individual-level themes influence PPMHS uptake.

4.2.4 Interpersonal Level Findings

4.2.4.1 Relational Support

(a) Lack of spousal/partner support

Participants reported that partners often lacked understanding of the importance of mental health support or were emotionally unavailable due to work and other demands. Some women refrained from confiding in their partners for fear of being judged or perceived as a burden. Healthcare providers noted that absent or uninvolved partners negatively impacted the delivery of comprehensive postpartum care.

Illustrative quotes:

> *"My husband is there, but he doesn't understand the challenges, and sometimes he thinks I'm crazy."* (P-204_PPW)

> *"My husband had a different response when it came to getting mental health support… he didn't understand why I wanted to go to the clinic to talk about my feelings. He would say, Hai, these are your things, you can't just sit still at home."* (P-210_PPW)

"They are alone, and they lack support, especially from the fathers of the children. They are alone and have not fully accepted the presence of their children; most of the time, they came as an inconvenience, usually, they (the partners) *just take a back seat. So, they are dealing with all that, they are dealing with the added financial pressure."* (P-106_CHW)

Limited partner support reflects gaps at the interpersonal level, influencing women's opportunities to discuss or seek help for possible PPMDs.

(b) Partner involvement encouraged by healthcare providers

Healthcare providers reported that encouraging partners to accompany women to visits and engage during early signs of distress promotes emotional support, shared caregiving responsibility, and stronger parental bonds.

Illustrative quotes:

"We do encourage men to be actively involved, even from the time the women are pregnant."(P-104_RN+MH)

"With the partners, we will just try to encourage them to come with them when they come for visits, especially when we see a problem." (P-102_RN+MH)

However, the degree and quality of partner support as noted by a healthcare provider remain variable, influenced by socio-economic inequalities, cultural expectations around sex-based roles, and prevailing norms of masculinity. In some cases, not all forms of partner involvement are beneficial; they may even exacerbate maternal distress.

Illustrative quote:

"If we find that the mother has spoken of issues related to domestic violence, and even if the violence is at an emotional level, or we try to be very careful on how then we would bring in the father. In that case, we try to be very careful so that we do not put the mother's life at risk. So, it's not a matter of just bringing in or asking the father to come in. We have to do it in a way that does not put the mother at risk of being harmed by the very same people that we're bringing in."

While the encouragement of partner involvement in postpartum care is an important facilitator, it is also important to note the nuances that can adversely affect this engagement. This dynamic

reflects broader socio-cultural and relational factors that shape how support is provided and received.

(c) Extended family influence limiting mental health help-seeking

Participants reported that family support often focuses on practical care and spiritual or emotional guidance, rather than addressing mental health needs. Cultural beliefs and family advice, particularly from mothers and husbands, frequently encouraged reliance on faith and prayer, while formal mental health services were overlooked or minimised.

Illustrative quotes:

> *"Mental health, you know, my mother encourages me to always trust in God. Whenever I'm not feeling okay, she'll encourage me to read the Word of God, pray more, and she prays for me too. That's the help she gives me. And my husband also, he helps like that. But to support, they don't know about that. No one thinks about it, like mental health is seen as something that is important, but not as something that you can go to the clinic to get help with."* (P-205_PPW)

> *"The judgment doesn't just come from strangers only; it comes from family, too. My own mother would say things like, 'We didn't have these problems in our days.' That makes it even harder because you don't want to disappoint them."* (P-208_PPW)

> *"In our culture... mothers* [Mother of the postpartum woman] *will come in and take care of the baby and the [new] mother... to alleviate the physical load of motherhood... but as soon as that help is gone, most mothers* [postpartum women] *regress and most mothers go through a lot because now the strength that they were having is now suddenly gone."* (P-106_CHW)

Family beliefs and practices, along with stigma and minimisation of mental health struggles, create barriers that can discourage women from seeking professional care and increase feelings of isolation.

(d) Supportive role of family in promoting mental health help-seeking

Participants reported that emotional and practical assistance from family members, including parents and siblings, reduces isolation and encourages help-seeking. Families provide childcare,

reassurance, and guidance, making it easier for mothers to attend therapy and engage with PPMHS. Healthcare providers emphasised that involving family members in care can also reduce stigma by framing mental health as a shared family responsibility.

Illustrative quotes:

> *"Their willingness to help at all times, no matter what, it really shows me that they understand the challenges I go through as a single mom. It shows me every day that I'm not alone in this life. They always encourage me to spend time alone just to get some air, they are so concerned about me and my situation. My sister always tells me that it is ok to ask for help, they can help anytime, everyone needs help sometimes. I am sure that if I need to get any mental health assistance, they will support me without any problem."* (P-206_PPW)

> *"The young mothers stay with their parents. So, we will try to encourage the parents to forgive their children and to assist them. We always tell them that it's okay to be angry, but at some point, you have to forgive and push forward."* (P-102_RN+MH)

> *"We involved the family, we asked that the mother come in and they did, what ended up occurring was that there was a little group session and the mother also came to advise the children on how to conduct themselves."* (P-103_RN)

Figure 4.2 illustrates how family support in this case study plays a critical role in fostering maternal well-being and facilitating engagement with PPMHS, highlighting how it can function as a barrier as well as a protective and enabling factor.

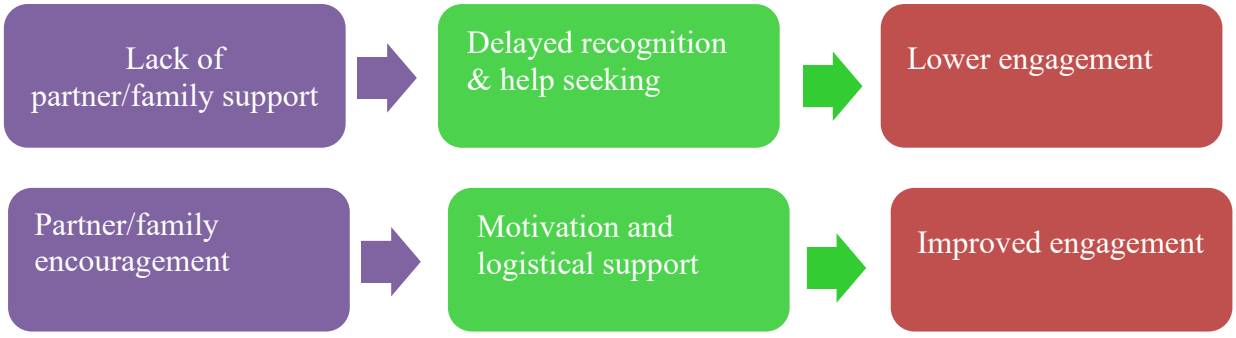


Figure 4.2: Illustration of how Interpersonal level themes influence PPMHS uptake

4.2.5 Organisational Level Findings

4.2.5.1 Resource Adequacy

(a) Inadequate Availability of Mental Health Service Providers

Both postpartum women and healthcare providers reported that the shortage of counsellors, social workers, and other mental health practitioners limits timely access to PPMHS, resulting in long waiting times and unmet mental health needs. Their limited numbers and inconsistent availability hinder service delivery at the CHC.

Illustrative quotes:

> *"We don't have enough staff... what we find is a high shortage of staff, professionals, and people who will be there to assist…The social worker doesn't come every day, so the resources are there, but they are not enough to accommodate everyone."* (P-106_CHW)
>
> *"I think having more mental health services, like counselling or support groups, would be really beneficial."* (P-201_PPW)
>
> *"Maybe have more nurses and counsellors at the clinic so that us mothers, if we need to see someone for our mental health, then we would not have to wait for so long."* (P-209_PPW)

Staff shortages at the CHC create delays in care, reduce service quality, and contribute to frustration among postpartum women seeking mental health support.

(b) On-site availability of mental health professionals as a facilitator

Healthcare providers reported that having psychiatrists, psychologists, mental health nursing specialists available ensures timely access to care and smooth referral pathways for postpartum women experiencing mental health challenges. The immediate availability of mental health staff reduces delays in care and allows women to receive support without having to seek services elsewhere.

Illustrative quotes:

> *"The Centre has a dedicated department, Mental Health, where women who have problems with psychiatry and psychiatric-related illnesses would go and get assistance."* (P-104_RN+MH)

"A mother will get help that she needs immediately. We can sometimes refer a mother immediately to see someone, and so it is just them being there available to assist." (P-102_RN+MH)

"That one patient was referred to the doctor, and the doctor then referred the woman to the mental health department." (P-103_RN)

On-site mental health professionals support integrated care at the CHC, ensuring postpartum women can access timely and appropriate interventions. These observations are supported by the *South African Health Services' Referral Policy and the Referral Implementation Guidelines* (2020), which stress the importance of cohesive referral systems to promote equitable and timely access to services.

(c) Inadequate routine screening for PPMH

This sub-theme highlights limited and superficial routine screening for PPMH at the CHC. Postpartum women reported that checklist-style assessments focus primarily on physical health and the baby, leaving little room to discuss emotional well-being. As a result, concerns about mental health are often overlooked, delaying identification and support for PPMDs.

Illustrative quotes:

"They asked me a lot of questions. But when it came to my emotions, it felt like they were trying, but they were also following a list – Are you feeling okay? Great, then they move on." (P-207_PPW)

"When I went there to the clinic, they ask me if I'm okay and if I'm coping, and I tell them I'm fine, I'm coping. And that's it. I don't remember anything else. They check the baby, if the baby's okay, the baby's gaining weight, the baby's healthy." (P-202_PPW)

"They ask you, 'Are you alright? Are you coping? Are you sleeping right?' but you just say yes." (P-203_PPW)

Inadequate screening practices reflect organisational-level gaps that hinder early detection of PPMDs and limit timely access to PPMHS.

(d) Proactive and integrated screening practices for PPMH

Healthcare providers reported that early identification of even a single symptom, combined with patient-centred screening and referral, enables timely intervention and prevents escalation of mental health issues. Training and education in mental health equip providers to recognise symptoms effectively, while integration of screening into routine postnatal care ensures continuous monitoring and holistic support.

Illustrative quotes:

> *"They (Mental health professionals at the CHC) teach us (CHWs) how to assist and counsel them... We also screen them on their mental health."* (P-107_CHW)
>
> *"We do offer the initial screening as part and parcel of what we do daily... we ask them about how they are doing, how are they coping, you know, the feelings and things like that."* (P-104_RN+MH)
>
> *"Yoh, it (tertiary level training) has assisted a lot because when we do this, it's like this is a comprehensive course (tertiary level training). So, for you to be able to pick up, maybe to screen the patient for postpartum, let's say it's postpartum depression or whatever, you need to have the basics of mental health…So even with just one symptom, we make it a point to refer them. It starts with you, then from there you carry this patient by hand."* (P-101_RN+MH)

Proactive and integrated screening at the CHC enables timely detection and support for postpartum women, ensuring mental health needs are addressed consistently within routine care.

(e) Insufficient mental health training among maternal healthcare providers

Non-specialist healthcare providers highlighted a systemic failure in the provision of proper workplace training, specifically in the fundamental skills necessary screen for PPMDs. The lack of structured mental health training not only hinders early detection and intervention but also leaves providers feeling incompetent to offer adequate support. Therefore, adding to continued underdiagnosis and unmet needs among postpartum women.

Illustrative quotes:

> *"No, sometimes they do send us to do short courses, but I personally have not attended on mental health, it is usually on TB or HIV"* (P-103_RN)
>
> *"Here? No, not really. We haven't received any courses on mental health. Not that I remember."* (P-106_CHW)

“Training on mental health is very important because we are the ones in the community, and we are often the first ones who seeing these things, we see mothers and how they attend to their children at home. So, if they give us more training, we can also know what to look for and refer to it.” (P-108_CHW)

The lack of mental health training reflect a systemic gap in preparing non-specialist healthcare providers to identify and refer for possible PPMDs.

4.2.5.2 Logistical Factors

(a) Transportation challenges affecting access to PPMH care

Ttransport related challenges were identified as a barrier affecting postpartum women accessing PPMHS at the CHC. Participants reported that time constraints, financial pressures, and managing childcare alongside long or uncomfortable commutes made attending appointments difficult. Crowded public transport, adverse weather, and the physical and emotional toll of travel added to these challenges, often leading women to prioritise other household needs over mental health care.

Illustrative quotes:

"Oh, getting to the clinic, that's a whole thing in itself, you know? First off, it's about finding the time. Like, I've got my hands full with the baby and my other kids, so just figuring out when I can actually go is a problem; we have to go in the morning. There's the whole money situation, so that day I have to budget for a taxi. Sometimes." (P-207_PPW)

"It’s not that far, I can walk to the clinic, but the problem is that the clinic – there’s appointments, they give you an appointment to go there and you queue and there’s other people who are getting help... I can go to the clinic once a month or so to vaccinate the baby, but I can’t go to the clinic again to see a counsellor or something. Like it will be too many visits, I can’t, I don’t have the time for that." (P-203_PPW)

"It's a bit of a trip, especially with a little one. So, because it is not always possible to walk with a baby, especially on rainy or cold days, I struggle and have to use public transport. With a little baby, it’s not easy. Sometimes the baby will be crying, then I have to breastfeed in the taxi, which sometimes is not ok, especially when, for example,

there is a man sitting next to you. So, for mental health, it would not be worth it, really." (P-209_PPW)

Transport challenges contribute to the de-prioritisation of mental health care compared to physical health needs among postpartum women at the CHC.

Figure 4.3 Shows how organisational level factors such as staff capacity, resource availability, and clinic accessibility play a critical role in influencing PPMHS uptake at the CHC, highlighting how positive organisational practices can enable access, while resource limitations and operational challenges can act as barriers.

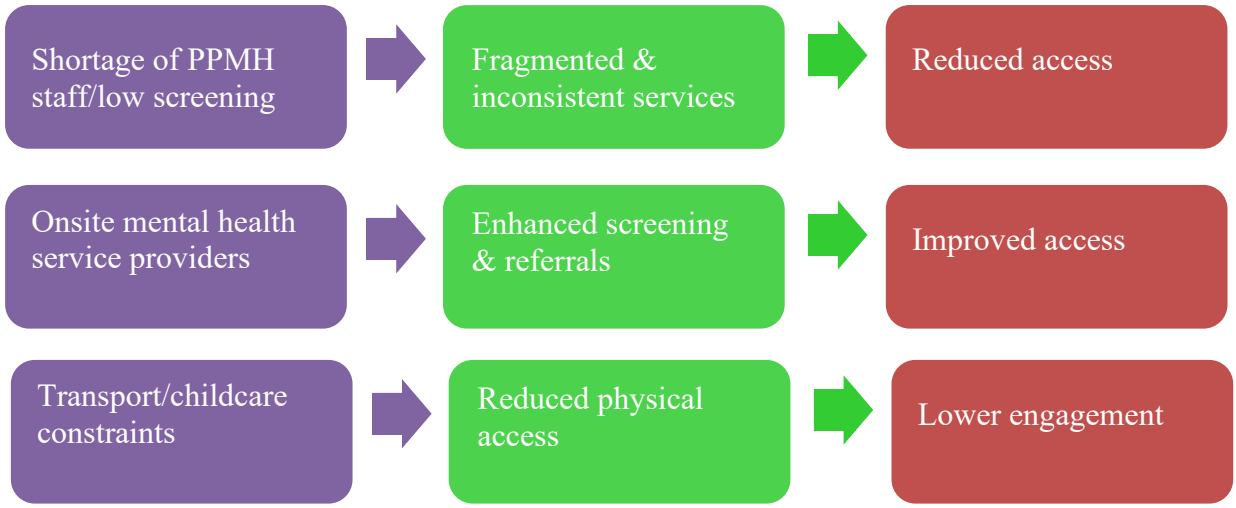


Figure 4.3: Illustration of how organisational-level themes influence PPMHS uptake.

4.2.6 Community Level Findings

4.2.6.1 Community Attitudes

(a) Negative influence of community norms and public perceptions on mental health-seeking

Negative communal attitudes and stigma towards PPMH was identified as a barrier by participants. Women reported fear of being perceived as weak or inadequate if they sought help, reflecting societal ideals of strength, independence, and sole responsibility in motherhood. Misunderstanding and lack of awareness about mental health, coupled with judgment from family and community members, discouraged help-seeking and reinforced misconceptions about PPMH.

Illustrative quotes:

“It’s this big thing that no one even dares to talk or think about, like if you admit you are struggling, you're weak, or something.” (P-207_PPW)

“Some of the negative comments I've heard include people saying things like, 'She just needs to get it together,' or 'She's being too dramatic.” (P-201_PPW)

“In our community, when a mom struggles after giving birth, it's not always easy for her to complain or let others know what is going on, like to talk about it, because they fear getting a negative reaction…There's this fear that if you go to the clinic for help, they’ll think you’re not fit to be a mother... The judgment doesn’t just come from strangers only; it comes from family too.” (P-209_PPW)

Negative community norms and public perceptions can strongly discourage women from seeking PPMH support, reinforcing stigma and delaying access to care.

4.2.6.2 Religious and Cultural Beliefs

(a) Cultural, religious, and linguistic factors hindering mental health-seeking behaviour

Barriers related to cultural, religious, and linguistic factors affecting postpartum women’s mental health-seeking behaviour at the CHC were also highlighted. Participants reported that spiritual or traditional beliefs may take precedence over clinical care, framing mental illness as an “affliction” rather than a medical condition. Language and cultural nuances were also noted to complicate communication, making clinical concepts less relatable and limiting understanding.

Illustrative quotes:

"The community doesn’t understand mental health. They think whenever someone has mental health, they need to go to church, they need deliverance, even if you just complain, they’ll just take you for deliverance." (P-203_PPW)

"So yes, the beliefs are that most of these challenges are spiritual first and foremost... when someone is not mentally okay, they think it's a spiritual or religious calling... they will try that first. And when that doesn't work, then they go to the clinic." (P-102_RN+MH)

"Language plays a role a lot... within our culture, there are rituals related to driving out evil spirits... If you do not fully understand the language and cultural context, you wouldn't understand what is being spoken about." (P-104_RN+MH)

Religious and cultural beliefs, alongside language barriers, act as significant obstacles to recognising PPMDs and seeking professional help, often resulting in delayed or untreated conditions.

(b) Cultural, religious, and linguistic practices enhancing engagement with PPMH Care

A Healthcare provider reported that acknowledging and integrating religious and cultural traditions, as well as accommodating language preferences acted as a facilitator by improving engagement and trust. Understanding naming conventions, cultural meanings, and communicating in the woman's preferred language enabled providers to build rapport and encourage more authentic expression of emotions.

Illustrate quotes:

"If the child's name is Sello... it might mean that a couple of things are meant. It means the context in which the child was born is linked either with some kind of grief, death of some kind or some kind of ill health. So, we start there, why is this child called Sello? ... then using the very same culture, how do we go about then making sure that this child receives the necessary support?" (P-105_C)

"Most women do prefer to be interviewed and sessions to take place in the language that they're comfortable with... being able to express yourself in a language that the client understands is very important. It plays a big role…" (P-105_C)

Culturally and linguistically tailored care can transforms potential barriers into facilitators, enhancing access to PPMH services and supporting more positive mental health outcomes.

4.2.6.3 Community Support Structures

(a) Limited access to community resources

The lack of knowledge about any structured, professional support systems for PPMH within the community as experienced by participants act as a barrier. Participants described a reliance on church-based organisations that provide spiritual guidance but little practical or emotional support. Healthcare providers emphasised the absence of government-led programmes and support groups designed for new mothers, reflecting a critical gap in community-level mental health infrastructure.

Illustrative quotes:

> *"There are no community programmes. I don't know anything in our community. When we need help, we go to church."* (P-203_PPW)

> *"The only thing that women do is... church groups, but otherwise, besides those church groups, and the church groups are for prayer... there's no groups that help mothers who have just given birth in those church groups. There's nothing like that."* (P-205_PPW)

> *"I think that the government should have support groups for mothers in our communities where they can meet up and discuss their problems with each other. Maybe if it is a separate facility."* (P-107_CHW)

The absence of formal community programmes leaves postpartum women dependent on informal networks that may offer limited psychological and emotional support, reinforcing disparities in access to PPMHS.

(b) Recommended community engagement strategies

While participants could not identify existing facilitators, they suggested practical ways to enhance awareness and support through community-driven initiatives. Community leaders, religious groups, and local organisations were viewed as key partners in promoting dialogue, reducing stigma, and strengthening mental health literacy.

Illustrative quotes:

> *"The government must work with community leaders, with churches especially... imagine things like gatherings where mothers lead discussions."* (P-207_PPW)

"Maybe if our government can work with like churches and... community forums, community groups where mothers can help each other, talk to each other, give each other advice and things like that." (P-205_PPW)

"If the health centre could run community awareness campaigns, maybe through local radio, social media, or community meetings, it would help." (P-208_PPW)

Figure 4.4 is an illustration of how community level influences identified in this study which include cultural norms, stigma, and local awareness play a critical role in shaping maternal engagement with PPMHS, highlighting how supportive community attitudes can facilitate uptake, whereas stigma and misconceptions can hinder access.

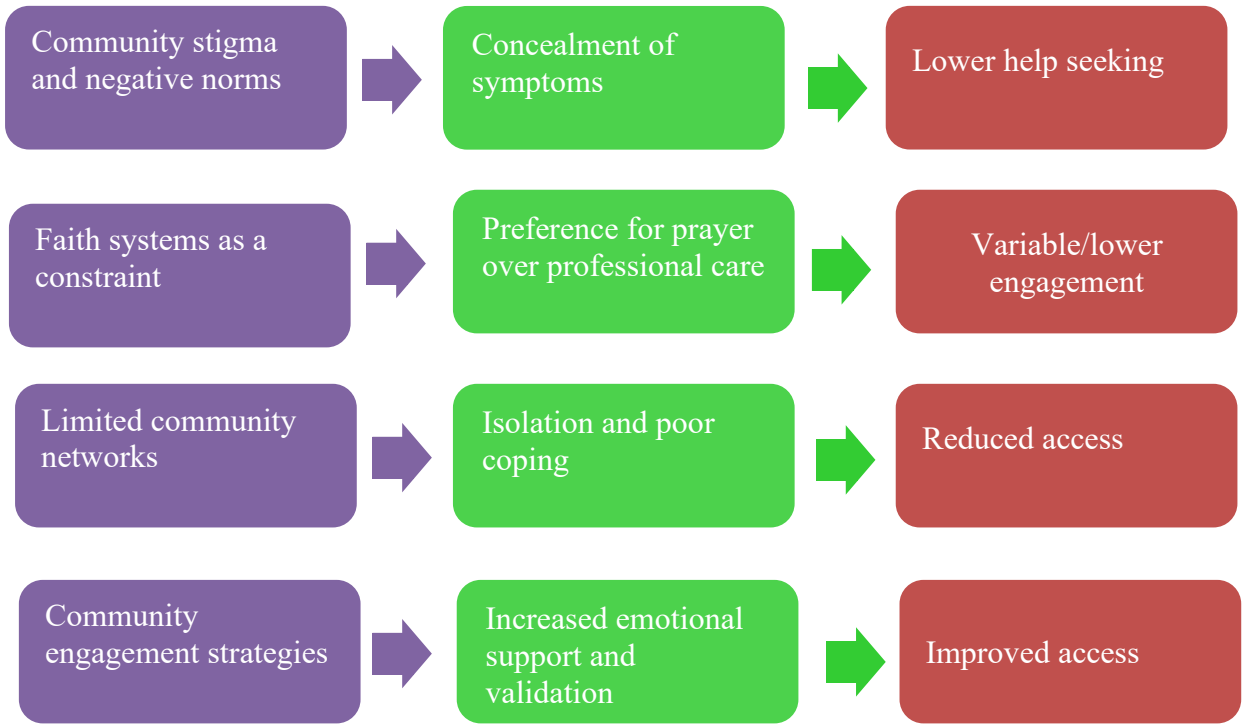


Figure 4.4: Illustration of how Community level themes influence PPMHS uptake

4.2.7 Societal Level Findings

4.2.7.1 Policy and Systemic Issues in PPMH care

(a) Challenges in policy implementation and effectiveness

Gaps were highlighted in the implementation of PPMH policies at the CHC. Healthcare providers reported that mandatory mental health screenings are often performed for compliance rather than genuine assessment, leading to missed opportunities for early intervention. They

also expressed concern that policy development is overly centralised, with limited input from frontline providers, resulting in policies that are difficult to operationalise at the facility level.

Illustrative quotes:

> *"The first basic one, it should be a policy to screen every woman, like now it is a policy because even in our data there is a section that you need to tick that you have screened this patient, but remember it shouldn't go with a tick, I've screened for mental health and that is it."* (P-101_RN+MH)

> *"There should be a way of saying that if you have screened all of them, really, we need to pick up something. You can't screen a hundred patients for mental health, asking all those questions and what have you, but at the end of the day, you didn't pick up even a single one."* (P-101_RN+MH)

> *"The policies are usually a top-down, they take a top-down process, and so those on the ground are not usually consulted to fully understand the extent of the problem. It's always the ones at the top who come and make the decisions for everyone at the bottom."* (P-105_C)

These findings point to the need for context-specific policy development processes that incorporate inputs from the frontline service providers.

(b) Recommendations for improving policy implementation and effectiveness

Healthcare providers did not highlight any specific facilitators related to PPMH policies and their implementation of PPMH policies. Rather, a healthcare provider, gave a recommendation on how to improve the policy implementation process at the CHC. They highlighted the importance of having measurable indicators in the implementation of mental health policies to evaluate the effectiveness of screening efforts. Metrics such as the number of patients screened and the prevalence of diagnosed mental conditions can help determine whether policies are achieving their intended outcomes.

Illustrative quote:

> *"There should be indicators that are monitored to say, okay, for mental health, we have seen so many numbers of patients and then we have screened so much, and then how many have we identified?"* (P-101_RN+MH)

The emphasis on measurable outcomes highlights the need for data-driven approaches to monitor policy impact.

4.2.7.2 Public Health Interventions

(a) Proposed national initiatives to enhance access and service delivery

Participants suggested strategies such as home visits, virtual consultations, and educational outreach to make care more accessible and responsive to women's needs. Home-based visits were seen as supportive and less intimidating, while telephonic or online check-ins provided flexibility during the demanding postpartum period. Participants also emphasised the importance of simple, accessible mental health education through pamphlets, posters, and social media platforms such as WhatsApp. Integrating more mental health professionals into communities was viewed as essential for bridging cultural gaps and building trust.

Illustrative quotes:

> *"I think implementing programmes where providers can visit moms at home and check on them after giving birth could be good."* (P-201_PPW)
>
> *"Maybe if we can call someone, someone who will not be judgmental, who will just advise us... a psychologist or social worker can come see us, talk to us, because we don't have time to be going to a clinic with the baby."* (P-203_PPW)
>
> *"If they had pamphlets or even posters in a language we can understand, that explained things, it could really help. Maybe also share WhatsApp videos on mental health."* (P-207_PPW)

These perspectives highlight a collective call for more flexible, community-linked, and information-driven approaches that align PPMH care with the realities of women's everyday lives.

Figure 4.5 illustrates how societal-level factors such as policy frameworks, legislation, and systemic structures play a critical role in influencing access to PPMHS, highlighting how effective policies can enable uptake, while gaps in implementation, funding, and enforcement can act as barriers as highlighted in this study.

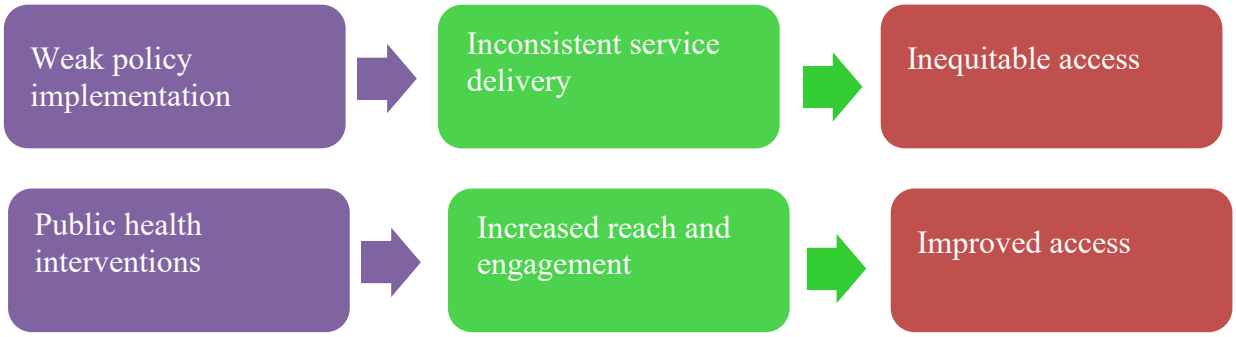


Figure 4.5: Illustration of how Societal level themes influence PPMHS uptake.

4.3 Conclusion

This chapter provided a comprehensive understanding of the barriers and facilitators influencing access to PPMHS at the peri-urban CHC studied, framed within the SEM. Thematic analysis revealed interconnected factors across the individual, interpersonal, organisational, community, and societal levels that shape postpartum women's access to mental health services. At the individual level, knowledge gaps, beliefs, and misconceptions about mental health were prominent. Interpersonal relationships played a crucial role in service uptake, particularly the presence or absence of social support. Organisational barriers such as resource constraints and limited operational hours further impacted access. At the community level, community and societal levels, prevailing attitudes and policy gaps added additional complexity. These insights provide a foundation for Chapter 5, which draws conclusions from the findings and offers practical, evidence-informed recommendations to address the identified challenges. The following chapter will focus on translating these findings into actionable strategies to enhance access to PPMH for postpartum women.

CHAPTER 5 :
DISCUSSION

5.1 Discussion of key Findings

This chapter provides a discussion of the study's findings, structured according to the key themes that were identified from the analysis. Each theme is examined in relation to existing literature and relevant theoretical frameworks. The discussion highlights the individual, interpersonal, organisational, community, and societal factors influencing access to PPMHS, exploring how these factors function as either barriers or facilitators.

5.1.1 Discussion on Individual Level Factors

5.1.1.1 Knowledge and Awareness

Limited maternal knowledge and awareness of PPMDs was pointed out as a barrier in this case study. Mental health literacy theory (Jorm, 2012) characterises this as more than an information deficit; symptom recognition is fundamental to help seeking, yet postpartum women in this study attributed emotional distress to standard maternal exhaustion, individual frailty, or the difficulty of tending an infant. This process places knowledge gaps within the broader cognitive appraisal of emotional experience, showing that failure to recognise symptoms is not simply an absence of knowledge but reflects complex individual level sense making. Empirical studies from South Africa support this perspective. A study by Spedding et al. (2018) conducted in a Western Cape district reported that 77.4% of the participants did not recognise symptoms of PPD as related to mental health; more than half of them attributed such symptoms to "weak character" or to stress. These findings indicate that maternal knowledge deficits are tightly interwoven with cognitive frameworks, shaping help seeking behaviours in ways that extend beyond simple awareness.

Facilitators identified at this level are limited but critical. Healthcare providers' expertise serves as a compensatory mechanism as they are able to identify more subtle indicators of distress that mothers may overlook. Clinical observation, and structured assessments as utilised by healthcare providers fill individual knowledge gaps while taking into account the social context in which the postpartum women live. Research highlights the relevance of strategies such as physical symptom observations and trauma-informed care, utilised by healthcare providers.

Mal-Sarkar et al. (2021) found an association between childhood trauma and antenatal depression in two South African cohorts in the Western Cape, highlighting the need for trauma-informed maternal mental healthcare. Likewise, a study in KwaZulu Natal demonstrated that adolescent mothers who were exposed to intimate partner violence experienced high PPD (Gebrekristos et al., 2023).

However, this understanding of limited knowledge requires a more nuanced interpretation. Postpartum knowledge is not just biomedical, but socially produced through cultural hegemonies, personal experience, and communal motherhood narratives. As Spedding et al. (2018) and Kathree et al. (2014) note, postnatal emotional distress may be 'normalised' or "spiritualised" in many South African contexts, regarded as part of the transition to motherhood, rather than pathology. Consequently, what appears to be limited knowledge may instead represent different explanatory frameworks through which women understand their experiences (Mayston et al., 2020).

Equally critical is emotional readiness. Awareness of signs and services does not always translate to help-seeking, women must also be psychologically ready to admit distress and respond to opportunity. A meta-review by Webb and colleagues (2023) found that emotional readiness includes the ability to identify vulnerability, prioritise well-being, and manage the potential stressors of service engagement such as leaving children unattended or employment obligations. Even when services are available, women will delay care if they're not emotionally prepared or are unable to make time, revealing a cognitive–emotional barrier that interestingly interacts with informational gaps. This interplay highlights that interventions need to address not only education but also ways to build mental and practical readiness. Azale et al. (2016) found that although PPMH was recognised among Ethiopian women, help seeking from formal services was frequently inhibited by cultural inclination towards traditional remedies and general mistrust of the healthcare system. In a similar vein, Galvin et al. (2024) found in Johannesburg, South Africa that most women preferred traditional methods, which was largely influenced by cultural norms. However, their study, which relied solely on interviews with Traditional Health Practitioners, may have slanted findings in that direction, providing less insight into general service preferences. Such examples highlight the intricate cultural factors at play in mental health decision-making and the difficulties in generating awareness across different settings. Such factors highlight the complex and multi-layered nature of PPMH literacy.

5.1.1.2 Personal Beliefs and Attitudes

Internalised stigma and misconceptions about PPMDs are key barriers influencing the interviewed postpartum women's involvement with PPMH. These obstacles are fundamentally rooted in individual conceptions of motherhood that idealise strength, emotional stoicism and self-sacrifice (Sorsdahl et al., 2012). Women internalise these ideals, producing cognitive and emotional pressures that discourage acknowledgement of distress or professional help-seeking. Stigma theory (Corrigan, 2004) elucidates how such internalised beliefs influence self-perception and behavioural choices, contributing to delays in accessing care or underreporting symptoms. Studies from South Africa and other LMICs support this understanding, demonstrating that internalised stigma can reduce self-esteem and create reluctance to engage with mental health services (Sorsdahl et al., 2012; Alemu et al., 2023).

Facilitators aimed at challenging these barriers are largely educational and proactive provider-level interventions, seeking to reframe mental health treatment as supportive rather than stigmatising. Making access equate not to severe mental health disorders, but rather to mitigate potential risk, reduces self-stigma and permits women to see help-seeking as a rational, self-directed decision. Mboweni et al. (2024), found that comprehensive mental health education can enhance health outcomes in their study based in rural Mpumalanga, South Africa. Brown and Sprague (2021) similarly emphasise that healthcare providers play a vital role in translating awareness into action by disseminating clear, actionable mental health information. Empowering postpartum women through such guidance is critical to improving uptake of the PPMHS.

This research did not yield any data on healthcare providers' own internalised beliefs, misconceptions or possible stigma, which can also significantly influence service delivery. Providers, as much as patients, work within cultural and social frameworks that shape how maternal distress is acknowledged and understood. These internalised perspectives can take the form of minimisation of culturally symbolic expressions of postpartum distress, prioritising biomedical interpretations over patient narratives, or more subtle forms of dismissive communication. Recognising the possible impact of provider perspectives highlights the intricacy of care dynamics within healthcare settings.

5.1.2 Discussion on Interpersonal Level Factors

5.1.2.1 Relational Support

Relational support from partners and family stood out as a critical factor in PPMH access in this case study. Lack of partner support is a profound barrier, as it reflects not only lack of understanding about PPMDs but also prevailing socio-cultural assumptions about sex-based caregiving duties. Partners who dismiss emotional distress or frame mental health treatment as trivial encourages internalised stigma, curtailing disclosure and help seeking. Studies from Ghana, Nigeria and South Africa support that low partner involvement is linked with higher postpartum depression prevalence (Amer et al., 2024; Adeyemo et al., 2020; Modjadji & Mokwena, 2020). The mental health challenges are further aggravated by the socio-economic challenges that many South African women face. According to Hall et al. (2024), most child support grant recipients are women, who disproportionately bear the bulk of unpaid caregiving and financial responsibilities. These pressures can deepen feelings of emotional isolation and distress. Compounding the issue is the lack of paternal co-residence, with only 38% of children in South Africa living with both parents (Hall et al., 2024). The absence of fathers in the household often translates into a loss of both practical and emotional support during the postpartum period, placing additional strain on women who may already be at heightened risk of mental health problems.

According to healthcare providers in this case study however, involvement of partners is not always beneficial, particularly where IPV, strained relationships, or unequal power dynamics are present. In such situations, well-intentioned efforts to involve partners could inadvertently increase harm or distress. Addressing these challenges requires nuanced, gender-sensitive interventions. A study by Engelbrecht et al. (2024) conducted in the Free State, province of South Africa, identified key socio-cultural, economic, and health system barriers to male involvement in maternal health. The authors recommend implementing gender-transformative approaches to challenge harmful gender norms alongside strengthening the health system to create safe and supportive environments for engaging both partners in maternal healthcare.

It is worth noting that relational absence may not always the result of neglect or dismissal. Structural pressures like employment, migratory work burdens, and institutionalised gendered inequalities can confine partners to limit their availability, making non-participation an adaptation to economic and social constraints rather than a conscious disregard of maternal mental well-being (Malinga & Ratele, 2022). Work-related dynamics often require men to prioritise income generation, leaving mothers to navigate the postpartum period with minimal emotional or practical support. These structural determinants higglights that interpersonal

barriers intersect with larger socio-economic realities, illustrating that relational support gaps cannot be fully separated from systemic inequities. By contrast, active partner involvement facilitates early detection of distress, distributed caregiving burden, and affective alignment; all of which help promote timely connection to mental health care (Yargawa & Leonardi-Bee, 2015). Male involvement has been shown to reduce PPD incidence and improve maternal outcomes in LMIC contexts (Yargawa & Leonardi-Bee, 2015).

Extended family support has also being shown to exerts a dual influence in this study. Traditional caregiving practices can alleviate immediate postpartum burdens, such as childcare and household management, which aligns with African conceptions of mental health that emphasise balance and collective well-being rather than purely individual clinical outcomes, although there is limited literature on these traditional practices in South Africa. A study by Chidi-Nebo (2022) based in Nigeria, discusses how the practice of "Omugwo" contributes to reducing anxiety, stress, and preventing PPD among new mothers. The study emphasises the importance of traditional postpartum care in promoting PPMH. At the same time, family networks may perpetuate non-biomedical interpretations of distress that unintentionally reinforce stigma and delay formal help-seeking. Evidence from Zambia shows that family-held beliefs often validate informal coping mechanisms while marginalising clinical interventions (Sichimba et al., 2022). These findings emphasise the complexity of interpersonal-level influences.

5.1.3 Discussion on Organisational Level Factors

5.1.3.1 Resource Adequacy

Resource adequacy at the CHC significantly shapes postpartum women's access to PPMHS. According to participants in this study, the shortage of mental health practioners at the CHC delays prompt and quality treatment and discourages postpartum women from pursuing treatment. This shortage of psychologists and psychiatrists is especially acute due to low local scholarly output and concentration in urban tertiary centers (Wolvaardt et al., 2025). Social workers and counsellors, while more numerous, are often only accessible on a part-time or rotating-shift basis. Registered counsellors, with post graduate Honours degrees in Psychology and HPCSA registration, are trained in basic mental health counselling (HPCSA, 2024). Social workers, with a four year BSW degree and registered under the Social Service Professions Act

110 of 1978, offer psychosocial assessment and counseling in primary care (Department of Social development, 1978; Poopedi & Bila, 2023). The imbalance between population needs and available professionals highlights structural constraints in South Africa's public health system (Wolvaardt et al., 2025; Poopedi & Bila, 2023).

The on-site presence of mental health professionals, though limited, still serve as an access facilitator. Healthcare providers highlighted that integrated service delivery at the CHC permits continuity of care. This aligns with Marais and Petersen (2015), who underscore that structured referral pathways and coordinated health systems are critical to effective mental health delivery.

Another barrier relates to the inadequacy of routine screening for PPMH. Participants reported that assessments are predominantly checklist-driven and prioritise physical health. This superficial engagement inhibits early detection and delays referral. Although some healthcare providers implement proactive screening, high workloads and limited training undermine consistency. These findings are consistent with South African research indicating that PPMH is often deprioritised in primary care (Mokwena, 2021; Brown & Sprague, 2021).

When effectively implemented, proactive and integrated screening represents a significant facilitator in this case study. Structured, evidence-based methods, such as the Adult Primary Care clinical guide (2023), support primary care providers in screening and treating common mental health disorders. Along those same lines, WHO's Mental Health Gap Action Programme (2023) offers simplified clinical algorithms that allow non-specialists to identify and manage people with mental health disorders. Integrating these frameworks within CHCs can standardise care and strengthen early detection pathways. Nevertheless, variability in training and capacity, as noted by Maphumulo and Bhengu (2019), alongside the need for system-wide support (Docrat et al., 2019), may limit the real-world effectiveness of these tools.

Lack of provider training also exacerbates obstacles. Participants highlighted limited exposure to structured mental health education, with short-term courses predominantly focusing on TB or HIV, resulting in reduced confidence and underdiagnosis. Evidence from South Africa corroborates these findings, showing that primary care nurses frequently lack adequate preparation for mental health responsibilities (Sibeko et al., 2018; Maconick et al., 2018).

These organisational-level dynamics at the CHC demonstrate the intertwined nature of human resource and structural factors in influencing PPMHS access.

5.1.3.2 Logistical Factors

Transportation challenges are a key organisational-level barrier that significantly limit postpartum women's access to PPMHS at the CHC. Within this context, the cost of transport, travel time and burden of commute collide with the realities of postpartum care, specifically childcare. Mothers with multiple young children often have to arrange childcare for the older children in order to meet up with appointments, sometimes with limited to no network of people to assist.

Public transport introduces additional barriers. In peri-urban South African communities, the prevalence of taxis as the primary form of transport is not without challenges for mothers travelling with infants. Postpartum women often need to breastfeed, carry essential baby items, and manage any physical discomfort associated with the postpartum period in crowded vehicles. Research corroborates these particular challenges. Field et al. (2020) found that young women in resource-limited areas of Cape Town often faced multiple transport-related obstacles, including the high cost of travel to mental health facilities. Although public mental healthcare is free, cumulative transport costs for repeated visits can be prohibitive for low-income women.

These difficulties demonstrate how logistical barriers go beyond been a financial burden to include physical, emotional, and psychosocial aspects. This often result in the implicit deprioritisation of mental health concerns among patient populations. Within this context, mental health is not conceived as an immediate or life-threatening condition, lacking the visible urgency associated with physical illness or emergency medical situations.

The lack of mitigating facilitators such home-visits or telehealth exacerbates these barriers. The CHC relies on conventional fixed-location service provision, leaving women to navigate complex travel arrangements alone. The potential for physical accessibility to facilitate PPMH support is not always realised because of the absence of organisational strategies to reduce the transport burden.

Situating these findings within theoretical frameworks highlights their structural nature. Penchansky and Thomas's (1981) model of access emphasises that accessibility encompasses not only the geographic availability of services but also the capacity of individuals to overcome logistical constraints. Andersen's Behavioral Model (1995) reinforces that even when predispositional factors such as perceived need exist, enabling resources including practical means to reach care are essential to translate intention into utilisation. The absence of enabling

mechanisms demonstrates how systemic and infrastructural failure can limit the impact of free service provision.

5.1.4 Discussion on Community Level Factors

5.1.4.1 Community Attitudes

Community norms and social perceptions can act as barriers to PPMHS in this case study, directly influencing postpartum women's engagement with services. The findings indicate that stigma and judgment operate not only at the individial and interpersonal level but are embedded within broader communal expectations of motherhood. Ideals that equate maternal strength with emotional resilience impose implicit penalties on women who experience distress, framing help-seeking as a sign of weakness or inadequacy. These internalised pressures are compounded by pervasive misconceptions about mental health, which persist in communities where psychiatric literacy is limited and mental health struggles are frequently interpreted as personal failings rather than legitimate health concerns.

Theoretical perspectives further elucidate these dynamics. Link and Phelan's (2001) conceptualisation of stigma emphasises the interdependence of labeling, stereotyping, and status loss within social hierarchies. In the context of PPMH, women's fear of community judgment reflects the social consequences of being labeled "weak" or "inadequate," which can extend to familial relationships. Similarly, SEMs underscore that individual help-seeking is contingent on both proximal interpersonal factors and distal community norms; in this case, communal expectations actively mediate the translation of personal recognition of distress into engagement with professional services (Place et al., 2024).

Evidence corroborates the findings. In South Africa, Egbe (2014) highlighted how psychiatric stigma delays help-seeking, often worsening mental health outcomes. Comparable patterns are observed in Ethiopia (Ahad et al., 2023), where entrenched cultural norms and community-level stigma significantly impede women's willingness to access services.

Alternative explanations warrant consideration. The prominence of negative community attitudes may, in part, reflect the limited visibility and integration of PPMH within the community, reinforcing perceptions that these services are exceptional or only for severe illness. Additionally, economic pressures and household responsibilities may amplify women's reluctance to engage with services, with stigma operating synergistically rather than independently. In this framing, addressing community attitudes alone may be insufficient

unless accompanied by structural interventions such as accessible psychoeducation, community outreach, and normalisation of mental health support to reduce both perceived and actual communal constraints.

Participants were unable to identify facilitators to accessing PPMHS within this theme. The absence of facilitators in this domain highlights the need to reframe cultural narratives and social norms that discourage the utilisation of PPMHS.

5.1.4.2 Religious and Cultural Beliefs

Religious and cultural beliefs are profound determinants that influence postpartum women's engagement with PPMHS at this CHC. The findings indicate that these beliefs frequently characterise possible mental health disorders as spiritual concerns rather than clinical conditions. This orientation can delay timely engagement with PPMHS and exacerbate untreated conditions. These beliefs operate not only as personal attitudes but as embedded social norms that influence what is perceived as normative or legitimate help-seeking behaviour. Within this frame, spiritual or culturally-informed narratives of suffering can generate a moral and epistemic hierarchy in which clinical care is sub-ordinated by faith-based explanations, reinforcing self-stigma and silencing help-seeking.

Studies done in South Africa confirm this pattern. Brown and Sprague (2021) highlight how traditional healing practices and spiritual beliefs can limit access to mental health services. Similarly, Davies et al. (2016) observed that postpartum women in a Cape Town township often favoured spiritual interpretations of PPD, reinforcing cultural barriers to clinical intervention.

However, research by Hlongwane and Juby (2023) presents a contrasting perspective. Among congregants of Pentecostal Christian charismatic churches in KwaZulu-Natal, there were high levels of mental health literacy and a preference for professional treatment, suggesting that faith in communities can also foster progressive attitudes toward mental health. Yet the generalisability of this research in single religious contexts is limited for broader application across diverse cultural and faith settings in South Africa.

It is plausible however that resistance to biomedical care is not necessarily oppositional but indicative of broader systemic distrust, historical marginalisation or the perceived irrelevance

of western mental health models. The dominance of Western paradigms in Sub-Saharan African mental health programmes (Anakwenze et al., 2022) may inadvertently marginalise indigenous knowledge systems, making services appear inaccessible or culturally incongruent. Therefore, the observed reliance on spiritual or traditional remedies may represent adaptive strategies within structurally constrained health environments rather than irrational avoidance.

Cultural and linguistic sensitivity was a facilitator to accessing PPMHS. In the case of this study,The healthcare provider who met patients on their own cultural terms and provided sessions in their preferred languages, encouraged rapport and emotional openness. But these strategies continued to be primarily linguistic and cultural, with little emphasis on spiritual and religious systems. With a lack of organised incorporation of spiritual spheres this means current practice creates a partial link between biomedical and culturally based perspectives. Engagement with these factors requires recognising the interplay of epistemic frameworks, linguistic accessibility, and rapport-building within clinical encounters.

5.1.4.3 Community Support Structures

The unawareness of professionally managed, locally accessible programmes by postpartum women and healthcare providers in this case study illustrates a systemic gap in translating PPMH policy into community-level action. Without structured support, women may internalise distress, delay help-seeking, or rely exclusively on informal mechanisms. South African studies, including Marais and Petersen (2015), have documented persistent underdevelopment of community mental health services due to slow institutional reform, workforce shortages, and ambiguous governance frameworks. Furthermore, Mboweni et al. (2024) emphasise that stigma, lack of information and cultural expectations continue to hinder the uptake of community-based mental health initiatives. This intersection of logistical scarcity and socio-cultural pressures illustrates how structural and cultural factors intersect to constrain postpartum mental health support at the community level.

Although several non-governmental and community-based mental health services exist in the area which includes FAMSA and Lifeline, the findings of this study suggest that postpartum women are largely unaware of them or unable to access their programmes and initiatives. This gap in awareness may reflect limited outreach capacity, insufficient integration with primary healthcare platforms, and the challenge of physical NGOs whose operations and activities are

often confined to specific localities and communities. Consequently, these services may fail to reach women, restricting the scale and scope of the impact.

Although the participants could not identify any pre-existing community-level facilitators, their suggestions highlight actionable intervention strategies. Community leaders' engagement and leveraging of culturally relevant institutions such as churches can also raise community awareness, de-stigmatise PPMDs and provide peer support. Awareness campaigns through mediums like local radio, social media and community forums can also bridge information gaps. This is supported by studies highlighting the impact of culturally tailored community-based support groups in enhancing maternal mental health outcomes (Davies et al., 2016; Mboweni et al., 2024).

5.1.5 Discussion on Societal Level Factors

5.1.5.1 Policy and Systemic Issues in PPMH care

The findings indicate that while policies mandating routine mental health screening exist at the CHC, their implementation is often superficial and administratively driven, rather than clinically meaningful. This raises critical questions about the capacity of top-down policy frameworks to translate into real-world improvements in maternal mental health outcomes.

According to the findings, the centralised nature of policy development compounds this barrier. Decisions originating from provincial or national health authorities, without meaningful consultation with frontline providers, risk producing interventions that are misaligned with local realities. Healthcare providers' perceptions that policies are top-down and insufficiently informed by contextual nuances echo broader critiques in literature. Mthetwa (2022) highlight that centralised policy-making in South Africa often overlooks the practical challenges of resource-constrained facilities, resulting in interventions that fail to achieve intended outcomes. In this light, policy implementation gaps cannot be attributed solely to frontline inadequacy. Rather, they reflect systemic misalignment between policy formulation, resource allocation, and service delivery capacity.

An additional barrier is the absence of facilitators at the societal level. Unlike at the organisational level, where integration of services ocan buffer systemic deficiencies, there is limited evidence of mechanisms to support effective policy uptake. Healthcare providers are expected to comply with screening mandates without the benefit of contextually relevant

guidance, or supportive supervision. This absence of enabling structures underscores a critical disjunction. Research by Mokwena and Masike (2020) report similar failures in policy implementation in a sub-district of Pretoria, South Africa, where routine screening protocols were inconsistently applied.

Nonetheless, superficial implementation may stem not only from structural misalignment but also from resource limitations, including staff shortages, limited training, and competing clinical priorities. Providers may be compelled to prioritise urgent physical health interventions over mental health assessments, reflecting rationing of scarce capacities rather than deliberate neglect. Moreover, the absence of postpartum-specific indicators within existing mental health monitoring frameworks constrains feedback loops, leaving policymakers blind to gaps in care and limiting opportunities for iterative improvement. The lack of PPMH data exemplifies how the structure of the health information system can inadvertently perpetuate neglect, even when policies nominally exist.

The recommendation to incorporate measurable indicators, while absent as an existing facilitator, highlights the potential for systemic solutions. By tracking the number of women screened, prevalence of diagnosed PPMDs, and referral outcomes, the health system could generate actionable data to guide evidence-based adjustments. Mboweni et al. (2024) advocate for the use of measurable indicators within mental health programmes. Similarly, Marais and Petersen (2015) emphasise the need for comprehensive screening processes to identify individuals needing urgent intervention. Without clear indicators, mental health policy lacks the necessary structure for monitoring progress and evaluating impact. Existing South African mental health policy includes five indicators: the mental health caseload, the PHC treatment rate for mental disorders, the mental health separation rate, the involuntary admission rate, and the attempted suicide rate for children and adolescents (DoH, 2023). Although these indicators provide a foundation for tracking mental health trends, they do not capture postpartum conditions. As a result, data specific to postpartum mental health remains difficult to isolate, limiting the potential to develop targeted interventions. This lack of disaggregated data hinders both timely policy responses and meaningful evaluation for this vulnerable group.

5.1.5.2 Public Health Interventions

The proposals identified by participants reflect an awareness that societal-level strategies are pivotal in bridging the persistent gaps in postpartum mental health service access. The emphasis on home visits and remote check-ins underscores a recognition that physical and logistical barriers cannot be resolved solely through clinic-based interventions. Conceptually, these suggestions resonate with models of patient-centred care and outreach-oriented public health, which argue that accessibility is contingent not only on service availability but also on its adaptability to the lived realities of target populations (Andersen, 1995; Penchansky & Thomas, 1981). By relocating mental health support into women's homes or integrating virtual platforms, these interventions could transform the environment of care from one that is institutional and potentially intimidating to one that is supportive and culturally attuned. It is worth noting that the feasibility and impact of home visits or teleconsultations may vary depending on contextual factors such as staffing capacity, provider training, and cultural acceptance of remote care. In resource-constrained environments, the implementation of these strategies might inadvertently exacerbate inequities if certain populations are unable to benefit.

Participants' recommendations also highlight the role of information dissemination in shaping mental health literacy. Pamphlets, posters, and social media interventions aim to address knowledge gaps, equipping women to identify symptoms and seek timely support. This aligns with the health belief model (Rosenstock, 1974), which posits that perceived susceptibility and self-efficacy are fundamental determinants of health-seeking behaviour. In contexts where internalised stigma and misconceptions persist, educational outreach functions not merely as an informational tool but as a mechanism for reshaping social norms and reducing the psychological barriers that impede engagement with formal care.

Although there is a dearth of studies on mental health innovations within South Africa, studies in other contexts have demonstrated the effectiveness of similar interventions. For example, a randomised controlled trial in Iran by Milani et al. (2015) found that telephonic support provided by health volunteers significantly reduced depressive symptoms in new mothers. Likewise, Niksalehi et al. (2018) showed that text messaging improved both the reach and quality of interventions for PPD. A systematic review by Hanach et al. (2021), drawing from studies conducted in Iran, the UK, Singapore, Canada, China, the USA, and Australia, reported significant reductions, further validating the use of media-based strategies. Additionally, a meta-analysis conducted by Pamungkasari and Prasetya (2023) across countries such as Tanzania, the UK, India, South Africa, the USA, and Pakistan found that home visits by CHWs reduced PPD levels among pregnant and postpartum women. Supporting the role of educational

outreach, Goodwin and Behab (2023) concluded in their systematic review that media-based interventions, including videos and online materials, could effectively prompt people's help-seeking behaviours for psychological issues.

5.1.6 Interdependence Across Socio-Ecological Levels

The study illustrates that access to PMHS is shaped by the dynamic interplay between individual, interpersonal, organisational, community, and societal factors as shown in figure 5.1. These levels do not operate independently (Place et al., 2024); Barriers or facilitators at one level can amplify or mitigate those at another, e.g., supportive family environments can, in certain instances, mitigate the impact of organisational deficiencies, whereas prevailing cultural stigma has the potential to weaken even those services that are adequately implemented. Likewise, limitations within organisations, such as insufficient staffing or gaps in staff training, may constrain the effectiveness of broader policy measures, thereby emphasising the importance of coordinated and integrated solutions.

.Figure 5.1 presents an explanatory network highlighting these multi-level interactions, providing a framework for understanding how factors collectively affect PPMH service access. It does not imply strict causality but illustrates explanatory relationships across levels.

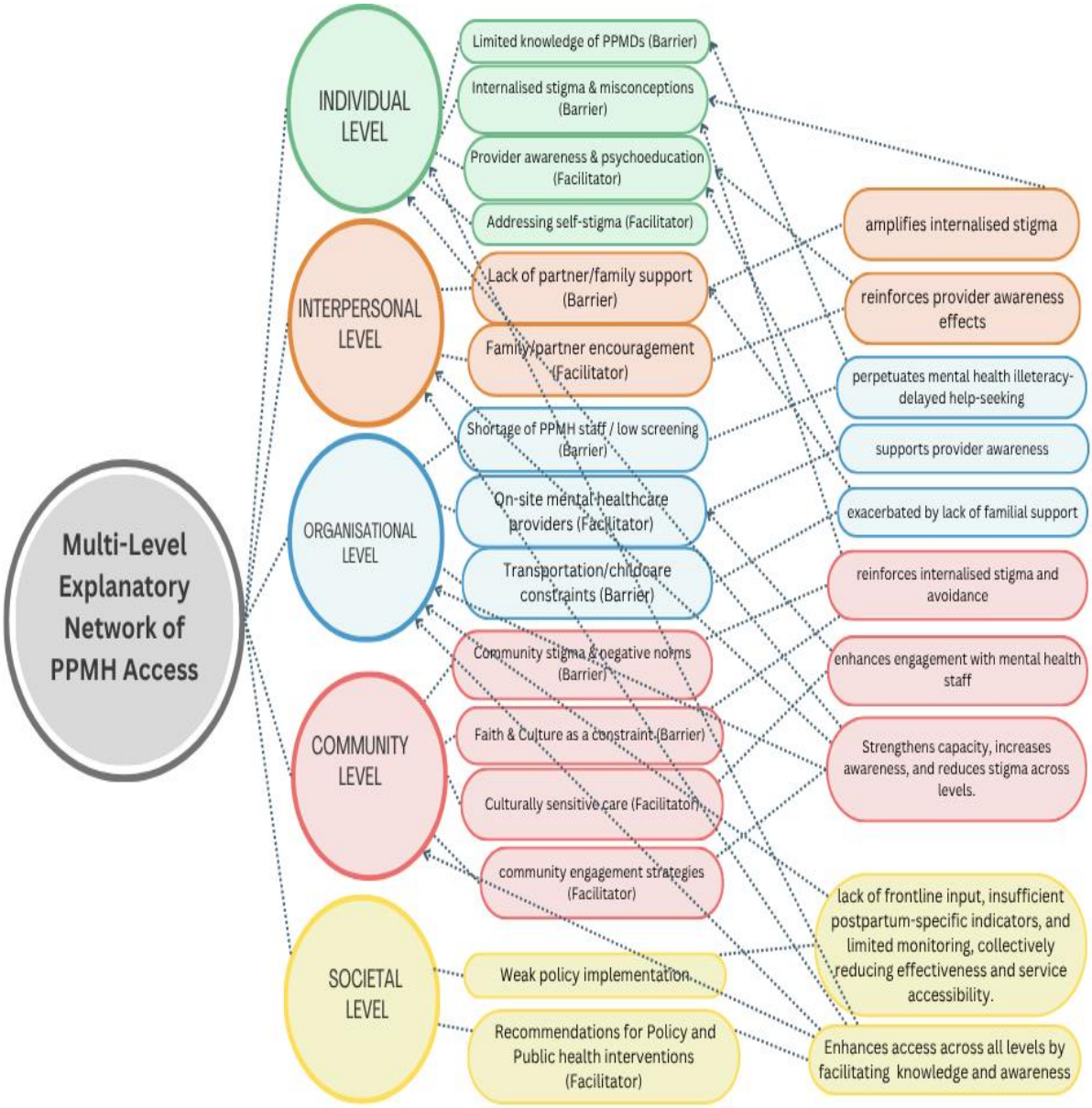


Figure 5.1: Explanatory network highlighting multi-level interactions across the SEM.

5.2 Conclusion

This chapter has discussed the study findings in relation to the key themes identified from the data, highlighting the individual, interpersonal, organisational, community, and societal factors that shape access to PPMHS. The discussion has contextualized these findings within existing literature and theoretical frameworks, providing a deeper understanding of the barriers and facilitators influencing service uptake. The next chapter will provide a synthesis of the study

findings, followed by a presentation of the implications, recommendations, and overall conclusions drawn from the research.

CHAPTER 6 :
SYNTHESIS OF FINDINGS, RECOMMENDATIONS, AND CONCLUSIONS

6.1 Introduction

This chapter provides an overview of the major findings of this study in relation to the research question and objectives. The findings are assessed through the lens of the SEM, which served as the theoretical framework for the case study. Implications are drawn based on these findings with a focus on providing recommendations that could be used by the Gauteng Provincial DoH to improve access to PPMHS at the CHC. The chapter ends with practical recommendations for service delivery, policy engagement insights, and future research suggestions.

6.2 Summary of Findings

6.2.1 Synthesis of Findings Across Socio-Ecological Model Levels

This study explored the different factors functioning as barriers and facilitators to PPMHS at a CHC across different levels of the SEM. The study further indicates that dynamic, non-linear interactions between these different levels shaped the experiences of postpartum women when seeking and obtaining PPMHS.

Limited knowledge and awareness of PPMDs were key barriers to help-seeking at the individual level. Many postpartum women normalised symptoms of emotional distress or attributed them to typical postpartum changes. Personal attitudes, encompassing emotions such as shame and self-blame, acted as deterrents to disclosure. In contrast, empathetic and trauma-informed engagement from healthcare providers was an important facilitator for earlier recognition and reporting of mental health challenges among postpartum women.

Social support from partners and family members was found to play a critical role in determining whether postpartum women sought and utilised PPMHS at the interpersonal level. Supportive relationships facilitated care-seeking, whereas the absence of understanding or the minimisation of symptoms by the family resulted in isolation and delays in accessing services. Therefore, involving families in awareness-raising and care processes was seen as essential by

healthcare providers in ensuring the effectiveness of support initiatives for postpartum women accessing services at the CHC.

At the organisational level, barriers included limited staffing, constrained mental health resources, and inconsistent screening practices. Although the provision of support was available, it was often fragmented, superficial and constrained due to a scarcity of dedicated personnel. Logistical difficulties, especially for mothers travelling with young children, further hindered regular access. Facilitators included early symptom detection, prompt referrals, and proactive screening by trained healthcare providers at the CHC.

Community norms and cultural expectations about motherhood discouraged open discussion about mental health and reinforced stigma. The perception that women should prioritise child care over self-care led many to conceal distress. Traditional and religious healing systems were often the first sources of help for postpartum women, a factor which occasionally delayed their engagement with clinical services. However, participation of community members and stakeholders was recommended an important element to strengthen PPMHS utilisation and reduce stigma.

Maternal mental health policies were noted to be inconsistently implemented, and monitoring frameworks were reported to be largely absent at the societal level. Insufficient resources as well as minimal engagement of frontline healthcare providers in policymaking, was seen as limiting the effective implementation of services. According to participants, practical strategies such as conducting home visits, implementing telehealth interventions, and enhancing data-tracking systems could strengthen both accountability and access to care.

6.3 Implications

6.3.1 Practical Implications for Service Delivery at the CHC

(a) Individual Level

Limited awareness of symptoms and services restricts early opportunity for intervention at the CHC. As Dennis and Chung-Lee (2006) highlight in a systematic review, unawareness of symptoms and available care is a common reason for delayed engagement with mental health services. This problem may be more pronounced in settings where emotional distress after childbirth is normalised or overlooked. In the context of the CHC, the provision of PPMHS is

likely to benefit from consistent and coherent mental health communication during antenatal and postnatal visits.

(b) Interpersonal Level

The findings of this case study show that emotional, practical, and financial support from partners and families can be a powerful predictor of PPMH use among postpartum women. In their absence, carelessness and lack of motivation can hinder service utilisation. Field et al. (2020) also established this in their study among postpartum adolescent mothers in Cape Town. When there were supportive relationships with family members, schoolteachers, or other adults they trusted, the women were more capable of accessing practical and emotional support. These findings point to the necessity of developing relational support networks to facilitate access to services. Thus, planning in the CHC must consider how to enhance such support in women's immediate social contexts.

(c) Organisational Level

This study identified that the non-specialist healthcare providers at the CHC lacked adequate mental health training, which would contribute to delayed identification and referral of PPMDs. Brown and Sprague (2021) emphasise the importance of improving mental health literacy among frontline workers to avoid misattribution of symptoms. Delays brought about by a limited number of mental healthcare provider affect consistent access to care. These organisational issues point to a need for training non-specialist healthcare providers and for increasing the number of mental health professionals.

(d) Community Level

The findings also highlight the vital role that community discourse and attitudes play in shaping postpartum women's interactions with mental health services. Ng'oma et al. (2020) validate that sociocultural beliefs and maternal mental illness stigma can affect attitudes towards care acceptability and accessibility. This case study's findings imply that CHC-based PPMHS uptake is determinatively influenced by the local community's conceptualisation and perception of mental health. Thus, Interventions in service delivery must consider these dynamics to enable greater uptake.

(e) Societal Level

The absence of direct indicators related to postpartum care within national guidelines has been highlighted as hindering implementation in this case study. In the absence of direct indicators to inform PPMH screening, identification, and referral, essential aspects of service provision are likely to be neglected. The fact that monitoring and evaluation systems are not in place suggests that existing frameworks were not able to respond comprehensively to the issues inherent in maternal mental health services. Aligning national priorities with facility-level realities requires clear protocols, and monitoring systems to ensure early detection, appropriate referral, and consistent care.

6.3.2 Theoretical Implications

6.3.2.1 Advancing understanding of self-stigma in PPMH

This study contributes to the existing body of literature on self-stigma by highlighting its role as a barrier to the utilisation of PPMHS at the CHC. While the discourse on stigma predominantly focuses on public stigma – negative perceptions of mental illness in the general public and institutional stigma – discriminatory behaviours by healthcare systems (Subu et al., 2021; Rüsch et al., 2005), self-stigma has received comparatively little attention, particularly among post-partum women in peri-urban South Africa. Operationally defined as the internalisation of negative beliefs about mental illness (Rüsch et al., 2005), self-stigma emerged in this study as a key deterrent to help-seeking. Women in this study described feelings of shame, guilt, and perceptions of being inadequate mothers. These experiences align with theoretical models of self-stigma, which suggest that individuals internalise societal narratives that equate help-seeking with failure or weakness (Dubreucq et al., 2021; Pattyn et al., 2014; Corrigan & Watson, 2002). This research extends theoretical understandings by demonstrating how gendered and cultural ideals of motherhood in this context exacerbate self-stigma in unique ways, distinguishing it from the self-stigma related to other mental conditions. The findings suggest the need for intervention initiatives that address internal cognitive barriers and external structural factors to improve access to PPMHS at the CHC.

6.3.2.2 Culturally and religiously responsive care models

This research highlights the need for culturally and religiously responsive healthcare to deliver PPMHS in this CHC. Patient-centred care is promoted in maternal mental healthcare worldwide (Khosravi et al., 2024; Attanasio et al., 2022). The findings from this study suggest that religion and culture shape how postpartum women accessing PPMHS at the CHC perceive mental health, define healing, and make decisions about seeking care. These findings underscore the importance of integrating cultural and religious sensitivity into approaches to enhance relevance, acceptability, and effectiveness. Albanese et al. (2021) argued that patient-centred care, characterised by empathy, respect, and responsiveness to patients' values, can significantly improve psychological outcomes.

6.3.3 Broader Implications

6.3.3.1 Implications for PPMH literacy

The findings of the present study, particularly the low PPMH literacy of postpartum women at the CHC, have implications for LMICs like South Africa and high-income countries (HICs). In South Africa, research by Spedding et al. (2018) indicated that 77.4% of the sample demonstrated poor knowledge of PPD. In contrast, studies in HICs report comparatively higher mental health literacy levels. A study in Saudi Arabia (Alsulami et al., 2024) found that 53.5% of postpartum women understood PPD well, and 50.7% of women in the United Kingdom demonstrated sufficient awareness (Swami et al., 2020). Although these differences between HICs may appear modest, they reflect a consistent trend of greater PPMH literacy in more affluent settings, necessitating context- based PPMH literacy initiatives in LMICs.

6.4 Study Limitations

6.4.1 Sampling Limitation

This study used purposive sampling to select postpartum women and healthcare providers with direct experience in accessing or providing postnatal healthcare services at the CHC. This was particularly appropriate given the exploratory nature of the research, which aimed to investigate experiences in a particular peri-urban context. Yet, purposive sampling may be prone to selection bias in that those women who are more accessible, better linked to services, or more assertive in describing their experiences are more likely to be overrepresented (Coyne, 1997).

Further, the voices of women experiencing high levels of psychological distress, widespread stigma, or structural exclusion may remain silenced despite being provided with an increased risk of facing obstacles in accessing care. This limitation decreases the range of learned experiences and may constrain understanding of access to PPMHS. To mitigate this limitation, source triangulation was employed in the study through the involvement of postpartum women and healthcare providers (Denzin, 1978). Whilst the voices of the most vulnerable women may not have been directly heard, healthcare providers provided perceptive commentary based on their daily interaction with a cross-section of service users, including the least likely postpartum women to engage in research. These commentaries enhanced the insight into access issues at the CHC.

6.4.2 Data Collection Method Limitation

The research used exclusively in-depth semi-structured interviews as its primary data collection tool. This individualised approach provided a personal and confidential environment, allowing participants to discuss intimate or stigmatised experiences that might have been difficult to disclose in group settings (Elmir et al., 2011). However, the use of a single data collection tool presents some disadvantages. The absence of methodological triangulation, for instance through the inclusion of focus groups, restricted the study's potential to examine shared social meanings, interaction between groups, and behavioural nuances capable of influencing PPMH care access (Carter et al., 2014). Focus groups, for example, would have effectively uncovered insightful information about shared cultural norms or variations in perceptions within peer groups, especially regarding community-level influences. As an exploratory study, this research was more interested in the depth of individual experience in a particular setting. The decision to use interviews only was also influenced by ethical considerations, particularly regarding the sensitivity of PPMH. Individual interviews fostered trust and provided a relaxed environment where participants felt free to express emotionally nuanced or stigmatised experiences (Liamputtong, 2007). While the lack of methodological triangulation may have restricted the range of contextual data, the interview data's richness yielded broad insights consistent with the study's exploratory approach and constructivist paradigm. Future research could consider using focus groups or other participatory approaches to gain insight into group dynamics, shared norms, and collective experiences of PPMH care.

6.4.3 Data Analysis Limitation

Data analysis in the present research encountered several limitations commonly associated with qualitative research. Relying on self-reported data from postpartum women and healthcare providers gathered via interviews introduced the possibility of social desirability bias. Although efforts were made to establish a neutral, empathetic interview environment, the participants may have inadvertently adjusted their responses to align with perceived social norms or expectations related to PPMH. To mitigate this bias, participants were assured of anonymity and reminded of the importance of providing honest, reflective answers. Nevertheless, the inherent limitations of self-reporting remain, as responses are often shaped by the desire to present oneself in a socially acceptable manner.

Another limitation relates to the cross-sectional nature of data collection. Since the findings are based on a single time point, they may not fully reflect the evolving nature of perinatal mental health needs and service utilisation across different phases of the prenatal and postpartum period. As mental health needs and service use patterns may evolve over time, using a single case study design in this study limits the study's ability to observe these dynamic processes occurring over time. Future research should consider employing longitudinal designs to track changes during pregnancy and across the postpartum period. Such an approach would provide a more comprehensive understanding of the temporal and contextual factors influencing access to PPMHS.

6.4.4 Generalisation Limitation

As a qualitative case study, the findings are not intended to be statistically generalised. The research was conducted in a particular peri-urban CHC in Gauteng, South Africa, among healthcare providers and postpartum women engaged care at that particular facility. While the findings are not broadly generalisable, they may be transferable to comparable to other low-resource, Sesotho-speaking peri-urban communities in South Africa that share similar social, cultural, and health system dynamics. By providing detailed descriptions of the study context, participant demographics, and CHC operational features, this study provides a foundation for others to assess the applicability of its insights to their own settings. However, care should be exercised when considering these findings in contexts with markedly different socioeconomic, cultural, or healthcare system characteristics.

6.4.5 Methodological Reflections: Limitations of Dichotomous Models

In healthcare research, dichotomous models that categorically classify factors as either "barriers" or "facilitators" have been criticised for oversimplifying the multifaceted and often fluid nature of healthcare access (Haynes & Loblay, 2024). This limitation was evident in the current research, where several identified determinants did not consistently function as barriers or facilitators. Instead, their influence appeared to shift depending on contextual conditions, individual agency, and the availability of resources.

One notable example is the role of social support in PPMH. While social support, particularly from the family, is typically regarded as a facilitator of mental health service utilisation, the study's findings suggest a more nuanced reality. For some women, family-based social support provided practical assistance and emotional relief, enabling them to prioritise mental health and well-being. However, in other cases, the same source of support reinforced traditional beliefs that discouraged formal heal-seeking. These findings are consistent with those of Hudson et al. (2016), who found that social support can simultaneously mitigate emotional distress and reinforce and perpetuate cultural norms that act as barriers to accessing formal healthcare services, especially among marginalised groups.

At the community level, similar complexities were observed. While prevailing gender norms and traditional beliefs about women's role as caregivers often hindered help-seeking, these same cultural norms also fostered communal networks of emotional support in religious institutions and traditional practices that some women found beneficial. Thus, community-level influences cannot be rigidly categorised; they may function as facilitators and barriers, depending on individual circumstances and broader social dynamics. These findings underscore the limitation of dichotomous models in fully capturing access to care's dynamic and context-dependent nature. Haynes and Loblay (2024) suggest that a more flexible conceptual approach is needed – one that recognises the fluidity of determinants and their capacity to operate differently across time, settings, and populations.

Notwithstanding these limitations, the present study retained the barriers-versus-facilitators framework for clarity and organisation. Using the SEM as a guiding framework helped mitigate some of the constraints of the binary categorisation, by illustrating how multiple levels of influence – individual, interpersonal, organisational, community, and societal – interact to shape postpartum women’s access to mental health services.

6.5 Recommendations

6.5.1 Public Awareness and Education

(a) Individual level

PPMH literacy should be promoted by CHC nurses, health promoters, and mental health practitioners during both antenatal and postnatal visits, as these encounters represent critical periods when women are most present to receive guidance from healthcare providers. The simplification of medical terminology, coupled with the presentation of relatable and culturally grounded examples in educational materials at all levels of the SEM is important to the success of PPMH literacy promotion.

According to El Ayadi et al. (2025), mobile-based interventions in Punjab, India, are characterised by the transmission of culturally adapted messages directly to women's phones and the consistent enhancement of postpartum distress recognition, with positive implications for timely help-seeking. Such an approach could be applied in this case study where mobile access is widespread. The dissemination of targeted educational content through sms's and whatsapp groups at key stages of pregnancy and the early postpartum period could serve to reinforce awareness and facilitate early interaction with mental healthcare practitioners.

(b) Interpersonal level

Health education should actively involve family members and partners, recognizing their essential function in facilitating women's access to services. E-health programmes in Nepal that engaged husbands in maternal mental health education improved spousal support and treatment adherence (Bhardwaj et al., 2024). At this CHC, brief family modules integrated into routine antenatal classes or immunisation visits could enable partners and relatives to recognise early signs of distress, reinforce timely referrals, and reduce household stigma around PPMH. Additionally, e-health tools such as mobile messaging and online educational platforms through services like Whatsapp could further extend the reach of these interventions outside of the normal operational hours of the CHC.

(c) Organisational level

Healthcare providers at the CHC must receive standardised training in culturally responsive care to ensure compassionate and effective service delivery, emphasising practical strategies and locally relevant idioms. In the context of Malawi, the evidence from Atif et al. (2022) demonstrates a significant enhancement in provider confidence and care quality, which was characterised by culturally competent training approaches lead to improved clinical outcomes. The co-design process of local training modules is recommended, which can involve the integration of role-play and reflective practice during CHC staff workshops, thereby ensuring the translation of theoretical knowledge into consistent, effective clinical behaviour.

(d) Community level

Community-based awareness campaigns should leverage established local networks, including churches, women's groups, and NGOs, to disseminate PPMH information. The involvement of community leaders and faith figures as cultural intermediaries allows biomedical explanations to be framed in locally meaningful ways, encouraging dialogue and care-seeking among postpartum women. According to studies from Ethiopia and Kenya, collaboration with traditional and biomedical healers significantly increased service utilisation and improved health outcomes in the same research (Baheretibeb et al., 2022; Musyimi et al., 2016). The application of this approach to this peri-urban South African setting through training programmes and stakeholder consultations could strengthen participatory governance and community ownership in PPMH initiatives.

(e) Societal level

In the public health context, the implementation of national campaigns should normalise PPMH narratives, which are aimed at reduction in stigma and an increase in equitable service uptake. According to evidence from Malawi (Zamawe et al., 2016), targeted media interventions were responsible for increasing, rather than decreasing antenatal and postnatal service utilisation. The coordination of similar media-based initiatives by the Department of Health through the narration of success stories could potentially target barriers at multiple levels the SEM.

6.5.2 Policy Recommendations

(a) Organisational level

Policy alignment at the CHC is essential for translating national priorities into daily practice. The study findings revealed that although national guidelines such as the Adult Primary Care guide (2023) include mental health provisions, their application within maternal care remains inconsistent. Policymakers should therefore require the routine integration of standardised mental health screening into postnatal checklists at all CHCs. This would ensure that the assessment for PPMDs becomes a normal component of postpartum follow up rather than an optional addition. To maintain accountability, facility managers should conduct monthly audits to ensure compliance. Healthcare providers at the CHC should undertake training on the screening of PPMDs. The WHO's mhGAP (2023) provides a defined framework for task sharing that can guide training and supervision of non-specialist healthcare providers. South Africa can use a phased implementation plan, beginning with trial sites and gradually adapting to localised areas..

(b) Societal level

The sustainability of societal reforms is highly dependent on decentralised decision-making and participatory governance in policy execution. Effective policies must empower the facility manager and all healthcare providers to interpret and adapt national directives to fit their local contexts. As this study illustrates, hierarchical top-down systems tend to block context-sensitive solutions, corroborating Ditlopo et al. (2014) who discovered that nurses in South Africa often feel excluded from policy making and implementation. To encourage context-responsive autonomy, provincial and district health authorities should provide the CHC with sufficient flexibility to determine, for example, what forms of community specific outreach programmes to develop. Such decentralisation should be complemented by strong monitoring and evaluation at national and disctrict level, gathering quantitative and qualitative feedback from service users and providers. Establishing routine stakeholder dialogues with mental health nurses, community health workers and service users every quarter would offer an opportunity to check in on progress and surface new challenges. As Abrahams (2015) points out, participatory monitoring and evaluation strengthen governance and cultivate systems that emphasise learning. By embedding these accountability measures, public trust is enhanced, thereby allowing policy development to be rooted in the actual experiences of individuals rather than solely in administrative assumptions.

6.5.3 Recommendations for Future Research

Future research should explore the psychological mechanisms underlying self-stigma among postpartum women in peri-urban South Africa because understanding these internalisation processes is crucial for developing culturally sensitive interventions that dismantle shame and self-blame among affected women. Participatory qualitative approaches like narrative inquiry or photovoice are especially suited for accessing lived experiences and contextual meanings of distress. Such an analogus research has being done in rural Ethiopia and kenya, which revealed how cultural narratives condition PPMH outcomes (Molenaar et al., 2020; Osok et al., 2018).

Further inquiry should investigate the feasibility, effectiveness, and acceptability of integrating telemedicine into PPMHS delivery at peri-urban CHCs. Studies could be conducted collaboratively by academic institutions, CHC healthcare providers, and health departments to assess how virtual and telephone consultations influence early detection, follow-up adherence, and user satisfaction. Mixed-method approaches should be employed to capture both clinical outcomes and lived experiences of postpartum women and healthcare providers. Such research, ideally piloted within existing maternal health programmes, would generate evidence to guide scalable and contextually appropriate digital interventions in South Africa.

Attention should also be given to identifying who should be trained within primary care systems, how training should be delivered, and what support mechanisms ensure sustained integration of PPMH into routine services. This study revealed substantial gaps in staff preparedness and confidence in managing PPMH issues at the facility. Implementation research then needs to develop and pilot mhGAP- aligned training models for non-specialist providers to establish their impact on clinical competence and knowledge retention. Further research is needed to establish the effectiveness of online continuing education programmes in providing ongoing, up-to-date learning for specialist healthcare providers.

Equally importpant is examining how community-based support structures can complement formal healthcare systems in extending PPMH reach to underserved populations such as this community, Understanding which interventions strengthen trust is essential for programme design. Collaborative research involving multiple stakeholders could evaluate hybrid service models that blend different approaches to care. Evidence from Kenya and Ethiopia shows that partnerships between traditional healers and CHWs improved maternal health outcomes and

reduced stigma in those communities (Musyimi et al., 2016; Baheretibeb et al., 2022). Longitudinal evaluation of such community partnerships in South Africa could assess their implementation potential and health impact in similar settings.

Qualitative research should also probe culturally-centred models of assessment and counselling that incorporate spiritual and religious awareness. This research might investigate how faith communities such as church, mosques and other African indigenous faiths can be facilitate discussions around mental health. It can also explore ways to integrate spiritual coping strategies such as prayer, meditation, or scripture reading alongside psychological interventions to bolster women's sense of meaning and agency. In addition, these models can train mental healthcare providers to diplomatically manage spiritual conversations during screening and counselling, encouraging a patient-centred approach. Lastly, studies might explore collaborative models in which traditional and biomedical practitioners share referral networks and psychoeducation resources to offer more holistic, culturally congruent care to postpartum women.

6.5.4 Recommendations for Healthcare System Improvement

To address the persistent treatment gap in mental health care, the Gauteng DoH should prioritise the employment of more mental health specialists, such as psychiatric nurses, psychologists, social workers, and psychiatrists, in CHCs. This effort must be complemented by sustained resource mobilisation to ensure the long-term integration of mental health services within primary health care systems. The National Mental Health Policy Framework and Strategic Plan 2023–2030 further recognises the necessity for greater investment in community-based mental health care, emphasising the importance of contracting trained professionals at CHCs to improve accessibility and quality of care (DoH, 2023).

6.6 Concluding Remarks

This research explored the determinants of access to PPMHS in a peri-urban South African CHC using the SEM to identify barriers and facilitators at multiple levels. The findings suggest that access to PPMHS in this CHC is determined by a complex interplay of individual, interpersonal, organisational, community, and societal factors. These determinants are both

dynamic and context-specific, thus going beyond micro-level models of healthcare access that fail to account for these interrelationships.

The research question, "What are the key barriers and facilitators influencing access to PPMHS at the CHC as identified within a SEM?", was addressed through in-depth investigation at each level of the model. At an individual level, the findings indicated that awareness, internalised stigma, and mental health literacy significantly influenced postpartum women's willingness and ability to seek care, thereby fulfilling the first objective. The interpersonal level, aligned with the second objective, was explored through participants' accounts of family and partner support. These relationships were found to either enable or constrain PPMHS uptake. At the organisational level, corresponding with the third objective, the study identified key barriers including inconsistent mental health screening, transport difficulties, and negative provider attitudes. Nonetheless, the presence of trained mental health professionals and referral efforts by healthcare providers were cited as facilitators of access. The fourth objective, which focussed on the community level was achieved by analysing the impact of social norms, religious views, and broader community attitudes. Although such factors often operated as barriers, especially through cultural stigma, examples of culturally responsive approaches in service delivery emerged as facilitators of care-seeking behaviours. At the societal level, the study highlighted how deficiencies in mental health policies, underinvestment in the health system, and poor implementation of these policies at the facility served as structural barriers.

The single-case study design allowed for in-depth interaction with healthcare providers and postpartum women, thus facilitating the collection of valuable contextual data for each level of the SEM. Applying the model helped structure a layered and holistic understanding of the challenges postpartum women face in their efforts to access care at the CHC. The findings underscore the need for comprehensive mental health care, that include routine screening, stigma reduction efforts, and stronger systems of support at all levels. In particular, strengthening family and community support systems, along with capacity building for service providers, emerged as crucial for enabling culturally competent and responsive mental health care tailored to the diverse needs of postpartum women at the facility. The research also revealed an emerging opportunity to leverage digital health solutions, such as WhatsApp interactions, and mobile education tools, to overcome barriers like poor mental health literacy

and limited in-person services. Participants' suggestions highlighted the promise of such platforms in improving outreach, flexibility, and accessibility.

While this research provides valuable insights into the barriers and facilitators of PPMHS at the CHC, it is critical to consider its limitations. Given that the research was conducted in a peri-urban South African CHC, the findings are specific to that context. Nevertheless, they may be transferable to similar low-resource, peri-urban communities, particularly those that are Sesotho-speaking or socioeconomically comparable. Future research should explore these issues in other contexts.

Ultimately, this study underscores the value of context-sensitive, multi-level interventions in strengthening PPMHS. By applying the SEM, it highlights the interconnected influence of individual, interpersonal, organisational, community, and societal factors on access to PPMH care. The findings emphasise that locally coordinated, and collaboratively designed interventions have the potential to lead to sustainable improvements in maternal mental health outcomes in the South African context.

References

Abel, M. 2015. Long-run effects of forced removal under apartheid on social capital. *Proceedings of the Harvard University Economic History Seminar*. Available from https://scholar.harvard.edu/files/abel/files/abel_homeland_social_capital.pdf [accessed 20 July 2024].

Abrahams, J.M. and Stellenberg, E.L. 2015. Prevalence of and factors influencing postnatal depression in a rural community in South Africa. *African Journal of Primary Health Care and Family Medicine,* 7(1), pp.1-8.

Abrahams, M.A. 2015. A review of the growth of monitoring and evaluation in South Africa: Monitoring and evaluation as a profession, an industry and a governance tool. *African Evaluation Journal*, 3(1), p.8.

Abrahams, Z. and Lund, C. 2022. Food insecurity and common mental disorders in perinatal women living in low socio-economic settings in Cape Town, South Africa during the COVID-19 pandemic: A cohort study. *Global Mental Health*, 9, pp.49-60.

Abrahams, Z., Jacobs, Y., Mohlamonyane, M., Boisits, S., Schneider, M., Honikman, S., Seward, N. and Lund, C., 2022. Implementation outcomes of a health systems strengthening intervention for perinatal women with common mental disorders and experiences of domestic violence in South Africa: Pilot feasibility and acceptability study. *BMC Health Services Research*, 22(1), p.641.

Acar-Ciftci, Y. 2020. Bridging knowledge and action in the workplace: an evaluation on internship learning outcomes of child development associate degree program students. *Journal of Education and Learning*, 9(3), pp.174-186.

Adams, Z.M., Ginapp, C.M., Price, C.R., Qin, Y., Madden, L.M., Yonkers, K. and Meyer, J.P. 2021. A good mother: Impact of motherhood identity on women's substance use and engagement in treatment across the lifespan. *Journal of Substance Abuse Treatment*, 130, p.108474.

Addati, L., Cattaneo, U. and Pozzan, E. 2022. *Care at work: Investing in care leave and services for a more gender-equal world of work.* Geneva: International Labour Organization.

Adeyemo, E.O., Oluwole, E.O., Kanma-Okafor, O.J., Izuka, O.M. and Odeyemi, K.A. 2020. Prevalence and predictors of postpartum depression among postnatal women in Lagos, Nigeria. *African health sciences*, 20(4), pp.1943-54.

Adlington, K., Vasquez, C., Pearce, E., Wilson, C.A., Nowland, R., Taylor, B.L., Spring, S. and Johnson, S. 2023. Just snap out of it - the experience of loneliness in women with perinatal depression: A meta-synthesis of qualitative studies. *BMC Psychiatry*, 23(1), p.110.

Adom, D., Yeboah, A. and Ankrah, A.K. 2016. Constructivism philosophical paradigm: implication for research, teaching and learning. *Global Journal of Arts, Humanities and Social Sciences*, 4(10), pp.1-9.

Ahad, A.A., Sanchez-Gonzalez, M. and Junquera, P., 2023. Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. Cureus, 15(5).

Ahsan, A., Nadeem, A., Habib, A., Basaria, A.A.A., Tariq, R. and Raufi, N. 2023. Post-traumatic stress disorder following childbirth: a neglected cause. *Frontiers in Global Women's Health*, 4, p.1273519.

Ajayi, A.I., Chamdimba, E., Sawadogo, N., Gitahi, N., Tarnagda, A.M., Ilboudo, A.K., Munthali, A., Thakwalakwa, C., Otukpa, E.O., Ushie, B.A. and Kabiru, C.W. 2023. Socio-ecological factors associated with probable depression among pregnant and parenting adolescent girls: Findings from a cross-sectional study in Burkina Faso and Malawi. *Reproductive Health***,** 20(1), p.38.

Akkineni, R., Rao, A. and Ganjekar, S. 2023. Guide for integration of perinatal mental health in maternal and child health services: A review. *Indian Journal of Social Psychiatry,* 39(3), pp.227-229.

Aktar, E., Qu, J., Lawrence, P.J., Tollenaar, M.S., Elzinga, B.M. and Bögels, S.M. 2019. Fetal and infant outcomes in the offspring of parents with perinatal mental disorders: Earliest influences. *Frontiers in Psychiatry,* 10, p.391.

Akunna, O. 2024. Negative implications of drug and substance use on mental health. *International Neuropsychiatric Disease Journal*, 21, p.4.

Al-Ababneh, M.M. 2020. Linking ontology, epistemology and research methodology. *Science & Philosophy*, 8(1), pp.75-91.

Alemu, W.G., Due, C., Muir-Cochrane, E., Mwanri, L. and Ziersch, A. 2023. Internalised stigma among people with mental illness in Africa, pooled effect estimates and subgroup analysis on each domain: systematic review and meta-analysis. *BMC psychiatry*, 23(1), p.480.

Aliyu, A.A., Bello, M.U., Kasim, R. and Martin, D. 2014. Positivist and non-positivist paradigm in social science research: conflicting paradigms or perfect partners? *Journal of Management and Sustainability*, 4(3), pp.79-95.

Amer, S.A., Zaitoun, N.A., Abdelsalam, H.A., Abbas, A., Ramadan, M.S., Ayal, H.M., Ba-Gais, S.E.A., Basha, N.M., Allahham, A., Agyenim, E.B. and Al-Shroby, W.A. 2024. Exploring predictors and prevalence of postpartum depression among mothers: Multinational study. *BMC Public Health*, 24(1), p.1308.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.

Amineh, R.J. and Asl, H.D. 2015. Review of constructivism and social constructivism. *Journal of Social Sciences, Literature and Languages*, 1(1), pp.9-16.

Anakwenze, O. 2022. The cultural sensitivity continuum of mental health interventions in Sub-Saharan Africa: A systematic review. *Social Science & Medicine*, 306, p.115124.

Anato, A., Baye, K., Tafese, Z. and Stoecker, B.J. 2020. Maternal depression is associated with child undernutrition: A cross-sectional study in Ethiopia. *Maternal and Child Nutrition,* 16(3). p.e12934.

Andersen, R.M. 1995. Revisiting the behavioral model and access to medical care: does it matter?. *Journal of health and social behavior*, pp.1-10.

Andrews, T. 2012. What is social constructionism? *Grounded Theory Review*, 11(1), pp.39-46.

Anjum, F. 2019. *An analytical study of contributory factors of postpartum depression among women in Punjab, Pakistan* (Doctoral dissertation). Government College University, Faisalabad, Pakistan.

Anniverno, R., Bramante, A., Mencacci, C. and Durbano, F. 2013. Anxiety disorders in pregnancy and the postpartum period. In F. Durbano (Ed.), *New insights into anxiety disorders* (pp.259-285). InTech.

Arora, N.K. and Mishra, I., 2019. United Nations Sustainable Development Goals 2030 and environmental sustainability: Race against time. *Environmental Sustainability*, 2(4), pp.339-342.

Ashaba, S., Kaida, A., Coleman, J.N., Burns, B.F., Dunkley, E., O'Neil, K., Kastner, J., Sanyu, N., Akatukwasa, C., Bangsberg, D.R. and Matthews, L.T. 2017. Psychosocial challenges facing women living with HIV during the perinatal period in rural Uganda. *PloS One*, 12, p.5.

Atif, N., Meltzer-Brody, S., Stewart, R.C. and Chirwa, E. 2022. Exploring the cultural appropriateness of a psychosocial intervention, the Thinking Healthy Programme-Peer delivered (THPP), for perinatal depression in Lilongwe, Malawi. Malawi Medical Journal, 34(2), pp.87-94.

Austin, Z. and Sutton, J. 2014. Qualitative research: getting started. *The Canadian Journal of Hospital Pharmacy*, 67(6), p.436.

Avendaño, M., Berkman, L.F., Brugiavini, A. and Pasini, G. 2015. The long-run effect of maternity leave benefits on mental health: evidence from European countries. *Social Science & Medicine*, 132, pp.45-53.

Awini, E., Agyepong, I.A., Owiredu, D., Gyimah, L., Ashinyo, M.E., Yevoo, L.L., Aye, S.G.E.V., Abbas, S., Cronin De Chavez, A., Kane, S., Mirzoev, T. and Danso-Appiah, A. 2023. Burden of mental health problems among pregnant and postpartum women in sub-Saharan Africa: Systematic review and meta-analysis protocol. *BMJ Open,* 13(6),p.e069545.

Azale, T., Fekadu, A. and Hanlon, C. 2016. Treatment gap and help-seeking for postpartum depression in a rural African setting. *BMC psychiatry*, 16(1), p.196.

Babbie, E. and Mouton, J., 2010. *The practice of social research* (10th ed). Cape Town: Oxford University Press Southern Africa.

Baheretibeb, Y., Soklaridis, S., Wondimagegn, D., Martimianakis, M.A. and Law, S. 2022. Transformative learning in the setting of religious healers: A case study of consultative mental health workshops with religious healers, Ethiopia. Frontiers in Psychiatry, 13, p.897833.

Baker, E.A. 2022. *Crafting Qualitative Research Questions: A Prequel to Design*. Los Angeles: SAGE Publications.

Bandelow, B., Allgulander, C., Baldwin, D.S., Costa, D.L.D.C., Denys, D., Dilbaz, N., Domschke, K., Eriksson, E., Fineberg, N.A., Hättenschwiler, J. and Hollander, E. 2023. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for treatment of anxiety,

obsessive-compulsive and posttraumatic stress disorders–Version 3. Part I: Anxiety disorders. *The World Journal of Biological Psychiatry*, 24(2), pp.79-117.

Bans-Akutey, A. and Tiimub, B.M. 2021. Triangulation in research. *Academia Letters*, 2, pp.1-6.

Baškarada, S. 2014. Qualitative case study guidelines. *The Qualitative Report*, 19(40), pp.1-25.

Bassuk, E.L. and Beardslee, W.R. 2014. Depression in homeless mothers: Addressing an unrecognized public health issue. *American Journal of Orthopsychiatry*, 84, p.73.

Batt, M.M., Duffy, K.A., Novick, A.M., Metcalf, C.A. and Epperson, C.N. 2020. Is postpartum depression different from depression occurring outside of the perinatal period? A review of the evidence. *FOCUS,* 18(2), pp.106-119.

Battle, C.L., Londono Tobon, A., Howard, M. and Miller, I.W. 2021. Father's perspectives on family relationships and mental health treatment participation in the context of maternal postpartum depression. *Frontiers in Psychology,* 12.

Bauer, A., Garman, E., Besada, D., Field, S., Knapp, M. and Honikman, S. 2022. Costs of common perinatal mental health problems in South Africa. *Global Mental Health,* 9, pp.429-438.

Bauer, A.E., Maegbaek, M.L., Liu, X., Wray, N.R., Sullivan, P.F., Miller, W.C., Meltzer-Brody, S. and Munk-Olsen, T. 2018. Familiality of psychiatric disorders and risk of postpartum psychiatric episodes: A population-based cohort study. *American Journal of Psychiatry*, 175(8), pp.783-791.

Bayeh, E. 2015. The political and economic legacy of colonialism in the post-independence African states. *International Journal in Commerce, IT & Social Sciences*, 2(2), p.90.

Bendavid, E., Boerma, T., Akseer, N., Langer, A., Malembaka, E.B., Okiro, E.A., Wise, P.H., Heft-Neal, S., Black, R.E., Bhutta, Z.A. and Bhutta, Z. 2021. The effects of armed conflict on the health of women and children. *The Lancet*, 397, pp.522-532.

Berger, P.L. and Luckmann, T. 1991. *The social construction of reality: A treatise in the sociology of knowledge*. Reprint ed. New York: Anchor Books.

Bergin, T. 2018. *An introduction to data analysis: Quantitative, qualitative and mixed methods*. London: SAGE.

Bernard-Bonnin, A.C., Canadian Paediatric Society and Mental Health and Developmental Disabilities Committee. 2004. Maternal depression and child development. *Paediatrics & Child Health,* 9(8), pp.575-583.

Bhandari, M.P. 2024. What is next for the sustainable development goals, what are the challenges concerning SDG 10—reduced inequalities? *Sustainable Earth Reviews,* 7(1), p.23.

Bhardwaj, A., Maharjan, S.M., Magar, A.J., Shrestha, R., Dongol, A., Hagaman, A., Van Heerden, A., Caracoglia, J., Gallo, J.J., Murray, S.M. and Kohrt, B.A. 2024. Engaging husbands in a digital mental health intervention to provide tailored counseling for women experiencing postpartum depression: A mixed methods study in Nepal. *SSM-Mental Health*, 6, p.100340.

Bhardwaj, S., Pattinson, R., Kauchali, S., Dlamini, N., Marshall, C., Van der Merwe, M. and Barron, P. 2018. Implementation of strategies to improve programme effectiveness lead to an improvement in maternal and child health outcomes in South Africa. *South African Medical Journal*, 108(3 Supplement 1), S44-S49.

Bieleninik, Ł., Ettenberger, M., Epstein, S., Elefant, C. and Arnon, S. 2021. Potential psychological and biological mechanisms underlying the effectiveness of neonatal music therapy during kangaroo mother care for preterm infants and their parents. *International Journal of Environmental Research and Public Health*, 18(16), p.8557.

Blaikie, N. and Priest, J. 2017. *Social research: Paradigms in action*. Cambridge: Polity Press.

Boddy, C.R. 2016. Sample size for qualitative research. *Qualitative market research: An international journal*, 19(4), pp.426-432.

Boldosser-Boesch, A., Brun, M., Carvajal, L., Chou, D., de Bernis, L., Fogg, K., Hill, K., Jolivet, R., McCallon, B., Moran, A., Say, L., Smith, J., Stanton, M. E., ten Hoope-Bender, P. and Wegner, M. N. 2017. Setting maternal mortality targets for the SDGs. *The Lancet*, 389(10070).

Bourke, B. 2014. Positionality: Reflecting on the research process. *The Qualitative Report*, 19(33), pp.1-9.

Boyland, J.R. 2019. A social constructivist approach to the gathering of empirical data. *Australian Counselling Research Journal*, 13(2), pp.30-34.

Braveman, P. and Gottlieb, L. 2014. The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, 129(Suppl. 2).

Bright, A. M., Doody, O. and Tuohy, T. 2022. Women with perinatal suicidal ideation-A scoping review of the biopsychosocial risk factors to inform health service provision and research. *PLoS ONE*, 17.

Brito, N. H., Werchan, D., Brandes-Aitken, A., Yoshikawa, H., Greaves, A. and Zhang, M. 2022. Paid maternal leave is associated with infant brain function at 3 months of age. *Child Development*, 93(4), pp.1030-1043.

Brohan, E., Chowdhary, N., Dua, T., Barbui, C., Thornicroft, G., Kestel, D., Ali, A., Assanangkornchai, S., Brodaty, H., Carli, V. and El Chammay, R. 2024. The WHO Mental Health Gap Action Programme for mental, neurological, and substance use conditions: the new and updated guideline recommendations. *The Lancet Psychiatry*, 11(2), pp.155-158.

Brown, S. and Sprague, C. 2021. Health care providers' perceptions of barriers to perinatal mental healthcare in South Africa. *BMC Public Health*, 21, pp.1-13.

Brown, S., Macnaughton, G. and Sprague, C. 2020. A right-to-health lens on perinatal mental health care in South Africa. *Health and Human Rights*, 22(2), p.125.

Browne, F.A., Gichane, M.W., Shangase, N., Ndirangu, J., Bonner, C.P. and Wechsberg, W.M. 2023. Social determinants of alcohol and other drug misuse among women living with HIV in economically underserved communities in Cape Town, South Africa: A cross-sectional study. *AIDS and Behavior*, 27, pp.1329-1338.

Bull, E., Al-Janabi, S. and Gittins, C. 2022. Are women with traits of perfectionism more likely to develop perinatal depression? A systematic review and meta-analysis. *Journal of Affective Disorders*, 296, pp.67-78

Burns, J. K. 2008. Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. *South African Medical Journal*, 98(1).

Burr, V. and Dick, P. 2017. Social constructionism. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp.59-80). London: Palgrave Macmillan.

Campbell-Clarke, K. 2023. Showing symptoms is not enough: A case study on identifying, intervening and mitigating postpartum depression. *Case Stud.,* 14(4): p.555894.

Çankaya, S. and Şimşek, B. 2021. Effects of antenatal education on fear of birth, depression, anxiety, childbirth self-efficacy, and mode of delivery in primiparous pregnant women: A prospective randomized controlled study. *Clinical Nursing Research*, 30(6), pp.818-829.

Caperon, L., Saville, F. and Ahern, S. 2022. Developing a socio-ecological model for community engagement in a health programme in an underserved urban area. *PLoS ONE*, 17(9).

Carcary, M. 2020. The research audit trail: Methodological guidance for application in practice. *Electronic Journal of Business Research Methods*, 18(2), pp.166-177.

Carmel, S. 2019. Health and well-being in late life: Gender differences worldwide. *Frontiers in Medicine*, 6, p.218.

Carroll, M., Daly, D. and Begley, C. M. 2016. The Sprevalence of women's emotional and physical health problems following a postpartum haemorrhage: A systematic review. *BMC Pregnancy and Childbirth*, 16(1), p.261.

Carter, H., Araya, R., Anjur, K., Deng, D. and Naslund, J.A. 2021. The emergence of digital mental health in low-income and middle-income countries: A review of recent advances and implications for the treatment and prevention of mental disorders. *Journal of Psychiatric Research,* 133, pp.223-246.

Carter, N., Bryant-Lukosius, D., Dicenso, A., Blythe, J. and Neville, A.J. 2014. The use of triangulation in qualitative research. *Oncology Nursing Forum*, 41, pp.545-547.

Caulfield, A., Vatansever, D., Lambert, G. and Van Bortel, T. 2019. WHO guidance on mental health training: a systematic review of the progress for non-specialist health workers. *BMJ Open,* 9(1), e024059.

Centre for Disease Control and Prevention. 2015. *The social-ecological model: A framework for prevention.* Available from https://www.cdc.gov/violence-prevention/about/index.html [accessed 3 November 2013]

Chakrabarti, S. 2024. Digital psychiatry in low-and-middle-income countries: new developments and the way forward. *World Journal of Psychiatry*, 14(3), p.350.

Chakwizira, J. 2019. Low-income housing backlogs and deficits "blues" in South Africa: What solutions can a lean construction approach proffer? *Journal of Settlements and Spatial Planning*, 10(2), pp.71-88.

Chand, S.P. 2023. Constructivism in education: Exploring the contributions of Piaget, Vygotsky, and Bruner. *International Journal of Science and Research (IJSR)*, 12(7), pp.274-278.

Chand, S.P. and Marwaha, R. 2022. *Anxiety.* Treasure Island (FL): StatPearls Publishing.

Chapman, A. R. 2016. Assessing the universal health coverage target in the Sustainable Development Goals from a human rights perspective. *BMC International Health and Human Rights*, 16(1), p.33.

Chapman, S.L.C. and Wu, L.T. 2013. Postpartum substance use and depressive symptoms: A review. *Women and Health*, 53(5), pp.479-503.

Charmaz, K. 2014. Constructing grounded theory: A practical guide through qualitative analysis (2nd ed). London: SAGE Publications.

Chauhan, G. and Tadi, P. 2022. *Physiology, Postpartum Changes Organ Systems Involved.* Treasure Island (FL): StatPearls Publishing.

Cho, Y.C. 2012. State identity formation in constructivist security studies: A suggestive essay. *Japanese Journal of Political Science*, 13, pp.299-316.

Cholley-Gomez, M., Laujac, S., Delpierre, C. and Carayol, M. 2023. Effectiveness of multilevel interventions based on socio-ecological model to decrease sedentary time in children: A systematic review of controlled studies. *Frontiers in Public Health*, 11, p.1106206.

Chopak-Foss, J., Harris, K. and Choongo, J. 2020. Applying the socio-ecological model to improving maternal mental health in Georgia. *Eagles Talking about Public Health*, 1-3.

Chidi-Nebo, A.N. & Ogunniyi, A. 2022. "Omugwo"—Preventing and managing postpartum depression. *Africa Healt*h, pp.10–11. Available at: https://africa-health.com/wp-content/uploads/2022/05/AH-2022-04-10-PPD.pdf [Accessed 10 June 2024].

Cislaghi, B. and Heise, L. 2020. Gender norms and social norms: Differences, similarities and why they matter in prevention science. *Sociology of Health and Illness*, 42(2), pp.407-422.

Cleveland, L.M., Bonugli, R.J. and McGlothen, K.S. 2016. The mothering experiences of women with substance use disorders. *Advances in Nursing Science*, 39(2), pp.119-129.

Coleman-Cowger, V.H. 2012. Mental health treatment need among pregnant and postpartum women/girls entering substance abuse treatment. *Psychology of Addictive Behaviors*, 26(2), p.345.

Colglazier, W. 2015. Sustainable development agenda: 2030. *Science*, 349(6252), pp.1048-1050.

Corr, T.E., Schaefer, E.W., Hollenbeak, C.S. and Leslie, D.L. 2020. One-year postpartum mental health outcomes of mothers of infants with neonatal abstinence syndrome. *Maternal and Child Health Journal*, 24(3), pp.283-290.

Corrigan, P. 2004. How stigma interferes with mental health care. *American psychologist*, 59(7), p.614.

Coyne, I.T. 1997. Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? Journal of Advanced Nursing, 26(3), pp.623-630.

Craig, A., Rochat, T., Naicker, S., Mapanga, W., Mtintsilana, A., Dlamini, S.N. and Norris, S.A. 2022. The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa. *Frontiers in Public Health*, 10, p.986531

Creswell, J.W. 2007. *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J.W. 2013. *Qualitative inquiry & research design: Choosing among the five approaches*. Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J.W. and Creswell, J.D. 2018. *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Los Angeles: SAGE.

Creswell, J.W. and Poth, C.N. 2018. *Qualitative inquiry and research design: Choosing among five approaches* (5th ed.). Thousand Oaks, CA: SAGE Publications.

Crotty, M. 1998. The foundations of social research: Meaning and perspective in the research process. London: SAGE.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A. and Sheikh, A. 2011. The case study approach. *BMC Medical Research Methodology*, 11(1), pp.100-108.

Daehn, D., Martens, C., Loew, V., Kemmler, L., Rudolf, S., Kochen, E., Renneberg, B. and Pawils, S. 2023. SmartMoms - a web application to raise awareness and provide information on postpartum depression. *BMC Pregnancy and Childbirth*, 23(1), p.402.

Daehn, D., Rudolf, S., Pawils, S. and Renneberg, B. 2022. Perinatal mental health literacy: Knowledge, attitudes, and help-seeking among perinatal women and the public - A systematic review. *BMC Pregnancy and Childbirth*, 22(1), p.574.

Dagher, R. K., Bruckheim, H. E., Colpe, L. J., Edwards, E. and White, D. B. 2021. Perinatal Depression: Challenges and Opportunities. *Journal of Women's Health*, 30(2), pp.154-159.

Danielyan, N. 2023. Immanuel Kant as the first epistemological constructivist. *SHS Web of Conferences*, 161(1), p.07004.

Davidoff, F. 2019. Understanding contexts: How explanatory theories can help. *Implementation Science*, 14(1), pp.1-9.

Davies, T., Lund, C. and Schneider, M. 2022. Implementation of a task-shared psychosocial intervention for perinatal depression in South Africa: A grounded theory process evaluation. *SSM-Mental health*, 2, p.100056.

Davies, T., Schneider, M., Nyatsanza, M. and 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), pp.286-312.

Dawson, D.N., Volpe, V.V. and Laurent, H.K. 2021. Synergistic effects of psychological intimate partner violence exposure and gender discrimination on postnatal mental health trajectories. *Journal of Interpersonal Violence*, 36(15), pp.NP8907-NP8932.

De Backer, K., Pali, A., Challacombe, F.L., Hildersley, R., Newburn, M., Silverio, S.A., Sandall, J., Howard, L.M. and Easter, A. 2024. Women's experiences of attempted suicide in the perinatal period (ASPEN-study)-a qualitative study. *BMC Psychiatry*, 24(1), p.255.

De Schutter, O., Frazer, H., Guio, A.-C. and Marlier, E. 2023. How poverty is perpetuated across generations. In O. de Schutter, H. Frazer, A.-C. Guio & E. Marlier (Eds.), *The escape from poverty: Breaking the vicious cycles perpetuating disadvantage* (pp.18-60). Bristol: Policy Press.

de Sousa Machado, T., Chur-Hansen, A. and Due, C. 2020. First-time mothers' perceptions of social support: Recommendations for best practice. *Health Psychology Open*, 7(1), p.2055102919898611.

DeBattista, C. 2005. Executive dysfunction in major depressive disorder. *Expert Review of Neurotherapeutics*, 5(1), pp.79-83.

DeJonckheere, M. and Vaughn, L.M. 2019. Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, 7(2), p.e000057.

Dennis, C.L., Singla, D.R., Brown, H.K., Savel, K., Clark, C.T., Grigoriadis, S. and Vigod, S.N. 2024. Postpartum depression: A clinical review of impact and current treatment solutions. *Drugs*, 84(6), pp.645-659.

Denzin, N.K. 1978. *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.

Denzin, N.K. and Lincoln, Y.S. 2000. *The handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage.

Department of Health (DoH). 2004. *Mental Health Care Act No. 17 of 2002*. *Government Gazette*, No. 24024. Pretoria: Government Printer.

Department of Health (DoH). 2013. *National Mental Health Policy Framework and Strategic Plan (2013-2020)*. Pretoria: Department of Health.

Department of Health (DoH). 2016. *Guidelines for Maternity Care in South Africa: A Manual for Clinics, Community Health Centres and District Hospitals*. Pretoria: Department of Health.

Department of Health (DoH). 2016. *Guidelines for Maternity Care in South Africa: A Manual for Clinics, Community Health Centres and District Hospitals*. Pretoria: Department of Health.

Department of Health (DoH). 2020. *Referral Policy and Referral Implementation Guideline.* Pretoria: Department of Health.

Department of Health (DoH). 2021. *South African Maternal, Perinatal and Neonatal Health Policy*. Available from https://knowledgehub.health.gov.za/system/files/elibdownloads/2021-06/SA%20MPNH%20Policy%2014-6-2021%20v9%20signed%20Web%20Version.pdf [accessed 12 February 2025]

Department of Health (DoH). 2023. *National Mental Health Policy Framework and Strategic Plan 2023-2030*. Pretoria: Department of Health.

Department of Health (DoH). 2024. *National Integrated Maternal and Perinatal Care Guidelines for South Africa*. Pretoria: Department of Health.

Department of Health (DoH). 2023. *Adult Primary Care (APC) Clinical Tool 2023.* Pretoria: NDoH. Available at: https://knowledgehub.health.gov.za

Department of Social Development (DsD), 1978. Social Service Professions Act 110 of 1978. Government of South Africa. Available at: https://www.gov.za/documents/social-and-associated-workers-act-16-apr-2015-0946 [Accessed 10 October 2025].

De Savigny, D. and Adam, T. eds., 2009. *Systems thinking for health systems strengthening*. World Health Organization.

Devooght, A., Stinnett, R., Philippi, K.J., Cahill, A. and Neuer Colburn, A.A. 2023. Promoting wellness for an inclusive perinatal population: Strategies for counselors. *Journal of Mental Health Counseling*, 45(3), pp.264-279.

Di Pierdomenico, K., Kamau, V., Njenga, M., Morrow, M. and Warkentin, R. 2024. Mental health in Kenya: Tensions between human rights approaches and colonial care. *Studies in Social Justice*, 18, pp.515-532.

DiCicco-Bloom, B. and Crabtree, B.F. 2006. The qualitative research interview. *Medical Education*, 40, pp.314-321.

Ditlopo, P., Blaauw, D., Penn-Kekana, L. and Rispel, L.C. 2014. Contestations and complexities of nurses' participation in policy-making in South Africa. *Global Health Action,* 7(1), p.25327.

Docrat, S., Besada, D., Cleary, S., Daviaud, E. and Lund, C. 2019. Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*, 34(9), 706-719.

Doyle, M., Carballedo, A. and O'Keane, V. 2015. Perinatal depression and psychosis: an update. *BJPsych Advances*, 21(1), pp.5-14.

Drigo, L., Makhado, L., Lebese, R.T. and Chueng, M.J. 2021. Influence of Cultural and Religious practices on the management of pregnancy at Mbombela Municipality, South Africa: an explorative study. *The Open Nursing Journal*, 15(1).

Duthé, G., Rossier, C., Bonnet, D., Soura, A.B. and Corker, J. 2016. Mental health and urban living in sub-Saharan Africa: Major depressive episodes among the urban poor in Ouagadougou, Burkina Faso. *Population Health Metrics*, 14(1), pp.1-10.

Ebneyamini, S. and Sadeghi Moghadam, M.R. 2018. Toward developing a framework for conducting case study research. *International Journal of Qualitative Methods*, 17(1), p.1609406918817954.

Eckerdal, P. 2018. Perinatal complications: Associations with postpartum depressive symptoms and neuroticism (Doctoral dissertation). Uppsala: Acta Universitatis Upsaliensis.

Egbe, C.O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G. and Petersen, I. 2014. Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders. *BMC Psychiatry*, 14(1), p.191.

Ekpenyong, M.S. and Munshitha, M. 2023. The impact of social support on postpartum depression in Asia: A systematic literature review. *Mental Health & Prevention*, 30, p.200262.

El Ayadi, A.M., Diamond-Smith, N.G., Duggal, M., Singh, P., Sharma, P., Kaur, J., Gopalakrishnan, L., Gill, N., Verma, G.S., Ahuja, A. and Kumar, V. 2025. Preliminary impact of an mHealth education and social support intervention on maternal health knowledge and outcomes among postpartum mothers in Punjab, India. *BMC Pregnancy and Childbirth,* 25(1), p.239.

Elder, J.P., Lytle, L., Sallis, J.F., Young, D.R., Steckler, A., Simons-Morton, D., Stone, E., Jobe, J.B., Stevens, J., Lohman, T. and Webber, L. 2007. A description of the social–ecological framework used in the trial of activity for adolescent girls (TAAG). *Health education research*, 22(2), pp.155-165.

El Zaatari, W. and Maalouf, I. 2022. How the Bronfenbrenner bio-ecological system theory explains the development of students' sense of belonging to school? *SAGE Open*, 12(4), p.21582440221134089.

Elmir, R., Schmied, V., Jackson, D. and Wilkes, L. 2011. Interviewing people about potentially sensitive topics. *Nurse Researcher,* 19(1), pp.12-16.

Elwell-Sutton, T., Folb, N., Clark, A., Fairall, L.R., Lund, C. and Bachmann, M.O. 2019. Socioeconomic position and depression in South African adults with long-term health conditions: a longitudinal study of causal pathways. *Epidemiology and Psychiatric Sciences*, 28(2), pp.199-209.

Engelbrecht, M., Mulu, N. and Kigozi-Male, G. 2024. Exploring factors associated with limited male partner involvement in maternal health: A Sesotho socio-cultural perspective from the Free State, South Africa. *International Journal of Environmental Research and Public Health,* 21(11), p.1482.

Erickson, C.K. 2018. *The science of addiction: From neurobiology to treatment*. New York: WW Norton & Company.

Eriksson, M., Ghazinour, M. and Hammarström, A. 2018. Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory and Health*, 16(4), pp.414-433.

Ettekal, A. and Mahoney, J.L. 2017. Ecological systems theory. In K. Peppler (Ed.), *The SAGE Encyclopedia of Out-of-School Learning* (pp.239-241).

Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danışman, G.T., de Vries, R., Kerkhof, A.J.F.M., Bhui, K. and Cuijpers, P. 2020. Stigma for common mental disorders in racial minorities and majorities: A systematic review and meta-analysis. *BMC Public Health*, 20(1), p.879.

Fadele, K.P., Igwe, S.C., Toluwalogo, N.O., Udokang, E.I., Ogaya, J.B. and Lucero-Prisno, D.E. 2024. Mental health challenges in Nigeria: Bridging the gap between demand and resources. *Cambridge Prisms: Global Mental Health*, 11, e29.

Family and Marriage Society of South Africa (FAMSA), n.d. Counselling services. Available at: https://www.famsapretoria.co.za/counselling-services/ (Accessed: 16 October 2025).

Fahey, J.O. and Shenassa, E. 2013. Understanding and meeting the needs of women in the postpartum period: The perinatal maternal health promotion model. *Journal of Midwifery and Women's Health*, 58(6), pp.613-621.

Fatema, K. and Lariscy, J.T. 2020. Mass media exposure and maternal healthcare utilization in South Asia. *SSM-population Health*, 11, p.100614.

Feinberg, E., Declercq, E., Lee, A. and Belanoff, C. 2022. The relationship between social support and postnatal anxiety and depression: Results from the Listening to Mothers in California survey. *Women's Health Issues*, 32(3), pp.251-260.

Fekadu, N., Shibeshi, W. and Engidawork, E. 2017. Major depressive disorder: Pathophysiology and clinical management. *J Depress Anxiety*, 6(1), pp.255-257.

Field, S., Abrahams, Z. and Honikman, S. 2020. Adolescent mothers: A qualitative study on barriers and facilitators to mental health in a low-resource setting in Cape Town, South Africa. *African Journal of Primary Health Care and Family Medicine*, 12(1), pp.1-9.

Field, S., Baron, E., Meintjes, I., van Heyningen, T. and Honikman, S. 2014. Maternal mental health care: Refining the components in a South African setting. In *Essentials of Global Mental Health* (pp.173-186). New York: Cambridge University Press.

Finlay, L. and Gough, B. 2008. *Reflexivity: A practical guide for researchers in health and social sciences*. Chichester: John Wiley & Sons.

Fischer, A.R., Green, S.R.M. and Gunn, H.E. 2021. Social-ecological considerations for the sleep health of rural mothers. *Journal of Behavioral Medicine*, 44(4), pp.507-518.

Fombad, M.C. 2019. Enhancing accountability in public-private partnerships in South Africa. *Southern African Business Review*, 18(3), pp.66-92.

Fosnot, C.T. 2013. *Constructivism: Theory, perspectives, and practice*. New York: Teachers College Press.

Fouché, C.B., Strydom, H. and Roestenburg, W.J.H. 2021. Interviews as a data collection method. In C.B. Fouché, H. Strydom & W.J.H. Roestenburg (Eds.), *Research at grass roots: For the social sciences and human service professions* (5th ed., pp.355-378). Pretoria: Van Schaik Publishers.

Freeman, M. 2022. Investing for population mental health in low- and middle-income countries—where and why? *International Journal of Mental Health Systems*, 16(1), p.38.

Frizelle, K. and Kell, G. 2010. A contextual account of motherhood. *Psychology in Society*, (39), pp.26-44.

Fusheini, A. and Eyles, J. 2016. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. *BMC Health Services Research*, 16(1), p.558.

Galvin, M., Chiwaye, L. and Moolla, A. 2023. Perceptions of causes and treatment of mental illness among traditional health practitioners in Johannesburg, South Africa. *South African Journal of Psychology*, 53(3), pp.403-415.

Galvin, M., Byansi, W., Chiwaye, L., Luvuno, Z. and Moolla, A. 2023. Pathways to care among patients with mental illness at two psychiatric facilities in Johannesburg, South Africa. *International Journal of Social Psychiatry*, 69(8), pp.2059-2067.

Garapati, J., Jajoo, S., Aradhya, D., Reddy, L.S., Dahiphale, S.M. and Patel, D.J. 2023. Postpartum mood disorders: insights into diagnosis, prevention, and treatment. *Cureus* 15(7), e42107.

Garcia, E.R. and Yim, I.S. 2017. A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy and Childbirth*, 17(Supp. 2), p.347.

García-Moreno, C. and Riecher-Rössler, A. 2013. *Violence Against Women and Mental Health.* Basel: Karger Publishers.

Garman, E.C., Schneider, M. and Lund, C. 2019. Perinatal depressive symptoms among low-income South African women at risk of depression: Trajectories and predictors. *BMC Pregnancy and Childbirth*, 19(1), p.202.

Garrison-Desany, H.M., Wilson, E., Munos, M., Sawadogo-Lewis, T., Maïga, A., Ako, O., Mkuwa, S., Hobbs, A.J. and Morgan, R. 2021. The role of gender power relations on women's health outcomes: Evidence from a maternal health coverage survey in Simiyu region, Tanzania. *BMC Public Health*, 21, pp.1-15.

Gbadamosi, I.T., Henneh, I.T., Aluko, O.M., Yawson, E.O., Fokoua, A.R., Koomson, A., Torbi, J., Olorunnado, S.E., Lewu, F.S., Yusha'u, Y. and Keji-Taofik, S.T. 2022. Depression in sub-Saharan Africa. *IBRO Neuroscience Reports*, 12, pp.309-322.

GBD. 2019. Mental Disorders Collaborators. 2022. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry*, 9(2), pp.137-150.

Gelabert, E., Gutierrez-Zotes, A., Navines, R., Labad, J., Puyané, M., Donadon, M.F., Guillamat, R., Mayoral, F., Jover, M., Canellas, F., Gratacós, M., Guitart, M., Gornemann, I., Roca, M., Costas, J., Ivorra, J.L., Subirà, S., de Diego, Y., Osorio, F.L. and Martin-Santos, R. 2020. The role of personality dimensions, depressive symptoms and other psychosocial variables in predicting postpartum suicidal ideation: A cohort study. *Archives of Women's Mental Health*, 23(4), pp.585-593.

Gelabert, E., Subirà, S., García-Esteve, L., Navarro, P., Plaza, A., Cuyàs, E., Navinés, R., Gratacòs, M., Valdés, M. and Martín-Santos, R. 2012. Perfectionism dimensions in major postpartum depression. *Journal of Affective Disorders*, 136, pp.1-2.

Ghaedrahmati, M., Kazemi, A., Kheirabadi, G., Ebrahimi, A. and Bahrami, M. 2017. Postpartum depression risk factors: A narrative review. *Journal of Education and Health Promotion*, 61(1), p.60.

Glanz, K., Rimer, B.K. and Viswanath, K. 2015. *Health behavior: Theory, research, and practice* (5th ed.). San Francisco: Jossey-Bass.

Golden, S.D. and Earp, J.A.L., 2012. Social ecological approaches to individuals and their contexts: twenty years of health education & behavior health promotion interventions. *Health Education and Behavior*, 39(3), pp.364-372.

Golden, S.D., McLeroy, K.R., Green, L.W., Earp, J.A.L. and Lieberman, L.D. 2015. Upending the social ecological model to guide health promotion efforts toward policy and environmental change. *Health Education & Behavior*, 42(Suppl. 1), pp.8S-14S.

Goodman, J.H. 2019. Perinatal depression and infant mental health. *Archives of Psychiatric Nursing,* 33(3), pp.217-224.

Goodwin, J. and Behan, L. 2023. Does media content have an impact on help-seeking behaviors for mental illness? A systematic review. *Mental Health Review Journal*, 28(3), pp.283-302.

Govender, I. 2023. Gender-based violence - An increasing epidemic in South Africa. *South African Family Practice*, 65(3), pp.1-2.

Groves, A., Kagee, A., Maman, S., Moodley, D. and Rouse, P. 2011. Associations between intimate partner violence and emotional distress among pregnant women in Durban, South Africa. *Journal of Interpersonal Violence*, 27, pp.1341-1356.

Groves, A., Moodley, D., Reyes, H., Martin, S., Foshee, V. and Maman, S. 2014. Prevalence, rates and correlates of intimate partner violence among South African women during pregnancy and the postpartum period. *Maternal and Child Health Journal*, 19, pp.487-495.

Gruszczyńska-Sińczak, I., Wachowska, K., Bliźniewska-Kowalska, K. and Gałecki, P. 2023. Psychiatric treatment in pregnancy: a narrative review. *Journal of Clinical Medicine,* 12(14), p.4746.

Guba, E.G. and Lincoln, Y.S. 2013. *The constructivist credo*. Walnut Creek, CA: Left Coast Press.

Guintivano, J., Sullivan, P.F., Stuebe, A.M., Penders, T., Thorp, J., Rubinow, D.R. and Meltzer-Brody, S. 2018. Adverse life events, psychiatric history, and biological predictors of

postpartum depression in an ethnically diverse sample of postpartum women. *Psychological Medicine*, 48(7), pp.1190-1200.

Gustafsson, J. 2017. Single case studies vs. multiple case studies: A comparative study. Academy of Business, Engineering and Science Halmstad University.

Hahn-Holbrook, J., Cornwell-Hinrichs, T. and Anaya, I. 2018. Economic and health predictors of national postpartum depression prevalence: A systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries. *Frontiers in Psychiatry*, 8, p.248.

Hall, K., Almeleh, C., Giese, S., Mphaphuli, E., Slemming, W., Mathys, R., Droomer, L., Proudlock, P., Kotze, J., & Sadan, M., 2024. *Support for Primary Caregivers*. In *South African Early Childhood Review* 2024 (pp. 1–20). Children's Institute, University of Cape Town.

Han, J.W. and Kim, D.J. 2020. Longitudinal relationship study of depression and self-esteem in postnatal Korean women using autoregressive cross-lagged modeling. *International journal of environmental research and public health*, 17(10), p.3743.

Hanach, N., de Vries, N., Radwan, H. and Bissani, N. 2021. The effectiveness of telemedicine interventions, delivered exclusively during the postnatal period, on postpartum depression in mothers without history or existing mental disorders: a systematic review and meta-analysis. *Midwifery*, 94, p.102906.

Hancock, D.R., Algozzine, B. and Lim, J.H. 2021. Doing case study research: A practical guide for beginning researchers. New York: Guilford Press.

Handa, A., Gaidhane, A. and Choudhari, S. 2024. Shedding light on maternal mental health in LMICs: a cornerstone of maternal and child health care. *Discover Mental Health,* 4(1), p.55.

Hankerson, S.H., Moise, N., Wilson, D., Waller, B.Y., Arnold, K.T., Duarte, C., Lugo-Candelas, C., Weissman, M.M., Wainberg, M., Yehuda, R. and Shim, R. 2022. The intergenerational impact of structural racism and cumulative trauma on depression. *American Journal of Psychiatry*, 179(6), pp.434-440.

Hanlon, C., Alem, A., Lund, C., Hailemariam, D., Assefa, E., Giorgis, T.W. and Chisholm, D. 2019. Moving towards universal health coverage for mental disorders in Ethiopia. *International Journal of Mental Health Systems,* 13(1), p.11.

Hannon, S., Gartland, D., Higgins, A., Brown, S.J., Carroll, M., Begley, C. and Daly, D. 2022. Maternal mental health in the first year postpartum in a large Irish population cohort: The MAMMI study. *Archives of Women's Mental Health*, 25(3), pp.641-653.

Haque, S. and Malebranche, M. 2020. Impact of culture on refugee women's conceptualization and experience of postpartum depression in high-income countries of resettlement: A scoping review. *PLOS ONE*, 15(9), p.e0238109.

Harriman, N.W., Williams, D.R., Morgan, J.W., Sewpaul, R., Manyaapelo, T., Sifunda, S., Mabaso, M., Mbewu, A.D. and Reddy, S.P. 2022. Racial disparities in psychological distress in post-apartheid South Africa: Results from the SANHANES-1 survey. *Social Psychiatry and Psychiatric Epidemiology*, 57(4), pp.843-857.

Harrison, J., MacGibbon, L. and Morton, M. 2001. Regimes of trustworthiness in qualitative research: The rigors of reciprocity. *Qualitative Inquiry*, 7, pp.323-345.

Harrison, P. and Todes, A. 2017. Satellite settlement on the spatial periphery: Lessons from international and Gauteng experience. Transformation: *Critical Perspectives on Southern Africa*, 95(1), pp.32-62.

Hartley, J. 2004. Case study research. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp.323-333). London: Sage.

Hasan, M.K., Zannat, Z. and Shoib, S. 2022. Mental health challenges in Bangladesh and the way forward. *Annals of Medicine and Surgery*, 80.

Hatch, M. and Posel, D. 2018. Who cares for children? A quantitative study of childcare in South Africa. *Development Southern Africa*, 35(2), pp.267-282.

Hawkins, M.M., Schmitt, M.E., Adebayo, C.T., Weitzel, J., Olukotun, O., Christensen, A.M., Ruiz, A.M., Gilman, K., Quigley, K., Dressel, A. and Mkandawire-Valhmu, L. 2021. Promoting the health of refugee women: A scoping literature review incorporating the social ecological model. *International Journal for Equity in Health*, 20(1), p.45.

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N. and Rao Gupta, G. 2019. Disrupting gender norms in health systems: Making the case for change. *The Lancet*, 393(10190), pp.2535-2549.

Haynes, A. and Loblay, V. 2024. Rethinking barriers and enablers in qualitative health research: Limitations, alternatives, and enhancements. *Qualitative Health Research*, 34(14), pp.1371-1383.

Health Professions Council of South Africa (HPCSA), 2024. *Guidelines for registered counsellors and psychologists*. Available at: https://www.hpcsa.co.za/board/psychology/guidelines [Accessed 16 October 2025].

Hendricks, S., Buch, E., Seekoe, E., Bossert, T. and Roberts, M. 2014. Decentralisation in South Africa: Options for District Health Authorities in South Africa. *South African Health Review*, 2014(1), pp.59-72.

Hendrix, J.S. 2019. Immanuel Kant: Philosophy of perception. *Architecture, Art, and Historic Preservation Faculty Publications*, 41.

Hennink, M., Hutter, I. and Bailey, A. 2020. Qualitative research methods. London: Sage.

Herbert, R. and Higgs, J. 2004. Complementary research paradigms-editorial. *Journal of Physiotherapy*, 50, pp.63-64.

Heslehurst, N., Brown, H., Pemu, A., Coleman, H. and Rankin, J. 2018. Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews. *BMC Medicine*, 16(1), p.89.

Hidalgo-Padilla, L., Toyama, M., Zafra-Tanaka, J.H., Vives, A. and Diez-Canseco, F. 2023. Association between maternity leave policies and postpartum depression: a systematic review. *Archives of Women's Mental Health,* 26(5), pp.571-580

Hlafa, B., Sibanda, K. and Hompashe, D.M. 2019. The impact of public health expenditure on health outcomes in South Africa. *International Journal of Environmental Research and Public Health*, 16(6), p.2993.

Hlongwane, N. and Juby, V. 2023. Knowledge, attitudes, and help-seeking behaviour for mental illness in a Christian community. *South African Journal of Psychiatry*, 29(1).

Holmes, A.G.D. 2020. Researcher positionality-A consideration of its influence and place in qualitative research-A new researcher guide. *Shanlax International Journal of Education*, 8(4), pp.1-10.

Honikman, S. and Field, S. 2019. Maternal mental health in South Africa and the opportunity for integration. In L.J. Kirmayer, R. Lemelson & C.A. Cummings (Eds.). *Psychosomatic medicine: An international guide for the primary care setting* (pp.335-342). Cham: Springer International Publishing.

Honikman, S., Van Heyningen, T., Field, S., Baron, E. and Tomlinson, M. 2012. Stepped care for maternal mental health: a case study of the perinatal mental health project in South Africa. *PLoS medicine*, 9(5), p.e1001222.

Horsch, A., Garthus-Niegel, S., Ayers, S., Chandra, P., Hartmann, K., Vaisbuch, E. and Lalor, J. 2024. Childbirth-related posttraumatic stress disorder: definition, risk factors, pathophysiology, diagnosis, prevention, and treatment. *American Journal of Obstetrics and Gynecology,* 230(3), pp.S1116-S1127.

Horwood, C., Haskins, L., Hinton, R., Connolly, C., Luthuli, S. and Rollins, N. 2021. Addressing the interaction between food insecurity, depression risk and informal work: findings of a cross-sectional survey among informal women workers with young children in South Africa. *BMC Women's Health,* 21(1), p.2.

Hudson, D.B., Campbell-Grossman, C., Kupzyk, K.A., Brown, S.E., Yates, B.C. and Hanna, K.M. 2016. Social support and psychosocial well-being among low-income, adolescent, African American, first-time mothers. *Clinical Nurse Specialist*, 30(3), pp.150-158.

Hung, K.J., Tomlinson, M., le Roux, I.M., Dewing, S., Chopra, M. and Tsai, A.C. 2014. Community-based prenatal screening for postpartum depression in a South African township. *International Journal of Gynecology and Obstetrics,* 126(1), pp.74-77.

Hunter-Adams, J. 2016. Mourning the support of women postpartum: The experiences of migrants in Cape Town, South Africa. *Health Care for Women International*, 37(9), pp.1010-1024.

Hwang, W.Y., Choi, S.Y. and An, H.J. 2022. Concept analysis of transition to motherhood: a methodological study. *Korean Journal of Women Health Nursing,* 28(1), pp.8-17.

Inekwe, J.N. and Lee, E. 2022. Perceived social support on postpartum mental health: An instrumental variable analysis. *PloS One*, 17(5), e0265941.

Isobel, S. 2023. Trauma and the perinatal period: A review of the theory and practice of trauma-sensitive interactions for nurses and midwives. *Nursing Open,* 10(12), pp.7585-7595.

Jack, H., Wagner, R.G., Petersen, I., Thom, R., Newton, C.R., Stein, A., Kahn, K., Tollman, S. and Hofman, K.J. 2014. Closing the mental health treatment gap in South Africa: a review of costs and cost-effectiveness. *Global Health Action, 7(1),* p.23431.

Jorm, A.F. 2012. Mental health literacy: empowering the community to take action for better mental health. *American psychologist*, 67(3), p.231.

Jolof, L., Rocca, P., Mazaheri, M., Okenwa Emegwa, L. and Carlsson, T. 2022. Experiences of armed conflicts and forced migration among women from countries in the Middle East, Balkans, and Africa: A systematic review of qualitative studies. *Conflict and Health*, 16(1), p.46.

Jongen, C., McCalman, J. and Bainbridge, R. 2018. Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research*, 18(1), p.232.

Jürgens, U., Donaldson, R., Rule, S. and Bähr, J. 2013. Townships in South African cities - Literature review and research perspectives. *Habitat International,* 39, pp.256-260.

Kamel, H., Navi, B.B., Sriram, N., Hovsepian, D.A., Devereux, R.B. and Elkind, M.S. 2014. Risk of a thrombotic event after the 6-week postpartum period. *New England Journal of Medicine*, 370(14), pp.1307-1315.

Kaminer, D., Owen, M. and Schwartz, B. 2018. Systematic review of the evidence base for treatment of common mental disorders in South Africa. *South African Journal of Psychology,* 48(1), pp.32-47.

Kapetanovic, S., Dass-Brailsford, P., Nora, D. and Talisman, N. 2014. Mental health of HIV-seropositive women during pregnancy and postpartum period: A comprehensive literature review. *AIDS and Behavior*, 18, pp.1152-1173.

Kariuki, E.W., Kuria, M.W., Were, F.N. and Ndetei, D.M. 2021. Effectiveness of a brief psychoeducational intervention on postnatal depression in the slums, Nairobi: a longitudinal study. *Archives of Women's Mental Health,* 24, pp.503-511.

Käss, S., Brosig, C., Westner, M. and Strahringer, S. 2024. Short and sweet: Multiple mini case studies as a form of rigorous case study research. *Information Systems and e-Business Management*, 22(2), pp.1-34.

Kathree, T., Selohilwe, O.M., Bhana, A. and Petersen, I. 2014. Perceptions of postnatal depression and health care needs in a South African sample: The “mental” in maternal health care. *BMC Women’s Health*, 14(1), p.140.

Keleynikov, M., Cohen, N. and Benatov, J. 2024. Maternal distress during the COVID-19 outbreak: A socio-ecological perspective. *PLoS One*, 19, e0302266.

Kelly, L., Martin-Kerry, J. and Prady, S. 2023. Postnatal depression and homelessness in women living in high-income countries: A scoping review. *Psychological Studies*, 68(4), pp.489-501.

Kent-Marvick, J., Simonsen, S., Pentecost, R., Taylor, E. and McFarland, M.M. 2022. Loneliness in pregnant and postpartum people and parents of children aged 5 years or younger: A scoping review. *Systematic Reviews*, 11(1), p.196.

Kiendrébéogo, J.A., de Allegri, M. and Meessen, B. 2020. Policy learning and Universal Health Coverage in low- and middle-income countries. *Health Research Policy and Systems*, 18(1), p.85.

Kilanowski, J.F. 2017. Breadth of the socio-ecological model. *Journal of Agromedicine*, 22(4), pp.295-297.

Kirmayer, L.J. and Pedersen, D. 2014. Toward a new architecture for global mental health. *Transcultural Psychiatry*, 51(6), pp.720-742.

Kivunja, C. and Kuyini, A.B. 2017. Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, 6(5), pp.26-41.

Kjeldsen, M.M.Z., Bricca, A., Liu, X., Frokjaer, V.G., Madsen, K.B. and Munk-Olsen, T. 2022. Family history of psychiatric disorders as a risk factor for maternal postpartum depression: A systematic review protocol. *Systematic Reviews*, 11.

Kjeldsen, M.M.Z., Bricca, A., Liu, X., Frokjaer, V.G., Madsen, K.B. and Munk-Olsen, T. 2022. Family history of psychiatric disorders as a risk factor for maternal postpartum depression: a systematic review and meta-analysis. *JAMA Psychiatry*, 79(10), pp.1004-1013.

Kleintjes, S. and Schneider, M. 2023. History and politics of mental health policy and care in South Africa. *SSM - Mental Health*, 3, p.100206.

Kolb, D.A. 2014. *Experiential learning: Experience as the source of learning and development*. Upper Saddle River, New Jersey: Pearson.

Kozhimannil, K.B., Trinacty, C.M., Busch, A.B., Huskamp, H.A. and Adams, A.S. 2011. Racial and ethnic disparities in postpartum depression care among low-income women. *Psychiatric Services*, 62(6), pp.619-625.

Kramers-Olen, A.L. 2014. Psychosocial rehabilitation and chronic mental illness: International trends and South African issues. *South African Journal of Psychology*, 44(4), pp.498-513.

Kukla, A. 2000. *Social constructivism and the philosophy of science*. London: Routledge.

Kula, N. and Fryatt, R.J. 2014. Public-private interactions on health in South Africa: Opportunities for scaling up. *Health Policy and Planning*, 29(5), pp.560-569.

Kumarasinghe, M., Herath, M.P., Hills, A.P. and Ahuja, K.D. 2024. Postpartum versus postnatal period: Do the name and duration matter?. *PloS one*, 19(4), p.e0300118.

Kuo, C., Schonbrun, Y.C., Zlotnick, C., Bates, N., Todorova, R., Kao, J.C.W. and Johnson, J. 2013. A qualitative study of treatment needs among pregnant and postpartum women with substance use and depression. *Substance Use and Misuse*, 48(14), pp.1498-1508.

Kurzhals, K. 2021. *Resource Recombination in Firms from a Dynamic Capability Perspective.* Wiesbaden: Springer.

Langlois, É.V., Miszkurka, M., Zunzunegui, M.V., Ghaffar, A., Ziegler, D. and Karp, I. 2015. Inequities in postnatal care in low- and middle-income countries: A systematic review and meta-analysis. *Bulletin of the World Health Organization*, 93, pp.259-270G.

Lavanya, L., Raman, K., Nambi, S. and Chandraleka, G. 2019. Familial bipolar variant of postpartum psychosis: A case report. *Indian Journal of Private Psychiatry*, 13(2), pp.82-84.

Legere, L.E., Wallace, K., Bowen, A., McQueen, K., Montgomery, P. and Evans, M. 2017. Approaches to health-care provider education and professional development in perinatal depression: A systematic review. *BMC Pregnancy and Childbirth*, 17(1), p.239.

Leichsenring, F., Abbass, A., Hilsenroth, M.J., Luyten, P., Munder, T., Rabung, S. and Steinert, C. 2018. Gold standards, plurality and monocultures: The need for diversity in psychotherapy. *Frontiers in Psychiatry*, 9, p.159.

Leonard, K.S., Evans, M.B., Kjerulff, K.H. and Symons Downs, D. 2020. Postpartum perceived stress explains the association between perceived social support and depressive symptoms. *Women's Health Issues*, 30(4), pp.231-239.

Le Roux, K.W., Almirol, E., Rezvan, P.H., Le Roux, I.M., Mbewu, N., Dippenaar, E., Stansert-Katzen, L., Baker, V., Tomlinson, M. and Rotheram-Borus, M.J. 2020. Community health workers impact on maternal and child health outcomes in rural South Africa–a non-randomized two-group comparison study. *BMC public health*, 20(1), p.1404.

Leung Soo, C., Pant Pai, N., Bartlett, S.J., Esmail, A., Dheda, K. and Bhatnagar, S. 2023. Socioeconomic factors impact the risk of HIV acquisition in the township population of South Africa: A Bayesian analysis. *PLOS Global Public Health*, 3(1), e0001502.

Lewis, B.A., Schuver, K., Dunsiger, S., Samson, L., Frayeh, A.L., Terrell, C.A. and Avery, M.D. 2021. Randomized trial examining the effect of exercise and wellness interventions on

preventing postpartum depression and perceived stress. *BMC Pregnancy and Childbirth*, 21(1), p.785.

Liamputtong, P. 2007. *Researching the Vulnerable: A Guide to Sensitive Research Methods*. London: SAGE Publications.

Lim, W.M. 2024. What is qualitative research? An overview and guidelines. *Australasian Marketing Journal*, 33(2), pp.199-229.

Lincoln, Y. and Guba, E. 2000. Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp.163-188). Thousand Oaks, CA: Sage.

Lincoln, Y.S. and Guba, E.G. 1985. *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Link, B.G. and Phelan, J.C. 2001. Conceptualizing stigma. *Annual review of Sociology*, 27(1), pp.363-385.

Liu, C.H. and Matthews, R. 2005. Vygotsky's philosophy: Constructivism and its criticisms examined. *International Education Journal*, 6(3), pp.386-399.

Liu, X., Wang, S. and Wang, G. 2022. Prevalence and risk factors of postpartum depression in women: A systematic review and meta-analysis. *Journal of Clinical Nursing*, 31(19-20), pp.2665-2677.

Lobo, M. A., Moeyaert, M., Baraldi Cunha, A., and Babik, I. 2017. Single-case design, analysis, and quality assessment for intervention research. *Journal of Neurologic Physical Therapy,* 41(3), pp.187-197.

Lovero, K.L., Lammie, S.L., van Zyl, A., Paul, S.N., Ngwepe, P., Mootz, J.J., Carlson, C., Sweetland, A.C., Shelton, R.C., Wainberg, M.L. and Medina-Marino, A. 2019. Mixed-methods evaluation of mental healthcare integration into tuberculosis and maternal-child healthcare services of four South African districts. *BMC Health Services Research*, 19(1), pp.1-12.

Lucas, P., Fleming, J. and Bhosale, J. 2018. The utility of case study as a methodology for work-integrated learning research. *International Journal of Work-Integrated Learning*, 19(3), pp.215-222.

Lund, C., Kleintjes, S., Kakuma, R., Flisher, A.J. and MHaPP Research Programme Consortium. 2010. Public sector mental health systems in South Africa: inter-provincial

comparisons and policy implications. *Social psychiatry and psychiatric epidemiology*, 45(3), pp.393-404.

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E.C., Breuer, E., Chandra, P., Haushofer, J., Herrman, H., Jordans, M., Kieling, C. and Medina-Mora, M.E. 2018. Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry*, 5(4), pp.357-369.

Lund, C., Kleintjes, S., Cooper, S., Petersen, I., Bhana, A., Flisher, A.J. and MHaPP Research Programme Consortium. 2011. Challenges facing South Africa's mental health care system: stakeholders' perceptions of causes and potential solutions. *International Journal of Culture and Mental Health,* 4(1), pp.23-38.

Lund, C., Petersen, I., Kleintjes, S. and Bhana, A. 2012. Mental health services in South Africa: Taking stock. *African Journal of Psychiatry,* 15(6), pp.402-405.

Luo, F., Zhu, Z., Du, Y., Chen, L. and Cheng, Y. 2023. Risk factors for postpartum depression based on genetic and epigenetic interactions. *Molecular Neurobiology*, 60(7), pp.3979-4003.

Luvo, K. and Saunders, Y.U. 2022. The role of culture in gender-based violence and its impacts on the lives and wellbeing of women: Implications for social work. *Ponte International Scientific Research Journal*, 78(12), pp.39-51.

Lyons, H.Z., Bike, D.H., Ojeda, L., Johnson, A., Rosales, R. and Flores, L.Y. 2013. Qualitative research as social justice practice with culturally diverse populations. *Journal for Social Action in Counseling & Psychology*, 5(2), pp.10-25.

Ma, P.H.X., Chan, Z.C.Y. and Loke, A.Y. 2017. The socio-ecological model approach to understanding barriers and facilitators to the accessing of health services by sex workers: A systematic review. *AIDS and Behavior*, 21(8), pp.2412-2438.

Mackenzie, N. and Knipe, S. 2006. Research dilemmas: paradigms, methods and methodology. *Issues in Educational Research*, 16(2), pp.193-205.

Maconick, L., Jenkins, L.S., Fisher, H., Petrie, A., Boon, L. and Reuter, H. 2018. Mental health in primary care: Integration through in-service training in a South African rural clinic. *African Journal of Primary Health Care and Family Medicine*, 10(1), pp.1-7.

Madeghe, B.A., Kogi-Makau, W., Ngala, S. and Kumar, M. 2022. Nutritional deficiencies and maternal depression: Associations and interventions in lower and middle-income countries: A systematic review of literature. *Global Social Welfare*, 9(1), pp.11-25.

Mahlatsi, K. 2021. Achieving Sustainable Development Goals (SDGs) in Africa: Challenges and prospects. *The Thinker*, 87(2), pp.61-69.

Maia, B.R., Pereira, A.T., Marques, M., Bos, S., Soares, M.J., Valente, J., Gomes, A.A., Azevedo, M.H. and Macedo, A. 2012. The role of perfectionism in postpartum depression and symptomatology. *Archives of Women's Mental Health*, 15(6), pp.459-468.

Mal-Sarkar, T., Keyes, K., Koen, N., Barnett, W., Myer, L., Rutherford, C., Zar, H.J., Stein, D.J. and Lund, C. 2021. The relationship between childhood trauma, socioeconomic status, and maternal depression among pregnant women in a South African birth cohort study. *SSM-population health*, 14, p.100770.

Malinga, M. and Ratele, K. 2022. Fatherhood among marginalised work-seeking men in South Africa. *Engaged fatherhood for men, families and gender equality*, p.265.

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E. and Magar, V. 2018. Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, 96(9), p.644.

Manfredo, M.J., Teel, T.L., Gavin, M.C. and Fulton, D. 2014. Considerations in representing human individuals in social-ecological models. In M.J. Manfredo, J.J. Vaske, A. Rechkemmer & E.A. Duke (Eds). *Understanding society and natural resources: Forging new strands of integration across the social sciences* (pp.137-158). Dordrecht: Springer.

Mann, C. and Stewart, F. 2021. *An introduction to research methods for undergraduate health profession students* (1st ed.). London: SAGE Publications.

Manolova, G., Waqas, A., Chowdhary, N., Salisbury, T.T. and Dua, T. 2023. Integrating perinatal mental healthcare into maternal and perinatal services in low and middle income countries. *BMJ (Clinical Research Ed.)*, 381, e073343.

Maphumulo, W.T. and Bhengu, B.R. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1), pp.1-9.

Marais, D.L. and Petersen, I. 2015. Health system governance to support integrated mental health care in South Africa: Challenges and opportunities. *International Journal of Mental Health Systems*, 9(1), p.14.

Martí, E. 2023. Constructivism. In V.P. Glăveanu (Ed.), The Palgrave Encyclopedia of the Possible (pp.237-243). Cham: Springer International Publishing.

Marutlulle, N.K. 2021. A critical analysis of housing inadequacy in South Africa and its ramifications. *Africa's Public Service Delivery & Performance Review*, 9(1), p.372.

Mary, E. and Antony, A. 2022. Framing childhood resilience through Bronfenbrenner's ecological systems theory: A discussion paper. *Cambridge Educational Research E-Journal*, 9, pp.244-257.

Mascayano, F., Armijo, J.E. and Yang, L.H. 2015. Addressing stigma relating to mental illness in low- and middle-income countries. *Frontiers in Psychiatry*, 6, p.38.

Masiko, N. and Xinwa, S. 2017. Substance abuse in South Africa, its linkages with gender-based violence and urban violence. *Centre for the Study of Violence and Reconciliation*. Available from https://docslib.org/doc/7441933/substance-abuse-in-south-africa-its-linkages-with-gender-based-violence-and-urban-violence [accessed 19 November 2024].

Massyn, N., Day, C., Ndlovu, N. and Padayachee, T. 2020. *District health barometer 2019/20*. Health Systems Trust. Available from https://www.hst.org.za/publications/Pages/DHB2019-20.aspx [accessed 20 July 2025[.

Mataboge, M.L.S., Beukes, S. and Nolte, A.G.W. 2016. The experiences of clients and healthcare providers regarding the provision of reproductive health services including the prevention of HIV and AIDS in an informal settlement in Tshwane. *Health SA Gesondheid*, 21(1), pp.67-76.

Mayston, R., Frissa, S., Tekola, B., Hanlon, C., Prince, M. and Fekadu, A. 2020. Explanatory models of depression in sub-Saharan Africa: Synthesis of qualitative evidence. *Social science & medicine*, 246, p.112760.

Mbaka, R. and Mwange, A. 2023. A critical narrative review of public-private partnerships in the health sector in selected Southern African countries. *Journal of Economics and Sustainable Development*, 14(13), pp.83-98.

Mboweni, E.N. 2024. *Perceptions and knowledge of community members regarding mental health disorders in Matsafeni Village, Ehlanzeni* (Doctoral dissertation).

Mboweni, E.N., Mphasha, M.H. and Skaal, L., 2023, December. Exploring mental health awareness: a study on knowledge and perceptions of mental health disorders among residents of Matsafeni village, Mbombela, Mpumalanga Province. In *Healthcare* (Vol. 12, No. 1, p. 85). MDPI.

McCartney, G., Dickie, E., Escobar, O. and Collins, C. 2021. Health inequalities, fundamental causes and power: Towards the practice of good theory. *Sociology of Health and Illness*, 43(1), pp.20-39.

McKelvey, M.M. and Espelin, J. 2018. Postpartum depression: Beyond the baby blues. *Nursing Made Incredibly Easy*, 16(3), pp.28-35.

McKenna, A., Abrahams, Z., Marsay, C. and Honikman, S. 2017. Screening for common perinatal mental disorders in South Africa. *Perinatal Mental Health*. UCT/Alan J. Fischer Centre for Mental Health/John Hopkins. Available from https://pmhp.za.org/wp-content/uploads/McKenna_CPMD-poster_6.pdf [accessed 20 July 2025].

McLeroy, K.R., Bibeau, D., Steckler, A. and Glanz, K. 1988. An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), pp.351-377.

McNab, S.E., Dryer, S.L., Fitzgerald, L., Gomez, P., Bhatti, A.M., Kenyi, E., Somji, A., Khadka, N. and Stalls, S. 2022. The silent burden: A landscape analysis of common perinatal mental disorders in low- and middle-income countries. *BMC Pregnancy and Childbirth*, 22(1), p.342.

McNab, S., Dryer, S., Gomez, P., Bhatti, A., Khadka, N. and Kenyi, E. 2021. *The silent burden: Common perinatal mental disorders in low- and middle-income countries*. Washington, DC: USAID MOMENTUM.

Meadows, D.H. 2008. *Thinking in Systems: A Primer*. White River Junction, VT: Chelsea Green Publishing.

Mehtälä, M.A.K., Sääkslahti, A.K., Inkinen, M.E. and Poskiparta, M.E.H. 2014. A socio-ecological approach to physical activity interventions in childcare: A systematic review. *International Journal of Behavioral Nutrition and Physical Activity*, 11(1), p.22.

Meltzer-Brody, S. and Munk-Olsen, T. 2018. Familiality of psychiatric disorders and risk of postpartum psychiatric episodes: A population-based cohort study. *American Journal of Psychiatry*, 175(8), pp.783-791.

Meyer, J.C., Matlala, M. and Chigome, A. 2019. Mental health care—a public health priority in South Africa. *South African Family Practice*, 61(5), pp.25-29.

Miani, C., Wandschneider, L., Niemann, J., Batram-Zantvoort, S. and Razum, O. 2021. Measurement of gender as a social determinant of health in epidemiology—a scoping review. *PLoS ONE*, 16(11), p.e0259223.

Michaels, C., Blake, L., Lynn, A., Greylord, T. and Benning, S. 2022. *Mental health and well-being ecological model*. Center for Leadership Education in Maternal & Child Public Health, University of Minnesota-Twin Cities.

Michalopoulos, S. and Papaioannou, E. 2016. The long-run effects of the scramble for Africa. *American Economic Review*, 106(7), pp.1802-1848.

Milani, H.S., Azargashb, E., Beyraghi, N., Defaie, S. and Asbaghi, T. 2015. Effect of telephone-based support on postpartum depression: a randomized controlled trial. *International journal of fertility & sterilit*y, 9(2), p.247.

Miles, R. 2015. Complexity, representation and practice: Case study as method and methodology. *Issues in Educational Research*, 25(3), pp.309-318.

Miller, E.S., Wisner, K.L., Gollan, J., Hamade, S., Gossett, D.R. and Grobman, W.A. 2019. Screening and treatment after implementation of a universal perinatal depression screening program. Obstetrics & Gynecology, 134(2), pp.303-309.

Mills, C. 2014. *Decolonizing global mental health: The psychopolitics of psychiatry*. London: Routledge.

Milosavljevic, M., Lecic-Tosevski, D., Rakic, S. and Vranes, T. 2024. Postpartum posttraumatic stress disorder.

Milosavljevic, M., Lecic-Tosevski, D., Rakic, S. and Vranes, T. 2024. Postpartum Posttraumatic Stress Disorder. In Z.O. Amarin (Ed.), *Childbirth-Clinical Assessment, Methods, and Management*. IntechOpen.

Mishra, A.K. and Varma, A.R. 2023. A comprehensive review of the generalized anxiety disorder. *Cureus*, 15(9), 46115.

Mkhwanazi, T. 2024. Assessing the National Health Insurance (NHI) in South Africa: Policy formulation, stakeholder engagement and implementation challenges. *European Journal of Medical and Health Research*, 2(6), pp.198-215.

Mmamabolo, T., Schwartz, K. and Vuma, P. 2020. Rendering victim-friendly services for women and children in South Africa: Why is the SAPS's response to victims still unsatisfactory? *Just Africa*, 5, pp.12-23.

Modak, A., Ronghe, V., Gomase, K.P., Mahakalkar, M.G. and Taksande, V. 2023. A comprehensive review of motherhood and mental health: Postpartum mood disorders in focus. *Cureus*, 15(9), e44139.

Modjadji, P. and Mokwena, K. 2020. Postnatal depression screening among postpartum women attending postnatal care at selected community health centres situated in the Nkangala District of South Africa. *The Open Public Health Journal*, 13(1), pp.696-704.

Mokwena, K. and Masike, I. 2020. The need for universal screening for postnatal depression in South Africa: Confirmation from a sub-district in Pretoria, South Africa. *International Journal of Environmental Research and Public Health*, 17(19), p.6980.

Mokwena, K. and Modjadj, P. 2022. A comparative study of postnatal depression and associated factors in Gauteng and Free State provinces, South Africa. *African Journal of Primary Health Care and Family Medicine*, 14.

Mokwena, K.E. 2021. Neglecting maternal depression compromises child health and development outcomes, and violates children's rights in South Africa. *Children*, 8(7), p.609.

Mokwena, K.E. and Ndlovu, J. 2021. Why do patients with mental disorders default treatment? A qualitative enquiry in rural KwaZulu-Natal, South Africa. *Healthcare (Switzerland)*, 9(4), p.452.

Molenaar, J., Hanlon, C., Alem, A., Wondimagegn, D., Medhin, G., Prince, M. and Stevenson, E.G. 2020. Perinatal mental distress in a rural Ethiopian community: a critical examination of psychiatric labels. *BMC psychiatry*, 20(1), p.223.

Monnapula-Mazabane, P. and Petersen, I. 2023. Mental health stigma experiences among caregivers and service users in South Africa: A qualitative investigation. *Current Psychology*, 42(11), pp.9427-9439.

Moodley, J., Fawcus, S. and Pattinson, R. 2018. Improvements in maternal mortality in South Africa. *South African Medical Journal*, 108(3), pp.4-8.

Moodley, S., Wolvaardt, J. and Grobler, C. 2022. Enabling mental health task-sharing: A collective case study of undergraduate clinical associate training programmes in South Africa. *BMC Medical Education*, 22(1), p.180.

Moore, L., Hallingberg, B., Wight, D., Turley, R., Segrott, J., Craig, P., Robling, M., Murphy, S., Simpson, S.A. and Moore, G. 2018. Exploratory studies to inform full-scale evaluations of

complex public health interventions: the need for guidance. *J Epidemiol Community Health*, 72, pp.865-866.

Morar, T., Breedt, J.E., Mdaka, N., Maaroganye, K. and Robertson, L. 2024. Is mental health in South Africa moving forward? *BJPsych International*, 21(1), pp.1-3.

Morgan, D.L. 2014. Integrating qualitative and quantitative methods: A pragmatic approach. Thousand Oaks: Sage.

Morse, A. and McEvoy, C. 2014. Qualitative research in sport management: Case study as a methodological approach. *The Qualitative Report,* 19(17), pp.1-3.

Mottola, M.F. 2002. Exercise in the postpartum period: Practical applications. *Current Sports Medicine Reports*, 1(6), pp.362-368.

Mthetwa, T.M., 2022. *The NHI as an Alternative to Developing South Africa's Healthcare System: A Retrospective Analysis* (Master's thesis, University of Pretoria (South Africa).

Mughal, S., Azhar, Y. and Siddiqui, W. 2018. *Postpartum depression.* Treasure Island (FL): StatPearls Publishing.

Mugwagwa, J. and Banda, G. 2020. *Exploring the role of public-private partnerships in health systems strengthening: Experience from Southern Africa.* Available from https://policycommons.net/artifacts/2232639/exploring-the-role-of-public-private-partnerships-in-health-systems-strengthening/2990432/ [accessed 5 June 2024].

Mukwena, N.V. and Manyisa, Z.M. 2022. Factors influencing the preparedness for the implementation of the national health insurance scheme at a selected hospital in Gauteng Province, South Africa. *BMC Health Services Research*, 22(1), p.1006.

Mulcahy, K. and Kollamparambil, U. 2016. The impact of rural-urban migration on subjective well-being in South Africa. *The Journal of Development Studies*, 52, pp.1357-1371.

Murray, L., Fearon, P. and Cooper, P. 2014. Postnatal depression, mother-infant interactions, and child development: Prospects for screening and treatment. In J. Milgrom & A.W. Gemmill (Eds.), *Identifying Perinatal Depression and Anxiety: Evidence-Based Practice in Screening, Psychosocial Assessment, and Management* (pp.139-164). New York: Wiley.

Musyimi, C.W., Mutiso, V.N., Nandoya, E.S. and Ndetei, D.M. 2016. Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a Kenyan setting: towards common grounds. Journal of Ethnobiology and Ethnomedicine, 12, pp.1-8.

Mutahi, J., Larsen, A., Cuijpers, P., Peterson, S.S., Unutzer, J., McKay, M., John-Stewart, G., Jewell, T., Kinuthia, J., Gohar, F., Lai, J., Wamalwa, D., Gachuno, O. and Kumar, M. 2022. Mental health problems and service gaps experienced by pregnant adolescents and young women in Sub-Saharan Africa: A systematic review. *EClinicalMedicine*, 44.

Myers, B., Carney, T. and Wechsberg, W.M. 2016. Not on the agenda: a qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa. *International Journal of Drug Policy*, 30, pp.52-58.

Myers, B., Petersen-Williams, P., van der Westhuizen, C., Lund, C., Lombard, C., Joska, J.A., Levitt, N.S., Butler, C., Naledi, T., Milligan, P., Stein, D.J. and Sorsdahl, K. 2019. Community health worker-delivered counselling for common mental disorders among chronic disease patients in South Africa: a feasibility study. *BMJ Open*, 9.

Nadkarni, A., Hanlon, C. and Patel, V. 2024. Mental health care models in low- and middle-income countries. In A. Tam (Ed.), *Tasman's Psychiatry* (pp.3347-3393). Cham: Springer International Publishing.

Naher, N., Hoque, R., Hassan, M.S., Balabanova, D., Adams, A.M. and Ahmed, S.M. 2020. The influence of corruption and governance in the delivery of frontline health care services in the public sector: a scoping review of current and future prospects in low and middle-income countries of South and South-East Asia. *BMC Public Health*, 20(1), p.880.

Naidoo, V., Suleman, F. and Bangalee, V. 2023. Policy developer's perceptions on the implementation of National Health Insurance in South Africa: a qualitative study. *Journal of Pharmaceutical Policy and Practice*, 16(1), p.61.

Nallala, S., Ghosh, U., Desaraju, S.S., Kadam, S., Kadarpeta, R.R. and Van Belle, S. 2023. Why are they "unreached"? Macro and meso determinants of health care access in hard to reach areas of Odisha, India. *International Journal for Equity in Health*, 22(1), p.2.

National Planning Commission. 2024. *National Mental Health Policy Framework and Strategic Plan 2023-2030*. Available from https://www.health.gov.za/wp-content/uploads/2024/02/National-Mental-Health-Policy-framework-and-strategic-Plan-2023-2030.pdf (Accessed: 23 March 2025).

Ndebele, N.C., Mlambo, V.H., Molepo, N.J. and Sibiya, L.M. 2021. The South African health sector and the World Health Organization: South Africa's health sector and its preparedness

for the National Health Insurance (NHI): challenges and opportunities. *European Journal of Economics, Law and Social Sciences.*

Ng'oma, M., Bitew, T., Kaiyo-Utete, M., Hanlon, C., Honikman, S. and Stewart, R.C. 2020. Perinatal mental health around the world: priorities for research and service development in Africa. *BJPsych International*, 17(3), pp.56-59.

Ngwenya, N., Nkosi, B., McHunu, L.S., Ferguson, J., Seeley, J. and Doyle, A.M. 2020. Behavioural and socio-ecological factors that influence access and utilisation of health services by young people living in rural KwaZulu-Natal, South Africa: implications for intervention. *PLoS ONE*, 15.

Nieuwenhuis, J. 2016. Introducing qualitative research. In K. Maree (Ed.). *First steps in research* (2nd ed.; pp.50-71). Pretoria: Van Schaik Publishers.

Niksalehi, S., Taghadosi, M., Mazhariazad, F. and Tashk, M. 2018. The effectiveness of mobile phone text massaging support for mothers with postpartum depression: A clinical before and after study. *Journal of Family Medicine and Primary Care*, 7(5), pp.1058-1062.

Nishimwe-Niymbanira, R. and Sabela, P.T. 2019. Gender dynamics in employment and labour force trends in South Africa. *International Journal of Economics and Finance Studies*, 11(2), pp.36-54.

Nolvi, S., Merz, E.C., Kataja, E.L. and Parsons, C.E. 2023. Prenatal stress and the developing braIn postnatal environments promoting resilience. *Biological Psychiatry*, 93, pp.942-952.

Nonyel, N.P., Wisseh, C., Riley, A.C., Campbell, H.E., Butler, L.M. and Shaw, T. 2021. Conceptualizing social ecological model in pharmacy to address racism as a social determinant of health. *American Journal of Pharmaceutical Education*, 85, p.8584.

Nsanzabaganwa, C., Musanabaganwa, C. and Mutesa, L. 2024. Thirty years of Rwanda's resilience and success: a sign of hope for mental health recovery after the 1994 genocide against the Tutsi. *Rwanda Public Health Bulletin*, 5(1), pp.7-10.

Nteta, T.P., Mokgatle-Nthabu, M. and Oguntibeju, O.O. 2010. Utilization of the primary health care services in the Tshwane Region of Gauteng Province, South Africa. *PloS one*, 5(11), p.e13909.

Nxumalo, N., Goudge, J. and Manderson, L. 2016. Community health workers, recipients' experiences and constraints to care in South Africa - a pathway to trust. *AIDS Care*, *28*(suppl. 4), pp.61-71.

Nyasulu, N.D., Taylor, M. and Khuzwayo, N. 2025. Community caregivers' perceptions: Family-centred postnatal care in KwaZulu-Natal, South Africa. *African journal of primary health care & family medicine*, 17(1), pp.1-9.

Nyoni, G. and Kollamparambil, U. 2022. Rural-urban migration and the well-being of the migrant-sending households: An impact evaluation study. *South African Journal of Economic and Management Sciences*, 25(1), p.4120.

Ogundare, T. 2020. Culture and mental health: Towards cultural competence in mental

O'hara, M.W. and McCabe, J.E. 2013. Postpartum depression: current status and future directions. *Annual Review of Clinical Psychology*, 9(1), pp.379-407.

Osok, J., Kigamwa, P., Huang, K.Y., Grote, N. and Kumar, M. 2018. Adversities and mental health needs of pregnant adolescents in Kenya: identifying interpersonal, practical, and cultural barriers to care. *BMC women's health*, 18(1), pp.1-18.

Olmos-Vega, F.M., Stalmeijer, R.E., Varpio, L. and Kahlke, R. 2023. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, 45, pp.241-251.

Omotoso, K.O. and Koch, S.F. 2018. Assessing changes in social determinants of health inequalities in South Africa: A decomposition analysis. *International Journal for Equity in Health*, 17, pp.1-13.

Onu, J.U., Olatayo, T.I., Okorie, A.C. and Ohaeri, J.U. 2023. Family, twin and adoption studies of severe mental disorders in sub-Saharan Africa: A scoping review. *Social Psychiatry and Psychiatric Epidemiology*, 58, pp.685-692.

Osborne, L.M. 2018. Recognizing and managing postpartum psychosis: A clinical guide for obstetric providers. *Obstetrics and Gynecology Clinics of North America*, 45(3), p.455.

Oyetunji, A. and Chandra, P. 2020. Postpartum stress and infant outcome: A review of current literature. *Psychiatry Research*, 284, p.112769.

Paddock, K., Wilson, C., Walshe, C. and Todd, C. 2018. Care home life and identity: A qualitative case study. *The Gerontologist*, 59, pp.655-664.

Palfreyman, A. and Gazeley, U. 2022. Adolescent perinatal mental health in South Asia and Sub-Saharan Africa: A systematic review of qualitative and quantitative evidence. *Social Science and Medicine*, 313, p.115413.

Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N. and Hoagwood, K. 2015. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), pp.533-544.

Pamungkasari, E.P. and Prasetya, H. 2023. Effect of home visit by community health cadre on postpartum depression: meta-analysis. *Journal of Maternal and Child Health*, 8(4), pp.460-471.

Pant, K.R. 2023. Eight moments in the history of qualitative research. *AMC Journal (Dhangadhi)*, 4, pp.38-44.

Parasian, L.C. 2021. Biological predictors of postpartum depression: A literature review. *Scientia Psychiatrica*, 3(2), pp.247-257.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P.Y., Cooper, J.L., Eaton, J. and Herrman, H. 2018. The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), pp.1553-1598.

Patton, M.Q. 2015. Qualitative research & evaluation methods: Integrating theory and practice (4th ed). Thousand Oaks, CA: SAGE Publications.

Payne, J.L. and Maguire, J. 2019. Pathophysiological mechanisms implicated in postpartum depression. *Frontiers in Neuroendocrinology*, 52, pp.165-180.

Penchansky, R. and Thomas, J.W. 1981. The concept of access: definition and relationship to consumer satisfaction. *Medical care*, 19(2), pp.127-140.

Pereira-Kotze, C., Feeley, A., Doherty, T. and Faber, M. 2023. Maternity protection entitlements for non-standard workers in low-and-middle-income countries and potential implications for breastfeeding practices: a scoping review of research since 2000. *International Breastfeeding Journal*, 18(1), p.9.

Pereira-Morales, A.J., Adan, A. and Forero, D.A. 2019. Perceived stress as a mediator of the relationship between neuroticism and depression and anxiety symptoms. *Current Psychology*, 38.

Perinatal Mental Health Project. (2010). *Policy Brief 15: Maternal Mental Health: Addressing Key Vulnerabilities*. Available at: https://pmhp.za.org/wp-content/uploads/2015/01/PolicyBrief_PMHP_0710.pdf

Perinatal Mental Health Project (PMHP), 2015. *Impact and outcomes. Cape Town: PMHP.* Available at: https://pmhp.za.org/wp-content/uploads/2015/01/PMHP_Outcome_Impact1.pdf [Accessed 16 October 2025].

Perron, N.C. 2017. Bronfenbrenner's ecological systems theory. In W.K. Killam, S. Degges-White & L.N. LMHC-IN (Eds.), *College Student Development: Applying Theory to Practice on the Diverse Campus* (pp.197-2010). Cham: Springer.

Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S., Hosegood, V., Flisher, A.J. and Mental Health and Poverty Research Programme Consortium. 2009. Planning for district mental health services in South Africa: a situational analysis of a rural district site. Health Policy and Planning, 24(2), pp.140-150.

Petersen, I., Lund, C., Bhana, A. and Flisher, A.J. 2012. A task shifting approach to primary mental health care for adults in South Africa: Human resource requirements and costs for rural settings. *Health Policy and Planning*, 27.

Petersen, I., Kemp, C.G., Rao, D., Wagenaar, B.H., Bachmann, M., Sherr, K., Kathree, T., Luvuno, Z., Van Rensburg, A., Gigaba, S.G. and Mthethwa, L. 2023. Strengthening integrated depression services within routine primary health care using the RE-AIM framework in South Africa. *PLOS Global Public Health*, 3(11), p.e0002604.

Peters, D.H. 2014. The application of systems thinking in health: why use systems thinking?. *Health research policy and systems*, 12(1), p.51.

Petty, S. 2023. *Women's experience of perinatal anxiety and help-seeking in the context of the COVID-19 pandemic* (Doctoral dissertation). Winnipeg: University of Manitoba.

Philip, K. 2014. A history of townships in South Africa. In S. Mahajan (Ed.), *Economics of South African Townships: Special Focus on Diepsloot*, 31-48. World Bank

Phoebe, E.D., Mustikasari, T., Harmada, W.S.P.A., Octaviana, D.S., Wolayan, G.A.C., Husnina, Q.K., Purnomo, N.F., Gotama, I.M., Tjoewinata, J.S. and Nyoman Sumiati. 2022. Anxiety disorders in pregnancy during the COVID-19 pandemic: What are the risk factors? *Jurnal Psikiatri Surabaya*, 11(2).

Pillay, Y., 2022. The role of non-governmental organisations in strengthening the South African health system: A commentary. *South African Journal of Psychology*, 52(2), pp.149-153.

Place, J.M.S., Renbarger, K., Van De Griend, K., Guinn, M., Wheatley, C. and Holmes, O. 2024. Barriers to help-seeking for postpartum depression mapped onto the socio-ecological model and recommendations to address barriers. *Frontiers in Global Women's Health*, 5, p.1335437.

Polit, D.F. and Beck, C.T. 2010. Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47, pp.1451-1458.

Poopedi, L.K. and Bila, N.J. 2023. The experiences of social workers providing mental health services at a mental health facility in Tshwane, South Africa. *Social Work/Maatskaplike Werk*, 59(4), pp.357-377.

Price, L., Centifanti, L. and Slade, P. 2020. Personality factors and vulnerability to post-traumatic stress responses after childbirth. *British Journal of Clinical Psychology*, 59(4), pp.480-502.

Priyadarshini, U., Rao, A.P. and Dash, S. 2023. Recommendations for maternal mental health policy in India. *Journal of Public Health Policy*, 44(1), p.90.

Puccio, J. 2023. They will never forget how you made them feel: Implementing harm reduction in the perinatal setting. *Maternal and Child Health Journal*, 27(Suppl 1), pp.122-127.

Phungula, N., Robertson, L. and Mall, S. 2024. Views held by South African primary health care nurses on caring for people living with mental illness. *South African Journal of Psychiatry*, 30(1).

Puyané, M., Subirà, S., Torres, A., Roca, A., Garcia-Esteve, L. and Gelabert, E. 2022. Personality traits as a risk factor for postpartum depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, 298, pp.577-589.

Qobadi, M., Collier, C. and Zhang, L. 2016. The effect of stressful life events on postpartum depression: Findings from the 2009-2011 Mississippi Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal*, 20(Suppl 1), pp.164-172.

Rahman, M.M. 2023. Navigating the landscape of research paradigms: An overview and critique. Available from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4392879 [accessed 12 March 2025].

Rahman, T., Gasbarro, D. and Alam, K. 2022. Financial risk protection from out-of-pocket health spending in low- and middle-income countries: a scoping review of the literature. *Health Research Policy and Systems*, 20(1), p.83.

Rai, S., Pathak, A. and Sharma, I. 2015. Postpartum psychiatric disorders: Early diagnosis and management. *Indian Journal of Psychiatry*, 57(Suppl 2), pp.S216-S221.

Rana, K., Poudel, P. and Chimoriya, R. 2023. Qualitative methodology in translational health research: Current practices and future directions. *Healthcare (Switzerland)*, 11(19), p. 2665.

Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L. and Naeem, F. 2017. Mental health service provision in low-and middle-income countries. *Health services insights*, 10, p.178632917694350.

Rehman, A.A. and Alharthi, K. 2016. An introduction to research paradigms. *International Journal of Educational Investigations*, 3, pp.51-59.

Reilly, T.J., Roberts, E., Sagnay De La Bastida, V.C., McGuire, P., Dazzan, P. and Cullen, A.E. 2023. Systematic review of the association between adverse life events and the onset and relapse of postpartum psychosis. *Frontiers in Psychiatry*, 14, p.1154557.

Reitan, T. 2019. Substance abuse during pregnancy: A 5-year follow-up of mothers and children. *Drugs: Education, Prevention and Policy*, 26.

Reiter, B. 2017. Theory and methodology of exploratory social science research. *International Journal of Science & Research Methodology*, 5, pp.129-150.

Remien, R.H., Stirratt, M.J., Nguyen, N., Robbins, R.N., Pala, A.N. and Mellins, C.A. 2019. Mental health and HIV/AIDS: The need for an integrated response. *Aids*, 33, pp.1411-1420.

Reupert, A., 2017. A socio-ecological framework for mental health and well-being. *Advances in Mental Health*, 15(2), pp.105-107.

Robertson, L.J. and Szabo, C.P. 2017. Community mental health services in southern Gauteng: An audit using Gauteng district health information systems data. *South African Journal of Psychiatry*, 23.

Roddy Mitchell, A., Gordon, H., Lindquist, A., Walker, S.P., Homer, C.S.E., Middleton, A., Cluver, C.A., Tong, S. and Hastie, R. 2023. Prevalence of perinatal depression in low- and middle-income countries. *JAMA Psychiatry*, 80(5), pp.425-431.

Romano, M., Cacciatore, A., Giordano, R. and la Rosa, B., 2010. Postpartum period: three distinct but continuous phases. *Journal of Prenatal Medicine*, 4(2), p.22.

Roos, V., Keating, N. and Kahl, C. 2019. Loneliness of older black South African women subjected to forcible relocation. *Global Health Action*, 12, p.1672329.

Rosenstock, I.M. 1974. The health belief model and preventive health behavior. *Health education monographs*, 2(4), pp.354-386.

Rössler, W. 2016. The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Reports*, 17(9), pp.1250-1253.

Ruffieux, Y., Efthimiou, O., van den Heuvel, L.L., Joska, J.A., Cornell, M., Seedat, S. and Haas, A.D. 2021. The treatment gap for mental disorders in adults enrolled in HIV treatment programmes in South Africa: A cohort study using linked electronic health records. *Epidemiology and Psychiatric Sciences*, 30, p.e37.

Saharoy, R., Potdukhe, A., Wanjari, M. and Taksande, A.B., 2023. Postpartum Depression and Maternal Care: Exploring the Complex Effects on Mothers and Infants. *Cureus, 15*(7), pp.1-11.

Saito, A., Creedy, D., Cooke, M. and Chaboyer, W. 2012. Effect of intimate partner violence on postpartum women's health in northeastern Thailand. *Nursing and Health Sciences*, 14, pp.345-351.

Salihu, H. 2014. Socio-ecological model as a framework for overcoming barriers and challenges in randomized control trials in minority and underserved communities. *International Journal of MCH and AIDS*, 3, p.85.

Sallis, J.F., Owen, N. and Fisher, E.B. 2015. Ecological m.odels of health behavior. In K. Glanz, B.K. Rimer & K. Viswanath (Eds.). *Health behavior: Theory, research, and practice* (pp.43-64). San Francisco: Jossey-Bass.

Sambrook Smith, M., Cairns, L., Pullen, L.S.W., Opondo, C., Fellmeth, G. and Alderdice, F., 2022. Validated tools to identify common mental disorders in the perinatal period: A systematic review of systematic reviews. *Journal of Affective Disorders*, 298, pp.634-643.

Sandelowski, M. 1995. Sample size in qualitative research. Research in nursing & health, 18(2), pp.179-183.

Sanjel, S. 2013. Gender-based violence: A crucial challenge for public health. *Kathmandu University Medical Journal*, 11(2), pp.179-184.

Santana, D.D., Cardoso, M.A., Santos, I.S., Malta, M.B., Lourenço, B.H., Castro, M.C., da Silveira, M.F., Domingues, M., Murray, J. and Matijasevich, A. 2021. Social inequalities in maternal depressive symptomatology after childbirth: Comparison across birth cohorts in Brazil. *Journal of Affective Disorders Reports*, 6, p.100247.

Scarneo, S.E., Kerr, Z.Y., Kroshus, E., Register-Mihalik, J.K., Hosokawa, Y., Stearns, R.L., DiStefano, L.J. and Casa, D.J. 2019. The socioecological framework: A multifaceted approach to preventing sport-related deaths in high school sports. *Journal of Athletic Training*, 54(4), pp.356-360.

Scharpf, F., Kaltenbach, E., Nickerson, A. and Hecker, T. 2021. A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. *Clinical Psychology Review*, 83, p.101930.

Scheibe, A., Shelly, S., Versfeld, A., Howell, S. and Marks, M. 2017. Safe treatment and treatment of safety: Call for a harm-reduction approach to drug-use disorders in South Africa. *South African Health Review*, 2017, pp.197-204.

Schoch, K. 2020. Case study research. Research design and methods: *An applied guide for the scholar-practitioner*,31, pp.245-258.

Schölmerich, V.L.N. and Kawachi, I. 2016. Translating the socio-ecological perspective into multilevel interventions: Gaps between theory and practice. *Health Education and Behavior*, 43(1), pp.17-20.

Schwab, W., Marth, C. and Bergant, A.M. 2012. Post-traumatic stress disorder post partum: The impact of birth on the prevalence of post-traumatic stress disorder (PTSD) in multiparous women. *Geburtshilfe Und Frauenheilkunde*, 72(1), pp.56-63.

Scotland, J. 2012. Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9), pp.9-16.

Seidi, P.A., Abas, N.Q., Jaff, D., Dunstan, R., Soltan, L., Brumwell, A., Wilson, M., Nicholson, T. and Palmquist, A.E.L. 2022. Assessment of perinatal depression risk among internally displaced Yazidi women in Iraq: A descriptive cross-sectional study. *BMC Pregnancy and Childbirth*, 22(1), p.359.

Seymour-Smith, M., Cruwys, T. and Haslam, S.A. 2021. More to lose? Longitudinal evidence that women whose social support declines following childbirth are at increased risk of depression. *Australian and New Zealand Journal of Public Health*, 45(4), pp.338-343.

Shange, S. and Ross, E. 2022. "The Question Is Not How but Why Things Happen": South African Traditional Healers' Explanatory Model of Mental Illness, Its Diagnosis and Treatment. *Journal of Cross-Cultural Psychology*, 53(5), pp.503-521.

Sharma, H. 2023. Gender Equality and the Sustainable Development Goals (SDGs): A Comprehensive Analysis. *International Journal of Science and Social Science Research*, 1(3), pp.162-172.

Sheppard, V. 2020. *Research methods for the social sciences: An introduction*. Available from https://opentextbc.ca/researchmethods [accessed: 20 August 2024].

Shi, P., Ren, H., Li, H. and Dai, Q. 2018. Maternal depression and suicide at immediate prenatal and early postpartum periods and psychosocial risk factors. *Psychiatry Research*, 261, pp.298-306.

Shiba, T.M. 2021. Social control in the 20th century and its impact on households: A case study of disarticulation from Sophiatown to Meadowlands, Soweto (Master thesis). University of South Africa.

Shields, G.S., Fassett-Carman, A., Gray, Z.J., Gonzales, J.E., Snyder, H.R. and Slavich, G.M. 2023. Why is subjective stress severity a stronger predictor of health than stressor exposure? A preregistered two-study test of two hypotheses. *Stress and Health*, 39, pp.87-102.

Shisana, O., Stein, D.J., Zungu, N.P. and Wolvaardt, G. 2024. The rationale for South Africa to prioritise mental health care as a critical aspect of overall health care. *Comprehensive Psychiatry*, 130, p.152458.

Shortt, N.K., Rind, E., Pearce, J. and Mitchell, R. 2014. Integrating environmental justice and socioecological models of health to understand population-level physical activity. *Environment and Planning A*, 46(6), pp.1479-1495.

Sibeko, G., Milligan, P.D., Roelofse, M., Molefe, L., Jonker, D., Ipser, J., Lund, C. and Stein, D.J. 2018. Piloting a mental health training programme for community health workers in South Africa: an exploration of changes in knowledge, confidence and attitudes. *BMC psychiatry*, 18(1), p.191.

Sibiya, M.N. and Hlongwa, E.N. 2019. A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into primary health care in KwaZulu-Natal province. African Journal of Primary Health Care and Family Medicine, 11(1), pp.1-8.

Sichimba, F., Janlöv, A.C. and Khalaf, A. 2022. Family caregivers' perspectives of cultural beliefs and practices towards mental illness in Zambia: an interview-based qualitative study. *Scientific Reports*, 12(1), p.21388.

Sigamoney, C. and Singh, P. 2023. Factors Hindering Access to Healthcare Services in Peri-Urban Communities in Johannesburg, South Africa. *International Journal of Business and Management Review*, 11(5), pp.67-79.

Sigamoney, C. and Singh, P. 2023. Factors hindering access to healthcare services in peri-urban communities in Johannesburg, South Africa. *International Journal of Business and Management Review*, 11(5), pp.67-79.

Sikrweqe, O., De Klerk, U. and Ally, Y. 2024. The influence of culture and religion in coping with a mental illness by the residents of the Eastern Cape Province, South Africa. *New Voices in Psychology*, 14(1), p.15.

Silverman, D.T., Killion, J.P., Evans, D., Coetzee, L., Rockers, P.C. and Hamer, D.H. 2022. Postpartum mental health in rural South Africa: Socioeconomic stressors and worsening mental health. *Maternal and Child Health Journal*, 26(2), pp.434-440.

Simons, H., 2020. Case Study Research: In-Depth Understanding in Context. In: P. Leavy, ed. *The Oxford Handbook of Qualitative Research*. 2nd ed. New York, NY: Oxford University Press, pp. 676–703.

Slomian, J., Honvo, G., Emonts, P., Reginster, J.Y. and Bruyère, O. 2019. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's Health*, 15, p.1745506519844044.

Smith, M.V. and Mazure, C.M. 2021. Mental health and wealth: Depression, gender, poverty, and parenting. *Annual Review of Clinical Psychology*, 17(1), pp.181-205.

Sol, K. and Heng, K. 2022. Understanding epistemology and its key approaches in research. *Cambodian Journal of Educational Research*, 2, pp.80-99.

Sorsdahl, K., Naledi, T., Lund, C., Levitt, N.S., Joska, J.A., Stein, D.J. and Myers, B. 2021. Integration of mental health counselling into chronic disease services at the primary health care level: Formative research on dedicated versus designated strategies in the Western Cape, South Africa. *Journal of Health Services Research and Policy*, 26(3), pp.172-179.

Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C. and Van Der Westhuizen, C. 2023. A reflection of the current status of the mental healthcare system in South Africa. *SSM-Mental Health*, 4, p.100247.

Sorsdahl, K.R., Kakuma, R., Wilson, Z. and Stein, D.J. 2012. The internalized stigma experienced by members of a mental health advocacy group in South Africa. *International Journal of Social Psychiatry*, 58(1), pp.55-61.

South African Federation for Mental Health. 2025. *Addressing Violence as a Significant Challenge to Mental Health in South Africa*. Available at: https://www.safmh.org/addressing-violence-as-a-significant-challenge-to-mental-health-in-south-africa/

South African Nursing Council (SANC), n.d. *Competencies for mental health nurses*. Available at: https://www.sanc.co.za/wp-content/uploads/2020/06/Competencies-Mental-Health-Nurse.pdf (Accessed: 16 October 2025).

Spedding, M.F., Stein, D.J. and Sorsdahl, K. 2015. Task-shifting psychosocial interventions in public mental health: A review of the evidence in the South African context. *South African Health Review*, 2014(1), pp.73-87.

Spedding, M.F., Stein, D.J. and Sorsdahl, K. 2015. Task-shifting psychosocial interventions in public mental health: A review of the evidence in the South African context. *South African Health Review*, 2014/15.

Spedding, M.F., Stein, D.J., Naledi, T. and Sorsdahl, K. 2018. Pregnant women's mental health literacy and perceptions of perinatal mental disorders in the Western Cape, South Africa. *Mental Health and Prevention*, 11, pp.16-23.

Statistics South Africa (Stats SA). n.d. *Statistics on population and housing: South Africa*. Available from https://www.statssa.gov.za/?page_id=4286&id=11173 [accessed 3 June 2023].

Stebbins, R.A. 2001. *Exploratory research in the social sciences*. Thousand Oaks: SAGE.

Steeves-Reece, A., Yuan, N. and Green, L. 2019. A qualitative study exploring the role of community health workers in promoting maternal postpartum mental health in Nicaragua. *Journal of Global Health Reports*, 3, p.e2019089.

Stellenberg, E.L. and Abrahams, J.M. 2015. Prevalence of and factors influencing postnatal depression in a rural community in South Africa. *African Journal of Primary Health Care and Family Medicine, 7(*1), pp.1-8.

Stentzel, U., Grabe, H.J., Schmidt, S., Tomczyk, S., van den Berg, N. and Beyer, A. 2023. Mental health-related telemedicine interventions for pregnant women and new mothers: a systematic literature review. BMC Psychiatry, 23(1), p.292.

Stewart, D.E. and Vigod, S.N. 2019. Postpartum depression: Pathophysiology, treatment, and emerging therapeutics. *Annual Review of Medicine*, 70(1), pp.183-196.

Stokols, D., 1992. Establishing and maintaining healthy environments: toward a social ecology of health promotion. *American psychologist*, 47(1), p.6.

Story, W.T., LeBan, K., Altobelli, L.C., Gebrian, B., Hossain, J., Lewis, J., Morrow, M., Nielsen, J.N., Rosales, A., Rubardt, M. and Shanklin, D. 2017. Institutionalizing community-focused maternal, newborn, and child health strategies to strengthen health systems: A new framework for the Sustainable Development Goal era. Globalization and Health, 13, pp.1-13.

Strauss, M. 2019. A historical exposition of spatial injustice and segregated urban settlement in South Africa. *Fundamina*, 25(2), pp.135-168.

Strumpher, J., Van Rooyen, R.M., Topper, K., Andersson, L.M.C. and Schierenback, I. 2014. Barriers to accessing mental health care in the Eastern Cape province of South Africa. *Africa Journal of Nursing and Midwifery*, 16(1), pp.45-59.

Sukeri, K. and Emsley, R. 2014. Lessons from the past: Historical perspectives of mental health in the Eastern Cape. *South African Journal of Psychiatry*, 20(2), pp.34-39.

Syed, S.T., Gerber, B.S. and Sharp, L.K. 2013. Traveling towards disease: transportation barriers to health care access. *Journal of community health*, 38(5), pp.976-993.

Szabo, C.P., Fine, J., Mayers, P., Naidoo, S., Zabow, T., Bornman, J., Petersen, F., Vogel, W., Damons, Z., Prinsloo, C., Smith, E., de Lange, E., Nassen, R., Moos, A., van Rensburg, B.J., Bracken, C., Mashile, S., Makobonyane, F., Mbele, Z. and Naude, J. 2017. Mental health

leadership and patient access to care: A public-private initiative in South Africa. *International Journal of Mental Health Systems*, 11, p.1.

Tappis, H., Freeman, J., Glass, N. and Doocy, S. 2016. Effectiveness of interventions, programs and strategies for gender-based violence prevention in refugee populations: An integrative review. *PLoS Currents*, 8.

Taylor, B.L., Nath, S., Sokolova, A.Y., Lewis, G., Howard, L.M., Johnson, S. and Sweeney, A. 2022. The relationship between social support in pregnancy and postnatal depression. *Social Psychiatry and Psychiatric Epidemiology*, 57, p.7.

Tessema, M., Abera, M. and Birhanu, Z. 2024. Effectiveness of group-based psycho-education on preventing postpartum depression among pregnant women by primary healthcare provider in primary healthcare institution: a cluster-randomized controlled trial. *Frontiers in Psychiatry*, 15, p.1433942.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. *The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research*. Available from https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html [accessed: 2 December 2024].

Thiel, F., Ein-Dor, T., Dishy, G., King, A. and Dekel, S. 2018. Examining symptom clusters of childbirth-related posttraumatic stress disorder. *The Primary Care Companion for CNS Disorders*, 20(5), p.26912.

Thiel, F., Ein-Dor, T., Dishy, G., King, A. and Dekel, S. 2018. Examining symptom clusters of childbirth-related posttraumatic stress disorder. *Primary Care Companion to the Journal of Clinical Psychiatry*, 20(5).

Thomas, H.L., Bell, S.O., Karp, C., Omoluabi, E., Kibira, S.P.S., Makumbi, F., Galadanci, H., Shiferaw, S., Seme, A., Moreau, C. and Wood, S.N. 2024. A qualitative exploration of reproductive coercion experiences and perceptions in four geo-culturally diverse sub-Saharan African settings. *SSM - Qualitative Research in Health*, 5, p.100383.

Thompson, J. 2022. A guide to abductive thematic analysis. *The Qualitative Report*, 27(5), pp.1410-1421.

Thompson, V.L.S., Bazile, A. and Akbar, M. 2004. African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35.

Thorsteinsson, E.B., Loi, N.M. and Farr, K. 2018. Changes in stigma and help-seeking in relation to postpartum depression: non-clinical parenting intervention sample. *PeerJ*, 6, p.e5893.

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C. and Henderson, C. 2016. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, 387(10023), pp.1123-1132.

Tight, M. 2017. *Understanding case study research: Small-scale research with meaning*. London: Sage.

Tikka, S.K., Thippeswamy, H. and Chandra, P.S., 2022. The influence of culture on perinatal mental health. In: M. Percudani, A. Bramante, V. Brenna and C. Pariante, eds. Key topics in perinatal mental health. Cham: Springer, pp. 287–302. Available from: https://link.springer.com/chapter/10.1007/978-3-030-91832-3_18 [Accessed 23 June 2025].

Tiruneh, D., Assefa, N. and Mengiste, B. 2021. Perinatal mortality and its determinants in Sub Saharan African countries: Systematic review and meta-analysis. *Maternal Health, Neonatology and Perinatology*, 7(1), p.1.

Tracy, S.J. 2024. *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Hoboken: John Wiley & Sons.

Tripp-Reimer, T. and Doebbeling, B. 2004. Qualitative perspectives in translational research. *Worldviews on Evidence-Based Nursing*, 1, S65-S72.

Truter, Z.M. 2023. Collaborative care for mental health in South Africa: a qualitative systematic review. *South African Journal of Psychology*, 53(1).

Tudge, J.R.H., Payir, A., Merçon-Vargas, E., Cao, H., Liang, Y., Li, J. and O'Brien, L. 2016. Still misused after all these years? A reevaluation of the uses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory and Review*, 8.

Turin, T.C., Raihan, M. and Chowdhury, N. 2024. Paradigms of approaches to research. *Bangabandhu Sheikh Mujib Medical University Journal*, 17, e73973.

Turner, R.E. and Honikman, S. 2016. Maternal mental health and the first 1 000 days: CME. *South African Medical Journal*, 106, pp.1164-1167.

Turok, I. 2012. *Urbanisation and development in South Africa: Economic imperatives, spatial distortions and strategic responses* (pp. 1-66). London: Human Settlements Group, International Institute for Environment and Development.

Uchendu, C., Windle, R. and Blake, H. 2020. Perceived facilitators and barriers to Nigerian nurses' engagement in health promoting behaviors: a socio-ecological model approach. *International Journal of Environmental Research and Public Health*, 17(4), p.1314.

Udenigwe, O. and Yaya, S. 2022. Leaving no woman or girl behind? Inclusion and participation in digital maternal health programs in sub-Saharan Africa. *Reproductive Health*, 19(1), p.54.

Udovičić, S. 2014. Big five personality traits and social support as predictors of postpartum depression. *Journal of European Psychology Students*, 5(3), pp.66-73.

Uhl, G.R., Koob, G.F. and Cable, J. 2019. The neurobiology of addiction. Annals of the New York Academy of Sciences, 1451(1), pp.25-28.

Ültanır, E. 2012. An epistemological glance at the constructivist approach: Constructivist learning in Dewey, Piaget, and Montessori. *International Journal of Instruction*, 5(2), pp.195-212.

Urcia, I.A. 2021. Comparisons of adaptations in grounded theory and phenomenology: Selecting the specific qualitative research methodology. *International Journal of Qualitative Methods*, 20, p.16094069211045474.

Urizar, G.G. and Muñoz, R.F. 2022. Role of maternal depression on child development: A prospective analysis from pregnancy to early childhood. *Child Psychiatry and Human Development*, 53(3), pp.502-514.

Vaismoradi, M. and Snelgrove, S. 2019. Theme in qualitative content analysis and thematic analysis. *Forum: Qualitative Social Research*, 20(3), Article 23.

van den Berg, V.L. 2016. Still lost in translation: Language barriers in South African health care remain. *South African Family Practice*, 58(6), pp.229-231.

van den Heever, A.M. 2016. South Africa's universal health coverage reforms in the post-apartheid period. *Health Policy*, 120(12), pp.1420-1428.

van der Zee-van den Berg, A.I., Boere-Boonekamp, M.M., Groothuis-Oudshoorn, C.G.M. and Reijneveld, S.A. 2021. Postpartum depression and anxiety: A community-based study on risk factors before, during and after pregnancy. *Journal of Affective Disorders*, 286.

van Niel, M.S., Bhatia, R., Riano, N.S., de Faria, L., Catapano-Friedman, L., Ravven, S., Weissman, B., Nzodom, C., Alexander, A., Budde, K. and Mangurian, C. 2020. The impact of paid maternity leave on the mental and physical health of mothers and children: A review of the literature and policy implications. *Harvard Review of Psychiatry*, 28(2), pp.113-126.

van Rensburg, B.J., Bracken, C., Mashile, S., Makobonyane, F., Mbele, Z. and Naude, J. 2017. Mental health leadership and patient access to care: A public-private initiative in South Africa. *International Journal of Mental Health Systems*, 11(1), p.52.

VanderKruik, R., Barreix, M., Chou, D., Allen, T., Say, L. and Cohen, L.S. 2017. The global prevalence of postpartum psychosis: a systematic review. *BMC Psychiatry*, 17(1), p.272.

VanWynsberghe, R. and Khan, S., 2007. Redefining case study. *International journal of qualitative methods*, 6(2), pp.80-94.

Vlassoff, C. 2019. Addressing mental health from a gender perspective: Challenges and opportunities in meeting SDG3. In L Whiteford & C McPherson (Eds.). *The Routledge Handbook of International Development, Mental Health and Wellbeing* (pp.109-127). London: Routledge.

Vogel, J.P., Jung, J., Lavin, T., Simpson, G., Kluwgant, D., Abalos, E., Diaz, V., Downe, S., Filippi, V., Gallos, I. and Galadanci, H. 2024. Neglected medium-term and long-term consequences of labour and childbirth: a systematic analysis of the burden, recommended practices, and a way forward. *The Lancet Global Health*, 12(2), pp.e317-e330.

Vygotsky, L.S. 1978. *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

Walwyn, D.R. and Nkolele, A.T. 2018. An evaluation of South Africa's public-private partnership for the localisation of vaccine research, manufacture and distribution. *Health Research Policy and Systems*, 16(1), p.30.

Wang, Z., Liu, J., Shuai, H., Cai, Z., Fu, X., Liu, Y., Xiao, X., Zhang, W., Krabbendam, E., Liu, S., Liu, Z., Li, Z. and Yang, B.X. 2021. Mapping global prevalence of depression among postpartum women. *Translational Psychiatry*, 11(1), p.543.

Webb, R., Uddin, N., Constantinou, G., Ford, E., Easter, A., Shakespeare, J., Hann, A., Roberts, N., Alderdice, F., Sinesi, A. and Coates, R. 2023. Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare. *BMJ open*, 13(7), p.e066703.

Wei, X., Wang, W., Law, Y.W. and Zhang, H. 2024. The impacts of intimate partner violence on postpartum depression: An updated meta-analysis. *Trauma, Violence, & Abuse*, 25(2), pp.1531-1550.

Weinstein, J.N., Geller, A., Negussie, Y. and Baciu, A. 2017. *Communities in action: Pathways to health equity*. Washington, D.C.: National Academies Press.

White, M.S., Govender, P. and Lister, H.E. 2017. Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal. *African Journal of Disability*, 6(1), pp.1-8.

Wicks, A. and Whiteford, G. 2003. Value of life stories in occupation-based research. *Australian Occupational Therapy Journal*, 50, pp.86-91.

Williamson, T., Wagstaff, D.L., Goodwin, J. and Smith, N. 2023. Mothering ideology: A qualitative exploration of mothers' perceptions of navigating motherhood pressures and partner relationships. *Sex Roles*, 88(1), pp.101-117.

Willie, M.M., Masekela, S. and Iyaloo, S. 2024. *Persistent inequalities in healthcare access in South Africa.* Pretoria: Council for Medical Schemes.

Wilson, C.A., Bublitz, M., Chandra, P., Hanley, S., Honikman, S., Kittel-Schneider, S., Rückl, S.C.Z., Leahy-Warren, P. and Byatt, N. 2024, October. A global perspective: Access to mental health care for perinatal populations. *Seminars in Perinatology,* 48(6), p.151942).

Winchester, M.S. and King, B. 2018. Decentralization, healthcare access, and inequality in Mpumalanga, South Africa. *Health & Place*, 51, pp.200-207.

Wittkowski, A., Patel, S. and Fox, J.R. 2017. The experience of postnatal depression in immigrant mothers living in Western countries: A meta-synthesis. *Clinical Psychology and Psychotherapy*, 24(2), pp.411-427.

Wold, B. and Mittelmark, M.B. 2018. Health-promotion research over three decades: The social-ecological model and challenges in implementation of interventions. *Scandinavian Journal of Public Health*, 46(20_suppl), pp.20-26.

Wold, B. and Mittelmark, M.B. 2018. Health-promotion research over three decades: The social-ecological model and challenges in implementation of interventions. *Scandinavian Journal of Public Health*, 46(20_suppl).

Wolf, Z.R. 2003. Exploring the audit trail for qualitative investigations. *Nurse Educator*, 28(4), pp.175-178.

Wolvaardt, G.G., Stein, D.J. and Mumbauer, A.E. 2025. South Africa's mental health human resources dilemma: from shortage to solution. *South African Health Review*, 27, pp.68-77.

World Health Organization (WHO). 2022. *Mental disorders.* Available from https://www.who.int/news-room/fact-sheets/detail/mental-disorders [accessed 4 September 2024]

World Health Organization (WHO). 2023. *Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders*. Geneva: World Health Organization.

World Health Organization (WHO). 2016. *Global Strategy on Human Resources for Health: Workforce 2030*. Geneva: WHO.

World Health Organization (WHO). 2022. *World Mental Health Report: Transforming Mental Health for All.* Geneva: WHO.

Wriedt, K., Oehm, D., Moss, B. and Chopra, P. 2014. Perinatal mental health cultural responsiveness training-an evaluation. The Journal of Mental Health Training, *Education and Practice*, 9(2), pp.109-122.

Yargawa, J. and Leonardi-Bee, J. 2015. Male involvement and maternal health outcomes: systematic review and meta-analysis. *J Epidemiol Community Health*, 69(6), pp.604-612.

Yankam, B.M., Adeagbo, O., Amu, H., Dowou, R.K., Nyamen, B.G.M., Ubechu, S.C., Félix, P.G., Nkfusai, N.C., Badru, O. & Bain, L.E. 2023. Task shifting and task sharing in the health sector in sub-Saharan Africa: evidence, success indicators, challenges, and opportunities. *Pan African Medical Journal*, 46(1).

Yator, O., Mathai, M., Albert, T. & Kumar, M. 2021. Burden of HIV-related stigma and post-partum depression: a cross-sectional study of patients attending prevention of mother-to-child transmission clinic at Kenyatta National Hospital in Nairobi. *Frontiers in Psychiatry*, 11, p.532557.

Yin, R.K. 2016. *Qualitative research from start to finish* (2nd ed.). New York: The Guilford Press.

Yin, R.K. 2018. *Case study research and applications: Design and methods* (6th ed.). Thousand Oaks, CA: Sage Publications.

Zamawe, C.O., Banda, M. and Dube, A.N. 2016. The impact of a community driven mass media campaign on the utilisation of maternal health care services in rural Malawi. *BMC Pregnancy and Childbirth*, 16(1), pp.1-8.

Zeleke, T.A., Getinet, W., Tadesse Tessema, Z. & Gebeyehu, K. 2021. Prevalence and associated factors of post-partum depression in Ethiopia. A systematic review and meta-analysis. *PloS One*, 16(2), p.e0247005.

Zhu, Q.Y., Huang, D.S., Lv, J.D., Guan, P. & Bai, X.H. 2019. Prevalence of perinatal depression among HIV-positive women: a systematic review and meta-analysis. *BMC Psychiatry*, 19(1), pp.1-12.

Zielińska, M., Łuszczki, E. and Dereń, K. 2023. Dietary nutrient deficiencies and risk of depression (review article 2018–2023). *Nutrients*, 15(11), p.2433.

Žuti, M. 2023. Biopsychosocial models of peripartum depression: a narrative review. *Clinica y Salud*, 34.

Appendices

Appendix 1: Semi-Structured Interview Guide – Postpartum Women

Semi-Structured Interview Guide – Postpartum Women

Demographic-related questions:

1. How old are you?
2. What is your highest highest level of education?
3. Are you currently employed?
4. How many children do you have?
5. What is your marital status?

Individual Level:

1. What do you understand about mental health after child birth?
Probe: Can you explain how you came to think about it this way, especially after becoming a mother?
2. Can you talk about some significant moments or emotions you've experienced during your journey as a mother?
Probe: How have these experiences changed the way you think and feel about being a mother?

Interpersonal Level:

1. Can you tell me about your partner's role in your life as a mother?
Probe: Can you give examples of times when their support was really helpful or challenging?
Probe: How have they influenced your decisions about getting help for your mental health?
2. How is your family involved in your role as a mother?
Probe: How do their actions and attitudes affect your choices about seeking mental health support?
Probe: Can you share specific examples of how their support or lack thereof affects you as a mother?

Organisational Level:

1. Can you talk about your experiences during postnatal visits at the Community Health Centre (CHC) when it comes to discussing mental health after giving birth?
Probe: How did these discussions, or the lack of them, affect how you?
2. How do the attitudes of the CHC staff impact your thoughts about getting mental health help?
3. What ideas do you have for making mental health services at the CHC better for mothers who have just giving birth?
4. Can you describe how getting to and from the CHC affects your decision to get mental health help?
5. How do the CHC's working hours affect your ability to get the mental health help you need?

Community Level:

1. How do people in your community generally view the challenges of mental health after giving birth, and how does this affect your own thoughts?
Probe: Can you share times when what the community thinks affected your decisions or feelings?
2. Can you discuss the beliefs about postpartum mental health in your community and how they affect your thoughts?
Probe: Have you faced challenges or support related to these beliefs?
3. Have you seen any community programmes that helped mothers' mental health after giving birth?
Probe: How did these programmes help moms?

Probe: If there are no such programmes, what do you think the community can do to support mothers' mental health better after giving birth?

Societal Level:

1. In your opinion, what can the government do to make it easier for women to get the mental health support they need after giving birth?
Probe: Can you think of specific rules or services that would be helpful for this?

Sesotho Translation of Interview Schedules for Mothers

Lenaneokopanyo la Puisano bakeng sa Bo-mme

Lipotso tse amanang le Boitsebiso ba Botho:

1. O lilemo li kae?

2. Ke boemo bofe bo phahameng ka ho fetisisa ba thuto boo u fihletseng ho bona?

3. Hona joale o sebetsa?

4. O na le bana ba bakae?

5. Boemo ba hao ba lenyalo ke bofe?

Boemong ba Motho ka Mong:

1. U utloisisa eng ka bophelo ba kelello kamora ho beleha?
Tlhahiso: O ka hlalosa hore na ke hobane'ng ha u e bona ka tsela eo, haholoholo kamora hore u be mme?

2. U ka bua ka linako tse itseng kapa maikutlo a matla ao u kopaneng le 'ona leetong la hao la ho ba mme?
Tlhahiso: Maikutlo ao a fetotse joang tsela eo u bonang kapa u utloang ka eona ho ba mme?

Boemo ba Batho ba Haufi (Interpersonal Level):

1. U ka mpolella ka karolo eo molekane oa hao a e bapalang bophelong ba hao joaloka mme?
Tlhahiso: U ka fana ka mehlala ea linako tseo tšehetso ea hae e ileng ea u thusa kapa ea ba phephetso?
Tlhahiso: O bile le tšusumetso joang litšoantšong tsa hao tsa ho batla thuso ea kelello?

2. Lelapa la hao le kenya letsoho joang bophelong ba hao ba ho ba mme?
Tlhahiso: Mekhoa le maikutlo a bona a ama litšoantšo tsa hao joang mabapi le ho batla thuso ea kelello?
Tlhahiso: U ka arolelana mehlala e itseng ea kamoo tšehetso ea bona kapa ho hloka eona ho u ama joaloka mme?

Boemo ba Mokhatlo (Organisational Level):

1. U kile oa ba le liphihlelo life nakong ea ho etela CHC kamora ho beleha mabapi le puisano ka bophelo ba kelello?
Tlhahiso: Lipuisano tseo kapa ho haella ha tsona li u amme joang?

2. Boikutlo ba basebetsi ba CHC bo ama maikutlo a hao joang ka ho batla thuso ea kelello?

3. Ke mehopolo efe eo u nang le eona ea ho ntlafatsa lits'ebeletso tsa kelello ho CHC bakeng sa bo-mme ba sa tsoa beleha?

4. Ho fihla le ho tloha CHC ho ama qeto ea hao joang ea ho batla thuso ea kelello?

5. Lihora tseo CHC e sebetsang ka tsona li ama bokhoni ba hao joang ba ho fumana thuso ea kelello?

Boemo ba Sechaba (Community Level):

1. Batho ba sechabeng sa hao ka kakaretso ba bona mathata a kelello kamora ho beleha joang, 'me sena se ama maikutlo a hao joang?
Tlhahiso: U ka arolelana linako tseo maikutlo a sechaba a ileng a ama qeto kapa maikutlo a hao?

2. U ka bua ka litumelo tse teng sechabeng sa hao mabapi le bophelo ba kelello kamora ho beleha le kamoo litumelo tseo li u amang kateng?
Tlhahiso: Na u kile ua tobana le liphephetso kapa tšehetso tse amanang le litumelo tseo?

3. Na u kile oa bona mananeo a sechaba a tšehetsang bophelo ba kelello ba bo-mme kamora ho beleha?
Tlhahiso: Mananeo ao a thusitse bo-mme joang?
Tlhahiso: Haeba mananeo a joalo a se teng, u nahana hore sechaba se ka etsa'ng ho tšehetsa bophelo ba kelello ba bo-mme kamora ho beleha?

Boemo ba Sechaba ka Bophara (Societal Level):

1. Ka maikutlo a hao, ’muso o ka etsa'ng ho nolofalletsa bo-mme ho fumana thuso ea kelello kamora ho beleha?
Tlhahiso: Na u ka nahana ka melao kapa lits'ebeletso tse itseng tse ka thusang ka sena?

Appendix 2: Semi-Structured Interview Guide – Healthcare Providers

Semi-Structured Interview Guide – Healthcare Providers

Demographic questions:

1.What qualifications do you have in your field?
Probe: Briefly describe any professional training you have received within the field of mental health?
2.How many years have you worked as a healthcare provider?
3. What is your current position at the facility?

Individual level:

1.What specific strategies do you employ to assess the unique mental health needs of postpartum women?
2.What are some common emotional or psychological challenges you have observed postpartum women facing?
Probe: how do you support them in navigating these challenges?

Interpersonal Level:

1.What strategies do you utilise to promote the involvement of partners in supporting the mental health of postpartum women?
2.What strategies do you utilise to promote the involvement of family members and close friends in supporting the mental health of postpartum women?

Organisational Level:

1.Can you describe how mental health screening and assessment are integrated into the postnatal visit process at the community health centre (CHC)?
Probe: what steps are taken to ensure that all postpartum women receive the necessary support?
2.What resources does the CHC provide to support the mental health needs of women after giving birth?
Probe: Are there any particular programmes or resources you find helpful?
3.What challenges have you encountered related to resource constraints in providing postpartum mental healthcare?
Probe: If any,how have you managed or overcome them?

Community Level:

1.What are your observations regarding community opinions that may influence women's decision to seek help for their mental health?
Probe: What are your observations regarding beliefs that may influence women's decision to seek help for their mental health?
2.How do you engage with community members to address opinions and cultural beliefs that may influence postpartum women's mental health?

Societal Level:

1. Are you aware of any policies or guidelines that influence how mental health services for postpartum women are delivered at this CHC?"
Probe: Can you tell me what that policy says or how it affects your work?

2. What policy changes do you believe would improve the availability and accessibility of mental health services for postpartum women?

Sesotho Translation of Interview Schedules for Healthcare Providers

Lenaneokopanyo la Puisano bakeng sa Basebetsi ba Bophelo

Lipotso tse Amanang le Boitsebiso ba Botho:

1. U na le mangolo afe kapa litifikeiti tšimong eo u sebetsang ho eona?
Tlhahiso: Hlalosa hanyane ka koetliso efe kapa efe eo u e fumaneng mabapi le bophelo ba kelello?

2. U sebetse lilemo tse kae joaloka mosebeletsi oa bophelo?

3. Boemo ba hau hona joale setsing see ke bofe?

Boemo ba Motho ka Mong:

1. Ke maano afe a ikhethileng ao u a sebelisang ho lemoha litlhoko tsa bophelo ba kelello tsa bo-mme ba sa tsoa beleha?

2. Ke liphephetso life tsa maikutlo kapa kelello tseo u li hlokometsoeng hangata ho bo-mme kamora ho beleha?
Tlhahiso: U ba tšehetsa joang ho sebetsana le liphephetso tseo?

Boemo ba Batho ba Haufi:

1. Ke maano afe ao u a sebelisang ho khothaletsa ho kenella ha balekane ho tšehetsa bophelo ba kelello ba bo-mme?

2. Ke maano afe ao u a sebelisang ho khothaletsa ho kenella ha lelapa kapa metsoalle e haufi ho tšehetsa bophelo ba kelello ba bo-mme?

Boemo ba Mokhatlo:

1. U ka hlalosa hore na ho hlahloba bophelo ba kelello ho kenngoa joang nakong ea ho etela CHC kamora ho beleha?
Tlhahiso: Mehato efe e nkuoang ho etsa bonnete ba hore bo-mme bohle ba fumana tšehetso e hlokahalang?

2. CHC e fana ka lisebelisoa life ho tšehetsa litlhoko tsa kelello tsa bo-mme kamora ho beleha?
Tlhahiso: Na ho na le mananeo kapa lisebelisoa tse itseng tseo u li bonang li thusa?

3. Ke liphephetso life tseo u kopaneng le tsona mabapi le khaello ea lisebelisoa ha u fana ka tlhokomelo ea kelello kamora ho beleha?
Tlhahiso: Haeba ho joalo, u li laola kapa u li hlōla joang?

Boemo ba Sechaba:

1. U boneng ho tsoa sechabeng mabapi le maikutlo kapa litumelo tse ka amang qeto ea basali ea ho batla thuso ea kelello?
Tlhahiso: U boneng mabapi le litumelo tse ka amang qeto ea basali ea ho batla thuso ea kelello?

2. U sebelisana joang le sechaba ho sebetsana le maikutlo le litumelo tsa setso tse ka amang bophelo ba kelello ba bo-mme?

Boemo ba Sechaba ka Bophara (Societal Level):

1. Na u tseba ka melaoana kapa tataiso efe kapa efe e amang tsela eo lits'ebeletso tsa kelello li fanoang ka eona ho bo-mme CHC ee?
Tlhahiso: U ka mpolella hore na molaoona o reng kapa o ama mosebetsi oa hao joang?

2. Ke liphetoho life tsa melaoana tseo u nahanang hore li ka ntlafatsa ho fumaneha ha lits'ebeletso tsa kelello bakeng sa bo-mme?

Appendix 3: Codebook

Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective. Codebook

Theme Colour Legend

Theme	Highlight Color
Knowledge and Awareness	yellow
Personal Beliefs and Attitudes	Grey
Relational Support	Blue
Resource Adequacy	Green
Logistical Factors	pink
Community Attitudes	Orange
Religious and Cultural Beliefs	Cyan
Community Support Structures	Violet
Policy and Systemic Issues in PPMH Care	red
Public Health Interventions	darkBlue

B/F (Barrier/Facilitator): Indicates whether the quote represents a barrier (B) or facilitator (F) to accessing postpartum mental healthcare services.

Individual Level

Quote	Code	Explanation	Researcher Notes	B/F	Sub-Theme	Theme
"So, for you to be able to pick up, maybe to screen the patient for postpartum, let's say it's postpartum depression or whatever, you need to have the basics of mental health... at least it gives you the whole understanding of mental health, not only postpartum.	**Mental Health Literacy for Providers**	Provider emphasises foundational mental health knowledge as critical for accurate screening. Training enables recognition of PPMDs beyond surface-level presentations. This underscores the need for competency- based clinician education.	Without standardised training, providers may overlook nuanced cases (e.g., high-functioning depression). Investment in continuous professional development is essential.	F	Healthcare provider knowledge and clinical observation	**Knowledge and Awareness**

Mental health is key." (P-101)						
"I don't want anyone to think I'm crazy." (P- 203)	**Fear of Stigma**	Participant avoids help- seeking due to fear of being labelled with severe mental illness. Colloquial language ("crazy") reflects prevalent stigmatising attitudes.	Anti-stigma interventions must address colloquial misconceptions about mental health conditions.	B	nternalised stigma and misconceptions surrounding PPMDs	**Personal Beliefs and Attitudes**
"I guess I haven't really thought about it... thinking about my own mental health support isn't something I usually do, I think I don't even know what to look out for, like the line between normal worries and depression and stuff." (P-208)	**Mental Health Awareness Gap**	Participant expresses uncertainty about distinguishing normal postpartum stress from clinical depression. The lack of clear mental health knowledge prevents self-identification of symptoms. This reflects systemic gaps in perinatal mental health education.	The conflation of normative stress with pathology underscores the need for targeted psychoeducation. Without clear benchmarks, women may delay care until crises emerge. Community-based awareness campaigns could bridge this gap.	B	Lack of understanding of PPMDs	**Knowledge and Awareness**
"If I knew that talking doesn't mean that I am, I mean like the baby is at risk or may be taken from me, then it would be easier." (P-207)	**Fear of Stigma**	Participant fears punitive consequences for disclosing mental health struggles. This reflects internalised stigma and mistrust of healthcare systems.	Legal protections for maternal mental health must be clearly communicated to counteract such fears.	B	Internalised stigma and misconceptions surrounding PPMDs	**Personal Beliefs and Attitudes**
"I feel like I'm supposed to be this superhero who never gets tired... it's hard when things don't go as planned. I feel like I'm failing." (P-207)	**Role Strain**	Participant describes dissonance between societal expectations of motherhood and her lived experience. The pressure to perform resilience exacerbates self-blame.	Cultural narratives of "perfect motherhood" require deconstruction through community dialogues and media campaigns.	B	Internalised stigma and misconceptions surrounding PPMDs	**Personal Beliefs and Attitudes**

"To be honest, I didn't also know at the time that my emotional health was something I should pay attention to, like maybe I could have called someone, like Lifeline you just told me about, I don't know." (P- 207)	**Mental Health Awareness Gap**	Participant retrospectively recognises her lack of awareness about mental health support options. The absence of proactive guidance left her unprepared to seek help. This highlights missed opportunities for early intervention.	The quote reveals how mental health resources are often invisible to those who need them most. Embedding resource information into routine postnatal care could mitigate this barrier.	B	Raising awareness of available PPMHS	**Knowledge and Awareness**
"When I had my first baby, I didn't even know that feeling sad or overwhelmed could be something more than just being tired. I thought it was normal to feel alone, and scared sometimes." (P-210)	**Mental Health Awareness Gap**	Participant pathologises her past experiences only in hindsight. The normalisation of symptoms as "typical motherhood" delayed recognition of potential mental health issues.	Symptom minimisation is common where mental health literacy is low. Universal screening during postnatal visits could counteract this tendency.	B	Lack of understanding of PPMDs	**Knowledge and Awareness**
"We are able to see that there is a problem... Such behaviour indicates a problem. We then analyse or observe their physical appearance. We are able to identify women who neglect themselves and their children." (P-103)	**Clinical Observation Skills**	Provider describes using behavioural cues (e.g., self-neglect) to identify distress in non-verbal patients. Observational skills compensate for low self- reporting in stigmatised contexts.	This approach is particularly valuable in settings where women underreport symptoms due to stigma. However, it risks overlooking less visible cases.	F	Healthcare provider knowledge and clinical observation	**Knowledge and Awareness**
"So, they think that by going to the mental health department, it means you are mentally ill... You need to explain... it just means you will see our psychologist, there is a psychiatrist, and a social worker. They can assist you." (P-101)	**Stigma Reduction**	Provider actively reframes mental health care as a spectrum of support rather than a marker of pathology. Clarifying roles of professionals demystifies services.	Normalising mental healthcare as akin to physical healthcare could reduce avoidance behaviours.	F	Addressing self-stigma and myths surrounding PPMDs	**Knowledge and Awareness**

"You know everything can be improved. You know you need to go back to the basics. Explaining to the patient. There is improvement in that. You know, we think of big things. But if you inform the patient and arm them with information, so that they can be aware of these services." (P-101)	**Education and Empowerment**	Provider advocates for clear, simple communication about services as a gateway to care. Demystifying mental health resources reduces perceived access barriers.	Information asymmetry disproportionately affects low-literacy populations. Visual aids and peer educators could enhance understanding.	F	Raising awareness of available PPMHS	**Knowledge and Awareness**
"If a mother comes in with a problem of substance abuse, we always know that there's an underlying problem that we will try to tackle... Every day is a challenge just to survive... all these things really compound into anxiety and depression." (P-105)	**Trauma-Informed Care**	Provider links substance use to co-occurring trauma and mental health issues. The recognition of compounding stressors facilitates holistic care.	Trauma-informed frameworks prevent reductionist diagnoses (e.g., attributing symptoms solely to substance use). Integrated care models are needed.	F	Healthcare provider knowledge and clinical observation	**Personal Beliefs and Attitudes**
"When they ask for help... they do not want others to know that they're seeking help because they feel that they automatically will not be living up to the cultural expectation of what a woman ought to be, which is a stronghold of the family." (P-105)	**Cultural Stigma**	Provider identifies cultural ideals of feminine strength as a barrier to disclosure. The tension between self-care and gendered roles perpetuates secrecy.	Culturally tailored interventions should engage family systems to redefine "strength" as including help-seeking.	B	Internalised stigma and misconceptions surrounding PPMDs	**Personal Beliefs and Attitudes**

"I have to admit that I don't know much about mental health. I find myself just trying to manage everything and make things work without really thinking about whether my feelings are normal or maybe if I might need help, like just to know." (P-206)	**Mental Health Awareness Gap**	Participant prioritises functional coping over self- assessment of mental health needs. The normalisation of distress perpetuates help-seeking delays. This reflects cultural scripts that equate motherhood with silent endurance.	Gendered expectations of resilience often override self-care. Clinicians should actively screen for distress rather than relying on self-reports in such contexts.	B	Lack of understanding of PPMDs	**Knowledge and Awareness**
"So, what you find is that we try to support them. We try to teach them on issues related to mental health. However, it is up to them to decide to take the next step whether they will seek help because they are the ones who will now be the ones who need to make the initiative." (P-104)	**Autonomy in Help-Seeking**	Provider balances education with respect for patient agency in help-seeking. This approach avoids coercion but may not address structural barriers to access.	Whilst autonomy is ethically vital, systemic obstacles (e.g., transport costs) may render "choice" theoretical for some women.	F	Raising awareness of available PPMHS	**Knowledge and Awareness**
"We then offer health talk and offer advice on where they can find mental health assistance." (P-107)	**Awareness and Guidance**	Healthcare provider offers direct guidance on how to access mental health services. This is a proactive step in overcoming barriers to care.	Direct referral pathways reduce confusion and facilitate quicker access to services.	F	Raising awareness of available PPMHS	**Knowledge and Awareness**

Interpersonal Level

Full Quote	Code	Explanation	Researcher Notes	B/F	Sub-Theme	Theme
"My husband is there, but he doesn't understand the challenges, and sometimes he thinks I'm crazy." (P-204)	**Partner Lack of Understanding**	Partners often fail to understand or trivialise the emotional struggles of postpartum women, leading to isolation and hindering the search for professional help.	This reflects the need for education to address misconceptions about mental health in partners.	B	Lack of spousal/partner support	**Relational Support**
"My husband had a different response when it came to getting mental health support... he didn't understand why I wanted to go to the clinic to talk about my feelings." (P-210)	**Partner Lack of Understanding**	Similar to previous quotes, partners dismiss the need for professional mental health support, perceiving it as unnecessary. This reinforces the idea of emotional neglect.	A focus on sensitising partners to mental health needs would help combat this barrier.	B	Lack of spousal/partner support	**Relational Support**
"And the partners, the problem is the partner... they feel like they don't get support from them and that's where the problem is." (P-101, Healthcare provider)	**Lack of Partner Support**	Healthcare providers confirm that partners' lack of emotional or practical support plays a significant role in postpartum mental health challenges.	Encouraging partner support should be a priority in both prenatal and postnatal care.	B	Lack of spousal/partner support	**Relational Support**
"Most of these young mothers, their partners are not present... Partners don't come in during postnatal, so we don't have a chance to really talk to the partners." (P-102, Healthcare provider)	**Partner Absence**	Healthcare providers note that the absence of partners during postnatal care leads to missed opportunities for support and psychoeducation, deepening maternal distress.	Ensuring partner involvement during postnatal care is crucial for shared caregiving and support.	B	Lack of spousal/partner support	**Relational Support**

"You find that the mother is struggling to get the father to be involved in the child's life, and so financially that is a problem." (P-105, Healthcare provider)	**Partner Absence (Financial)**	Healthcare providers highlight how partner disengagement, especially in terms of both emotional and financial involvement, increases the strain on mothers.	Addressing financial involvement alongside emotional support is necessary for a balanced caregiving dynamic.	B	Lack of spousal/partner support	**Relational Support**
"They are alone, and they lack support, especially from the fathers of the children. They are alone and have not fully accepted the presence of their children; most of the time, they came as an inconvenience, usually, they (the partners) just take a back seat. So, they are dealing with all that, they are dealing with the added financial pressure." (P-106, Healthcare provider)	**Emotional and Financial Strain from Partner Absence**	The absence of the partner leads to emotional neglect, further compounded by financial stress, trapping postpartum women in a cycle of isolation.	Interventions that address both emotional and financial support from partners are key to alleviating postpartum distress.	B	Lack of spousal/partner support	**Relational Support**
"We do encourage men to be actively involved, even from the time the women are pregnant." (P-104)	**Provider Encourages Partner Involvement**	Healthcare providers emphasise the importance of involving partners early to create supportive relationships during the perinatal period.	Early interventions can normalise partner involvement in maternal health.	F	Partner involvement encouraged by healthcare providers	**Relational Support**

"With the partners, we will just try to encourage them to come with them when they come for visits, especially when we see a problem." (P-102)	**Provider Encourages Partner Involvement**	Healthcare providers actively encourage partners to attend postnatal visits, particularly if any issues arise, to enhance mutual understanding and support for the mother.	Providers can play a key role in bridging communication gaps and ensuring both partners are involved in postpartum care.	F	Partner involvement encouraged by healthcare providers	**Relational Support**
"Mental health, you know, my mother encourages me to always trust in God. Whenever I'm not feeling okay, she'll encourage me to read the Word of God, pray more, and she prays for me too. That's the help she gives me. And my husband also, he helps like that. But to support, they don't know about that. No one thinks about it, like mental health is seen as something that is important, but not as something that you can go to the clinic to get help with." (P-205)	**Family Encourages Spiritual Coping**	Family members often encourage spiritual coping mechanisms (e.g., prayer) over seeking professional mental health support, demonstrating a cultural preference for informal help-seeking.	Integrating both spiritual and clinical support could help bridge the gap between cultural norms and mental health care.	B	Extended family influence limiting mental health help-seeking	**Relational Support**
"The judgement doesn't just come from strangers only; it comes from family, too. My own mother would say things like, 'We didn't have these problems in our days.'" (P-208)	**Family Judgement and Stigma**	Family members often invalidate mental health struggles, viewing them as weaknesses or failures, further entrenching stigma and discouraging women from seeking help.	Changing generational attitudes about mental health is crucial to reducing stigma.	B	Extended family influence limiting mental health help-seeking	**Relational Support**

"There's this fear that if you go to the clinic for help, they'll think you're not fit to be a mother... The judgement doesn't just come from strangers only; it comes from family too." (P-209)	**Family Judgement and Stigma**	Fear of judgement from family members reinforces stigma around mental health, deterring women from seeking professional help for fear of being perceived as unfit mothers.	Community-based anti-stigma interventions could help alleviate this fear and promote help-seeking.	B	Extended family influence limiting mental health help-seeking	**Relational Support**
"Some yes, they will be giving porridge to eat, but they become excited about the child... And sometimes we get a lot of these, especially the young mother, you find that she is staying with her mother or granny, and the mum is working, and she is alone, and nobody picks it up that this person is not coping at all." (P-101, Healthcare provider)	**Family Oversight and Mental Health**	Families often focus on physical care for the baby, neglecting the mental health needs of the mother, leaving her unassisted in her emotional struggles.	Screening tools for family members could improve early detection of maternal mental health issues.	B	Extended family influence limiting mental health help-seeking	**Relational Support**
"In our culture... mothers [of the postpartum woman] will come in and take care of the baby... but as soon as that help is gone, most mothers regress." (P-106, Healthcare provider)	**Temporary Family Support**	Postpartum women may receive initial support from family members, but once that support fades, mothers are left to manage their mental health challenges alone, leading to a crisis.	Ongoing support, including peer networks, could help prevent the "cliff effect" when family support ends.	B	Extended family influence limiting mental health help-seeking	**Relational Support**
"We find sometimes we ask families to come in and, sometimes, actually when they get home, they get backlash for actually attending therapy." (P-105, Healthcare provider)	**Family Resistance to Therapy**	Family members sometimes resist participating in therapy, either due to stigma or cultural views on mental health, which limits support for the woman.	Ensuring confidentiality and providing culturally sensitive therapy options can help overcome this resistance.	B	Extended family influence limiting mental health help-seeking	**Relational Support**

"Their willingness to help at all times, no matter what, it really shows me that they understand the challenges I go through as a single mum. It shows me every day that I'm not alone in this life. They always encourage me to spend time alone just to get some air, they are so concerned about me and my situation. My sister always tells me that it is ok to ask for help, they can help anytime, everyone needs help sometimes. I am sure that if I need to get any mental health assistance, they will support me without any problem." (P-206)	**Family Support for Mental Health**	Strong family support, particularly from siblings and parents, provides emotional and practical assistance that encourages postpartum women to seek professional mental health care.	Family education on the importance of mental health could improve help-seeking behaviours.	F	Supportive role of family in promoting mental health help-seeking	**Relational Support**

"The young mothers stay with their parents. So, we will try to encourage the parents to forgive their children and to assist them. We always tell them that it's okay to be angry, but at some point, you have to forgive and push forward." (P-102, Healthcare provider)	**Family Reconciliation and Support**	Healthcare providers encourage family reconciliation to restore essential support systems, recognising the importance of family support for postpartum mental health.	Mediation skills could be incorporated into healthcare providers' training to help facilitate this reconciliation process.	F	Supportive role of family in promoting mental health help-seeking	**Relational Support**
"We involved the family, we asked that the mother come in and they did, what ended up occurring was that there was a little group session and the mother also came to advise the children on how to conduct themselves." (P- 103, Healthcare provider)	**Family Involvement in Therapy**	Family involvement in therapy can reduce stigma and encourage collective support for postpartum women, making mental health care a shared responsibility.	Implementing family therapy sessions can help normalise postpartum mental health care.	F	Supportive role of family in promoting mental health help-seeking	**Relational Support**

Organisational Level

Full Quote	Code	Explanation	Researcher Notes	B/F	Sub-Theme	Theme
"By the time you enter to see the nurse, you're so tired. You have to take a taxi with a little one and the baby is grumpy, and the baby is not happy. You get there, sometimes it's cold. You're just tired, you just want to leave." (P-203)	**Transport Barrier**	Embodied exhaustion from multi- stage journey involving childcare logistics and environmental stressors	The physical/emotional toll of transit may eclipse potential treatment benefits, creating paradoxical barriers where those most needing support are least able to access it	B	Transportation Challenges	**Logistical Factors**
"The social worker doesn't come every day, so the resources are there, but they are not enough to accommodate everyone." (P-106)	**Staff Shortage**	Intermittent service availability creating unreliable care access	The 'sometimes available' model generates false hope and erodes institutional trust more severely than complete service absence	B	Inadequate Availability of MH Professionals	**Resource Adequacy**
"They (Mental health professionals at the CHC) teach us (CHWs) how to assist and counsel them... We also screen them on their mental health." (P-107)	**Proactive Screening**	Task-shifting model building lay provider competencies through apprenticeship	This peer-to-peer training approach builds sustainable capacity whilst respecting community health workers' existing social capital	F	Proactive Screening Practices	**Resource Adequacy**
"We don't have enough staff... what we find is a high shortage of staff, professionals, and people who will be there to assist." (P-106)	**Staff Shortage**	Systemic understaffing across multiple professional categories	The explicit 'high shortage' framing reveals provider frustration with chronic structural deficiencies rather than temporary gaps	B	Inadequate Availability of MH Professionals	**Resource Adequacy**

"They ask you, 'Are you alright? Are you coping? Are you sleeping right?' but you just say yes." (P-203)	**Superficial Screening**	Ritualised closed-ended questioning discouraging disclosure	The power asymmetry in clinician-patient interactions transforms screening into a performative exercise rather than therapeutic engagement	B	Inadequate Routine Screening	**Resource Adequacy**
"The Centre has a dedicated department, Mental Health, where women who have problems with psychiatry and psychiatric-related illnesses would go and get assistance." (P-104)	**On-site Services**	Structural integration of specialty mental healthcare	Co-location eliminates referral attrition that typically occurs when patients must navigate between separate facilities	F	On-site Availability of MH Professionals	**Resource Adequacy**
"It's a bit of a trip, especially with a little one... breastfeeding in the taxi, which sometimes is not ok, especially when there is a man sitting next to you." (P-209)	**Transport Barrier**	Gendered spatial politics complicating care access	The intersection of infant care needs and patriarchal public space norms creates unique mobility barriers rarely addressed in health policy	B	Transportation Challenges	**Logistical Factors**
"I think having more mental health services, like counselling or support groups, would be really beneficial." (P-201)	**Service Gap**	Patient-identified need for diverse therapeutic options	The specificity of desired services ('counselling/support groups') reveals sophisticated understanding of ideal care despite systemic limitations	B	Inadequate Availability of MH Professionals	**Resource Adequacy**
"When I went there to the clinic, they ask me if I'm okay and if I'm coping, and I tell them I'm fine, I'm coping. And that's it. I don't remember anything else. They check the baby, if the baby's okay, the baby's gaining weight, the baby's healthy." (P-202)	**Superficial Screening**	Institutional prioritisation of paediatric over maternal mental health	The stark contrast between detailed paediatric checks and perfunctory maternal mental health assessment reveals embedded systemic biases	B	Inadequate Routine	**Resource Adequacy**

"Maybe have more nurses and counsellors at the clinic so that us mothers, if we need to see someone for our mental health, then we would not have to wait for so long." (P-209)	**Service Gap**	Consequences of rationed mental healthcare	The explicit linkage between staffing levels and wait times demonstrates how structural constraints directly impact patient experience	B	Inadequate Availability of MH Professionals	**Resource Adequacy**
"A mother will get help that she needs immediately. We can sometimes refer a mother immediately to see someone, and so it is just them being there available to assist." (P-102)	**On-site Services**	Real-time care coordination benefits	The immediacy of access ('right away') highlights how structural integration can overcome typical health system delays	F	On-site Availability of MH Professionals	**Resource Adequacy**
"That one patient was referred to the doctor, and the doctor then referred the woman to the mental health department." (P- 103)	**On-site Services**	Multi-step referral within co-located system	Whilst the pathway remains complex, physical proximity prevents the referral dropout common in fragmented systems	F	On-site Availability of MH Professionals	**Resource Adequacy**
"They asked me a lot of questions. But when it came to my emotions, it felt like they were trying, but they were also following a list -- Are you feeling okay? Great, then they move on." (P-207)	**Superficial Screening**	Protocol-driven emotional assessment	The participant's awareness of clinicians 'following a list' reveals how standardised tools can undermine authentic engagement	B	Inadequate Routine Screening	**Resource Adequacy**
"So even with just one symptom, we make it a point to refer them. It starts with you, then from there you carry this patient by hand." (P-101)	**Proactive Screening**	Vigilant symptom response with care continuity	The 'carry by hand' metaphor embodies an ideal of accompaniment rarely achieved in overburdened systems	F	Proactive Screening Practices	**Resource Adequacy**

"We do offer the initial screening as part and parcel of what we do daily... we ask them about how they are doing, how are they coping, you know, the feelings and things like that." (P-104)	**Proactive Screening**	Routine embedded mental health assessment	The phrase 'part and parcel' suggests successful integration of mental health into standard care practices	F	Proactive Screening Practices	**Resource Adequacy**
"Yoh, it has assisted a lot because when we do this, it's like this is a comprehensive course (tertiary level training). So, for you to be able to pick up, maybe to screen the patient for postpartum, let's say it's postpartum depression or whatever, you need to have the basics of mental health." (P-101)	**Tertiary-level training Impact**	Transformative professional development	The 'comprehensive course' metaphor suggests training reconfigured clinical reasoning, not just added skills	F	Proactive Screening Practices	**Resource Adequacy**
"No, sometimes they do send us to do short courses, but I personally have not attended on mental health, it is usually on TB or HIV." (P-103)	**Training Gap**	Competing disease priorities in training	The TB/HIV focus reflects historical funding priorities that continue to marginalise mental health capacity building	B	Insufficient MH Training	**Resource Adequacy**
"Here? No, not really. We haven't received any courses on mental health. Not that I remember." (P-106)	**Training Gap**	Complete absence of mental health training	The need for recall ('not that I remember') underscores how exceptional such training would be	B	Insufficient MH Training	**Resource Adequacy**

"Training on mental health is very important because we are the ones in the community, and we are often the first ones who seeing these things, we see mothers and how they attend to their children at home. So, if they give us more training, we can also know what to look for and refer to it." (P-108)	**Training Gap**	Frontline recognition of competency gaps	The explicit linkage between training and improved detection/referral shows workers understand systemic needs	B	Insufficient MH Training	**Resource Adequacy**
"Oh, getting to the clinic, that's a whole thing in itself, you know? First off, it's about finding the time. Like, I've got my hands full with the baby and my other kids, so just figuring out when I can actually go is a problem; we have to go in the morning. There's the whole money situation, so that day I have to budget for a taxi. Sometimes." (P-207)	**Transport Barrier**	Intersectional access challenges	The cumulative burden of time poverty, childcare logistics, and financial constraints creates insurmountable barriers for many	B	Transportation Challenges	**Logistical Factors**
"It's not that far, I can walk to the clinic, but the problem is that the clinic -- there's appointments, they give you an appointment to go there and you queue and there's other people who are getting help... I can go to the clinic once a month or so to vaccinate the baby, but I can't go to the clinic again to see a counsellor or something. Like it will be too many visits, I can't, I don't have the time for that." (P-203)	**Transport Barrier**	Competing care priorities	Mental health services are deprioritised not due to perceived irrelevance, but impossible logistical trade-offs	B	Transportation Challenges	**Logistical Factors**

"Getting to the clinic is also a hassle. I have to take a taxi because I don't have a car... public transport with a baby and all the things we need is tough. Sometimes the taxis are crowded. It makes the whole trip stressful from start to finish." (P-208)	**Transport Barrier**	Anxiety- inducing transit conditions	The 'hassle' framing reduces a systemic failure to an individual burden, masking structural solutions needed	B	Transportation Challenges	**Logistical Factors**
"The clinic is close so that I can walk here. It's only a problem when I have to travel with the child. Sometimes it's too hot or too cold, so the weather may not be okay sometimes for a small child, so those are some of the challenges with carrying a child to the clinic alone." (P- 206)	**Transport Barrier**	Environmental childcare burdens	Climate vulnerability compounds the gendered labour of healthcare access for postpartum women	B	Transportation Challenges	**Logistical Factors**

Community Level

Full Quote	**Code**	**Explanation**	**Researcher Notes**	**B/F**	**Sub-Theme**	**Theme**
"The community doesn't understand mental health. They think whenever someone has mental health, they need to go to church, they need deliverance, even if you just complain, they'll just take you for deliverance." (P-203)	**Spiritual Override**	The community's perception of mental health as a spiritual issue delays seeking clinical help.	The reliance on spiritual practices over clinical care can lead to delayed treatment.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**

"There are no community programmes. I don't know anything in our community. When we need help, we go to church." (P-203)	**Lack of Resources**	The absence of formal community support systems leads to a reliance on informal networks like church groups.	Lack of community-based mental health services forces women to depend on non-professional networks.	B	Limited access to community resources	**Community Support Structures**
"The world gives us the responsibility of taking care of the child. Whether you are sick or can be tired, it is you that has to do everything." (P-203)	**Gendered Norms**	Societal expectations place a heavy responsibility on mothers, overshadowing their mental health needs.	The pressure to fulfil motherhood ideals without support exacerbates mental health struggles.	B	Negative influence of community norms	**Community Attitudes**
"People gossip, like it is terrible here, judging everything, like all that you do... When you have a child young, like I did, it's even worse." (P-208)	**Gossip**	The fear of gossip within the community discourages postpartum women from seeking help for mental health.	The social stigma from gossip further isolates women from accessing support.	B	Negative influence of community norms	**Community Attitudes**
"There's a belief that mental health issues can be prayed away, so most women just seek prayers for their challenges and don't really come to the clinic." (P-108, Healthcare provider)	**Spiritual Override**	The belief that mental health issues are spiritual in nature prevents women from seeking clinical treatment.	Spiritual intervention is prioritised over medical care, delaying necessary treatment.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**

"I think that the government should have support groups for mothers in our communities where they can meet up and discuss their problems with each other. Maybe if it is a separate facility." (P- 107, Healthcare provider)	**Support Groups**	The need for formalised community support groups for postpartum women to addressmental health concerns.	Government-led support groups would alleviate pressure on informal networks and enhance mental health care access.	F	Recommended community engagement strategies	**Community Support Structures**
"The community doesn't know anything about these things. They don't know what mental health is. We just hear stories there, but we don't know anything about it." (P-203)	**Lack of Awareness**	The lack of community awareness about mental health issues contributes to stigmatisation and misunderstanding.	The absence of mental health education within communities prevents women from accessing necessary care.	B	Negative influence of community norms	**Community Attitudes**
"So yes, the beliefs are that most of these challenges are spiritual first and foremost... when someone is not mentally okay, they think it's a spiritual or religious calling... they will try that first. And when that doesn't work, then they go to the clinic." (P-102, Healthcare provider)	**Spiritual Override**	A belief in spiritual causes of mental health issues delays seeking professional help.	The delay in clinical treatment arises from prioritising spiritual or religious solutions.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**
"Most women do prefer to be interviewed and sessions to take place in the language that they're comfortable with... being able to express yourself in a language that the client understands is very important." (P-105)	**Linguistic Facilitation**	Language preference enhances communication and engagement during mental health treatment.	Culturally appropriate language use fosters better understanding and emotional expression in therapy.	F	Cultural practices enhancing care	**Religious/ Cultural Beliefs**

"There's issues related to when you have mental health problems. It's seen as an affliction of some kind... people always try to first try to go this traditional or spiritual path." (P-104, Healthcare provider)	**Spiritual Override**	Mental health is perceived as an affliction, which leads women to seek traditional or spiritual solutions before professional care.	Cultural perceptions of mental illness as an affliction delay the initiation of clinical treatment.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**
"If the health centre could run community awareness campaigns, maybe through local radio, social media, or community meetings, it would help." (P-208)	**Community Awareness**	Raising awareness through media and community platforms could reduce stigma and promote PPMH services.	Awareness campaigns can bridge knowledge gaps and reduce mental health stigma in communities.	F	Recommended community engagement strategies	**Community Support Structures**
"In our community, when a mum struggles after giving birth, it's not always easy for her to complain or let others know what is going on, like to talk about it, because they fear getting a negative reaction." (P-209)	**Social Pressure**	Fear of negative judgement from others, including family and community members, hinders disclosure of mental health issues.	Social pressure surrounding motherhood creates significant barriers to seeking mental health support.	B	Negative influence of community norms	**Community Attitudes**
"The government must work with community leaders, with churches especially... imagine things like gatherings where mothers lead discussions." (P-207)	**Community Engagement**	Government partnerships with community leaders, particularly religious groups, could foster discussions on mental health.	Incorporating community leaders into mental health initiatives enhances cultural relevance and acceptance.	F	Recommended community engagement strategies	**Community Support Structures**

"There are no community programmes. I don't know anything in our community. When we need help, we go to church." (P-203)	**Lack of Resources**	The lack of structured community resources leaves women reliant on informal networks for mental health support.	The lack of organised community programs exacerbates the isolation experienced by postpartum women.	B	Limited access to community resources	**Community Support Structures**
"Language plays a role a lot... within our culture, there are rituals related to driving out evil spirits... If you do not fully understand the language and cultural context, you wouldn't understand what is being spoken about." (P-104, Healthcare provider)	**Linguistic Barriers**	Cultural and linguistic differences hinder effective communication and understanding of mental health.	The inability to communicate in culturally appropriate ways limits the effectiveness of mental health interventions.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**
"The church may be pulling them away from seeking mental health services, especially now that we have a lot of denominations performing rituals." (P-101, Healthcare provider)	**Spiritual Override**	The growing prominence of spiritual and ritualistic practices diverts women from seeking professional mental health care.	The competition between religious denominations for mental health interventions may hinder access to clinical services.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**
"Maybe if our government can work with like churches and... community forums, community groups where mothers can help each other, talk to each other, give each other advice and things like that." (P-205)	**Community Engagement**	Collaborative community initiatives to encourage peer support and mental health dialogue can reduce stigma.	Community forums and partnerships can promote mental health awareness and reduce the reliance on informal support.	F	Recommended community engagement strategies	**Community Support Structures**

"I think that the government should have support groups for mothers in our communities where they can meet up and discuss their problems with each other." (P-107, Healthcare provider)	**Support Groups**	Support groups for postpartum women in communities could enhance mental health care accessibility.	Formalised support groups create a space for women to share experiences and seek help in a supportive environment.	F	Recommended community engagement strategies	**Community Support Structures**
"So yes, the beliefs are that most of these challenges are spiritual first and foremost... when someone is not mentally okay, they think it's a spiritual or religious calling... they will try that first. And when that doesn't work, then they go to the clinic." (P-102, Healthcare provider)	**Spiritual Override**	Spiritual beliefs often delay the seeking of professional care, as women first turn to religious interventions.	This approach postpones timely clinical intervention and treatment for postpartum mental health issues.	B	Cultural/religious hindrances	**Religious/ Cultural Beliefs**
"Most women do prefer to be interviewed and sessions to take place in the language that they're comfortable with... being able to express yourself in a language that the client understands is very important." (P-105)	**Linguistic Facilitation**	Conducting mental health sessions in the client's preferred language fosters better communication and care.	Ensuring culturally and linguistically appropriate services enhances trust and engagement in mental health treatment.	F	Cultural practices enhancing care	**Religious/ Cultural Beliefs**
"The community doesn't know anything about these things. They don't know what mental health is. We just hear stories there, but we don't know anything about it." (P-203)	**Lack of Awareness**	A lack of mental health education in communities contributes to the stigma and misunderstanding of mental health.	Community-wide education is essential for addressing mental health stigma and promoting help-seeking behaviour.	B	Negative influence of community norms	**Community Attitudes**
"If the child's name is Sello...it might mean that a couple of things are meant. It means the context in which the child was born is linked either with some kind of grief, death of some kind or some kind of ill	**Cultural Entry Point**	Culturally sensitive approaches to care, such as understanding naming conventions, enhance engagement with the client.	By utilising cultural insights to guide care, providers can create meaningful, personalised support for	F	Cultural practices enhancing care	**Religious/ Cultural Beliefs**

health. So, we start there, why is this child called Sello? ... then using the very same culture, how do we go about then making sure that this child receives the necessary support?" (P- 105)			postpartum women.			

Societal Level

Full Quote	Code	Explanation	Researcher Notes	B/F	Sub-Theme	Theme
"If mothers were receiving check-ins, even if it's just a phone call, it would make a big difference. Are you coping? Are you okay?" (P-106, Healthcare provider)	**Remote Support**	Regular emotional check-ins create systemic touchpoints for early intervention. The simplicity of phone calls lowers implementation barriers whilst maintaining human connection. This approach acknowledges the isolating nature of postpartum periods.	Proactive outreach redistributes care burden from vulnerable patients to healthcare systems. Integration with existing maternal health programmes could create natural delivery channels. Resistance may emerge from workforce capacity concerns requiring task-shifting solutions.	F	Proposed national initiatives to enhance access and service delivery	**Public Health Interventions**
"The policies are usually a top-down, they take a top-down process, and so those on the ground are not usually consulted to fully understand the extent of the problem. It's always the ones at the top who come and make the decisions for everyone at the bottom." (P-105)	**Policy Centralisation**	Hierarchical policymaking excludes frontline clinical realities from decision- making processes. The spatial and ideological distance between planners and implementers breeds policy-practice dissonance. This centralisation reflects systemic power asymmetries in healthcare governance.	Without participatory design, policies become theoretical exercises divorced from resource constraints. Frontline providers develop workarounds that further fragment care delivery. Decentralised piloting with rapid feedback loops could mitigate this historical	B	Challenges in policy implementation and effectiveness	**Policy and Systemic Issues in PPMH care**

			challenge.			
"There should be indicators that are monitored to say, okay, for mental health, we have seen so many numbers of patients and then we have screened so much, and then how many have we identified?" (P-101)	**Outcome Metrics**	Quantifiable performance measures could transform screening from ceremonial to consequential. The proposed indicators focus on detection yield rather than just process completion. This reflects demand for accountability in mental health service delivery.	Current indicator frameworks privilege throughput over outcomes, creating perverse incentives. Postpartum-specific metrics would require disaggregating existing mental health data streams. Resistance may emerge from facilities fearing performance penalties under more transparent systems.	F	Recommendations for improving policy implementation and effectiveness	**Policy and Systemic Issues in PPMH care**
"Maybe if we can call someone, someone who will not be judgemental, who will just advise us... a psychologist or social worker can come see us, talk to us, because we don't have time to be going to a clinic with	**Remote Support**	Telehealth solutions address both logistical barriers and psychological safety concerns. The emphasis on non-judgemental professionals	Remote modalities must balance accessibility with therapeutic integrity - a challenge in under-resourced	F	Proposed national initiatives to enhance access and service delivery	**Public Health Interventions**

the baby." (P-203)		reveals stigma as a dual access barrier. Time poverty emerges as a critical determinant of help-seeking behaviour.	systems. Peer support networks could extend professional capacity whilst maintaining quality. Infrastructure limitations (e.g., data costs, connectivity) may exclude the most vulnerable without subsidies.			
"The first basic one, it should be a policy to screen every woman, like now it is a policy because even in our data there is a section that you need to tick that you have screened this patient, but remember it shouldn't go with a tick, I've screened for mental health and that is it." (P-101)	**Screening Ritualisation**	Policy compliance has been reduced to performative documentation rather than clinical engagement. Tick-box exercises create the illusion of care without substantive diagnostic value. This reflects institutional capture by bureaucratic requirements.	When documentation becomes the primary outcome, clinical judgement is supplanted by administrative performance. Power dynamics compel providers to prioritise visible compliance over patient needs. Reforming incentive structures could realign priorities with patient outcomes.	B	Challenges in policy implementation and effectiveness	**Policy and Systemic Issues in PPMH care**

"If they had pamphlets or even posters in a language we can understand, that explained things, it could really help. Maybe also share WhatsApp videos on mental health." (P- 207)	**Health Literacy Tools**	Culturally adapted materials address both linguistic and technological access barriers. Multi-format dissemination leverages existing community communication channels. The suggestion reveals an untapped potential for low-cost health education strategies.	Passive education must be paired with activation strategies to bridge the knowledge-behaviour gap. Community health workers could transform static materials into conversational tools. Sustainability requires institutionalising content updates and distribution networks.	F	Proposed national initiatives to enhance access and service delivery	**Public Health Interventions**
"There should be a way of saying that if you have screened all of them, really, we need to pick up something. You can't screen a hundred patients for mental health, asking all those questions and what have you, but at the end of the day, you didn't pick up even a single one." (P-101)	**Screening Ritualisation**	Epidemiologically improbable zero-detection rates expose either flawed tools or disengaged administration. The absence of positive cases suggests screening has become decoupled from diagnostic intent. This indicates systemic failure in case-finding mechanisms.	When sensitivity approaches zero, screening programmes lose clinical and economic justification. Providers may shortcut protocols due to unrealistic workloads or inadequate training. Regular calibration of tools and processes is needed to maintain diagnostic integrity.	B	Challenges in policy implementation and effectiveness	**Policy and Systemic Issues in PPMH care**

"I think implementing programmes where providers can visit mums at home and check on them after giving birth could be good." (P- 201)	**Remote Support**	Community-based care delivery circumvents facility access barriers whilst fostering therapeutic alliances. The home environment may enhance disclosure through familiar surroundings and reduced power differentials. This aligns with recovery-oriented mental health care principles.	Workforce constraints require innovative deployment of community health workers with specialist supervision. Privacy concerns and safety protocols must be balanced with accessibility benefits. Successful models demonstrate improved outcomes through relational continuity.	F	Proposed national initiatives to enhance access and service delivery	**Public Health Interventions**

Appendix 4: Approval Letter – General/Human Research Ethics Committee

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS UV

GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)

23-Oct-2023

Dear Mrs Palesa Leshaba

Application Approved

Research Project Title:
Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective.

Ethical Clearance number:
UFS-HSD2023/0862

We are pleased to inform you that your application for ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Yours sincerely

Dr Adri Du Plessis
Chairperson: General/Human Research Ethics Committee

Dr Adri du Plessis
Digitally signed by Dr Adri du Plessis
Date: 2023.10.23 18:07:57 +02'00'

205 Nelson Mandela Drive
Park West
Bloemfontein 9301
South Africa

P.O. Box 339
Bloemfontein 9300
Tel: +27 (0)51 401 9337
duplessisA@ufs.ac.za
www.ufs.ac.za

Appendix 5: Approval Letter – Gauteng Department of Health and the CHC

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Sedibeng District Health Services
Enquiries: Ms. N. Tuswa
Tel: 016 950 6255
Email: Nomonde.Tuswa@gauteng.gov.za

Ms. Palesa Leshaba
University of Free State
855 Phase 1, Tshepiso
Vereeniging
1928

Dear Ms. Leshaba

RE: EXPLORING ACCESS TO POSTPARTUM MENTAL HEALTHCARE AT PERI-URBAN COMMUNITY HEALTH CENTRE: A SOCIO ECOLOGICAL PERSPECTIVE

Please be informed that permission has been granted for you to carry out the above-mentioned research at Sharpeville CHC in Sedibeng District. It is noted that you have already obtained Provincial Ethics Committee as well as Research Ethics Clearance from the University of Free State.

Kindly note that a copy of the report on the findings (especially) that concerns Sedibeng District Health Services should be submitted to the Chief Director's office at the completion of the study.

This permission is also subject to the conditions stated in the protocol and any change in design and methodology must be communicated to the Chief Director.

We wish you success in your research endeavours.

Recommended / Not recommended / Recommended as amended

Prof. OB Omole
Chairperson: Sedibeng District Research Committee
Date: 02/10/2023

Approved / Not approved / Approved as amended

Ms. M.A. Madolo
Acting Chief Director: Sedibeng District Health Services
Gauteng Health Department
Date: 02/10/2023

NHRD REF: GP_202308_018

Sedibeng District Research protocol assessment template

Study title: Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective

NHRD Ref: GP_202308_018

Reviewer: Dr M. Makgata **Date:** 29/08/2023

1. Is / are the issue(s) being studied important for Sedibeng health district and aligned to the district health priorities? **Yes. Mental health, including issues of access, is a departmental priority.**

2. Are the study objectives clear? **Yes**

3. At the completion of the study, are study findings likely to be beneficial and useful for service improvement or mitigation of health risks? **Yes. Identifying potential barriers to access is very important and results might assist the district in improving services.**

4. Is the proposed study design doable within the district context and in timelines? **The study is feasible but recruitment and data gathering timelines of two weeks might be unrealistic.**

5. Will the proposed design / methods:
   a. Significantly, interrupt or distract the rendering of healthcare services? **Disruptions are likely to occur but could be minimized if the researcher will have the flexibility to avail herself at times convenient for the clinic.**

   b. Involve utilizing the district resources: instruments, tests, drugs and personnel? **Yes. Office space will be needed and some staff members might participate in the research. Due to space constraints and shortage of personnel, interviews might be possible on particular days or hours of the day.**

   c. Did the proposal clearly address issues of consent, assent, confidentiality and human rights? **Yes.**

   d. Are there potential adverse effects to participants and non-participants? **Although no potential adverse effects are anticipated, the researcher has addressed issues of referral which could be needed for some participants**

6. **Has ethics clearance and any other permissions been obtained from recognized entities?** Yes. Conditional approval has been granted by the University of the Free State's General/Human Research Ethics Committee (GHREC) pending the District's granting of approval.

Other comments:

...Non.....

7. **Recommendation: Tick**
   - Permission to be granted [**X**]
   - Permission not to be granted [ ]
   - Permission granted with conditions [ ]

Signature: ..... Date: .....29/08/2023.....

Appendix 6: Informed Consent Forms

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM FOR POSTPARTUM WOMEN

DATE

01/08/2023

TITLE OF THE RESEARCH PROJECT

Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective.

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER:

Palesa Leshaba 2022159996 0719163779

FACULTY AND DEPARTMENT:

Humanities
Centre for Health Systems Research & Development

STUDY LEADER(S) NAME AND CONTACT NUMBER:

Prof Gladys Kigozi-Male
Dr Ngwi Nnam Thecla Mulu
051 4013333

WHAT IS THE AIM / PURPOSE OF THE STUDY?

The main goal of this study is to understand the different factors that make it hard or easy for women to receive postpartum mental health services at a Community Health Center in a peri-urban area of Gauteng province. The researcher wants to look at the perspectives of both healthcare providers and women who have given birth in the last six months. By using a socio-ecological framework, we can take a closer look at the barriers and supports in accessing these services.

WHO IS DOING THE RESEARCH?

I am a student researcher at the University of Free State. I am conducting this research project as part of my academic studies under the supervision of Prof Gladys Kigozi-Male and Dr Ngwi Nnam Thecla Mulu . The project is being conducted to fulfill the requirements of my degree programme.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Human Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher.

Approval number:

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You are invited to take part in this research project because you are a postpartum woman who has given birth in the last six months and has received healthcare services at the Community Health Centre. Your participation is valuable in helping us understand the factors influencing access to mental healthcare services from the perspective of postpartum women. The selection procedures involved collaboration with staff at the Community Health Centre. Approximately 10 postpartum women are expected to take part in this study.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

Your participation in this study will involve engaging in a semi-structured interview, which provides a flexible conversation format. During the interview, you will be asked specific questions about your experiences in accessing postpartum mental healthcare services. The interview is expected to last approximately 45 minutes and will be conducted in a single session at your convenience.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Participation in this study is voluntary, and there will be no penalty or loss of benefit if you choose not to participate or decide to withdraw at any point without giving a reason. You are free to decline participation or withdraw from the study without facing any consequences. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

By participating in this study, you can contribute to improving the understanding of access to postpartum mental healthcare services. Your insights and experiences will help identify barriers to and facilitators of accessing postpartum mental health services at the Community Health Centre. There are no direct benefits to you as a participant.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

Participating in this study may involve some inconvenience, such as taking time out of your schedule to attend the interview session. There are minimal risks associated with participating in the study, and these include potential discomfort or emotional sensitivity when discussing your experiences in accessing postpartum mental health services. However, the interviewer will create a supportive and respectful environment to minimise any potential distress or harm. If you require mental health support, Lifeline Vaal is here to assist you. You can reach them at 076 867 6593 for counseling assistance. Walk-ins are welcome at their facilities, located at the Govan Mbeki Community Centre on Sekati Street, Tshepiso. If you need 24-hour telephonic counseling, please call 0861 322 322. Furthermore, the researcher will provide a direct referral form to Lifeline Vaal, ensuring immediate post-study support for participants in need of counseling. If you experience any discomfort or need to stop the interview, you are encouraged to communicate this to the interviewer.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

Confidentiality of your information is of utmost importance in this study. While the researcher will require participants' names on the consent form, rest assured that your name and personal identifying information will not be recorded anywhere else. Instead, your answers will be assigned a fictitious code number or pseudonym for identification purposes. Only the research team members directly involved in the study will have access to the data, and measures will be taken to ensure confidentiality.In addition, any external individuals involved in tasks such as transcription or coding will be required to sign a confidentiality agreement, further safeguarding the protection of your information. Your participation and responses will be treated with strict confidentiality. It's important to note that the data collected during this study may be used for other research purposes, such as research reports, journal articles, or conference presentations. However, in any publication or dissemination of information, your identity will remain anonymous. Your participation and the information you provide will be presented in an aggregated and de-identified manner to protect your privacy.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Hard copies of your consent forms and interview transcriptions will be stored by the researcher in a locked cupboard or filing cabinet at the home of the researcher for a period of five years for potential future research or academic purposes. Electronic information (such as audio-recordings and transcripts) will be stored on a password-protected computer. Any future use of the stored data will be subject to further Research Ethics Review and approval, if applicable. At the end of the retention period, all data collected will be securely destroyed. This includes shredding hard copies of the interviews and permanently deleting electronic files. Your confidentiality and privacy will be maintained throughout the data storage and destruction processes.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICPATING IN THIS STUDY?

You will not receive any financial payment or incentives for taking part in this study. However, your participation holds immense value in contributing to the understanding and advancement of knowledge in the field of healthcare.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

If you would like to be informed of the final research findings or have any queries about the research as a whole, please contact Palesa Leshaba at 0719163779 or email 2022159996@ufs4life.ac.za. Please note that the results will be shared in an aggregated form without disclosing individual participants' identities. If you have any further questions, require additional information, or need to contact the researcher regarding any aspect of this study, please feel free to reach out to Palesa Leshaba at 0719163779 or email 2022159996@ufs4life.ac.za. Should you have any concerns about the way the research has been conducted, you may contact Professor Gladys Kigozi-Male at kigozign@ufs.ac.za as well as the Human Research Ethics Committee ,University of the Free State at (051) 4052812.

Thank you for taking the time to read this information sheet and for participating in this study.

CONSENT TO PARTICIPATE IN THIS STUDY

I, the undersigned,

_____ *(participant's full names to be included), (the "**Participant**")*

confirm that I voluntarily agree to participate in the research study referred to as:

"Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective"

_____

and which Study is being conducted by

Palesa Leshaba

_____

*(insert the name of the researcher), (the "**Researcher**").*

I, the undersigned Participant, further confirm that–

1. *the Researcher has explained the nature, procedure, potential benefits and anticipated inconvenience of my participation in the Study;*
2. *I have read (or had explained to me) and understood the Study as explained in the attached information sheet;*
3. *I have had sufficient opportunity to ask questions and am prepared to participate in the Study;*
4. *I understand that my participation in the Study is entirely voluntary and that I am free to withdraw at any time without penalty (if applicable);*
5. *I voluntarily provide the UFS and the Researcher with my personal information and consent to the UFS and the Researcher collecting, disclosing and processing my personal information in order to conduct the Study and any related activities in relation thereto;*
6. *I hereby acknowledge and confirm that I understand the purpose for which the UFS and the Researcher may collect, store, use, delete, destroy, outsource, transfer or otherwise process, as the context and circumstances may require and as contemplated in terms of POPIA, my personal information as set out herein;*
7. *I am aware that the findings of the Study will be anonymously processed into a research report, journal publications and/or conference proceedings and that my personal information will be aggregated and deidentified at such stage;*
8. *I also give the UFS permission to share, without notification, the collected data with other researchers at the UFS or other Higher Education Institutions. This permission is dependent on the same principles of ethical research practices, anonymity/confidentiality, safekeeping of information, and other issues listed above applying.*

I, the Participant, agree to the audio recording

Full Name of Participant: _____

Signature of Participant: _____ *Date:* _____

Full Name of Researcher : _____

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

Signature of Researcher: _____ *Date:* _____

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM FOR HEALTHCARE PROVIDERS

DATE

01/08/2023

TITLE OF THE RESEARCH PROJECT

Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective.

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER:

Palesa Leshaba *2022159996* *0719163779*

FACULTY AND DEPARTMENT:

Humanities
Centre for Health Systems Research & Development

STUDY LEADER(S) NAME AND CONTACT NUMBER:

Prof Gladys Kigozi-Male
Dr Ngwi Nnam Thecla Mulu
051 4013333

WHAT IS THE AIM / PURPOSE OF THE STUDY?

The primary aim of this study is to utilise a socio-ecological framework to comprehensively examine the barriers to and facilitators of accessing postpartum mental health services (PPMHS) at a peri-urban Community Health Center (CHC) in Gauteng province. The study will specifically focus on the perspectives of healthcare service providers and postpartum women within the first six months of giving birth.

WHO IS DOING THE RESEARCH?

I am a student researcher at the University of Free State. I am conducting this research project as part of my academic studies under the supervision of Prof Gladys Kigozi-Male and Dr Ngwi Nnam Thecla Mulu . The project is being conducted to fulfill the requirements of my degree programme.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Human Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher.

Approval number:

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You are invited to take part in this research project because you are a healthcare provider who has experience in providing or managing healthcare services to postpartum women at the Community Health Centre. Your participation is valuable in helping us understand the factors influencing access to mental healthcare services from a healthcare provider's perspective. The participants were selected based on their experience in managing or delivering postpartum healthcare services or mental health services at the Community Health Centre. Approximately 10 healthcare providers are expected to take part in this study.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

Your participation in this study will involve engaging in a semi-structured interview, which provides a flexible conversation format. During the interview, you will be asked specific questions about your experiences in assisting women in accessing postpartum mental healthcare services. The interview is expected to last approximately 45 minutes and will be conducted in a single session at your convenience.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Participation in this study is voluntary, and there will be no penalty or loss of benefit if you choose not to participate or decide to withdraw at any point without giving a reason. You are free to decline participation or withdraw from the study without facing any consequences. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

By participating in this study, you can contribute to improving the understanding of access to postpartum mental healthcare services. Your insights and experiences will help identify barriers to and facilitators of accessing postpartum mental health services at the Community Health Centre. There are no direct benefits to you as a participant.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

Participating in this study may involve some inconvenience, such as taking time out of your schedule to attend the interview session. There are minimal risks associated with participating in the study, and these include potential discomfort or emotional sensitivity when discussing your experiences with working with patients with mental health challenges. However, the interviewer will create a supportive and respectful environment to minimise any potential distress or harm. If you require mental health support, Lifeline Vaal is here to assist you. You can reach them at 076 867 6593 for counseling assistance. Walk-ins are welcome at their facilities, located at the Govan Mbeki Community Centre on Sekati Street, Tshepiso. If you need 24-hour telephonic counseling, please call 0861 322 322. Furthermore, the researcher will provide a direct referral form to Lifeline Vaal, ensuring immediate post-study support for participants in need of counseling. If you experience any discomfort or need to stop the interview, you are encouraged to communicate this to the interviewer.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

Confidentiality of your information is of utmost importance in this study. While the researcher will require participants' names on the consent form, rest assured that your name and personal identifying information will not be recorded anywhere else. Instead, your answers will be assigned a fictitious code number or pseudonym for identification purposes. Only the research team members directly involved in the study will have access to the data, and measures will be taken to ensure confidentiality.In addition, any external individuals involved in tasks such as transcription or coding will be required to sign a confidentiality agreement, further safeguarding the protection of your information. Your participation and responses will be treated with strict confidentiality. It's important to note that the data collected during this study may be used for other research purposes, such as research reports, journal articles, or conference presentations. However, in any publication or dissemination of information, your identity will remain anonymous. Your participation and the information you provide will be presented in an aggregated and de-identified manner to protect your privacy.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Hard copies of your consent forms and interview transcriptions will be stored by the researcher in a locked cupboard or filing cabinet at the home of the researcher for a period of five years for potential future research or academic purposes. Electronic information (such as audio-recordings and transcripts) will be stored on a password-protected computer. Any future use of the stored data will be subject to further Research Ethics Review and approval, if applicable. At the end of the retention period, all data collected will be securely destroyed. This includes shredding hard copies of the interviews and permanently deleting electronic files. Your confidentiality and privacy will be maintained throughout the data storage and destruction processes.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICPATING IN THIS STUDY?

You will not receive any financial payment or incentives for taking part in this study. However, your participation holds immense value in contributing to the understanding and advancement of knowledge in the field of healthcare.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

If you would like to be informed of the final research findings or have any queries about the research as a whole, please contact Palesa Leshaba at 0719163779 or email 2022159996@ufs4life.ac.za. Please note that the results will be shared in an aggregated form without disclosing individual participants' identities. If you have any further questions, require additional information, or need to contact the researcher regarding any aspect of this study, please feel free to reach out to Palesa Leshaba at 0719163779 or email 2022159996@ufs4life.ac.za. Should you have any concerns about the way the research has been conducted, you may contact Professor Gladys Kigozi-Male at kigozign@ufs.ac.za as well as the Human Research Ethics Committee ,University of the Free State at (051) 4052812.

Thank you for taking the time to read this information sheet and for participating in this study.

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

CONSENT TO PARTICIPATE IN THIS STUDY

I, the undersigned,

_____ *(participant's full names to be included), (the "**Participant**")*

confirm that I voluntarily agree to participate in the research study referred to as:

"Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective"

_____

and which Study is being conducted by

Palesa Leshaba

_____

*(insert the name of the researcher), (the "**Researcher**").*

I, the undersigned Participant, further confirm that–

1. *the Researcher has explained the nature, procedure, potential benefits and anticipated inconvenience of my participation in the Study;*
2. *I have read (or had explained to me) and understood the Study as explained in the attached information sheet;*
3. *I have had sufficient opportunity to ask questions and am prepared to participate in the Study;*
4. *I understand that my participation in the Study is entirely voluntary and that I am free to withdraw at any time without penalty (if applicable);*
5. *I voluntarily provide the UFS and the Researcher with my personal information and consent to the UFS and the Researcher collecting, disclosing and processing my personal information in order to conduct the Study and any related activities in relation thereto;*
6. *I hereby acknowledge and confirm that I understand the purpose for which the UFS and the Researcher may collect, store, use, delete, destroy, outsource, transfer or otherwise process, as the context and circumstances may require and as contemplated in terms of POPIA, my personal information as set out herein;*
7. *I am aware that the findings of the Study will be anonymously processed into a research report, journal publications and/or conference proceedings and that my personal information will be aggregated and deidentified at such stage;*
8. *I also give the UFS permission to share, without notification, the collected data with other researchers at the UFS or other Higher Education Institutions. This permission is dependent on the same principles of ethical research practices, anonymity/confidentiality, safekeeping of information, and other issues listed above applying.*

I, the Participant, agree to the audio recording.

Full Name of Participant: _____

*Signature of Participant:*_____ *Date:* _____

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

Full Name(s) of Researcher(s): _____

*Signature of Researcher:*_____*Date:*_____

Appendix 7: Confidentiality Agreements

CONFIDENTIALITY AGREEMENT

This confidentiality agreement is made between the researcher, Palesa Leshaba and the staff members of the Community Health Centre involved in recruitment .

Purpose of Agreement
The purpose of this Agreement is to establish confidentiality measures and guidelines to protect the privacy of potential research participants and maintain the confidentiality of their personal information during the research study.

Collaborative Relationship
The Researcher and the Staff acknowledge their collaborative relationship in the recruitment process for the research study. The Staff, including postnatal nurses and mental health specialists, have direct access to the personal data of potential participants during postnatal visits.

Confidentiality Obligations
The Staff agrees to maintain strict confidentiality and not disclose any personal or sensitive information obtained during postnatal visits, including but not limited to participants' identities, health conditions, or any other details that could potentially identify the participants.

Confidentiality Agreements
Confidentiality agreements will be established between the Researcher and the Staff involved in recruitment. These agreements will serve as a reminder and commitment to maintain privacy and protect the confidentiality of participants' information.

Informed Consent Management
Informed consent management will be a priority for the research study. The Researcher will provide clear guidelines to the CHC Staff, emphasizing the importance of obtaining informed consent from potential participants. The Staff will ensure that participants fully understand the purpose of the study, their rights, and the voluntary nature of their participation.

Duration of Agreement
This Agreement shall remain in effect for the duration of the research study and until such time that the collected data has been appropriately stored, analyzed, and reported.

Compliance with Legal and Ethical Standards
Both the Researcher and the Staff agree to comply with all applicable laws, regulations, and ethical standards regarding the handling, storage, and use of personal information obtained during the research study.

Termination
Either party may terminate this Agreement with written notice if there is a breach of confidentiality obligations or if required by law or regulatory requirements.
By signing below, the Researcher and the Staff acknowledge their understanding and agreement to the terms and conditions of this confidentiality agreement.

Researcher:

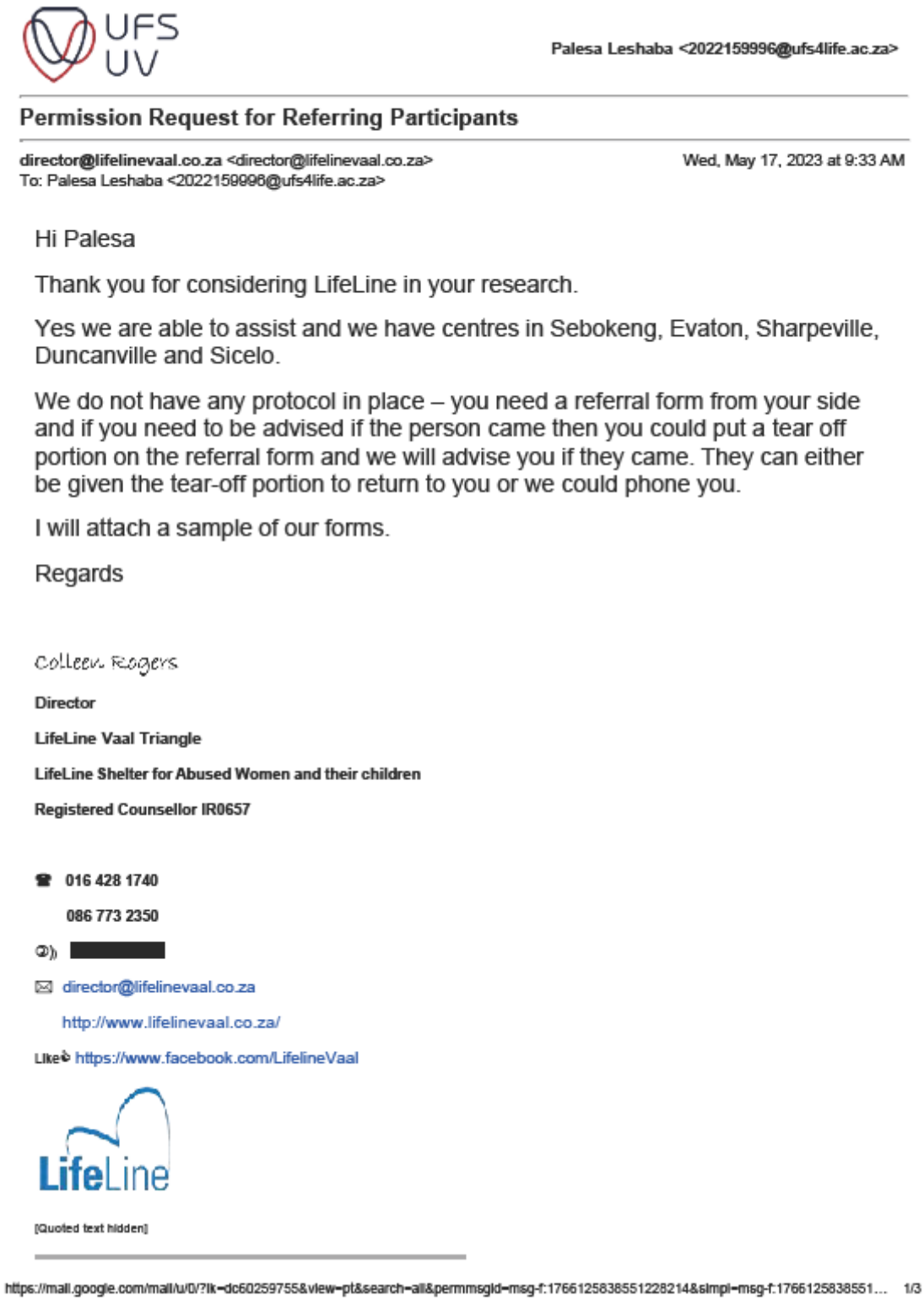
Palesa Leshaba
Date: _____ Signature:_____

Staff:

Staff's Name:

Date: _____ Signature:_____

Appendix 8: Agreement With Lifeline to Provide Free Counselling Services to Participants



UFS UV

Palesa Leshaba <2022159996@ufs4life.ac.za>

Permission Request for Referring Participants

director@lifelinevaal.co.za <director@lifelinevaal.co.za> Wed, May 17, 2023 at 9:33 AM
To: Palesa Leshaba <2022159996@ufs4life.ac.za>

Hi Palesa

Thank you for considering LifeLine in your research.

Yes we are able to assist and we have centres in Sebokeng, Evaton, Sharpeville, Duncanville and Sicelo.

We do not have any protocol in place – you need a referral form from your side and if you need to be advised if the person came then you could put a tear off portion on the referral form and we will advise you if they came. They can either be given the tear-off portion to return to you or we could phone you.

I will attach a sample of our forms.

Regards

Colleen Rogers

Director

LifeLine Vaal Triangle

LifeLine Shelter for Abused Women and their children

Registered Counsellor IR0657

☎ **016 428 1740**

086 773 2350

[redacted]

director@lifelinevaal.co.za

http://www.lifelinevaal.co.za/

Like https://www.facebook.com/LifelineVaal

LifeLine

[Quoted text hidden]

https://mail.google.com/mail/u/0/?ik=dc60259755&view=pt&search=all&permmsgid=msg-f:1766125838551228214&simpl=msg-f:1766125838551... 1/3

Appendix 9: Lifeline Direct Referral Form

LifeLine
Mental and Emotional Health for all

LifeLine Vaal Triangle
Reg. No. 001-885NPO
Monument Road, Duncanville 1939
P.O. Box 20
ARCON PARK 1937

Officer: (016) 428 1740
Fax.: (016) 428 1741
or 086 733 2350
24 Hour Counselling: (016) 428 1640
National 24 hour number: 0861 322 322
e-mail: director@lifelinevaal.co.za
website: www.lifelinevaal.co.za

Date:

Referral Letter

Name of client:..... **Gender**.....

ID Number:.....

Address:.....

.....

Referral to:.....

Would you please assist Mr/Mrs/Ms.....

on the following issue:

.....

.....

.....

Yours in LifeLine

.....

Name:

Chairman: Jacques Loots Director: Colleen Rogers

July 2022

Appendix 10: Letter From Language Editor

CARMEN NEL
REGISTERED PROFESSIONAL LIBRARIAN (SA)
BINF HONS (UNISA)

EDITING SERVICES
072 377 5585
carmen@ufs.ac.za

CERTIFICATE OF LANGUAGE EDITING

This certifies that I have edited the research proposal detailed below for language.

Title:

"Exploring access to postpartum mental healthcare at a peri-urban community health centre: A socio-ecological perspective"

by

Palesa Leshaba

Regards

Carmen Nel

Carmen Nel
22 July 2025

Appendix 11: Turn It In Report

Exploring access to postpartum mental healthcare at a peri-urban community health centre_A socio-ecological perspective.docx

ORIGINALITY REPORT

8%	6%	4%	1%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	researchspace.ukzn.ac.za Internet Source	1%
2	"The Palgrave Handbook of Mental Health Practice in Sub-Saharan Africa", Springer Science and Business Media LLC, 2025 Publication	<1%
3	pure.uva.nl Internet Source	<1%
4	repository.up.ac.za Internet Source	<1%
5	Abbs, Garry. "Exploring Factors Influencing High School Graduates' Career Choices in Hospitality: A Qualitative Exploratory Case Study.", University of Phoenix Publication	<1%
6	core.ac.uk Internet Source	<1%
7	www.health.gov.za Internet Source	<1%
8	uir.unisa.ac.za Internet Source	<1%
9	www.frontiersin.org Internet Source	<1%
10	scholar.sun.ac.za Internet Source	

		<1%
11	hdl.handle.net Internet Source	<1%
12	Knapp, Martin, McDaid, David, Mossialos, Elias. "Mental Health Policy and Practice Across Europe", Mental Health Policy and Practice Across Europe, 2006 Publication	<1%
13	Faith Atewologun, Olaniyi Abideen Adigun, Olalekan John Okesanya, Hakeem Kayode Hassan et al. "A comprehensive review of mental health services across selected countries in sub-Saharan Africa: assessing progress, challenges, and future direction", Discover Mental Health, 2025 Publication	<1%
14	Submitted to University of the Free State Student Paper	<1%
15	vital.seals.ac.za:8080 Internet Source	<1%
16	Franklin, Bridgette Berger. "Nonprofit Supervisors in Foster Care/Adoption Agencies and Employee Retention: Interpersonal Communication and Coaching.", Grand Canyon University Publication	<1%
17	scholar.ufs.ac.za Internet Source	<1%
18	dspace.nwu.ac.za Internet Source	<1%
19	wiredspace.wits.ac.za Internet Source	<1%

20	vdoc.pub Internet Source	<1 %
21	Aderoju, Rebecca Taiwo. ""We Live in a Spiritual Country": The Associations Among Health Literacy, Quality of Life, and Religious Spiritual Personal Beliefs Among the Nigerian Population", The University of Memphis Publication	<1 %
22	www.researchgate.net Internet Source	<1 %
23	journals.kmanpub.com Internet Source	<1 %
24	Chobany, Mariah L.. "The Ethics of Involuntary Psychiatric Hospitalization: A Comprehensive Analysis of Policies, Practice, and Ethical Oversight", Duquesne University Publication	<1 %
25	Hale, Gabrielle E.. "The Role of Professional Football Clubs in Enhancing the Mental Health and Well-Being of Young People", University of South Wales (United Kingdom), 2024 Publication	<1 %
26	ebin.pub Internet Source	<1 %
27	pmc.ncbi.nlm.nih.gov Internet Source	<1 %
28	open.uct.ac.za Internet Source	<1 %
29	rsisinternational.org Internet Source	<1 %
30	www.science.gov Internet Source	<1 %

31	Hunter, Seft G.. "A Narrative Policy Framework Analysis of LGBTQ+ Adoptive Fathers' Experiences in Georgia", Walden University Publication	<1%
32	Makhale, Masodi Esther. "Strategies to Facilitate Advocacy for the Human Rights of Mental Health Care Users by Psychiatric Nurses in the Sedibeng District of Gauteng Province", University of Johannesburg (South Africa), 2023 Publication	<1%
33	scholar.ufs.ac.za:8080 Internet Source	<1%
34	bura.brunel.ac.uk Internet Source	<1%
35	etd.uovs.ac.za Internet Source	<1%
36	www.psychiatryjournal.in Internet Source	<1%
37	Submitted to American College of Education Student Paper	<1%
38	"Abstracts: The Gerontological Society of America 59th Annual Scientific Meeting November 16-20, 2006 Dallas, TX", The Gerontologist, 2010. Publication	<1%
39	km2ciutat.net Internet Source	<1%
40	David Mulenga. "Understanding Public Health in Africa - Issues and Cases", Routledge, 2025 Publication	<1%

41	Small, LaTrice R.. "Understanding Code-Switching of Black Businesswomen in Arkansas: Organizational Strategies for a Better Workplace", Franklin University, 2024 Publication	<1 %
42	neurolaunch.com Internet Source	<1 %
43	Submitted to Nottingham Trent University Student Paper	<1 %
44	Submitted to Adtalem Global Education Student Paper	<1 %
45	Ramaremisa, Gibbon Khathutshelo. "An In-Depth Identification and Characterisation of Microplastics in the Vaal River, South Africa", University of the Witwatersrand, Johannesburg (South Africa), 2025 Publication	<1 %
46	Submitted to th-koeln Student Paper	<1 %
47	www.samrc.ac.za Internet Source	<1 %
48	Molepo, Nesta Thembisile. "Implementation of Postpartum Care Guidelines in Gauteng Province: A Qualitative Document Analysis.", University of Johannesburg (South Africa) Publication	<1 %
49	Submitted to Victoria University Student Paper	<1 %
50	encyclopedia.arabpsychology.com Internet Source	<1 %
51	gotranscript.com Internet Source	<1 %

52	repository.up.ac.za:8080 Internet Source	<1 %
53	staging-jmir.jmir.org Internet Source	<1 %
54	www.aitusrj.org Internet Source	<1 %
55	www.coursehero.com Internet Source	<1 %
56	Roland J. Thorpe, DeMond S. Miller. "Health Disparities, Disasters, and Crises - Approaches for a Culture of Preparedness", Routledge, 2023 Publication	<1 %
57	aran.library.nuigalway.ie Internet Source	<1 %
58	era.ed.ac.uk Internet Source	<1 %
59	www.ufs.ac.za Internet Source	<1 %
60	repository.out.ac.tz Internet Source	<1 %
61	ruor.uottawa.ca Internet Source	<1 %
62	Rogers, Anne, Pilgrim, David. "EBOOK: A Sociology of Mental Health and Illness", EBOOK: A Sociology of Mental Health and Illness, 2014 Publication	<1 %
63	Submitted to University of Hull Student Paper	<1 %
64	healtheduj.com Internet Source	

		<1%
65	oda.oslomet.no Internet Source	<1%
66	www.springermedizin.de Internet Source	<1%
67	Submitted to Brunel University Student Paper	<1%
68	Letitia Pienaar. "The Evolution of Mental Health Legislation in South Africa: Towards a Rights-Based Approach", Laws, 2025 Publication	<1%
69	Marule, Innocentia Ntomboxolo. "State Capacity in the Provision of Services in Sedibeng District Municipality", University of the Witwatersrand, Johannesburg (South Africa), 2025 Publication	<1%
70	Submitted to RMIT University Student Paper	<1%
71	Submitted to Rose-Hulman Institute of Technology Student Paper	<1%
72	Submitted to Sheffield Hallam University Student Paper	<1%
73	Submitted to University of KwaZulu-Natal Student Paper	<1%
74	Submitted to University of Venda Student Paper	<1%
75	Mary-Louise Fleming, Louise Baldwin. "Health Promotion in the 21st Century - New	<1%

	approaches to achieving health for all", Routledge, 2020 Publication	
76	Submitted to Nelson Mandela Metropolitan University Student Paper	<1 %
77	Submitted to University of the Western Cape Student Paper	<1 %
78	Submitted to Woodstock School Student Paper	<1 %
79	apcaso.org Internet Source	<1 %
80	confocal-manawatu.pbworks.com Internet Source	<1 %
81	etd.cput.ac.za Internet Source	<1 %
82	iussp.org Internet Source	<1 %
83	socialprotection.org Internet Source	<1 %
84	David P. Gradwell, Elizabeth S. Wilkinson. "Ernsting's Aviation and Space Medicine", CRC Press, 2025 Publication	<1 %
85	Submitted to National University of Singapore Student Paper	<1 %
86	Submitted to The University of Texas at Arlington Student Paper	<1 %
87	ia801903.us.archive.org Internet Source	<1 %
	researchopenworld.com	

88	Internet Source	<1%
89	www.ideals.illinois.edu Internet Source	<1%
90	www.washingtonpost.com Internet Source	<1%
91	discol.umk.edu.my Internet Source	<1%
92	doaj.org Internet Source	<1%
93	escholarship.org Internet Source	<1%
94	pretorianews.co.za Internet Source	<1%
95	psychiatry.smhs.gwu.edu Internet Source	<1%
96	repository.nida.ac.th Internet Source	<1%
97	repository.nwu.ac.za Internet Source	<1%
98	Submitted to universititeknologimara Student Paper	<1%
99	www.charliehealth.com Internet Source	<1%
100	www.pubfacts.com Internet Source	<1%
101	Byamah Brian Mutamba, Sauharda Rai, Lynn Semakula, David Cappo, Laura Asher, Wilfred Gwaikolo, Brandon A. Kohrt. "Strengthening care in collaboration with people with lived experience of psychosis in Uganda (SCAPE-U):	<1%

	A protocol for a cluster randomized controlled feasibility trial", Pilot and Feasibility Studies, 2025 Publication	
102	Submitted to California Southern University Student Paper	<1 %
103	cmbinary.gauteng.gov.za Internet Source	<1 %
104	epdf.tips Internet Source	<1 %
105	ir.nbu.ac.in Internet Source	<1 %
106	mro.massey.ac.nz Internet Source	<1 %
107	repository.smuc.edu.et Internet Source	<1 %
108	richestph.com Internet Source	<1 %
109	viurrspace.ca Internet Source	<1 %
110	www.collegesidekick.com Internet Source	<1 %
111	www.grafiati.com Internet Source	<1 %
112	www.healthfinanceinstitute.org Internet Source	<1 %
113	www.mm3admin.co.za Internet Source	<1 %
114	www.nice.org.uk Internet Source	<1 %
	www.sciencegate.app	

115	Internet Source	<1%
116	www.who.int Internet Source	<1%
117	Akm Monjurul Hoque, Maariyah Hoque, Rafiul Hoque, Mir Anwar, Abm Mahbub-ul Alam, Somaya Buckus. "Audit of Unplanned Pregnancy–Prevalence and Risk Factors: Experience from a Community Health Care Facility in Durban, South Africa, 2023", European Journal of Medical and Health Sciences, 2025 Publication	<1%
118	Bramble, Amy. "Teachers' Implementation of Arts Integration: A Qualitative Exploratory Case Study.", University of Phoenix, 2019 Publication	<1%
119	Chalk, Stephanie. "Posttraumatic Growth During Covid-19: A Quantitative Analysis of Individualist and Collectivist Values", James Madison University, 2021 Publication	<1%
120	Gillian England-Mason, Jennifer Khoury, Leslie Atkinson, Geoffrey B. Hall, Andrea Gonzalez. "Attentional Avoidance of Emotional Stimuli in Postpartum Women With Childhood History of Maltreatment and Difficulties With Emotion Regulation.", Emotion, 2017 Publication	<1%
121	Jasmine Titova, Margie H. Davenport, Susan Williams, Melanie Hayman. "What Support Do Australian Sporting Organizational Policies Provide to Pregnant and Parenting Elite	<1%

	Athletes? A Scoping Review", Journal of Sport Management, 2025 Publication	
122	PHILIP KWASI ELIKE. "Impact of Experiences in the United States on Ghanaian Clergy's Approach to Mental Illness: Implications for Social Work and Human Rights", Springer Science and Business Media LLC, 2025 Publication	<1 %
123	assets-eu.researchsquare.com Internet Source	<1 %
124	bmcnurs.biomedcentral.com Internet Source	<1 %
125	catalog.ncu.edu Internet Source	<1 %
126	digital.library.adelaide.edu.au Internet Source	<1 %
127	docslib.org Internet Source	<1 %
128	doi.org Internet Source	<1 %
129	doras.dcu.ie Internet Source	<1 %
130	fbsf.wyb.ac.lk Internet Source	<1 %
131	ir.canterbury.ac.nz Internet Source	<1 %
132	napier-repository.worktribe.com Internet Source	<1 %
133	pure.coventry.ac.uk Internet Source	<1 %

134	purehost.bath.ac.uk Internet Source	<1 %
135	repository.mdx.ac.uk Internet Source	<1 %
136	researchportal.port.ac.uk Internet Source	<1 %
137	srhrindex.srhrforall.org Internet Source	<1 %
138	stacks.cdc.gov Internet Source	<1 %
139	ulspace.ul.ac.za Internet Source	<1 %
140	uscode.house.gov Internet Source	<1 %
141	www.mdpi.com Internet Source	<1 %
142	www.uspreventiveservicestaskforce.org Internet Source	<1 %
143	www.wapr.org Internet Source	<1 %
144	Shah, Bhumit Anishkumar. "A Study on Measuring the Perception for Selected Health Care Services Provided by Primary Health Care Centers (PHCs) in Selected Villages of the Vadodara District", Maharaja Sayajirao University of Baroda (India), 2024 Publication	<1 %

Exclude quotes	On	Exclude matches	< 5 words
Exclude bibliography	On		