Nazarbayev University School of Medicine

Master of Public Health Program

AWARENESS, PERCEPTIONS AND UNDERSTANDING OF POSTPARTUM WOMEN AND HEALTHCARE PROVIDERS ABOUT THE POSTPARTUM DEPRESSION: A QUALITATIVE STUDY

Master of Public Health Thesis Project Utilizing Professional Publication Framework

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Abstract

Introduction: Postpartum depression is a major public health problem and linked to mothers' reduced ability of sensitive parenting and increased risk of developmental delays of children. Its prevalence was estimated as 13% in Western countries and 19.8% in lower and middle-income countries. No previous studies have explored the perspectives of postpartum women and healthcare providers regarding postpartum depression in Kazakhstan. The aim of this research is to explore postpartum women's and healthcare providers' awareness, understanding and perceptions of postpartum depression, acceptability of the Edinburgh Postnatal Depression Scale (EPDS), and postpartum mental healthcare practices in Kazakhstani context.

Methods: A qualitative study was conducted at the outpatient clinics at the Republican Diagnostic Center and the National Research Center for Maternal and Child Health in Astana. Thirty qualitative interviews were conducted. Purposive sampling was used for recruiting 20 postpartum women and 10 healthcare providers, including gynecologists, pediatricians, nurses and psychologists. The inductive analytical approach was utilized and NVivo program was used for qualitative analysis.

Results: Respondents were mostly aware of postpartum depression, but varied in its perceived prevalence. Identified symptoms were social relations, mood changes, and physiological symptoms. Risk factors were divided into psychosocial, socioeconomic and physiological. For treatment, respondents named psychological, informational, informal, and instrumental support, self-management, and medications. There was variability in time, place and specialist to conduct screening. EPDS questions were understandable for most participants. Finally, barriers for maternal mental healthcare provision were identified.

Conclusion: Obviously, there is a need for introducing a screening tool, addressing time barriers for women, improving doctor-patient communication, increasing a number of psychologists, increasing public awareness, and opening more support centers. Finally, this study creates an evidence-base to develop recommendations to improve postpartum mental healthcare practices in Kazakhstan.

1. INTRODUCTION

1.1 Background information of the main issue

Maternal postpartum depression is recognized as a major public health problem (Wisner et al., 2006). Postpartum depression is defined as an episode of major depressive disorder that occurs in a postpartum period within the first year of giving birth and has negative consequences for a woman's life and a mother-infant bonding relationship (O'Hara, 2013). It generally affects 10% to 20% of postpartum women (Gjerdingen and Yawn, 2007) and accounts for approximately 19.8% in low and middle-income countries (Shidhaye and Giri, 2014). Though, other studies suggest that prevalence rates of postpartum depression in Asian countries may range from 11.0% to 60.8% (Halbreich and Karkun, 2006).

Postpartum depression has been linked to mothers' reduced ability of sensitive parenting and increased risk of various developmental delays of a child (Field et al., 2004). Clinical picture of postpartum depression includes a sense of hopelessness, helplessness, fatigue, feeling guilty, loneliness, obsessive thinking, reduced concentration, depressed mood, insomnia, substantial weight loss or gain, mood swings, depressive thoughts, suicidal ideation, and sleep deprivation (Gjerdingen and Yawn, 2007). Moreover, children of such women may have delayed psychological, neurological, and psychomotor development (Gjerdingen and Yawn, 2007).

Effective screening tools have been developed and recommended for early detection of postpartum depression. Edinburgh Postnatal Depression Scale (EPDS) is the most frequently used tool that has been extensively validated in different countries (Hewitt et al., 2009).

Since the negative consequences of postpartum depression for families are well documented, effective policy changes are required. The main barriers for early recognition and treatment of postpartum depression are low mental health literacy of the population, stigmatizing beliefs about depression, and personal barriers to help-seeking behavior of women. Thus, the effective

implementation of evidence-based interventions must incorporate thorough knowledge of the context that influences the impact of the interventions (Jorm A.F., 2000).

1.2 Rationale and significance of the study

Major depressive disorder in women is a major health problem across all nations and one of the main causes of disability-adjusted life years globally (Bennett, 2004). Though this is a big problem worldwide, there are little attention being paid to the problem of postpartum depression and no available information on its prevalence in Kazakhstan. There is also no formal postpartum depression screening instrument in Kazakhstan, such as Edinburgh Postnatal Depression Scale.

Even though internationally recommended evidence-based interventions for improving maternal and child health have been pilot-tested and introduced, most of these initiatives are not sustainable in the long-term. Therefore, for successful implementation of postpartum depression screening instruments and policy interventions, one has to get primary understanding of postpartum women and healthcare providers' views on postpartum depression, its screening and treatment choices.

Hence, to the best of our knowledge, no official published studies have explored the awareness, perspectives, and understanding of postpartum women and healthcare providers regarding the postpartum mood disorders in Kazakhstani context to guide the development of effective practice changes. Further, this study's findings will help develop recommendations for sustainable implementation of evidence-based postpartum mental health care practices in Kazakhstan taking into account cultural context. It also contributes to the aim of sustainable development of research capacity and advancing the research in the field of reproductive health in Kazakhstan.

1.3 Study aim and objectives

The aim of this qualitative research is to gain an insight into postpartum women and healthcare providers' awareness, understanding and perceptions of postpartum depression, acceptability of the EPDS depression-screening tool, and postpartum mental healthcare practices in Kazakhstani context. The objectives of this qualitative research are:

1. to explore postpartum women and healthcare providers' awareness and understanding of postpartum depression and its symptoms;
2. to identify the most prevailing views about cultural and other risk factors associated with postpartum depression;
3. to discover the perceived importance and awareness of postpartum depression screening tools;
4. to explore the acceptability of the EPDS depression-screening tool;
5. to explore the perceived importance and awareness of postpartum depression treatment choices;
6. to gather the perspectives on provision gaps and barriers in postpartum depression screening and treatment.

1.4 Overview of the literature relevant to the research question

The problem of postpartum mood disorders did not deserve much attention until recently, which explains a lack of research articles on this topic published in Kazakhstan. That is why, the overview of the literature was done based primarily on abroad studies. Though not Kazakhstani, the overview of this literature is justified, since it helps to gain a global understanding of postpartum women and healthcare providers' perceptions of postpartum mood disorders and get familiar with the evidence-based recommendations on postpartum depression screening and treatment practices.

Though, it might differ depending on the cultural context and the level of healthcare quality in corresponding countries. Therefore, it is important to conduct such sort of study in Kazakhstani context as well.

Prevalence

Based on the qualitative study on the perspectives of women and health professionals on symptoms of postpartum depression by Chew-Graham et al. (2009), 8-15% of UK women suffer from postpartum depression, which was determined to have long-term negative impact on maternal mood and adequate child development. Furthermore, it was found that the prevalence of postpartum depression is high both in Asia as well as Europe. More specifically, the prevalence in Asian countries was quite fluctuating with minimum of 3.5% and maximum of 63.3% (Klainin, 2009). Another qualitative study by Oates et al. (2004) was conducted in 11 countries and concluded that most people are aware of postpartum depression; however, not all of them consider this condition as treatable by medical interventions. Though the concepts like depression are frequently attributed to Western cultures, this study demonstrated the universality of experience of postpartum depression across nations.

Risk factors

A study by Klainin (2009) provides a literature review of postpartum depression studies conducted in 17 Asian countries and describes risk factors for postpartum depression in Asian cultures. As a result, risk factors associated with postpartum depression were combined into five groups: biological/physical (low body mass index, medical conditions), socio-demographic (immigrant status, financial burden, lack of support from husband and family), psychological (low self-esteem, stressful life events, child care stress), obstetric/pediatric (complications during pregnancy, previous abortion, the absence of breastfeeding, unplanned pregnancy), and cultural

factors (conflicts with mothers or mothers-in-law regarding childcare and child's gender). Another study was conducted in Kong-Hong by Chan (2002) and involved women diagnosed with postpartum depression. After gaining an insight into their lives and experiences of postpartum depression, it was found that uncaring husband, controlling mothers-in-law, sense of helplessness and hopelessness were common in those women. Thus, potential risk factors of postpartum depression among Kazakhstani women have to be identified taking into account local cultural differences in order to develop effective screening and treatment measures.

Symptoms

An evidence suggests that the postpartum fatigue is effective at predicting postpartum depression (Corwin, 2005). Physiological indicators of postpartum fatigue include iron deficiency anemia, thyroid hormone deficiency, and postpartum inflammatory status. Study conducted by Ugarizza (2002) in Miami-Dade County, Florida, involved qualitative interviews among postpartum depressed women as they themselves reported. Interestingly, women were found to be scared of being unable to recover their ability to complete tasks and get rid of their uselessness. Moreover, they were afraid of harming their baby. Though, these women did not have suicidal ideation.

Treatment

Study conducted by Ugarriza (2002) found that women chose education and promotion, antidepressant therapies, support groups, getting help with the baby, and having more spare time away from their child as the best treatment options. In a study by Chan (2002), women reported that homicide and suicide as the only means for women to escape from this situation. This study demonstrates the underestimated importance of this topic, whereby awareness of postpartum depression has to be increased and effective screening tools and policy interventions should immediately follow. In a cluster randomized trial, Yawn suggests that screening of postnatal

depression and follow-up care can be best conducted in the context of family medicine (Yawn et al. 2012). This is in part because women usually have close contacts with their family doctors. On the other hand, women who recently delivered do not tend to have regular relationships with their primary care physicians. Therefore, Chaudron argues that most of the times it is the child's pediatrician who postnatal women have close contacts with (Chaudron et al. 2004). For that reason, it is questioned if children's pediatricians should screen and diagnose mothers for postpartum depression. Further, one study found that UK health workers claimed that shortfalls of healthcare delivery for women with postpartum depression can be solved with the provision of more resources, more training, and more health professionals (Oates et al., 2004). Talking therapies were found to be in demand as well. The same study presents the views of the UK general practitioners, who emphasize the increased need for more training programs for health visitors, more mental health professionals and more counsellors.

Screening

Gjerdingen and Yawn (2007) underlined the importance, implications, and barriers associated with postpartum depression screening. Nowadays only half of the cases of postpartum depression is diagnosed, while the rest is left out without attention. So, there are huge benefits of mass screening. Routine screening of postpartum women for depression during their regular visits to a doctor's office substantially improves the disclosure of postpartum depression. It was also concluded that timely diagnoses, collaborations between general practitioners and mental health providers, longitudinal follow-up of target patients, and proper treatment are all necessary to ensure improved clinical outcomes. Thus, trained health professionals are required to ensure effective clinical outcomes following the early detection of postpartum depression. This conclusion can be also applied to Kazakhstani context. Regarding screening administration, according to the perinatal mental health model, the EPDS screening tool is administered "on a laptop computer with the assistance of a bilingual facilitator" in the waiting room before entering a doctor's office (Connelly et al., 2010).

After the completion, a woman is given educational materials on psychosocial issues and women with positive test results are given a list of available resources for further management. Though, there is little evidence on optimal time to conduct screening. According to US Preventive services task force, it is suggested to conduct screening at least once in both pregnancy and postpartum period (2016). The American Academy of Pediatrics suggests that pediatricians conduct screening of women for postpartum depression at the infant's 1-, 2-, and 4-month visits (2010).

It was also determined that the EPDS is the most frequently used measure with reasonable psychometric properties (Gjerdingen and Yawn, 2007). This conclusion might be taken into consideration when developing screening tool for Kazakhstani postpartum women. However, the previous research suggests that when screening instruments for postpartum depression are translated from English to native languages, the translated versions might lose their psychometric properties (Klainin, 2009). Hence, one must be careful when developing and translating screening tools for Kazakhstani population. Overall, a decent screening instrument should be inexpensive, easy to administer, and have an adequate sensitivity and specificity.

Barriers

Gjerdingen and Yawn (2007) concluded that 80% of women are not against of being screened for postpartum depression in the outpatient settings. However, most providers are reluctant to screen women for postpartum depression, and a lack of training and experience might be a reason for that. Overall, two possibilities for postpartum depression screening are available, which are mothers' postpartum office visits and their infants' well-child visits. In addition, three types of barriers to postpartum depression diagnosis were identified in the same study. The first is a patient-centered barrier, which refers to a lack of insurance, social stigma, treatment nonadherence, and a lack of time. The second is a physician-centered barrier, which includes a lack of training and knowledge, negative

legal consequences, a lack of time and others. Finally, a systems-based barrier includes irregular and infrequent mothers' follow-up visits and a division of primary care and mental health services. Similar barriers hindering a timely diagnosis and maternal depression treatment were identified by Goldman et al. (1999). Likewise, Japanese and Italian obstetricians and pediatricians underlined their concerns on the lack of psychiatric services (Oates et al., 2004).

2. RESEARCH METHODOLOGY

2.1 Study design

A qualitative research design was chosen to meet the objectives of this study. In contrast, study findings from the quantitative studies would not be all-encompassing and comprehensive enough to meet the study objectives at the initial stage of research, when the primary in-depth elucidation of the main topic is important. Qualitative semi-structured open-ended individual interviews were the primary data collection mode for this qualitative study.

The interview guides were developed separately for postpartum women (Appendix 3, 4 & 5) and healthcare providers (Appendix 6, 7 & 8) in English, Russian and Kazakh languages. The interview guides were composed of a set of semi-structured open-ended questions, providing a basis for an insightful understanding of participants' views on the main issues. Prior to the actual interviews, a pre-test of the interview guides was conducted.

The acceptability of the EPDS tool was also explored as a part of an interview. The 10-item EPDS tool was first developed in Scotland at health centers in Livingston and Edinburgh in 1987 to aid the detection of postpartum depression in mothers (Cox et al., 1987). The instrument has a good sensitivity (86%) and specificity (78%) levels. For our research purposes, a validated Russian version of EPDS (Appendix 9) was provided by An agency of the Provincial Health Services Authority. Perinatal services BC (2018). Further, an original English version of EPDS tool was translated into

Kazakh, after which the process of back-translation was done. Afterwards, back-translated and original English versions were compared to ensure the accuracy and quality of the original Kazakh translation (Appendix 10). Moreover, a pretest for a Kazakh EPDS version was also done.

2.2 Settings

The qualitative study was conducted at outpatient clinics at the Republican Diagnostic Center and the National Research Center for Maternal and Child Health in Astana, Republic of Kazakhstan (further referred to as Centers). These leading medical-diagnostic and scientific-educational institutions provide treatment for women and children from the various regions of the country. More specifically, interviews with healthcare providers were conducted in their offices, while interviews with postpartum women were conducted in Healthy Child Units.

2.3 Sampling and study participants

In order to meet the objectives of the research, the subjects for the given study were chosen to be postpartum women and healthcare providers. Purposive convenience sampling was used for recruiting postpartum women and healthcare providers for the interviews. Participants were at least 18 years old postpartum women at the moment of recruitment and healthcare providers working at the corresponding outpatient clinics, as inclusion criteria. Exclusion criteria were being younger than 18 years old, inability to read and understand Russian, Kazakh or English, and having severe psychiatric illnesses. According to the Council for International Organizations of Medical Sciences (CIOMS 2016) publication “International Ethical Guidelines for Health-related Research Involving Humans”, pregnant and breast-feeding postpartum women must not be considered as vulnerable population. Since the qualitative research methods do not essentially require the calculation of the sample size, it was overall planned to interview about 20 postpartum women and 10 healthcare providers until the saturation point in themes and categories is reached. As a result, 20 postpartum women and 10

healthcare providers, among which are 2 psychologists, 4 gynecologists, 2 pediatricians, 1 Healthy Child Unit's nurse and 1 obstetrician, were recruited. Taking into consideration Kazakhstani context and the diversity of local languages, inability to communicate in English was avoided, since the interview was offered to conduct in either of three most frequently used languages, including Kazakh, Russian or English.

Subject Recruitment

Purposive convenience sampling was used for recruiting postpartum women and healthcare providers as was said above. The researcher came to the outpatient clinics at the Centers every day from Monday to Friday between December 2017 and February 2018 in order to recruit postpartum women for the interviews. In the Republican Diagnostic Center, postpartum women who came to visit a pediatrician or for well-child visits were recruited. In the National Research Center for Maternal and Child Health, postpartum women who came to visit a gynecologist were recruited. Thus, an interviewer individually approached each woman who is waiting for the doctor's appointment. Similarly, recruitment and interviewing of healthcare providers working at the Centers was conducted during the work hours depending on their availability and work schedule. Following a brief explanation of the aim and important highlights of the research, the interviewer obtained verbal informed consents in Russian, Kazakh, or English (Appendix 2) in case of potential participants' willingness, preparedness, and agreement to participate in the study. In case of obtaining the informed consents, the interviews were conducted in the coordinated time convenient for participants.

2.4 Data collection

The primary data collection mode for this qualitative study were qualitative semi-structured open-ended individual interviews, as was said above. Thus, data was collected with the help of interview guides, described earlier. The interviews were recorded with the help of audio recorder.

Approximately, 2-3 interviews were conducted per day. Generally, one interview lasted for about 30 to 50 minutes.

2.5 Data analysis

A preliminary data analysis was continuously made starting from the beginning of a data collection process. Such approach allowed for continuous monitoring of newly emerging themes and categories (Merriam, 2016). It also helped to hold onto the purpose of the study and sustain the main research focus. The NVivo program was used for the qualitative analysis of obtained data. The 30 qualitative interviews were transcribed and translated into English, since they were mostly conducted in Russian and Kazakh. Hence, a descriptive account of data allowed for coding of the 30 interview transcripts. The inductive analytical approach was used to interpret the findings. Thus, after coding, a construction of themes responsive to the research question was performed. Further interpretive analysis included identification of specific patterns and interrelationships among these themes by comparing and contrasting them. This allowed to construct category schemes, which combined together the emergent themes representing the same topic or issue. Thereby, inferences about a posed research question were made and the objectives of the research were achieved.

3. ETHICAL CONSIDERATIONS

An ethical permission to conduct this research study has been obtained from NUSOM REC and UMC the Medical Research Ethics Committee. A verbal informed consent was obtained from each study participant on a voluntary basis. Interviewees had a right to withdraw from the study at any moment, skip sensitive questions, and change or delete any of their responses without any consequences. The interviewees were asked for the permission to make audio recordings of the interviews. To ensure the protection of interviewees' identity, no identifiable information was used and all the collected data has been kept confidential.

There were no known risks to participants expected that are greater than they would normally encounter in their daily life. All the minimal risks resulting from the participation in the interview in regards to some sensitive questions and time inconvenience for conducting interview were explained to participants in advance. There were no known direct benefits to participants as well. Nevertheless, there is an overall benefit to people in future since the information obtained may have a great impact on maternal and child healthcare in our country. By better understanding women and healthcare providers' perspectives on postpartum depression, screening, and treatment choices, it becomes possible to develop better preventive measures and screening programs for addressing this health problem.

4. RESULTS

Table 1 represents the sociodemographic characteristics of postpartum women, which were recruited for the interviews.

Table 1. Sociodemographic characteristics of postpartum women in the Republican Diagnostic Center and the National Research Center for Maternal and Child Health (n=20).

	Postpartum women n (%)
Age range (years)	
18-23	3 (15%)
24-29	8 (40%)
30-35	5 (25%)
36-40	4 (20%)
Mean age (years)	29.05

Recent postpartum status	
Less than 1 week	0
2-4 weeks	4 (20%)
More than1 month	3 (15%)
2-6 months	7 (35%)
More than 6 months	6 (30%)
Gravidity	
1	7 (35%)
2	6 (30%)
3	5 (25%)
4	1 (5%)
7	1 (5%)
Parity	
1	7 (35%)
2	6 (30%)
3	5 (25%)
4	1 (5%)
5	1 (5%)
Marital status	
Married	19 (95%)
Single	0
Divorced	0
Widowed	0
Cohabiting	1 (5%)
Type of family	
Extended	4 (20%)
Nuclear	16 (80%)
Highest education degree so far	
Elementary school	0
High school	0
College	3 (15%)
University undergraduate level	16 (80%)
University postgraduate level	1 (5%)

Occupation	
Medicine	2 (10%)
Government employee	7 (35%)
Employee of private company	1 (5%)
Business owner	0
Self-employed	10 (50%)
Unemployed/Housewife	0
Student postgraduate	
Previous history of mental health problems	
Yes	0
No	20 (100%)
Amount of money spent in one month (in tenge)	
Less than 100 000	1 (5%)
100 000 – 199 000	8 (40%)
200 000 – 299 000	7 (35%)
300 000 –399 000	4 (20%)
400 000 – 499 000	0
500 000 and above	0
Nationality	
Kazakh	17 (85%)
Russian	3 (15%)
Other	0
Place of residence	
Astana	18 (90%)
Akmolinskaya oblast	2 (10%)
Other	0

Table 2 represents the emergent themes and categories, which resulted from the qualitative analysis of 30 interview transcripts.

Table 2. Categories and themes identified in interviews.

Category and themes	Postpartum women n=20 % (n)	Healthcare providers n=10 % (n)
1. Awareness		
Awareness of postpartum depression	95% (19)	100% (10)
Variability in awareness of prevalence:		
Not aware	20% (4)	20% (2)
Not prevalent	35% (7)	10% (1)
Prevalent	45% (9)	70% (7)
2. Knowledge of symptoms		
Social relations and roles/tasks	90% (18)	80% (8)
Emotional issues and mood changes	100% (20)	100% (10)
Physiological symptoms and issues	85% (17)	30% (3)
3. Understanding of risk factors		
Psychosocial factors	100% (20)	100% (10)
Socioeconomic/social factors	75% (15)	50% (5)
Physiological factors	60% (12)	80% (8)
4. Treatment options		
Perceived necessity of treatment		
Necessary	60% (12)	100% (10)
Not necessary	40% (8)	(0)
Psychological support	100% (20)	100% (10)
Informational support	85% (17)	80% (8)
Informal social support	100% (20)	100% (10)
Self-management / self-help	45% (9)	40% (4)
Medications and over-the-counter meds	90% (18)	70% (7)
Instrumental support	65% (13)	20% (2)
5. Perceptions of screening		
Screening for all women	95% (19)	90% (9)
Perception of the depression screening instrument:		
Satisfied	90% (18)	100% (10)
Unsatisfied	10% (2)	(0)
Variability in place where to conduct screening:		
In-home	55% (11)	10% (1)
Clinic	30% (6)	70% (7)
Maternity center	15% (3)	20% (2)

Variability in time when to conduct screening:		
during pregnancy	5% (1)	3rd day postpartum: 20% (2)
pregnancy and postpartum	20% (4)	1 month postpartum: 80% (8)
two times postpartum	5% (1)	
one month postpartum	70% (14)	
Variability in specialist who should administer the EPDS tool and is able to disclose postpartum depression		
Psychologist	85% (17)	30% (3)
GP or nurse	10% (2)	30% (3)
Pediatrician	5% (1)	20%(2)
Gynecologist or nurse	(0)	20% (2)
Screening tools for postpartum depression in Kazakhstan	50% (10)	100% (10)
No screening tool	25% (5)	60% (6)
Surveys at maternity center	25% (5)	30% (3)
		Beck's depression scale is used: 10% (1)
6. Barriers and provision gaps followed by participants' recommendations for maternal mental health services		
Lack of protocols/screening tools	75% (15)	100% (10)
Problems with access	95% (19)	70% (7)
Health providers' capacity and doctor-patient communication	85% (17)	50% (5)
Lack of public awareness and stigmatization	50% (10)	80% (8)
Lack of relaxation units	80% (16)	40% (4)

4.1 Category 1: Awareness of postpartum depression

Theme 1: Awareness of postpartum depression

Women were quite aware about the potential existence of psychological issues and postpartum depression in particular. Moreover, almost half of the women respondents had acquaintances with women suffering from postpartum depression. The same is true for health care providers. Some of them turned out to have quite frequent contacts with postpartum women experiencing depressive symptoms. A nurse from Healthy Child unit pointed out that she meets 3-4 women with depression per month, who often share and express their hardships. Almost all health

care providers responded that women come to their office with a complaint for postpartum depression and they try to disclose their symptoms. Only one participant responded that this is not a common practice and another participant told that she met only one woman with postpartum depression in 25 years of work experience. There also were extreme examples remembered by a pediatrician,

As I remember, there were several cases when a woman left her child on a street, but she didn't remember that. She went to a police and said that someone kidnapped her baby. On the other hand, another woman thought that everyone is representing a danger and a threat for her baby. So, she hided in my office.

Theme 2: Awareness of prevalence and perceived importance of postpartum depression

Regarding the perceptions of women and healthcare providers about prevalence of postpartum depression in Kazakhstan, the variability in answers were found. Thus, 4 women had no idea whether postpartum depression has important influence or not and 9 women responded that it is quite widespread state of women. Thus, 7 women concluded that it is not prevalent and unimportant disease. As one woman said,

I think it is not prevalent at all. However, even if it is not spread, when doctors frequently say about it, then susceptible women might think that they have postpartum depression even if they don't.

Similar patterns of responses were received from health care providers. So, while 2 respondents had no idea on the prevalence and importance of postpartum depression in the country, 1 respondent concluded that it is not widespread saying that, *"Kazakh families are big and everyone helps each other, which is why postpartum depression is not common".* Another respondent said that, *"When parents live together postpartum depression is absent".* Thus, 7 other respondents believed that it is quite widespread.

4.2 Category 2: Knowledge of postpartum depression symptoms

Theme 1: Social relations and roles/tasks

This theme revealed that one of the symptoms that respondents consider important is *poor emotional contact with a child*. This includes detachment, aggressive attitude and negativity towards childcare and motherhood, and not being able to accept this child. As one of the women said,

When a mother with postpartum depression feels negativity and no emotional contact towards her child, this child will also feel and absorb these negative emotions. Such children rarely grow up as healthy and happy people.

Moreover, participants reported that women with postpartum depression refuse to breastfeed. Also, they shout at both infants and elder siblings. As healthcare providers reported, postpartum depression women are not interested in answering doctor's questions about childcare. Some of the women even have a desire better not to have that child as was reported by some of the health professionals. Thus, except for two women, most respondents understood that *postpartum depression negatively affects a child*. So, women mostly reported that all emotions are sent from mother to child, including negative emotions, too. So, as one of the women said,

When a mother feels bad, then a baby also suffers. If she doesn't feed him properly, there can be serious problems both with physical and mental health...a baby can go crazy and be hysterical.

Similarly, health care providers believed that postpartum depression has negative influence on mother's life and health and the development of child, both physical and psychological. For example, one pediatrician reported that when mother is happy and calm, then child is happy, has no sleeping problems, and even cramps become less prominent. On the other hand, doctors reported that in a family where a mother suffers from postpartum depression, other siblings suffer, too,

Not only an infant suffers from that, but its elder siblings, too. Since such mothers don't have enough time and energy to pay attention to other children, they may have problems at school and they won't receive as much love as they need.

Also, it was mentioned that because of sleep deprivation and other negative emotions, milk can disappear, tactile bond disappears, and child grows like a withdrawn person. Surprisingly, two healthcare providers believed that postpartum depression has no negative effect on children.

Next, respondents pointed out that *not being able to accomplish tasks* is also frequent in postpartum depression women. So, they are not able to take care of a child and cannot cope with new responsibilities and housework. In addition, health care providers noticed that postpartum depression women often have disrespectful or *neglectful attitude to themselves*,

From my experience, I always pay attention to how a woman is dressed up, whether her clothes are neat, tidy and clean, and also to how this woman answers my question. When she is not interested in answering my questions, I already suspect that this woman has a wrong attitude towards her baby and her role as a mother. Such women don't look at me, look at the window, or start crying. They have neglectful attitude to themselves.

Theme 2: Emotional and mood changes

Frequent mood changes, including the whole specter of emotions, were reported as one of the common manifestations of postpartum depression. These include anger, irritability, melancholy, frustration, aggressiveness, anxiety, being inactive and faded, fear, sadness, loneliness and feeling isolated. Also, postpartum depression women were reported to want to cry all the time. They blame themselves and those who are around, take offense at family members, and stress out because of their scars and physical appearance as was reported by women. As a psychologist pointed out,

When a woman blames her husband or parents, I means that she doesn't want to find a source of problems inside herself. She just simply shifts responsibility and the blame on others. But of course there are cases when husbands are uncaring.

Theme 3: Physiological symptoms

Women respondents mentioned that postpartum depression women may experience issues with their appetite. For example, as one women reported, *"my friend suffering from postpartum depression used to have to eat lots of carbs, cakes and chocolate at that time".* Moreover, it was

mentioned that postpartum depression women feel tired and fatigue all the time.

4.3 Category 3: Understanding of risk factors and perceived causes

Theme 1: Psychosocial factors

Psychosocial factors as a social response to birth were considered most important to women. All women underlined that a *lack of family support*, especially a husband's support, may greatly influence the development of postpartum depression. Furthermore, when in-laws are too demanding and strict, depressive symptoms may arise. The same was true for healthcare providers' responses. They also mentioned that attention deficiency, not receiving love and appreciation, criticizing husbands and in-laws may cause depressive symptoms in women. As one of the nurses said, "*mothers can be oversensitive to in-laws' even simple kind recommendations, which causes or caused by postpartum depression*". Moreover, not having a husband also was called as a risk factor. At the same time, *domestic violence* was also called as an important risk factor by health professionals. Also, one of the psychologists also mentioned that *women from orphanages or single-parent families* may be prone to develop postpartum depression. On the other hand, as psychologists reported, *"being a single child in a family may be a reason why a young woman becomes selfish and spoon-fed person, who is definitely not able to take care of another person, her child"*.

Also, one of the substantial causes reported by all respondents of postpartum depression is *unplanned pregnancy* or when a father does not want that child. Though a *negative attitude to a childcare* was mentioned as one of the symptoms of postpartum depression, it was underlined as a risk factor, too. So, as women reported, some women predisposed to postpartum depression are prone to develop negative attitude not only to childcare but also everything new coming into their life. So, *psychological unpreparedness for pregnancy and motherhood* can be an important risk factor.

Giving birth to "*a first child, lack of experience with childcare and absence of a kind person who would be able to give pieces of advices* [on childcare]" was mentioned as a risk factor as well by women and healthcare providers. However, another risk factor mentioned by women is when women have *many children*, especially young toddlers. Also, when women *stay at home for a long time* because of a child, then this can be a risk factor, too.

Poor time management and not having strict daily routine can be also a risk factor, as women respondents and health care professionals report. This in turn causes not being able to cope with tasks, which is one of the symptoms of postpartum depression, as reported by respondents. In this light, when *reality does not meet expectations*, women may develop postpartum depression. Therefore, as women and healthcare providers said,

When postpartum women are too young or over their 30s, they may be at risk of developing postpartum depression, because they are unexperienced for childcare and are used to dedicate time for themselves only.

Theme 2: Socioeconomic/social risk factors

Socioeconomic risk factors were also mentioned by respondents. For example, not having enough money and having poor living conditions were frequently mentioned by women respondents. One of the nurses also said that, *"women even at the maternity hospitals start comparing themselves to other rich women and feel jealous".* This also can be a risk factor for postpartum depression. But, as healthcare providers mentioned, not only low SES was mentioned as a risk factor, but being rich and spoon fed can be a cause why a woman cannot cope with her new important responsibilities and develop postpartum depression.

Theme 3: Physiological risk factors

Physiological risk factors were mentioned by women and healthcare providers, too. So, women thought that *sleep deprivation* may influence the development of postpartum depression.

Also, as most respondents said, *Caesarian section, suffering from other chronic conditions, having birth complications and difficult painful labor* may also be risk factors for postpartum depression. About 4 women and 3 health care providers highlighted *hormonal and endocrine profile changes* as a possible reason of postpartum depression. As one of the gynecologists said, *"only progesterone deficiency causes postpartum depression and not any other factors".* In addition, several women mentioned *bad physical appearance and gaining extra weight* after pregnancy as a potential cause of postpartum depression.

Surprisingly, one gynecologist had no idea of risk factors of postpartum depression saying, *"the reason is unclear for me".* Another gynecologist said, *"No undernutrition and no other disease affects postpartum depression as much as psychological factors".* However, third gynecologist ignored all psychosocial factors and asserted that only hormonal imbalance is the only cause of postpartum depression.

4.4 Category 4: postpartum depression treatment options

Theme 1: Perceived necessity of treatment

Postpartum women's responses demonstrated ambivalence in their perceptions in the necessity of treatment. So, while 12 women responded that postpartum depression cannot disappear itself without treatment, 8 women decided that treatment is not necessary. One woman claimed that time is the only remedy and three women told that all women experience postpartum depression symptoms, but it definitely disappears after 3-4 months. Finally, one woman said that treatment is necessary in complicated cases of postpartum depression only. Surprisingly, all health care providers agreed upon the necessity of postpartum depression treatment and that it cannot go away on its own.

Theme 2: Psychological support

Postpartum women named a psychologist's consultations is the first choice to go in case of postpartum depression. All women insisted that they prefer in-home based psychological support because they *"have no time to go to the clinics and have no place to leave a child"*. In this light, some of the women said that online and telephone (call-center) consultations would be very helpful for women with postpartum depression. They also highlighted the importance of psychological consultations for other family members, including husbands and in-laws,

A psychologist has to work both with woman and man. A partner should listen to "a person in a white coat", otherwise he won't believe his wife has postpartum depression.

Healthcare providers also highlighted the importance of psychological consultations and individual approach to each woman. Psychologists shared that they use active listening, giving recommendations, and gestalt therapy in their practice with postpartum depression women. Healthcare providers also told about the availability of psychologists at the clinics and maternity hospitals, Healthy Child units, physicians and nurses' home visits, though not so extensive.

Theme 3: Informational support

Women express their wish to receive useful recommendations on how to avoid postpartum depression and prepare themselves for happy motherhood from the whole array of specialists, including gynecologists, nurses, obstetricians, pediatricians, GPs and psychologists. Women also wish *"doctors would listen to each woman very carefully and give pieces of advice"*. Preparatory courses, lectures, trainings, seminars were also named as necessary treatment option. Postpartum respondents and health care professionals mentioned that there are several preparatory courses and gynecologists/psychologists' lectures for future mothers, though not much.

Health care providers also highlighted the importance of mother's education on childcare

and motherhood starting from the first trimester of pregnancy and the necessity of *"adaptation courses for young mothers and family members"*. This is because *"prophylaxis and primary prevention is important"*, as healthcare professionals claim.

Theme 4: Informal social support

Strong family, friends', and neighbors' support and emotional support from optimistic people were named as one of the important treatment options by women and healthcare providers, too. Similarly, women prefer relaxation rooms, art-therapy, and fitness as tools to combat postpartum depression symptoms,

In addition to being close to optimistic people and attending special relaxation rooms, a woman should have own hobbies, art-therapy, clay-therapy, and yoga classes. This is because in addition to psychologists' consultations, women have to fill themselves only with positive emotions.

Yoga was a common treatment preference for both women and healthcare providers. In addition, going for a walk in a fresh air was named as a nice way for a woman to uplift emotionally and embrace herself. Healthcare professionals also reported that interaction and constant communication with positive people can decrease postpartum depression symptoms. One healthcare provider also said that it is important to eliminate irritating factors and have only positive thoughts.

Theme 5: Self-management / self-help

Women respondents talked a lot about self-management approaches as the alternative to treatment. So, one woman said, *"women should not think someone is responsible for that, so only she has to be responsible for herself and cope with her problems by herself".* Interestingly, healthcare providers also shared this point of view, saying that a woman has to be a manager for herself. Healthcare providers claimed that women have to develop a healthy sleep routine and healthy nutrition for themselves, also *"they have to be well disciplined and organized to cope with tasks".*

Theme 6: Medications and over-the-counter meds

Some women named sedatives, calming sedative herbs, vitamins as a possible medication for postpartum depression treatment. Two women were not sure about medicaments and called them as "useless". Several women named hormonal therapy for postpartum depression women as well. Those women who mostly preferred emotional support also chose good nutrition and health resorts treatment.

Healthcare providers also referred to hormonal therapy. However, one gynecologist insisted that prescribing sedatives is *"totally incorrect, because postpartum depression is caused only by hormonal misbalance and hormonal therapy is necessary to treat postpartum depression".* Nevertheless, several other health professionals named antidepressants as a treatment option. However, other health professionals were against medicaments, because they are unfavorable and have side-effects since women breastfeed.

Theme 7: Instrumental support

Most women referred to financial help from the government as a remedy to postpartum depression. So, in their opinion, state/public assistance, including child allowance and maternity leave allowance, would help decrease the burden of socioeconomic risk factors. In this light, one gynecologist pointed out that *"since Kazakhstani women go to maternity leave in the last trimester only and stress out because of work, early maternity leave is necessary. Women should enjoy their pregnancy and not stress out because of hectic work schedule or their demanding bosses".* Moreover, women respondents expressed their dissatisfaction with in-kind assistance from the government, *"maternity hospitals gave us several diapers and baby wipes, but these sanitary items are not enough, this is too little".* Interestingly, only two health care providers mentioned instrumental support for postpartum depression treatment.

4. 5 Category 5: Perceptions of postpartum depression screening

Theme 1: Screening for all women

Almost all women agreed upon introducing postpartum depression screening for all women postpartum. Only one woman thought that only risk population groups should be administered postpartum depression screening tool. Similarly, almost all healthcare providers agreed that postpartum depression screening should be introduced for all women. Only one health professional thought that there is no need to screen all women for postpartum depression,

I don't think all women have to be screened for postpartum depression, but only those in the population of risk. There is no need to screen all women.

Theme 2: Perception of the depression screening instrument

Women and healthcare professionals were mostly positive about EPDS questions and scale. They claimed that EPDS tool contained no misleading or difficult questions. Questions were acceptable and culturally appropriate for them, too. However, two women shared their opinion that Kazakstani women would rarely answer such questions, which are "embarrassing and shameful". So, as one of the women reported,

I think that the questions are understandable and related to the topic. However, I worry that women would not be ready to be honest. Questions should not be asked explicitly not to frighten women.

Theme 3: Variability in place where to conduct screening

There also was a variability in place where to conduct screening. Eleven women preferred in-home diagnostics, including "online surveys". This was explained by the fact that young mothers "*have no time to go to the hospital and have no one to leave a child with".* Moreover, women reported the necessity to share the screening results with family members,

One of the reasons why I would like to go through the screening at home is that I think it is important to show the screening test results to family members, they have to see and know that a woman suffers. Otherwise they won't believe us.

In addition, six women preferred doing screening during monthly check-up in clinic, and three women suggested to conduct screening at the maternity hospital on the 3rd day postpartum.

One healthcare provider shared the opinion that in-home diagnostics would be effective and comfortable. On the other hand, seven healthcare providers thought that screening should be conducted during monthly check-up in clinic and two of them also shared their view that it can be conducted on the 3rd day postpartum at the maternity hospital. As a nurse from Healthy Child unit claimed,

It is incorrect to do screening at home. Since women have no desire to share their true feelings in front of their husband or in-laws, the answers might be false. For instance, at home, she will never admit that she wants to do harm to herself. But the atmosphere at the medical centers is official and entirely different.

Theme 4: Variability in time when to conduct screening

The opinions of women were ambivalent regarding the time when to conduct postpartum depression screening. So, whilst one respondent said that postpartum depression screening should be conducted during pregnancy, four women said that it should be conducted both in the post- and prenatal period, and one woman said that a screening should be conducted two times postpartum, the rest of the respondents reported that they would like this screening to be about one month after birth.

There also was variability in health professionals' responses regarding time of screening. So, eight healthcare providers claimed that it should be conducted in one month after birth and two healthcare providers thought that it should be conducted on the 3rd day postpartum,

At the maternity hospitals there are only 3 days of hospital stay. So, it is too early and difficult to diagnose postpartum depression, and it is even impossible because women are still under strong emotional impression after labor pain and overall childbirth. She doesn't realize the essence

of motherhood and her new responsibilities until she returns home. Moreover, women have hormonal changes during the first month postpartum.

Theme 5: Variability in specialist who should administer the EPDS tool and is able to disclose postpartum depression

Regarding a specialist who can administer the EPDS tool, a psychologist was named by 17 women, a pediatrician was recalled by one woman, and GP or nurse were named by two women.

There was a great variability of answers among healthcare providers regarding who should administer the EPDS tool and is able to disclose postpartum depression. Contrary to the women's opinion, only three healthcare providers said that sociologists or psychologists should be the first to administer EPDS and disclose postpartum depression in patients, especially by receiving a feedback from pediatricians' and gynecologists' offices. Two healthcare providers highlighted that since pediatricians work closely with mothers and children, they should be able to early detect postpartum depression in mothers and then refer them to psychologists. Two more healthcare providers also responded that gynecologists should be able to administer screening tool and early detect postpartum depression in women, because they start working and communicating with women from the pregnancy. The rest of health professionals (3) also told that GPs should be the first to disclose postpartum depression in patients.

Theme 6: Diagnostics/screening tools of postpartum depression in Kazakhstan

About five women shared the view that there is nothing done to detect postpartum depression in Kazakhstani hospitals. Another five women said that they were given surveys at the maternity centers with 100, 50 or 30 questions to determine if they had depressive symptoms. However, as these women report, *"we were not given the results of these surveys. It seemed like it was done just for the sake of box-checking".*

Six healthcare providers claimed that they don't work on screening of postpartum depression with the help of official screening tools for postpartum depression. One healthcare professional said that *"even if some doctors conduct sort of diagnostics by themselves, there is no official protocol for postpartum depression enforced in our clinics".* In addition, a psychologist said that *"I usually determine her level of anxiety and risk group using Anxiety Scale".* One healthcare professional said that she refers patients, who she thinks shows postpartum depression symptoms, to psychologists. Next, three healthcare professionals recalled that sometimes postpartum depression diagnostics is done at the maternity hospitals. Also, only one gynecologist said that she heard that Beck's depression scale is enforced in Kazakhstan, but it is not extensively used.

4. 6 Category 6: Barriers and provision gaps followed by participants' recommendations for maternal mental health services

Theme 1: Lack of protocols/screening tools for postpartum depression diagnostics

This was also discussed in the previous section Category 5, where the variability of answers about existing screening tools was obtained. Highlighting the importance of early diagnosis and treatment of postpartum depression, women expressed their wish to introduce screening tools and "surveys in each clinic".

As healthcare providers pointed out, there are no protocols on postpartum depression in their clinics. Thus, Healthy Child unit's nurse suggested *"to incorporate screening tools and special scales of emotional well-being into practice"*. Another health professional also highlighted that *"a special plan should be developed for preparing mothers for pregnancy and motherhood"*. Gynecologist proposed *"to conduct regular check-ups and enforce protocols for hormonal therapy for postpartum depression treatment".*

Theme 2: Problems with access

Lack of time and a person to leave a child with were named as barriers to diagnostics and treatment of postpartum depression by both health professionals and women. As one woman reported, *"I simply have no one to leave my child with, so I cannot afford myself going to a psychologist's office".* Similarly, one doctor pointed out that,

Sometimes women stop coming to psychologist's consultations after one session, they have no opportunity to see a doctor because of time limitations and no place to leave a child. They wait until they are brought on ambulance machine to the hospital.

Long waiting lists were also mentioned as a barrier to mother's healthcare by almost all women and healthcare providers.

Theme 3: Healthcare providers' capacity and doctor-patient communication

Women underlined poor communication skills of the doctors and nurses they encountered so far and highlighted the importance of empathy, attentiveness, careful listening, and strong communication skills for doctor-patient communication. Some women also reported that sometimes decisions about medical care were made without taking their wishes and concerns into account. One of the healthcare providers also pointed out the importance of improving doctor-patient communication in Kazakhstan.

Doctors and nurses should be very attentive and carefully listen to each woman to timely detect any changes in her mood or behavior. Doctors should be trained for that kind of communication skills. More time has to be allocated for each consultation.

The lack and necessity of qualified specialists, including nurses and psychologists, was also mentioned by most respondents. Women noticed that more trainings for healthcare providers should be held in the light of postpartum depression. Moreover, healthcare providers mentioned a lack or an absence of social workers for postpartum depression women, too. One of the nurses suggested that

there are should be separate psychologists for children, pre- and postnatal women, and the rest of the adult population,

I think it is incorrect when one psychologist works with different cases alone, it is very difficult for them to switch their attention and focus back and forth from one category of people to another.

Moreover, women told that doctors overwork and too little time is allocated for appointment. As one of the respondents said, *"We have too much paper work and no time to talk to patients. I think we need to increase the role of nurses and introduce e-passports/e-records to save time".*
Healthcare providers also talked about tough schedule of health care workers who simply have not enough time and little energy to notice emotional disturbances in women.

So, by telling that gynecologists are most of the time are busy with physiological disorders, one of the respondents underlined the importance of work in a *"multidisciplinary team"*, where all healthcare providers communicate with one another.

Some of the women also mentioned that only a child gets examined during a monthly check-up and they would like to be paid attention and get examined, too.

Theme 4: Lack of special/relaxation/Healthy child units/rooms for mothers and children in polyclinics

Lack of support centers and relaxation rooms for mothers was mentioned by most women. Moreover, healthcare providers also mentioned a lack of special rooms for mothers and children in polyclinics. As a nurse from Healthy Child Unit said, *"Healthy Child units should be opened everywhere, but even currently healthy child units do not work to their full potential".*

Theme 5: Lack of public awareness of postpartum depression and stigmatization of mental health issues

Lack of public understanding of postpartum depression turned out to be an issue as well. As woman said, *"people would probably think you are abnormal if you visit a psychologist".* Some

women do not even know that there are psychologists' office in the clinic or hospital. Women told about the importance of prevention and prophylaxis and proposed to teach about pregnancy, motherhood and childcare at high schools and universities. Also, *"Launching Schools of young mothers to conduct more teaching seminars/preparatory courses"* was mentioned by women and healthcare providers as well.

As healthcare providers highlighted, *"our women, especially in south regions, are not brave and open enough to share their psychological or emotional issues, so anonymous call centers are needed"*. Another psychologist said that *"women don't talk about postpartum depression and they do not fully understand what does this term mean. Kazakh women underestimate the work and the role of psychologists. So, teaching seminars on postpartum depression for health professionals, pregnant and postpartum women should be held"*.

5. DISCUSSION

The present qualitative study has explored the awareness, perceptions and understanding of postpartum women and healthcare providers regarding the postpartum depression in the Kazakhstani context. To achieve research objectives, 30 qualitative semi-structured open-ended individual interviews were conducted among 20 postpartum women and 10 healthcare providers at the Republican Diagnostic Center and the National Research Center for Maternal and Child Health in Astana, Republic of Kazakhstan. The following six categories emerged as the result of the analysis of qualitative interviews: Awareness of postpartum depression; Knowledge of postpartum depression symptoms; Understanding of risk factors and perceived causes; postpartum depression treatment options; Perceptions of postpartum depression screening; and Barriers and provision gaps followed by participants' recommendations for maternal mental health services.

Awareness of postpartum depression

Surprisingly, all women and healthcare providers turned out to be aware of postpartum depression. Moreover, almost all healthcare providers shared that they always try to notice depressive symptoms or unusual behavioral patterns in both pregnant and postpartum women. This finding is different from what was found in Chew-Graham's (2009) study. According to the results, UK health professionals are often reluctant to make a diagnosis of postnatal depression. Thus, most physicians inhibit disclosure of postnatal depression and feel reluctant to inform women about their postnatal depression. A lack of available resources and the absence of services to which to refer women for the treatment are the main reasons for this reluctant behavior. In contrast, in our study, Kazakhstani healthcare providers responded that they refer those women to psychologists even if there is also a lack of human and material resources. Thus, it was determined that most health practitioners diagnose postnatal depression by relying on the clinical intuition rather than on screening guidelines. Similarly to our findings, LaRocco-Cockburn et al. (2003) suggested that even though healthcare workers in Washington were not provided with necessary skills and resources, they still felt a responsibility to diagnose depression.

Knowledge of postpartum depression symptoms

Regarding the knowledge of postpartum depression symptoms, many women pointed out that social relations and roles might deteriorate in women with postpartum depression. Mainly, women talked about such things like negativity and aggressiveness towards a child and women themselves. However, respondents did not mention the deterioration of relationships with husbands and in-laws as a postpartum depression symptom. Instead, most women mentioned that relations with strict and demanding in-laws deteriorate and husband is not supportive mainly in the light of the postpartum depression risk factors. This could mean that women consider changes in relationships with husbands and in-laws as postpartum depression cause and not a symptom. Comparisons with the

previous literature demonstrates that symptoms of postpartum depression are quite similar among women worldwide. Thus, a study conducted by Chan (2002) in Kong-Hong involved women diagnosed with postnatal depression and gained an insight into their lives and experiences of postpartum depression. As a result, it was found that a sense of helplessness and hopelessness, poor self-esteem, anxiety and fear, loss of control over their emotions, anger, feeling guilty, tiredness, not being able to accomplish the tasks, and ambivalence towards a child were common in those women. Study by Ugarizza (2002) also suggested that postpartum depression women are not able to complete the tasks. Moreover, Letourneau (2007) also refers to such symptoms as feeling isolated, alone and overwhelmed, having a lack of energy, and feeling worthless. Also, as Corwin (2005) suggests, postpartum fatigue is a common indicator of postpartum depression in women. Obviously, these symptoms resonate with the answers of Kazakhstani women in our study.

Understanding of risk factors and perceived causes

Overall, three main categories of risk factors were found in our study and many themes overlap with those found in the study by Klainin (2009), except for child's gender. This can be explained by the transition of Kazakhstani society towards more Westernized cultures where child's gender is not as important as in the Asian traditional families. In addition, the study was conducted in Astana and one can assume that people from South Kazakhstan would actually care about child's gender. Speaking of socioeconomic and social risk factors, women named poor housing, poor living conditions and low income as main signs of a low socioeconomic status. In this light, when housing conditions are poor and a young family lives together with in-laws and other relatives in an extended family, then psychosocial risk factors can also add up and contribute to the development of postpartum depression. Similar to our findings, Mohammad (2011) found that financial problems might be a risk factor for postpartum depression as well. However, we found that not only low socioeconomic status, but also being rich could be a risk factor, too. This important finding illustrates

that when a woman has always been spoon fed, then her new duties and a feeling of being responsible for a new human being can make her feel overwhelmed and cause depressive symptoms. Other risk factors determined by Mohammad's study (2011), which are low maternal self-efficacy, a lack of information and knowledge, unplanned pregnancy, low social support, and difficult marital relationship also resonate with our findings.

As Chew-Graham (2009) also found, health professionals view psychosocial and physiological factors as contributing to postnatal depression, which is a social response to birth and a response to physical changes. This is also similar to our findings.

Overall, psychosocial risk factors, which is mostly a lack of family support, were the most important risk factors for postpartum depression for respondents. On the other hand, even though healthcare providers also mentioned both psychosocial and socioeconomic risk factors, mostly they talked about physiological risk factors. These findings illustrate that healthcare providers and patients have different perceptions of the degree of importance of postpartum depression risk factors. While family relations were more important for women, physiological status was more important for healthcare professionals. Moreover, healthcare providers have different perspectives depending on their specialty and background. Thus, some gynecologists tend to ignore psychosocial factors saying that they do not affect the onset of postpartum depression in any way. Nonetheless, postpartum depression is multifactorial, as highlighted in Chew-Graham's (2009) study, which is why policy interventions have to be implemented on the different levels of influence.

Postpartum depression treatment options

There was a great discrepancy in the perceived necessity of postpartum depression treatment. Interestingly, women did not all agree on the necessity of treatment, while all healthcare providers realize that the treatment is needed for women with postpartum depression. This variability might be explained by the insufficient understanding of women about the necessity of treatment.

Findings presented by Ugarizza (2002) resonate with our study findings on treatment choices of postpartum women. Surprisingly, some women and healthcare providers pointed out that self-management and self-help is a treatment for postpartum depression patients. This could mean that these respondents mostly neglect all other external postpartum depression risk factors and fasten the blame on the women themselves. This might be a barrier, which hinders effective healthcare provision for postpartum depression patients because as these respondents think, women have to deal with her problems all by herself.

Our findings resonate with the existing literature. Thus, Letourneau (2007) in their study also mentioned the importance of instrumental, informational, and emotional support highlighted by women. Women in Letourneau's study also preferred in-home easily accessible telephone support, which resonates with the opinion of this study's most respondents.

One study highlighted that women prefer a proactive contact with mental health advisors, who review any issues and symptomatology, educate mothers, provide support, encourages mothers to receive help from others, educates on cognitive-behavioral strategies, and helps in accessing treatment options (Connelly et al., 2010). Moreover, after two follow-up points, a woman receives a follow-up call from her mental health advisor to determine the progress or any issues.

Perceptions of postpartum depression screening

Surprisingly, most of the respondents agreed on the necessity of postpartum depression screening tool in Kazakhstan and this fact should be considered by health policy makers.
The variability of responses among all participants about time when to conduct screening point to the fact that both women and healthcare professionals have different understanding of the essence of screening tool and the onset time of postpartum depression in women at which screening tools will be effective in detecting postpartum depression.

The variability of responses among women regarding the place to conduct screening points to social issues, such as time and place to leave a child. This has to be taken into account when developing policy regulations for postpartum depression screening. While in our study most of women responded that they would like to be screened at home, Buist et al. (2006) and Gemmill et al. (2006) found that 80% women in Australia prefer being screened in the outpatient clinic.

While most of the women and healthcare providers were positive about EPDS screening tool and considered all the questions as acceptable and fully relevant, it is still necessary to test this tool and to do a pilot project to discover if women fully understand it. Questions on the EPDS were comfortable and had meaning to women, as Connelly et al. (2010) found in their study conducted among women in Southern California.

Regarding a specialist who should notice postpartum depression in women, screen them and provide follow-up care and treatment, our findings demonstrate a great variability. On the contrary, Yawn (2012) and Chaudron (2004) argue that these should be family doctors and pediatricians, respectively.

Interestingly, a theme on the necessity to disclose women's screening results to family members emerged. This can be explained by the mentality of Kazakhstani women, which is the opposite of Western women, who highly value anonymity and confidentiality. Moreover, some of the questions in the EPDS were named as embarrassing for some women and this is also explained by cultural differences.

Barriers and provision gaps followed by participants' recommendations for maternal mental health services

Overall, the barriers identified in our study repeat those found in a study by Gjerdingen and Yawn (2007), which are patient-centered, physician-centered and systems-centered barriers. Regarding the need for provision of more training for specialists, more resources and more health

professionals, our study findings resonate those of Gjerdingen and Yawn (2007) and Oates et al. (2004). Most of the respondents expressed the opinion that there are no screening tools and protocol guides for postpartum depression in Kazakhstan. This demonstrates the general picture of the current situation with postpartum depression in the country. Similar to our findings, Chew-Graham (2009) referred to organizational factors, which hinder postpartum depression management, too. Indeed, a lack of screening methods and treatment services for postnatal depression hinder effective management of postpartum mood disorders. Besides, our healthcare providers expressed the need for creating a multidisciplinary team and collaborations between specialists, which is similar to findings of Gjerdingen and Yawn (2007).

Women respondents expressed the attitude that doctors frequently make decisions without considering women's opinions and wishes. For this purpose, doctor-patient communication should be improved. This resonates with Mohammad (2011) study showing that this can be a risk factor for postpartum depression. As in our study, Letourneau (2007) also pointed out that the available supports for postpartum depression are not easily accessible and there are lots of access barriers to support just like this study's participants responded. Issues of stigmatization of mental health problems were also raised by Connelly et al. (2010), similar to our findings. Lack of public awareness and stigmatization have to be worked on through health education and promotion and can be explained by cultural differences and mindset of Kazakhstani women.

Perceived needs and public health implications

The importance of introducing screening tools and enforcing protocols for early detection of postpartum depression was a recurring theme across all participants. Furthermore, interviewees underlined the need to address challenges related to long waiting lists, time and space barriers to early diagnostics of postpartum depression. This also resonates with postpartum depression socioeconomic risk factors, such as poor living conditions and financial troubles. All this underlines the role of

poverty both in being associated with the onset of postpartum depression and hindering access to timely mental healthcare provision. Next, taking into account the respondents' opinions, there is an urgent need for improving doctor-patient communication, increasing the role of nurses, conducting teaching trainings for healthcare providers, reducing doctors' workload, and increasing the number of psychologists and social workers in healthcare facilities. Regarding facilities and infrastructure, more support centers, relaxation rooms and Healthy Child Units should be opened throughout polyclinics. Last but not the least, increasing public awareness on postpartum depression prevention and treatment and diminishing stigmatization of postpartum depression through health education should also be a priority for policy makers. All of these recommendations must be taken into account while developing corresponding policy interventions and practice changes to address effectively maternal mental health problems.

Strengths and limitations

One of the limitations of this study was that insufficient time was sometimes dedicated for an interview. This can be explained by the fact that women were in a postpartum period and in a hurry because of their small babies. Secondly, only one researcher conducted coding and themes extraction, while it is preferential to be done by several independent researchers.

Taking into account insufficient data on postpartum depression in Kazakhstan, this is one of the first qualitative research studies on this topic conducted in the country. Moreover, this study explored the perspectives of both postpartum women and healthcare providers, which gives an advantage of exploring patients and health professionals' perceptions on the given issues altogether. Furthermore, this study explored the cultural adaptation of the widely validated screening tool for postpartum depression in the population of Kazakhstani women. Finally, this study contributes to an evidence-base for effective policy interventions and practice changes.

6. CONCLUSION

To sum up, a topical issue on the current state of the mental healthcare practices was explored in this qualitative research study. The following topics were discovered in this study among postpartum women and healthcare professionals: the awareness of postpartum depression, knowledge of risk factors and perceived causes of postpartum depression, understanding of signs and symptoms of postpartum depression, perceived importance of postpartum depression treatment and knowledge of existing treatment options, perceived importance of postpartum depression screening and knowledge of available diagnostic tools, acceptability and understanding of EPDS screening tool, and perceived healthcare provision gaps and barriers in postpartum depression screening and treatment.

As a result, six categories and corresponding themes emerged, which demonstrated that the participants were mostly aware of postpartum depression, its symptoms, risk factors, and importance of its treatment and screening. Moreover, they underlined the necessity of introduction of postpartum depression screening in the country, and the acceptability and appropriateness of EPDS questions in Kazakhstani context. Finally, participants pointed out the existence of a handful of provision gaps in postpartum depression diagnostics and treatment, including low public awareness, stigmatization, a lack of healthcare professionals, and poor healthcare management. Thus, introducing a postpartum depression screening tool, improving management of healthcare provision, reducing waiting lists, addressing time barriers for women, improving a doctor-patient communication, increasing a number of psychologists, increasing public awareness and diminishing stigmatization of postpartum depression through education and promotion for women and teaching trainings for healthcare providers, and opening more support centers and relaxation rooms are the major recommendations for the improvement of mental healthcare practices in Kazakhstan.

Several future research directions can be named. Following a qualitative study, a quantitative study on postpartum depression prevalence and risk factors in Kazakhstan can be conducted along with quantitative studies on validity and reliability of postpartum depression screening tool. Speaking of qualitative studies, interviews with postpartum women's partners and husbands can be conducted to extract more themes and grasp even deeper understanding of the issue from the point of view of those who are the closest to postpartum women. Secondly, focus group interviews can be conducted. Such interactive group discussions will provide additional information on the topic and allow observation of participants' possible experiences of postpartum depression, experience of possible barriers towards screening and diagnosis, thoughts on possible etiologic factors, and other feelings.

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APPENDIX

1. Informed Consents (English, Russian, and Kazakh versions)

NAZARBAYEV UNIVERSITY

Kabanbay Batyr ave 53,
Astana, Republic of Kazakhstan
010000

Consent Form for the Research Study Entitled "Awareness, perceptions and understanding of postpartum mood disorders among postpartum women and physicians-gynecologists at the outpatient clinics of the corporate fund "University Medical Center" in Astana city."

Names of the Researchers: Raushan Alibekova, Akbota Kanderzhanova

Date: _____, 2017

Verbal Informed Consent

Background and Purpose of the Study

The Nazarbayev University School of Medicine is inviting you to participate in the research, aimed to explore awareness and perception of postpartum mood disorders among postpartum women and physicians-gynecologists in the outpatient clinics at the Republican Diagnostic Center and the National Research Center for *Maternal and Child Health* in Astana city. Your participation will help us to identify problems and gaps in understanding the postnatal depression (defined as depression around childbirth or within the first year postpartum), perceived importance of depression screening, and the acceptability of the Edinburgh Postnatal Depression Scale screening tool. Thus, your participation in the study will be beneficial for the implementation and improvement of the programs aimed at early detection and effective screening of postpartum depression in Kazakhstan, which will help to reduce the adverse health effects caused by postnatal depression and improve life quality among postpartum women.

Procedures

If you decide you would like to participate in the study, you will be asked to take part in the interview. The questions will include general demographic questions and questions related to awareness and understanding of postnatal depression, its causes, preferred treatment options, and screening. Also, a pilot testing of Edinburgh Postnatal Depression Scale will be conducted to explore your perception of this type of screening tool. A separate room will be provided for the interview, in order to ensure your privacy and confidentiality. The interview will take about 40-50 minutes and you will be asked for the permission to make audio recording of the interview.

Privacy and confidentiality

Any information provided in the interview will not be released to the outside parties. Only the investigators will have access to the study data. The data collected from all participants will be combined together for the completely anonymous data analysis, so it is impossible to recognize or identify individual participants.

In order to insure the confidentiality, no identifiable information will be used and a number will be assigned to the interview audio tape instead of your name. The audio tapes will not be used anywhere else and will be kept in a hidden secure place known only to principle researcher. The tapes will be liquidated in 2 months when the process of interview transcription is finished.

Risks and Benefits

There are no known risks to you expected that are greater than you would normally encounter in your daily life. There are no known direct benefits to you. The information provided by you will have a great impact on maternal and child healthcare in our country. Your answers will help researchers to better understand women's and physicians-gynecologists' perspectives on postpartum depression, screening and treatment choices. Understanding of your perspectives will enable development of better preventive measures and postnatal depression screening programs for addressing this important health problem.

Rights as a Volunteer

Your participation in this interview on postnatal depression is completely on voluntary basis. During the interview, you have a right to skip any of the questions, if you feel uncomfortable with them. You have a right to change or delete any of the answers at the end of the interview process. You have a right not to participate at all or stop the interview at any time, if you feel unease. Your refusal will not bear any negative consequences for you and for medical services you are receiving.

Do you have any questions? Would like to ask about any additional details?

Permission to Proceed

Are you interested to participate in this study? YES [ ] NO [ ]

Contact Information:

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Пр. Кабанбай батыра, 53,
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Форма информированного согласия для научного исследования под названием: Осведомленность, убеждения и понимание послеродовых эмоциональных расстройств среди женщин послеродового периода и врачей в поликлиниках Корпоративного фонда “University Medical Center” в городе Астана.
Исследователи: Раушан Алибекова, Акбота Кандержанова

Дата: _____, 2017

Информация для пациента с устной формой информированного согласия

Краткое описание и цель исследования
Медицинская школа Назарбаев Университета приглашает Вас участвовать в исследовании, нацеленном исследовать осведомленность и восприятие послеродовых эмоциональных расстройств среди послеродовых женщин и врачей в амбулаторных клиниках в Республиканском Диагностическом Центре и Национальном научном центре материнства и детства в городе Астана. Ваше участие поможет нам определить проблемы и пробелы в понимании послеродовой депрессии (определяемой как депрессия, возникающая в течение первого месяца либо одного года после родов), в воспринимаемой важности скрининга депрессии и в приемлемости Эдинбургской Шкалы Послеродовой Депрессии. Таким образом, Ваше участие в исследовании будет полезным для внедрения и улучшения программ, нацеленных на раннее обнаружение и эффективную диагностику послеродовой депрессии в Казахстане, что, в свою очередь, будет способствовать снижению побочного вреда для здоровья, вызванного послеродовой депрессией, и улучшению качества жизни послеродовых женщин.

Процедуры
Если Вы примите решение участвовать в исследовании, Вас попросят принять участие в интервью. Вопросы будут включать в себя общие демографические вопросы и вопросы, связанные с осведомленностью и пониманием послеродовой депрессии и ее причин, предпочитаемыми вариантами лечения и скринингом. Для интервью будет предоставлена отдельная комната в целях обеспечения неприкосновенности Вашей личной информации и конфиденциальности. Интервью займет приблизительно 40-50 минут, и Вас попросят дать свое согласие сделать аудиозапись интервью.

Личная информация и конфиденциальность
Любая информация, предоставленная в интервью, не будет передана третьим лицам. Доступ к материалам исследования будут иметь только исследователи. Данные, собранные ото всех участников, будут объединены вместе для абсолютно анонимного анализа данных, так что распознавание или идентификация отдельных участников будет невозможной.
Никакая идентифицируемая информация не будет использоваться для обеспечения конфиденциальности, и вместо Вашего имени аудиозаписи интервью будет присвоен номер. Аудиозаписи не будут использоваться нигде больше и будут храниться в тайном безопасном

месте, известном только главному исследователю. Записи будут уничтожены через 2 месяца, когда процесс расшифровки интервью будет закончен.

Риски и польза

Вас не ожидают никакие известные риски больше, чем те, с которыми Вы обычно сталкиваетесь в своей повседневной жизни. Также нет никаких известных прямых льгот для Вас. Информация, предоставленная Вами, окажет огромное влияние на здравоохранение матери и ребенка в нашей стране. Ваши ответы помогут исследователям лучше понять взгляды женщин и врачей на послеродовую депрессию, скрининг и методы лечения. Понимание Ваших взглядов поспособствует развитию лучших превентивных мер и программ скрининга послеродовой депрессии для решения этой важной проблемы здравоохранения.

Ваши права как волонтера

Ваше участие в этом интервью на предмет послеродовой депрессии проходит полностью на добровольной основе. Во время интервью Вы имеете право пропустить любой из вопросов, если они ставят Вас в неловкое положение. Вы имеете право изменить или удалить любой из ответов в конце интервью. Вы имеете право не участвовать вообще или остановить интервью в любое время, если почувствуете неловкость. Ваш отказ не понесет за собой никаких негативных последствий для Вас и получаемых Вами медицинских услуг.

У Вас есть вопросы? Хотели бы спросить о каких-либо дополнительных деталях?

Разрешение продолжать

Вы заинтересованы в участии в этом исследовании? ДА [ ] НЕТ [ ]

Контактная информация:

Акбота Кандержанова

Медицинская школа Назарбаев Университета

Программа магистратуры здравоохранения

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Қазақстан Республикасы, Астана қ.
Қабанбай батыр даңғ., 53,
010000

Жоба атауы: «Босанғаннан кейінгі кезеңдегі әйелдер мен Астана қаласының "UniversityMedicalCenter" Корпоративтік қордың поликлиникаларындағы дәрігерлер арасындағы босанғаннан кейінгі эмоциялық жабырқаушылықтан хабардар болуы және оған сену мен оны түсінуі» атты жобасының ақпараттандыру келісімінің формасы.

Зерттеушілер: Раушан Алибекова, Акбота Кандержанова

Күні: _____, 2017

Ақпараттандыру келісімінің ауызша түріне қатысты емделушіге арналған ақпарат

Зерттеудің қысқаша сипаты мен мақсаты
Назарбаев Университетінің Медицина мектебі, сізді Босанғаннан кейінгі кезеңдегі әйелдер мен Астана қаласының Республикалық диагностикалық орталығында және Ұлттық ана мен бала ғылыми орталығындағы емханалық клиникалардағы дәрігерлер арасындағы босанғаннан кейінгі эмоциялық жабырқаушылықтан хабардар болу және оған сену мен оны түсінуді зерттеуге бағытталған зерттеуге қатысуға шақырамыз. Сіздің қатысуыңыз босанғаннан кейінгі депрессияны (босанғаннан кейін бірінші ай ішінде немесе бір жыл ішінде пайда болатын депрессия ретінде анықталатын) түсінудегі, депрессияны скринингтеудің маңыздылығын түсінуінде және Босанғаннан кейінгі депрессияның Эдинбургтік шкаласының қолайлығындағы проблемалар мен кемшіліктерді анықтауға көмек береді. Осылайша, зерттеудегі сіздің қатысуыңыз Қазақстандағы босанғаннан кейінгі депрессияны ерте анықтау мен тиімді диагностикалауға бағытталған бағдарламаларды енгізу мен жақсарту үшін пайдалы болады, ол өз кезегінде босанғаннан кейінгі депрессиядан туындаған денсаулыққа қосымша зиянды төмендетуге, босанғаннан кейінгі кезеңдегі әйелдердің өмір сапасын жақсартуға көмек беретін болады.

Процедуралар
Егер сіз зерттеуге қатысу туралы шешім қаблдасаңыз, сізден сұхбатқа қатысуды сұрайды. Сұрақтарға жалпы демографиялық сұрақтар және босанғаннан кейінгі депрессия туралы хабардар болуы мен оны түсінуге және оның себептеріне, емдеудің қолайлы нұсқаларымен және скринингпен байланысты сұрақтар кіретін болады. Сұхбат үшін сіздің жеке ақпаратыңызға және құпиялылығыңызға қатысты дербес құқықты қамтамасыз ету мақсатында жеке бөлме ұсынылатын болады. Сұхбат шамамен 40-50 минуттан тұрады, аудиожазба жасауға сіздің келісіміңізді беруді сұрайды.

Жеке ақпарат пен құпиялылық
Сұхбатта ұсынылған кез келген ақпарат үшінші тұлғаларға берілмейді. Зерттеу материалдарына кіруге рұқсат тек қана зерттеушілерде болады. Барлық қатысушылардан жинақталған мәліметтер, деректерді абсолютті түрде құпия талдау үшін бірге жинақталатын болады, сол себепті бөлек қатысушыларды анықтау немесе сәйкестендіру мүмкін емес болады.
Ешқандай сәйкестендірілген ақпарат құпиялылықты қамтамасыз ету үшін пайдаланылмайды, сұхбаттың аудиожазбасындағы сіздің атыңыздың орнына нөмір берілетін болады.

Аудиожазбалар ешқайда қайталанып пайдаланылмайтын болады және тек бас зерттеушіге белгілі қауіпсіз құпия жерде сақталатын болады. Жазбалар сұхбаттың мағынасын ашу үрдісі аяқталған кезде 2 айдан кейін жойылатын болады.

Қауіпі мен пайдасы
Сіздің алдыңызда өзіңіздің күнделікті өміріңізде кездесетін белгілі қауіптерден басқа ешқандай қауіптілер кездеспейді. Сондай-ақ сіз үшін ешқандай белгілі тікелей жеңілділіктер жоқ. Сіз берген ақпарат біздің еліміздегі ана мен баланың денсаулығын сақтауға үлкен әсер етеді. Сіздің жауаптарыңыз зерттеушілерге әйелдер мен дәрігерлердің босанғаннан кейінгі депрессияға, скринингке және емдеу әдістеріне қатысты ой-пікірді жақсырақ түсінуге көмектеседі. Сіздің пікіріңізді түсіну денсаулықты сақтаудың осы маңызды проблемасын шешу үшін босанғаннан кейінгі депрессияны ең жақсы алдын-алу шараларды және скрининг бағдарламасын жақсартуға мүмкіндік береді.

Ерікті ретінде сіздің құқықтарыңыз
Осы босанғаннан кейінгі депрессия тақырыбындағы сұхбатқа сіздің қатысуыңыз толығымен өз еркіңізбен өтеді. Егер сұрақтар сізді жайсыз күйге ұшыратса, сұхбат барысында сұрақтардың кез келгенін қалдыруға құқылысыз. Сіз сұхбат соңында сұрақтардың кез келгенін өзгертуге немесе жоюға құқылысыз. Сіз сұхбатқа мүлдем қатыспауға немесе егер сұрақтар сізді жайсыз күйге ұшыратса, сұхбатты кез келген уақытта тоқтатуға құқылысыз. Сіздің бас тартуыңыз, сіз үшін және сіз алып жатқан медициналық қызметтер үшін ешқандай жағымсыз зардаптарға алып келмейді.

Сұрақтар бар ма? Сіз қандай да бір қосымша бөліктер туралы сұрағыңыз келе ма?

Жалғастыруға рұқсат
Сіз осы зерттеуге қатысуға мүдделісіз бе? ИӘ [] ЖОҚ []

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2. Interview guide for postpartum women (English version):

- **Introductory Demographic Questions:**

1. Please tell me what is your age? *(write in)* _____	2. What is your recent postpartum status? □ Less than 1 week □ 2-4 weeks □ More than1 month □ 2-6 months □ More than 6 months
3. What number is your recent pregnancy? _____	4. How many children do you have? *(write in)* _____
5. What is your marital status? □ Married □ Single □ Divorced □ Widowed □ Cohabiting	6. In what type of family do you live? □ Extended □ Nuclear
7. What is your highest education degree so far? □ Elementary school □ High school □ College □ University	8. What is your occupation? □ Medicine □ Government employee □ Employee of private company □ Business owner □ Self-employed □ Unemployed/Housewife □ Student postgraduate
9. Do you have a previous history of mental health problems? □ Yes □ No	10. How much money do you approximately spend in one month (in tenge)? □ Less than 100 000 □ 100 000 – 199 000 □ 200 000 – 299 000 □ 300 000 –399 000 □ 400 000 – 499 000 □ 500 000 and above
11. What is your nationality? □ Kazakh □ Russian □ Other_____ _____	12. What is your place of residence? □ Astana □ Akmolinskaya oblast □ Other_____ _____

- **Postpartum women's personal experience:**

1. Tell me, please, about your personal experience of your child bearing and childbirth process? How was it? How did you feel? Did you feel yourself prepared for this?
2. Where did you give birth?
3. How much time passed since your last childbirth?

- **Postpartum women's awareness and understanding of postpartum mood disorders**

1. What do you think to be major health problems that may be experienced after birth and in the first year?

2. What do you think to be the major mental health problems that may be experienced after birth and in the first year?

- types of problems, severity and consequences

3. Did you hear about the term "postnatal depression"? Do you know what does it mean? What do you think you know about being emotionally unwell following birth?

- What do you think about commonality of postnatal depression as a part of having a baby?
- Did you ever know personally a woman who had experienced a postnatal depression?

4. What are your beliefs about the seriousness of postnatal depression?
5. Can you identify the signs and symptoms of postnatal depression, if, for example, your friend has it? What do you think they are?

- **Risk factors and perceived causes of postpartum depression**

Why do you think women may experience postnatal depression?

- **Preferences in treatment choices**

1. When a woman experiences postnatal depression, what do you think can be done to help her?

- Do you believe postnatal depression can go away on its own?
- Do you believe postnatal depression requires special treatment?

2. When a woman experiences postnatal depression, what do you believe local health services can/should do for a woman to help her?

3. Imagine one of your friends suffers from postpartum depression. What types of treatment would you consider suitable for her? What would be your advice?

4. What would be your advice regarding her first choice to go if she thinks she has depression during the postnatal period? Who do you think should help a woman with postnatal depression? And where?

- **Perceived importance of depression screening**

1. In your opinion, how is postnatal depression diagnosed in healthcare organizations?

- Do you believe all women should be checked for depression during pregnancy or after birth?
- Did you visit a doctor with a complaint for depression during pregnancy or after birth?

2. What do think about the adequacy of local health services on detection of postnatal depression?
   (what are the local services, gaps in provision, reasons for gaps, what should be done to address these)

3. What suggestions do you have for improving diagnosis of postnatal depression if it is even necessary?

- Edinburgh Postnatal Depression Scale
- **Acceptability and understanding of the EPDS**

1. How do you generally feel about completing the EPDS? What do you think about the level of difficulty of these 10 statements?
2. Were the words in the questions commonly used in discussions with family, friends, and the community where you live?
3. What do you think about each question? If there are questions that you did not like, please explain why?
4. How could the questions be improved in your opinion?
5. What do you think is an appropriate place to complete the EPDS?
6. When do you think it is appropriate for women to complete the EPDS in order to timely diagnose the postpartum depression?
7. Who (what specialist) do you think should administer this screening tool?
8. What do you think about the cultural acceptability of the 10 EPDS items in our country?
9. What are your perspectives on receiving a feedback about the results of the screening?
   Where do you think screening results should be referred for further management?

3. Interview guide for postpartum women (Russian version):

- **Ознакомительные демографические вопросы:**

1. Укажите свой возраст: *(впишите)* _____	2. На каком этапе послеродового периода Вы сейчас находитесь: □ Меньше 1 недели □ 2-4 недели □ Больше 1 месяца □ 2-6 месяцев □ Больше 6 месяцев
3. Какая была по счету последняя беременность? _____	4. Сколько у Вас детей? *(впишите)* _____
5. Ваше семейное положение? □ Замужем □ Не замужем □ Разведена □ Вдова □ Состою в гражданском браке	6. В каком типе семьи Вы проживаете? □ Нуклеарная (родители и дети) □ Расширенная (родители, дети и другие родственники)
7. Каков Ваш уровень образования на данный момент? □ Начальная школа □ Среднее образование □ Среднее специальное образование □ Высшее образование □ Последипломное образование (магистратура, докторантура)	8. Ваш род занятий? □ Медицинский работник □ Госслужащий / Бюджетник □ Сотрудник частной компании □ Частный предприниматель □ Самозанятый □ Безработный / Домохозяйка □ Студент
9. Испытывали ли Вы в прошлом проблемы с психическим здоровьем? □ Да □ Нет	10. Сколько денег Вы примерно тратите ежемесячно? □ Меньше 100 000 □ 100 000 – 199 000 □ 200 000 – 299 000 □ 300 000 –399 000 □ 400 000 – 499 000 □ 500 000 и больше
11. Ваша национальность? □ Казашка □ Русская □ Другое _____	12. Ваше место жительства? □ Астана □ Акмолинская область □ Другое (впишите)_____

- **Личный опыт послеродовых женщин:**

1. Расскажите мне, пожалуйста, о Вашем опыте беременности и родов? Как прошли роды? Как Вы себя чувствовали? Чувствовали ли Вы себя подготовленной к этому?

2. Где Вы рожали?

3. Сколько времени прошло с момента последних родов?

- **Осведомленность и понимание женщин послеродового периода относительно послеродовых эмоциональных расстройств**

1. Какие проблемы со здоровьем Вы считаете наиболее серьезными после родов и в течение первого года после родов?

2. Какие проблемы психического здоровья Вы считаете наиболее серьезными после родов и в течение первого года после родов?

- типы проблем, степень опасности, последствия

3. Слышали ли Вы о послеродовой депрессии? Вы знаете, что означает этот термин?

- Как Вы думаете, что Вы знаете о том, чтобы быть эмоционально нездоровым после родов?
- Что Вы думаете о распространенности послеродовой депрессии?
- Вы когда-либо были знакомы с женщиной, страдающей от послеродовой депрессии?

4. Что Вы думаете о степени серьезности послеродовой депрессии?

5. Сможете ли Вы обозначить признаки и симптомы послеродовой депрессии, если, к примеру, у Вашей подруги будет послеродовая депрессия? Какие это признаки и симптомы?

- **Убеждения насчет факторов риска и возможных причин послеродовой депрессии**

1. Как Вы думаете, почему женщины страдают от послеродовой депрессии?

- **Убеждения касательно предпочитаемых видов лечения:**

1. Как Вы думаете, как можно помочь женщине с послеродовой депрессией?

- Вы верите, что послеродовая депрессия может исчезнуть самостоятельно?
- Вы верите, что послеродовая депрессия требует специального лечения?

2. Как Вы думаете, как медицинские учреждения могут помочь женщине с послеродовой депрессией?

3. Представьте, что у Вашей подруги послеродовая депрессия. По Вашему мнению, какие виды лечения являются наиболее подходящими для нее? Что бы Вы посоветовали?
4. Если бы у Вашей подруги была послеродовая депрессия, к кому и куда бы Вы посоветовали ей обратиться за помощью в первую очередь?

- **Убеждения касательно важности и необходимости скрининга послеродовой депрессии:**

1. По Вашему мнению, как послеродовая депрессия диагносцируется в медицинских учреждениях?
   - Вы верите, что все женщины должны быть обследованы на депрессию во время беременности или после родов ?
   - Обращались ли Вы к врачу с жалобой на депрессию во время беременности или после родов?

2. Каково Ваше мнение касательно качества и компетентности местных медицинских учреждений в диагностике послеродовой депрессии?

   (пробелы в обеспечении/обслуживании, причины этих пробелов, как можно решить эти проблемы)

3. Что, по вашему мнению, можно предпринять для улучшения диагностики послеродовой депрессии, если такая диагностика необходима?

Эдинбургская Шкала Послеродовой Депрессии

- **Приемлемость и понимание Эдинбургской Шкалы Послеродовой Депрессии**

1. Каковы Ваши ощущения касательно заполнения данного опросника? Что Вы думаете о сложности этих 10 вопросов?

2. Использовались ли слова/термины с опросника в обсуждениях/беседах с семьей, друзьями и в обществе, в котором Вы проживаете?

3. Что Вы думаете по поводу каждого вопроса? Если Вам не понравились какие-то вопросы, то, пожалуйста, объясните почему?

4. Как вопросы могут быть улучшены?

5. По Вашему мнению, какое место является наиболее подходящим для прохождения данного опросника?

6. Когда, Вы считаете, наиболее подходящий момент/время для заполнения данного опросника, чтобы вовремя диагностировать послеродовую депрессию?

7. Кто (какой специалист) должен проводить этот метод диагностики (опрос)?

8. Что Вы думаете о культурной уместности 10 вопросов данного опросника в нашей стране?

9. Что Вы думаете касательно получения результатов пройденного Вами опросника? Куда должны быть направлены результаты для последующих действий?

4. Interview guide for postpartum women (Kazakh version):

- **Демографиялық таныстыру сұрақтары:**

8. Өзіңіздің жасыңызды көрсетіңіз: *(қосып жазыңыз)* _____	9. Сіз босанғаннан кейінгі кезеңнің қандай кезеңіндесіз: □ 1 аптадан кем □ 2-4 апта □ 1 айдан көп □ 2-6 ай □ 6 айдан көп
10. Соңғы жүктілігіңіз есеппен қандай болған? _____	11. Сізде қанша балаңыз бар? _____
12. Сіздің отбасылық жағдайыңыз? □ Тұрмыста □ Бойдақ □ Ажырасқан □ Жесір әйел □ Азаматтық некеде	6. Сіздің отбасыңыздын түрі? □ Нуклеарлық (ата-анасы мен балалары) □ Кеңейтілген (ата-анасы мен балалары және басқа туыс-туысқандары)
7. Қазіргі сәтте сіздің білім деңгейіңіз қандай? □ Бастауыш мектеп □ Орта білім □ Орта кәсіптік білім □ Жоғарғы білім □ Дипломнан кейінгі білім (магистратура, докторантура)	8. Сіздің айналысатын жұмыс түріңіз? • Медициналық қызметкер • Мемлекеттік/Бюджеттік қызметкер • Жеке меншік компания қызметкері • Жеке кәсіпкер • Өзін-өзі жұмыспен қамтушы • Жұмыссыз / үй шаруасындағы әйел • Студент • Басқа (қосып жазыңыз) _____
9. Өткеніңізде жүйке денсаулығының ақаулығы болды ма? □ Иә □ Жоқ	10. Сіздің отбасыңыз бір айда қанша ақша жұмсайды (теңгемен)? • 100 000 кем

	• 100 000 – 199 000 • 200 000 – 299 000 • 300 000 –399 000 • 400 000 – 499 000 • 500 000 және одан да көп
11. Сіздің ұлтыңыз ? • Қазақ • Орыс • Басқа _____	12. Сіздің тұратын жеріңіз? • Астана • Ақмола облысы • Басқа (қосып жазыңыз) _____

- **Босанғаннан кейінгі кезеңдегі әйелдердің жеке тәжірибесі:**

1. Өзіңіздің жүктілік және босану жайлы тәжірибеңіз туралы не айта аласыз? Өзіңізді қалай сезіндіңіз? Өзіңізді босануға дайынмын деп сезіндіңіз бе?

2. Сіз қай жерде босандыңыз?

3. Соңғы жүктілігіңіз қанша уақыт бұрын болды?

- **Босанғаннан кейінгі кезеңдегі әйелдердің босанғаннан кейінгі эмоциялық жабырқаушылықтан хабардар болуы және оны түсінуі**

3. Сіз босанғаннан кейін және босанғаннан кейінгі бірінші жылдың ішіндегі денсаулыққа қатысты қандай проблемаларды ең маңызды деп санайсыз?

4. Сіз босанғаннан кейін және босанғаннан кейінгі бірінші жылдың ішіндегі қандай психикалық денсаулық проблемаларды ең маңызды деп санайсыз?
– проблемалар түрі, қауіптілік дәрежесі және оның зардаптары

3. Босанғаннан кейінгі депрессия туралы естідіңіз бе? Бұл термин нені білдіретінін білесіз бе?

- Сіз босанғаннан кейін эмоциялық ауру болу (босанғаннан кейінгі депрессия) туралы не білесіз деп ойлайсыз?
- Босанғаннан кейінгі депрессияның таралуы туралы не ойлайсыз?
- Сіз бір кездері босанғаннан кейінгі депрессиядан қиналып жүрген әйел адаммен таныс болдыңыз ба?

4. Сіз босанғаннан кейінгі депрессияның қауіптілік дәрежелері туралы не ойлайсыз?

5. Егер сіздің досыңызда босанғаннан кейінгі депрессия болса, сіз босанғаннан кейінгі депрессияның белгілерін және нышандарын көрсете аласыз ба? Бұл қандай белгілер мен нышандар?

- **Босанғаннан кейінгі депрессияның қауіптілік факторлары мен орын алу себептеріне қатысты сенімдер**

2. Сіз қалай ойлайсыз, неге әйелдердер босанғаннан кейінгі депрессиядан қиналады?

- **Емделудің ұнамды түрлеріне қатысты сенімдер:**

5. Босанғаннан кейінгі депрессиясы бар әйелге қалай көмектесуге болатыны туралы не ойлайсыз?

- Сіз босанғаннан кейінгі депрессия өзбетінше жоғалатындығына сенесіз бе?
- Сіз босанғаннан кейінгі депрессия арнайы емді қажет ететініне сенесіз бе?

6. Сіз босанғаннан кейінгі депрессиясы бар әйелге медициналық мекемелер қалай көмектесе алады деп ойлайсыз?

3. Егер сіздің досыңызда босанғаннан кейінгі депрессия болса, онда, сіздің ойыңызша, емделудің қандай түрлері досыңыз үшін ең лайықты болып табылады?

4. Егер сіздің досыңызда босанғаннан кейінгі депрессия болса, онда оған бірінші болып кімнен көмек сұрауға кеңес беруші едіңіз?

- **Босанғаннан кейінгі депрессияның скринингтан өту маңыздылығы мен қажеттілігіне қатысты сенімдер:**

1. Сіздің ойыңызша, босанғаннан кейінгі депрессия медициналық мекемелерде қалай диагностикаланады?

- Сіз барлық әйелдер жүктілігі кезінде немесе босанғаннан кейін депрессияға қатысты тексерілуі керек екендігіне сенесіз бе?
- Сіз жүктілік кезінде немесе босанғаннан кейін депрессияға қатысты шағымымен дәрігерге бардыңыз ба?

2. Сіздің босанғаннан кейінгі депрессияны диагностикалауда жергілікті медициналық мекемелердің сапасы мен біліктігіне қатысты ойыңыз қандай?
(қызмет көрсетудегі/қамтамасыз етудегі кемшіліктер, осы кемшіліктердің себептері, осы проблемаларды қалай шешуге болады)

3. Сіздің ойыңызша, босанғаннан кейінгі депрессияны диагностикалауды жақсарту үшін не жасауға болады, егер мұндай диагностика қажет болса?

- **Босанғаннан кейінгі Эдинбургтік депрессияның жарамдылығы мен түсінігі**

1. Осы сауалнаманы толтыруға қатысты сіздің сезімдеріңіз қандай? Бұл сұрақтардың күрделігі жөнінде нойлайсыз? Бұл сұрақтар қаншалықты түсінікті?

2. Сіз тұрып жатқан отбасымен, достарымен және қоғаммен талқылау/сұхбаттарда сауалнамалардағы сөздер/терминдер пайдаланылады ма?

3. Әрбір сұрақ жайында не ойласыз? Егер ұнамаған сұрақтарыңыз болса, себебін айтыңыз?

4. Сұрақтар қалай жақсартылуы мүмкін?

5. Сіздің ойыңызша, аталған сұхбатты өткізу үшін қандай жер/орын ең қолайлы болып табылады?

6. Күйзелісті мезгілінде анықтау үшін, сауалнаманы қай уақытта толтыру жөн деп санайсыз?

7. Бұл сауалнаманы кім (қандай дәрігер) жүргізу керек?

8. Қаншалықты бұл сұрақтар біздің елде мәдени ұғымға сай келеді?

9. Сіз тапсырған сұхбаттардың нәтижелерін алуға қатысты не ойлайсыз? Сіздің ойыңызша, сауалнама нәтижелері қайда жіберілуі керек? Денсаулық сақтау мекемелері қандай шара қолдануы керек?

5. Interview guide for healthcare providers (English version):

- **Healthcare providers' work experience**

1. How many years do you work in healthcare?? What is your position currently?
2. Have you ever met a patient with depression? If yes, how often do you encounter such women?

- **Healthcare providers' understanding of postpartum mood disorders**

6. What do you think to be major health problems experienced by women after birth and in the first year?

7. What do you think to be the major mental health problems that may be experienced after birth and in the first year?

- Types of problems, severity and consequences
- What do you think about commonality of postnatal depression as a part of having a baby?

8. What are your beliefs about the seriousness of consequences of postnatal depression?
9. How often do you see signs and symptoms of postnatal depression in women? Can you give me an example? Which women are in risk groups?

- **Risk factors and perceived causes of postpartum depression**

1. Why do you think women may experience postnatal depression? What do you think causes this condition?

- **Preferences in treatment**

5. When a woman experiences postnatal depression, what do you think can be done to help her?

- Do you believe postnatal depression can go away on its own?
- Do you believe postnatal depression requires special treatment?

6. When a woman experiences postnatal depression, what do you believe local health services can/should do for a woman to help her? What should be an ideal healthcare system's response?

7. What types of treatment do you think are suitable for a woman with postnatal depression?
8. What types of treatment do you think are available and used in local hospitals and clinics?

- **Perceived importance of depression screening**

1. In your practice, how is postnatal depression diagnosed in healthcare organizations?

- Did women come to your office with a complaint for depression during pregnancy or after birth?
- Do you usually disclose or identify signs of postnatal depression in women?

- Have you ever diagnosed women for postnatal depression?

2. Who do you think would be the first choice to go if a woman thinks that she has depression during the postnatal period?
- Who do you think needs to diagnose postnatal depression, if it is needed? Who do you think is the first person to be able to detect postnatal depression in women?

3. What do think about the adequacy of local health services on detection of postnatal depression?
   (gaps in provision, reasons for gaps, what should be done to address those)

4. What suggestions do you have for improving diagnosis of postnatal depression if it is even necessary? Do we need some postpartum depression screening tools in Kazakhstan?

- Edinburgh Postnatal Depression Scale
- **Acceptability and understanding of the EPDS**

10. What do you think about the level of difficulty of these 10 statements? Do you think they are understandable for women? Do you believe women are able to answer these statements?
11. Are the words in the questions commonly used in discussions with family, friends, and the community where women live?
12. What do you think about the cultural acceptability of the 10 EPDS items in our country?
13. What do you think about each question? If there are questions that you did not like, please explain why?
14. How could the questions be improved?
15. What do you think is an appropriate place to complete the EPDS?
16. When do you think it is appropriate for women to complete the EPDS in order to timely diagnose the postpartum depression?
17. Who (what specialist) do you think should administer this screening tool?
18. Where do you think screening results should be referred for further management? How should the healthcare system react?

6. Interview guide for healthcare providers (Russian version):

- **Личный опыт медицинского работника:**

1. Сколько лет Вы работаете в здравоохранении? Какая у Вас должность?

2. Встречали ли Вы пациентов с депрессией? Если да, то, как часто Вы встречаете таких женщин?

- **Осведомленность и понимание медицинских работников относительно послеродовых эмоциональных расстройств**

5. Какие проблемы со здоровьем Вы считаете наиболее серьезными после родов и в течение первого года после родов?

6. Какие проблемы психического здоровья Вы считаете наиболее серьезными после родов и в течение первого года после родов?

- типы проблем, степень опасности, последствия
- что Вы думаете о распространенности послеродовой депрессии?

3. Что Вы думаете о степени серьезности послеродовой депрессии?

4. Как часто Вы видите признаки и симптомы послеродовой депрессии у женщин? Можете привести примеры? Какие женщины в группе риска?

- **Убеждения насчет факторов риска и возможных причин послеродовой депрессии**

3. Как Вы думаете, почему женщины страдают от послеродовой депрессии? Что, по Вашему мнению, вызывает это состояние?

- **Убеждения касательно предпочитаемых видов лечения:**

7. Как Вы думаете, как можно помочь женщине с послеродовой депрессией?

- Вы верите, что послеродовая депрессия может исчезнуть самостоятельно?
- Вы верите, что послеродовая депрессия требует специального лечения?

2. Как Вы думаете, как медицинские учреждения могут помочь женщине с послеродовой депрессией? Какой была бы идеальная реакция/реагирование медицинских учреждений?

3. По Вашему мнению, какие виды лечения являются наиболее подходящими для женщин с послеродовой депрессией?

4. По Вашему мнению, какие виды лечения для женщин с послеродовой депрессией доступны в местных поликлиниках и больницах?

- **Убеждения касательно важности и необходимости скрининга послеродовой депрессии:**

4. В Вашей практике, как послеродовая депрессия диагносцируется в медицинских учреждениях?
   - Обращались ли женщины к Вам с жалобой на депрессию во время беременности или после родов?
   - Пытаетесь ли Вы обычно выявить или обнаружить признаки послеродовой депрессии у женщин во время приемов?
   - Вы когда-нибудь диагностировали послеродовую депрессию у женщин?

5. Если бы у женщины была послеродовая депрессия, то, по Вашему мнению, к кому бы она обратились за помощью в первую очередь?
   - Как Вы думаете, кто должен диагностировать послеродовую депрессию у женщин, если это вообще необходимо? Кто может быть первым человеком, способным раньше всех диагностировать послеродовую депрессию у женщин?

6. Каково Вашем мнение касательно качества и компетентности местных медицинских учреждений в диагностике послеродовой депрессии?

   (пробелы в обеспечении/обслуживании, причины этих пробелов, как можно решить эти проблемы)

7. Что, по Вашему мнению, можно предпринять для улучшения диагностики послеродовой депрессии, если такая диагностика необходима? Нужны ли в Казахстане специальные методы скрининга послеродовой депрессии?

Эдинбургская Шкала Послеродовой Депрессии

- **Приемлемость и понимание Эдинбургской Шкалы Послеродовой Депрессии**

   2. Что Вы думаете о сложности этих 10 вопросов? Будет ли понятен этот опросник для женщин? Считаете ли Вы, что женщины будут в состоянии заполнить его?

   2. Используются ли слова/термины с опросника в обсуждениях/беседах с семьей, друзьями и обществе, в котором проживают женщины?

   3. Что Вы думаете о культурной уместности 10 вопросов данного опросника в нашей стране?

   4. Что Вы думаете по поводу каждого вопроса? Если Вам не понравились какие-то вопросы, то, пожалуйста, объясните почему?

   5. Как вопросы могут быть улучшены?

   6. По Вашему мнению, какое место является наиболее подходящим для прохождения данного опросника?

7. Когда, Вы считаете, наиболее подходящий момент/время для заполнения данного опросника, чтобы вовремя диагностировать послеродовую депрессию?

8. Кто (какой специалист) должен проводить этот метод диагностики (опрос)?

9. Как Вы думаете, куда должны быть направлены результаты для последующих действий? Как должна отреагировать система здравоохранения?

7. Interview guide for healthcare providers (Kazakh version):

- **Медицина жұмыскерінің жеке тәжірибесі:**

1. Медицина саласында қанша жыл жұмыс істейсіз? Сіздің қызметтегі дәрежеңіз қандай?

2. Күйзеліске ұшыраған пациенттерді кездестірдіңіз бе? Егер «иә» десеңіз, қаншалықты жиі кздестірдіңіз?

- **Медицина жұмыскерінің босанғаннан кейінгі эмоциялық жабырқаушылықтан хабардар болуы және оны түсінуі**

Сіз босанғаннан кейін және босанғаннан кейінгі бірінші жылдың ішіндегі денсаулыққа қатысты қандай проблемаларды ең маңызды деп санайсыз?

7. Сіз босанғаннан кейін және босанғаннан кейінгі бірінші жылдың ішіндегі қандай психикалық денсаулық проблемаларды ең маңызды деп санайсыз?

- проблемалар типі, қауіптілік дәрежесі және оның зардаптары

- босанғаннан кейінгі депрессияның таралуы туралы не ойлайсыз?

3. Сіз босанғаннан кейінгі депрессия жағдайының қауіптілік дәрежелері туралы не ойлайсыз?

4. Қаншалықты Сіз босанғаннан кейінгі депрессияның белгілерін және нышандарын жиі көресіз? Қандай топтағы әйелдер күйзеліске жиі ұшырайды?

- **Босанғаннан кейінгі депрессияның қауіптілік факторлары мен орын алу себептеріне қатысты сенімдер**

4. Сіз қалай ойлайсыз, неге әйелдердер босанғаннан кейінгі депрессиядан қиналады? Сіздің ойыңызша осы күй неден пайда болады?

- **Емделудің ұнамды түрлеріне қатысты сенімдер:**

8. Босанғаннан кейінгі депрессиясы бар әйелге қалай көмектесуге болатыны туралы не ойлайсыз?

- Сіз босанғаннан кейінгі депрессия өзбетінше жоғалатындығына сенесіз бе?
- Сіз босанғаннан кейінгі депрессия арнайы емді қажет ететініне сенесіз бе?

2. Сіз босанғаннан кейінгі депрессиясы бар әйелге медициналық мекемелер қалай көмектесе алады деп ойлайсыз? Медициналық мекемелердің бұл жағдадағы жауабы қандай болу керек?

3. Сіздің ойыңызша, босанғаннан кейінгі депрессиясы бар әйелдер үшін емделудің қандай түрлері ең лайықты болып табылады?

4. Сіздің ойыңызша, босанғаннан кейінгі депрессиясы бар әйелдер үшін жергілікті поликлиникалар мен емханаларда емделулердің қандай түрлері қолжетімді?

- **Босанғаннан кейінгі депрессияның скринингтан өту маңыздылығы мен қажеттілігіне қатысты сенімдер:**

8. Сіздің тәжірибеңізде, босанғаннан кейінгі депрессия медициналық мекемелерде қалай диагностикаланады?
   - Сізге әйелдер жүктілігі кезінде немесе босанғаннан кейін депрессияға қатысты шағымымен келді ме?
   - Сіз қабылдаулар уақытында әйелдердегі босағаннан кейінгі депрессияның белгілерін анықтауға немесе табуға тырысасыз ба?
   - Сіз қашанда әйелдерде босанғаннан кейінгі депрессияны диагностикаладыңыз ба?

9. Егер де әйелдерде босанғаннан кейінгі депрессия болса, онда сіздің ойыңызша, ол бірінші болып кімнен көмек сұрайды?
   - Егер қажет болса, сіздің ойыңызша, әйелдерде босанғаннан кейінгі депрессияны кім диагностикалау керек? Кім ең алғаншқы болып әйелдегі босанғаннан кейінгі күйзелісін тусіне алады?

3. Сіздің босанғаннан кейінгі депрессияны диагностикалауда жергілікті медициналық мекемелердің сапасы мен біліктігіне қатысты ойыңыз қандай?

(қызмет көрсетудегі/қамтамасыз етудегі кемшіліктер, осы кемшіліктердің себептері, осы проблемаларды қалай шешуге болады)

- Қазақстанда мұндай скринингтің ресми әдісі неге жоқ деп ойлайсыз?

4. Сіздің ойыңызша, босанғаннан кейінгі депрессияны диагностикалауды жақсарту үшін не жасауға болады, егер мұндай диагностика қажет болса? Қазақстанда босанғаннан кейінгі депрессияның скрининг шаралары керек пе?

Босанғаннан кейінгі депрессияның Эдинбургтік шкаласы

- **Босанғаннан кейінгі Эдинбургтік депрессияның жарамдылығы мен түсінігі**

3. Бұл сұрақтардың күрделігі жөнінде нойлайсыз? Бұл сұрақтар әйелдер үшін қаншалықты түсінікті? Сіздің ойынызша, бұл сұрақтарға әйелдер жауап бере ала ма?

2. Әйелдер тұрып жатқан отбасымен, достарымен және қоғаммен талқылау/сұхбаттарда сауалнамалардағы сөздер/терминдер пайдаланылады ма?

3. Қаншалықты бұл сұрақтар біздің елде мәдени ұғымға сай келеді?

4. Әрбір сұрақ жайында не ойласыз? Егер ұнамаған сұрақтарыңыз болса, себебін айтыңыз?

5. Сұрақтар қалай жақсартылуы мүмкін?

6. Сіздің ойыңызша, аталған сұхбатты өткізу үшін қандай жер/орын ең қолайлы болып табылады?

7. Күйзелісті мезгілінде анықтау үшін, сауалнаманы қай уақытта толтыру жөн деп санайсыз?

8. Бұл сауалнаманы кім (қандай дәрігер) жүргізу керек?

9. Сіздің ойыңызша, сауалнама нәтижелері қайда жіберілуі керек? Денсаулық сақтау мекемелері қандай шара қолдануы керек?

8. Edinburgh Postnatal Depression Scale[1] (EPDS)

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

1 Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.
2 Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

9. Edinburgh Postnatal Depression Scale (Russian version)

Эдинбургская Шкала Послеродовой Депрессии

В течение последних 7 дней:

1. Я могла смеяться и замечать смешное вокруг себя
   - Так же, как обычно
   - Несколько меньше, чем обычно
   - Нет, гораздо меньше, чем обычно
   - Нет, совсем не могла

2. Я ощущала радость, думая о будущем
   - Так же, как обычно
   - Несколько меньше, чем обычно
   - Значительно меньше, чем обычно
   - Практически никогда

3. Я корила себя понапрасну, когда дела шли не так, как надо
   - Да, все время
   - Да, иногда
   - Нет, не так часто
   - Нет, никогда

4. Я тревожилась и беспокоилась понапрасну
   - Нет, никогда
   - Нет, почти никогда
   - Да, иногда
   - Да, очень часто

5. Меня охватывали беспричинный страх и паника
   - Да, почти все время
   - Да, иногда
   - Нет, очень редко
   - Нет, не так часто

6. На меня слишком много всего навалилось
   - Да, я почти ни с чем не справлялась
   - Да, иногда я кое с чем не справлялась
   - Нет, по большей части я со всем справлялась
   - Нет, я справлялась со всем, как обычно

7. Мне было так плохо, что я не могла спать:
   - Да, почти все время
   - Да, иногда
   - Нет, очень редко
   - Нет, никогда

8. Я чувствовала себя грустной или несчастной:
   - Да, большую часть времени
   - Да, довольно часто
   - Нет, не так часто
   - Нет, никогда

9. Мне было так плохо, что я плакала:
   - Да, почти все время
   - Да, довольно часто
   - Очень редко
   - Нет, никогда

10. Меня приходило в голову сделать с собой что-нибудь плохое
    - Да, очень часто
    - Иногда
    - Нет, почти никогда
    - Нет, никогда

10. Edinburgh Postnatal Depression Scale (Kazakh version)

Соңғы 7 күннің ішінде:

1. Мен күлуге және әр нәрсенің қызық жағын көруге қабілетті болдым
   - ☐ Әдеттегідей
   - ☐ Әдеттегіден азырақ
   - ☐ Әдеттегіден әлдеқайда азырақ
   - ☐ Мүлдем қабілетті болмадым

2. Мен болашақтағы әрбір нәрсені қуана-қуана күттім
   - ☐ Әдеттегідей
   - ☐ Әдеттегіден азырақ
   - ☐ Әдеттегіден әлдеқайда азырақ
   - ☐ Мүлдем қуанбадым

3. Бірдеңе дұрыс жүрмесе мен өзімді босқа кінәләдім
   - ☐ Иә, көбінесе
   - ☐ Иә, кейде
   - ☐ Жоқ, өте жиі емес
   - ☐ Жоқ, ешқашан

4. Мен ешбір себепсіз алаңдау мен уайымға шалдықтым
   - ☐ Жоқ, ешқашан
   - ☐ Жоқ, өте сирек
   - ☐ Иә, кей уақытта
   - ☐ Иә, өте жиі

5. Мен ешбір себепсіз қорқу мен үйреге шалдықтым
   - ☐ Иә, өте жиі
   - ☐ Иә, кей уақытта
   - ☐ Жоқ, жиі емес
   - ☐ Жоқ, ешқашан

6. Тірлігімде қапылыс көбейіп кетті
   - ☐ Иә, көбінесе тірлігімді орындауға шамам келмеді
   - ☐ Иә, кейде тірлігімді түгел орындай алған жоқпын
   - ☐ Жоқ, көбінесе тірлігімнің бәрін орындай алдым
   - ☐ Жоқ, тірлігімнің бәрін әдеттегідей орындадым

7. Жабырқанудың себебінен ұйқым қашты
   - ☐ Иә, жиі
   - ☐ Иә, кейде
   - ☐ Жоқ, өте жиі емес
   - ☐ Жоқ, ешқашан

8. Мен өзімді көңілсіз немесе бақытсыз сезіндім
   - ☐ Иә, көбінесе
   - ☐ Иә, кейде
   - ☐ Жоқ, өте жиі емес
   - ☐ Жоқ, ешқашан

9. Жабырқанудың себебінен жылауға дейін бардым
   - ☐ Иә, жиі
   - ☐ Иә, кейде
   - ☐ Жоқ, өте жиі емес
   - ☐ Жоқ, ешқашан

10. Маған өзіме зиян келтіру жайлы ойлар келді
   - ☐ Иә, жиі
   - ☐ Иә, кейде
   - ☐ Жоқ, өте жиі емес
   - ☐ Жоқ, ешқашан