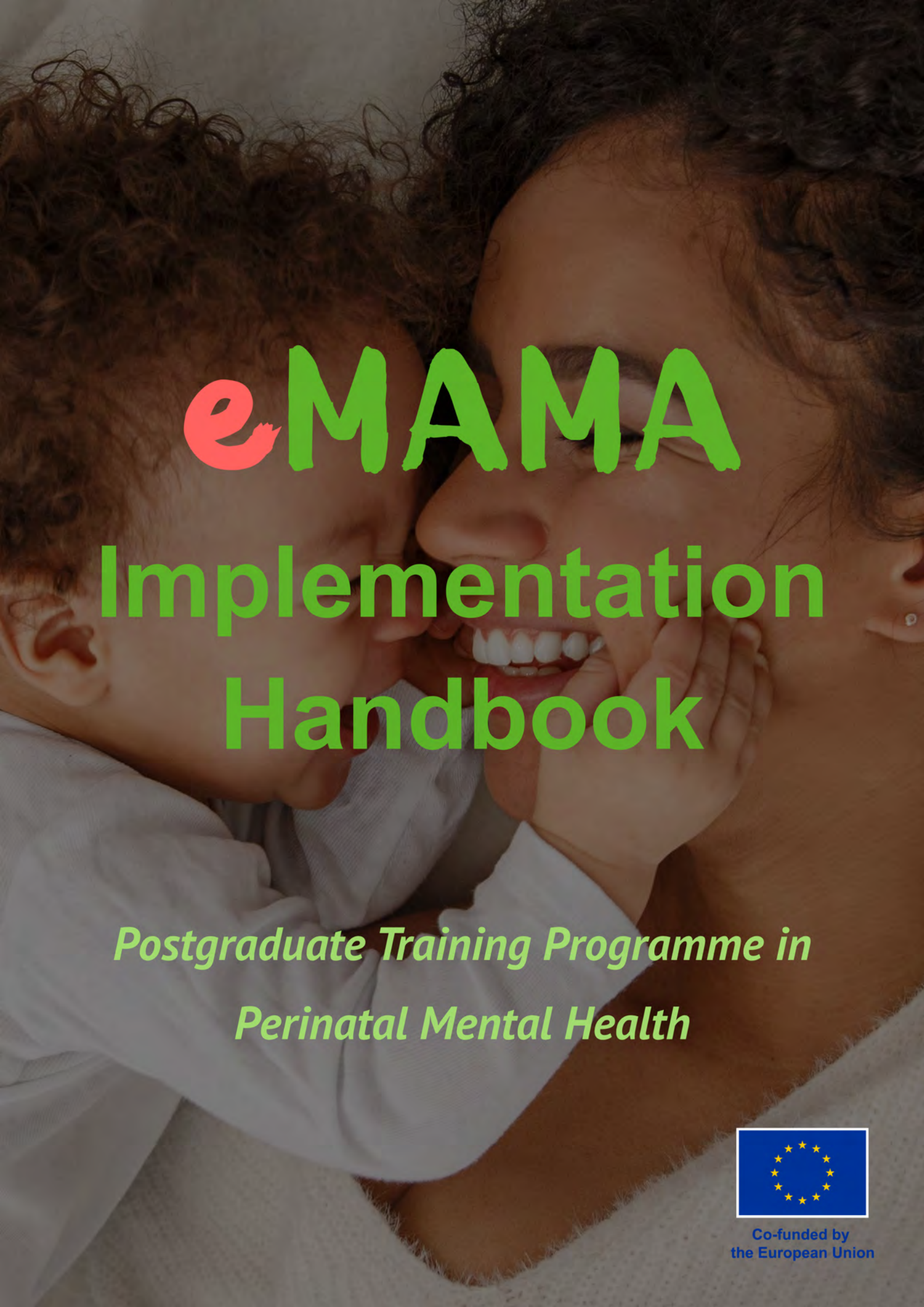

eMAMA

Implementation Handbook

Postgraduate Training Programme in Perinatal Mental Health

Co-funded by the European Union

Project title: Developing Post Graduate Training Programme for Maternal Mental Health in Sub-Saharan Africa, eMAMA
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Consortium: Turku University of Applied Sciences, Finland (coordinator); Kamuzu University of Health Sciences, Malawi; Catholic University of Malawi; University of Namibia; International University of Management, Namibia; University of Zambia; Mulungushi University, Zambia; University of West Attica, Greece; Riga Technical University, Latvia.

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Perinatal mental health conditions — depression, anxiety, and psychosis arising during pregnancy or within the first year postpartum — affect roughly one in four women in low- and middle-income countries, compared to around one in ten in high-income settings [1,2]. In sub-Saharan Africa specifically, prevalence estimates for perinatal depression range from 16% to 25% depending on country, setting, and screening method [3,4,5], with rural and adolescent populations consistently at the higher end [4,6]. These are not marginal numbers. They translate to millions of women each year whose mental health needs go unrecognised and untreated during one of the most vulnerable periods of their lives.

The consequences extend beyond the mother. Untreated perinatal mental illness is associated with poorer antenatal care attendance, lower rates of exclusive breastfeeding, impaired mother-infant bonding, stunted child cognitive and emotional development, and elevated risk of suicide — now among the leading causes of maternal death in several African countries [5,7,8].

Yet the treatment gap remains stark. Across much of sub-Saharan Africa, mental health receives less than 1% of national health budgets [9]. Specialist psychiatric services are concentrated in capital cities and serve a fraction of the population [10]. In Malawi, Namibia, and Zambia, the ratio of mental health professionals to population is among the lowest globally [9,11]. The frontline workers who actually encounter pregnant and postpartum women — midwives, nurses, clinical officers, community health workers — typically receive minimal training in identifying or responding to mental health concerns during their pre-service education [12].

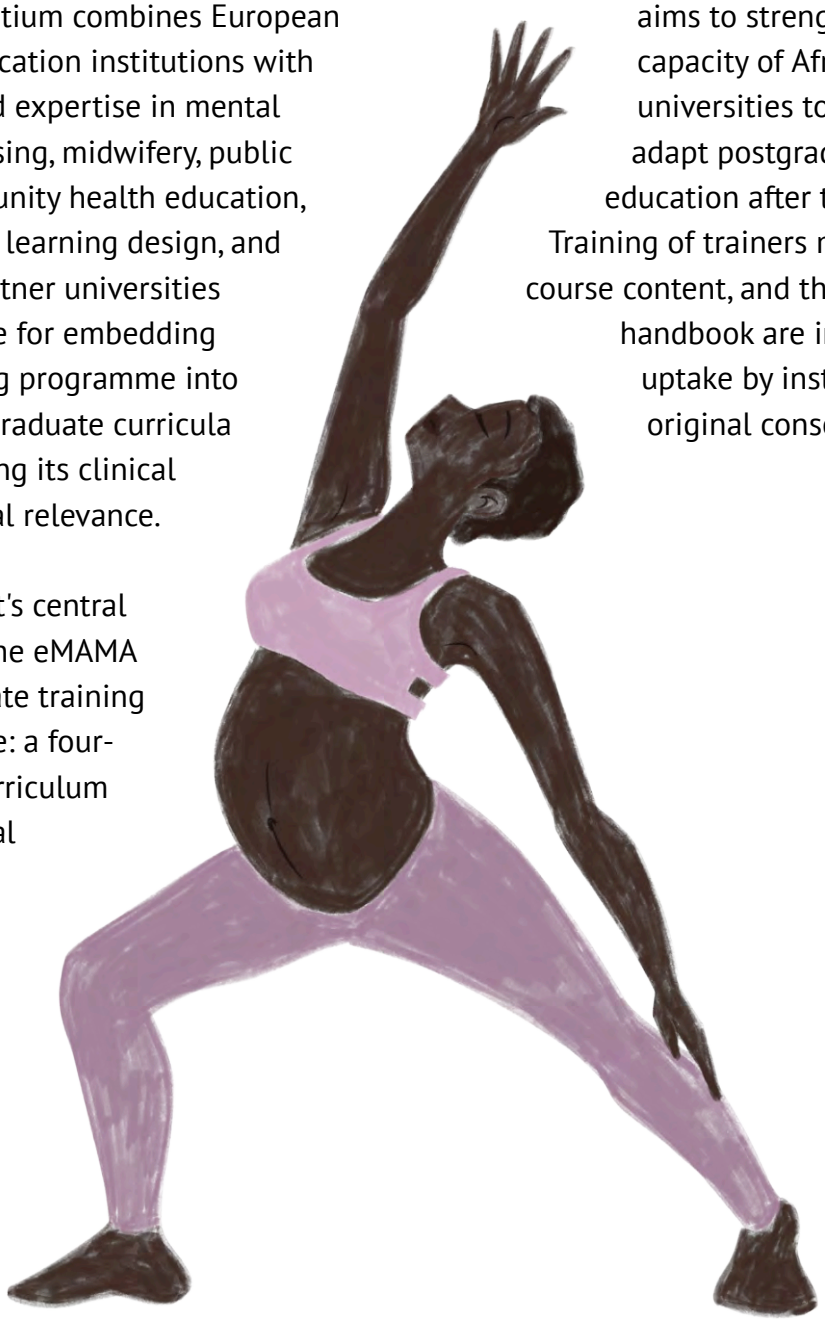
This is the gap eMAMA was designed to address: not by trying to create specialists, but by equipping the existing perinatal workforce with the knowledge, skills, and tools to recognise, support, and appropriately refer women experiencing mental health difficulties around childbirth.

[1] https://doi.org/10.1001/jamapsychiatry.2023.0069; [2] https://doi.org/10.1016/j.jad.2017.05.003; [3] https://doi.org/10.4102/sajpsychiatry.v28i0.1859; [4] https://doi.org/10.1186/s12884-020-02929-5; [5] https://doi.org/10.1016/S2215-0366(22)00197-3; [6] https://doi.org/10.1017/gmh.2023.64; [7] https://doi.org/10.1186/s13690-022-00792-8; [8] https://doi.org/10.3949/ccjm.87a.19054; [9] https://www.who.int/publications/i/item/9789240036703; [10] https://thehealthpulse.org/2026/05/05/mental-health-treatment-gap-in-sub-saharan-africa/; [11] https://www.unicef.org/esa/press-releases/mental-health-a-human-right; [12] https://doi.org/10.1111/jpm.12992

eMAMA - Developing Post Graduate Training Programme for Maternal Mental Health in Sub-Saharan Africa is an Erasmus+ Capacity Building in Higher Education project running from 01.09.2023 to 31.08.2026, co-funded by the European Union under grant agreement 101082701. The project is coordinated by Turku University of Applied Sciences (Finland) and brings together 9 partner institutions across Europe and sub-Saharan Africa.

The consortium combines European higher education institutions with established expertise in mental health nursing, midwifery, public and community health education, and digital learning design, and African partner universities responsible for embedding the training programme into local postgraduate curricula and ensuring its clinical and cultural relevance.

The project's central output is the eMAMA postgraduate training programme: a four-module curriculum on perinatal mental health, delivered through Moodle and supported by a dedicated mobile application, designed for health professionals working in maternal and child health services. The programme is co-developed by all consortium partners and validated across the three African partner countries — Malawi, Namibia, and Zambia — to ensure it reflects the realities of local clinical practice, health system structures, and cultural context.



Beyond the curriculum itself, eMAMA aims to strengthen the institutional capacity of African partner universities to deliver, sustain, and adapt postgraduate mental health education after the project ends. Training of trainers materials, open-access course content, and this implementation handbook are intended to support uptake by institutions beyond the original consortium.

Introduction to the eMAMA training programme

eMAMA is a postgraduate-level training programme in perinatal mental health, intended for health professionals who already hold a qualifying degree in nursing, midwifery, medicine, clinical medicine, or a closely related field, and who work — or intend to work — with women during pregnancy, childbirth, and the postpartum period. The programme is not designed for pre-service students or for general public audiences.

The curriculum is organised into four modules covering the foundations of perinatal mental health, assessment and screening, intervention and support, and a supervised applied project (see section 4 for the full curriculum table). Modules can be taken as a complete programme or selected individually, depending on institutional needs and learner background.

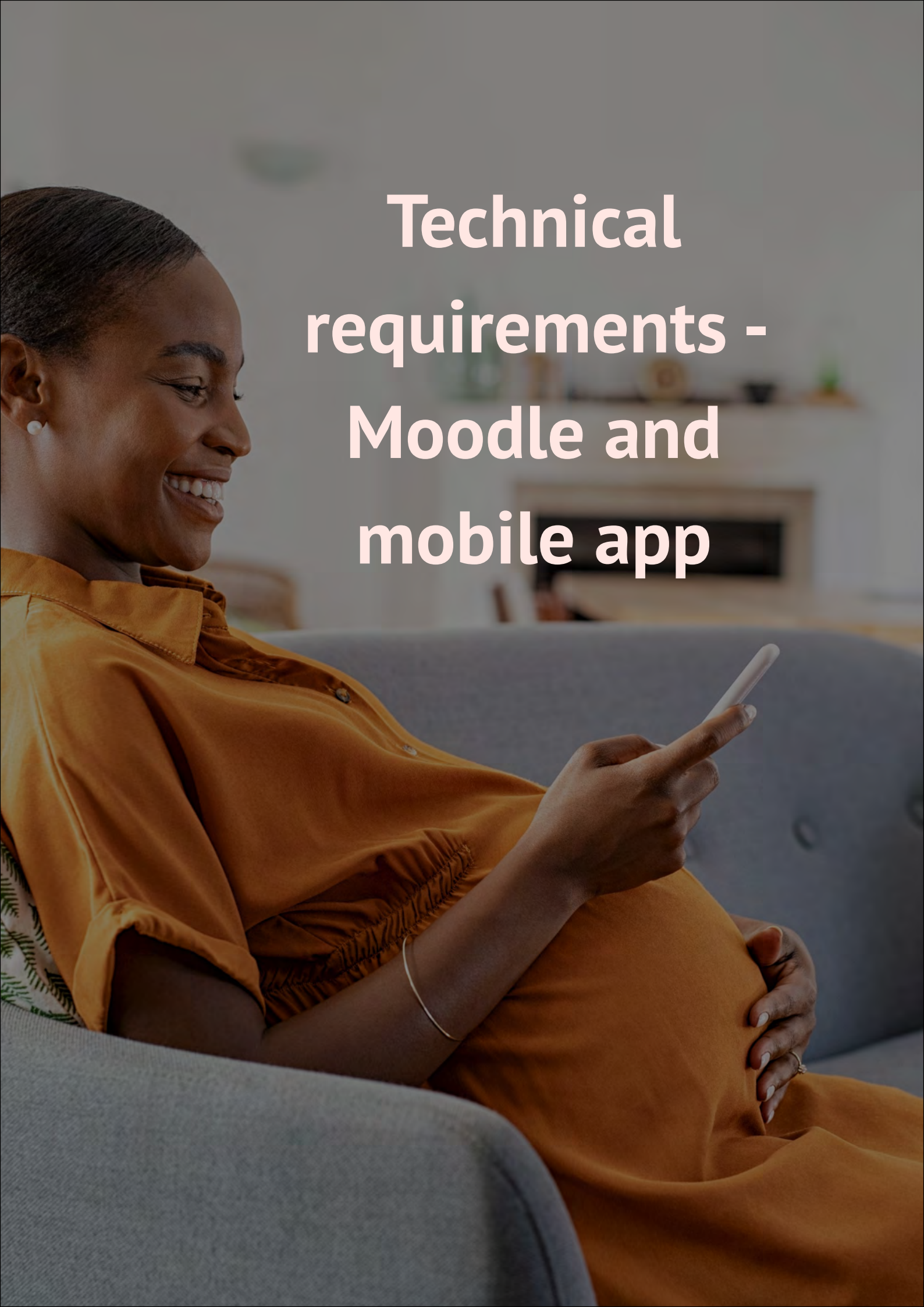
The programme is not standalone. This is the single most important point for any institution considering adoption. eMAMA is designed to be delivered with active teacher involvement, not as a self-paced online course that students complete in isolation.

While the core learning content is hosted on Moodle and accessible asynchronously, the programme assumes:

- A designated teacher or course coordinator at the host institution
- Live or synchronous engagement with students (webinars, tutorials, or in-person sessions) particularly during Modules 1 – 3
- Direct supervision of student work in Module 4, which involves an applied project
- Local assessment decisions for pass/fail components, made by the teacher against the criteria provided

This design reflects a deliberate pedagogical choice. Mental health practice is relational, context-dependent, and shaped by local clinical norms and cultural meanings. A purely self-directed online course cannot adequately prepare a healthcare professional in Lilongwe or Lusaka to navigate a real conversation with a distressed postpartum woman. Teacher mediation — bringing local examples, facilitating discussion, supervising applied work — is what allows the standardised content to land usefully in a specific setting.

Institutions adopting eMAMA should therefore plan for teacher workload from the outset. The handbook's later sections (5 onwards) provide more detailed guidance on what this involvement looks like in practice.



Technical requirements - Moodle and mobile app

The eMAMA training programme is delivered through two technical components: a Moodle course environment hosting all learning materials, assignments, and assessments, and a dedicated mobile application that supports applied learning. Both are required for full programme delivery.

Moodle

Moodle (Modular Object-Oriented Dynamic Learning environment) is an open-source learning management system that allows educators to create and deliver online courses.

You can **download the eMAMA course** as a backup into your own Moodle. The backup file can be modified for your own, noncommercial purposes, following the Creative Commons Attribution-ShareAlike 4.0 International License.

To use the course, you must have your own Moodle installation. To run a Moodle course, you will need:

- Web server software
- PHP
- A database management system
- Sufficient memory and disk space
- A compatible web browser
- A stable internet connection
- A user account with administrative privileges in Moodle

In addition to the study material, the course consists of different types of Moodle assignments, as well as assignments using the H5P plugin. The H5P tool can be found inside Moodle and contains a wide range of different types of tasks. It can be used to create interactive videos, different self-study tests, or material presented in different ways. It is essential that the teacher has previously constructed the task with the correct answers and feedback. In this way, the H5P task or material serves as self-study material for the student.

You will also need the Custom Certificate plugin to create a course certificate after completing all eMAMA mandatory tasks.

The eMAMA mobile application

The eMAMA application is developed by Riga Technical University as part of Work Package 3. Unlike the Moodle course, which is designed specifically for postgraduate health professional students, the app serves a wider audience and can be used independently of the training programme.

Three user groups

The app contains separate content streams for three distinct audiences:

Health professionals — including the postgraduate students taking the eMAMA course, but also any nurse, midwife, clinical officer, or other practitioner who wants structured learning on maternal mental health. For eMAMA course students, the app is a companion to the Moodle modules; for other professionals, it functions as a standalone continuing-education resource.

Mothers — pregnant women and women in the postpartum period, who can access age-appropriate information about perinatal mental health, signs to watch for, and self-care.

Community — partners, family members, and the wider community around a pregnant or postpartum woman, with content aimed at recognising distress in someone close to them and knowing how to respond.

This means the app can be recommended beyond the course itself. Teachers running the eMAMA programme may also point patients, family members, or community health workers to the app even if those people are not enrolled as students.

Device requirements and access

The app is available for Android devices via the Google Play Store. An iOS version is not available at the time of writing.

For users without access to an Android device, the same materials are also available on the eMAMA project website at https://emama.turkuamk.fi/emama-resource-library/. The web-based materials cover the core educational content for all three user groups, but the interactive features of the app — live sessions, quizzes with score tracking, and mood check-in — are only available through the mobile application.

Educational content in the app is accessible offline once downloaded; live sessions and account features require an internet connection.

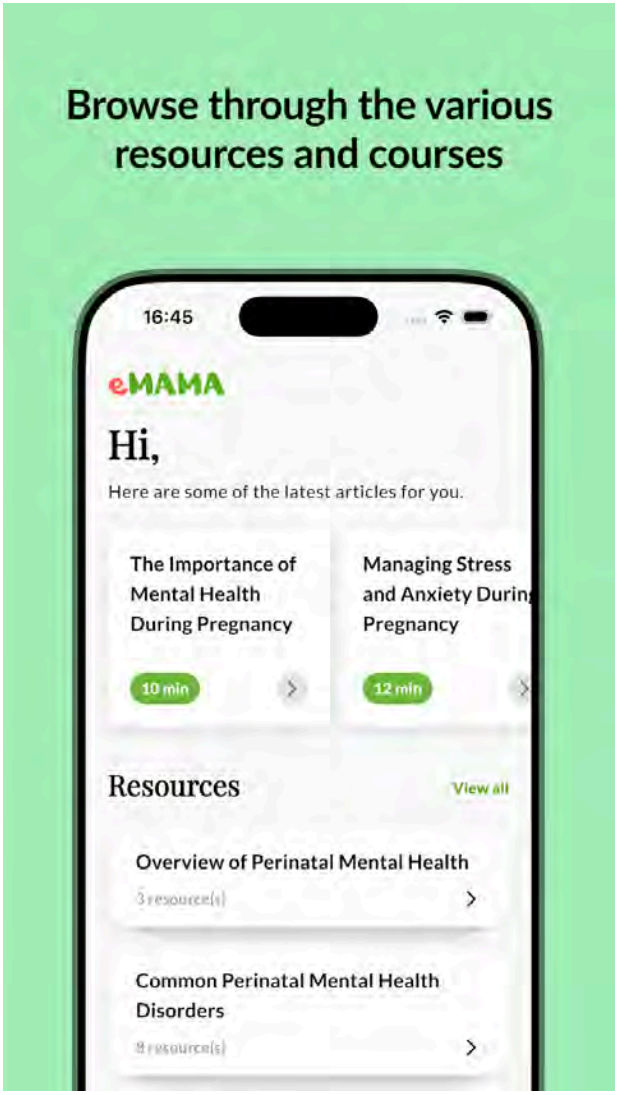
Installation

On an Android device, open the Google Play Store.

- Search for "eMAMA", or use the direct link: https://play.google.com/store/apps/details?id=com.rtu.emama

- Tap Install.

- Open the app and follow the on-screen prompts to set up your account and select your user group.



Key features

Educational content library. Structured learning modules and longer-form articles, organised by user group. Health professional content covers clinical topics aligned with the eMAMA postgraduate curriculum; mother and community content is written in accessible language for non-clinical audiences. Materials are downloadable for offline use. Content is reached from the home screen carousel or from the dedicated Library tab.

Knowledge quizzes. Interactive quizzes accompany the learning content. They can be opened from the unit resource screen or from the Activity tab. After each answer the user sees the correct response, and a score is given at the end. Quiz history is retained so users can track their progress over time.

Live interactive sessions. Teachers or facilitators create live sessions during webinars, class activities, or community sessions, and participants join by scanning a QR code or entering a session code. The session owner creates discussion boards; participants post anonymously to the active board. Only the most recent board accepts new messages, but earlier boards remain visible. This feature supports the synchronous teacher-led elements of Modules 1–3 of the course, but can equally be used for facilitated community discussion sessions outside the formal training programme.

To create or join a session, open the Activity tab and tap the icon in the top right corner.

Mood check-in. Users can record a daily mood entry and view their emotional well-being over time as a graph. Mood data is stored locally on the device and is not visible to teachers, facilitators, or the project. This feature is relevant for all three user groups but is particularly directed at mothers as a self-awareness tool during the perinatal period.

Integrating the app into the postgraduate course

For institutions delivering the eMAMA postgraduate course, the app supports teaching in several ways. Section 6 provides further guidance on integrating the app into teaching practice.

The live session function can be used during webinars to collect anonymous reflections or discussion points from students

The health professional content library serves as a supplementary resource alongside the Moodle modules

The quiz feature offers low-stakes practice before the graded Moodle tests

Teachers can introduce students to the mother and community content streams as resources they can later recommend to the women and families they work with — extending the reach of the training beyond the classroom

Modules of the training programme

Module 1:
Fundamentals of perinatal mental health

Objectives

Module 1 establishes the foundations on which the rest of the programme is built. By the end of the module, students will be able to articulate why perinatal mental health matters clinically, recognise the conditions they are most likely to encounter in practice, and think critically about the factors that shape mental health outcomes for women in their own setting.

Specifically, students completing Module 1 will:

- Understand the significance of perinatal mental health in improving maternal and neonatal outcomes, and articulate why it deserves attention as a core component of perinatal care rather than as a specialist concern.

- Identify and describe the common mental health disorders experienced during pregnancy and postpartum period, presentation, course, and implications for the mother, the infant, and the family.

- Analyse the key risk factors that contribute to perinatal mental health challenges, drawing on biological, psychological, and social determinants.

- Recognise early symptoms and risk indicators of perinatal mental health disorders in clinical encounters, with the aim of earlier identification and timely response.

- Reflect on the multifaceted impact of socio-cultural, environmental, and biological factors on maternal mental health, with particular attention to the contexts in which they themselves practise.

Content

The module is divided into six (6) units. Each unit is in turn divided into several sub-units. Each unit has a core text and an exercise at the end.

Implementation

Module 1, Fundamentals of Perinatal Mental Health, is the first of three theoretical modules that form the foundation of the eMAMA postgraduate programme. It introduces students to the conceptual, clinical, and contextual material on which the rest of the curriculum depends.

Structure and duration

The module is organised into six content units, each with its own core reading, podcast, and weekly quiz:

- Overview of Perinatal Mental Health
- Common Perinatal Mental Health Disorders
- Risk Factors for Perinatal Mental Health Challenges
- Protective Factors
- Evidence-Based Interventions
- Preventive Strategies

The pilot delivery ran across approximately six weeks. Institutions adapting the module can shorten or extend this, but should preserve the weekly rhythm of reading → podcast → quiz, with discussion and case work layered in. Compressing the module below four weeks tends to undermine the reflective and discussion-based elements that distinguish eMAMA from a purely content-transfer course.

Delivery on Moodle

All core materials are hosted on Moodle: reading PDFs, audio podcasts, weekly quizzes, discussion forums, the case study workshop, and the final exam. Institutions adopting the module can download a backup of the course and host it on their own Moodle installation under the CC BY-NC-SA licence.

Recommended weekly flow

Each unit follows a consistent structure that students can quickly internalise:

1. Read the core reading PDF for the unit
2. Listen to the accompanying podcast, which gives an audio overview of the same material
3. Complete the weekly quiz (15 questions, 20 minutes, multiple choice / true-false / matching, pass mark 50%)
4. Participate in the discussion forum where one is scheduled for that unit (Units 1 and 3 in the pilot delivery)
5. Apply the content to the running case study, which is submitted at the end of Unit 5

Reading the core material first matters. The quizzes, discussion posts, case study, and final exam all draw directly on it, and students who skip to the podcast or rely on the discussion alone tend to underperform on the final exam.

Teacher engagement during the module

The consortium strongly recommends active teacher involvement throughout. Specifically:

- **An introductory webinar** at the start of the module, framing what perinatal mental health is, why it matters in the student's context, and how the module is structured. This is also the right moment to address sensitive content and to signal that distress in response to the material is possible and that support is available.

- **Regular presence in the discussion forums.** The discussion activities require students to post one initial post and respond to at least two peers. Teachers should visit the forums regularly to read posts, answer questions, like good contributions, and gently redirect discussions that drift off track. The pilot used two discussion topics — one on theoretical frameworks (Unit 1) and one on risk factors (Unit 3) — and this is a sensible pattern to retain.

- **A mid-module check-in around Unit 3**, when students are encountering the more emotionally heavy content (disorders, risk factors). A short live session at this point helps students process the material and surfaces any difficulties before the case study assessment.

- **A closing session at the end of the module** to consolidate, debrief on the case study, and bridge into Module 2.

Assessments and weighting

Module 1 follows the eMAMA programme-wide assessment model: knowledge tests carry 50% of the grade, and the remaining components are pass/fail. Each pass/fail component has explicit assessment criteria so that teachers can apply the judgement consistently across students and across cohorts.

Component	Format	Weight
Weekly quizzes (×5) and final exam	Automated Moodle grading	50% (graded)
Discussion forum participation	Initial post (200–250 words) + 2 peer responses (100–150 words each) per discussion activity, assessed against criteria	Pass/fail
Case study analysis	1000-word case analysis submitted via Moodle Workshop, peer-assessed using a structured five-criterion rubric	Pass/fail

The graded 50% is split between the five weekly quizzes and the final exam, with the exam carrying the larger share. In the pilot, the weekly quizzes used 15 questions over 20 minutes with a 50% pass mark per quiz, and the final exam used 75 questions over 2 hours with a 50% pass mark, unlimited attempts, and a 24-hour gap between attempts. The exam is designed to support mastery rather than to filter — students who do not pass on the first attempt are expected to review the material and try again.

The pass/fail components do real work in this assessment design and should not be treated as formalities. The discussion participation requirement holds students accountable for engaging with their peers' thinking, not just consuming the content. The case study tests whether students can integrate material from all five units and apply it to a specific clinical situation — something the quizzes and exam, as knowledge-testing instruments, cannot reach. A student who passes the tests but fails the case study has not actually completed Module 1; they have demonstrated recall without competence.

Assessment criteria for pass/fail components

To support consistent teacher judgement, each pass/fail component has explicit criteria.

Discussion participation. A passing contribution requires:

- An initial post of 200–250 words submitted by the deadline
- The post addresses the prompt directly and draws on the unit's core reading
- The post shows independent reflection rather than restating the reading
- At least two peer responses of 100–150 words each
- Responses engage substantively with the peer's argument (comparing, extending, questioning) rather than offering only affirmation

Students who post late, copy from sources without engagement, or post peer responses that are purely complimentary should be marked fail and asked to resubmit.

Case study analysis. A passing case study requires:

- The submitted analysis follows the provided 1000-word template
- The student correctly identifies the perinatal mental health concerns presented in the case
- The analysis draws on material from across the five units, not just one
- Risk factors, protective factors, and possible interventions are all addressed
- The proposed approach is realistic for the woman's specific context
- The student's three peer assessments are completed thoughtfully against the rubric

The case study

The case study is the central applied assessment of Module 1 and deserves specific attention from teachers. The pilot case scenario described a 28-year-old woman 8 weeks postpartum, with intrusive thoughts about a complicated emergency caesarean delivery, sleep difficulties, hyperarousal, disconnection from her baby, and a history of well-controlled generalised anxiety disorder. The case is deliberately rich — students cannot complete it well by recall alone; they have to draw together material from across the five units.

Two implementation notes:

The case scenario can be localised. Institutions adapting the module for their own context can substitute a case that better reflects the clinical realities of their students' practice — for example, a case set in a rural antenatal clinic, or one involving a young first-time mother. The peer-assessment rubric should be reviewed and adjusted accordingly if the case is changed substantively.

Peer assessment requires discipline. Because peer assessment depends on students submitting on time, late submission is handled through a separate teacher-assessed route. Teachers should remind students of the submission deadline at least once during the assessment phase, and should be prepared to assess late submissions themselves rather than letting them slip through.

Adapting the assessment

Institutions adopting the module can adjust specific elements within the 50% tests / 50% pass-fail structure (see section 5.6). For example:

- The quiz pass mark and exam pass mark can be raised or lowered to match institutional standards

- The internal split between weekly quizzes and the final exam can shift — some institutions may prefer to weight quizzes more heavily to encourage steady engagement, others may prefer a single comprehensive exam

- The case study scenario can be localised to better reflect the student's clinical context

- Additional pass/fail components (reflective journals, oral presentations) can be added if institutional regulations require them

What should not change is the underlying split between knowledge testing and competence-based pass/fail components. Module 1 is designed to assess both, and removing either side undermines what the module is supposed to do.

One configuration choice worth checking against local academic regulations: the pilot final exam allowed unlimited attempts with the highest score recorded. This is pedagogically deliberate — the exam is designed to support mastery rather than to filter — but some institutions have regulations that prohibit unlimited attempts or require averaging across attempts. Confirm what your institution permits before adoption.

Feedback

The module ends with a feedback questionnaire that students are encouraged to complete.

Course coordination

Adopting institutions should appoint a clear course coordinator who acts as the single point of contact for students, manages the Moodle environment, monitors discussion forums, and makes the final pass/fail decision on the discussion participation and case study components. In the pilot, the module was coordinated by teaching staff at KUHeS. Coordinator workload is heaviest at the start of the module (introductory webinar, early forum engagement), during the case study assessment phase (managing peer assessment, handling late submissions), and at the final exam. Plan staffing accordingly.

Student feedback highlights

- Students valued the relevance and practical importance of the module.
- Many participants found the workload demanding alongside full-time work.
- Clearer assignment instructions and stronger tutor interaction were repeatedly requested.
- Technical issues with quizzes and completion tracking caused frustration.
- Live sessions and opportunities for discussion were highly appreciated.

Implementation tips

- Maintain flexible timelines where possible to support participants balancing clinical work, studies, and personal responsibilities.
- Monitor workload carefully, especially in modules with multiple assessments or peer-review tasks.
- Keep assignment instructions concise and easy to follow.
- Ensure regular tutor communication and opportunities for live interaction.
- Test quiz settings and Moodle completion tracking before launch.
- Record live sessions for participants with connectivity or scheduling challenges

eMAMA consortium, partner meeting in Malawi, 2024

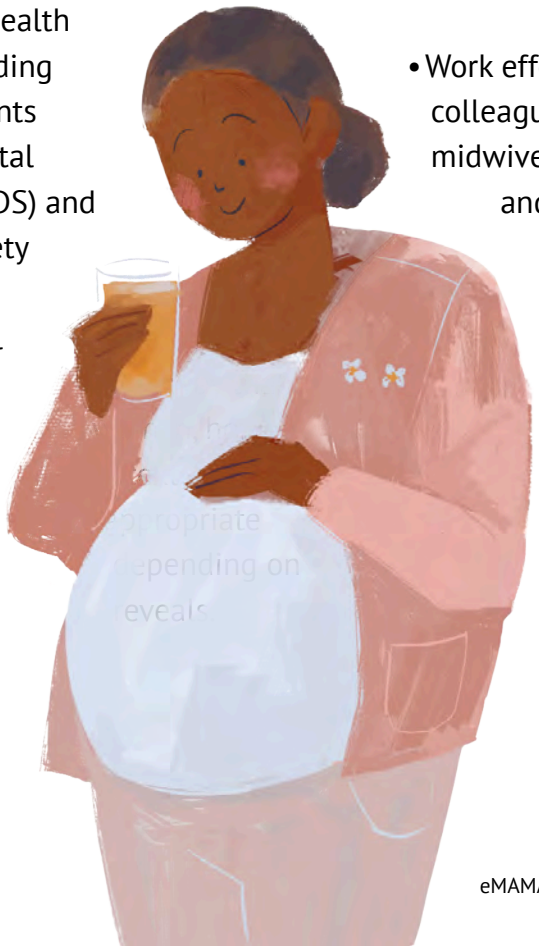
Module 2:
Enhancing Clinical Competence

Objectives

Module 2, Enhancing Clinical Competence, builds on the foundational knowledge from Module 1 and develops the practical skills students need to work confidently with women experiencing perinatal mental health difficulties. Where Module 1 asks what these conditions are and why they matter, Module 2 asks how a practitioner identifies them, supports the woman through them, and works with colleagues across disciplines to deliver care that holds together.

By the end of Module 2, students will be able to:

- Administer, interpret, and act on perinatal mental health screening tools, including widely used instruments the Edinburgh Postnatal Depression Scale (EPDS) and the Generalised Anxiety Disorder 7-item scale (GAD-7). Students will introduce screening is acceptable to the interpret results in what the next step looks like what the screening



- Provide guidance and counselling to women experiencing perinatal mental health concerns, both individually and in group settings, using approaches that are appropriate to the student's scope of practice and the woman's needs.

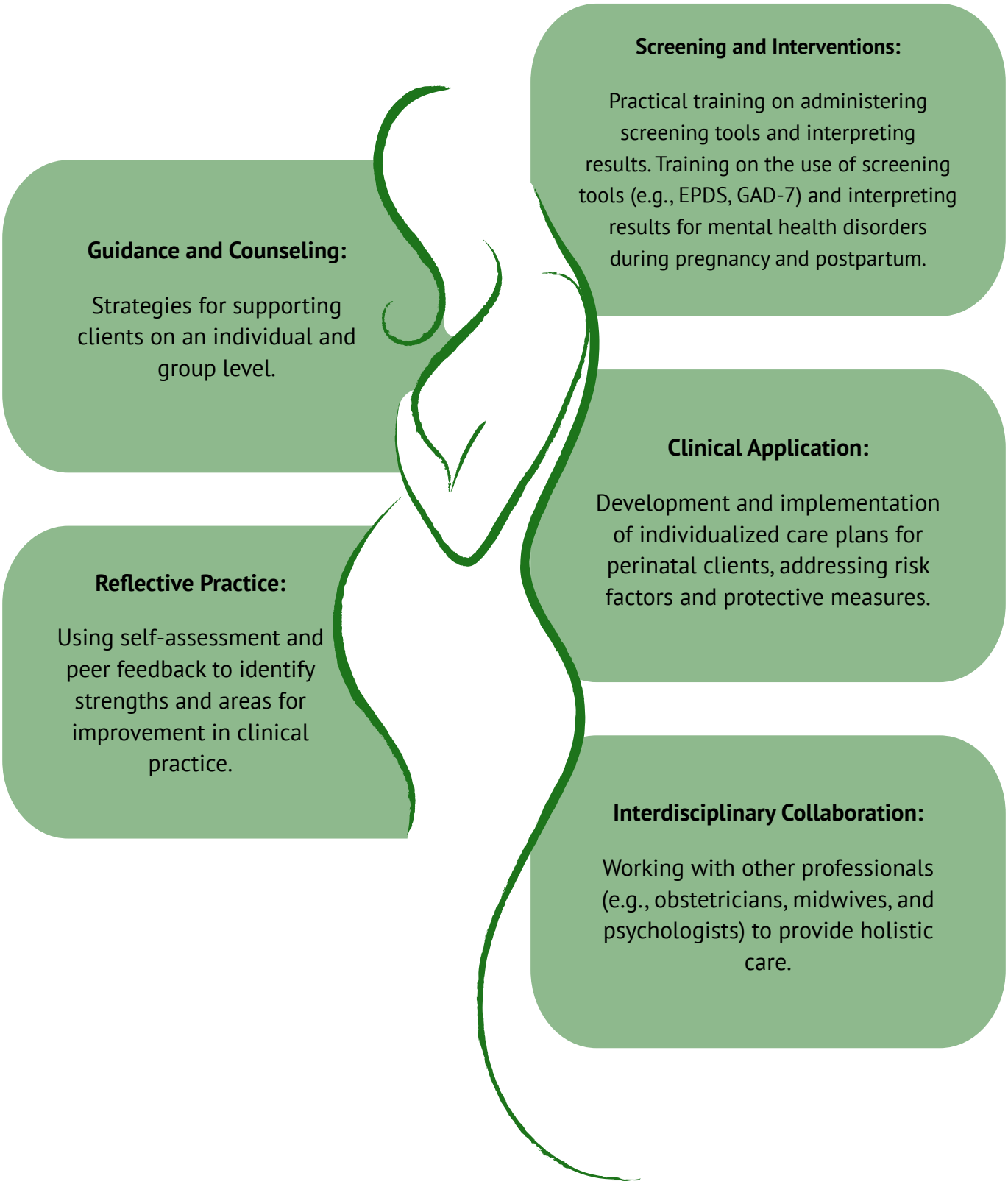
- Develop and implement individualised care plans for perinatal clients, addressing both risk and protective factors, and adapting the plan as the woman's situation evolves through pregnancy and the postpartum period.

- Engage in reflective practice through self-assessment and peer feedback, identifying personal strengths and areas for development as a foundation for ongoing professional growth.

- Work effectively across disciplines with colleagues such as obstetricians, midwives, psychologists, social workers, and community health workers, recognising that perinatal mental health care is rarely delivered well by any single professional working alone.

Content

The module is divided into five (5) units. Each unit is in turn divided into several sub-units. Each unit has a core text and an exercise at the end.



Implementation

Module 2, Enhancing Clinical Competence, is the second of three theoretical modules in the eMAMA programme. Where Module 1 establishes the foundations of perinatal mental health, Module 2 develops the skills students need to work confidently with women experiencing these conditions: screening, counselling, individualised care planning, reflective practice, and interdisciplinary working.

Structure and duration

The module is organised into five content units, each with its own core reading, podcast, and unit quiz:

- Screening Tools and Interventions
- Guidance and Counselling for Perinatal Mental Health Problems
- Clinical Application: Development and Implementation of Individualised Care Plans
- Reflective Practice in Managing Perinatal Mental Health Problems
- Interdisciplinary Collaboration

The unit sequence matters. Screening (Unit 1) comes first because everything else depends on it — students cannot counsel, plan care, reflect on practice, or collaborate effectively around a problem they have not identified. Reflective practice (Unit 4) and interdisciplinary collaboration (Unit 5) close the module because they are the practices that hold the rest together over time.

Like Module 1, this module is designed to run across approximately six weeks. Institutions can shorten or extend this, but should preserve the per-unit rhythm of reading → podcast → applied work → quiz.

Delivery on Moodle

All core materials are hosted on Moodle: reading PDFs, audio podcasts, unit quizzes, the discussion forum (Unit 2), the reflective practice audit (Unit 4), and the final exam.

Recommended weekly flow

1. Each unit follows a consistent structure:
2. Read the core reading PDF for the unit
3. Listen to the accompanying podcast
4. Complete the applied work for the unit
5. Pass the unit quiz to unlock the next unit
6. Move on to the next unit

Teacher engagement during the module

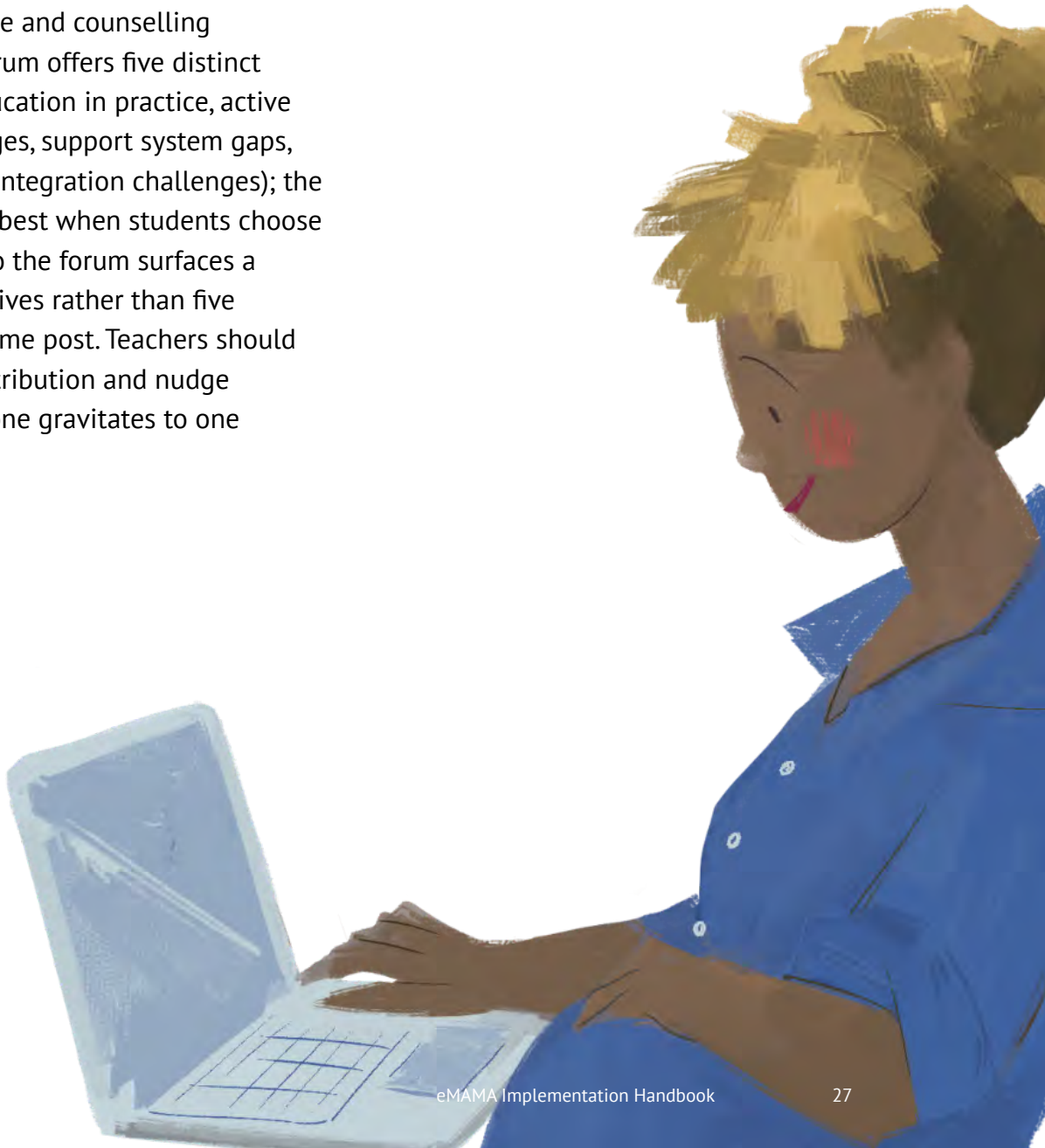
Module 2 carries a higher demand on teachers than Module 1. The content is more applied, and Unit 4's reflective practice audit involves private reflections shared between student and instructor. Specifically:

- **An introductory webinar** at the start of the module, with particular attention to introducing the screening tools (EPDS, PHQ-9, GAD-7, Whooley). Students benefit from seeing each tool used in a brief role-play or video before they encounter it in the unit reading.

- **Active presence in the Unit 2 discussion forum** on guidance and counselling strategies. The forum offers five distinct topics (psychoeducation in practice, active listening challenges, support system gaps, reducing stigma, integration challenges); the discussion works best when students choose different topics so the forum surfaces a range of perspectives rather than five versions of the same post. Teachers should monitor topic distribution and nudge students if everyone gravitates to one option.

- **Individual engagement with each student's reflective practice audit in Unit 4**. The audit is private between student and instructor by design (see below), which means it cannot be delegated to peer review. Although ungraded, it is the most time-intensive teacher commitment in the module and should be planned for.

- **A closing session** at the end of the module to consolidate, discuss the interdisciplinary scenario from the final exam, and bridge into Module 3.



Assessments and weighting

Module 2 follows the eMAMA programme-wide assessment model: knowledge tests carry 50% of the grade, and the remaining components are pass/fail with explicit assessment criteria. The Personal Reflective Practice Audit in Unit 4 is a reflective learning activity that is not graded.

Component	Format	Weight
Unit quizzes (×5) and final exam	Automated Moodle grading; quizzes are gating (must pass to proceed)	50% (graded)
Forum discussion (Unit 2)	1 initial post (250–300 words) + 2 peer responses (100–150 words each) on different topics	Pass/fail
Personal Reflective Practice Audit (Unit 4)	Self-directed reflective audit conducted over one week	Not graded

The pilot quiz format used 5 multiple-choice and 5 true/false questions per unit quiz, with a passing grade required to unlock the next unit. The final exam is built around a scenario-based case (Nido, a 28-year-old pregnant woman with anxiety, depression, history of mental health issues, and limited support) that requires students to draw together material from all five units.

Assessment criteria for pass/fail components

To support consistent teacher judgement, each pass/fail component has explicit criteria.

Forum discussion (Unit 2). A passing contribution requires:

- An initial post of 250–300 words on one of the five offered topics, submitted by the deadline
- The post references specific course materials and includes practical examples or scenarios
- The post shares professional insight or raises substantive questions, rather than restating the reading
- Two peer responses of 100–150 words each, on different topics from the student's own initial post
- Responses add a new perspective, share a relevant example, ask a thoughtful follow-up question, or suggest additional considerations
- The tone is respectful and constructive throughout

Students who post late, copy from sources without engagement, or post responses that are purely complimentary should be marked fail and asked to resubmit.

The Reflective Practice Audit in Unit 4 is not graded and does not contribute to the pass/fail outcome of the module. This is deliberate. The audit asks students to examine their own practice honestly — to identify weaknesses, reflect on critical incidents from their own experience, and set development goals. Grading work of this kind distorts it: students write what they think the assessor wants rather than what is actually true about their practice. By keeping the audit ungraded, the module preserves the conditions under which genuine reflection becomes possible.

Students design their own audit: they choose the practice areas to examine, select a critical incident from their own experience, and pick the reflective framework that best fits the incident. The audit runs across approximately one week and typically includes:

- An honest self-assessment of the student's current strengths, challenges, and personal influences as a practitioner
- Application of the chosen reflective framework to a real critical incident from the student's own practice or training experience
- Synthesis of insights into SMART development goals with a realistic plan for ongoing reflective practice

A note on privacy: all reflections in the audit remain private between the student and the instructor. This is a deliberate design feature — reflective practice on real clinical encounters requires psychological safety, and students will not be honest about their own struggles if they know peers will read their work. Teachers must respect this boundary absolutely. Audit content should never be shared with other students, used as a teaching example, or referenced in group sessions without explicit consent.

The fact that the audit is ungraded does not mean it is optional in spirit. Teachers should engage seriously with each student's audit, offer individual feedback, and treat it as one of the more important interactions in the module — even though no mark is attached.

Localising the module

Two specific localisation considerations for Module 2:

Screening tools. The pilot focused on the EPDS as the most acceptable and effective tool for primary care use in the partner countries, with PHQ-9, GAD-7, and Whooley also covered. Institutions in other settings may have nationally adopted screening tools that should be added or substituted. The unit content is the framework for using any screening tool, not advocacy for one specific instrument.

The Nido case (final exam). Like the Module 1 case, the final exam scenario can be localised. The Nido case describes a 28-year-old pregnant woman with anxiety, depression, and limited support — this is generic enough to work across settings, but institutions may want to adapt details (age, parity, presenting symptoms, family structure) to better reflect the women their students actually encounter.

Feedback

The module ends with a feedback questionnaire that students are encouraged to complete.

Course coordination

Adopting institutions should appoint a clear course coordinator who manages the Moodle environment, monitors the discussion forum, and — crucially — provides individual instructor engagement on the reflective practice audits. In the pilot, the module was coordinated by teaching staff at KUHeS. Coordinator workload is highest during Unit 4 (one-to-one engagement with each student's audit) and at the end of the module (marking the interdisciplinary final exam). Plan staffing accordingly — a single coordinator can realistically support 15–20 students through the audit; larger cohorts will need additional instructor support.

Student feedback highlights

- Students valued the practical and clinically relevant focus of the module.
- Flexible pacing and the absence of strict time pressure were appreciated.
- The reflective practice activity was considered useful but time-consuming.
- Loss of written work due to missing auto-save functionality caused frustration.
- Students requested more tutor interaction, live sessions, and downloadable materials.

Implementation tips

- Ensure students receive sufficient practical orientation to screening tools such as EPDS, PHQ-9, GAD-7, and Whooley.
- Explain gated progression clearly at the start of the module so students understand the cumulative learning structure.
- Maintain active tutor engagement, particularly in discussion forums and reflective activities.
- Plan staff workload carefully, particularly for reflective and feedback-intensive activities. Keep timelines flexible where possible to support working professionals.
- Ensure reflective activities can be saved progressively to prevent loss of work during internet interruptions.
- Provide downloadable learning materials to support students with unstable internet access.
- Encourage diverse discussion topics to promote broader interdisciplinary perspectives.
- Preserve psychological safety and confidentiality in reflective practice activities.
- Record live sessions whenever possible to improve accessibility for students unable to attend synchronously.

Module 3:
Community Care and Support

Objectives

Module 3 shifts the focus outward from the individual clinical encounter to the wider system of family, community, and society in which perinatal mental health care happens — or fails to happen.

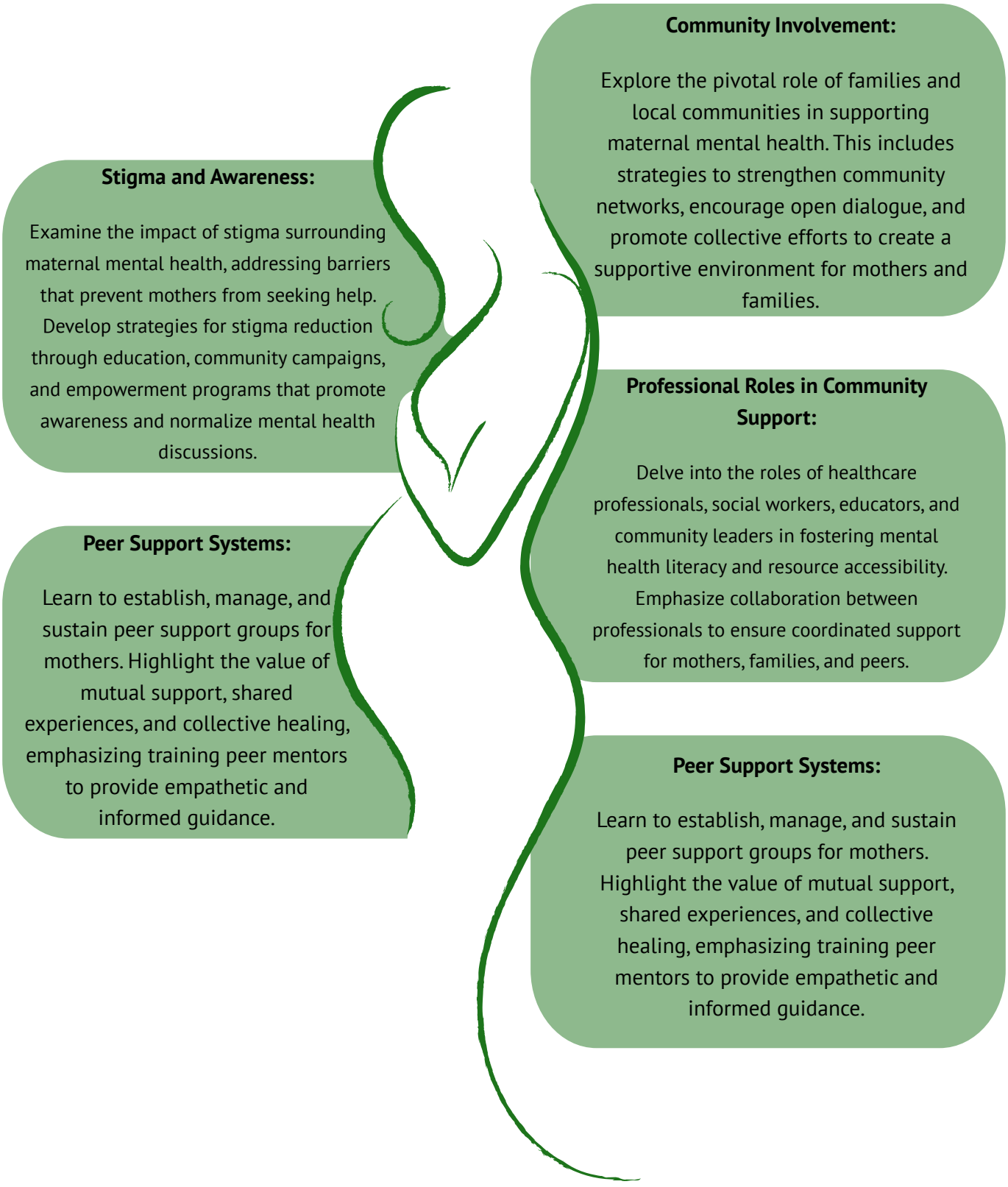
The premise of the module is that even the most skilled clinician can do limited good if women in their community do not feel able to disclose distress, if local stigma prevents them from seeking help, or if there is no network of support around them once help has been offered. Module 3 prepares students to work at this wider level. By the end of Module 3, students will be able to:

- Recognise and address stigma as a barrier to maternal mental health care within their communities, understanding how stigma operates at individual, family, community, and institutional levels, and identify which kinds of intervention shift it.
- Lead and support mental health awareness initiatives that empower communities to promote well-being, ranging from small-scale activities within a single clinic or village to larger campaigns coordinated with local leaders and organisations.
- Collaborate effectively with interdisciplinary teams and community leaders to enhance maternal mental health services, recognising that durable improvements in access and outcomes require coordinated action across health professionals, social workers, educators, traditional and religious leaders, and the women themselves.

These objectives prepare students to act not only as clinicians but as advocates and community-level change agents — a role that becomes especially relevant in the supervised applied project in Module 4.

Content

The module is divided into five (5) units. Each unit is in turn divided into several sub-units. Each unit has a core text and an exercise at the end.



Implementation

Module 3, Community Care and Support, is the third and final theoretical module in the eMAMA programme. Where Module 1 establishes foundations and Module 2 develops clinical skills, Module 3 shifts the focus outward — to the families, communities, and social structures within which perinatal mental health care succeeds or fails. The premise of the module is that even a skilled clinician with a working screening tool can do limited good if stigma keeps women silent, if no peer support network exists for them after they leave the clinic, or if the cultural framing of mental illness in their community treats their distress as something other than what it is.

Structure and duration

The module is organised into five content units, each with its own core reading, applied activity, and unit quiz:

- Community Involvement
- Stigma and Awareness
- Professional Roles in Community Support
- Peer Support Systems
- Cultural Sensitivity

The unit sequence builds from the wider context inward to the practitioner: starting with the community as a whole (Unit 1), examining stigma as the central barrier (Unit 2), locating the professional within that landscape (Unit 3), introducing peer support as a complement to professional care (Unit 4), and closing with cultural sensitivity as the lens that runs through all of the above (Unit 5).

Like Modules 1 and 2, this module is designed to run across approximately six weeks. Institutions can shorten or extend this, but should preserve the per-unit rhythm of reading → applied work → quiz.

Delivery on Moodle

All core materials are hosted on Moodle: reading PDFs and slide decks, recommended additional readings, unit quizzes, discussion forums, and the practical assessments (the needs assessment in Unit 3, the support group advertisement in Unit 4, the cultural sensitivity case study in Unit 5). Institutions adopting the module can download a backup and host it on their own installation under the CC BY-NC-SA licence.

Recommended weekly flow

Each unit follows a consistent structure:

1. Read the core reading material for the unit (and recommended additional readings where time allows)
2. Engage with the applied activity for the unit — discussion forum, needs assessment, support group advertisement, or case study, depending on the unit
3. Pass the unit quiz (15 questions, unlimited attempts, pass mark >8)
4. Move on to the next unit

Teaching cultural context: locally generated examples are non-negotiable

Module 3 is the module where eMAMA most explicitly intersects with the specific cultural and community realities of the partner countries. Cultural sensitivity is the closing unit, but cultural context runs through every part of the module — community involvement looks different in a rural Zambian village and an urban Lilongwe neighbourhood; stigma takes different forms in different ethnic and religious communities; peer support models that work in one setting may fail in another.

The single most important implementation point for this module is that teachers must use **locally generated examples and student experience throughout**, not just in Unit 5. Treating cultural context as a chapter to be covered — a lecture on Giger and Davidhizar's model, a case study set somewhere distant, and a quiz to confirm recall — is the failure mode this module is most vulnerable to. It produces students who can name cultural frameworks but cannot apply them to the women they will actually encounter.

Specifically, teachers should:

- **Replace or supplement the provided cases with local ones.** The pilot Unit 5 case describes a 25-year-old Herero-speaking woman in Namibia. This is appropriate for Namibian students but would be a missed opportunity for Malawian or Zambian students whose practice context is different. Teachers in each setting should add at least one case drawn from their own clinical or community context.

- **Use student experience as primary material.** Most postgraduate students on this course will have already encountered the issues the module describes — stigma in their own communities, family resistance to mental health care, peer support groups that exist informally without being named as such. Webinars and discussion sessions should actively draw out these experiences rather than treating the readings as the main source of knowledge.

- **Name specific communities, languages, and beliefs.** Generic discussion of "cultural sensitivity" is much weaker than specific discussion of how distress is described in Chichewa, how mental illness is understood in Tonga communities, or how religious leaders in a particular district can be engaged as allies. Teachers should push students toward this level of specificity in their discussion posts and assignments.

- **Treat Unit 5 as a synthesis, not an introduction.** By the time students reach the cultural sensitivity unit, they should already have encountered cultural context as a thread running through Units 1–4. Unit 5 then functions as a chance to step back and consolidate, rather than as the first time cultural questions are raised.

Teacher engagement during the module

Module 3 is the most teacher-intensive of the three theoretical modules, because so much of its value depends on facilitation that connects the content to local context. Specifically:

- **An introductory webinar** at the start of the module, framing why community care matters as much as clinical care, and explicitly inviting students to bring their own experience to the discussions throughout.

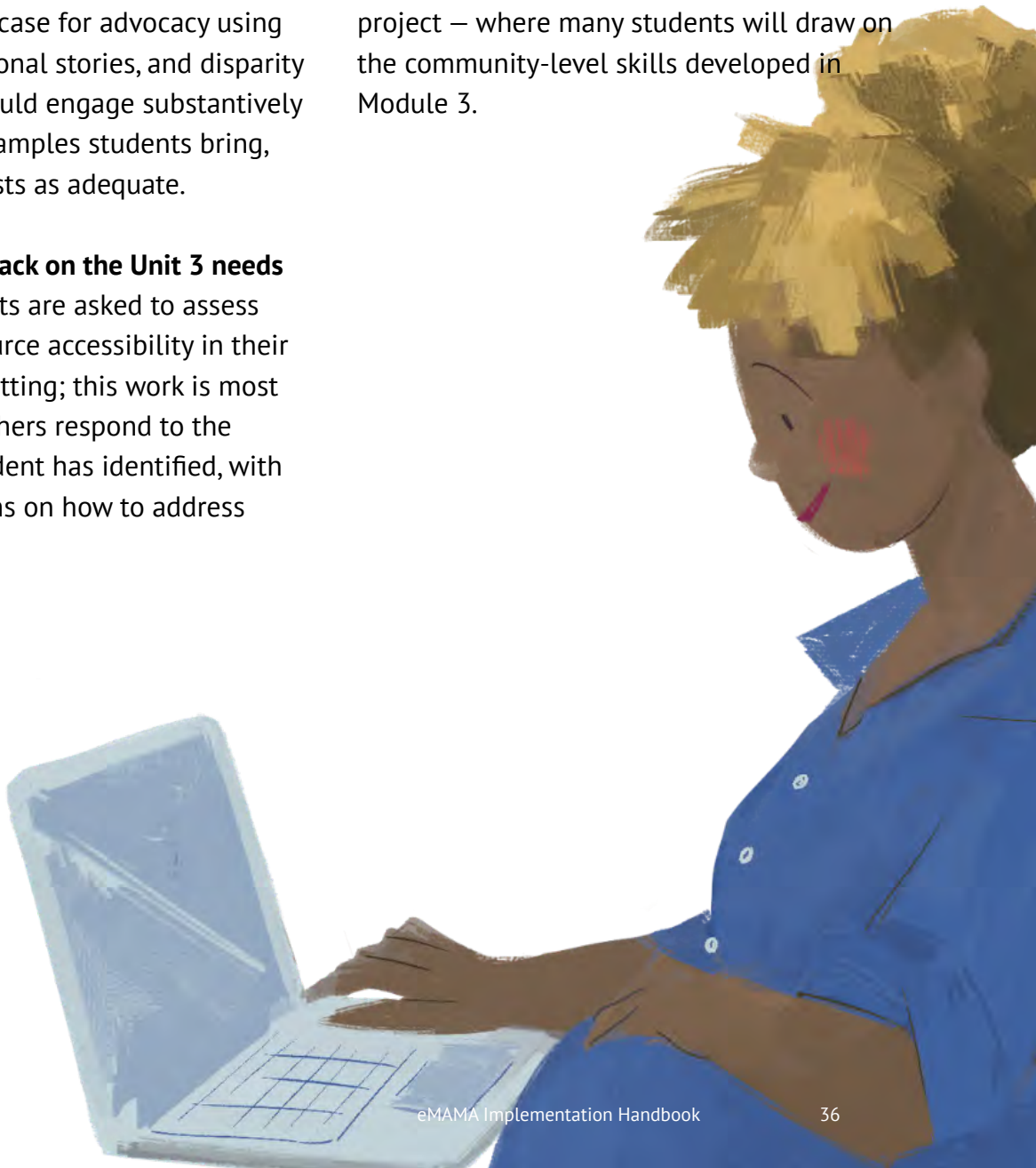
- **Active presence in the Unit 1 discussion forum** on advocacy. The forum prompt asks students to make a case for advocacy using local numbers, personal stories, and disparity data — teachers should engage substantively with the specific examples students bring, not just rate the posts as adequate.

- **Individual feedback on the Unit 3 needs assessment.** Students are asked to assess mental health resource accessibility in their own professional setting; this work is most valuable when teachers respond to the actual gaps the student has identified, with practical suggestions on how to address them.

- **Engagement with the Unit 4 support group advertisement**. This is a creative communication task, not a clinical one, and many students will find it unfamiliar. Teachers should be prepared to give feedback on design and messaging as well as on content.

- **Active presence in the Unit 5 discussion forum** on cultural sensitivity, with attention to ensuring students engage with the SPIKES protocol practically rather than only describing it.

- **A closing session** at the end of the module, with particular attention to bridging into Module 4 — the supervised applied project — where many students will draw on the community-level skills developed in Module 3.



Assessments and weighting

Module 3 follows the eMAMA programme-wide assessment model: knowledge tests carry 50% of the grade, and the remaining components are pass/fail with explicit assessment criteria.

Component	Format	Weight
Unit quizzes (×5)	15 questions per unit, unlimited attempts, pass mark >8	50% (graded)
Unit 1 discussion forum (advocacy)	1 initial post (250–300 words) + 2 peer responses (100–150 words each)	Pass/fail
Unit 3 needs assessment	Submitted needs assessment report (Word or PDF) with self-assessment against provided criteria	Pass/fail
Unit 4 support group advertisement	One-page advertisement for a local perinatal support group, peer-assessed via Moodle Workshop	Pass/fail
Unit 5 case study	Three-question written assessment on Giger and Davidhizar's Transcultural Assessment Model, peer-assessed via Moodle Workshop	Pass/fail
Unit 5 discussion forum (cultural sensitivity)	Post (200–300 words) responding to two cultural scenarios; reply to at least one peer	Pass/fail

The pilot also provided a **late submission return box** for the advertisement and case study. Late submissions are assessed by lecturers rather than peers and receive a single combined grade across both pieces. Adopting institutions can preserve this arrangement or set their own late submission policy.

Peer assessment in Module 3

Two of the pass/fail components — the Unit 4 support group advertisement and the Unit 5 case study — are peer-assessed using Moodle Workshop, the same mechanism used for the Module 1 case study. This is a deliberate design choice: peer assessment exposes students to a wider range of approaches to the same task than they would see from teacher feedback alone, and the act of assessing peers' work develops the student's own critical judgement.

The peer assessment structure follows the standard Moodle Workshop pattern:

- **Submission phase.** Students submit their work by the stated deadline.
- **Assessment phase.** After the deadline, each student is automatically assigned three peers to review using a structured rubric.
- **Grading.** The student's pass/fail outcome is based on a combination of how peers rate their submission (the larger share) and the quality of their own peer assessments (the smaller share).

As in Module 1, peer assessment depends on students submitting on time. Teachers should remind students of the submission deadline at least once during the assessment phase, and the late submission route exists for cases where peer assessment is no longer possible.

Assessment criteria for pass/fail components

Unit 1 discussion forum (advocacy). A passing contribution requires:

- An initial post of 250–300 words on why advocacy matters in maternal mental health
- The post includes specific numbers about local impact, a personal or borrowed story, a clear "hook" to connect with the audience, and information about disparities
- Two peer responses of 100–150 words each, adding new perspective, sharing a relevant example, asking a follow-up question, or suggesting additional considerations

Unit 3 needs assessment. A passing needs assessment requires:

- A submitted report (Word or PDF) assessing the current landscape of mental health resource accessibility in the student's professional setting
- Identification of existing barriers to access
- Concrete strategies the student could implement within their own setting to improve accessibility
- A completed self-assessment against the provided criteria

Assessment criteria for pass/fail components

Unit 4 support group advertisement. A passing advertisement requires:

- A one-page advertisement targeted at new mothers in the student's community, submitted by the deadline (so that peer assessment can proceed)
- Application of design principles appropriate to health communication
- Demonstration of target audience considerations — literacy level, cultural appropriateness, accessibility
- Empathetic, supportive messaging that invites rather than stigmatises
- The student's three peer assessments are completed thoughtfully against the rubric

Unit 5 case study. A passing case study requires substantive answers to three questions, submitted by the deadline:

- A clear definition of Giger and Davidhizar's Transcultural Assessment Model and its relevance to maternal mental health care
- Application of the model to the provided scenario (the 25-year-old Herero-speaking woman in the pilot, or a locally substituted case) — identification of three cultural phenomena from the model and two culturally sensitive healthcare interventions
- A reflective response on a real or hypothetical situation where cultural misunderstanding could affect maternal mental health outcomes, using the Gibbs reflective model
- The student's three peer assessments are completed thoughtfully against the rubric

Unit 5 discussion forum. A passing contribution requires:

- A post of 200–300 words responding to the two cultural scenarios (fear of spirits after childbirth; refusal of medication due to cultural beliefs)
- Description of how the student would approach each scenario, including specific culturally sensitive strategies and application of the SPIKES protocol
- Empathetic, respectful, and mindful engagement with diverse worldviews
- A reply to at least one peer that builds constructively on their ideas

Localising the module

Module 3 should be localised more extensively than Modules 1 or 2. Specific considerations:

Substitute or supplement the Unit 5 case scenario with at least one case drawn from the local clinical or community context. The Herero-speaking case is a good model — specific, named, culturally located — but it works best when students recognise the woman as someone they could plausibly meet.

Adapt the Unit 4 advertisement task to the actual support group landscape in the student's setting. If no local perinatal support groups exist, the assignment can be reframed as advertising for a hypothetical group the student would set up.

Add local examples to the Unit 2 stigma content. The core reading addresses stigma in general terms; teachers should add specific examples of how stigma manifests in their setting, drawing on student experience where possible.

Tailor the Unit 3 needs assessment to local healthcare structures. The needs assessment template should reflect the actual professional landscape the student is working within — different countries have different mental health workforce structures, referral pathways, and policy frameworks.

Feedback

The module ends with a feedback questionnaire that students are encouraged to complete.

Course coordination

Adopting institutions should appoint a clear course coordinator who manages the Moodle environment, monitors the multiple discussion forums and assignment submissions, and gives individual feedback on the needs assessment. Coordinator workload in Module 3 is more evenly distributed across the module than in Modules 1 and 2, because pass/fail components appear in nearly every unit rather than being concentrated at the end. Plan staffing accordingly.

Student feedback highlights

- Students valued the strong community and cultural focus of the module.
- Peer discussions and practical examples supported engagement and learning.
- Some participants experienced the workload as demanding.
- Students requested more visual and easily accessible learning materials.
- Tutor interaction and live discussions were considered important.

Implementation tips

Use locally relevant cultural and community examples throughout the module.

Encourage students to connect discussions and assignments to their own practice settings.

Keep learning materials concise, clearly structured, and accessible.

Consider providing downloadable video materials where possible.

Maintain active tutor facilitation during discussions and peer-assessment activities.

Monitor workload and assignment scheduling carefully.

Remind students regularly about peer-assessment deadlines.

Ensure Moodle completion tracking functions correctly before implementation.

Create a respectful and psychologically safe environment for sensitive discussions.

Module 4:
Community-Centered Clinical Practice

What Module 4 is

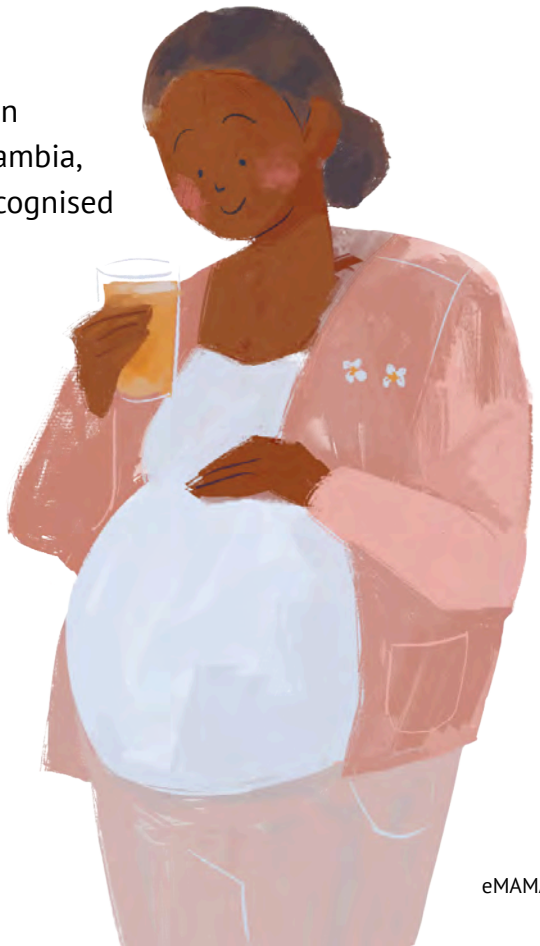
Module 4 is the applied component of the eMAMA programme. Where Modules 1–3 build knowledge and clinical competence through structured online study, Module 4 asks students to put that learning to work: each student designs and carries out a small work-based development project addressing a specific maternal mental health need in their own clinical or community setting, under the supervision of a clinical teacher.

The module is assessed through two written assignments — a Portfolio and a Final Report — and is graded pass/fail.

Why this module matters in Malawi, Namibia, and Zambia

Perinatal mental health problems are common in Malawi, Namibia, and Zambia, they are often under-recognised and undertreated. Depression, anxiety, psychosis, and trauma-related disorders can severely affect the health of both mother and infant. Health workers in rural and primary care settings are frequently the first — and sometimes the only — point of contact for pregnant and postpartum women, yet they often lack training in recognising and managing these conditions.

Modules 1–3 address this training gap in the classroom. Module 4 closes the loop: students apply screening, assessment, and support skills in real practice, in a culturally responsive and resource-appropriate way, and leave behind a concrete improvement in their own setting.



Learning objectives

By the end of Module 4, students will be able to:

- Conduct a work-based development project addressing a specific mental health need
- Collaborate with stakeholders to ensure the project's relevance and sustainability
- Work effectively with interdisciplinary teams
- Build community networks that enhance access to resources
- Evaluate the impact of the project and propose strategies for long-term improvement

Competencies developed

The module develops four core competencies:

- **Community engagement and networking**. Building and maintaining partnerships with community organisations and stakeholders to improve access to maternal mental health resources.
- **Project planning and execution.** Designing and implementing a development project with stakeholder involvement and measurable outcomes.
- **Ethical and cultural competence.** Applying culturally sensitive and ethical approaches in all aspects of the project.
- **Reflective and professional practice.** Using reflective tools to analyse personal performance and identify opportunities for growth.

In terms of knowledge, students deepen their understanding of perinatal mental health challenges, risk factors, and cultural contexts; familiarise themselves with evidence-based and community-centred practices; and grasp the principles of sustainable mental health interventions.

In terms of skills, students learn to use screening tools and intervention protocols effectively, develop individualised care plans for perinatal clients, collaborate with interdisciplinary teams, execute a community-based development project, and evaluate mental health initiatives and propose improvements.

In terms of attitudes and values, students are expected to demonstrate ethical awareness and cultural sensitivity, maintain a reflective log documenting insights, challenges, and progress, promote sustainable and community-driven solutions, and value interdisciplinary collaboration and community networks.

Workload and credits

Module 4 carries 15 ECTS in total, divided into two components:

Written work — 5 ECTS (135 hours). Covers reading, lesson planning, reflective reports, and the final written assignments. Suggested allocation: approximately 9 weeks at 15 hours per week.

Practice — 10 ECTS (270 hours). The clinical placement during which the development project is carried out.

Suggested allocations:

- 6 weeks × 45 hours per week (intensive placement, close to full-time), or
- 9 weeks × 30 hours per week (moderate load, comparable to typical Finnish practice modules)

Assessment

Grading scheme: Pass / Fail.

Students submit two assignments to their clinical teacher at the end of the placement, using clear academic writing and the agreed referencing format (APA or Harvard):

1. **Portfolio** — a structured record of reflective learning during the placement
2. **Final Report** — an evaluation of and reflection on the project outcomes

The Final Report

The Final Report summarises the student's work-based development project in maternal mental health. Total length is approximately 1,500–2,000 words, structured as follows:

1. Executive Summary (150–200 words)
2. Background and Rationale (200–300 words)
3. Project Planning and Implementation (300–400 words)
4. Evaluation and Impact (200–300 words)
5. Sustainability and Recommendations (200–300 words)
6. Reflection (300–400 words)
7. References (APA or Harvard style)

The Portfolio

The Portfolio has three sections:

Section 1 — Introduction. A short personal and professional biography (70–100 words).

Section 2 — Summaries of reflective log entries. Three concise summaries — one for each of the following topics — based on the student's reflective log:

1. Screening for perinatal mental health problems
2. Making referrals for women with perinatal mental health problems
3. Providing psychosocial support to women with perinatal mental health problems

Each summary includes:

- A brief description of the clinical experience: context, what went well, what could have been improved
- The main theoretical concepts linked to the experience
- Key learning points and planned evidence-based responses for the future
- The references used in the original log entry (minimum of four per topic in the log)

The Portfolio

Section 3 — Overall reflection. A final reflection drawing together the learning from all three areas. It should discuss common themes across the experiences; reflect on how the student's skills, knowledge, and professional attitudes have developed; identify how the learning will be applied in future clinical practice; address ethical considerations, cultural sensitivity, and patient-centred approaches; and be supported by relevant literature where appropriate.

The Reflective Log

The Reflective Log is the foundation on which the Portfolio is built. It records the student's reflections on specific clinical experiences in perinatal mental health care throughout the placement. The log itself is not submitted for assessment, but it is strongly recommended: the Portfolio's Section 2 summaries are drawn directly from it, and students who keep the log as they go produce markedly stronger portfolios than those who attempt to reconstruct their experiences afterwards. A guidance tool for the log is provided on the Moodle platform.

Each reflective account in the log includes:

1. **Clinical experience description (100–150 words)**: context and setting, what went well, what could be improved. Full anonymity must be ensured.
2. **Reflection and theoretical analysis (150–200 words)**: linking theories, models, or concepts to the experience.
3. **Planned future practice response (150–200 words)**: what was learned and how the student would respond in a similar situation.
4. **References**: a minimum of four academic sources per entry (two for the reflection, two for the future response).

Guiding learning questions

Students should use the following questions to guide their writing in the Reflective Log, the Portfolio, and the Final Report:

- **Identifying need or gap** — What specific need or gap in maternal mental health did you identify in your clinical setting, and how did this shape your focus?
- **Methods** — What methods did you use to plan, implement, and evaluate your work or project, and why were they appropriate for your setting?
- **Ethical considerations** — How did you ensure ethical practice, including patient consent, confidentiality, and cultural sensitivity?
- **Outcomes and impact** — What were the main outcomes or impacts of your work or project, and how did you measure them?
- **Professional growth** — How has this experience influenced your understanding of maternal mental health, and how will it inform your future practice?

Required reading

WHO (2022). Mental health of women during pregnancy and after childbirth. Module 4: Perinatal Mental Health Practicum
Patel, V. et al. (2018). Global Mental Health: Principles and Practice
Relevant country-specific mental health policies and maternal health guidelines

Tips for implementation

The first eMAMA cohort completed Module 4 across Malawi, Namibia, and Zambia, and several practical lessons emerged that should shape how adopting institutions plan and run this module. These recommendations are drawn from the consortium's own evaluation of the pilot.

Plan for lower completion rates than in Modules 1–3. Completion rates were noticeably lower for Module 4 than for the three theoretical modules. The principal reason was the difficulty of combining a workplace-based clinical attachment with full-time professional responsibilities — most students on the eMAMA programme are practising clinicians, and finding seven weeks of dedicated time within an existing workload is genuinely hard. Adopting institutions should expect this pattern and build it into their planning rather than treating attrition as a failure.

Negotiate study leave early. The single most impactful intervention for completion is institutional recognition of the module as legitimate professional development, including arrangements for study leave or workload reduction during the attachment period. Where this is not possible, consider:

- Allowing students to complete the module in stages rather than as a continuous seven-week block

- Permitting the project to take place within the student's existing workplace rather than requiring an external attachment

- Adjusting the project scope downward if the student's available time is genuinely limited (a smaller, completed project is more valuable than a more ambitious one abandoned halfway)

The handbook strongly recommends that institutions adopting the programme negotiate formal integration of eMAMA into their own academic and professional development frameworks, so students can access study leave on the same basis as other postgraduate work.

Secure clinical site access in advance. The pilot encountered delays in securing institutional approvals — particularly Memoranda of Understanding (MOUs) — for clinical site access. These delays affected when students could start the module and how much of their attachment time was usable. Adopting institutions should:

- Map potential clinical sites at the start of the programme (not at the start of Module 4)

- Begin MOU negotiations during Module 3 at the latest

- Maintain a list of sites with active agreements that students can choose from, rather than requiring each student to negotiate their own access

Establish country-specific WhatsApp groups for Module 4. During the pilot, a single programme-wide WhatsApp group worked well for the theoretical phase (Modules 1–3) but became unwieldy during the practical phase, when students' questions and logistical needs became country-specific.

The consortium responded by establishing dedicated WhatsApp groups for each participating country, which strengthened communication between students and in-country facilitators, supported MOU and clinical site arrangements, and enabled timely mentorship. Adopting institutions running Module 4 across more than one country should plan for this structure from the start rather than waiting for the single-group approach to strain.

Use hybrid mentorship. The pilot used a hybrid mentorship model combining the student's own clinical supervisor on site with eMAMA programme facilitators reachable remotely. This worked well: on-site supervisors provided clinical and contextual judgement; programme facilitators provided continuity with the rest of the curriculum and could troubleshoot when local supervision was thin. Adopting institutions should not rely on a single supervisor model where the student's clinical supervisor is also the only programme contact.

Use case-based learning to anchor relevance. Students who used real cases from their own clinical setting as the foundation of their project consistently produced stronger work than those who attempted more abstract service-development projects. Supervisors should push students toward case-anchored work during early scoping conversations.

Anticipate practical constraints in primary care settings. Pilot evaluation surfaced several recurring practical constraints that affected students' ability to conduct their projects effectively. Supervisors should help students think through these early:

- **Private space for screening**. Many primary care facilities lack a private space for confidential mental health conversations. Where this is the case, the project plan should address how confidentiality will be maintained — even if the answer is "this is the constraint, and these are its limits."

- **Language barriers**. Students working with women whose first language is not the student's or the dominant clinical language will face communication limits that affect both screening and intervention quality. Worth naming explicitly in the project plan.

- **Workforce shortages and competing clinical priorities**. Students who are also covering routine clinical duties during their attachment will not be able to spend the full notional project time on the module. Scoping conversations should be realistic about this.

Frame the project around what's sustainable. The pilot found that the most valuable projects were ones whose changes might survive after the student left the site — a screening practice that one trained colleague continues, a referral pathway that becomes part of clinic routine, an education session that other staff repeat. Supervisors should ask students early: "what part of this will still be happening six months after you finish?" Projects that have no plausible answer to that question are usually scoped wrong.

Examples of Module 4 student projects

The following examples are drawn from completed Module 4 projects across the eMAMA pilot cohorts in Malawi, Namibia, and Zambia. They are presented in generalised form to indicate the range and scope of work that students have undertaken successfully, not as templates to be copied. Module 4 is deliberately flexible — each student should design a project that fits their own clinical context, role, and the gaps they see in their own setting.

Example 1: Integrating maternal mental health screening into routine antenatal care

A nurse-midwife at a rural health centre identified that mental health screening was not part of routine antenatal or postnatal visits, despite frequent encounters with women showing signs of emotional distress. Over the course of the module, the student introduced systematic screening using a validated tool (the PHQ-9 in this case; the EPDS was used by others), trained two colleagues to administer it, established a referral pathway to the district hospital for women scoring above the clinical threshold, and documented outcomes for the women screened during the project period. The project also included brief psychoeducation sessions with women during clinic waiting times.

This is the most common Module 4 project pattern. It is well-scoped, locally relevant, and produces practical evidence of change in the student's own setting.

Example 2: Antenatal health education focused on emotional wellbeing

A nursing student on placement at a primary care clinic observed that routine antenatal health talks covered nutrition, immunisation, and danger signs, but rarely addressed emotional wellbeing or mental health. The student developed a short structured health education session covering early ANC attendance, common emotional changes during pregnancy, simple stress management techniques, when and where to seek help, and stigma reduction. Sessions were delivered in the local language during routine clinic days over four weeks. Evaluation drew on informal feedback from mothers, observation of engagement patterns, and discussions with clinic staff.

This pattern works well for students earlier in their careers or in settings where introducing formal screening is not yet feasible. The deliverable is an integrated health education approach that clinic staff can continue using after the project ends.

Example 3: Six-week clinical attachment with documented case work

A registered nurse with several years of clinical experience undertook a six-week attachment in the maternal and child health department of a level-one hospital. During the placement, the student engaged with the routine flow of antenatal, delivery, and postnatal care and identified three specific women whose situations illustrated the complexity of perinatal mental health: a married woman experiencing neglect within a polygamous household, a single mother whose partner had rejected the pregnancy,

and a teenage mother facing rejection and later reconciliation with her partner. For each case, the student documented the assessment, the interventions provided (individual counselling, psychoeducation, family engagement, referral, community linkage), and the outcomes observed. The project closed with reflections on practice and recommendations for integrating mental health care into routine maternity services at the hospital.

This pattern works well for students who already have clinical caseloads and want to use the module to deepen their case-level practice rather than introduce a system-level change.

Example 4: Reflective portfolio of practice encounters

A nurse-midwife at a rural health centre used the module to document cases drawn from her ongoing routine work, with one encounter chosen for each of three competence areas: screening, referral, and psychosocial support. Each case followed a consistent reflective structure — what happened, what went well, what could be improved, the theoretical frameworks relevant to the encounter, what was learned, and what the student would do differently in future. The reflections drew on theoretical models such as Rubin's Maternal Role Attainment, Watson's Theory of Human Caring, Kolcaba's Theory of Comfort, and the WHO stepped-care approach. The overall reflection identified patterns across cases — the prevalence of physical presentations masking emotional distress, the role of social and partner support, the value of cultural sensitivity.

This pattern works well for students who cannot easily mount a discrete intervention but encounter relevant cases regularly through their existing role.

Example 5: Community-level mental health awareness and referral project

A clinical professional working at an antenatal clinic in an urban setting designed a structured community-level intervention spanning routine clinic days over several months. The project combined brief group education sessions with pregnant women during clinic waiting times, individual interviews to assess mental health status and identify stressors, sensitisation sessions for clinic staff, and the establishment of clearer referral pathways to mental health specialists at nearby facilities. The project documented quantitative outputs (women engaged, women referred) alongside qualitative reflections on staff engagement, stigma reduction, and the feasibility of integrating mental health support into routine antenatal care.

This pattern works well for students with a coordinating or research role who can engage a larger number of women and produce more structured data.

Common features of successful projects

Across the project examples above, several features recur in the projects that work well:

- **Locally identified problem.** The student names a specific gap they have seen in their own clinical or community setting — not a generic global issue.

- **Realistic scope.** The project is small enough to complete in the module timeframe and to evaluate meaningfully. Students who try to redesign an entire service typically struggle; those who introduce one well-targeted change typically succeed.

- **Ethical conduct.** Informed consent, confidentiality, and respect for cultural values are addressed explicitly, particularly when working with named individual cases.

- **Multidisciplinary engagement.** Successful projects involve at least one colleague — clinical or community-based — rather than being carried out by the student alone.

- **Reflective analysis.** The project is not only described but interrogated: what worked, what didn't, what the student learned, and what they would do differently.

- **Recommendations for sustainability.** The student articulates how the change might continue after the project ends, even if sustainability is not the student's responsibility to deliver.

Supervisors should use these features as anchors when guiding students through scoping decisions early in the module.

eMAMA consortium, parner meeting in Namibia, 2025

Guidelines and best practices for implementation

Modules can be implemented and used separately

The eMAMA curriculum is built as four modules, but they do not have to be delivered as a single block. Institutions can adopt the programme in several configurations:

Full programme. All four modules delivered sequentially as a postgraduate course or continuing professional development programme. This is the model the curriculum was designed around and is the route to the full eMAMA certificate.

Selected modules. Individual modules can be integrated into existing postgraduate programmes — for example, embedding Module 1 (foundations) into a midwifery master's curriculum, or using Module 3 (intervention) as a stand-alone CPD workshop for working clinicians. Each module has its own learning outcomes and assessments and can be used independently.

Reference materials. Beyond formal teaching, the module content, articles, and app library can be used as reference resources for clinical staff, for trainers preparing their own teaching, or for community-facing health programmes.

The one thing that does not work is delivering eMAMA as a fully self-directed online course with no teacher involvement. The reasoning is given in section 2 and reinforced below.

Module 4 requires supervision

Module 4 is an applied project module in which students design and carry out a small piece of work — typically an intervention, an awareness activity, a service-development proposal, or a structured case analysis — within their own clinical or community setting. This module cannot be delivered without a designated supervisor at the host institution.

The supervisor's role includes:

- Helping the student scope the project so it is feasible within the module timeframe and locally relevant
- Reviewing the project plan before the student begins
- Being available for at least two check-in conversations during the project (more if the project is complex or runs into difficulty)
- Reviewing the final project output and making the pass/fail decision against the criteria provided in the Moodle assessment guidance
- Flagging any ethical or safeguarding concerns that arise during the work

This is the most teacher-intensive component of the programme. Institutions should budget supervisor time accordingly: as a rough estimate, plan for two to four hours of supervisor time per student across the duration of Module 4. Module 4 part of this handbook shows examples of student projects from the eMAMA pilot cohort to give a sense of typical scope.

Pedagogical side – training of trainers materials on the website

Teachers preparing to deliver the eMAMA programme for the first time are encouraged to work through the Innovation Pedagogy (Innopeda) training package developed under the project and hosted on the eMAMA website. The package is designed for educators in higher education and continuing professional development, and provides the underlying pedagogical framework on which the eMAMA modules are built.

Innovation Pedagogy is a strategic approach to teaching and learning, embedded in institutional structures and processes rather than confined to individual classroom techniques. Its core principles are:

- **Integration** — connecting teaching with real-world applications, in our case with the day-to-day reality of perinatal care in the student's clinical setting

- **Flexible curricula** — adapting learning based on student needs and context

- **Multidisciplinary learning** — encouraging cross-sector collaboration (highly relevant for perinatal mental health, which sits across midwifery, nursing, medicine, social work, and community health)

- **Active learning methods** — focusing on problem-solving and teamwork rather than passive content delivery

- **Versatile assessment** — moving beyond exams to real-world competency evaluation, which is reflected in eMAMA's mix of knowledge tests and applied Module 4 work

- **New teacher and student roles** — shifting from passive learning to co-creation of knowledge

The package is available at: https://emama.turkuamk.fi/innovation-pedagogy-package/

How to use Innopeda alongside eMAMA

The Innopeda package provides the pedagogical foundation — how to design and run student-centred, active, digitally-supported learning. The eMAMA Moodle modules provide the subject-matter content — what perinatal mental health teaching for sub-Saharan African contexts actually looks like. Teachers new to the programme will benefit from working through both.

A reasonable preparation sequence is:

1. Work through Innopeda Modules 1 and 4 first (principles and assessment), since these shape how you approach the eMAMA curriculum overall

2. Review Innopeda Modules 2 and 3 (interactive methods, digital tools) before designing your webinar plan for eMAMA Modules 1–3

3. Then read through the eMAMA module content itself, ideally in full, before delivering it to students

4. For Module 4 supervision specifically, consult the assessment criteria in the Moodle course and reach out to the eMAMA consortium if you have questions about scope or standards

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