

Artikel Asli/Original Article

**Healthcare Practitioners' Views of Postnatal Depression: A Qualitative Synthesis
(Persepsi Kakitangan Kesihatan terhadap Kemurungan Selepas Bersalin: Sintesis Kualitatif)**

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ABSTRACT

The World Health Organisation recommends healthcare practitioners to equip themselves with appropriate skills to assess the psychological distress in women attending the antenatal and postnatal healthcare. Nevertheless, little is known about the healthcare practitioners' perceptions of postnatal depression and its management. The aims of this review were: (1) to explore the experiences of healthcare practitioners in caring for women with postnatal depression in different countries and (2) to identify any qualitative study conducted in Malaysia regarding the healthcare practitioners' perceptions of postnatal depression. To achieve these objectives, a qualitative synthesis of studies reporting the healthcare practitioners' experience of managing women with postnatal depression was conducted. A search in CINAHL, PubMed, MEDLINE, PsycINFO and ASSIA databases was performed using specific keywords and published peer-reviewed articles from 2006 to 2016 were screened for inclusion criteria. A total of 15 relevant studies were identified and reviewed. The studies included were conducted in eight different countries: America, Australia, United Kingdom, Brazil, Canada, Greece, Mexico and Slovenia. No study conducted in Malaysia was found. This review suggested that the experiences of managing women with postnatal depression were relatively similar among the healthcare professionals in different countries. The main limitations reported by the healthcare practitioners were the lack of resources on maternal mental health and the absence of policy regarding the management of postnatal depression. Further research should investigate how Malaysian healthcare practitioners perceive postnatal depression and their roles in its management to provide more insights into the current clinical practice in Malaysia for postnatal depression.

Keywords: Healthcare practitioners; postnatal depression; postpartum depression; experience; perspectives; qualitative studies

ABSTRAK

Pertubuhan Kesihatan Sedunia mengesyorkan kakitangan kesihatan untuk melengkapkan diri mereka dengan kemahiran yang sesuai untuk menilai gangguan psikologi pada wanita yang datang untuk pemeriksaan antenatal dan selepas bersalin. Walau bagaimanapun, tidak banyak yang diketahui tentang persepsi kakitangan kesihatan terhadap kemurungan selepas bersalin dan pengurusannya. Tujuan kajian ini adalah: (1) untuk mengetahui pengalaman kakitangan kesihatan dalam menjaga wanita dengan kemurungan selepas bersalin di pelbagai negara yang berlainan dan (2) untuk mengenal pasti sebarang kajian kualitatif yang dijalankan di Malaysia mengenai persepsi kakitangan kesihatan terhadap kemurungan selepas bersalin. Untuk mencapai matlamat ini, sintesis kualitatif telah dilakukan ke atas kajian-kajian yang berkaitan dengan pengalaman kakitangan kesihatan menguruskan wanita dengan kemurungan selepas bersalin. Carian dalam pangkalan data CINAHL, PubMed, MEDLINE, PsycINFO dan ASSIA yang dilakukan menggunakan kata kunci tertentu dan artikel-artikel yang diterbitkan dari tahun 2006 hingga 2016 telah disaring untuk kriteria kemasukan. Sebanyak 15 kajian yang berkaitan telah dikenal pasti dan diteliti. Kajian-kajian tersebut telah dijalankan di lapan negara: Amerika, Australia, United Kingdom, Brazil, Kanada, Yunani, Mexico, dan Slovenia. Tiada kajian yang dijalankan di Malaysia. Kajian ini mencadangkan bahawa kakitangan kesihatan mempunyai pengalaman yang lebih kurang sama dalam menguruskan wanita dengan kemurungan selepas bersalin, walaupun di negara yang berbeza. Halangan utama yang dilaporkan oleh kakitangan kesihatan adalah kekurangan sumber berkaitan kesihatan mental ibu dan ketiadaan dasar mengenai pengurusan kemurungan selepas bersalin. Penyelidikan lanjut perlu dilakukan untuk mengkaji bagaimana kakitangan kesihatan di Malaysia memahami kemurungan selepas bersalin dan bagaimana mereka memahami peranan mereka dalam pengurusannya untuk memberikan gambaran lebih jelas mengenai amalan semasa di Malaysia..

Kata kunci: Kakitangan kesihatan; kemurungan selepas bersalin; pengalaman; perspektif; kajian kualitatif

INTRODUCTION

Postnatal depression (PND) is a common maternal mental health problem which occurs worldwide at a prevalence ranging from 4.0% to 63.9% (Siti et al. 2018). Recent studies have shown that PND not only causes an increased risk of suicide among the postnatal women (Weng et al. 2016) but also contributes to the behavioural problems and negative emotions in the children (Netsi et al. 2017; Prenoveau et al. 2017). Despite the various negative consequences associated with PND, there is still a lack of effective measures taken to prevent PND. In fact, it has been reported that within the clinical practices, PND is often underdiagnosed and undertreated (Yawn et al. 2012).

Healthcare practitioners (HCPS) within the perinatal care provision are expected to facilitate the awareness of maternal mental health and promote the help-seeking behaviour among women who experience depressive episodes postnatally. In addition, HCPS should recognize any early depressive symptoms and warning signs in the affected mothers to allow early detection and intervention for postnatal depression. As recommended by the World Health Organisation, all HCPS should have appropriate skills to assess psychological distress in women attending the antenatal and postnatal healthcare (WHO 2008). To improve the effectiveness of PND management, it is important to explore the HCPS' perceptions of this mental health issue and their experience in providing care for the affected women.

Over the years, numerous studies have been conducted to investigate the HCPS' perceptions of PND. Nevertheless, there is little evidence in the existing literature which evaluates the perceptions of HCPS about PND and its management, across different cultures and countries. Therefore, this research aimed to review the experiences of HCPS in caring for women with PND in different countries and cultures. The second objective of this study was to identify any qualitative study regarding HCP's perceptions of PND that has been conducted in Malaysia. It is believed that understanding how the HCPS perceive PND and their roles in managing it would uncover important details of PND management in the current clinical practices.

METHODOLOGY

A qualitative synthesis of studies reporting the experiences of HCPS in managing women with postnatal depression was conducted. This approach was selected as it would allow the researchers to aggregate or summarize the previous qualitative data through a systematic method of scientific inquiry (Noblit & Hare 1988). Unlike literature reviews, the outcome of this qualitative synthesis would be a generation of new themes or new areas of inquiry. The quality of the papers and the methods and methodology of the selected articles were assessed using the Critical Appraisal Skills Program (CASP) (Public Health Resource Unit 2006). In

addition, the results of this research were reported based on the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement.

SEARCH STRATEGIES

The following online databases were searched: CINAHL, PubMed, MEDLINE, PsycINFO and ASSIA. Keywords including healthcare practitioners, postnatal depression, postpartum depression, experience, perspectives and qualitative studies were used in various combinations. Additionally, the reference lists of the included studies were inspected to capture more relevant references. The eligibility of the studies was then assessed in three different stages: screening titles, abstracts and full text (Figure 1).

Based on the inclusion criteria (Table 1), the search finally identified a total of 15 studies which provided information related to the experiences of HCPS in caring for women with PND.

APPROACH TO ANALYSIS

A thematic synthesis approach was used to identify the domains related to the experiences of HCPS in treating women with PND across different cultures and countries. Adopting this approach, recurring concepts across the selected articles were determined. These concepts were analyzed and the new interpretations were then drawn (Khan et al. 2007; Thomas & Harden 2008). Specifically, the outcomes were achieved via three analytical stages: free line-by-line coding of textual findings, organization of 'descriptive themes' and generation of 'analytical themes' (Thomas & Harden 2008).

The analysis of the articles began with the coding of the textual findings whereby the findings section of the articles was read line by line. Following this step, the 'descriptive themes' were developed and then compared among the selected articles. Next, the 'descriptive themes' were refined to introduce a higher level of abstraction. Within this step, some initial themes were retained, whereas others were grouped into a more abstract level as the analysis progressed. Furthermore, new language/terms were used to represent the original meaning of the participants' descriptions in the selected articles while retaining their overall meaning. The finalized theme of this process was known as the 'analytical themes'. The 'descriptive themes' and 'analytical themes' were developed within consensus among research team. Subsequently, a final consensus regarding the themes was generated and the credibility and confirmability of the findings were verified. The analyses of the results reported by the included studies were organized under five themes in this paper: (1) understanding postnatal depression; (2) perceived causes; (3) managing women with postnatal depression; (4) challenges and limitations; and (5) strategies for interventions. The findings were further discussed in the following sections.

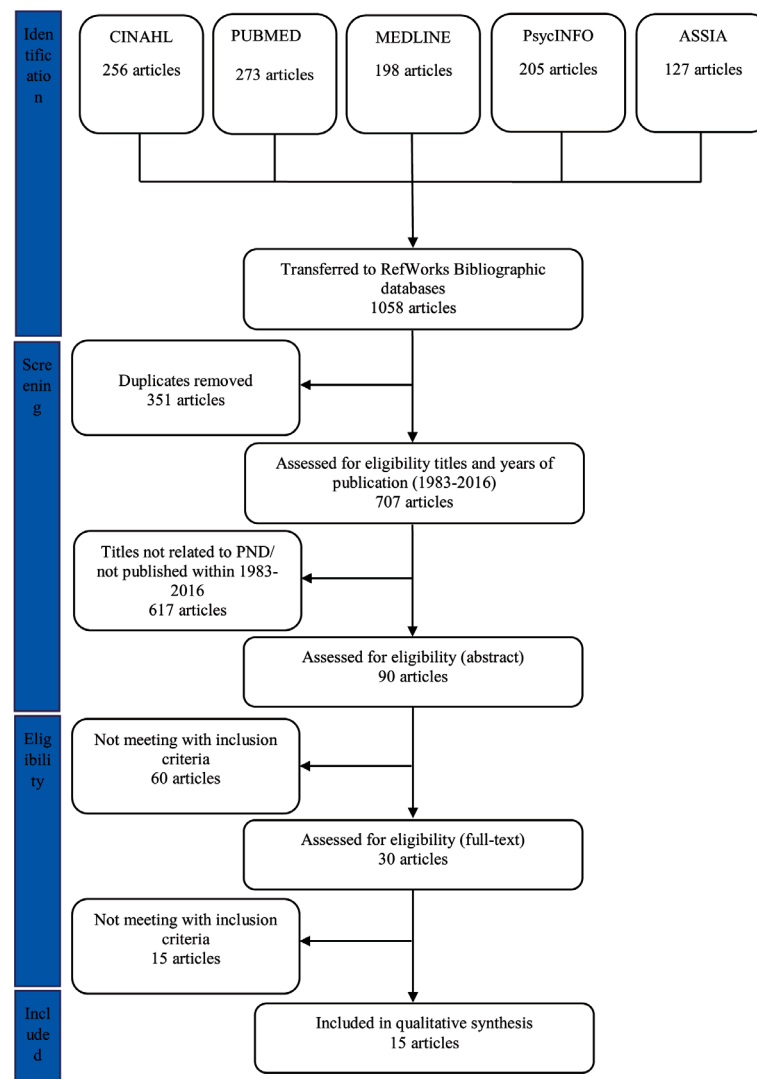


FIGURE 1. Flow diagram of the search strategy

TABLE 1. Inclusion and exclusion criteria of the selected articles

Inclusion criteria	Exclusion criteria
Described HCPs' experiences in caring for women with PND	Not peer reviewed papers
Were carried out among HCPs (e.g. midwives, nurses, health visitors, doctors, general practitioners and paediatricians)	Not published in English/Malay
Used qualitative methods of data collection and analysis (either a stand-alone study or a discrete part of a larger mixed method study)	
Have been peer reviewed	
Published in English/Malay in academic journals between 1983 and 2016	

QUALITY APPRAISAL

Based on the CASP quality assessment (Table 2), the overall quality of the included papers was high. Among the 15 papers, only one study fully met the CASP criteria and 14 studies fulfilled most of the criteria. The most common

limitation of the included studies was related to the issues of reflexivity (not reported in 13 studies).

TABLE 2. Quality appraisal outcome using Critical Appraisal Skills Programme

Authors (Year)	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Quality rating
Tong & Chamberlain (1999)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Most
Lloyd & Hawe (2003)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Can't tell	Most
Bilszta (2010)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes	Most
Rush (2012)	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	Yes	Yes	Most
Belle & Willis (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Most
McConnel (2005)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Most
Brown & Ruth (2006)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Can't tell	Yes	Most
Chew-Graham et al. (2008)	Yes	Yes	Can't tell	Yes	Yes	No	No	Yes	Yes	Yes	Most
Junior et al. (2013)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Most
Teng et al. (2007)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Most
Agapidaki et al. (2014)	Yes	Yes	Can't tell	Yes	Yes	No	Can't tell	Yes	Yes	Yes	Most
Place et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	All
Mivšek et al. (2008)	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Can't tell	Yes	Yes	Most

RESULTS

As shown in Table 3, the selected studies were conducted in eight different countries: five studies in Australia, three in the UK, two in the USA, one in Brazil, one in Canada, one in Greece, one in Mexico and one in Slovenia. There was no study conducted in Malaysia. Furthermore, Table 3 presented the characteristics of the included studies. A total of 267 HCPS were involved. Among the 15 papers, ten involved face to face in-depth interviews, three involved focus groups, one involved telephone interview and one involved a combination of interviews, observations and field diary records. All studies were conducted among HCPS except for one study which also included the women with PND and the community members.

In this paper, the analyses of the results of the included studies were organized under the thematic clusters of (1) understanding postnatal depression; (2) perceived causes; (3) managing women with postnatal depression; (4) challenges and limitations; and (5) strategies for interventions.

Despite the varying perspectives demonstrated by the HCPS on PND, the majority of them agreed that PND was caused by the personal experience and the social circumstances of the women. Generally, the HCPS acknowledged their roles in treating women with PND and how their limited knowledge about PND would impact on the care provided to these women. Nevertheless, other limitations in the management of this maternal mental health issue were also reported. The two main limitations were the lack of resources within the healthcare system and a poor understanding of PND among the women. Considering these limitations, most of the HCPS believed that the strategies to improve the management of PND should include upgrading the existing healthcare services and raising awareness in the society.

UNDERSTANDING POSTNATAL DEPRESSION

The HCPS from different studies demonstrated varying understanding and perspectives of PND. Most commonly, PND were discussed based on the signs and symptoms by the HCPS. These HCPS mainly detected PND from the observational or empirical signs, such as withdrawal, sadness, lack of interest in the infant and weight loss (Heneghan et al. 2007; Mivsek et al. 2008; Junior et al. 2013; Agapidaki et al. 2014; Place et al. 2015). On the other hand, some HCPS conceptualized PND based on the impacts it could have on the functioning and well-being of the women, the child and the family (Lloyd & Hawe 2003). These impacts included inability of the women to fulfil maternal duties, self-harm or harm of others, child abuse and developmental problems for the child (Lloyd & Hawe 2003; Agapidaki et al. 2014; Place et al. 2015). In addition, there were HCPS who did not conceptualize all distress as PND. Instead, these HCPS viewed PND as ‘a worry about their condition and their situation at home’,

‘emotional turmoil rather than depression’ or described the distress as ‘pathologized’ or exaggerated by the women (Lloyd & Hawe 2003; Chew-Graham et al. 2008; Place et al. 2015).

PERCEIVED CAUSES

In explaining the causes of PND, the HCPS primarily described psychosocial factors as the origins of the disorder with only a minority of them perceiving biological factors as the important causes (Junior et al. 2013; Place et al. 2015). In this review, psychosocial factors refer to the women’s psychological aspects and their interactions with the social network. Two psychosocial factors, namely the personal factors and the social circumstances would be further discussed in relation to women.

Women’s personal factors refer to the adjustment to motherhood and their personality (Lloyd & Hawe 2003; Belle & Willis 2013; Bilszta et al. 2010; Place et al. 2015). It was claimed by the HCPS that women were more likely to develop PND when they were unable to accept the changes of motherhood. The HCPS were reported to believe that PND occurred when a woman failed to adapt to the features of motherhood, such as sleep deprivation, stress of taking care of a newborn and modifications in the family dynamics (Place et al. 2015). Additionally, some HCPS perceived the personality of a woman as the contributing factor of PND particularly when the woman was ‘prone to perfection’ (Mivsek et al. 2008).

Compared to the women’s personal factors, social circumstances were more often regarded as the cause of PND by the HCPS. A large number of the HCPS attributed PND mainly to the social circumstances, such as a lack of social and family support, financial problems and unemployment (Lloyd & Hawe 2003; Belle & Willis 2013; Agapidaki et al. 2014; Place et al. 2015). Furthermore, previous history of mental health problems or depression, unplanned pregnancies, unfulfilled expectations, difficulty in birth and child’s health problems were also the well-recognized social factors that could precipitate PND (Chew-Graham et al. 2008; Belle & Willis 2013; Agapidaki et al. 2014; Place et al. 2015). In addition to these circumstances, HCPS stated that the tendency of the media to portray mothers as the glamorous figures could result in an underestimation of the difficulties that the women may experience following childbirth. They explained that not only do women have unrealistic expectations on motherhood but the community also understand little about the magnitude of change that women, partners and families experience after having a newborn (Lloyd & Hawe 2003; Bilszta et al. 2010; Belle & Willis 2013).

In summary, most HCPS believed that psychosocial factors contributed majorly to the occurrence of PND among women. A comparison of the perceived causes between studies or countries could not be made as the causes were not reported in six studies (McConnell et al. 2005; Brown & Bacigalupo 2006; Heneghan et al. 2007; Teng et al.

TABLE 3. Characteristics of the included studies

Country	Authors	Objectives	Research design	Data collection	Qualitative analysis
Australia	Heneghan et al. (2007)	To assess the paediatricians' beliefs about discussing maternal depressive symptoms during a paediatric visit; and to determine the methods used by the paediatricians to identify mothers with depressive symptoms.	Qualitative approach	Open-ended interviews with ten nurses and seven physicians; observations and field diary records.	Inductive content analysis
	Abrams et al. (2009)	To investigate the barriers to formal help-seeking for PPD symptoms among the low-income ethnic minority mothers in the United States.	Grounded theory approach	Two focus groups: 12 medical setting service providers and social workers (also involved focus groups and individual interviews with 14 mothers with PPD symptoms and 11 community key informants).	Constant comparison
Brazil	Junior et al. (2013)	To explore the experiences of Brazilian physicians and nurses caring for women with postpartum depression in the primary healthcare settings.	Qualitative approach	Semi-structured telephone interviews: 18 participants.	Content analysis
Canada	Teng et al. (2007)	To identify the potential barriers to care that recent immigrant women may encounter as perceived by the healthcare workers; and to identify challenges healthcare workers felt that they faced as providers of care to this population.	Qualitative approach	Semi structured interview: 16 key informants from various disciplines employed by healthcare agencies providing care to postpartum immigrant women in Toronto.	Constant comparison
Mexico	Place et al. (2015)	To describe the knowledge frameworksto conceptualize postpartum depression.	Grounded theory approach	Semi structured interviews: 61 physicians, nurses, social workersand psychologists from five public-sector health care facilities.	Grounded theory analysis
UK	McConnel (2005) Brown & Ruth (2006) Chew-Graham et al. (2008)	To examine how health visitors understand and make sense of PND. To determine how health visitors identify PND and the implications this may have for practice. To explore the views of GPs and health visitors on the diagnosis and management of PND.	Qualitative approach Qualitative approach A qualitative study nested within a multicentre randomised controlled trial	Semi structured interviews: eight health visitors. Semi structured interviews: six health visitors.	Grounded theory analysis Thematic analysis Qualitative analysis
Greek	Agapidaki et al. (2014)	To investigate, identify and interpret the views of paediatric primary healthcare providers on the recognition and management of maternal depression in the context of a weak primary healthcare system.	Qualitative approach	Face to face in-depth interviews: 26 paediatricians and health visitors.	Framework analysis
Slovenia	Mivšek et al. (2008)	To explore the knowledge and attitude of Slovenian midwives and nurses in relation to postnatal mood disorders.	Qualitative approach	Two focus groups: ten HCPs working in the maternity hospital and in the community centre.	Qualitative analysis
Australia	Tong & Chamberlain (1999) Lloyd & Hawe (2003) Bilszta (2010)	To investigate the midwife's knowledge of PND and awareness of risk factors. To investigate the different ways in which PND is framed and to give clues to alternative approaches in solving the problem of PND. To gain insight into the experiences, beliefs, attitudes and personal views of postnatal emotional distress, from the perspective of the HCPs.	Phenomenology Qualitative approach Qualitative approach	Semi structured interviews: seven midwives. A series of one-to-one semi structured interviews were conducted among ten professionals who were academics, clinicians and bureaucrats in two Australian cities. Two focus groups: 16 HCPs	Colaizzoi's phenomenological approach Firming analysis Qualitative analysis
Australia	Rush (2012) Belle & Willis (2013)	To improve the understanding of the experience of MCH nurses responding to women at risk of PPD To explore the extent to which Child and Family Health Nurses (CHNs) exercise autonomy as specialist HCPs within the community health setting.	Phenomenology Qualitative approach	Interview: 8 MCH nurses (two were sought from each of the four councils). Semi structured interviews: 10 community nurses.	Phenomenological method Thematic analysis

2007; Junior et al. 2013; Rush 2012). Meanwhile, the role of hormonal imbalance in the development of PND was only mentioned in two studies (Junior et al. 2013; Place et al. 2015).

MANAGING WOMEN WITH POSTNATAL DEPRESSION

With regards to the management of PND, there were mixed opinions as to whether caring for women with PND was part of the roles of HCPS. HCPS who denied treating the affected women as part of their responsibilities justified their opinion by claiming that they 'had nothing to offer women themselves and no resources to refer women to', 'have no role in the prevention and treatment of PND', 'were not familiar with PND' and that PND should be treated by other HCPS, such as general practitioner, psychologists and psychiatrist (Chew-Graham et al. 2008; Mivsek et al. 2008; Place et al. 2015; Junior et al. 2013).

On the contrary, some HCPS opined that it should be their obligation to care for the women with PND. In relation to the postnatal adjustment, it was believed that the HCPS should create an opportunity to discuss and explore 'what is normal' and 'what is depression' with the women after childbirth (Bilszta et al. 2010; Agapidaki et al. 2014). For instance, the psychologists in Mexico appeared to consider themselves as 'the professionals who determined the legitimacy of PND', whereas the community health nurses in Australia seemed to view maternal sadness as 'distinct to her role' (Belle and Willis 2013; Place et al. 2015). Meanwhile, the paediatricians in the USA appeared to believe themselves as part of the women's support system because they 'have frequent contact' with the women (Heneghan et al. 2007).

Furthermore, the HCPS who acknowledged their roles in the management of PND discussed their responsibilities in making diagnosis, initiating treatment and providing support for the women. One of the initial strategies to diagnose PND was to identify the clinical features of the disorder. For early detection of the signs and symptoms of PND, the most common approach used by the HCPS was to conduct a general assessment in their routine care using the Edinburgh Postnatal Depression Scale (EPDS) (Place et al. 2012; Rush 2012; Belle & Willis 2013; Agapidaki et al. 2014). In addition, HCPS including the social workers, nurses, health visitors, physicians and paediatricians claimed to pay careful attention to the 'observable depressive symptoms' during the medical exams or when obtaining patients' vital signs or social histories (Agapidaki et al. 2014; Place et al. 2015). Moreover, the HCPS believed that a good rapport between them and the women could facilitate the maternal disclosure of any depressive symptoms, thus allowing an early diagnosis and intervention of the disorder (Heneghan et al. 2007; Chew-Graham et al. 2008; Mivsek et al. 2008; Agapidaki et al. 2014). Furthermore, the review revealed that HCPS often prioritized the physical well-being of the patients over the maternal mental health, leading to the underdiagnosis and undertreatment of PND.

Additionally, making referral was deemed as an important step by the HCPS in managing or initiating treatment for women with PND (Junior et al. 2013; Rush 2012; Belle & Willis 2013; Agapidaki et al. 2014). They explained that the purpose of making referral was to ensure a better care for the mother from the mental health specialist and more importantly, the safety of both the mother and the child (Agapidaki et al. 2014). Depending on which disciplines the HCPS were in, the referral centre could be general practitioners, parenting services, mother and baby units, social workers, psychologists, or psychiatrists (Junior et al. 2013; Rush 2012; Belle & Willis 2013).

Based on the review, treatment options for PND were not discussed in any study except for one Australian study whereby Rush (2012) explored the experience of eight MCH nurses in responding to women with PND. Among treatment options mentioned by the nurses were open sessions, additional visits/phone calls, new parents' groups, support groups and special programmes (e.g. baby steps and 'managing motherhood').

CHALLENGES AND LIMITATIONS

Although some HCPS recognized their roles in the management of PND, they were challenged by numerous limitations that originated from their personal boundaries, the healthcare system and the women's society. While these limitations were repeatedly highlighted by the HCPS from other countries, the Australian HCPS seemed to discuss the limitations less (Rush 2012; Bilszta et al. 2010).

From the perspective of HCPS, the common barriers reported across the studies were time constraints and inadequate knowledge (Heneghan et al. 2007; Mivsek et al. 2008; Junior et al. 2013; Rush 2012; Agapidaki et al. 2014). Due to the time-limited visits, HCPS often failed to establish a good relationship with the women, therefore reducing their ability to detect the depressive symptoms in the affected mothers (Mivsek et al. 2008). Furthermore, a lack of knowledge and training resulted in (1) misunderstanding of the signs and symptoms of PND; (2) inability to differentiate PND from other types of maternal distress; (3) uncertainty in detecting mild postnatal depressive symptoms; (4) unpreparedness to respond to women with PND in an efficient way; (5) lack of confidence in approaching women who could potentially be suffering from PND; (6) underestimation of the incidence of this mental disorder; (7) incorrectly labelling depressive symptoms as a normal part of motherhood; and (8) conducting the assessment of PND based on the women's appearance, childcare skills and communication styles (Abrams et al. 2009; Bilszta et al. 2010; Mivsek et al. 2008; Junior et al. 2013; Place et al. 2012; Agapidaki et al. 2014).

In addition, inadequacies within the healthcare system were claimed to have an impact on the management of this maternal mental health issue. Two limitations which were commonly reported by the HCPS were the lack of resources

and the absence of policy regarding the management of PND. In relation to the resources, the HCPS claimed that the PND management was limited by a lack of expertise in the maternal mental health, an unavailability of the free community mental health services, a poor collaboration between the community services and the mental health services and the absence of assessment tools within the clinical practice (Heneghan et al. 2007; Teng et al. 2007; Chew-Graham et al. 2008; Mivsek et al. 2008; Place et al. 2012; Agapidaki et al. 2014).

Next, the women's views and perceptions of PND were also described by the HCPS as an important factor influencing the management of PND. It was reported that the care provided by the HCPS was challenged when the women had fears of being stigmatized. The women were described as hesitant in using the psychotropic medication, unreceptive to options such as referral, not acknowledging the feelings of depression or anxiety and believing that they should always display an image of good mother (Heneghan et al. 2007; Teng et al. 2007; Chew-Graham et al. 2008; Abrams et al. 2009; Bilszta et al. 2010; Agapidaki et al. 2014). Due to the stigmas of mental disorder and motherhood, the women affected with PND were often reluctant to seek help, therefore limiting the management of their emotional distress.

STRATEGIES FOR IMPROVEMENT

In response to the abovementioned limitations in delivering care for women with PND, several strategies were proposed by the HCPS, including upgrading the healthcare system and creating awareness about PND in the society. Again, it was noted that such interventions were discussed more by the HCPS from other countries, such as Greek and the USA but were not widely described by the HCPS in Australia.

There were various potential interventions suggested by the HCPS to upgrade the healthcare services, especially the maternal mental health services. Based on the review, HCPS appeared to be aware of the preference of women for non-medical language and their resistance to being regarded as mentally ill (Abrams et al. 2009; Bilszta et al. 2010). Due to these reasons, the HCPS recommended framing treatment for PND to be non-judgmental and not fully based on the medical model (Heneghan et al. 2007; Abrams et al. 2009; Bilszta et al. 2010). In addition, training courses were suggested by the HCPS to build their confidence and enhance their knowledge about PND (Heneghan et al. 2007; Teng et al. 2007; Agapidaki et al. 2014). Early detection of postnatal depressive symptoms was also suggested although there were mixed opinions regarding the use of screening tools (Heneghan et al. 2007; Bilszta et al. 2010; Junior et al. 2013; Agapidaki et al. 2014). Furthermore, the HCPS also highlighted the importance of the availability of appropriate physical facilities; the accessibility of a mental health specialist for consultation in the community setting; and the collaboration between community health and mental health services in improving the healthcare services

for women with PND (Heneghan et al. 2007; Bilszta et al. 2010; Agapidaki et al. 2014).

On the other hand, in creating awareness in the societies, HCPS proposed that the interventions for the prevention of PND could be targeted at the mothers, the partners, the family, the community networks and the local governments (Lloyd and Hawe 2003; Heneghan et al. 2007; Mivsek et al. 2008; Bilszta et al. 2010; Junior et al. 2013; Agapidaki et al. 2014). Moreover, parenting classes and telephone information hotlines were suggested as ways to provide women with information and support to reduce their stress of parenting and therefore alleviate any depressive symptoms (Heneghan et al. 2007). Although the mechanism of these interventions remained unspecified, HCPS believed that such interventions, if designed to increase the public awareness on PND, could eliminate the stigmatization associated with it (Agapidaki et al. 2014).

DISCUSSION

Based on the review, it could not be concluded whether the HCPS from different countries shared similar definitions of PND as this was not directly reported in all studies. This finding was mainly because the focus of the studies and the discussions about PND by the HCPS varied within the articles. Nevertheless, it could be established from this review that the experiences of HCPS in caring for women with PND were not entirely different across the different countries and cultures.

Generally, the HCPS' perception of their roles in the management of PND appeared to be influenced by the availability of policy and training received by them regarding maternal mental health. For instance, most of the Australian HCPS were less likely to report limitations in the PND as compared to the HCPS from other countries, suggesting that they had received more training on the maternal mental health (Tong & Chamberlain 1999; Lloyd & Hawe 2003; Belle & Willis 2013). In a study conducted in Australia, the majority of the MCH nurses claimed to be confident in responding to women with PND due to their familiarity with the local GPs and counsellors, self-education, clinical supervision and on-the-job experience (Rush 2012). The author justified that, in Australia, there were numerous resources available with regards to PND: pamphlets of emotional health during pregnancy and early parenthood, screening programmes for PND and various interventions for the mothers at risk of PND, such as additional consultations by home visit, clinic visit or telephone (Rush 2012; Belle and Willis 2013). Presumably, the presence of these resources increased the confidence of the HCPS in Australia in managing PND, regardless of their seniority or level of positions.

This review found no qualitative studies on the HCPS' perceptions of PND in Malaysia. A small-scale quantitative study conducted in a teaching hospital in Malaysia suggested that more than 50% of the nurse-

midwives confused PND with postnatal 'blues' (Keng 2005). This finding clearly indicated a lack of knowledge of PND among the Malaysian nurses. Nevertheless, the quantitative approach used by the study limited further explanation of the misconception, signifying the need for further qualitative research on this topic.

CONCLUSION

Overall, this review established two important findings. Firstly, although the HCPS' experiences of caring for women with PND across different countries were not entirely different, the HCPS' perception of their roles in managing PND appeared to be influenced by the presence or absence of the policy and guidelines. Secondly, no qualitative study on the HCPS' perspectives of PND had been conducted in Malaysia. Therefore, further research should be conducted to investigate how Malaysian HCPS perceive PND and their roles in its management to gain more insights into the current clinical practice in Malaysia for PND.

Additionally, this review discovered that the HCPS were often challenged by the social stigma in managing women with PND, whereby the affected women were reluctant to seek help due to their fear of being diagnosed. It was uncertain if such stigmatization would exist in different cultures or countries due to the lack of qualitative studies conducted in the multicultural communities.

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