

THE CONTEXT OF POSTNATAL DEPRESSION IN MALAYSIA: AN OVERVIEW

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Abstract

Sociocultural contexts of motherhood have been found to have a link with postnatal depression. Malaysia has a wide-range of cultural and ethnic backgrounds that offers a wonderful chance to understand the different role of cultures and postnatal practices in relation to postnatal depression. The purpose of this paper is to discuss the link between the Malaysian healthcare system, social and cultural context, the existing health policy and postnatal depression. This paper highlights that while there are different levels of nurses who work collaboratively to manage pregnant and postnatal mothers in the maternal and child health clinic, the focus of their care is more on physical health. The international guidelines for diagnosing PND were not commonly used within the clinics, although the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has been widely used within psychiatric setting in Malaysia. There is no formal mechanism or assessment to detect PND in the clinics. There are no guidelines that specifically focused on the management of PND were found. It is questionable whether the current approaches to promote and manage maternal mental health in Malaysia have a sense of cultural-based strategies. These significant gaps call for empirical evidence that explicitly focussed on the experiences and perceptions of PND in Malaysia.

Introduction

The experience of postnatal depression (PND) are not fully shared by women across different cultures. Such experience can be influenced by societal and cultural interpretation and labelling of symptoms. Previous quantitative and qualitative studies have shown that there was a link between sociocultural factors and PND (Abdollahi et al. 2014; Gao et al., 2010). Within Asian culture, the traditional postnatal practice of staying inside the house for a month was described by the women as contributing to PND (Gao et al., 2010). The issue of gender preference of the baby and the existence of an ‘external power’ are two common factors linked to PND as reported by Asian women. Chinese and Indian women reported that they experienced conflict with their husbands and in-laws as they were blamed for not being able to give birth to a male child (Morrow et al., 2008; Gao et al., 2010). The existence of an ‘external power’ was particularly reported by South Asian and Chinese women (Edhborg et al. 2015; Wittkowski et al. 2012).

The Malaysian population has a wide-range of cultural and ethnic backgrounds that offers a great opportunity to understand the different role of cultures and postnatal practices in relation to PND. Malaysia, a multi-ethnic country located in Southeast Asia. It covers an area of 329,847 square kilometres and has a total population of over 28.3 million (Department of Statistics Malaysia 2010). Malaysian citizens comprise three main races, including Malay (53.3%), Chinese (26.0%) and Indian (7.7%) (Khader 2012). Another 13% of the Malaysian population is made up by other ethnic populations in Sabah and Sarawak (Ishak 2009). While the Malays are regarded as the local or native population, the Chinese and Indian population in Malaysia today are descendants of those who originally migrated before the independence of Malaysia from Southern China and Southern India, respectively (Chee et al. 2005). The

presence of the differences and similarities within Malaysian cultural backgrounds should be acknowledged as associated traditions may affect the women's experience of PND (Fisher et al. 2004).

The purpose of this paper is to provide an overview of the Malaysian healthcare system and the sociocultural context and to understand how these elements were linked with the management of PND. Towards the end of this paper, a review of policy regarding management of PND in the Malaysian healthcare system is also presented.

Healthcare system in Malaysia

The healthcare system in Malaysia is comprised of a combination of both the private and public sector. Private clinics and hospitals are widely accessible in the urban areas and managed by non-government companies. The public sector is operated by the Ministry of Health (MOH) and is the main healthcare service, encompassing a system of hospitals and primary care clinics. Hospital services provided by the MOH consist of small district hospitals in towns, to large hospitals in larger urban areas (Country Report 2006). In the primary care settings, the MOH provides healthcare services under a two tier system, including small clinics (also known as community clinics) and larger community polyclinics (also known as health clinics).

Whilst community clinics provide healthcare services for approximately 2,000 to 4,000 mothers and children in rural areas (Jaafar et al. 2007), the health clinics offer a comprehensive range of services in larger towns and urban regions of approximately 15,000 to 20,000 persons (Ministry of Health Malaysia 2012). Currently, health clinics often include a mix of the following health professionals: family medicine specialists; medical officers; physiotherapists; occupational therapists; nurses; assistant medical officers; nutritionists; and dieticians

(Mustapha et al. 2014). Maternal and child health (MCH) clinics are attached to the health clinics. Generally, these are managed by the nurses and a medical officer.

Nursing and Midwifery in Malaysia

There are several tiers of the nurses in Malaysia: community nurses, registered nurses, nurse-midwives, and head nurses. A community nurse is a person who has undergone a formal course of community nurse education (two years training in the community nursing college). A registered nurse is a person who has undergone a formal course of nursing education (either three years diploma or four years degree programme) and registered with the Malaysian Nursing Board (Malaysia Nursing Board 2015). A nurse-midwife (or known as midwife in the UK) is a registered nurse who has successfully completed a one-year course of studies in midwifery, and has acquired the requisite qualifications to be registered, and legally licensed to practice midwifery (Ministry of Health Malaysia 2013). This is contrast to the United Kingdom (UK) system, where midwives have their own separate training, and do not have to study nursing first. A head nurse is a registered nurse or a nurse-midwife who generally will have had 15 years working in clinical practices.

The different levels of nurses (community nurses, registered nurses, nurse-midwives, and head nurses) work collaboratively to manage pregnant and postnatal mothers in the MCH clinic. They are trained and educated to provide healthcare services offered within the clinics. Such services are largely provided by the community nurses and nurse-midwives. In general, community nurses provide care for low risk mothers, while nurse-midwives provide care for high risk mothers. When it is necessary, they may refer an abnormal case to the head nurse and/or the medical doctor for further care and treatment.

Healthcare services offered within MCH clinics include antenatal, postnatal, and child care (Country Report 2006). Antenatal care begins when a pregnant woman visits the clinic for

the antenatal booking assessment around 10 to 12 weeks of gestation and continues until the birth. In this first visit, community nurses or nurse-midwives perform antenatal assessment, which includes: height and weight, last menstrual period (LMP), family history of diseases such as diabetes and high blood pressure, breast examination, blood tests, estimated due date (EDD), and a urine test (to check for protein and glucose levels). Subsequent visits mostly follow the schedule of: once a month until the seventh month of pregnancy (first booking-28th week), fortnightly in the eighth month of pregnancy (32nd-36th week), and once a week from the 37th week until delivery (BabyCenter 2015). In these visits, the community nurse or nurse-midwives conduct routine assessments such as: fetal movement, urine test for protein and glucose, blood pressure, body weight, and abdominal palpation. They also conduct the Oral Glucose Tolerance Test (OGTT) and assist in ultrasound scans when it is required (BabyCenter 2015).

Most women give birth in a maternity hospital, where they will be looked after during labour by nurse-midwives, medical doctor and/ or obstetrician. Postnatal care includes home visits, breastfeeding guidance, and family planning, which is also delivered by the community nurses and/ or nurse midwives. Malaysian Ministry of Health guidelines for home visits are a total of eight visits, 1st, 2nd, 3rd, 4th, 6th, 8th, 10th and 20th postnatal days by the community nurses or nurse-midwives (Kaur and Sigh 2011). On the 42nd (or 30th) postnatal day, a routine examination for mother and baby is performed at the MCH clinic by the medical officer. Child healthcare services covered by the community nurses or nurse-midwives include child immunisation, child development monitoring up to four years of age, nutrition assessment, and food supplement for those under-weight, and home visits for high risk babies and malnourished children (Country Report 2006).

In addition to the aforementioned roles, the nurses who work in the MCH clinics serve as link between the mothers and health services, educate and advise mothers within healthcare services, and play an important role in the prevention of maternal mortality and morbidity and of premature, stillbirth, and neonatal deaths (Manap 1975).

The services offered by the MCH clinics play a major role in the promotive and preventive care for the urban and rural population. The referral system connects primary health care facilities with the hospitals (Ministry of Health Malaysia 2008). Both health clinics and hospitals have common policies and operating procedures to facilitate management of referred cases. Community clinics are able to refer to health clinics or directly to the hospitals, according to established patient-management protocols (Mustapha et al. 2014).

Management of perinatal mental health in Malaysia

It should be noted in the aforementioned discussion that the focus of antenatal and postnatal care within the MCH clinics in Malaysia is more on physical health. Ng (2014) suggested that one of the reasons for the undiagnosed depressed cases in Malaysia is related to the HCPs' over focus on physical issues. Such a focus results in less attention on the roles of managing mental health issues within their clinical practice. The international guidelines for diagnosing PND (e.g., DSM-5 and ICD-10) are not commonly used within the MCH clinics, although the DSM-5 has been widely used within psychiatric setting in Malaysia.

Yusuff et al. (2015) recommended that management and referral of depressed women should be included in Malaysian maternal health policy in order to prevent PND. Yet, there is no formal mechanism or assessment to detect PND in the MCH clinics. Although several screening tools have been translated into the Malay language with established psychometric properties (e.g., Beck Depression Inventory (BDI), Depression, Anxiety and Stress Scale (DASS), Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression

Scale (HADS), and Patient Health Questionnaire 9 (PHQ-9)), these are not routinely applied within the clinics (Mukhtar and Oei 2011). Rather, they have only generally been used in research studies on depression or PND.

Without a specific policy on screening and care for maternal mental health problems, antenatal or postnatal women with any mental health issues (including PND) are commonly referred from MCH clinic to the psychiatric unit in the hospital. When it is required, they are then treated within the same psychiatric setting as patients with general depression, and other psychiatric problems.

The local guideline for managing general depression is known as Clinical Practice Guideline (CPG) for the Management of Depression (Ministry of Health Malaysia 2007). While this local treatment guideline recommends both psychotherapy and pharmacotherapy (Ng 2014), the main form of treatment for depression in community settings and hospitals in Malaysia is pharmacological treatment (Razali and Hasanah 1999). In severe cases of puerperal psychosis, pharmacotherapy or electro-convulsive therapy is the main choice of treatment. Monotherapy with selective serotonin reuptake inhibitor is the first line of pharmacotherapy treatment recommended in the guideline (Ng 2014).

Although psychotherapy for the treatment of depression are applied clinically in Malaysian clinical settings, there is less emphasis on the psychological aspects in the process of disease recognition and understanding, particularly for depression (Deva 2006). There is also no empirical evidence to suggest that such use has been established, and therefore it is still unknown whether psychological instruments for the assessment of depression, and the theories for depression are valid and reliable for use in Malaysia (Mukhtar and Oei 2011). There is also less attention to primary prevention such as public education, awareness programmes, and

screening activities, although they have been recommended for all levels of the population (Yusuff et al. 2015; Ng 2014).

Screening tools for postnatal depression

As discussed in the previous section, the common assessment tools used to screen for depression in Malaysia are: BDI, DASS, EPDS, and PHQ-9 (Mukhtar and Oei 2011). These tools have been translated into the Malay language and their psychometric properties have been established (Mukhtar and Oei 2011).

The BDI is one of the most commonly used screening tools either in a clinical setting or in research on depression worldwide (Stahl 2000). The use of BDI as an instrument to measure levels of depressive symptoms in Malaysia has also been established with the Cronbach's alpha between 0.56 to 0.90, and test-retest reliability between 0.56 to 0.87, indicating acceptable reliability (Mukhtar and Oei 2011; Oei and Mukhtar 2008). The Depression Anxiety Stress Scale (DASS) is commonly used to screen for depression among general populations within outpatient clinics in Malaysia. The Cronbach's alpha and test-retest reliability for DASS-21 are between 0.74–0.83 and 0.82–0.84, respectively, indicating good reliability. The Cronbach's alpha of the PHQ-9 and HADS is 0.67 and test-retest reliability is 0.73, indicating good reliability (Mukhtar and Oei 2011).

While the abovementioned instruments have been validated within Malaysian population, they are commonly used to screen for general depressive symptoms. They were not specifically designed for screening for postnatal depressive symptoms.

The EPDS was developed by Cox et al. (1987). It is a self-administered questionnaire designed specifically to measure the risk of PND (Cox et al. 1987). It consists of 10 items with four response scores of 0, 1, 2, and 3 according to increased severity of the symptoms (Siti et

al. 2014). The total score of the EPDS ranges from 0 to 30. The reliability and validity of the Malay version of the EPDS has been verified (Kadir et al. 2004; Wan Mohd Rushidi et al. 2003). It was found to have good internal consistency with Cronbach's alpha 0.86, and split half reliability with Spearman split half coefficient 0.83 (Wan Mohd Rushidi et al. 2003). The score of 11.5 represents the optimum cut-off point for 72.7% sensitivity, 95% specificity, and positive predictive value of 80% (Kadir et al. 2004). As the cut off of 11/12 was recommended to determine a woman at risk of developing PND (Yusuf et al. 2015; Wan Mohd Rushidi et al. 2003), women with an EPDS score ≥ 12 were categorised as having depressive symptoms in this study.

The PHQ was developed by Spitzer et al. (1999). It is the most commonly used screening tool for the initial screening for major depression in primary care (worldwide) (Mitchell et al. 2016). The PHQ-9 consist of 9 questions regarding depression: 8 questions assess symptoms and 1 question assesses functional impairment. The questions are scored on a scale of 0 to 3 (Kroenke et al. 2001). The validity and reliability of the Malay version of the PHQ was conducted by Sherina et al. (2012). The PHQ was found to be a valid and reliable instrument for detecting depression in primary care. Sherina et al. (2012) suggested that the PHQ-9 had a sensitivity of 87% (95% confidence interval 71% to 95%), a specificity of 82% (74% to 88%), positive Likelihood Ratio (LR) of 4.8 (3.2 to 7.2), and negative LR of 0.16 (0.06 to 0.40). The sensitivity of the PHQ-9 at the cut-off value of 10 and above was 87% and the specificity was 82%.

The sociocultural context of postnatal depression in Malaysia

Postnatal practices in Malaysia

There are slight differences in the postnatal practices among the three main cultures in Malaysia, such as in defining the period of the confinement. However, they share several similarities in terms of the key elements used in the postnatal practice, dietary restrictions, and companions for the postnatal period.

Within the Malaysian communities, the postnatal period is commonly referred to as postnatal confinement. In Malay society, the postnatal period is called *masa dalam pantang* (Ministry of Health Malaysia 2014) and both mother and baby are expected to remain house-bound for around 44 days. In Chinese communities, the postnatal period is the point from the baby's birth up to one month later, whereas the postpartum period in the Indian community refers to the period after the childbirth until between 30 and 40 days later (BabyCenter 2014b).

The elements of herbs, heat and massage are traditionally practiced among newly delivered women in Malaysia, as a means of avoiding any health problems (BabyCenter 2014a). Among Malaysian communities, there is a practice of avoiding 'cooling food' such as cucumber and cabbage during postnatal confinement as these practices are said to enhance the blood circulation and toughen the joints of the mother (BabyCenter 2014a).

In the postnatal period, most of the women will be taken care of by their own mother or mother-in-law. In this situation, some new mothers may have different views and beliefs from their caregivers, such as whether or not to follow restrictions in confinement diet and traditional

practices of bathing and massage. Given that the sociocultural contexts of motherhood have a link with PND, an understanding of this concept in the Malaysian context may be of value (Buultjens and Liamputtong 2007).

Studies on the sociocultural practices and postnatal depression in Malaysia

In the past 30 years, Stern and Kruckman (1983) have suggested that the incidence of PND was lower in Asian compared to western countries. Culturally based postnatal behavioural constraints were speculated as protecting Asian women from PND. However, with the changes from traditional to modern lifestyles in recent decades, this may no longer be the case in Malaysian society. In fact, some of the sociocultural elements have been highlighted in two Malaysian studies as being contributing factors towards development of PND (Azidah et al. 2006; Grace et al. 2001).

Azidah et al. (2006) explored the association between sociocultural practices during the postnatal period and PND in Malaysia. This cross-sectional study employed the EPDS to screen 421 pregnant women between 36-42 weeks of pregnancy, 1 week and 4-6 weeks postnatal. They found that women undertaking traditional practices such as consuming traditional medication and practicing traditional massage were found to have 10-fold risk of getting PND.

Azidah's findings corresponded to the earlier result by Grace et al. (2001) who studied a smaller sample size of 145 postnatal women in Seremban General Hospital, Malaysia. The women provided data at six months postnatal regarding participation in three traditional practices: birth patterning, warming practices and following a special diet. Their findings indicated that a stronger adherence to traditional postnatal practices was linked with a higher depression score although this was not statistically significant.

Both researchers hypothesised that women with higher levels of PND were more likely to participate in traditional postnatal practices and/or that some element or substances in traditional practices may play a role in the development of PND. Furthermore, during the postnatal confinement period, Malaysian women were not allowed to leave the 'confinement house' and they were expected to adhere to certain traditional practices to avoid unwelcomed consequences (Azidah et al. 2006). In this case, postnatal women probably suffered from depressed feelings without any assistance or referral to an appropriate channel. However, both studies used a quantitative design which may have limited the information on the nature and experience of PND in Malaysia.

Policy related to postnatal depression in Malaysia

A general search on google was conducted to explore potential websites associated with healthcare policy in Malaysia. The websites of the Ministry of Health (MOH) Malaysia, the Malaysian Psychiatric Association, the Academy of Medicine Malaysia, and the Malaysian Mental Health Association were searched. Keywords used individually or combined were: postnatal depression, post-natal depression, postpartum depression, post-partum depression, maternal mental health, mothers and women. No relevant documents were found on the websites except from the website of the MOH. A range of different documents were identified from this website ranging from clinical practice guidelines, health services policy, and health bulletins. The search was restricted to 2000-2016 as it was felt this was related to the implementation of community mental health programme in Malaysia (which begins in 2000). Eleven documents were identified which were then read and summarised (Table 1). However, none of these were directly related to the management of PND.

Table 1: Included policy documents

Title	Year
Community Mental Health in Malaysia: Marriage of Psychiatry and Public Health	2000
Laws of Malaysia: Act 615- Mental Health Act 2001	2001
Clinical Practice Guidelines: Management of Major Depressive Disorders	2007
Ministry of Health Malaysia Strategic Plan 2006 – 2010	2008
National Strategic Plan for Non-Communicable Disease (2010-2014)	2010
General Hospital without Consultation-Liaison Psychiatrist	2010
Psychiatric and Mental Health Services Operational Policy	2011
Country Health Plan: 10 th Malaysia Plan 2011-2015	2011
The Mental Health Development in Malaysia: History, Current Issue and Future Development	2013
Home Visiting	No Date
Traditional Postnatal Care in Restoring Women’s Physical and Mental Health Executive Summary	2015

The provision of mental health services in Malaysia is relatively new. In the early 1900s the mental health policy was based on British and Indian law (Chong et al. 2013). In 2001, the National Mental Health Act was introduced. This act encompasses detailed policy guidelines for the delivery of mental health services that brought huge changes to the mental health system in Malaysia. Despite this achievement, it was argued that the act treats mental disorders as a medical problem, rather than a phenomenon that is triggered by a whole range of psychosocial factors within the larger society (Crabtree and Chong 2001).

A year before the act was enforced, community mental health was launched. This resulted in mental health care in Malaysia moving from hospital-based settings towards community-based care. There are two forms of community mental health services: formal and informal. Whilst formal services are linked with primary care services provided in a community, informal services are provided by local community members other than HCPs, including traditional healers, community support groups, and non-government organisations (Jamaiyah 2000). Despite having a well-planned and comprehensive programme, the implementation of the community mental health service had faced several challenges. This included resistance to change from both psychiatrists and public health personnel. For example, some psychiatrists were hesitant to change from illness-oriented to wellness-oriented approaches, and some HCPs in the community were hardly involved with people who had mental disorders. There was also a lack of mental health practitioners (e.g., clinical psychologists, community mental health

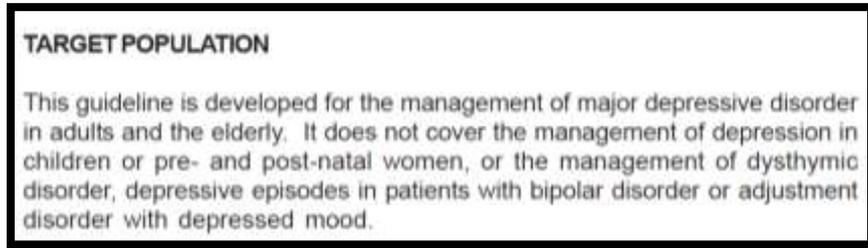
nurses), a lack of continuity care, problems in referral (especially for district hospitals without psychiatrists), and a lack of proper patient information flow (Jamaiyah 2000).

Although all of the above challenges may not have been totally resolved, mental health care is currently integrated into all the health clinics, administratively under the public health division of the MOH. In 2010, in addition to psychiatric services in hospitals, 671 health clinics (82.9%) provide mental health services in the community (Ministry of Health Malaysia 2011).

Out of 11 the documents identified, only one document directly related to PND. This was a report of a review conducted to examine the effectiveness of traditional postnatal care. The review concluded that: (i) there were limited retrievable evidences to suggest the effectiveness of traditional postnatal care in restoring women's physical and mental health and (ii) there was no retrievable evidence on safety and cost-effectiveness of traditional postnatal care (Akmal et al. 2015). Despite this conclusion, the Malay postnatal care package consisting of massage, hot compression (*bertungku*), and abdominal wrapping (*barut*), as well as postnatal breast massage, are still provided in the Traditional and Complementary Unit in several dedicated governmental hospitals in Malaysia.

In the absence of clinical practice guidelines for PND (or any form of maternal distress), the only source available is Clinical Practice Guidelines for Management of Major Depressive Disorders, which was introduced in 2007 (Ministry of Health Malaysia 2007). However, it does not cover the management of depression in antenatal and postnatal women as stated in Figure 1 below:

Figure 1: Target population of clinical practice guidelines for management of major depressive disorders



(Source: Ministry of Health Malaysia 2007)

Conclusion

This paper highlights that the focus of the current care for antenatal and postnatal women within maternal and child health clinics is more on physical health rather than psychological wellbeing. There were no guidelines that specifically focused on the management of PND were found, therefore PND was not formally assessed and detected within the clinics. In the absence of reliable scientific evidence, and policy, and guidelines, it is questionable whether the current approaches to promote and manage maternal mental health in Malaysia have a sense of cultural-based strategies. These significant gaps indicate the need for an empirical evidence that explicitly focussed on the experiences and perceptions of PND in Malaysia.

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