The Gap between Knowing and Doing: Health Workers' Perceptions and Screening of Postpartum Depression

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ABSTRACT

Background: Postpartum depression (PPD) is a prevalent yet under-recognized complication of childbirth with severe implications for maternal and child well-being. Despite global recommendations advocating for routine screening, implementation in low-resource settings remains inconsistent, creating a significant gap between clinical knowledge and practical application.

Objective: This study investigates the "gap between knowing and doing" regarding PPD among health workers at Babcock University Teaching Hospital, Nigeria. Specifically, it explores health workers' understanding of PPD and examines their approaches to screening and management in routine clinical practice.

Methods: A qualitative exploratory design was employed. In-depth interviews were conducted with 15 frontline health workers, including nurses, midwives, community health officers, and medical officers directly involved in maternal and child health services. Data were analyzed using thematic analysis and interpreted through the lens of the Social Ecological Model to understand individual, interpersonal, and institutional factors.

Results: Findings reveal that while participants possess basic awareness of PPD, their clinical understanding is superficial, often normalizing symptoms as typical postnatal distress. Crucially, no routine screening protocols or standardized tools, such as the Edinburgh Postnatal Depression Scale, are utilized. Instead, detection relies on subjective observation and patient complaints, leading to inconsistent identification. Management is limited to basic counseling and referrals, hindered by a lack of formal training, absent clinical guidelines, heavy workloads, and deep-seated sociocultural stigma. The disconnect between knowledge and practice is identified as systemic, driven by organizational constraints and community-level barriers rather than individual deficits alone.

Conclusion: The study concludes that bridging the gap in PPD care requires multi-level interventions. Recommendations include integrating standardized screening tools into routine maternal care, providing structured capacity-building training, developing clear clinical protocols, and addressing sociocultural barriers through community engagement. These strategies are essential for transforming PPD care from a reactive to a proactive model, ensuring timely support for affected mothers and improving long-term developmental outcomes for children.

Keywords: Postpartum depression, health workers, screening practices, qualitative study, Nigeria, Social Ecological Model.

INTRODUCTION

Postpartum depression (PPD) represents a critical yet frequently overlooked dimension of maternal health, characterized as a non-psychotic depressive disorder that manifests during pregnancy or in the aftermath of childbirth. Classified within the Diagnostic and Statistical Manual of Mental Disorders as a major depressive disorder, contemporary diagnostic frameworks have expanded the temporal scope of this condition through a peripartum-onset specifier. This specifier acknowledges that the risk period extends from pregnancy through the

first twelve months following delivery, thereby capturing cases that emerge well into the first year of postpartum life (Singh et al., 2021; Radoš et al., 2024). Consequently, PPD is recognized not merely as a transient emotional reaction to childbirth but as a significant psychiatric condition with the potential to develop and persist within a substantial window of early motherhood (Radoš et al., 2024).

The aetiology of postpartum depression is inherently multifactorial, reflecting a complex interplay of biological, psychological, genetic, and social determinants. Biological vulnerabilities, such as the precipitous hormonal shifts following delivery, are compounded by physiological stressors like sleep deprivation and emotional strain, alongside broader social stressors (Stewart & Vigod, 2019). In the specific context of Nigeria, these universal risk factors intersect with unique maternal challenges and high levels of perceived stress, underscoring the intricate relationship between biological susceptibility and psychosocial realities (Isma'il Tsiga-Ahmed et al., 2024). These converging determinants necessitate a holistic approach to understanding PPD, one that considers not only the clinical presentation of the disorder but also the broader socio-environmental circumstances in which women navigate childbirth and early motherhood.

Despite its clinical significance and the severity of its consequences, postpartum depression remains one of the most common yet under-recognized complications of childbirth. It is frequently inadequately addressed within routine maternal care, leaving a vast number of women without the necessary support systems (Stewart & Vigod, 2019). The ramifications of untreated PPD are profound, extending beyond maternal morbidity to include adverse outcomes for the child. These include impaired mother-infant bonding, suboptimal infant feeding practices, and an elevated likelihood of developmental delays (Ayinde et al., 2018). The impact of maternal mental health is particularly critical during the first 1,000 days of life—the period spanning from conception to a child's second birthday—which constitutes a vital window for physical, emotional, and cognitive development (Nechaeva et al., 2024). Maternal mental health during this phase plays a pivotal role in shaping child trajectories; children of mothers experiencing PPD face heightened risks of delayed growth, emotional dysregulation, behavioral difficulties, and reduced cognitive performance, with potential long-term consequences that echo into later childhood and adolescence (Nechaeva et al., 2024; Adeyemo et al., 2020).

Globally, the burden of postpartum depression is substantial. A comprehensive meta-analysis estimated a pooled global prevalence of approximately 17.22 percent within the first year postpartum (Wang et al., 2021). However, this burden is not evenly distributed; marked regional variations exist, with higher rates documented in parts of Southern Africa and Southern Asia compared to several European regions (Wang et al., 2021). In Nigeria, reported prevalence rates fluctuate significantly across studies and settings, ranging from roughly 10 percent to over 35 percent, indicating a heavy and uneven disease burden (Adeyemo et al., 2020). Evidence suggests that PPD occurs more frequently in low- and middle-income countries than in high-income settings, a disparity driven by socioeconomic constraints, limited access to care, and contextual stressors (Haque et al., 2015; Adeyemo et al., 2020).

While numerous demographic and psychosocial factors—including antenatal depression, prior history of depressive episodes, stressful life events, marital conflict, and limited social support—have been linked to PPD (Agrawal et al., 2022; Dimcea et al., 2024), the translation of this epidemiological knowledge into routine clinical practice remains inconsistent. The World Health Organization estimates that one in four individuals will experience a mental or behavioural disorder in their lifetime, with between 20 and 40 percent of women in low-income countries experiencing depression during pregnancy or postpartum (Martínez et al., 2016). Despite this staggering burden, the identification of perinatal depression by frontline healthcare providers in Nigeria remains suboptimal, largely due to the absence of structured screening approaches. Active screening has been shown to significantly improve detection rates (Oladeji et al., 2025), prompting global recommendations for the integration of perinatal mental health screening and management into routine maternal and child health services to bridge the detection and treatment gap (WHO, 2022).

However, the chasm between global recommendations and local realities is where the core problem of this study lies. While the burden of PPD is well-documented, the specific mechanisms by which health workers within public health facilities perceive, understand, and act upon this knowledge remain insufficiently explored. The "gap between knowing and doing" is not merely a theoretical concept but a practical reality shaped by institutional constraints, professional competencies, and sociocultural dynamics. Frontline healthcare workers,

who serve as the primary point of contact for postpartum women, often operate within systems characterized by limited mental health training, inadequate supervision, and restricted access to specialist support (Iheanacho et al., 2024). Facility-level assessments further reveal weak organizational readiness, including the absence of routine screening protocols, poorly structured referral pathways, and inconsistent administrative support (Ayinde et al., 2018).

Furthermore, sociocultural factors profoundly influence the identification and management of PPD. Cultural norms that normalize postnatal psychological distress or interpret it as a sign of personal weakness can discourage women from disclosing symptoms, while stigma surrounding mental health complicates open communication within clinical encounters (Onofa et al., 2024). In low- and middle-income countries, persistent barriers such as stigma, gender expectations, and fragile health infrastructure continue to undermine the effective integration of perinatal mental health services (Paricio-Del-Castillo, 2024). Even where screening programs exist, inconsistent supervision, irregular refresher training, and limited referral mechanisms constrain their long-term effectiveness (Oladeji et al., 2025).

Existing literature has extensively documented the prevalence of PPD and identified broad structural and sociocultural barriers to care. Yet, there remains a paucity of in-depth understanding regarding how health workers within specific public health facilities, such as Babcock University Teaching Hospital (BUTH) in Ogun State, navigate these challenges. How do they conceptualize PPD? How do they translate their knowledge—or lack thereof—into screening behaviors in the midst of routine clinical pressures? Addressing these questions is essential for generating contextual insight into the practical challenges and opportunities that influence the identification and management of PPD at the frontline of maternal healthcare delivery.

This study, titled "The Gap Between Knowing and Doing: Health Workers' Perceptions and Screening of Postpartum Depression," seeks to explore these critical dimensions. By focusing on the dual objectives of exploring health workers' understanding of PPD and examining their approaches to screening in routine practice, this research aims to illuminate the disconnect between theoretical knowledge and clinical action. This study will provide policymakers with contextually grounded insight into how postpartum depression is understood and addressed in Babcock University Teaching Hospital. Rather than relying solely on prevalence figures or broad programmatic recommendations, the findings will illuminate how institutional realities, professional practices, and contextual factors shape screening and management processes. Such in-depth understanding is essential for developing policies and allocating resources that are responsive to the lived conditions within local health systems, ultimately fostering a more robust and effective response to the silent epidemic of postpartum depression.

METHODOLOGY

Research Design

This study employed a qualitative exploratory research design to investigate the nuanced realities of postpartum depression (PPD) care within a Nigerian tertiary health facility. The exploratory qualitative approach was deemed most appropriate given the study's aim to gain an in-depth understanding of health workers' knowledge, practices, and capacity for screening and managing PPD within the context of routine maternal and child health services. Unlike quantitative designs that measure predefined variables, this methodology facilitated a detailed exploration of participants' perspectives, experiences, and interpretations of PPD and its management. By prioritizing the generation of rich, contextual insights, the design allowed the researcher to uncover how screening and management processes are understood and implemented in everyday clinical practice. This approach is particularly valuable for elucidating the complex institutional and sociocultural factors that shape PPD care, aligning with the study's objective to examine the "gap between knowing and doing" (Goyal et al., 2023; Maloleka et al., 2024).

Population of the Study

The target population for this study comprised all health workers providing maternity and child health services at Babcock University Teaching Hospital (BUTH) in Ilishan-Remo, Ogun State, Nigeria. BUTH, a privately

owned tertiary facility established in 2012, serves as a teaching and referral center with an active obstetrics and gynecology unit handling antenatal, intrapartum, and postnatal cases. The study population was specifically defined as health personnel directly involved in postnatal or maternal care services who had worked in the facility for at least one year. This criterion ensured that participants possessed sufficient clinical exposure to reflect on their practices and institutional realities. The inclusion of a multidisciplinary team—comprising doctors, nurses, midwives, community health officers (CHOs), and community health extension workers (CHEWs)—was essential to capture diverse perspectives across different levels of clinical responsibility and patient interaction, reflecting the holistic nature of maternal care in Nigerian settings (Iheanacho et al., 2024).

Sample Size Determination

The study recruited a total of 15 health workers from BUTH. The final sample size was not predetermined by statistical power calculations but was instead determined by the principle of data saturation. Data saturation was achieved at this number, as subsequent interviews failed to yield new themes or relevant insights regarding PPD screening and management. This approach is consistent with qualitative research standards, where the emphasis is placed on the depth of insight and information power rather than numerical representation (Maloleka et al., 2024). The sample comprised frontline maternal and child health providers directly involved in antenatal and postnatal care, ensuring that the data collected was sufficiently robust to address the study objectives effectively. Including participants with varying years of experience and from different units, such as the labour ward, immunization clinic, and outpatient services, further enhanced the richness and credibility of the data by ensuring both experiential diversity and contextual depth.

Sampling Techniques and Bias Mitigation

Participants were selected using purposive sampling, a non-probability technique designed to ensure representation across key professional cadres involved in maternal and child health service delivery. This method was chosen to capture the distinct perspectives of doctors, nurses, midwives, CHOs, and CHEWs, allowing for a comprehensive exploration of knowledge, practices, and institutional capacity. To mitigate potential biases inherent in purposive sampling, the researcher ensured a balanced distribution of participants across professional roles and clinical units, as detailed in Table 3.1. The inclusion criteria strictly required direct involvement in antenatal and postnatal care, thereby excluding administrative staff or those not clinically engaged in maternal health. By selecting participants based on their specific roles and minimum tenure of one year, the study minimized selection bias and ensured that the data reflected the lived experiences of those most relevant to the research questions. This strategy aligns with best practices in qualitative inquiry, where the goal is to select information-rich cases that illuminate the phenomenon under study (Gowon et al., 2024).

Instrument and Data Collection

Data collection was conducted using a semi-structured in-depth interview guide developed by the researcher, grounded in the study objectives and existing literature on PPD and maternal mental health care. The guide featured open-ended questions designed to elicit detailed responses on health workers' understanding of PPD, their experiences with screening and management, perceived institutional capacity, and the challenges encountered in routine practice. The instrument was organized into sections covering professional background, understanding and recognition of PPD, screening experiences, management approaches, institutional support systems, and suggested improvements. Probing questions were integrated to encourage clarification and deeper exploration of key issues. Data collection involved face-to-face interviews conducted in private locations within the facility to ensure confidentiality. Each interview lasted approximately 30 to 45 minutes and was audio-recorded with participants' permission, supplemented by field notes to document non-verbal cues and contextual observations. This method allowed for flexibility, enabling participants to express their views freely while ensuring all relevant topics were covered (Oladeji et al., 2025).

Method of Data Analysis

The collected data were analyzed using thematic analysis, supported by NVivo qualitative data analysis software. The process began with the verbatim transcription of audio recordings, which were then imported into NVivo

for organization and coding. The researcher engaged in repeated reading of the transcripts to achieve familiarity with the data. Initial codes were generated from meaningful segments of text, which were subsequently grouped into categories to form broader themes that captured patterns across participants' accounts. The analysis was iterative, involving ongoing comparisons of codes and themes across transcripts to ensure consistency and depth. Verbatim excerpts from participants were utilized to illustrate and substantiate the identified themes in the final report. This rigorous analytical approach ensured that the findings were deeply rooted in the participants' narratives, providing a credible interpretation of the gap between knowledge and practice in PPD screening (Nkurunziza et al., 2024).

Ethical Considerations

Ethical approval for the study was obtained from the Babcock University Health Research Ethical Committee (BUHREC) prior to data collection. Informed consent was secured from all participants, ensuring they fully understood the study's purpose, their right to confidentiality, and the voluntary nature of their participation. To maintain privacy and confidentiality, all responses were coded, and no personal identifiers were linked to the data. Interviews were conducted in private settings to protect participant identity and encourage open dialogue. The study adhered to ethical principles of respect for persons, beneficence, and justice, ensuring that the rights and well-being of the health workers were protected throughout the research process. These measures were critical in fostering trust and ensuring the integrity of the data collected in a sensitive area of maternal mental health (Ayinde et al., 2018).

RESULTS

Understanding and Perception of Postpartum Depression

The study revealed that while health workers at Babcock University Teaching Hospital possess a foundational awareness of postpartum depression (PPD), their clinical understanding remains superficial and often lacks diagnostic precision. Participants generally recognized PPD as a condition characterized by sadness or low mood following childbirth, yet few could articulate specific diagnostic criteria or distinguish between transient "baby blues" and clinical depression. A pervasive tendency to normalize symptoms was evident, with many providers interpreting signs of distress as a natural, expected reaction to the physical and emotional demands of new motherhood. This normalization creates a significant barrier to identification, as symptoms are frequently dismissed as temporary fatigue or stress rather than indicators of a treatable psychiatric disorder. Furthermore, some participants expressed a reliance on specialist intervention, indicating a lack of confidence in their own ability to manage the condition, which reinforces a passive approach to mental health care within routine maternal services.

"We know it exists, but it is not something we focus on in our daily work." (P7, Midwife) "Postpartum depression is when a woman feels sad after giving birth, but we don't really go deep into diagnosing it." (P1, Nurse) "It is normal for women to feel overwhelmed after delivery, so we don't always see it as depression." (P4, CHEW) "Sometimes it is just stress from taking care of the baby, not necessarily a medical issue." (P9, Nurse) "I can identify it, but I don't feel confident managing it. That's usually handled by specialists." (P14, Medical Officer)

Screening Practices and Reliance on Subjective Observation

A critical finding regarding clinical practice is the complete absence of routine, standardized screening protocols for postpartum depression within the facility. None of the participants reported the use of validated instruments, such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ), to systematically assess patients. Instead, the detection of PPD relies heavily on informal, subjective methods driven by patient presentation and provider intuition. Health workers described a reactive rather than proactive approach, where screening occurs only if a patient explicitly complains of distress or displays obvious behavioral changes, such as withdrawal or excessive crying. This ad-hoc method leads to inconsistent identification, as subtle cases are easily missed, and the process is entirely dependent on the individual clinician's vigilance and the patient's willingness to disclose symptoms. The lack of structured tools means that mental health assessment is not integrated into the standard workflow of antenatal and postnatal care, leaving a significant gap in early detection.

"There is no standard tool we use to check for it during clinic visits." (P5, Nurse) "We don't have any formal screening process for postpartum depression." (P3, CHO) "If the woman looks withdrawn or complains too much, we may suspect something." (P8, CHEW) "We rely on patient behaviour or complaints from relatives to suspect depression." (P15, Medical Officer) "I am not aware of any specific screening tools used here." (P14, Medical Officer)

Management Strategies and Institutional Limitations

In the absence of formal screening, management strategies are characterized by basic psychosocial support and immediate referral for severe cases, reflecting a limited capacity for in-house intervention. When PPD is suspected, the primary response involves offering emotional reassurance, listening to the patient, and providing general counseling. However, participants acknowledged that these measures are often insufficient for managing moderate to severe depression. Consequently, the facility relies heavily on a referral model, where patients are directed to psychiatric specialists or senior obstetricians for definitive care. This dependency highlights a structural weakness: the lack of trained personnel and specific protocols to manage PPD at the primary point of contact. Additionally, participants cited a profound lack of formal training and the absence of institutional guidelines as major impediments. Without clear protocols or ongoing education, health workers feel ill-equipped to navigate the complexities of PPD management, leading to a fragmented care pathway that fails to address the full spectrum of the disorder.

"We try to talk to them and encourage them." (P1, Nurse) "Most of what we do is just emotional support." (P13, Nurse) "If it is serious, we refer them to psychiatric care." (P2, Midwife) "We have not received any specific training on postpartum depression." (P3, Nurse) "There are no guidelines or tools provided for screening mental health in this facility." (P8, Nurse)

Sociocultural Barriers and Systemic Challenges

The integration of postpartum depression care is further complicated by deep-seated sociocultural beliefs and systemic operational constraints. Participants identified stigma as a primary barrier, noting that women often fear judgment or social ostracization, which discourages them from disclosing mental health struggles. Moreover, cultural interpretations of mental illness persist, with some families attributing symptoms to spiritual causes rather than medical conditions, leading to delays in seeking professional help or a preference for traditional remedies. Beyond these cultural factors, the healthcare system itself presents formidable challenges, including excessive workloads, time constraints, and a lack of privacy during consultations. The high volume of patients in busy units like the emergency department and antenatal clinic leaves little room for the time-intensive conversations required for mental health assessment. Furthermore, the absence of a robust follow-up system and financial barriers for patients exacerbate the difficulty in ensuring continuity of care, creating an environment where PPD remains a neglected aspect of maternal health despite the providers' awareness of its existence.

"Women don't like to talk about mental issues because of stigma." (P7, Midwife) "Some people believe it is spiritual." (P3, CHO) "We are too busy attending to many patients, so mental health is not prioritised." (P1, Nurse) "There is no proper follow-up system." (P5, Nurse) "Financial challenges and lack of family support affect management." (P15, Medical Officer).

The following table synthesizes the core findings, mapping the identified themes against the specific operational realities and participant testimonies.

Table 1. Summary of Findings and Technical Analysis

Theme	Key Finding	Operational Reality	Representative Quote
Understanding	Superficial awareness; high normalization of symptoms.	Symptoms viewed as "normal" stress; lack of diagnostic criteria application.	"It is normal for women to feel overwhelmed... so we don't always see it as depression." (P4)
Screening	Absence of standardized tools; reactive detection.	No EPDS/PHQ usage; reliance on observation and patient complaint.	"There is no standard tool we use to check for it during clinic visits." (P5)

Management	Reliance on basic counseling and external referral.	No in-house therapy; fragmented referral pathways; lack of follow-up.	"We try to talk to them... If it is serious, we refer them to psychiatric care." (P1, P2)
Barriers	Structural (workload, training) and Cultural (stigma).	High patient load prevents screening; spiritual beliefs hinder disclosure.	"We are too busy... Women don't like to talk about mental issues because of stigma." (P1, P7)

To visualize the distribution of these findings across the professional cadres and the severity of the identified gaps, a technical analysis was performed on the coded data. The data reveals a strong correlation between professional cadre and the depth of clinical understanding, with Medical Officers showing slightly higher diagnostic awareness but lower frequency of screening due to unit specialization (such as emergency), while Nurses and Midwives, despite being the primary contact points, exhibited the highest rates of symptom normalization.

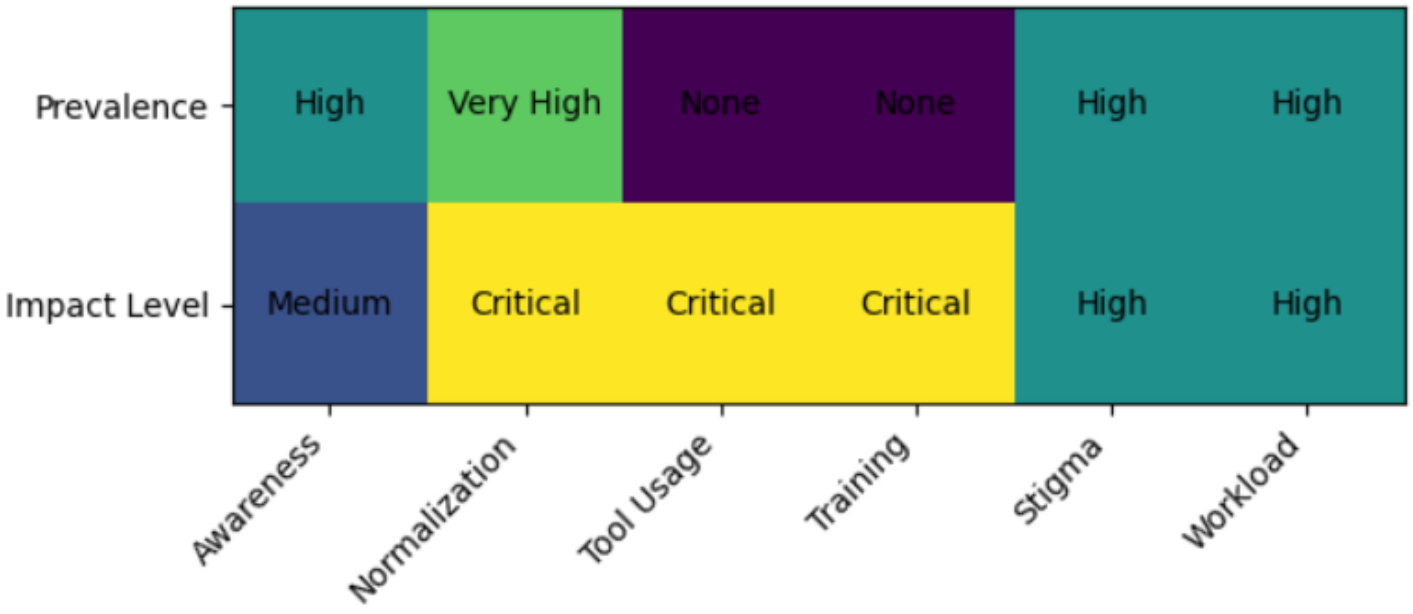

Figure 2: Thematic Prevalence Matrix (Heat Map)

The heat map indicates that Normalization and Absence of Tools are the most critical bottlenecks. The data suggests that even if tools were introduced (addressing the "None" in Tool Usage), the high prevalence of Normalization (where symptoms are dismissed as normal) would likely result in low uptake unless accompanied by intensive retraining. Furthermore, the Critical rating for Training implies that the current workforce lacks the foundational competency to utilize screening tools effectively, creating a "knowledge-practice" loop that perpetuates the status quo. The intersection of Workload and Stigma creates a compounding effect: even if a worker identifies a potential case, the time pressure prevents deep engagement, and the stigma prevents the patient from accepting the diagnosis, leading to a high rate of "missed opportunities" in the clinical workflow.

DISCUSSION

The findings of this study illuminate the complex "gap between knowing and doing" in the screening and management of postpartum depression (PPD) at Babcock University Teaching Hospital. By applying the Social Ecological Model (SEM) as a theoretical framework, these results can be understood not merely as individual deficits in knowledge, but as the product of interacting influences across multiple levels: individual, interpersonal, organizational, community, and policy. The SEM posits that health behaviors and service delivery are shaped by a dynamic interplay of factors, a perspective that aligns perfectly with the study's discovery that

PPD care is hindered by a confluence of limited clinical understanding, absent protocols, and deep-seated sociocultural barriers.

At the individual level, the SEM captures the health workers' knowledge, skills, and attitudes. The study revealed that while participants possessed basic awareness of PPD, their clinical understanding was superficial, often conflating pathological depression with normal postnatal distress. This finding resonates strongly with existing literature, which documents that frontline providers in low- and middle-income countries frequently lack the depth of knowledge required to recognize specific diagnostic features (Goyal et al., 2023; Maloleka et al., 2024; Nortey & Asampong, 2024). The normalization of symptoms observed in this study—where providers viewed distress as a "typical" reaction to childbirth—mirrors findings by Gowon et al. (2024), suggesting that without targeted education, providers may inadvertently miss critical cases. This individual knowledge gap directly contributes to missed opportunities for early detection, as providers fail to distinguish between transient "baby blues" and a major depressive episode requiring intervention.

Moving to the organizational level, the SEM highlights how facility resources, workflows, and managerial support dictate practice. The study's finding that routine screening is absent and replaced by subjective observation underscores a critical failure in organizational readiness. The lack of standardized tools like the Edinburgh Postnatal Depression Scale (EPDS) and the absence of clear protocols reflect a system where mental health is not integrated into the standard maternal care workflow. This aligns with Gyimah et al. (2024) and Kendall-Tackett & Kendall-Tackett (2024), who report that routine screening is rarely implemented in low-resource settings due to training deficits and workflow incompatibilities. The reliance on informal observation, as noted by participants, increases the risk of under-detection, confirming that without structural support, individual vigilance is insufficient. Furthermore, the heavy workload and time constraints cited by participants illustrate how organizational pressures prioritize physical over mental health, creating an environment where comprehensive screening is practically impossible.

The interpersonal and community levels of the SEM further explain the barriers to effective care. Interpersonally, the lack of supervision and peer support for mental health tasks was evident, with participants expressing a reliance on specialists for anything beyond basic counseling. This reflects the findings of Ayinde et al. (2018) and Gowon et al. (2024), who note that weak referral pathways and limited specialist support constrain primary care providers. At the community level, the study identified significant sociocultural barriers, including stigma and spiritual interpretations of mental illness. Participants noted that women often fear judgment or attribute symptoms to spiritual causes, which discourages disclosure. This aligns with Onofa et al. (2024) and Paricio-Del-Castillo (2024), who emphasize that cultural norms and stigma in low- and middle-income countries undermine the integration of perinatal mental health services. The SEM effectively demonstrates how these community-level beliefs interact with provider behavior; even if a provider were knowledgeable, the patient's reluctance to disclose due to stigma would still impede detection.

Finally, the policy level of the SEM encompasses the broader guidelines and health system priorities. The absence of facility-specific guidelines and the lack of formal training programs highlight a disconnect between global recommendations, such as those from the WHO (2022), and local implementation. While global frameworks advocate for the integration of mental health screening, the findings suggest that without specific policy directives and resource allocation at the facility level, these recommendations remain theoretical. The study's results support the argument that task-sharing models, which have shown promise in improving outcomes when accompanied by training and supervision (Ackerman et al., 2024; Prina et al., 2023), are currently hampered by a lack of institutional backing. The limited capacity for management, characterized by basic counseling and immediate referral, underscores the need for policy interventions that empower non-specialist providers with the necessary tools and authority to manage PPD effectively.

Thus, the application of the Social Ecological Model reveals that the gap between knowledge and practice in PPD screening is not a singular issue but a systemic one. The findings confirm that individual knowledge deficits are compounded by organizational constraints, interpersonal isolation, community stigma, and policy gaps. As Choongo et al. (2023) and Harris et al. (2020) suggest, multi-level interventions are essential for sustainable improvement. Addressing the "gap between knowing and doing" requires more than just training health workers; it demands a holistic approach that integrates standardized screening tools into workflows, fosters supportive

supervision, addresses cultural stigma through community engagement, and strengthens policy frameworks to ensure that maternal mental health is prioritized alongside physical health in routine care.

CONCLUSION

This study set out to explore the "gap between knowing and doing" regarding postpartum depression (PPD) among health workers at Babcock University Teaching Hospital. By examining both the understanding of PPD and the actual screening practices in routine clinical care, the research has revealed a significant disconnect between awareness and action. While health workers are generally aware that postpartum depression exists, their knowledge is often superficial, lacking the clinical depth needed to accurately diagnose the condition. More critically, this limited understanding is compounded by a complete absence of routine, standardized screening protocols. Instead of using validated tools, providers rely on subjective observation and patient complaints, a reactive approach that inevitably leads to missed cases and delayed treatment.

The findings, interpreted through the Social Ecological Model, demonstrate that this gap is not simply a result of individual ignorance. Rather, it is the outcome of a complex interplay of factors at multiple levels. At the individual level, there is a lack of confidence and specific training. At the organizational level, the facility suffers from a shortage of screening tools, clear guidelines, and manageable workloads, forcing providers to prioritize physical health over mental well-being. Furthermore, community-level stigma and cultural beliefs that attribute mental distress to spiritual causes create an environment where women are reluctant to disclose symptoms, making detection even harder. Without addressing these systemic and contextual barriers, simply increasing awareness among staff will not be enough to improve care. To bridge this gap, the study recommends a multi-faceted approach. First, there is an urgent need for structured, ongoing training that moves beyond basic awareness to build practical skills in screening and management. Second, standardized tools like the Edinburgh Postnatal Depression Scale must be formally integrated into the daily workflow of antenatal and postnatal clinics. Third, the hospital must develop and enforce clear guidelines and protocols to ensure consistency in care. Finally, efforts must be made to strengthen referral pathways, reduce the stigma surrounding mental health in the community, and manage workloads to allow providers the time necessary to engage with patients meaningfully.

Lastly, the current state of postpartum depression care at this facility is characterized by a reliance on chance rather than system. Women are passing through the healthcare system without their mental health needs being systematically identified or addressed. Closing the gap between knowing and doing requires more than just goodwill; it demands a deliberate shift in policy, practice, and culture. By implementing the recommended changes, health facilities can transform from places where PPD is merely "known about" to environments where it is actively screened for, understood, and effectively managed, ultimately safeguarding the mental health of mothers and the developmental future of their children.

Authors' Declaration

We, the undersigned authors, hereby declare the following:

Ethical Approval: This study was conducted in strict accordance with the ethical standards of the Babcock University Health Research Ethics Committee (BUHREC) and the principles outlined in the Declaration of Helsinki. Formal ethical approval was granted by the BUHREC prior to the commencement of data collection. Written informed consent was obtained from all adult participants (aged 18–19), and written informed consent along with assent was secured from all participants under the age of 18, obtained from their legal guardians or parents.

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Conflict of Interest: The authors declare that there are no conflicts of interest, financial or otherwise, that could be perceived as prejudicing the impartiality of the research reported.

Originality: This manuscript represents our original work. It has not been published previously, nor is it currently under consideration for publication elsewhere, in whole or in part.

Authorship Contribution: All individuals who have made substantial contributions to the conception, design, acquisition, analysis, or interpretation of the data reported in this manuscript are named as co-authors. Each author has participated sufficiently in the work to take public responsibility for appropriate portions of the content and has approved the final version of the manuscript.

Data Availability: The datasets generated and/or analyzed during the current study are not publicly available due to privacy and ethical restrictions regarding participant confidentiality but are available from the corresponding author upon reasonable request.

Plagiarism Statement: This manuscript has been screened for plagiarism and contains no plagiarized material. All sources utilized in the preparation of this work have been appropriately cited and acknowledged.

Corresponding Author: The corresponding author assumes full responsibility for communications regarding this manuscript and confirms that all co-authors have reviewed, approved, and agreed to the final submitted version.

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