
MOTHERS MATTER:

AN EVALUATION OF THE *TOGETHER FROM THE BEGINNING* VIDEO CARD IN A LOCAL GOVERNMENT ANTENATAL CLINIC



Research Report

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SUMMARY

Objective

With more and more scientific knowledge being produced to support the development of infants during the first thousand days of their lives (from conception to age two), it is vital that the caregivers of infants, from varying socioeconomic backgrounds, receive the information and support to provide their infants with the necessary care and resources to thrive. The aim of the research project was to pilot and test the feasibility, efficacy and sustainability of the video card, *Together from the Beginning*, in the waiting areas of a local government clinic.

Goals

The video card, a small portable screen, approximately A5 in size, which contains a thirteen minute video (available in English, Afrikaans and isiXhosa), attempts to increase the awareness in parents regarding their infants' developmental needs. The research took place over a period of two months in the waiting areas of the antenatal clinic and Midwife Obstetrics Unit (MOU) at the Kraaifontein Community Health Clinic. During this time, sixty pregnant women participated in the research study. The study involved interviews with women before and after they had viewed the video card, as well as input from nursing staff at the local antenatal clinic. Fifty pregnant women completed interviews before and after viewing the video card. Pregnant women, waiting in the antenatal clinic waiting areas, were targeted as the main participants because it was believed that the earlier the mothers learned the information, the greater impact it would have on their prenatal and antenatal care of their infants.

Outcomes

Overall, the video card received positive feedback from both the pregnant women and the nurses in the antenatal clinic and MOU. Not only were the participants able to handle the video cards with ease, but they "learned a lot" from the video content, which they also enjoyed watching. The majority of nurses and pregnant women found the video card to be very informative, as well as more interesting and effective as a "patient education" tool than information booklets and pamphlets, as the content evoked emotional responses from the viewers, which enabled self-reflection. The video card was also easy to operate and was small enough to lock away for safekeeping.

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BACKGROUND

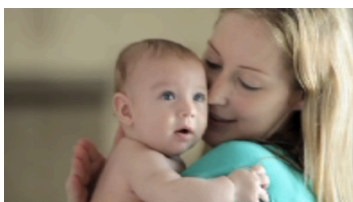
The purpose of this research project was to pilot the video card, *Together from the Beginning*, in the waiting areas of a local government clinic and to subsequently evaluate its feasibility, efficacy and sustainability amongst waiting patients and nursing staff. The video card, which was created by child and adolescent psychiatrist, Prof. Astrid Berg in conjunction with the Department of Health, is an interactive handheld device the size of an A5 book. A video plays automatically once the video card is opened. It is approximately 13-minutes long and is available in English, Afrikaans and isiXhosa. Because it was created from the perspectives of a clinician with extensive working experience in the Khayelitsha community, particular care was taken to name facts in such a way that they would be acceptable to even the most vulnerable mothers. The video content specifically displays childcare scenarios from different socioeconomic backgrounds, representing the diversity of families and caregiving in the Western Cape and South Africa at large. In the video, three infants at different developmental stages are introduced. Each infant encounters his or her own set of potentially harmful social experiences, which are told as narratives from the infants' perspectives:

Somi, boy, ante-natally and after birth, then at 13 months



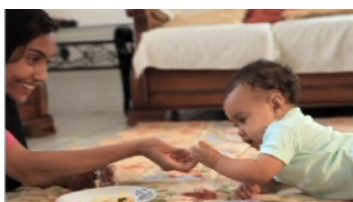
While in the womb, Somi is aware of both his internal and external environments. When his mother smokes and drinks during pregnancy, the infant is negatively affected by it. Somi's mother also suffers from depression, but she seeks emotional support from the Kuyasa Clinic in Khayelitsha once her son is born. By doing so, Somi's mother's overall health and well-being improves and she is able to take better care of Somi.

Josh, boy, 4 months



Josh's mother lets him cry for too long because she is busy cooking. His parents also fight in his presence, which causes him great distress. Only once the mother, or both the mother and the father, begin to pay attention to Josh and begin to talk and play with him, does his mood improve. He smiles back at his parents when they engage gently and lovingly with him.

Radheefa, girl, 9 months



Radheefa's mother leaves her with a stranger (caretaker) before she goes to work. Being left with a stranger causes the infant to cry after her mother. Only once Radheefa's mother spends time with her and the new caretaker and reassures the Radheefa that she is safe, does the infant begin to feel comfortable being taken care of a stranger.

Overall, the *Together from the Beginning* video card attempts to emphasise:

- (1) the awareness that infants have of what is going on
- (2) the need for togetherness of parents
- (3) the need for love, play and stimulation

The video card further advocates that mothers visit their local clinics (here demonstrated by reference to Kuyasa Clinic) and hospitals (in this case, the Red Cross Children's Hospital) regularly in order to seek emotional support and medical assistance where and when needed. In addition, as outlined in the original research proposal by Prof. Astrid Berg (2006), the video highlights the following:

- The importance of maternal health during pregnancy, such as the deleterious effects that smoking and drinking have on the baby
- The importance of the feeding relationship between mother and baby
- Showing developmental milestones, such as smiling, babbling, and motor development
- The normal curiosity and activity of toddler-hood
- The importance of sibling and peer relationships
- Considering caregiving arrangements from the baby's point of view – to prevent disrupted attachment experiences

Given the content and target messages, the video card was thus intended to be shown to pregnant women, particularly those in their early stages of their pregnancy, so as to ensure optimal impact.

The importance of
maternal health during
pregnancy

The importance of the
feeding relationship
between mother and
baby

Showing
developmental
milestones

The normal curiosity
and activity of toddler-
hood

The importance of
sibling and peer
relationships

To think about
caregiving
arrangements from the
baby's point of view

Objectives

The objectives of the research project were to test the feasibility, efficacy and sustainability of the *Together from the Beginning* video card in the waiting areas of a local government clinic.

The **feasibility** of the video card was to be tested specifically in the waiting areas of the antenatal clinic and Midwife Obstetrics Unit (MOU), where pregnant women spent a large amount of time waiting to be seen by the nurses. Observations of the video card being used by pregnant women in the waiting area would reveal whether the women are interested in the intervention, and also whether they are able to use the video card effectively without the assistance from nursing staff.

The **efficacy** of the video card was to be tested by interviewing the pregnant women and nurses before and after they watched the video. Interviewing the pregnant women would demonstrate whether they understand the video content and are able to relate to the messages being relayed in the video; interviewing the nurses would provide information about the content of the video, as well as about the management of the video card in the busy setting of the clinics.

The **sustainability** of the video card was to be tested by allowing the nurses to manage and administer the cards, without the assistance of the researcher, over a short period of time. The robustness (in terms of theft and durability) of the video card would also be tested during this time, since nurses would not always be capable of keeping track of the video cards when they have other responsibilities in the clinic. Recommendations from the nurses would then be recorded once they had managed the video cards on their own for a short period.

Methodology

Research participants were recruited from the Kraaifontein Community Health Clinic. The pilot study, which took place over a two-month period (7 March – 6 May 2016), was approved by University of Cape Town's Anthropology Section (EARC2015-20b), the Human Research Ethics Committee from the Faculty of Health Science, University of Cape Town (HREC REF: 810/2015), and the Western Cape Government Department of Health (REF: WC_2015RP52_37). The video card was then shown to pregnant women waiting in the waiting areas of the antenatal clinic, as well as the Midwife Obstetrics Unit (MOU).

The aim of the research was to evaluate both the content and the usage of the video card, *Together from the Beginning*: to determine whether the pregnant women and nurses were supportive of the intervention, whether they could provide suggestions to improve the video, and also whether the video card was a feasible and sustainable intervention in the clinic. The participation and support of not only the pregnant women, but also the nurses in the clinic, was vital because the intervention was intended to assist the nurses in disseminating important information to pregnant women about their behaviours, habits, and childcare practices while they were still pregnant and once their babies were born. While the video could have essentially been shown to all patients waiting in the clinic, pregnant women and their partners (when present) were targeted as the primary participants. All pregnant women, regardless of their stage of pregnancy, were allowed to view the video and participate in the study; however, it is important to note that women were allowed to view the video without partaking in the study.

When this research project was first approved by the manager of the Kraaifontein Community Health Clinic, it was suggested that the video card be shown in the antenatal clinic and the MOU, both of which were run by the head nurse. However, the majority of the research took place in the antenatal clinic rather than in the MOU, for the following reasons:

- (1) The head nurse suggested that the antenatal clinic would be better since it was busier than the MOU;
- (2) the antenatal clinic had benches to accommodate at least forty patients, whereas the MOU only had enough plastic chairs to seat fifteen patients; and
- (3) given the content of the video card (which covers antenatal and infant care) it seemed appropriate to show the video women who were currently pregnant ("the earlier, the better").



Pregnant women were therefore identified while sitting on the benches in the waiting area of the antenatal clinic and were informed individually, in pairs or in groups of four, about the purpose of the research study. Those who showed interest in the intervention were then selected to become a research participant. After obtaining informed consent (in writing) from the pregnant women, each woman completed a demographic survey. Thereafter, they were interviewed using a structured questionnaire, which was divided into two sections: *pre-intervention* and *post-intervention* interview questions. These questions were made available in both English and Afrikaans.

The *pre-intervention* interview questions were asked before the pregnant women watched the video, and sought to ask questions about their:

- expectations and experiences of their pregnancy
- ideas about foetal care
- support structures (including who takes care of them and their children)
- healthcare resources
- partner's (father of baby) involvement in their pregnancy

A single video card was then handed to the participant, who could watch it on her own or with the other pregnant women seated on the bench next to her. Participants were observed during this time while they were watching and handling the video card. Once the video was done playing, the researcher would return to the participant to ask another set of questions.

The *post-intervention* interview questions related to the content of the video, the process of watching the video card, information sharing, as well as suggestions for future interventions. In total, the duration of the interviews ranged between six to twenty minutes per participant. All *pre-intervention* and *post-intervention* interviews with the participants were recorded (using a dictaphone) and transcribed verbatim. All participants were given a pseudonym to protect their identities. Nurses were also interviewed after having watched the video cards, as well as after administering the video cards on their own for a period of two weeks. During the entire process, I also observed the rhythms and routines of the clinic, noting the extent to which the viewing of the video card interrupted or was interrupted by the clinic flow.

Limitations

A. PRACTICAL APPLICATION

The efficacy of the video card was only determined based on the verbal feedback from the participants directly after they viewed the video card. While many of the pregnant women *said* that they enjoyed the video cards and would attempt to “change” their behaviour (such as stressing less or being happier), it was not possible to observe these changes occur, given the specific scope of the short-term pilot study. As such, it would be beneficial to conduct an additional, long-term study that tracks the pregnant women throughout the duration of their pregnancies and also once they have given birth in order to identify the lasting impact of the video content in the lives of the mothers.

B. PARTICIPANT INVOLVEMENT

Although the video card could have been shown to a wider audience, pregnant women and mothers in general were chosen as the key participants in order to achieve the greatest possible impact. Even though eight partners/fathers of the babies joined the pregnant women in answering some of the interview questions, fathers played a much smaller role in this study. With that said, gaining the insight of not only the partners and fathers, but also of other family members and friends related to or close to the pregnant women would strengthen the data that supports overall efficiency and feasibility of the video card.

C. LANGUAGE BARRIERS

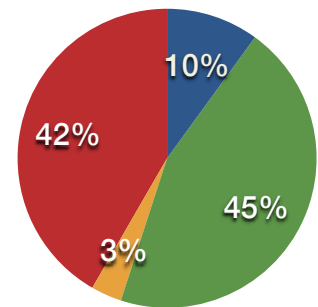
Even though the video card was made available to the pregnant women in English, Afrikaans and isiXhosa, the interviews were only conducted in English and Afrikaans. As a result, feedback from primarily isiXhosa speaking participants was difficult to obtain. Conducting an additional study that includes an isiXhosa researcher or research assistant will eliminate further language barriers, and will also ensure a more widespread coverage of responses and richer data. Additional South African and African languages could also be incorporated into future studies.

RESULTS

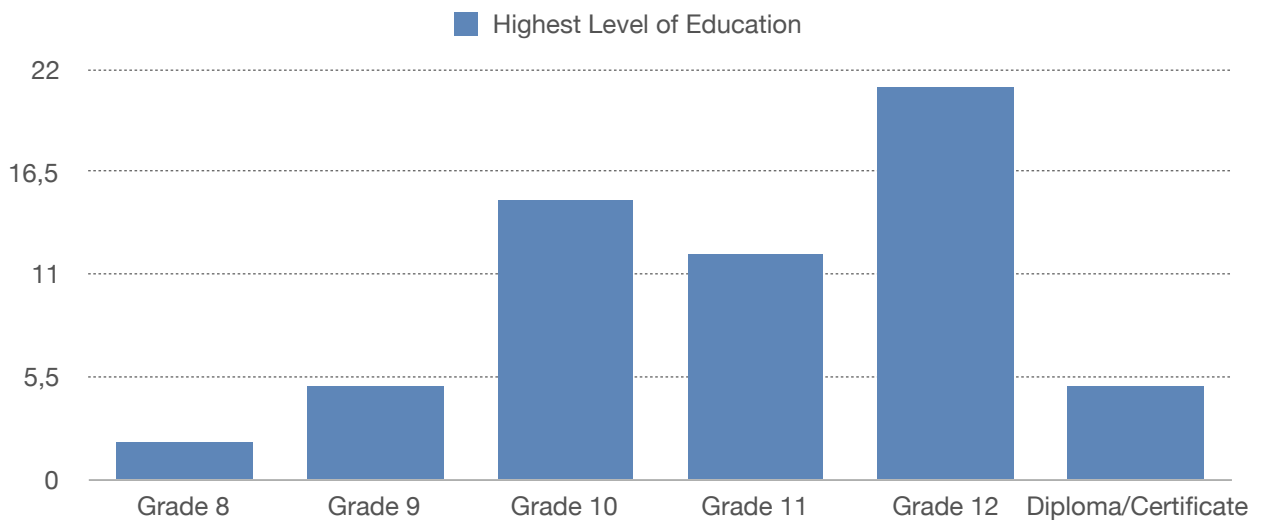
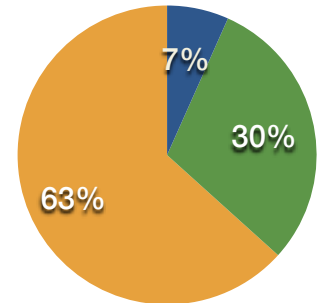
Demographic data

As outlined in Table 1 (see appendices), a total of sixty pregnant women agreed to participate in the pilot study ($n = 60$). Fifty of the women completed all of the interview questions. As the interviews took place in the waiting areas of the clinic, many of the interviews were interrupted because participants were called by the nurses into their antenatal appointments. While most women returned to complete both sets of the interview questions after their appointments, ten women did not. There were also participants who opted to only watch the video without answering the interview questions and participating in the pilot study. Of the sixty women who completed the demographic survey, 50% of the participants were Black, 43% Coloured, 5% White, and 2% Indian, and their ages ranged between 17 and 38 (median: 26). The majority of the women were either married (42%) or in a relationship (45%). Ten per cent of the pregnant women were single at the time of the study. Many of the pregnant women had not completed high school; only 35% ($n = 21$) had obtained their Matric certificates. Twenty per cent of the women were pregnant for the first time, 25% of women were expecting their second child, and 13% were expecting their third child. Most (63%) of the pregnant women who participated in the study were already in the third trimester of their pregnancies, while 30% were in their second trimester, and only 7% were in their first trimester at the time.

● Single ● Relationship
● Engaged ● Married



● First trimester
● Second trimester
● Third trimester



Pre-intervention

It was important to understand what pregnant women already knew about foetal care and also to understand where they received their information from. Regarding foetal care, most pregnant women answered that they knew not to drink and smoke during pregnancy, to eat healthy food and drink water, to exercise, and also to rest while they were pregnant. Five of the participants referred to these foetal care practices as “the basics”. Other participants also mentioned that taking vitamins and antiretroviral (ARV) tablets were important while they were pregnant, as well as not wearing high heels, and “using protection” or “condomising” when having sex during pregnancy. Once the baby was born, pregnant women also explained that breastfeeding was vital because “it is where the baby gets all the nutrients and vitamins from”.

When asked where the pregnant women received their information from, the majority answered that the clinic was their main source of information. This included the *Mother, Child Health and Nutrition* booklets and pamphlets that all pregnant women receive upon their first visit to the clinic, as well as from conversations with the nurses and counsellors. In addition, others mentioned that they received information about foetal and child care from their mothers, families, friends, other people whom have had children before, television programmes, and books. As the vast majority of the participants ($n = 40$) had been pregnant before and had at least one child already, they also relied on their own prior experiences to guide their current pregnancies. Furthermore, twenty-three of the participants said that they ‘Googled’ (i.e. used the internet to Google) as a source of information, which they found to be convenient and believed to be trustworthy. One participant also mentioned that she had joined a Facebook group that teaches her about pregnancy, and another mentioned sending and receiving SMS messages from a service¹.

¹ This SMS service may have been *MomConnect*, however, the participant was unsure of the exact name.

Post-intervention

Perceptions of video cards

Based on the interviews conducted with the pregnant participants *after* they viewed the videos, the overall feedback from the pregnant women was very positive. The majority of the women expressed that they “learned a lot from the video” and used some of the following adjectives to describe the video card and content:

informative, good, important, emotional, exciting, interesting, educational, nice, *noodsaaklik* (necessary), joyful, inspirational, touching, helpful, different, really cool, personal, good idea, attractive, relaxing, good points, sad, *baie hartseer* (very heartbreaking), painful, *lekker* (nice), good information, cute, *skokkend* (shocking), enlightening.

Furthermore, while the pregnant women did not necessarily interact with each other after watching the video, one of the participants did mention that the video card is “more personal, you can actually interact with other people if you want”. The video card therefore offered up a space and opportunity for pregnant women to engage with one another, if they wanted to. In addition, another pregnant women commented: “it was good, it took my mind away for a while, the waiting and, make up for the whole morning sitting here”. The video was also said to be better and more convenient than televisions, which everyone would be expected to watch together.

Content

Participants enjoyed the video content. At least ten of the participants mentioned that they most enjoyed viewing the foetus and learning that they could communicate with their unborn babies – information which many of the participants did not previously have. Others said that they enjoyed seeing the the infants and parents happy, especially when the couples took care of the infants together (as opposed to the mother caring for the child on her own).

At least twenty-two of the pregnant women expressed that their least favourite section of the video related to the neglect of the infant, specifically when the mother was busy preparing food and the parents were arguing in from of the infant, which caused the infant to cry. In addition, eighteen of the participants referred to substance abuse as their least favourite part of the video, mainly where the mother drank alcohol and smoked while she was pregnant.

Pamphlets vs. video cards

Of the twenty-two participants who were asked about their preferences, all of them preferred the video cards over the pamphlets that they received at the clinic. This despite the fact that all were literate and had accurate prior information which they attributed to the booklets and pamphlets. Many of the pregnant women argued that the video card had a greater impact on them because “you can see what they are talking about”, whereas the pamphlets only had a few pictures to look at. Even for those women who had heard this type of information before felt that the video card had a greater impact on them. Below are additional reasons why women preferred the video cards over the pamphlets:

“I heard it [the information] before, but it did not leave an impression on me as it did now, how can I say, when one sees or reads these leaflets or pamphlets, then it's not so, as when one sees it oneself, it actually makes a difference when one sees it like this.” [“Ek het dit gehoor, maar dit het nie so 'n indruk gemaak soos nou, soos ek dit nou sien, hoe kan ek se, as jy so blaaitjies lees of pamflette dit sien of lees, dan is nie so, as jy dit self sien nie, dis nogals 'n verskil as jy dit so sien.”] — (age 32, five months pregnant).

“Ja [yes], it's better to watch it instead of reading it because when you read you don't see what's in there ja [yes].” — (age 27, eight months pregnant).

“For me, it will be much better if it [the video] is shown to someone, as I said myself, now you maybe give the pamphlet to another person, that pamphlet might just end up in the bin, but if they can see it themselves, then it will click, yes.” [“Vir my sal dit baie beter is as dit vir iemand wys, soos ek self gese het, nou gee jy miskien vir die person daai pamphlet, daai pamphlet le netnou maar in die drom en as hy dit self kan sien, dan sal dit ook... 'click', ja.”] — (age 24, six months pregnant).

“Because you can see the kids moving, playing around and stuff, then in the pamphlet you just see the picture, that's all.” — (age 31, five months pregnant).

“The video is much better because you can see it, you can hear it and that... It is better to see it because not everyone is going to read (yes) does not actually want to read, that's actually the thing/problem.” [“Die video is baie betere, want jy kan dit sien, jy kan dit hoor en daai... is beter om dit te kan sien, want almal gaan nou nie lees nie (ja) wil nie lees eintlik nie, daai's eintlik die ding.”] — (age 24, five months pregnant).

“I liked the video very much, 'cause if you see something you never forget ja, ja. [yes, yes]” — (age 29, eight months pregnant).

Various participants also suggested that the video cards were better because people do not read (“no one really wants to read all the time”), do not enjoy reading (“honestly I haven't read the pamphlet yet, but I watched videos and stuff”), or perhaps could not read well (“video is better, I'm not good in reading”). Moreover, through the visual component of the video, many of the participants experienced an emotional response, feeling sad, pained, emotional, heartbroken, shocked. The various stories portrayed in the video left an immense impact on many of the pregnant women; mostly positive, some negative. In particular, participants pointed out that it was the voices of the infants (as narrators), as well as their ability to relate to the different stories in the video, that made them respond to the video cards the way they did. The video format therefore proved more effective and impactful than the pamphlets in terms creating an emotional connection.

Feedback from nurses

Nurses' feedback regarding the video was mainly positive; however, it was made clear that nurses did not have the time to administer the video cards because of their numerous responsibilities within the clinic. While most nurses agreed that the video card was easy to operate and simple to hand out to waiting patients, some nurses felt that providing televisions and DVDs to the waiting rooms would be even more convenient and easier to implement. Nevertheless, nurses noticed that their information pamphlets were often left behind once the pregnant women left after their antenatal appointments and thus noted that, since many of the women did not or could not read, the video card was in fact a "good idea" because the women could see the pictures and "connect" to the messages better. In addition, while nurses felt that the video was "useful" and "close to reality" and offered many positive messages, there were also many negative features pointed out. One nurse, in particular, found the message about alcohol consumption and smoking during pregnancy to be of most value, since it was believed that many pregnant women who visit the clinic smoke and drink; however, the nurse also cautioned against some of the messages being relayed in the video (such as the story about Radheefa being left alone with a stranger) that may potentially trigger feelings of guilt within the pregnant women and result in adverse effects, such as high blood pressure. One nurse also suggested that the video cards could be used to show other health-related videos.

Two-week trial period

In order to test the sustainability of the video cards, two video cards were left with the nurses in the antenatal clinic and two video cards were left with the nurses in the MOU for a period of two weeks. Nurses were instructed to handout the video cards to the waiting patients and to monitor the usage amongst patients. After the two weeks, feedback from the head nurse, as well as from nurses from both the antenatal clinic and MOU was both positive and negative. On the one hand, the nursing staff found that the video cards were easy to implement and described them as "informative", "nice idea", "educating", "eye-opening", "positive", and "promotes thinking". Despite the one "faulty" video card² that was reported, the nurses experienced no problems operating the video cards and enjoyed sharing them with the waiting patients. On the other hand, the head nurse, who is in charge of both the antenatal clinic and MOU, regarded the video card as a "good idea" (applicable to both nurses and patients), as well as "important" because "it is easy to overlook children as human beings". However, in terms of the management of the video card, she found the video cards to be burdensome, especially because she was primarily responsible for handing out the video cards to the MOU and antenatal clinic nurses every morning, collecting the video cards from the nurses in the afternoon, charging the video cards, and locking them away at the end of every day. The head nurse mentioned that "patient education" was part of the nurses job description, but admitted that there was "no time to speak to them". As such, despite the value that the video cards offer as alternative "patient education" tools, the head nurse often forgot to hand them out to the waiting pregnant women, especially when there were too many patients to tend to or clinic problems to manage.

² The video did not play once the video card was opened, due to a software problem.

DISCUSSION

Over the last five decades, the use of videos to educate patients in public waiting places has grown in popularity. Video interventions have been used to determine and improve patient satisfaction in waiting areas during clinic visits (Oermann, 2003); to educate patients about myocardial infarction in waiting rooms of hospitals in India (Dhawan, et al., 2008); to improve informed consent for parents of children with leukaemia (Hazen, et al., 2010); and to instruct sexually abused children and their caregivers about medical examination procedures and to decrease distressed associated with the exam (Rheingold, et al., 2012). Video interventions have also extensively been used to educate patients about sexually transmitted diseases (STD) and related topics in South Africa and globally (Mathews, et al., 2002; Warner, et al., 2008; Myint-U, et al., 2010; DeShazo, et al., 2011; Gift, et al., 2016). The role of video and other audiovisual presentations, especially in waiting rooms of health care facilities is thus not only effective in increasing the awareness and knowledge of patients, but it also productively occupies the time that patients spend waiting to be tended to by medical staff. Videos in waiting rooms therefore constitute a form of “equipped waiting” (Gasparini, 1995) that is specifically aimed at lessening the unpleasantness of waiting.

Despite the overall potential that video interventions have in increasing patient awareness and knowledge of various health-related issues, especially in the waiting areas of public health care facilities, are videos the preferred medium for patient education? As presented in the study by Kathleen Gaffney and Lauren Altieri (2001), it was an underlying assumption that mothers would participate more fully in interventions that they found most appealing and that were tailored to their preferences, which would, in turn, lead to positive infant health outcomes. The purpose of their study was thus to determine which of the eight widely-implemented clinical intervention strategies low-income mothers preferred, in addition to the reasons for their preferences. The results revealed that the mothers most preferred interventions that allowed for two-way communication, either with a nurse, health worker or counsellor: home visit by a nurse; group sessions with other mothers, led by a nurse; home visit by a lay community health worker; and classes in the clinic. Health diaries, videotapes in the homes, brochures, and videotapes in the clinic were ranked the least preferred interventions. According to interviews conducted with the mothers, on the one hand, videotapes in their homes were considered advantageous because they could listen to the content in their own time and when they were in the mood to do so; they could watch it on repeat, and they could watch it with their families. The disadvantages included having no one to ask questions to afterwards, and they needed to return the videos once they were done with them (Gaffney and Altieri, 2001: 513). On the other hand, the advantages of watching the videos in the clinics included having the content clarified by a nurse afterwards (if and when available), convenient for watching while waiting in the clinic, it helps to see the content visually, and good for those who did not enjoy reading. The disadvantages of watching the video in the clinic were related to difficulty learning from the video due to distractions in the clinic environment and lack of interest in the content. Some mothers also felt that they could not ask questions (when nurses were unavailable), and that they did not always have enough time to watch the video (Gaffney and Altieri, 2001: 514).

Participant observation in the waiting areas of the Kraaifontein Community Health Clinic antenatal clinic, plus interviews with the pregnant women revealed similar advantages and disadvantages of using video cards, as outlined by Gaffney and Altieri (2001). These will be discussed below in terms of the overall feasibility, efficacy and sustainability of the video card, as well as via the various recommendations.

Feasibility

ADDITIONAL WORK

Within the Kraaifontein Community Health Clinic antenatal clinic, there were only five to six nurses on duty at any given time. These nurses were responsible for checking the (psychosocial, medical and obstetrics history) records; examining the pregnant women's bodies for possible problems (blood pressure, obstetrical exam); screening and testing blood; treating possible STIs; offering preventative measures; and offering health education, advice, and/or counselling for *all* pregnant women present. While it was possible for the nurses to fulfil these duties on Tuesdays and Fridays (first-time visits), when only thirty women were allowed to make appointments (which equated to four or five patients per hour), on Mondays and Wednesdays (follow-up visits), the nurses were expected to assist fifteen patients per hour. The follow-up visit days were thus significantly busier than the first-time visit days. Nevertheless, despite the reduced workload for antenatal clinic nurses on follow-up visit days, nurses were still very busy and spent more time tending to pregnant patients in their individual clinic rooms than in the waiting areas. In fact, the only times that nurses entered the waiting areas was when they needed to call the next patient, when they needed to make an announcement to the group of waiting patients, when they were walking to nurses in the other clinic rooms, or when they left for their lunch breaks. Nurses could therefore not always monitor the video cards in the waiting rooms, and often lost track of the video cards once they re-emerged from their rooms. Nurses were too busy with work to assist pregnant women with the video cards when they needed help or had questions about the video content.

FIRST-TIME ANTENATAL VISITS

The Kraaifontein antenatal clinic procedures for first-time visits (Tuesdays and Fridays) differed from follow-up visits (Mondays and Wednesdays)³. After their initial first-time visit to the clinic, pregnant women were given specific dates and times for their follow-up clinic visits. As such, even though the video card was viewed by different groups of pregnant women everyday of the week, the video card proved most feasible in the antenatal clinic waiting areas during the pregnant women's first-time visits (Tuesdays and Fridays). This was because fewer pregnant women attended the antenatal clinic for first-time visits as compared to follow-up visits. Circulating the video cards amongst waiting pregnant women on these specific days enabled nurses to track the whereabouts of the video cards in smaller groups, which, in turn, ensured that all pregnant women present viewed the videos. More importantly, the video card proved more feasible and effective for first-time antenatal visits because it was the earliest possible time for pregnant women to watch the video, and it also guaranteed that all women in follow-up antenatal visits would have seen the video card before. In addition, showing the video cards to pregnant women *before* their antenatal appointments in the mornings was ideal.

³ The antenatal clinic was closed on Thursdays because nurses worked at the clinic in Durbanville for the day.

INTERRUPTIONS

Regardless of whether it was the first-time or a follow-up visit to the antenatal clinic, pregnant women generally spent anywhere between twenty minutes and six hours waiting to be assisted by the nurses. While most of the participants were able to watch the video card from start to end in one sitting, many were called into their appointments while they were watching the video. There were also a few instances when pregnant women, while viewing the video, would not hear their names being called by the nurses. Nurses therefore repeatedly called the women's names until they responded. As such, while the video card (to a minimal extent) interrupted the work flow of the nurses, the pregnant women's viewing of the video cards was also interrupted.

Efficiency

INCREASED AWARENESS

Science is beginning to have an immense influence on how parents understand and practice early childcare. Scientific research, for instance, has revealed that an infant's brain is at its most receptive during the first eighteen months of life (Schore, 2001) and that trauma and stress can alter the architecture of the brain (Lou, 1994; Pollak et al., 2010). Furthermore, the sensory systems of infants are acute, allowing them to make immediate connections (Stern, 1985; Farroni et al., 2002). This scientific knowledge about foetal and infant brain development, however, is not widely accessible to all parents and pregnant women. The *Together from the Beginning* video card therefore attempted to bridge the gap between (abstract) scientific knowledge and (practical) antenatal and child care, by teaching and encouraging mothers and caregivers to raise their babies in the "best ways possible".

Although a number of pregnant women shared that they had learned "some" of the information shared in the video card (from the clinic, books, family members, friends, and even school), the majority of them expressed that they "learned a lot" from the video card. For instance, while most of the women knew not to drink and smoke while they were pregnant, many of them were surprised to learn that they could speak to their babies while they were pregnant, and that their unborn babies were affected by their mothers' emotions. Although it was not possible to observe whether the women practiced what they learned from the video, a large number of women seemed to have internalised the messages and expressed that they would "change" their behaviour based on what they learned from the video cards. Some women mentioned that they would try to "take it easy and think of the baby"; to stress less and be happier, sing to their babies, and decrease the stress that infants experience when they are left alone with strangers or other caregivers. Further positive responses from pregnant women include:

"Yes, I enjoyed it, I learnt, I've learnt also [pause] I learnt that um, er, I, I need to be happier, a lot of times were for my baby's sake... because then she understands everything that I'm going through, (ja) when I go through stuff, it's not for me alone, it's the two of us." — (age 32, five months pregnant).

"I will, when the baby is born, I will sing to the baby (ja) since I know that the child, from the womb, I know the child likes the music, just put the music on [laugh] there." — (age 29, nine months pregnant).

“Aaah, I feel good, I feel good, I learnt so much, so I’m going to try my best... I just try, try to, I’ma try just to be happy, so that my baby inside, when I’m happy also.” — (age 26, six months pregnant).

“Um, I feel great, I feel great, because now I know what to do for a change in the future, to stop this and do this (ja) because seriously, if I’m not learning, how can I know? (mmm) you see, so if I know how to love my baby, take care of him or her, you see and play with her, that’s the best, ‘cause all I want is a a a happy baby.” — (age 25, nine months pregnant).

The information shared in the video card was also useful for first time mothers, for whom infant care can be a difficult process and adjustment (see Lupton, 2000). As one first time mother said: “I actually feel good to learn this type of information because I can, how can I say, have an idea (yes) of how to raise a child” [“ek voel eintlik goed om sulke goed te leer sodat ek kan, hoe kan ek se, ‘n idee kan het (ja) van hoe om ‘n kind groot te maak.”] — (age 19, nine months pregnant).

EMOTIONAL RESPONSES

There were, however, mixed reactions from some of the participants regarding the video content. While the majority of pregnant women felt that they enjoyed the video and often felt happy or positive after watching the video, at least five out of the sixty women felt “emotional” after watching the video and indirectly expressed feelings of guilt about their own caring practices. This was a concern that one of the nurses also conveyed after watching the video. Even though the video does not explicitly tell parents/mothers how they *should* care for their infants (pre- and antenatally), but instead demonstrates various lived realities of mother-child care relationships, pregnant women were emotionally affected by the voices of the infants in the videos, as well as by the (physical and emotional) moving pictures. The moving pictures of the video therefore enabled pregnant women to reflect on their own childcare practices. In a very emotional interview with one pregnant woman (who had been waiting six hours in the antenatal clinic), she used the messages from the video card to reflect on her own experience with her baby:

“But it makes you realise, because you think that the baby can’t hear you while you’re pregnant, but they really can, they don’t hear the voice, but they recognise your voice”. It was at this point that the pregnant woman began to cry, but continued to explain that: “Oh, as parents we do like mistakes we do not realise, but then by watching the video then you realise certain things that you also do, unintentionally to hurt the child but then, you do, in the long run yes” — (age 23, six months pregnant).

While this was an extreme case, the different scenarios displayed in the video card presented women with an opportunity to reflect on their own childcare experiences, whether positive or negative. “Many women carry the burden of societal (and professional) disapproval, either because they do not fit society’s idealized view of motherhood or because they behave in ways that are not considered appropriate for mothers” (Jackson and Mannix, 2004: 151). The video card content therefore indirectly challenged the pregnant women’s standards of childrearing, as framed by idealised views motherhood within the “good mother” discourse.

In a study conducted by Deborah Lupton (2000) about the ideals and experiences of first-time mothers, many women revealed a “love/hate relationship” with their infants. In terms of their conceptualisation of a ‘good mother’, Lupton notes that:

Many descriptions revolved around the notion that a good mother should have patience, remain calm and be able to cope and deal attentively with the demands of infants and all children. It was thought by a number of women that the mother’s state of mind could be passed on to her children (including in utero), and that, therefore, pregnant women and mothers should attempt to cultivate calm and avoid stress in the interests of both themselves and their children (Lupton, 2000: 54).

As such, when mothers are unable to provide this idealised form of child care, they feel “bad”, guilty, or may blame themselves for their “inadequacies”. These feelings may cause the pregnant women to stress or feel worried about their childcare behaviour, which, in turn, may have adverse effects on their unborn babies.

Sustainability

SAFETY

The Kraaifontein Community Health Clinic implemented multiple layers of security, including safety gates, a full body metal detector, and security guards. At the MOU, a security guard sat by the entrance and required all new patients and visitors to sign into a book before entering the wards. The waiting areas of the antenatal clinic, however, overlapped with the mental health patients, the sonar patients, the day hospital patients and the dressing patients. With that said, without regular supervision of the video cards in the antenatal waiting areas, the video cards could have easily been misplaced, given its small size and large volumes of patients in the waiting areas. Despite the fact that the pregnant women generally only passed the video cards to one another in the waiting rooms, patients from other sections of the clinic could have obtained the cards without difficulty.

“Locking the video cards away” was another important point that the head nurse raised. While she did not specifically mention “theft” as being a problem experienced in the Kraaifontein Community Health clinic, she did emphasise that “it was not good for the video cards to lie around” and that it needed to be locked up after usage. By the end of the two-week trial period, all four of the video cards were returned. This not only demonstrated the robustness of the video card, but also the ability of nurses to successfully monitor the whereabouts of the video cards over a short duration of time.

DURABILITY

When shared between two waiting patients, a minimum of fifteen women watched and handled the video card on any given day at the antenatal clinic. Since the video card gets passed on from one waiting patient to the next, the cardboard cover of the device became dirty quickly. The cardboard, however, was sturdy enough for participants to hold and did not undergo any damage over the two months of usage. In terms of battery life, each video card played between seven and ten times before the battery died.

CONCLUSION

The video card stirred the interest of everyone at the Kraaifontein Community Health Clinic — from the facility manager, the nurses, and peer counsellors to the pregnant patients, their partners, family members and the young children accompanying them. The clinic staff were intrigued by the innovative device and many thought that the video card intervention was “something different” [“iets anders”]. Many of the pregnant women were also excited to be part of the pilot study and to interact with the video card, which they described as “interesting”, “informative”, “helpful”, and “touching”. While a number of pregnant women had learned “some” of the information shared in the video card — either from the clinic, books, family members, friends, or school — the majority of the women expressed that they “learned a lot” from the video card. And although the video card on its own did not stimulate as much engagement amongst the waiting pregnant women as was anticipated and intended, the video card did provide a space and opportunity for potential engagement, as it enabled pregnant women to watch the video cards together, whether they personally knew each other or not.

In terms of feasibility, first-time antenatal clinic visits proved to be the opportune time to show the video cards to the pregnant women. Not only were these days less busy than the follow-up visit days, which made it easier and faster to circulate the video cards to all thirty pregnant women present in the waiting areas, but the first-time antenatal clinic visits also enabled the earliest possible time for pregnant women to watch the video. Nurses, however, were not always able to keep track of the video cards in the waiting areas and were also unable to assist pregnant women who had questions related to the video or who needed assistance with the physical video cards. This was because nurses were inundated with work, and were also busy with patients inside their individual clinic rooms and thus spent little to no time with patients in the waiting rooms. In some cases, pregnant women, while watching the video card, were called by the nurses to begin their antenatal appointments. While this, to a minimal extent, interrupted the work flow of the nurses, who consequently needed to repeatedly call the names of the women, it also interrupted the viewing of the video.

The video content mostly had a positive influence on the pregnant women, who not only enjoyed watching the video and operated the video card with ease, but also expressed that they gained more knowledge from the intervention. However, since this research was primarily conducted in the waiting areas of the antenatal clinic and MOU, it was not possible to observe whether the women practiced what they learned from the video. Nonetheless, a number of pregnant women appeared to internalise the messages and suggested that they would “change” their behaviour based on what they learned from the video cards. For some pregnant women, the video evoked an emotional response, and also enabled them to reflect on their own childcare experiences. To some extent, the video content can indirectly be perceived as representing an idealised form of motherhood, causing some women to feel guilty about their own childcare practices. These feelings may cause the pregnant women to stress, which, in turn, may have adverse effects on their unborn babies.

Overall, the video card was a success amongst pregnant women in the waiting areas of the antenatal clinic and MOU at the Kraaifontein Community Health Clinic. The majority of nurses and pregnant women found the video card to be very informative and also more interesting and effective as a “patient education” tool than information booklets and pamphlets, as the content evoked emotional responses from the viewers, which enabled self-reflection. The video card was also easy to operate and was small enough to lock away for safekeeping. With that said, however, the video card was difficult for nurses to administer and track, given their busy work schedules. Furthermore, the video card device lacked certain physical features, and the video content made some pregnant women feel “guilty” about their childcare practices because they were comparing themselves to the idealised form of mothering presented in the video. As such, the following recommendations have been prepared to potentially improve the video card device for future dissemination and use.

Recommendations

A. ADMINISTRATION

While the pregnant women were able to operate the video cards on their own, a **counsellor or facilitator** could be employed to ensure that the video cards are administered appropriately. This would place less strain on the nurses who already have full workloads.

The facilitator would be responsible for:

- explaining the purpose of the video card to the group of waiting patients
- demonstrating how the video card works
- assisting if/when patients struggle to operate the video cards
- ensuring that all of the patients in the waiting areas watch the video card
- collecting the video cards from the patients once they have all watched it
- charging the video cards once the battery becomes too low or at the end of every day

In addition, the facilitator would also be able to facilitate discussion once the group of waiting patients has watched the video card.

Possible **discussion questions** to the group could include:

- Could you relate to the video?
- What did you learn from the video card?
- What was your favourite part of the video?
- What was your least favourite part of the video?
- Will you be able to share this information with others?
- How will you be able to adopt some of the ideas that you learned from the video?

B. VIDEO CARD: DEVICE

The video card cover can be **branded** with images to make the device more appealing to viewers. Questions to stimulate engagement can also be printed on the inside of the card cover. In addition, an **alternative material**, such as plastic, or a laminated cover, that is easy to wipe clean can be used instead of cardboard.

Pregnant women were often called into their appointments while they watched the videos on the video cards. This meant that, upon their return to their seats, they either had to re-watch the entire video or not continue watching at all. Some women also accidentally closed the video card (which automatically switched the video card off) while they were watching the video. In these cases, an **on/off button**, as well as a **pause button** on the video card would prove useful.

The noise levels varied in the waiting areas of the antenatal clinic: some days were noisy, whereas other days were quiet. On the noisier days, some of the pregnant women struggled to hear the video content. While earphones could be used, this would prevent the pregnant women from hearing their names being called by the nurses. An alternative option would be to include a **volume button** onto the video card or to include **subtitles** in the videos to compensate for the poor sound or low volume settings.

Some of the women suggested that it would be useful to take the video cards **home** with them. Not only would this enable them to watch the video card in their own time and on repeat, thus reinforcing the messages, but they would also be able to share the information with others — including their partners, family members, neighbours, and children. While this would be a costly option, patients could possibly borrow or “rent” the video cards to show to family or community members and then return the video cards upon their next visit to the antenatal clinic.

C. VIDEO CARD: CONTENT AND SUPPORT

The fathers of the infants rarely appear in the video content. **Fathers and other caregivers** could play a greater role in the narratives, so as to remove or redirect some of the pressure and responsibilities placed on women and mothers as primary caregivers. Moreover, while the video offers a fair representation of South Africa’s diverse childrearing practices, one of the partners of the pregnant women suggested that the video needed to be more “**culturally representative**”; i.e. including other South African cultural groups or mixed-race couples. Given the sensitive nature of the video content in its ability to promote self-reflection and evoke emotional responses from viewers, **support** should be offered to patients after they watch the video. This could be in the form of a counselling session or a possible group debriefing, where women, if comfortable, can share their feelings with other mothers who may be struggling with personal problems. Alternatively, the video card could potentially be used prior to counselling sessions as a precursor for discussing sensitive topics related to negative childcare experiences and behaviours that pregnant women may be experiencing. As one of the nurses recommended, the video card could also be used to share other **health-related videos**, including topics such as foetal alcohol syndrome, tuberculosis, breastfeeding, child development, to name a few.

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APPENDICES

Table 1: Demographic characteristics of pregnant women in the video card study

	Participants (<i>n</i> = 60)	
	<i>N</i>	%
Age		
15-19	8	13
20-24	16	27
25-29	22	37
30-34	11	18
35-39	3	5
Ethnicity		
Black	30	50
Coloured	26	43
Indian	1	2
White	3	5
Nationality		
Congo	1	1
Democratic Republic of Congo	2	3
Malawi	1	2
Rwanda	1	2
South Africa	51	85
Zimbabwe	4	7
Education		
Grade 8	2	3.3
Grade 9	5	8.3
Grade 10	15	25
Grade 11	12	20
Matric	21	35
Diploma/Certificate	5	8.3
Work		
Yes	25	42
No	35	58
Relationship status		
Engaged	2	3
Married	25	42
Relationship	27	45
Single	6	10
Previous pregnancies		
None (first time)	20	33.3
One	25	41.7
Two	13	21.7
Three	1	1.7
Four	1	1.7
Stage of pregnancy		
First trimester	4	7
Second trimester	18	30
Third trimester	38	63

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

Consent form

I _____, resident

at _____

agree to participate (without remuneration) in a pilot research project that is examining the reception of “Together from the Beginning”, an educational video card intervention, at the Kraaifontein Community Health Clinic.

I understand the objectives of the research.

I understand that I can withdraw from the research at any time without penalty.

Signed _____

At _____

On _____

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

Toestemmingsvorm

Ek _____, inwoner

van _____

stem saam om deel te neem (sonder vergoeding) in 'n loods navorsingsprojek wat die onvangs van die "Saam van die Begin" opvoedkundige videokartaat intervensie, by die Kraaifontein Gemeenskap Gesondheids Klinik ondersoek.

Ek verstaan die doelwitte van hierdie navorsingsprojek.

Ek verstaan dat ek enige tyd van hierdie navorsingsprojek kan onttrek sonder straf.

Onderteken _____

By _____

Op _____

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

Toestemmingsvorm

Ek _____, inwoner

van _____

stem saam om deel te neem (sonder vergoeding) in 'n loods navorsingsprojek wat die onvangs van die "Saam van die Begin" opvoedkundige videokartaat intervensie, by die Kraaifontein Gemeenskap Gesondheids Klinik ondersoek.

Ek verstaan die doelwitte van hierdie navorsingsprojek.

Ek verstaan dat ek enige tyd van hierdie navorsingsprojek kan onttrek sonder straf.

Onderteken _____

By _____

Op _____

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

DEMOGRAPHIC DATA			
Identifier (name/ pseudonym):			
Age:		Ethnicity:	<ul style="list-style-type: none"> Black Coloured Indian White Other
Place of residence:			
Education level:		Source of income:	
Relationship status:	<ul style="list-style-type: none"> Single Engaged Married Divorced In a relationship 	Household composition:	
Children under the age of 18:	Yes _____	No	I am currently pregnant
PREGNANCY			
Stage of pregnancy:		Complications to date (if any):	
Number of prior pregnancies (if any):		Prior birthing histories, if appropriate:	

Date:

Time:

#

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

<i>Pre-intervention</i>	
What have been some of your expectations and experiences of pregnancy to date?	
What do you know about foetal care?	
Who takes care of you/pregnant women? Who takes care of the children (while you are here)?	
What health care and other resources are available to you?	
What problems (if any) do you have in accessing information and care?	
Who are the significant role players in this pregnancy?	
What is the father's current involvement?	

Date:

Time:

#

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

<i>Post-intervention</i>	
What did you think of the intervention?	
Have you encountered this kind of information before? If so, where and how?	
What did you learn from the intervention?	
How does it make you feel about the ways you have been caring for themselves and the foetus to date?	
If you anticipate changes as a result of the video, what resources are available to support you in this?	
How did you feel about the process of viewing the video?	
What did you like/dislike/not understand?	
Would you be able to use this information to inform fathers and others central to the pregnancy and infant?	
What barriers might there be to doing so?	
Suggestions for future interventions?	

Date:

Time:

#

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

DEMOGRAFIESE DATA			
Identifier (naam/ skuilnaam):			
Ouderdom:		Etnisiteit:	
Woonplek:			
Vlak van opvoeding:		Bron van inkomste:	
Verhoudingstatus:	<ul style="list-style-type: none"> • Enkel • Verloof • Getroud • Geskei • In 'n verhouding 	Huishoudelike samestelling:	
Kinders onder die ouderdom van 18:	Ja _____	Nee	Ek is tans swanger
SWANGERSKAP			
Stadium van swangerskap:		Komplikasies tot op datum (indien enige):	
No. vorige swangerskappe (indien enige):		Geskiedenis van vorige geboorte, waar toepaslik:	

Date:

Time:

#

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

<i>Voor-intervensie</i>	
Wat was jou verwagtinge en ondervindings van swangerskappe tot op hede?	
Dra jy enige kennis van fetale sorg?	
Wie sorg vir swanger vroue? Wie sorg vir die kinders?	
Watter gesondheidsorg en bronne is beskikbaar tot jou?	
Watter probleme (indien enige) ondervind jy om inligting te bekom?	
Wie is die sleutel rol verdelers in die swangerskap?	
Wat is die vader se huidige betrokkenheid?	

Date:

Time:

#

**Mothers Matter:
Exploring the First Thousand Days of Life within Developmental Interventions**

<i>Na-intervensie</i>	
Wat is jou mening oor die intervensie?	
Het jy hierdie tipe inligting voorheen ondervind? Indien, waar en hoe?	
Wat het jy wys geraak van die intervensie?	
Hoe laat dit jou voel oor die manier waarop jy tot dusver vir jouself en jou ongebore baba gersorg het?	
Indien jy veranderinge beoog na die video, watter bronne is beskikbaar om hulle te ondersteun?	
Nadat jy die video gesien het, wat dink jy van die hele proses?	
Waarvan het jy gehou/nie gehou nie/of nie verstaan nie?	
Sal jy by magte wees om die inligting oor te dra aan vaders en andere betrokke by die swangerskap en baba?	
Watter struikelblokke voorsien jy om dit te doen?	
Voorstelle vir toekomstige intervensies?	

Date:

Time:

#