

Prevalence of Postpartum Depression among Recently-Delivered Mothers in Selected Tertiary Hospitals, Osun State, Nigeria

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Abstract: Depression remains a leading global psychiatric concern, with postpartum depression (PPD) affecting a significant number of women in the immediate postnatal period. This study investigated the prevalence and associated socio-demographic factors of PPD among recently-delivered mothers at two tertiary healthcare facilities in Osun State, Nigeria - University of Teaching Hospital (UTH) and Obafemi Awolowo University Teaching Hospital Complex (OAUTHC). A descriptive cross-sectional survey design was adopted. A total of 196 postnatal women were recruited using proportionate and convenient sampling based on delivery records from both hospitals. Data were collected using a structured questionnaire comprising socio-demographic variables and the Edinburgh Postnatal Depression Scale (EPDS). The instrument's reliability was confirmed through a pilot test (Cronbach's alpha), and its validity was assessed by mental health and nursing experts. Statistical analysis was conducted using SPSS version 25, employing descriptive and inferential statistics, including chi-square. Findings revealed that 66.8% of respondents exhibited mild symptoms of PPD, while 33.2% showed severe symptoms, indicating a high prevalence. Significant associations were found between PPD and socio-demographic variables such as age, residential area, family type, education, occupation, and income ($p < 0.05$). Younger mothers (20–29 years), those in monogamous families, with tertiary education, and stable income demonstrated lower PPD prevalence. The study concludes that PPD is notably prevalent among postpartum women in tertiary care settings. It recommends routine mental health screening during prenatal and postnatal visits, early diagnosis, and integration of mental health into maternal health policies. Collaborative postnatal follow-up guidelines focusing on mental health are essential to improve outcomes.

Keywords: postpartum depression (PPD), prevalence, socio-demographic factors, postnatal women

INTRODUCTION

Depression remains one of the most prevalent psychiatric conditions globally, with an estimated 300 million individuals affected according to the World Health Organization (WHO, 2019). The American Psychiatric Association (APA, 2019) classifies depression under a broader category that includes major depressive disorder (MDD), bipolar disorder, postpartum depression (PPD), and post-traumatic stress disorder (PTSD). Among these, MDD is characterised by persistent low mood or loss of interest in daily activities for at least two weeks. Reid and Myles (2012) identified depression as the fourth leading cause of disability in the early 21st century, projecting it to become the second leading cause by 2020. A particularly common but under-acknowledged type of depression among women is postpartum depression, which affects 10-15% of women globally after childbirth (Adeyemo et al., 2020; Alfshari et al., 2020). Al Nars et al. (2020) also highlighted postpartum depression as a critical health issue that can significantly impact the well-being of new mothers. Despite its widespread nature, PPD often remains undiagnosed or ignored, especially in less-developed healthcare systems.

Postpartum depression is described as a non-psychotic depressive episode occurring after childbirth, typically within six weeks, and is characterised by symptoms ranging from mild to moderate severity. Often referred to as the “thief that steals motherhood,” PPD disrupts maternal bonding and emotional well-being, posing serious consequences for both mother and child (Okonoda et al., 2017; Mokhele et al., 2019; Adeyemo et al., 2020). This form of depression not only affects the mother’s mental and physical health but also jeopardises interpersonal relationships and the cognitive and emotional development of the child (Agarwala et al., 2018). In developed nations where maternal healthcare systems are more robust, PPD is treated as a significant public health concern. However, in developing countries, the condition is frequently overlooked, both at community and institutional levels, leading to long-term family disruptions (Mollard et al., 2016; Agarwala et al., 2018). Untreated PPD may evolve into chronic or recurrent depression, with far-reaching consequences. Robertson et al. (2003) and Asaye et al. (2020) note that children of affected mothers may later exhibit behavioural, emotional, and cognitive impairments due to poor early bonding. Thus, addressing PPD is vital not only for the immediate postnatal period but also for long-term maternal and child health outcomes.

The prevalence of postpartum depression varies widely across the globe, influenced by the screening tools employed, the time of assessment, and the geographical region. It was estimated that the global prevalence of maternal PPD at 13%, but actual figures range from as low as 0.5% to as high as 60.8%, with developing countries showing consistently higher rates (Azad et al., 2019). For instance, in Africa, the average prevalence is 18.4% (Adeyemo et al., 2020), though certain countries report significantly higher rates—Uganda and Cameroon at 23-40%, while Ethiopia, Ghana, and Morocco report lower rates of 3-12% using the Edinburgh Postnatal Depression Scale (Adeyemo et al., 2020). In Nigeria, estimates range from 14% to 23% nationally (Obindo, 2013; Adeyemo et al., 2020), but with notable regional disparities such as a 10.7%

prevalence in parts of South-Eastern Nigeria compared to a staggering 44.5% in Northern Nigeria. These variations can be attributed to differing screening methods, geographical settings, socioeconomic conditions, and cultural factors. Several determinants such as maternal age, education, ethnicity, and economic status significantly influence the likelihood of developing PPD (Azad et al., 2019). Additional contributors include social stressors like poverty, intimate partner violence, history of pregnancy loss, and unintended pregnancies, all of which adversely affect maternal well-being (Azale et al., 2016). Moreover, obstetric and infant care factors such as unplanned pregnancies, pregnancy complications, unhealthy babies, infant deaths, parity, and a history of abortion have also been linked to higher risks of postpartum depression (Adeyemo et al., 2020). These complexities underscore the need for targeted screening, prevention, and intervention strategies tailored to the unique contexts of each population.

Paddy et al. (2021) reported a 14.1% prevalence of postpartum depression (PPD) among Ghanaian women in the Accra metropolis, which exceeds rates found in developed countries such as the United States (8.3%), Canada (8%), Brazil (10.4%), Ukraine (8.4%), Norway (10%), and Sweden (13%) (Chinawa et al., 2016). It also surpasses the prevalence observed in some Sub-Saharan African countries like Sudan (9.2%) and Nairobi (10.6%). Nonetheless, the rate in Accra is similar to that in Saudi Arabia (14%) but is slightly lower than the prevalence rates in Australia (15%), Cameroon (23.4%), Uganda (43%), Nigeria (22.9%), and Kumasi, Ghana (22.3%) (Adama et al., 2015; Chinawa et al., 2016). A meta-analytic review conducted by Gelaaye et al. (2016) highlights that the overall prevalence of PPD in developing countries is approximately 19.0% (ranging between 15.5% and 23.0%), with broader estimates spanning from 1.9% to 82.1%. In contrast, prevalence in developed countries ranges from 5.2% to 74.0%, indicating significant variations globally due to methodological differences and socio-cultural contexts.

In a related study, Al Nasr et al. (2020) found that 38.5% of women scored 13 or more on the Edinburgh Postnatal Depression Scale (EPDS), indicating PPD, while 61.5% had normal scores below 13. They estimated the overall prevalence of PPD to be 27.1% (95% CI: 22.2–32.5), independent of parity or delivery method. Key risk factors linked to PPD included low perceived social support, HIV-positive status, rural residency, obstetric complications, and excessive infant crying (Al Nasr et al., 2020; Atuhaire et al., 2021). Furthermore, Atuhaire et al. (2021) noted that socio-demographic factors like age and education level were not significantly associated with PPD. Their findings showed 35.6% of women aged 16–25 years and 40% of those above 25 years experienced PPD, with similar trends across education levels. However, unsupportive spousal relationships ($P = 0.023$) and recent stressful life events ($P = 0.003$) were significantly associated with the development of PPD, underlining the importance of psychosocial factors in maternal mental health.

Based on literature search, despite increased number of recently-delivered mothers ending with PPD; there is limited study on prevalence of PPD among recently-delivered mothers (postpartum women) in Southwest Nigeria and no known study had been conducted on the topic in the study setting, thus, the researcher is interested in determining the prevalence of PPD among recently-delivered mothers in selected tertiary hospitals in Osun State, Southwest Nigeria.

METHODS

In this study, a descriptive research survey design was employed to collect relevant data from respondents. The target population consisted of recently-delivered mothers who gave birth at the University of Teaching Hospital (UTH) and Obafemi Awolowo University Teaching Hospital Complex (OAUTHC) in Osun State. According to the delivery registers, UTH recorded 120 postnatal women over two months, while OAUTHC recorded approximately 200, giving a total population of 320 postnatal women. Based on this, the sample size was determined using the Leslie Kish formula (1978), resulting in a base sample size of 178. An additional 10% was added to account for attrition, making the final sample size 196. A proportionate distribution approach was applied, allocating 74 respondents to UTH (37.5%) and 122 to OAUTHC (62.5%), reflecting the respective delivery volumes at each facility.

Purposive sampling was used to select the two tertiary hospitals, while convenient sampling was adopted to recruit eligible postnatal women present at the facilities during the study period. This sampling technique was chosen to focus on participants with specific characteristics relevant to the research objectives. Inclusion criteria for participation required that respondents be postnatal women, regardless of literacy status, who had delivered through spontaneous vaginal delivery (SVD) or caesarean section (CS), were available at the time of data collection, and consented to take part. Conversely, the study excluded women in labour and those who had recently delivered but declined participation. This method ensured that the data collected reflected the experiences of mothers in the immediate postnatal period within the selected tertiary healthcare settings.

The instrument used for data collection in this study was a structured questionnaire designed to align with the study's objectives and research questions, as guided by the literature review. The questionnaire comprised two sections: Section A gathered socio-demographic data from postnatal women, including variables such as age, religion, ethnicity, residence, marital status, type of family, parity, level of education, occupation, and income, with a total of nine questions. Section B focused on assessing the prevalence of postpartum depression (PPD) using the Edinburgh Postnatal Depression Scale (EPDS), which consists of 14 short statements rated on a 4-point scale. Responses were scored based on severity, with reverse scoring applied to items 3 and 5 to 14. A cumulative score was computed, and any score ≥ 13 indicated a likelihood of PPD. To ensure the validity of the instrument, the questionnaire and adapted EPDS were subjected to rigorous review by experts in maternal and mental health nursing, as well as statisticians, to confirm content and face validity. For reliability, the instrument was pre-tested on 20 participants from a similar but different setting, and the internal consistency was measured using Cronbach's alpha coefficient.

Data were collected using the adapted and self-developed questionnaire administered to postnatal women during clinic visits. Respondents were supported during the process, particularly those with literacy challenges, and data collection occurred over eight weeks. A total of 196 completed questionnaires were retrieved. Data were analysed using SPSS version 25. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarise socio-demographic data, while inferential statistics, including chi-square and logistic regressions (bi-

variate and multivariate), were employed to examine associations between variables, with adjusted odds ratios and 95% confidence intervals providing insights into the strength and direction of these associations. Ethical clearance for the study was obtained from the Ethical Committees of the State Ministry of Health, UTH, and OAUTHC. Participants were fully informed about the study's purpose and procedures, assured of confidentiality, and gave voluntary informed consent, with their right to withdraw respected at all times.

RESULTS

Majority of the respondents- 60.2% (118) were aged 20-29 years with mean age of 24.5 ($\pm$ SD) and majority 93.0% (184) of respondents were married. Most of them 72.4% (142) were living in urban area, Christians were 96 (49.0%), Yoruba 93.9% (184) and those from monogamy family setting were 65.3% (128) family setting. Also, majority- 71.8% (140) had tertiary education, while 52.0% (102) were traders (occupation) and with their earnings ranging between 20,000-50,000 naira monthly as revealed in the table below:

Table 1: Demographic Characteristics of the Respondent (n = 196)

Variables		Frequency	Percentage
Age	Less than 20 years	8	4.1
	20-29 years	118	60.2
	30-39 Years	56	28.6
	More than 40 years	14	7.1
Mean Age	24.5 years		
Marital status	Married	184	93.9
	Unmarried	12	6.1
Residence	Rural	54	27.6
	Urban	142	72.4
Religion	Christianity	96	49.0
	Muslim	82	41.8
	Traditional	18	9.2
Type of family	Polygamy	68	34.7
	Monogamy	128	65.3
Ethnicity	Yoruba	184	93.9
	Igbo	4	2.0
	Hausa	8	4.1
Educational level	No Formal Education	22	11.2
	Secondary Education	34	17.3
	Tertiary Education	140	71.4
Occupation	Trading	102	52.0
	Unemployed	22	11.2
	Schooling	26	13.3
	Civil Servant	46	23.5
Monthly income	Less than 20, 000 naira	60	30.6
	20,000-50,000 naira	82	41.8
	51,000-80,000 naira	22	11.2
	More than 80,000 naira	32	16.3

Table 2: Obstetrical Profile of the Respondents

Variables		Frequency	Percentage
Number of pregnancy	1-2	126	64.3
	3-4	52	26.5
	5-6	18	9.2
Number of living children	1-2	103	52.6
	3-4	78	39.8
	5-6	15	7.7
History of miscarriage	Yes	38	19.4
	No	158	80.6
Number of pregnancy termination	1-2	24	63.2
	3-4	10	26.3
	5-6	4	10.5
History of baby death	Yes	18	9.2
	No	178	90.8
Intended/planned pregnancy	Yes	132	67.3
	No	64	32.7
Gestational age	Preterm birth	34	17.3
	Term birth	162	82.7
Complications in the last pregnancy	Yes	46	23.5
	No	150	76.5
Complication in index pregnancy	Yes	34	17.3
	No	162	82.7
Mode of delivery	SVD	122	62.2
	CS	74	37.8
Mother health since delivery	Well	192	98.0
	Unwell	4	2.0
Post partum blue	Yes	66	33.7
	No	130	66.3

In table 2, majority 126(64.3%) of the respondents had 1-2 pregnancies, 1-2 children 103(52.6%), no history of miscarriage 158(80.0%). Sixty-three point two percent of respondents with history of pregnancy termination had 1-2 episodes. Majority of the respondents 178(90.8%) had no history of baby death, planned pregnancy 132(67.3%) with term birth 162(82.7%), no complications in pregnancy 162(82.7%) and delivered their babies through SVD 122(62.2%). Majority of the respondents were healthy/well after delivery 192(98.0%) and no history of puerperal blue 130(66.3%) as stated as follows:

Table 3: Prevalence of Postpartum Depression

Variables		Frequency	Percentage
I have been able to laugh and see the funny side of things	As much as I always could	142	72.4
	Not quite so much	16	8.2
	Definitely not so much	6	3.1
	Not at all	32	16.3
I have looked forward with enjoyment to things	As much as I ever did	140	71.4
	Rather less than I used to	18	9.2
	Definitely less than I used to	16	8.2
	Hardly at all	22	11.2
I have blamed myself unnecessarily when things went wrong	Yes most of the time	26	13.3
	Yes, some of the time	60	30.6
	Not very often	52	26.5
	No, never	58	29.6
I have been anxious or worried for no good reason	No not at all	110	56.1
	Hardly ever	22	11.2
	Yes sometimes	42	21.4
	Yes very often	22	11.2
I have felt scared or panicky for no good reason	Yes, most of the time I haven't been able to cope at all	24	12.2
	Yes, sometimes I haven't been coping as well as usual	50	25.5
	No, most of the time I have coped quite well	32	16.3
	No, I have been coping as well as ever	90	45.9
Things have been getting to me	Yes, most of the time	46	23.5
	Yes quite often	40	20.4
	Not very often	52	26.5
	No not at all	58	29.6
I have been so unhappy that I have had difficulty sleeping	Yes, most of the time	42	21.4
	Yes quite often	58	29.6
	Not very often	38	19.4
	No not at all	58	29.6
I have find it difficult to work up the initiative to do things	Yes, most of the time	42	21.4
	Yes quite often	48	24.5
	Not very often	42	21.4
	No not at all	64	32.7
I felt sad or miserable	Yes, quite often	32	16.3
	Sometimes	28	14.3
	Hardly ever	30	15.3
	Never	106	54.1
I have been so unhappy that I have been crying	Yes Always	22	11.2
	Yes, quite often	22	11.2

	Sometimes	44	22.4
	Never	108	55.1
I could not feel to experience any positive feelings	Yes Always	24	12.2
	Yes, quite often	16	8.2
	Sometimes	40	20.4
	Never	116	59.2
I felt I did not worth as a person	Yes, quite often	38	19.4
	Sometimes	10	5.1
	Hardly ever	16	8.2
	Never	132	67.3
The thought of harming myself has occurred to me	Yes, quite often	8	4.1
	Sometimes	44	22.4
	Hardly ever	28	14.3
	Never	116	59.2
I felt like life was meaningless	Yes, quite often	28	14.3
	Sometimes	14	7.1
	Hardly ever	18	9.2
	Never	136	69.4

Revealed respondents' negative manifestations towards developing PPD as: Not been able to laugh - 32(16.3%), hardly look forward with enjoyment to things - 22(11.2%), blamed self unnecessarily when things went wrong - 26(13.3%), been anxious or worried for no good reason - 22(11.2%), felt scared or panicky for no good reason - 24(12.2%), Things have been getting to me - 46(23.5%), have been so unhappy that I have had difficulty sleeping- 42(21.4%), find it difficult to work up the initiative to do things - 42(21.4%), felt sad or miserable - 32(16.3%), been so unhappy and have been crying - 22(11.2%), could not feel to experience any positive feelings - 24(12.2%), felt no worth as a person- 38(19.4%), thought of harming myself has occurred to me - 8(4.1%), and felt like life was meaningless- 28(14.3%).

In table 4, the prevalence of PPD from the study shows that more than half 131(66.8%) of the respondents had mild symptoms of postpartum depression, while 65(33.2%) had severe symptoms PPD. This result showed that the prevalence of PPD is on the high side of 33.2%

Table 4: Summary of Prevalence of Postpartum Depression

Prevalence of PPD	Scores (0-42)	Frequency	Percentage
Mild symptom of PPD (Low prevalence of PPD)	1-21	131	66.8%
Severe symptoms of PPD (High prevalence of PPD)	22-42	65	33.2
Total		196	100

Pearson chi-square test was used to establish relationship between socio-demographic characteristics and prevalence of postpartum depression. The result shows a statistically significant relationship between socio-demographic characteristics of age ($\chi^2 = 21.021$; $df = 3$; $p\text{-value} = 0.000$), residential area ($\chi^2 = 5.503$; $df = 1$; $p\text{-value} = 0.019$), type of family ($\chi^2 = 7.428$; $df = 1$; $p\text{-value} = 0.006$), level of education ($\chi^2 = 8.889$; $df = 2$; $p\text{-value} = 0.012$), occupation ($\chi^2 = 15.844$; $df = 3$; $p\text{-value} = 0.001$), and monthly income ($\chi^2 = 20.008$; $df = 3$; $p\text{-value} = 0.000$), and prevalence of PPD. More so, majority 90(76.3%) of the respondents aged 20-29 years demonstrated low symptoms of PPD (low prevalence of PPD) while 30(53.6%) of the respondents aged 30-39 years showed evidence of PPD. This suggests that PPD increases with age. The result further showed that low prevalence of PPD was observed among Married women- 121(51.8%), respondents living in urban area- 88(66.9%), Christian- 62(64.6%) in monogamy- 77(60.2%) family setting, tertiary level of education- 86(61.4%), traders were about 70(68.6%) with 57(69.5%) of the respondent earning between 20,000 and 50,000-naira income as shown below:

Table 5: Showing Association between Respondents' Socio-Demographic Characteristics and Prevalence of PPD

Socio-Demographic Characteristics	Prevalence of PPD		Total	Chi-square	Df	p-value
Age	Low	High				
	F (%)	F (%)		21.021 ^a	3	.000*
20-29 years	90 (76.3)	28(23.7)	118(60.2)			
30-39 years	26(46.4)	30(53.6)	56(28.6)			
More than 40 years	7(50)	7(50)	14(7.1)			
Total	131(66.8)	65(33.2)	196(100)			
Marital status						
Married	121(65.8)	63(34.2)	184	1.569 ^a	1	.210
Unmarried	10(83.0)	2(17.0)	12			
Total	131(66.8)	65(33.2)	196(100)			
Residential						
Rural	43(79.6)	11(20.2)	54(27.6)	5.503 ^a	1	.019*
Urban	88(61.9)	54(38.1)	142(72.4)			
Total	131(66.8)	65(33.2)	196(100)			
Religion						
Christianity	62(64.6%)	34(35.4)	96(48.9)	.534 ^a	2	.766
Muslim	56(68.3)	26(31.7)	82(41.8)			
Traditional	13(72.2)	5(27.8)	18(9.2)			
Total	131(66.8)	65(33.2)	196(100)			
Type of family						
Polygamy	54(79.4)	14(10.6)	68(34.7)	7.428 ^a	1	.006*
Monogamy	77(60.2)	51(39.8)	128(65.3)			

Total	131(66.8)	65(33.2)	196(100)			
Ethnicity						
Yoruba	125(63.8)	59(34.2)	184(93.9)	1.635^a	2	.442
Igbo	2(50)	2(50)	4(2.0)			
Hausa	4(50)	4(50)	8(4.1)			
Total	131(66.8)	65(33.2)	196(100)			
Level of Education						
No Formal Education	15(68.2)	7(31.8)	22(11.2)	8.889^a	2	.012*
Secondary Education	30(88.2)	4(11.8)	34(17.3)			
Tertiary Education	86(61.4)	54(38.6)	140(71.4)			
Total	131(66.8)	65(33.2)	196(100)			
Occupation						
Trading	70(68.6)	32(31.4)	102(52.0)	15.844^a	3	.001*
Unemployed	21(95.5)	1(4.5)	22(11.2)			
Schooling	18(69.2)	8(30.8)	26(13.3)			
Civil Servant	22(47.8)	24(22.2)	46(23.5)			
Total	131(66.8)	65(33.2)	196(100)			
Monthly Income						
Less than 20, 000 naira	49(81.7)	11(18.3)	60(30.6)	20.008^a	3	.000*
20,000-50,000 naira	57(69.5)	25(30.5)	82(41.8)			
51,000-80,000 naira	7(31.8)	15(69.2)	22(11.2)			
More than 80,000 naira	18(56.3)	14(43.77)	32(16.3)			
Total	131(66.8)	65(33.2)	196(100)			

DISCUSSION OF FINDINGS

The study revealed that more than half (66.8%) of the respondents had mild symptoms of postpartum depression, while (33.2%) had severe symptoms PPD. This result showed that the prevalence of PPD is (33.2%) which is in contrast with the result of Adeyemo et al. (2018) with prevalence of PPD ranging from (14.6%) to (23.0%). In contrast to result of the study, Obindo (2014) reported prevalence rate of (10.7%) while (21.8%) was reported by Peindl, et al. (2004). However, global prevalence rate of PPD was estimated to be (13%) according to Nasr et al. (2020). The differences observed in the prevalence rate of PPD from other studies compare to this current study may be attributed to different scales used, demographic status, the cut off score of the screening instrument and other risk factors exposed to.

The result shows a statistically significant relationship between socio-demographic characteristics of age ($\chi^2 = 21.021$; $df = 3$; $p\text{-value} = 0.000$), residential area ($\chi^2 = 5.503$; $df = 1$; $p\text{-value} = 0.019$), type of family ($\chi^2 = 7.428$; $df = 1$; $p\text{-value} = 0.006$), level of education ($\chi^2 =$

8.889; $df = 2$; p -value = 0.012), occupation ($\chi^2 = 15.844$; $df = 3$; p -value = 0.001), and monthly income ($\chi^2 = 20.008$; $df = 3$; p -value = 0.000), and prevalence of PPD. More so, majority (76.3%) of the respondents aged 20-29 years demonstrated low symptoms of PPD (low prevalence of PPD) while 53.6% of the respondents aged 30-39 years showed evidence of PPD.

Thus, the findings suggest that PPD increases with age. The result further showed that low prevalence of PPD was observed among Married Women with 51.8%; respondents living in urban area (66.9%), Christian (64.6%) in monogamy 60.2% family setting, tertiary level of education (61.4%). More than half of the respondents (68.6%) are traders with 20-50,000-naira income consists of 69.5% among other levels of income. More so, logistic regression showed that respondents within the age range of 20-29 years were 3 times more likely to exhibit mild symptoms of postpartum depression which indicate low prevalence of PPD among women aged 20-29 years (Sig = 0.043; p – value < 0.05; OR = 3.21; CI = 1.04-9.95) compared to other age groups. Respondents living in rural area were 2 times likely to express mild symptoms of PPD (Sig = 0.021; p -value < 0.05; OR = 2.399; CI = 1.140-5.047) compared to those living in urban area. This indicates that there is low prevalence of PPD among residents of rural community.

In contrast to the findings from this study, Chinawa et al., (2016) reported that socio-demographic characteristics have no correlation with development of postpartum depression. However, Ahmed et al., (2012) reported that low socio-economic profile of women contribute to development of PPD. In addition, Kim et al., (2008) stated that most socio-demographic predictors of PPD include maternal-partner relationship status as well as legal marital status. Atubaire et al., (2021) also reported that the only socio-demographic characteristics associated with PPD were place of residence. This was different from the findings from the study.

CONCLUSION

It was revealed in the study that the prevalence of PPD among the recently-delivered mothers was 32.2%. There was also relationship between participants' educational background, age, employment status, income level and prevalence of PPD.

Recommendations

Based on the outcomes from this study, the following are recommended:

1. Prevention is critical in reducing prevalence of PPD; hence, preventive activities should be reinforced by the nurse stakeholders/policymakers advocacy and to drive policy review or information as may be necessary to facilitate provision of effective screening methods for PPD.

2. Provision of simple screening methods early in the preconception/perinatal/postpartum periods should be made routine for all women attending pre-pregnancy/ANC/Postnatal clinics.
3. Early diagnosis and effective treatment in collaboration with other sectors/specialists to improving the clinical outcome and reducing the incidence.
4. Development of guideline for postnatal follow-up in collaboration with the Ministry of Health that will include mental and reproductive health screening.

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