

Implementing Guidelines to Manage Perinatal Depression: Exploration of the Healthcare Provider's Perceptions

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Abstract

Perinatal mental health guidelines are still lacking in more than 80% of low- and middle-income countries. World Health Organization has outlined the importance of an evidence-informed approach for developing and sustaining high-quality integrated mental health services for women during the perinatal period.

Method: The study explored healthcare providers' perceptions of implementing guidelines to manage perinatal depression in primary healthcare settings in Namibia. A qualitative, explorative, descriptive, and contextual design was applied to collect data from a purposively selected sample of 12 healthcare providers. This involved two focus groups with healthcare providers. Thematic analysis of the interview transcripts was conducted simultaneously with data collection.

Findings: The study highlighted three major themes for successfully implementing the guidelines to manage perinatal depression: the significance of implementing the guidelines, integration of the guidelines into perinatal care settings, and barriers to implementing the guidelines.

Conclusion: Healthcare providers were aware of poor maternal mental health provision within perinatal care settings and were ready to implement the guidelines to manage perinatal depression. Professional training and continuous education on perinatal depression are fundamental components in fostering quality of care and community awareness, as well as improving stigma within the community and healthcare providers.



Keywords: depression; implementation; perinatal depression; perinatal period; perinatal guidelines

Introduction and Background

Perinatal depression is disregarded as a public health concern that has only recently received proper attention during the past 20-30 years (Burger, 2020). According to DSM 5, perinatal depression is a major depressive episode occurring in the antenatal or postpartum period (American Psychiatric Association, 2013). Perinatal depression is associated with numerous adverse outcomes, such as disrupted maternal functioning, disordered mother-infant interactions, impaired growth and development of the infant, as well as psychological, behavioural, and cognitive difficulties in descendants (Gentile, 2017). Concerning the detrimental effects perinatal depression has on women and babies, perinatal mental health is now gradually being included in policy and clinical practice considerations for maternal, newborn, and child health around the world to improve health outcomes. In 2022, the World Health Organization (WHO) published the *Guide for integrating perinatal mental health in maternal and child health services*. The guide draws an evidence-informed approach for developing and sustaining high-quality integrated mental health services for women during the perinatal period (WHO, 2022).

The incidence of perinatal depression is higher in women from low- and middle-income countries. A study in five low- and middle-income countries, namely Ethiopia, India, Nepal, Uganda, and South Africa, found that the prevalence of perinatal depression ranged between 30% and 50% (Baron et al., 2016). Worldwide, perinatal depressive disorders contribute between 5% and 20% of the disease burden of women during the perinatal period (Gressier et al., 2017). About 11.9% of women affected by perinatal depression are from low- and middle-income countries, including Namibia (Woody et al., 2017).

A situational analysis conducted in five low- and middle-income countries, namely Ethiopia, India, Nepal, South Africa, and Uganda, found that maternal mental health services and around 80% of guidelines to manage perinatal depression were sorely lacking (Baron et al., 2016). Although strategies and guidelines for the provision of maternal mental health have been developed, some have yet to be fully implemented (Baron et al., 2016).

Perinatal depression and its associated contributing risk factors may be addressed through psychosocial interventions and screening (Stewart et al., 2013). Maternal mental health guidelines in reproductive health care, integration of depression management in existing screening tools, awareness creation, task shifting, and capacity building are recommended as tools to effectively address perinatal depression (Ng'oma et al., 2019). There is evidence that midwives may effectively intercede to reduce depressive symptoms during perinatal screening (Pratico, 2019).

A screening programme conducted by Khanlari, Ogbo, and Eastwood (2019) in Sydney, Australia, identified that screening for perinatal depression improved early detection, assessment, and management of perinatal depression. Several screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS), Self-Reporting Questionnaire (SRQ), Beck Depression Index (BDI), Hopkins Symptoms Check List (HSCL-15), and Centre for Epidemiological Studies Depression Scale, have been validated for use during perinatal care in various countries and low-resource settings, because of their accuracy, sensitivity, specificity and clinical usefulness (Chorwe-Sungani & Chipps, 2017; Natamba et al., 2014). However, none of the abovementioned tools have been used in Namibian perinatal care settings. Additionally, there are no guidelines to manage perinatal depression in women attending perinatal care settings in Namibia, and mental health services are not always readily available.

Despite challenges in reaching the maternal and child health millennium developmental goals, Namibia has achieved 95% perinatal care coverage, above the ratified target (MOHSS 2017). The researchers believe that high enrolment in perinatal care in many parts of the country offers an excellent opportunity to introduce guidelines to manage perinatal depression. Dealing with perinatal depression and its causes may aid in achieving Sustainable Development Goal (SDG) 3, which focuses on safeguarding healthy lives and promoting well-being for all ages (Izutsu et al., 2015; Patel et al., 2018). There is a global need for countries to scale up services for women affected by mental disorders, including perinatal depression (Rahman et al., 2013).

Therefore, the implementation of guidelines to manage perinatal depression in primary healthcare settings may address the gap in screening for perinatal depression. It will also play a role in achieving the Government of Namibia's aim of integrating perinatal mental health into primary health care settings (MOHSS, 2017), making perinatal depression a public health agenda in Namibia.

Methods

Design

The study used a qualitative exploratory, descriptive, and contextual design to collect data from 12 healthcare providers. The exploratory design was important to use since little was known about the implementation of guidelines to manage perinatal depression. The descriptive design delivered an in-depth and holistic description of the implementation of these guidelines. Focus group interviews were used to allow healthcare providers to engage and elicit details from each other on their perceptions of the implementation of guidelines to manage perinatal depression.

Study Participants and Sampling Strategy.

The researchers purposively selected participants at two perinatal healthcare facilities in Namibia's Windhoek district. The sites were selected as they serve large populations of perinatal women. The criteria for participation in the study were healthcare providers

working in two perinatal care settings, including midwives, doctors, social workers, and nurse managers, with two years of working experience. These healthcare providers were invited for semi-structured interviews. The researchers explained the study's aim and read the information sheet to prospective participants, including the benefits and risks of the study. Twelve healthcare providers consented and participated in the study.

Data Collection

The data collection occurred in the boardrooms at the two hospitals in the Windhoek district. Two focus groups of 4 and 8 participants were held, including nurse managers, social workers, and senior midwives. Due to a busy schedule, doctors did not attend focus group discussions. Discussions were audiotaped and recorded. The focus group discussions were semi-structured, with the researchers as facilitators asking questions to start the debate but allowing participants to debate and speak freely. Participants were recommended to speak one after another until a specific theme was saturated, and then the facilitator would ask another question. The questions used as a focus group guide were:

What is your perception of the implementation of the guidelines to manage perinatal depression?

What could be the barriers/hindrances to the feasibility and acceptability of the implementation of guidelines to manage perinatal depression at the Primary Health Care level?

Table 1: Research Participants

| | Senior midwives | Social worker | Nurse manager | Work experience of perinatal care |
|---------------|-----------------|---------------|---------------|-----------------------------------|
| Focus group 1 | 5 | 1 | 2 | 5 and above |
| Focus group 2 | 2 | 0 | 2 | 5 and above |

Data Analysis.

The transcripts of the audio tape recordings from the focus groups were analysed using thematic analysis. First, the interviews were transcribed verbatim. All three researchers participated in analysing transcripts, interpreting the focus group data, and creating themes and subthemes from the data. The researchers read the transcripts and listened numerous times to the audio recordings to familiarise themselves with the data and confirm the transcripts' accuracy. The researchers coded the data separately and grouped

themselves to discuss the themes and subthemes. The discussion aimed to acquire the many ways in which the data were interpreted and to justify such interpretations and not seek consensus. Researchers were permitted to change their themes based on discussion to ensure that all themes and subthemes could be linked with the quotes from the participants. The difference in interpretations was required to create some form of theme saturation, such that if any different researchers were given the same data, they would produce the same themes and subthemes. This ensured the confirmability of the data.

Trustworthiness

The study ensured trustworthiness using the criteria of transferability, credibility, dependability, and conformability (Polit & Beck, 2017). The researchers ensured credibility by audio recording the interviews, transcribing the recordings verbatim, observational notes, and member-checking. Confirmability was guaranteed by keeping an audit trail, recording interviews, and supporting the themes with participants' quotes. Data consistency ensured dependability, and the researchers agreed on the final themes and sub-themes. Transferability in this study was enhanced by giving a dense description of the context, the setting of the study, and the participants' characteristics.

Ethical Considerations

Before data collection, the Research Ethics Committee of the Namibian Ministry of Health and Social Services granted ethical approval, and the medical superintendents of the two hospitals also granted permission.

Findings

The data analyses from the healthcare providers in focus groups 1 and 2 generated almost similar findings, and we, therefore, chose to present them together, distinguished by representing focus groups one, a and b, and focus group two. Three main themes emerged from this study; namely, the significance of implementing the guidelines to manage perinatal depression, integration of the guidelines to manage perinatal depression into perinatal care settings, and barriers to the implementation of the guidelines to manage perinatal depression and their sub-themes are presented in Table 2. They are described in the subsections that follow.

| Theme | Sub-themes |
|--|--|
| 1. The significance of implementing the guidelines to manage perinatal depression. | <ol style="list-style-type: none"> 1. Preventing babies from being abandoned and infanticide. 2. Providing psychosocial interventions. 3. Prevent complications during pregnancy and post-natal 4. Early identification of prenatal depression 6. Providing holistic care |
| 2. Integration of the guidelines to manage perinatal depression into perinatal care settings | <ol style="list-style-type: none"> 1. Routine screening for perinatal depression 2. Short, valid, and cultural screening tool 3 Providing adequate resources. 4. Multidisciplinary team 5 Creating awareness. |
| 3. Barriers to the implementation of the guidelines to manage perinatal depression. | <ol style="list-style-type: none"> 1. Lack of knowledge of how to manage perinatal depression. 2. Healthcare provider's negative attitudes 3. Lack of ethical consideration |

Theme One: Significance of Implementing the Guidelines to Manage Perinatal.

The first theme during data analysis was the significance of implementing guidelines to manage perinatal depression, and six sub-themes are described.

Sub-theme 1: Preventing Babies from Being Abandoned and Infanticide.

According to the participants, the implementation of the guidelines might prevent some social phenomena from happening in society, such as baby abandoning, killing, and suicide. According to the participants:

P1a: Implementing the guidelines is especially important because it is going to help the mothers and the babies; if we intervene during pregnancy, it might avoid consequences such as baby killing and neglect.

P2a: Implementing the guidelines may prevent some of the evil things mothers are committing, such as baby dumping, baby killing, and putting them in the freeze.

P5a: Currently, we are faced with social issues such as mothers dumbing their babies at once after giving birth and suicide among pregnant and postnatal mothers. I believe some of these social issues might be prevented with the implementation of the guidelines.

Sub-theme 2: Providing Psychosocial Interventions.

Participants believed that the implementation of the guidelines would help women diagnosed with depressive symptoms as they would be provided with different

psychosocial interventions. They would learn how to cope and face the challenges. According to participants:

P2a: The importance of screening patients will be aware of what happens during pregnancy because we will counsel them.

P3a: The good thing about the guidelines is everyone will know what to do when it comes to perinatal depression; those with depressive symptoms, we give them psychosocial interventions; as you said, there are different interventions because if there is no policy or guidelines, everyone is doing whatever she thinks is best, we need to screen and prepare them or give them psychosocial interventions.

P4b: We can screen the mothers during pregnancy and give them psychosocial interventions at the beginning while they are pregnant.

P7a: Women who are diagnosed with perinatal depression will receive needed psychosocial interventions that will help them cope and face the challenges.

Sub-theme 3 Prevent Complications During Pregnancy and Post-Natal.

According to the participants, implementing guidelines to manage perinatal depression might assist in preventing some of the complications occurring during pregnancy, such as prematurity and postnatal depression, according to participants.

P 3a: I think it is particularly important to implement these guidelines as it might reduce complications during pregnancy, such as premature births, which could be caused by depression. Healthy mothers give birth to healthy babies.

P4a: But if these guidelines are used, for example, when they come for an antenatal visit, and there is a screening tool, we might prevent some complications such as postnatal depression and suicide.

P4b: I think it will also prevent postnatal depression.

P8a: Implementing these guidelines will be helpful because it will act as a preventative measure, and I think it will help us manage cases.

Sub-theme 4: Early Identification of Prenatal Depression

According to the participants, implementing guidelines is of paramount importance as prenatal depression would be detected early and managed accordingly. At present, the symptoms of undetected prenatal depression manifest during the postnatal period when women start crying hysterically and refuse to take responsibility for their babies. According to participants:

P 4a Early identification of perinatal depression while they are still at the clinic and not just waiting for the product when the mothers deliver, now they do not want babies, just crying hysterically then we give attention.

P8a: This is a good idea because I do not think there is not a month going by without seeing a patient experiencing some problems that lead to depression, and the better we diagnose them, the earlier treatment we give them, and they should be able to take care of themselves and their babies after delivery.

P5a So, screening them initially will help us to find those symptoms early.

P3b: Because patients delivered and they go, and midwives do not know the outcomes, now with screening, we will know that 10% developed depression during the postnatal period and 20% developed depression during pregnancy.

Sub-theme 5: Providing Holistic Care.

The participants indicated a need to implement the guidelines to provide holistic care to women during the perinatal period. They pointed out that currently, they only pay attention to physical symptoms, leaving out mental and emotional aspects, and there is no screening for maternal depression, according to participants:

P 1b: I think this is a good thing because maternal depression is not considered in this country; although healthcare providers only pay attention to physical symptoms, if the benefits are well explained and understood, it will help our patients holistically.

P5a: Implementing these guidelines is long overdue because they remind us as healthcare workers to focus on women's mental well-being during perinatal care, not just their physical well-being.

P3b: I think this is a particularly good initiative to start with. It will help to sharpen our system and our patients because now we only focus on giving physical support to those with pregnancy symptoms, but we do not screen our patients when it comes to maternal depression.

Theme Two. Integration of Screening for Perinatal Depression into Perinatal Care Service

The second theme that emerged during data analysis was integrating screening for perinatal depression into perinatal care service and the five sub-themes described below.

Sub-theme 1: Routine Screening for Perinatal Depression.

The participants suggested that screening for perinatal depression should be integrated into existing perinatal care. They pointed out that the Prevention of mother-to-child transmission (PMTCT) program was integrated into perinatal care in Namibia and is now running smoothly. They suggested they will use the same effort to implement the guidelines to manage perinatal depression in Namibia.

P1a: Integrating mental health care into the entire Antenatal care (ANC) package will make us more aware and better treat our patients.

P2b: For example, with the PMTCT program, there were some challenges as well at the beginning, but now the PMTCT program is integrated into ANC as a route program. So, we are going to start this same way. If we managers put more effort and emphasis into making sure that our staff members integrate these guidelines, the guidelines will be implemented well.

P1b: Yes! We can make it part of our routine care. We can even add it to our ANC passport and give health education about depression. **(Sound optimistic)**

P 3a: Screening tools can be added to antenatal care passports to make it part of our routine care.

P3 b: I think this is a good idea so that we won't be able to miss anyone since this is going to be an assessment-like tool for all our ANC patients, and it should be everywhere. **(Yes, yes, nodding the head).**

P4 b: Just as we screen for HIV / AIDS. I think screening should be compulsory. Each woman attending ante-natal care should be screened for perinatal depression.

Sub-theme 2: Short, Valid, and Cultural Screening Tool

The participants suggested that the tool should be short, not take too long to complete, and be valid. Participants also raised concerns about women who cannot understand English and suggested that the tool be translated into different local languages. Participants believed that when the tool is not translated into local languages, women might leave the forms uncompleted in the clinics due to a lack of understanding.

P1b: Patients filling in the form will be one of the challenges because we do not know whether they will fill in the right things. Sometimes, they can be led by the question to answer the way they will answer. On the other hand, they might just leave the form lying around in ANC.

P 4a: Because you cannot ask someone if you are depressed. They might not even know what the signs of depression are. But if these guidelines can give us a short tool, you know, like a guide, like asking certain questions, like how do you feel in the morning? Do you look forward to waking up in the morning? Are you looking forward to life? These are some key questions one can ask to pick up if the patient is fine. Do they need further screening?

P4 b: Katutura Hospital has a high number of illiterate patients, unlike Windhoek Central Hospital, so giving them this form to fill in will be a problem for them to complete. For example, even with the Home Affairs form, they are always here for us to fill it in for them, saying I don't know how to read, so this will be a barrier as well. This tool must be translated into the patients' mother language to accommodate the different languages.

Sub-theme 3: Providing Adequate Resources.

However, some participants had mixed reactions and doubts about the feasibility of implementing the guidelines in perinatal care settings. Most participants believed that the feasibility depends on the availability of resources. As many women seek help, human resources such as nurses and social workers must be increased. A one-stop centre is also needed to avoid sending women from one place to another.

P4a: Its feasibility will depend on the availability of resources; I think now we need to increase the resources such as nurses and social workers. As there are many interventions, more staff will be required to screen. There will be more mothers for the first visit because they get awareness. For example, September is mental health suicide prevention month. When Mothers find out about screening for depression, there will be a lot of these mothers who need to pass through different intervention lines or referrals.

P 2b: Resources will be needed (**Looks worried**). Because now, we do not want the mothers to come here and then go to the next room for counselling, and then you will say, now you should walk to mental health for psychiatric and psychology because we do not have them here. Some mothers are from Katutura far and they came here at six. What are we going to do? Can we have a one-stop center where can have other disciplines according to the interventions you have to solve this in the same place? Nurses are already understaffed. We should think about that in terms of feasibility. I think the line will increase with screening. Let us consider that.

Sub-theme 4: Multidisciplinary Team

Participants pointed out the need to share responsibilities. They raised a concern that nurses would primarily screen and educate the women about perinatal depression, while social workers would mostly do counselling. According to participants, other healthcare providers, including community counsellors, doctors, psychiatrists, and psychologists, need to be involved in easing the workload.

P3a: We will need to share responsibilities. Now, we need to think about whether we have enough people to do that. Nurses will screen and educate women, but they will not do counselling. Nurses will refer patients to a social worker, for example. Some will go to a psychiatrist, and some will see a psychologist. Everyone should be involved.

P4a: But I think these guidelines will be good ones, and I like that they involve us social workers. I think I should also involve other healthcare providers, such as community counsellors, doctors, psychologists, and psychiatrists. I mean, everyone must be involved.

Sub-theme 5: Creating Awareness.

The participants indicated that awareness is needed so that people would know what perinatal depression is and where the services can be accessed. The participants suggested that during antenatal care, women need to be sensitised about the causes of perinatal depression, such as gender-based violence. According to participants:

P2b: Even in our maternity file, there's a part that asks about gender-based violence; we need to start this in ANC, creating awareness on the causes of perinatal depression so that patients don't get surprised. Why suddenly? When they are admitted to the labour ward when filling in this part of the file. Because gender-based violence is the leading cause of perinatal depression, in ANC, they are those mothers who come with their partners, and sensitising them in ANC will also make their partners aware and have a better understanding that screening is available.

P1b: Mental health is ignored as part of route care in ANC, and sensitising it will help our patients there and inform them that they can talk to any healthcare providers.

P3b: We must let them know that screening for perinatal depression is now available while they are waiting in the queue. Like with health education, we give them health education outside together as a group, but we still re-emphasise health education in the rooms.

Theme Three: Barriers to Implementing the Guidelines to Manage Perinatal Depression.

Participants were able to outline the barriers that might hinder the implementation of the guidelines to manage perinatal depression.

Sub-theme 1: Lack of Knowledge of How to Manage Perinatal Depression.

Participants raised a concern that a lack of knowledge of how to manage perinatal depression might hinder the implementation. Therefore, they suggested that healthcare providers should be trained.

P7a: It could be a lack of knowledge and understanding. The staff needs to be trained to screen so that we give out the right information and do the right thing.

P5a: Midwives should be well informed or trained on how to deal with mental issues to gain knowledge of how to detect and manage perinatal depression.

P3b: Lack of knowledge might hinder the implementation of guidelines; healthcare providers need to be trained to gain knowledge and understanding.

Sub-theme 2: Healthcare Providers' Negative Attitude

Participants raised concerns that healthcare providers have negative behaviour toward women with perinatal depressive symptoms. They also raised a concern that often, when mothers present with depressive symptoms, healthcare providers think that they are pretending. Some healthcare providers do not see it as a problem when teenagers develop perinatal depression after being scolded or reprimanded by parents. Sensitivity is paramount when dealing with teenagers, as what seems like a normal reprimand might be hurtful to them. According to participants:

P2a: Attitude! Midwives need to change their behaviour toward mothers with mental issues because sometimes they think they are pretending and treat them badly.

P3a: We grow up in a society that is somehow toxic. When you fall pregnant at the age of 15, your parents will scold you. Now, this generation is very fragile, and their mental health is especially important to them, so scolding is an issue for them. Now, healthcare providers will be like, we also are scolded, which is just how it is. Some of the healthcare providers will not think is particularly important if a 15-year-old is pregnant and comes in crying because of being scolded. Healthcare providers will look at it as okay, but you went to get pregnant, and you support being in school because a nurse's mindset is a certain way because of their upbringing.

Sub-theme 3: Lack of Ethical Consideration

Another barrier raised by participants is the lack of ethical consideration and empathy when speaking to women with perinatal depression. They also raised a concern that there are not enough rooms in perinatal settings, thus compromising confidentiality and privacy. They suggested that women need to give consent before being screened.

P1a: Depending on the question, this is a sensitive topic; where are we going to sit and screen patients? Privacy is critical here.

P2b: Regarding confidentiality, the question of where patients will sit and fill out this sensitive form is still being raised. Tracing the patient if the test is positive will be difficult since this form is kept in the patient's health passport.

P3b: Depression is an overly sensitive topic! Healthcare providers should speak with empathy. If we speak with empathy, the patient will open; for example, the mother will tell us that I am trying to abort this pregnancy. But with a lack of empathy, mothers will not open up, will go home, have an abortion, or start drinking. We need to do it with care.

P4a: We can add to health education, but ideally, screening should be done privately because if we do it during health education, no one will come out.

P5a: Health education should be done to create awareness, but screening should be done privately, and results should be confidential.

P6a: Mothers should also give consent so they won't feel forced to be screened. Information should not be made public to all family members. Some family members may spread information wrongly. For example, if a woman wants to abort the pregnancy, that should be kept confidential. Some people would think it would be better if I committed suicide because now the whole village would know, and my mother called all the aunties; she tried to find a way to abort it. Healthcare providers will be that's life, whether you swim or drown. The training should be detailed to avoid these issues.

Discussion

Participants were of the view that implementation of the guidelines to manage perinatal depression would prevent complications affecting women during the perinatal period, such as infanticide and abandoning. In South Africa, Mokwena (2021) recommended the implementation of guidelines to manage perinatal depression to promote the health and developmental outcomes of children and reduce child mortality. Therefore, implementing the guidelines to manage perinatal depression may have clinical benefits such as initiation of treatment and early referral for support (American College of Obstetricians and Gynaecologists (ACOG), 2018).

Participants believed that the implementation of guidelines to manage perinatal mental depression health in primary healthcare settings is of paramount importance. This could transform routine perinatal care settings into a one-stop clinic supplying holistic care to address physical and mental health needs. The implementation of the guidelines to manage perinatal depression could improve women's care, affect policymaking, and ensure consistency of care across different perinatal care settings (Motrico et al., 2022).

The implementation of guidelines is the first step to providing psychosocial interventions to women with perinatal depressive symptoms. Earlier evidence supports the efficacy of various psychosocial management approaches for maternal perinatal depression (Stefan et al., 2019; Gureje et al., 2019). Among psychological approaches for managing depressive disorder in the perinatal period that have been evaluated to be effective include psychoeducation, interpersonal psychotherapy, a problem-solving approach, cognitive behavioural therapy, a thinking healthy program, and mindfulness-based Cognitive Therapy and parenting education to increase knowledge on maternal mental health among perinatal women (Rahman et al., 2013; Evans et al., 2021; Stefan et al., 2019; Ng'oma et al., 2019; Dimidjian et al., 2016). Psychosocial interventions, which include social support, are considered central in the transition to motherhood and impact emotional coping strategies. It directly affects emotional strength, lessens the effects of stressful life events, and prevents perinatal depression (Milgrom et al., 2019). Psychosocial intervention is regarded as an alternative for women who are pregnant or breastfeeding and, therefore, prefer not to take antidepressants due to fear of teratogenicity that could cause congenital malformation and neonatal complications (Harsha, 2019).

Literature has linked poor mental health issues in childbearing women with numerous adverse outcomes and perinatal complications, including prolonged labour, cesarean section, preterm birth, low birth weight, and other social problems such as suicide and substance abuse which may increase the risk of developing chronic illnesses later in life (Biratu & Haile, 2015; Jarde et al., 2016; Hartos, 2021; Cook et al., 2018). Therefore, implementing the guidelines would standardise an effective method for detecting, managing, and preventing complications of perinatal depression.

The implementation of guidelines may help detect and address the social stressors met, such as suicide. Perinatal women have higher suicidal ideation than their comparison group in the general population, meaning maternal suicide and infanticide are two of the most severe adverse consequences of severe perinatal depression (Al-halabí et al., 2021). It is, therefore, essential to show and evaluate thoughts of self-harm and infant harm during depression screening. An umbrella review by Motrico et al. (2023) supports this finding in the United States, which reported that guidelines to manage perinatal depression have a significant effect on the reduction of perinatal depressive symptomatology such as feeling sad, angry, quiet, and suicidal thoughts and intense emotions like madness. A similar study by O'Connor et al. (2019) reveals that implementing the perinatal depressive guidelines will not only help in the identification of pregnant and postpartum women with depression but also improve their understanding of Perinatal depression.

Participants in this study believed that screening for perinatal depression should be part of routine perinatal care. Consequently, involvement in perinatal depression screening programs has identified women at risk, which helps in the timely detection of pregnant women with depression, increases referrals, and engages them with services, which has a positive impact on mental health outcomes (Reilly et al., 2020). According to Yafit et al. (2021), screening for perinatal depression should be conducted effectively and respectfully to support women through their journey towards treatment and remission. Integrating perinatal mental health care into routine maternal care is an important strategy for improving access to mental health care and addressing care access gaps in healthcare within resource-limited settings (Byatt et al., 2018; Prom et al., 2022).

A valid and reliable screening tool is required to assist in detecting depressive symptoms and treat and refer women during perinatal in low- and middle-income settings, where depressive disorders are more prevalent and where access to full diagnostic work-up is of no existence (Maselko et al., 2018). The Edinburgh Postnatal Depression Scale (EPDS) was adopted for use during screening. EPDS is a tool specifically designed to find ante-natal and postnatal depressive symptoms.

To ease the workload, a multidisciplinary approach, including community counsellors, doctors, psychiatrists, and psychologists, is needed for successful implementation. This is supported by a study by Blackmore et al. (2022), which revealed that implementing screening programs within antenatal services requires action from different departments within the health service and across disciplines of health professionals.

The participants were able to mention barriers that might hinder the implementation of guidelines, including lack of knowledge of how to manage perinatal depression, healthcare providers' negative attitudes and lack of ethical consideration. Similar barriers were reported in a study by Smith et al. (2019), which includes health administrators' low literacy about perinatal depression as individual-level barriers, lack of community awareness, health-seeking behaviours, and cultural norms about perinatal

depression as socio-cultural level barriers. Other challenges mentioned in this study are lack of government capacity, readiness, and priority of screening and managing perinatal depression, and lack of mental health policy and strategies as organisational level barriers.

Recommendations and Implications for Future Research

A focus group used in this study is an effective qualitative technique in generating ideas and participants debating on the barriers that may hinder the implementation of the guidelines to manage perinatal depression. In practice, healthcare providers should ensure that the relevant policies and the developed guidelines are available to facilitate the implementation of screening for perinatal depression. Ensure confidentiality, informed consent, and privacy during screening for perinatal depression and assessment of psychosocial risk factors. Involve the partners and families of women with perinatal depression in the management. Educate women on the signs, symptoms, and causes of perinatal depression and psychosocial risk factors influencing perinatal depression, such as gender-based violence. The government and the Ministry of Health and Social Services should provide adequate resources. Provide psychosocial interventions to women diagnosed with perinatal depression. Future research should focus on the effectiveness of the implemented guidelines to manage perinatal depression in perinatal care settings in Namibia.

Limitations

This study was conducted in Windhoek, the capital city of Namibia; a specific location might hinder the generalisation of the findings. The researcher purposively invited 12 healthcare providers to discuss implementing the guidelines to manage perinatal depression; a small number of participants might be a limitation restricting the applicability of the study findings.

Conclusion.

The implementation of the guidelines to manage perinatal depression should enable healthcare providers to effectively detect, manage, and refer women with severe perinatal depression. The guidelines should also improve accessibility to mental health care and promote women's safety in the perinatal period.

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