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Publisher: Routledge

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## Health Care for Women International

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/uhcw20>

### Conflicting Cultural Perspectives: Meanings and Experiences of Postnatal Depression Among Women in Indian Communities

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Accepted author version posted online: 31 May 2013.

To cite this article: Anita Jain & David Levy (2013): Conflicting Cultural Perspectives: Meanings and Experiences of Postnatal Depression Among Women in Indian Communities, Health Care for Women International, DOI:10.1080/07399332.2013.807258

To link to this article: <http://dx.doi.org/10.1080/07399332.2013.807258>

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## **Conflicting Cultural Perspectives: Meanings and Experiences of Postnatal Depression Among Women in Indian Communities**

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### **Abstract**

A woman's cultural and social context affects her experience of postnatal depression. In this literature review, the authors explore questions regarding the normal and abnormal postnatal experiences of Indian women with consideration to cross cultural perspectives. Although postnatal distress or sadness is recognised among many cultures, it is constructed as a transient state in some cultures and as an illness in others. A major challenge for health care providers in Western countries like the UK and Australia is to develop culturally sensitive approaches to postnatal care for migrant mothers.

Received 18 Oct 2010; accepted 15 May 2013.

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Childbirth and new motherhood are universally regarded as important life events (Cox, 1988). The experience of an altered or depressed mood for a woman during the postnatal period is not an unusual occurrence and has been acknowledged across diverse cultures (Goldbort, 2006; Oates et al., 2004). The physiological and psychosocial experiences of women from different ethnic backgrounds may be similar, but within cultures and communities such as those in India, the UK and Australia this state is recognised with diverse attitudes, values and responses (Goyal et al., 2006; Oates et al., 2004). The differences in understanding and the response to women's experiences may be due to a fundamental difference in the definition of the experience, as a *disease*, or as a *normal transient state*.

Adopting a culturally relevant approach, we explored complex perspectives through an analysis of studies on Indian women with postnatal depression<sup>1</sup> living among their own communities, either in their homeland, or in the UK and Australia. This is significant at a time when global migration is commonplace and Indians represent a significant proportion of the migrant community in these countries. In Australia, during 2010–2011 there were 21,932 Indian-born new Australian residents, making India the third largest source of new migrants to Australia, after China and New Zealand (Australian Government, Department of Immigration and Citizenship, 2012). Among the UK population between 2004 and 2011, the five most common non-UK countries of birth have remained largely consistent; India being the most common non-UK country of birth each year (Office for National Statistics, UK, 2012). In

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<sup>1</sup> The terms *postnatal depression* and *postpartum depression* are synonymous and are used interchangeably according to the paper cited in this literature review.

response to the emerging presence of Indians in these countries, the healthcare services may be unprepared to receive and support women from such culturally diverse backgrounds.

Our research included a review of studies cited on the PubMed database using the keywords above. We thematically explored the literature discussing the cultural experiences of women with postnatal depression, including applications of the Edinburgh Postnatal Depression Scale (EPDS) and the experiences of migrant women in Western countries. A grounded theory approach was utilised as we developed questions arising from the literature and interviews conducted. A limitation of this exploratory study was the lack of peer reviewed English language papers that examined postnatal depression *particularly* among Indian women. By comparison, a similar search of studies on postnatal depression among Chinese communities provided a considerably larger yield of resources. This validates the need to continue bringing research to the forefront in communication and planning between Indian cultural communities and multicultural health care providers.

Whilst focussing on Indian experiences, we included research from other South Asian countries in this region, such as Sri Lanka, Bangladesh and Nepal as many of the cultural practises following childbirth share a common base with India. To support and emphasise personal experiences we have included data from selected personal communications derived from professional and occupational contacts. These were recorded from email and telephone communications with a midwife (KB), a mother in the postpartum recovery stage (SK) and a Complementary Healthcare Practitioner (ES).

## **Background: Postnatal Depression**

The recognised symptom picture of postnatal depression in a mother includes a depressed mood, tearfulness, insomnia and lack of interest in her newborn infant (DSM-IV, 1994). Postnatal depression closely resembles the symptoms of major depression where the distinguishing feature is that the depression begins within four weeks after giving birth. A common pattern emerges where women often do not ask for help and may withdraw socially. As the symptoms become overwhelming the mother is unable to function or focus on daily tasks and this can evolve into feeling inadequate and losing self-confidence as a mother and/or wife. The causes of postnatal depression are still uncertain but are thought to be multi-factorial, including biological and psychological risk factors as well as social and contextual issues (Goldbort, 2006). Lack of family support, sleep deprivation, babies with feeding or sleeping difficulties and financial constraints can contribute to postnatal depression.

Postnatal depression has significant effects on a woman's psychological health, which in turn can have implications for the well-being of her family and the development of her newborn child. Statistics for postnatal depression in developed nations show an average of 13% of women are affected (O' Hara & Swain, 1996). There is limited literature from countries in the South-East Asian region, including India, where research from the World Health Organisation shows the prevalence of postnatal depression at between 3% and 36% of mothers in the postpartum stage (Thara & Patel, 2001). This remarkable discrepancy raises questions about the ease of detection of postnatal depression and the validity of screening tools like the Edinburgh Postnatal Depression Scale when applied to Indian women.

## **Postpartum care**

There are diverse models of postpartum care across cultures. These differ widely where, for example, the committed practice or *rituals* among Indian communities emphasise support for customs thought to protect the physical, mental and spiritual health of the mother and her infant. In contrast, the model for postpartum care in countries such as the UK and Australia has a greater emphasis on monitoring physical health. In Australia, the government-supported Medicare Benefit Scheme (MBS) offers postpartum services focussing on immediate afterbirth care, and postnatal interventions which address medically related complications (Australian Government, Department of Health and Aging, 2009, p.46). The need to provide additional support in the postpartum stage has been emphasised when observing the obstetrics services and benefits provided under the MBS. From 2007-2008, less than 1% of services were allocated for postpartum care compared with 85% for antenatal attendances.

The role of health care providers in multicultural communities becomes very important in the challenge to develop awareness of diverse and complex cultural attitudes. A more culturally sensitive approach to antenatal and postnatal care would theoretically benefit the new mother, her family and community, and health care providers. A woman's experience of postpartum care is an important determinant of how she adjusts to her new role as a mother. There are variations in the type and focus of care provided. In the UK and Australia, postpartum care focuses on the use of medical technologies to monitor and assess the health of the mother and her newborn baby. The medical benchmarks observed include healing of the perineum, normalised bladder and bowel function, and the baby's satisfactory vital signs. On achieving the required medical benchmarks, the mother and infant are usually discharged from hospital within two days of giving birth (a Caesarean section delivery requires a stay in hospital of five days). She will be

provided with instructions concerning infant feeding, diet and exercise (Posmontier & Horowitz, 2004).

In the UK and Australia, the healthcare support network offers home visits, where required, from a community midwife. After discharge from hospital, a midwife will normally provide home visits for up to ten days to monitor the mother's physical improvement and the baby's development (KB, personal communication, August, 2009). Generally, the UK and Australian model does not include access to social support (Posmontier & Horowitz, 2004) and it may not be unusual to see mothers returning to their normal activities two weeks after the delivery (Cox, 1998). In the UK, moves to encourage greater social and domestic support include the implementation of paid or unpaid paternity leave. This acknowledges the need for women to be physically and emotionally supported by their spouse during the postpartum stage. In contrast, the Indian model of postpartum care is one in which the main focus is to mobilise social support through the family, and sometimes through neighbourhood networks. Although technology is also utilised to monitor the physical well-being of the mother and infant (particularly if the delivery has been complicated), family and social support is the dominant care model adopted.

## **Rituals and traditions**

In the Indian sub-continent there is a relationship with postpartum practices which is represented by rituals or rites of passage (Cox, 1988; Oates et al., 2004). A ritual is a committed practice which is embedded in a culture and is symbolic of traditional beliefs; the rituals are adhered to in order to enhance the mother's recovery at a physical level (Huang & Mathers, 2001), to create psychological and emotional balance, and to provide spiritual protection (Hanlon et al., 2009).

The transition to motherhood in India (Goyal et al., 2006) is marked with postpartum rituals that are observed to provide protection and support for the new mother, ensuring that she maintains optimal health in the interests *of the baby*. The postpartum period is defined as 30-40 days (Posmontier & Horowitz, 2004) and is considered a time when the mother and infant are particularly vulnerable to poor health. Limits are therefore placed on exposure to people and normal daily activities. Special diets, a warm environment, massage and traditional healing foods are offered to the mother to help with recovery from childbirth and also to meet the demands of breastfeeding. It is here that the extended family network and community have an important and supportive role in relieving the mother of all her domestic duties. This allows her time with her infant; provides energy for her to heal and ensures that she feels fully supported. The importance of these cultural practices lies in the belief that they offer a positive experience to a new mother. However, as cultures evolve and adapt due to the influence and appeal of non-Indian lifestyle models, conflict with traditional postpartum practices can arise for some mothers who choose to follow practices not readily accepted by their family. The relationship between these practices and postnatal depression are complex; here the cultural influences can be both positive and negative (Bina, 2008). Some women may feel uncomfortable with decisions about care for the baby and themselves being under the control of extended family members. In some cases women do not perceive these practices to be supportive, for example where there is a difficult relationship with the carer, particularly when this person is the mother-in-law (Bina, 2008). Stressful family relationships may therefore contribute towards the psychological risk of postnatal depression even in circumstances where there is adequate support and protective rituals are practiced.



## **Cultural attitudes**

An Indian community may be reluctant to accept the cultural construction of postnatal depression, its existence as a clinical condition or its prevalence in their society. Dubey et al. (2012) acknowledge that maternal mental health is largely ignored in India, despite at least 6% of women being at risk of peripartum depression. This lack of acknowledgement must cause additional stress for a woman who is aware that she is psychologically unbalanced and recognises that she needs some form of assistance. An investigation of the cross cultural equivalence of postnatal depression was conducted in eleven countries (Oates et al., 2004). The aim of this qualitative study was to explore whether postnatal depression is a concept confined to Western countries such as the UK and Australia. Interviews and focus groups were conducted in the native language with participants from three groups; new mothers, relatives and health professionals. The areas of inquiry included views, beliefs and the understanding of factors leading to 'happiness or unhappiness' during the perinatal period. Although postnatal depression was universally identified, some communities did not regard professional or medical help to be appropriate and felt that treatment was unnecessary. The solutions to these altered moods were sought from support within the family. This study found that unhappiness felt by mothers was most likely to be seen as a normal response to childbirth and was *not* labelled as an illness, disease or condition requiring medical or psychological intervention.

Other specific cultural attitudes present within a community can influence a mother's postnatal state. Pressure to deliver *male* babies in some South Asian cultures like India is a significant additional concern for mothers (Dubey et al., 2012). A study of 270 mothers in Goa,

India, found 23% suffered postnatal depression (Patel et al., 2002). The gender of the newborn was a risk factor; where a mother already had a female child the risk of postnatal depression was higher when the newborn was female. The relative risk was nearly three times greater than when the newborn was male. Social factors among those who had suffered violence, experienced poverty and had poor marital relationships were studied where these mothers were also found to be at increased risk of having postnatal depression.

Some women with postnatal depression find it difficult to have a name or medical label given to their condition (Illich, 1975), particularly given the prevailing cultural attitudes towards psychological disorders. In a qualitative study of mothers in Goa, India (Rodrigues et al. 2003), mothers who experienced symptoms of emotional distress would not consider a psychiatric classification to describe their state. Their husbands also followed this attitude. In this type of situation sufferers may remain unsupported, untreated and unassisted unless postnatal depression can be identified when a mother is visiting a health care professional for her child.

Postnatal depression is evidently not a medical condition confined to Western societies such as the UK and Australia (Oates et al., 2004). However, the criteria used to determine postnatal depression cannot be easily superimposed onto an Indian biopsychosocial model of disease. The breadth of psychological and emotional states experienced by these mothers after giving birth presents within the wider context of normal behaviour. Generally, this is seen as part of the early mothering process or a natural part of moving towards a new role (Dubey et al., 2012; ES, personal communication, December, 2009).

## **Implications for the mother, infant and family**

There are imminent changes in responsibility and status for new mothers within their particular society (Oates et al., 2004). Images of the cultural stereotypes of a mother's role are reinforced by the family, schools and the media. Within Indian communities inside and outside India, being a mother elevates a woman to a higher status among her community and is central to her capacity to live a fulfilling life.

The stigma attached to having a mental illness (Goyal et al., 2006, Werrett et al., 2006) like postnatal depression in an Indian community has consequences that impact upon the rest of the nuclear and extended family. High esteem is placed on a woman whose 'natural duty' is to bear and nurture children (Morrow et al., 2008). Should it be apparent that the mother is unable to fulfil her role as carer through the manifestation of unusual emotional behaviour, this can be perceived as a personal weakness in the mother, as well as a 'loss of face' or embarrassment to her family. The situation can be further aggravated by pressure directed towards the woman to conform to the norms of idealised maternal behaviour within the framework of her culture. She may internalise the problem leading to a state of emotional resignation (Ghosh, 2005).

A child's physical development is also affected by the psychological and emotional health of its mother. Babies of depressed mothers showed significantly poorer growth outcomes and mental development scores when evaluated at six months of age (Patel et al., 2003). Rodrigues et al. (2003) concluded that mothers with postnatal depression felt their symptoms had an adverse effect on their relationship with their baby. Although mothers felt happy and joyful towards their babies, almost half described feeling angry and irritable which had a negative effect on their relationship with their children. The World Health Organisation also reports that; "There is a compelling body of evidence implicating postnatal depression in a range of adverse

child cognitive and emotional outcomes” (Thara & Patel, 2001). This emphasises the need to implement screening programs and to raise awareness of postnatal depression in Indian communities.

## **Migration and motherhood**

As societies become increasingly culturally diverse there is a growing need to understand the social and cultural backgrounds of the emerging communities. For an Indian mother living in a non-Indian country, migration brings with it lifestyle transformation. For the migrant who does not have family members or friends this can be a time of social isolation while adjusting to the cultural differences of a new country (Ghosh, 2005; Morrow et al., 2008). With additional pressures such as financial constraints and career adjustments for her spouse, this may create vulnerability to a depressed state for the woman in the perinatal stage.

In the Indian framework of postpartum care, the father has a secondary role to that of female family members. If the new mother is living with her parents-in-law, as is often the case in India (but also a tradition practised among many other Asian migrants living in the UK and Australia), the mother-in-law has a primary role in the care of the new baby. Emotional support may be difficult for the father to provide if he is not accustomed to such a role. For a solitary migrant family there may be no family support or the financial option for the father to take leave from his work in order to provide domestic support to his wife (Morrow et al., 2008). Where a woman’s belief system regarding postpartum care is focussed around a set of clearly defined cultural rituals, this can be very destabilising when unprepared for this situation (ES, personal communication, December, 2009).

### Response and treatment

Depression, as a concept, does not have a direct translation in some non-European languages (Patel, 2001). This may explain a community's response to a woman experiencing an altered postnatal mood. For example, some Bangladeshi languages do not have a word for depression, so the English word is used when required (Ghosh, 2005, p.89). Rather than point to the non-existence of postnatal depression within a culture, it questions cultural attitudes to women's mental health and to childbirth. "In India, incorporating postpartum depression into Maternal Child Health (MCH) services has been a relatively new initiative" (Hema, 2008, p.43). This acknowledgement demonstrates an emerging awareness of the need for such services. In India, cultural issues have been cited as the reasons why the management and recognition of postnatal depression has received little attention from both patients and health care providers (Dubey et al., 2012; Hema, 2008). The fear of being stigmatised with an undesirable psychological state, and the perception of this stigma, are amongst the cultural attitudes and obstacles that need to be addressed.

A woman's cultural background determines *how* she will experience symptoms of postnatal depression. "A constellation of symptoms which are defined as depression in Western societies, an illness, are seen as part of life by South Asian people because their cultural system or social capital understands and interprets these symptoms differently" (Ghosh, 2005, p.3). This construction complicates the notion of whether a problem actually exists for a mother, and at what point assistance needs to be offered. If the depression is acknowledged and the mother is given support then there are considerable benefits. "The detection of postnatal depression is of

great public health interest not only because of its profound impact on maternal and child health but also due to the abundant evidence that simple inexpensive interventions such as non-directive counselling are of significant benefit in terms of remission of postnatal depression”, reports the World Health Organisation (Thara & Patel, 2001).

The response to a state of postnatal sadness can also be influenced by religious perspectives, as observed for example among Sri Lankan Buddhists; life may be seen as a destiny rather than for enjoyment, which brings with it cycles of sorrow and suffering (Ghosh, 2005). Again, this is regarded as an experience which falls within the framework of normal life changes for a new mother.

### **Edinburgh Postnatal Depression Scale (EPDS) as a tool**

Globally, a number of specific tools are utilised to measure postnatal depression. These include the Postpartum Depression Screening Scale (PDSS), Beck Depression Inventory II (BDI-II), and the Edinburgh Postnatal Depression Scale (EPDS), one of the most widely used (Cox et al., 1987). The EPDS was utilised in many studies explored in this literature review, having been designed to assist health care professionals to detect postnatal depression through a series of questions relating to a woman’s state during the antenatal and postnatal stages. As a screening device, the EPDS is used worldwide and has been translated into numerous languages. The test consists of ten short statements with four possible responses which are weighted with a score from 0 to 3. Cut-off scores for totals between 10 and 13 have been used in various studies to indicate that a woman has postnatal depression. The recommended cut off score is 13 (Cox et al.,

1987), however different scores have been applied in cultural studies in order to achieve optimal sensitivity and specificity of the tool.

A postnatal depression screening tool must have the capability to accommodate cultural variation. It is also important that a validated tool has the flexibility to be used by mothers from different cultures in order to be properly regarded as a culturally-sensitive diagnostic aid. In practice it is questionable whether the scale utilised can effectively capture the defined state of postnatal depression for *every* culture (Ghosh, 2009; Small, 2006). When examining the use of the English translation of the EPDS amongst a group of mothers (English educated) in India, some questions were found difficult to understand and interpret (Hema, 2008). For example, Question 1 states: *I have been able to laugh and see the funny side of things*. This was perceived by Indian women as meaning to laugh in the literal sense rather than to explore and express feelings of being able to relax. Also, Question 6 states: *Things have been getting on top of me*. The particular vernacular which appears in the EPDS was found to be difficult to interpret and required clarification.

The process of completing the EPDS provided insight into the opinions of what *might* be normative experiences in the postnatal period for women of different cultural backgrounds. The feedback from participants in this study indicated that being anxious or worried was a normal occurrence happening most of the time, as were sleep disturbances (Hema, 2008). In another study of Bangladeshi mothers living in Australia, it was reported that *how* women answered the EPDS questions was actually an expression of the anxiety and frustration experienced in response to their social and financial situation in the postnatal stage rather than postnatal depression (Ghosh, 2005). As the questions in the EPDS do not mention pregnancy or childbirth,

the accuracy of the scores may be distorted due to a mother's interpretation of the questionnaire and the impending stressful circumstances brought about by childbirth.

Some studies were favourable in their reported outcomes on the use of the EPDS in specific communities in which there are few published papers. The Punjabi version of the EPDS was validated as an acceptable tool (Werrett & Clifford, 2006) while screening mothers in the UK Indian community. The threshold or cut-off scores of 11.5/12.5 used in the Punjabi scale was considered more appropriate to ensure sensitivity and specificity of the tests conducted. However, as noted by Werrett & Clifford, the relatively small sample size of twenty participants from eleven clinics challenges the reliability of the results of this three year study. It also highlights the possible reasons behind the lack of willingness by Indian women to participate in a study of this nature, and the need to continue raising awareness of postnatal depression in order to tackle the issue of social stigma.

Validation of the Sinhala version of the EPDS among 265 antenatal and 204 postnatal women in Sri Lanka (Rowel et al., 2008) found the EPDS to be a reliable assessment tool when the cut-off score of 9 was used. The application of the English version of the EPDS was assessed among 100 postnatal Nepalese women in Kathmandu (Regmi et al., 2002) using cut-off scores of 13. While the results indicated the ease and reliability of the EPDS, there was no discussion of how the trained nurses translated the questionnaire for women or how many women understood English. Based on the inconsistent measures and applications of the EPDS, the accuracy of prevalence rates of postnatal depression may be problematic. Variable quantitative and qualitative application and interpretation of the EPDS have made it difficult to measure postnatal depression across cultures.



The EPDS would be a useful screening tool when employed as part of a series of assessments that include structured in-depth interviews as well as the expertise of professionals trained to operate in culturally specific backgrounds. A limitation is the consistency of interpretation of results when studying groups of mothers with literacy issues (Akhtar, 2010). The method of delivering a tool in this situation requires a more guided approach to explaining the questionnaire but also allows for the possibility of suggestion and bias in the scores. The challenge remains to try to standardise the EPDS to ensure its successful use among mothers of different cultural and social backgrounds.

## **Challenges for healthcare professionals**

Health professionals in Western countries such as the UK and Australia are working towards a greater understanding of migrant mothers with postnatal depression by developing educational programs and awareness of cultural backgrounds and postpartum practices (Goldbort, 2006). They face the challenge to bring issues to the forefront so that appropriate beneficial treatment and assistance can be offered. Creating greater awareness among ethnic communities helps to reduce the stigma attached (Goldbort, 2006) and might provide mothers with more culturally appropriate care.

In Australia, postnatal depression screening programs are utilised in some communities where postnatal care includes mothers completing a questionnaire regarding symptoms of postnatal depression. This is appropriate for the early detection of postnatal depression. However, one Indian mother (SK, personal communication, October, 2009) reported that in completing this form she felt some questions were too suggestive of feelings being abnormal and

did not want to be drawn into a process of further evaluation by the medical system. This raises possible concerns about bias and misinterpretation in questionnaires such as the EPDS, tools which need to accommodate differences in culture, and demonstrate sensitivity towards diversity of languages and values. In Australia, the New South Wales Multicultural Health Communication Service has published a factsheet on postnatal depression in numerous languages titled *Sad Feelings after Birth*. The title omits the word ‘depression’ which is indicative of an increasingly culturally sensitive, realistic and more inclusive approach to the subject.

Definitions of postpartum care vary across cultures (Akhtar, 2010; Posmontier, 2004). The UK and Australian model of maternity care is in many respects a poor fit for migrant Indian women having their first or subsequent child. Details of specific cultural practices regarding the delivery environment, diet and personal care would be useful information for health care professionals including hospital nutritionists, dieticians and managers and would help to avert a potentially distressing situation for new mothers. Discussion between Indian community networks, for example women’s groups, religious or cultural groups, and healthcare professionals would be beneficial. This would empower healthcare providers in their efforts to understand the perception and needs of Indian women. Indian community leaders would also benefit from understanding the provisions and limitations of their specific healthcare environment.

## **Conclusion**

We have examined three important perspectives in regards to postnatal depression; a new mother's recognition of her unhealthy state (where it exists), definitions of normal and abnormal experiences in the postnatal period utilised within various cultures, and the ability of healthcare services to acknowledge and respond to different belief systems about childbirth and postpartum care. For each set of issues we have considered the perception and construction of postnatal depression and reflected upon what courses of action might be taken to effect change.

The role of traditional postpartum practices for women is both integral to identity and extremely complex. For an Indian new mother cultural and postpartum practices or rituals can have an influence on both the occurrence and prevention of postnatal depression. The relationship with the family carer and the modernity of a woman can shape the comfort or confrontation of her experience. An emotionally unstable postnatal state can be interpreted as *feelings* or *symptoms* depending on its particular cultural construction. The concern for health care services should be to reassure a cultural community that safe and reliable assistance can be offered to a mother, whether she is perceived as being distressed or as having postnatal depression. For a suffering mother and her family, accepting the title or label of postnatal depression means confronting mental illness along with the social stigma attached to it. This can further complicate the route to recovery challenged by predefined attitudes to mental illness.

The sociocultural issues of postnatal depression can be further complicated by migration to a country which adopts different approaches to childbirth and postpartum care. Infant growth and development can be affected where a mother is suffering from postnatal depression. While postnatal sadness or unhappiness is recognised across cultures, in some cultures it is classified as a disease whilst in others it is considered within a normal range of postnatal feelings.

Healthcare services in countries like the UK and Australia are moving towards providing antenatal and postnatal care that is more culturally specific and addresses the needs of the individual. Whilst the EPDS is an important and widely used tool, part of the challenge is to provide screening devices that recognise culturally equivalent states to conventional definitions of postnatal depression. Culturally sensitive approaches utilising health promotion and education programs to inform and support the community are also required.

While exploring postnatal issues confronting Indian women, further research could investigate the social and educational background of migrant sufferers, their adherence to postpartum practices and the occurrence of postnatal depression. A limitation of our review is the use of English language papers. Further scope for research would consider incorporating studies published in indigenous languages.

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