Research Article

Understanding lived experiences and perceptions of perinatal depression in Nigeria: a qualitative evidence synthesis

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Keywords: Pregnancy, Perinatal Depression, Nigeria

https://doi.org/10.29392/001c.122278

Journal of Global Health Reports

Vol. 8, 2024

Background

Perinatal depression is a common mental health disorder which spans during and after pregnancy. Unfortunately, there is poor healthcare-seeking behaviour for this treatable condition. Additionally, maternal healthcare workers sometimes overlook the signs and symptoms, failing to diagnose it adequately. This review aims to provide a framework for understanding the in-depth perceptions and implementation gaps surrounding perinatal depression in Nigeria.

Methods

This study employed a rigorous qualitative evidence synthesis methodology to gather and analyse both published and unpublished qualitative research on the lived experiences and perceptions of perinatal depression in Nigeria. The research was conducted by searching multiple electronic databases, citation chaining, and checking reference lists. The studies were then screened by title, abstract, and full text, and the quality of the included studies was evaluated using the Critical Appraisal Skills Programme (CASP) checklist for appraising a qualitative study. The data extracted from these studies were then synthesized using the 'best-fit' framework method, which combines deductive and inductive approaches to analysis.

Results

10 eligible papers were identified. Data were organised into themes eight themes mapped to an already existing framework: Recognitions of perinatal mental distress, labelling of mental distress, symptom patterns, social norms, roles and expectations, supernatural factors, physical/bodily issues, coping strategies, help-seeking from professionals/ medical institutions. No study was excluded as a result of methodological limitations.

Conclusions

The review highlights the significance of integrating mental health services into routine perinatal care and the need for comprehensive interventions that consider sociocultural factors. The findings emphasize the importance of increasing awareness and education among women and healthcare providers to improve early detection and intervention. Healthcare professionals play a crucial role in identifying and managing perinatal depression; therefore, it is essential to provide them with comprehensive and regular training.

Maternal health encompasses the period of pregnancy, labour and delivery, and the postpartum period. In addition to the most common complications of pregnancy such as haemorrhage, infections, hypertensive disorders, obstructed labour, and unsafe abortion, mental health disorders are also prevalent and often go underdiagnosed.[1] Depression is a common mental health disorder occurring during the period of pregnancy and the postnatal period.[2, 3] Also referred to as perinatal depression, it is a mood disorder, either antenatal or postnatal, that is characterised by

feelings of helplessness, hopelessness, and loss of interest in previously pleasurable activities.[4-6] Symptoms may last for weeks or months for an episode but are usually of longer duration, being differentiated from "maternal blues", a feeling of tiredness and sadness experienced by a woman after childbirth lasting for a shorter period.[4,5]

Globally, antenatal depression occurs in 10% of pregnant women, while 13% occurs in the postnatal period.[3] These figures are higher in developing countries, where 15.6% and 19.8% develop depression in the antenatal and postnatal periods, respectively.[7] Beyond the direct impact on the mother, the new baby is also at risk of maternal deprivation, with attendant poor growth and development.[7] Additionally, because of genetic and environmental factors, or a combination of these, children of mothers with depression may themselves be at an increased risk of developing mental health problems later in life.[7,8] Partners may be overwhelmed by the extra responsibilities of caring for the children and household while trying to support the mother.[9, 10] Parental conflicts may arise because of a lack of understanding from a partner of the severity and implications of maternal depression.[10] If unresolved, such conflict can further disrupt family dynamics, leading to family dysfunction.[9,10]

Although maternal depression is a treatable condition, healthcare workers tend to overlook the signs and symptoms, failing to identify and diagnose it adequately. This lack of recognition has resulted in alarmingly low rates of diagnosis and treatment for maternal depression. Such gross under-diagnosis and under-treatment emphasise the pressing need for focused research, as well as efforts to raise awareness and educate healthcare professionals about maternal depression and its profound impacts.[11] Despite being integrated within maternal and child health services, mental health assessment, including screening for maternal depression, remains rudimentary in developing countries like Nigeria.[12] This review provides a framework for understanding the implementation gaps and deficient state of maternal mental health service as it pertains to depression. This will guide the optimization of complete care service delivery both in terms of quality and coverage, in the context of a developing country like Nigeria.[13]

Public health efforts around maternal depression often concentrate on postpartum depression and women exhibiting obvious clinical levels of depressive symptoms. However, this approach neglects antenatal or prenatal depression, which research has shown can predict the development of postpartum depression. Both antenatal and postpartum depression exist on a continuum, with impacts spanning from the mother to the child. Collectively, maternal depression in all its forms poses a significant public health threat that warrants greater attention.[14] A comprehensive review is needed to consolidate and synthesize the evidence required to catalyse health promotion and disease prevention policies targeting maternal depression. This is particularly vital in low-income and middle-income countries, where maternal depression receives inadequate policy attention despite being a significant public health burden.[14] This deficiency in policy is further compounded by a correspondingly inadequate number of health interventions to address the health challenge, potentially attributable to a lack of supporting evidence. This systematic review will provide decision-makers with informed choices and conclusions, particularly when faced with similar and contrasting reviews of varying quality and scope, to guide the selection and planning of appropriate and acceptable interventions.[15]

Understanding how mothers perceive the experience of maternal depression will guide the adoption of appropriate responses that either capitalise upon, reinforce or dispel inherent beliefs. This can be achieved by factoring in the values and preferences of the mothers, their significant others,[16] and other caregivers. By aiming to resolve conflicting ideas and notions the intention is to create a conducive and supportive environment that avoids the precipitants of maternal depression. Furthermore, interventions addressing identified concerns can be tailored to both participants and context using appropriate technology and strategies. Furthermore, perceived health-seeking behaviours which are not scientifically sound will be weighed alongside those that are in line with global best practices, and, being judged according to their merits and demerits, targeted for appropriate health actions.

Qualitative data affords an appropriate way to understand the perception and lived experiences of perinatal depression from multiple perspectives. Pregnancy, delivery, and the postpartum period are accompanied by numerous changes, both physiological and mental, for the woman.[17, 18] Multiple, sometimes complex, factors shape how the woman responds to these changes.[19,20] In addition, the healthcare worker who is usually a part of this process can draw upon rich experiences that help to give deeper meaning.[21] Thus, a qualitative evidence synthesis will adequately explore those experiences and present them in a manner in an easy to understand way by stakeholders.[22]

The findings of this review will help caregivers and healthcare workers relate to, and better understand, the perspective and lived experiences of mothers especially when contending with extreme maternal depression. This review will further add to the body of knowledge by consolidating the few studies that address the perception and lived experience of mothers regarding maternal depression in Nigeria given the absence of a previous QES on this topic.[16]

This paper seeks to explore the lived experiences and perceptions of perinatal depression in Nigeria, and to provide recommendations for healthcare workers, policymakers, and stakeholders on ways to reduce the burden of perinatal depression in Nigeria.

METHODS

This review is a qualitative evidence synthesis (QES) in which qualitative findings, reported either in qualitative studies or mixed-method studies, were eligible for inclusion. Qualitative findings are critical in exploring the lived experiences and perspectives of participants.[23] Therefore, a

synthesis of qualitative findings is critical to addressing the objectives of this review.

The research question for this review was formulated by adapting the concept of PICO to apply to qualitative studies.[24] PICO is an acronym for Population of interest, Intervention, Comparator, and Outcome. Thus, in the context of this review, the components employed are PEO, as there is no planned intervention (but instead Exposure to perinatal depression) and there is no comparative group. The components are stated in Table S1 in the Online Supplementary Document (OSD), which also describes the eligibility criteria.

SEARCH STRATEGY

Search strategy development involved using combinations of medical subject headings (MeSH), Boolean operators (AND, OR, and NOT), and search syntaxes like truncations (*) and wildcards (?) to search for relevant studies.[25] The "pearl" strategy was used to develop the search terms used for the databases as guided by the PEO framework.[26] This was achieved by identifying a key paper on perinatal depression and following how the terms were stated. These terms were then modified and combined using Boolean operators to effectively search the databases.[27] Given the anticipated limited number of studies for perinatal depression in Nigeria, permutations using the technique of "drop a concept" were entered to enhance the sensitivity of the search.[28] The search strategy of EMBASE is shown in Appendix S1 in the OSD , and the same structure was applied to the other databases.

DATA SOURCES

An exhaustive search of MEDLINE, CINAHL, EMBASE via Ovid, CINAHL, Psych INFO, Web of Science, and ProQuest Dissertation was conducted to retrieve references to published papers on perinatal depression in Nigeria. An additional search on Google and the Federal Ministry of Health of Nigeria website was undertaken to identify grey literature. Databases were selected due to their relevance to both qualitative research and the topic. Searches were conducted in May 2023. Citations and references of the selected articles were reviewed using Google Scholar to mitigate any deficiencies in the search strategies or the indexing of the databases.[29] To avoid publication bias, unpublished papers in addition to published papers were considered eligible for this QES.[30] No date cut-off was applied as the aim was to retrieve a comprehensive sample of relevant studies.

STUDY SELECTION

The study selection process took place after the searches were completed. The papers were exported to the Mendeley reference manager, duplicates removed, and further assessed by title, abstract, and full text.[31] One of the authors undertook the searches, while two screened the references simultaneously and screening outcomes were compared to which showed consistency.

DATA EXTRACTION

Data extraction was handled using an Excel spreadsheet to ensure consistency in the data collected across the studies in addition to quality assessment of the studies. Both processes were undertaken concurrently.[26] These were carried out by two researchers and a third researcher did the final review to check any disagreements and ensure validity in all the data. F.I.O and T.T.O assessed the findings from the individual studies while S.E.M did the final review. All three are trained researchers with vast experience in conducting systematic reviews.

QUALITY ASSESSMENT

This quality assessment was conducted using the Critical Appraisal Skills Programme (CASP) tool for qualitative studies.[32] This checklist is noted for being easy both to interpret and to apply. The tool utilises ten questions that facilitate the easy and transparent process of assessing the studies. Although originally designed for assessment of single papers this checklist continues to be one of the tools of choice for determining the quality of diverse qualitative studies for inclusion in a synthesis.[27] In addition, no paper was excluded on the basis of methodological limitations. This approach recognises that every paper, even if flawed, holds the potential to yield qualitative findings that may contribute to answering the research question to some degree or other.[33]

SYNTHESIS OF RESULTS

Although qualitative findings may be found in different parts of a qualitative paper, the review team decided to focus on the Results section as this consistently contains the highest concentration of findings .[34] Both verbatim text extracts and authors' interpretations were considered as data and extracted in order to gain a complementary understanding of the data.[27] Best-fit framework synthesis was used to synthesise the data.[35] A multi-context review on perinatal depression was identified from the literature and chosen to supply a "best-fit" framework for the synthesis.[36] Data was then mapped to the pre-existing themes deductively. Data that did not "fit" were mapped inductively to give the framework additional nuance, wider transferability, and enhanced sensitivity to the Nigerian context.

ETHICAL CONSIDERATIONS

This research is a systematic review of qualitative evidence from publicly available data, and as such, human subjects are not involved. As a consequence, ethical approval is not required.

RESULTS

A search in all the databases yielded 749 references (Table S2 in OSD). The records for these references were imported into Mendeley and after duplicates were removed, a total of 504 references remained. After title and abstract screening,

10 reports were retrieved for full-text reading and assessment, out of which 7 were found eligible. Three additional articles were found via citation and reference searching of the 7 eligible reports using Google Scholar, making a total of 10 reports from 10 different studies, now included in this review (Table S3 in OSD). The PRISMA diagram in Figure S1 in OSD shows how the reports were selected.

CHARACTERISTICS OF STUDIES INCLUDED

The key characteristics of the ten selected studies are included in Table S3 in OSD. The included studies were published between 2017 and 2023. Eight of them were conducted in Oyo state in South West Nigeria [16,37-43] and the remaining two of the studies were conducted in Plateau state in North Central Nigeria[44] and Enugu[45] South East Nigeria.

Health facilities were featured as a study setting in 7 studies: exclusively in five studies and together with the community in a further two studies. A further study focused exclusively on the community. Collectively, these studies suggest a comprehensive approach that integrates facility-based care with community-based resources and support systems for mothers. Finally, "traditional/faith-based healing homes in rural and urban areas" appear in one study. This unique inclusion highlights the importance of understanding the diverse cultural and traditional contexts in which maternal depression is experienced and addressed. A comprehensive and culturally sensitive approach to maternal mental health, therefore, engages across multiple social support systems, community resources, and traditional practices in addressing maternal depression.

The views of mothers and of "healthcare providers" in general were each represented in 4 studies: three times together and one each separately. Specifically, primary care involvement of health providers was captured in a further three studies (two as "primary care providers" and one as "primary maternal health care providers"). Similarly, two studies of specific maternal populations were identified; one study focused on the unique challenges faced by adolescent mothers, a particularly vulnerable population, while the other concentrated on a specific subset of adolescent mothers with a history of depression during the perinatal period. Supportive perspectives, caregivers, and clergy were represented in one study each.

QUALITY ASSESSMENT OF INCLUDED STUDIES

A quality assessment was conducted for the ten studies that were included using the CASP checklist (Table S4 in OSD).[32]

Two studies received a low-quality rating, five received a medium-quality rating, and three received a high-quality rating. The low—and medium-quality studies did not consider the research's positionality in data collection. No study was excluded due to methodological limitations.

OUTCOME OF DATA EXTRACTION OF QUALITATIVE FINDINGS

Data were extracted from each of the included studies relevant to the research question. Ten included studies were mapped to the pre-existing thematic framework (Appendix S2 in OSD).[46]

SYNTHESIS OF FINDINGS

Table S5 in OSD shows the thematic areas as mapped from the individual studies. Areas shaded green show findings that support that thematic area in the aligned studies. Two thematic areas of the framework, "casual explanations" and "difficult circumstances and adverse life events," were not represented in our studies. Two thematic areas, "recognition of perinatal mental illness" and "help-seeking from professionals", had the most adequacy of data as this was represented in the majority of the studies. This implies how critical these areas are in the Nigerian context.

RECOGNITION OF PERINATAL MENTAL DISTRESS

Mothers and healthcare providers generally recognise the features of perinatal mental distress. Some mothers are however not aware that they have any form of mental distress and view their symptoms as being normal in pregnancy, until diagnosis by a healthcare provider.[43] When mental distress is recognized by mothers, it is described as a change in feelings during and after pregnancy.[39] It was noted that,

> "The thinking I experienced when I was pregnant, was the same experienced after birth." (Nursing mother, 37 years, community FGD).[39]

Perinatal mental distress was recognised by mental and actual body phenomena, "*thinking too much",* sensations of body heat and poor sleep.[38] Also, perinatal depression is linked to underlying social and interpersonal issues in mothers who experience it.[37]

The ability of healthcare providers to recognise these symptoms was greatly enhanced by the training they had received.[41,42]

> "We were taught in school. They taught us about depression, but we were not taught deeply. They taught us about depression and psychosis, but it was not so deep. It was for just about 3 months." (Community health officer).[41]

The need to create awareness of and promptly recognise maternal depression was emphasised by heads of healthcare facilities.[47]

> "From the public health point of view, an awareness has to be created to the larger community at the public level either through media either radio, newspaper, television to make people aware" (PHC coordinator).[47]

It was also noted that the presence of structured treatment instructions on the management of patients improved

the identification and management of mental health issues in young mothers, by the healthcare providers.[40]

LABELLING OF MENTAL DISTRESS

Mental distress was described by healthcare providers in mostly derogatory terms.[38,42] It was stated by a healthcare provider that,

> "Her problem started when she delivered her baby, she started behaving abnormally, quite aggressive. It was terrible to the point that she attempted killing her baby." (Healthcare provider/Faith healer).[38]

Perinatal mental distress also had traditional names by which it was described particularly in the Yoruba language,

> "Abisinwin is a Yoruba term used for the sickness [that] happens to people after giving birth which could be caused by overstress, sleeplessness, and spiritual attack". (60 year old, female, faith healer).[37]
> "Aare okan", is also another Yoruba term meaning "sickness of the mind" and "irewesi okan" which means "low mood". (38 year old man, community FGD).[47]

Mothers attested to being labelled with a mental illness,

> "If you are moody or withdrawn for some other reason, they could term it to mean mental illness." (28-year-old woman with PPD).[38]

SYMPTOM PATTERNS

Various symptoms of depression were highlighted by the mothers, family caregivers and healthcare providers. These symptoms identified were both psychological and somatic in nature and include sadness, loss of interest, headache, loss of appetite, irrational talk and neglect of child care.[37]

The symptoms of perinatal depression were identified by the mothers,

> "I can't sleep. Even the pain itself, during labour, is enough source of stress to me, and you know if you are stressed up, so many things will come to your mind, the way you think may change and everything easily makes me angry," (22-year-old nursing mother, FGD).[44]

Healthcare providers also retorted,

> "She just had her baby. Her primary doctor, a gynaecologist, met us and the chief complaint was she was sleeping poorly and didn't have energy and she was also having inappropriate and excessive guilt and she was also having episodes of weeping; she was just weeping." (Healthcare provider, Psychiatrist).[38]

Some healthcare providers further outlined the inability to function well as a mother, loss of touch with one's immediate environment, lethargy, lack of self-care and suicidal ideation as symptoms of maternal depression.[47] Family caregivers in addition to other symptoms of depression mentioned, included social withdrawal. A clergyman mentioned erratic speech and laughter, hallucinations, abnormal phobias, sleepless nights and poor reasoning as symptoms of maternal depression.[45]

SOCIAL NORMS, ROLES, AND EXPECTATIONS

Perinatal depression was linked to positive and negative effects of social norms within the society. On the positive side, one mother in the study by Jidong et al reported,

> "In our culture, each time I gave birth to my child, my mother-in-law comes to perform the necessary rituals that are culturally bound to keep the state of my health and my baby. She [grandmother of newborn] usually stays with me for a period of 6 months" (27-year-old mother, FGD)[44]

This portrays the social support the family provides to mothers which staves off the symptoms of perinatal depression. Lack of spousal support, on the other hand, sets the stage for perinatal depression. Adeponle et al., 2017 stated that,

> "Lack of support from a spouse was often described in households in which the patient, her spouse, mother-in-law and rival wives (in the case of polygamous households) lived: the patient was subordinated to both her mother-in-law and rival wives, and even if he favoured her, the husband was unable to protect the patient from maltreatment by mother-in-law or rival wives." (52 year old, female,)

Kola et al reported mixed reviews on the social support received by young mothers with perinatal depression.

> "The relatives of the young girls are often disappointed because many of the pregnancies are unplanned. So, the girls get low support from these relatives, and in many cases, the men who got them pregnant also do not show up" (Healthcare provider, FGD).[40]

Some young mothers, however, reported having social and emotional support from other women in their community. It was stated,

> "There is a woman near my house who helped with my baby because she saw that I was a young woman who needed to be guided. She is my friend. She would carry my baby for me and help me clean her up sometimes. She was a big source of comfort to me also, because she was always talking to me on how to get on with life." (Adolescent mother, FGD).[40]

SUPERNATURAL FACTORS

The cause of perinatal depression was in some cases assumed to be due to some supernatural forces such as "spiritual attacks" which could only be addressed by unorthodox medicine through traditional healers as well as the church. The sources of these "spiritual attacks" were said to be rivals in marriage and/or trade/career.[37] One mother recounted in a study by Adeponle et al that,

"After giving birth, I was unable to sleep. So, they (my family) brought me to the hospital. Afterwards, we went to my town to verify the source of what happened to me from an herbalist who told us that we needed to make animal sacrifices to appease the gods and we did it." (28-year-old woman with PPD)[38]

Furthermore, the clergy shared these same culture-based beliefs. Iheanacho et al reported one clergy informant as saying,

> "Mental illness can be inflicted through charms. I hear people talk about it in areas where we have witch doctors." (Clergyman, FGD).[45]

Evil spirits, in Igbo, *"ajo nmuo"* were also reported to cause mental illness in mothers.[45]

It was not however stated if the women who sought help from these unorthodox practitioners experienced any relief. Both traditional healers and faith healers stated that mothers who presented to them did so on account of failure to find a solution to their problem from hospitals. A traditional healer noted,

> "Despite their effort of moving from one hospital to the other, the sickness persisted, even the doctor told them to go treat her spiritually. Later someone directed them to my healing centre. Through our investigation, we discover that it was a spiritual attack and orthodox medicine cannot provide a solution to it in any way." (Traditional healer, IDI).[38]

PHYSICAL/BODILY ISSUES

Cultural expectations require that a new mother combines house chores, catering to the needs of other family members and caring for the new baby. This physical exertion was identified as a source of mental distress.

> "Combining the work of child upbringing and other domestic chores alone is a big source of stress so it's not easy." (27-year-old mother, FGD).[44]

COPING STRATEGIES

Coping with perinatal depression is challenging. Mothers depend on individual resilience and self-coping strategies.[38,42]

> "Initially I was ashamed of myself, anytime I remember all I was told I did (when I was sick), but I later pulled myself together and continued with my life ... some (people) abandoned me when I was sick and looked at me suspiciously but now people are friendly towards me." (24-year-old mother with PPD).[38]

Despite their self-resilience, mothers still experience difficulties which may be worsened by poor family support.

> "I would like to maintain personal hygiene like keeping myself and my baby clean, eating a balanced diet including fruits and vegetables is very good in healing and rebuilding the body even sleeping at the appropriate time but it is difficult with the small-pikin [little child]." (23-year-old mother).[44]

HEALTH SEEKING FROM PROFESSIONALS/MEDICAL INSTITUTIONS

Care for perinatal depression was reported to be sought by the mothers themselves or family members where the mother is incapable of doing so herself.(40) Mothers asserted that consulting with healthcare providers in the hospital significantly improved their symptoms, *"I was in a bad state when I went to the clinic. I thought my life was over. However, the more I visited the clinic and talked to the matron, the better I felt"* (Mother, FGD).[42]

> "The nurse that treated me was very good. No matter how bad I felt or looked at the clinic, she always had kind words for me, so I look forward to seeing her every time." (Adolescent mother, FGD).[40,42]

The mothers occasionally had unmet expectations from healthcare providers,

> "Such care is not well set up at the same time, it exists. The reason I said it is not well set up is that the nurses do not yet understand this kind of problem in the scenario. If they do they will educate us about it regularly." (32-year-old nursing mother).[39]

Healthcare providers believed in their ability to care for mothers with perinatal depression and attributed this to being properly trained.[41-43]

> "The reason for being adequate is that we don't stress them too much before we refer them to Adeoyo or UCH (secondary and tertiary centres respectively) because most people that come here are low cadre people. Here is a local government, a primary health care centre, so with the treatment we give them, it is adequate." (Community health extension worker).[41]

Despite the satisfaction reported by mothers accessing care for perinatal depression, they sometimes face discrimination from providers which made some of these mothers sceptical about the care they received. A mother stated,

> "One day in the clinic, I felt so ashamed of myself when one of the other nurses asked me why I got pregnant at such a young age. I was so ashamed I felt sad even throughout the day. To avoid this kind of situation, I go to the clinic only when I have no other choice." (Adolescent mother, FGD).[40,42]

Another factor reported to negatively affect the mothers' health-seeking behaviour was the long waiting time at the clinics due to inadequate personnel,

> "Going to the clinic was a whole day's work even when a person gets there early. Sometimes, I don't like to go to the clinic because many times there are many people and the queues are long" (Adolescent mother, FGD).[40]

Healthcare providers agreed with the mothers,

> "Clinic days for pregnant women are busy because we the members of staff are not enough for that period. Many times we just give the women with depression another appointment outside the period, so they are not just kept waiting because of the crowd." (Healthcare provider, FGD).[40]

The clergy also play a role in providing care to mothers seeking care for their mental health needs. A clergyman stated,

> "I try to find the basis of their fear. Like I try to make them understand that people can't harm them from such distance the way they think." (Clergyman, FGD).[45]

They also attempt to follow up on those they have helped and make referrals to psychiatric facilities if needed.

DISCUSSION

These themes shed light on the biological, psychological and sociological substrate of perinatal depression.[48] It also highlights pertinent risks and protective factors that contribute to its understanding and management within the Nigerian context.

Gelder *et al,* (2007), defined insight in psychopathology as "the awareness of morbid change in oneself and correct attitude to this change, in appropriate cases, a realization that it signifies a mental disorder".[49] The first theme focuses on the recognition of signs and symptoms of perinatal depression by both mothers and healthcare providers. It includes the understanding of symptoms, experiences, and the distinction between normal hormonal pregnancy changes and mental distress. Furthermore, this theme showed that many mothers were unaware that their symptoms were indicative of perinatal depression. Instead, they viewed these symptoms as typical aspects of pregnancy. Tesfaye et al. (2021) conducted a systematic review and meta-analysis of the prevalence and factors associated with perinatal depression in Africa. Their results align with our findings regarding the recognition of symptoms. They reported that many women in African countries, similar to Nigerian mothers, were not aware that they had perinatal depression and considered their symptoms as normal during pregnancy.[50] This highlights the need for increased awareness and education among both women and healthcare providers to enhance early detection and intervention.

Similarly, a qualitative study conducted within the cultural context of Ethiopia found that many women with perinatal depression initially attributed their symptoms to normal pregnancy experiences and were unaware of their mental distress until diagnosed by healthcare providers.[51] This highlights a shared experience among women globally, wherein perinatal depression may go unrecognized or be normalized until professional intervention occurs. This lack of awareness underscores the need for improved education and awareness campaigns targeting both mothers and healthcare providers. Early recognition and accurate diagnosis are crucial for timely intervention and support. It is imperative, though, that any improved education on the recognition and understanding of signs, symptoms and diagnosis of perinatal depression focuses on interventions that are shaped by local context, idioms of distress and local explanatory models.[52,53]

The influence of sociocultural norms and expectations on perinatal depression is not unique to Nigeria.[54] Ngoma *et al.,* (2019) found that societal pressures, gender roles, and family dynamics in Malawi were identified as contributing factors to the development and exacerbation of perinatal depression. Gelaye et al. (2016) conducted a systematic review of maternal mental health in low- and middle-income countries, providing a broader perspective on the topic. Their study highlighted the complex interplay of social, cultural, and economic factors in influencing maternal mental health outcomes.[55] This aligns with our findings regarding the role of social norms, expectations, and lack of support as contributing factors to perinatal depression. Recognizing these contextual factors is crucial for designing effective interventions that are sensitive to the unique cultural and social contexts of each population. Most Africans, regardless of their level of education, adhere in varying degrees to a belief in the supernatural causation of disease, thus leading to consultations with traditional healers and religious institutions. It is argued that this belief system affects psychiatric symptoms and health-seeking behaviour; hence the need for a service built on an in-depth understanding of the local context.[56]

Coping strategies identified in this review, such as individual resilience and self-coping, align with findings from other studies. Women often employ personal resources and adaptive strategies to manage their symptoms and navigate the challenges of perinatal depression.[57] However, the QES also highlights the need for enhanced family support, as the burden of household responsibilities and childcare can exacerbate the mental distress experienced by mothers.

The healthcare-seeking behaviour of mothers, their interactions with healthcare providers, and their experiences within the healthcare system. It includes accessing care, expectations from providers, discrimination, and trust in the healthcare system. Healthcare Seeking and Provider Interactions play a pivotal role in the management of perinatal depression. However, there are areas for improvement in the healthcare system's response to perinatal depression.

This review's findings underscore the crucial role of healthcare professionals in the identification and management of perinatal depression. Similar to the experiences reported in this review, other research has highlighted the importance of training healthcare providers to improve their knowledge and recognition of perinatal mental health disorders.[58] Additionally, the need for a supportive and non-discriminatory healthcare environment is crucial to ensure that women feel comfortable seeking help and receiving appropriate care.

Women with perinatal depression living in LMIC are more likely to be denied quality care and have access to facilities that are poorly resourced, at an additional disadvantage that is attributable to the perverse stigma associated with mental illness.[59-61] Therefore, it is imperative that the complex interface between clinical governance and the set-up of any such facilities, including provider behaviour, is forensically examined to ensure these women have access to good quality care and outcomes.

The clinical implications of this qualitative review are significant. Healthcare providers should receive comprehensive training on perinatal mental health to improve their ability to recognize and address the symptoms of depression among women in the perinatal period. It is crucial to create supportive and non-judgmental environments where women feel comfortable discussing their mental health concerns and seeking help. Interventions should fo-

cus on promoting awareness among women, families, and communities about perinatal depression, its symptoms, and available resources for support and treatment.

In the case of utilising available resources for support and treatment, it is important that any such approaches are deeply rooted in evidence-based and cost-effective interventions. There are limited resources for managing mental disorders in primary care in developing countries, and as a result, it could be argued that innovation and technology can serve as viable means of providing patient-centred care.[62]

From a public health perspective, these findings highlight the importance of adopting and adapting a biopsychosocial perspective into the design of perinatal mental health services. This includes early screening for perinatal depression, establishing effective referral pathways, and providing accessible and evidence-based interventions with local adaptations. Addressing the sociocultural factors that contribute to perinatal depression, such as social norms, gender roles, and family dynamics, requires a comprehensive approach involving collaboration with community leaders, policymakers, and relevant stakeholders.

STRENGTHS AND LIMITATIONS

Qualitative Evidence Synthesis was considered the method of choice in this study for capturing the collective phenomenon of lived experiences and perspectives of pregnant women, their relatives, caregivers and healthcare workers.[25] The multiple perspectives and settings documented in the included studies are an important strength of this review. In addition, the review being contextualized to a specific country provided findings of relevance to engage policymakers and inform policy in Nigeria.

The qualitative review relied on a limited number of studies conducted in Nigeria, which may not fully represent the diverse experiences and perspectives across the country, given that eight out of ten studies are from the same state. The inclusion of studies conducted in other regions could have provided a comprehensive understanding of perinatal depression in different contexts. Therefore, more primary studies need to be conducted in this subject area. However, this limitation is mitigated by the fact that, as referenced in the discussion, several of the findings are corroborated by studies from other parts of Africa (e.g. Malawi and Ethiopia). A protocol for this review was not published which guarantees replicability and methodological transparency. However, our methods section was made as explicit as possible.

CONCLUSIONS

In conclusion, this qualitative review of women's lived experiences of perinatal depression in Nigeria reveals important insights into the multifaceted nature of the condition and highlights the significance of sociocultural influences, coping and support, recognition and perception, and healthcare-seeking and provider interactions. The findings underscore the need for increased awareness and education among both women and healthcare providers to enhance early detection and intervention. Furthermore, the review emphasizes the importance of addressing cultural and social factors when designing interventions and support systems for women experiencing perinatal depression, regardless of the geographical context. The research highlights the crucial role of healthcare professionals in the identification and management of perinatal depression and underscores the importance of training healthcare providers and creating supportive and non-discriminatory healthcare environments. The review has important clinical and public health implications, suggesting the integration of mental health services into routine perinatal care and the need for comprehensive interventions that consider sociocultural factors.

FUNDING

This research received no specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

AUTHORSHIP CONTRIBUTIONS

NDG, SEM, FIO and DJM conceptualised the study. EC, TTO and FIO wrote the introduction of the study. SEM conducted the search to the database while SEM, FIO, TTO, EC, and DJM did the data extraction and result synthesis. EC and JAUS wrote the discussion and conclusion. AB gave overall inputs and methodological guidance, and SEM, TTO did the final manuscript preparation.

COMPETING INTEREST

"The authors completed the Unified Competing Interest form at http://www.icmje.org/disclosure-of-interest/ (available upon request from the corresponding author) and disclose no relevant interest."

ADDITIONAL MATERIAL

The article contains additional information as an Online Supplementary Document.

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Submitted: April 26, 2024 BST, Accepted: July 27, 2024 BST

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SUPPLEMENTARY MATERIALS

Online Supplementary Document

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