

Postpartum Depression Awareness, Information Sources, And Help-Seeking Behaviour Among Women In Northern Nigeria: A Cross-Sectional Analysis

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Abstract

Postpartum depression is an important maternal mental health issue that can hurt women's health, their families' functioning and their infant development. Few people may be aware, or understand the meaning of, the signs of a problem, and may not seek professional help because of stigma and lack of information. The present study evaluated the awareness, information sources, social influences and help-seeking of postpartum depression among women in Northern Nigeria. The method of this study adopted was a quantitative cross-sectional design with a sample of 380 women who agreed to participate. Categorical variables were summarised using descriptive statistics, and associations between these variables were tested using chi-square and Fisher's exact tests. 18.7 % (71) had heard of postpartum depression before. When questioned about common symptoms, 93.0% of the aware respondents identified them; 90.1% of them saw the condition as needing medical attention and support. A small number of respondents (19.7% of those who knew) sought help, primarily from health care providers. The main barriers were stigma, awareness and access to services. The results highlight the importance of culturally responsive education, improved communication of maternal mental health, regular checks and easy referral systems.

Keywords: postpartum depression; maternal mental health; awareness; information sources; help-seeking behaviour; cultural beliefs

1. Introduction

Postpartum depression is a mental health problem that develops after giving birth, which can impact a mom's health, functioning, relationships and caring for her baby. It is frequently described as a constant state of sadness, anxiety, lethargy, loss of interest, self-perceived worthlessness, sleep problems, and challenges with the mother–infant bond. If not treated, PPD can impact family life and may lead to poor outcomes for mom and baby. Depressive disorders during the peripartum period are also prevalent worldwide, and postpartum depression is a significant public health issue (Ferrari et al., 2026; Ji & Wang, 2025).

In low and middle-income countries, a woman's risk of having postpartum depression can be high because she could be poor, not have access to mental health services, be at a disadvantage due to gender, not have a good referral system, or not have social support. A systematic review in low and middle-income countries found perinatal depression to be prevalent in a variety of social and healthcare environments (Roddy Mitchell et al., 2023). Data from Africa also shows that there is a significant burden of postnatal depression, which is affected by factors such as socioeconomic hardship, obstetric complications, marital status, intimate partner violence, lack of social support, and prior mental health issues (Atuhaire et al., 2020; Dadi et al., 2020b). The risk can be higher for vulnerable groups, for instance, antenatal depression amongst HIV positive women in sub-Saharan Africa (Abebe et al., 2024).

Postpartum depression has a wider impact than just the mother's depression. Maternal depressiveness can have an impact on breastfeeding, sleep, mother's responsiveness to baby, bonding and the quality of early caregiving. Several systematic reviews have found that postnatal depression has been associated with poor health outcomes for the infant in LMICs (Dadi et al., 2020a) and adverse birth and infant outcomes in African populations (Dadi, 2022). More recent evidence also suggests that perinatal depression is linked to delays or problems in the development of the infant or toddler's brain (Fan et al., 2024), which reinforces the need for early detection and intervention. Psychological distress can extend into mothers' everyday care practices, including sleeping habits and sleeping together with their infant, showing how mothers' depressive symptoms may influence sleeping patterns (Barry & D'Souza, 2024). On the other hand, parent-focused interventions can help to alleviate depression symptoms and enhance developmental conditions for infants, highlighting the importance of integrated maternal and child support (Adina et al., 2022).

Even with this load, PND is often overlooked and undiagnosed. The screening practices are different in various countries, and routine identification is not always part of the maternal healthcare system (El-Den et al., 2022). Low opportunities for detection and referral in many African settings are due to a lack of trained personnel, inadequate mental health infrastructure, and other competing maternal health priorities. In sub-Saharan Africa, there is a need to both better monitor and plan services for women diagnosed with mental health problems during pregnancy and postpartum in a context-appropriate way (Awini et al., 2023). The biological, psychological, obstetric and social risk factors are also demonstrated to be associated with postpartum depression, necessitating a multidimensional approach to preventing and responding to postpartum depression (Liu et al., 2022).

Early recognition and help-seeking are linked to awareness and mental health literacy. Postpartum depression symptoms may be overlooked by women who believe that emotional responses are natural, feel that they are weak, vulnerable or being influenced by their spiritual life, or think it is a family issue (Daehn et al., 2022). Access to information can be through antenatal clinics, postnatal clinics, healthcare providers, family members, friends, community leaders, radio, television and social media. These sources can influence the credibility, accessibility, and cultural relevance of the sources, which could affect women's awareness of symptoms and access to timely, appropriate care.

Stigma and cost, family approval, service availability, and cultural beliefs about mental illness also influence help-seeking behaviour. These influences may be more critical in northern Nigerian communities, where norms, the role of the family and religious

interpretation are intertwined in decisions regarding maternal well-being, as is formal health care. The epidemiological effects of pPD on Africa are extensive, but there is a limited number of studies that combine awareness, information pathways, social influences, and help-seeking into one single community-based analysis. The gap can be addressed in order to support culturally appropriate education, boost up communication of maternal healthcare, and enhance referral strategy.

Objectives

1. To evaluate levels of awareness and knowledge about postpartum depression (PPD) among women in Northern Nigeria.
2. Establish the primary sources of information and social factors which can impact perceptions of postpartum depression.
3. Investigate how help-seeking behaviour and access to professional assistance is hindered.

2. Methodology

2.1 Study Design

The study adopted a quantitative cross-sectional design with secondary data collected from the data set titled “Data Insights on Postpartum Depression: How Information Sources and Social Factors Influence Help-Seeking Behaviour Among Women in Northern Nigeria” of Eneh et al. (2025). The design was deemed to be suitable as the data were gathered with respondents at one time, and the study incorporated information about awareness of postpartum depression, information sources, social and cultural influences, and the self-reported help-seeking behaviour.

2.2 Study Setting

This survey was originally carried out in Bosso and Chanchaga Local Government Areas of Minna, Niger State, Nigeria. Niger State is in the North-Central part of Nigeria and part of the northern part of the country. The selected areas are urban and peri-urban communities that have primary healthcare centres, community health workers and other maternal healthcare services.

2.3 Study Population and Eligibility Criteria

The study population was women aged 18-49 years with a minimum of one child living within the study areas. Participants were eligible for the study if they were willing to give informed consent and fill out the demographic and postpartum depression awareness components of the questionnaire. Those who refused to participate were not included in the analysis. The original data set included 384 responses, but four were not consented for inclusion in the data set for analysis; thus, a total of 380 responses were included for analysis.

2.4 Data Source and Instrument

Information was gathered from the structured questionnaire with the data set. The instrument comprised sociodemographic data, maternal data, knowledge and understanding of PPD, information sources and information exposure, communication preferences, cultural and social perceptions, prior help-seeking habits, information sources of support, and obstacles and facilitators to health care-seeking. Healthcare providers, television, radio, newspapers, social media, family and friends were sources of information. Healthcare professionals, community health workers, family/friends, religious leaders and traditional healers were all sources of help-seeking.

2.5 Study Variables

The primary outcome measures were self-reported help-seeking behaviour and awareness of postpartum depression. Awareness was measured primarily by whether respondents answered yes when asked about being familiar with the term postpartum depression and the answers to

questions about symptoms, incidence and the need for professional help. Help-seeking was assessed by asking participants if they had previously sought help for their PPD and what kinds of help they had taken. Explanatory variables included information sources, cultural beliefs, perceived stigma, confidentiality, treatment cost, family influence, religious influence and sociodemographic characteristics.

2.6 Data Management

The Microsoft Excel dataset was checked for completeness, duplicates, and agreement with the questionnaire, as well as with the consent status. Those who did not provide consent were excluded prior to analysis. Items that were generated because of a conditional questionnaire section were counted as structurally missing and not used as normal missing data. To enable frequency analysis and multiple-response analysis, multiple-response variables were coded as binary ones.

2.7 Statistical Analysis

Appropriate statistical software was used to analyse the data. Data on participant characteristics, awareness of postpartum depression, information sources, cultural perceptions and help-seeking behaviour were summarised using descriptive statistics (frequencies and percentages). Chi-square tests were performed for associations between categorical variables, and Fisher's exact test for small, expected cell frequencies. A binary logistic regression was analyzed to determine factors associated with postpartum depression awareness. Since a few respondents reported on past help-seeking, the analyses of help-seeking behaviour were mainly descriptive, and regression modelling was limited to a relatively small number of theoretically relevant predictors. Odds ratios, 95% confidence intervals and significance level ($p < 0.05$) were used to present the results.

2.8 Ethical Considerations

The secondary data did not include any personally identifiable information. The participation in the original survey was voluntary, and only results of those who gave informed consent were included in the analysis. Confidentiality and anonymity have been maintained during the process of data handling, analysis and reports. All the data reported in the study were presented in summary format to avoid the identification of individual respondents.

3. Results

3.1 Participant Inclusion and Sociodemographic Characteristics

There was a total of 384 responses in the dataset. Because 4 of the respondents refused to participate, 380 women agreed to be included in the analyses. The ages of the women in the study were presented in Table 1, showing that the largest age group (34.5%) was between 26 and 33 years, while the second largest age group (31.8%) was between 34 and 41 years. A majority of the respondents had completed senior secondary education (47.1%), 20.8% had primary education, and 7.4% had no formal education. Most respondents were married (87.6%), Muslim (79.5%) and had one to five children (92.9%). About three-quarters of the respondents had the youngest child aged 0–1 year. The participants came from Chanchaga Local Government Area (52.6%) and Bosso Local Government Area (47.4%) of the sample.

Table 1. Sociodemographic and maternal characteristics of respondents (N = 380)

Characteristic	Category	n	%
Age group	18–25 years	56	14.7
	26–33 years	131	34.5
	34–41 years	121	31.8
	42–49 years	72	18.9
Educational qualification	No formal education	28	7.4

	Primary school certificate	79	20.8
	SSCE	179	47.1
	NCE	6	1.6
	Ordinary National Diploma	9	2.4
	Higher National Diploma	16	4.2
	Bachelor's degree	48	12.6
	Postgraduate degree	15	3.9
	Unemployed	130	34.2
	Entrepreneur	100	26.3
	Artisan	72	18.9
Employment status	White-collar employment	35	9.2
	Self-employed	24	6.3
	Student	9	2.4
	Other	10	2.6
	Married	333	87.6
Marital status	Single	24	6.3
	Widowed	15	3.9
	Divorced	8	2.1
	Islam	302	79.5
Religion	Christianity	73	19.2
	Traditional religion	5	1.3
	1–5	353	92.9
Number of children	6–10	27	7.1
	0–1 year	284	74.7
Age of youngest child	2–20 years	89	23.4
	21 years and above	7	1.8

3.2 Awareness and Knowledge of Postpartum Depression

Overall, 18.7% (71 of 380) of the respondents were aware of PPD. Figure 1 shows that the other 309 women (81.3%) did not know about the condition. The knowledge of the main features of postpartum depression was overall high among the 71 respondents who knew about it. As can be seen in Table 2, 93.0% agreed that the symptoms of postpartum depression could include sadness, anxiety, isolation and fatigue, and 91.5% agreed that the PPD could affect any mother regardless of her background or culture. Likewise, 90.1% expressed their agreement that the condition needed medical attention and support. A smaller percentage, however, (78.9%) believed that postpartum depression was common among new mothers.

Table 2. Awareness and knowledge of postpartum depression among aware respondents (n = 71)

Awareness statement	Agree/strongly agree n (%)	Undecided n (%)	Disagree/strongly disagree n (%)
Had a very good understanding of postpartum depression	62 (87.3)	4 (5.6)	5 (7.0)
PPD is common among new mothers	56 (78.9)	5 (7.0)	10 (14.1)

PPD can affect any new mother regardless of background or culture	65 (91.5)	1 (1.4)	5 (7.0)
Symptoms can include sadness, anxiety, isolation and fatigue	66 (93.0)	1 (1.4)	4 (5.6)
PPD requires medical attention and support	64 (90.1)	2 (2.8)	5 (7.0)

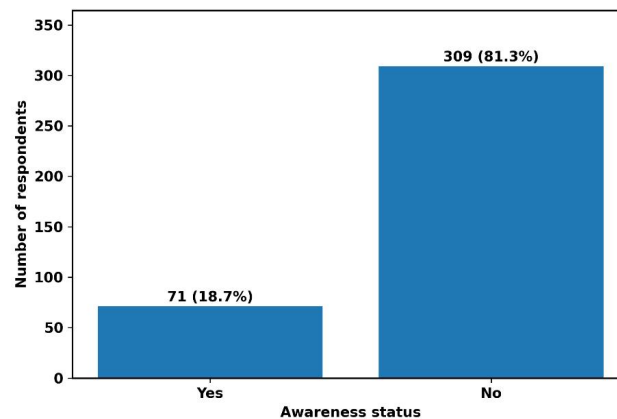


Figure 1. Awareness of postpartum depression among respondents

3.3 Sources and Frequency of Postpartum Depression Information

Twenty-seven of the 71 respondents who were aware (38.0%) reported that their first source of information about postpartum depression was social media. The first source was healthcare providers with 25.4%, and family members/friends were the second source at 23.9% for PPD. The other major sources were television (2.8%) and radio (1.4%). These patterns are shown in Figure 2. Of those who knew about postpartum depression, only 38 reported having received information about it in the last year. Of these respondents, the most recent source of information was healthcare providers (44.7%), social media (39.5%) and family or friends (28.9%). As multiple sources of information could be checked, the percentages added up to more than 100% when combined. The distribution of recent information sources is shown in Figure 3. Table 3 showed that both healthcare and social media were chosen as the most effective communication channels, with 34.2% each.

Table 3. Sources, frequency and perceived effectiveness of postpartum depression information

Information characteristic	Category	n	%
First information source, n = 71	Social media	27	38.0
	Healthcare providers	18	25.4
	Family/friends	17	23.9
	Other sources	6	8.5
	Television	2	2.8
	Radio	1	1.4
Information received during the previous year, n = 38 ¹	Healthcare providers	17	44.7
	Social media	15	39.5

	Family/friends	11	28.9
	Television	4	10.5
	Radio	2	5.3
	Other sources	2	5.3
	Newspapers	1	2.6
	Rarely	29	76.3
Frequency of information exposure, n = 38	Monthly	6	15.8
	Weekly	2	5.3
	Daily	1	2.6
	Social media	13	34.2
	Healthcare providers	13	34.2
Most effective channel, n = 38	Family/friends	8	21.1
	Other sources	2	5.3
	Television	1	2.6
	Radio	1	2.6

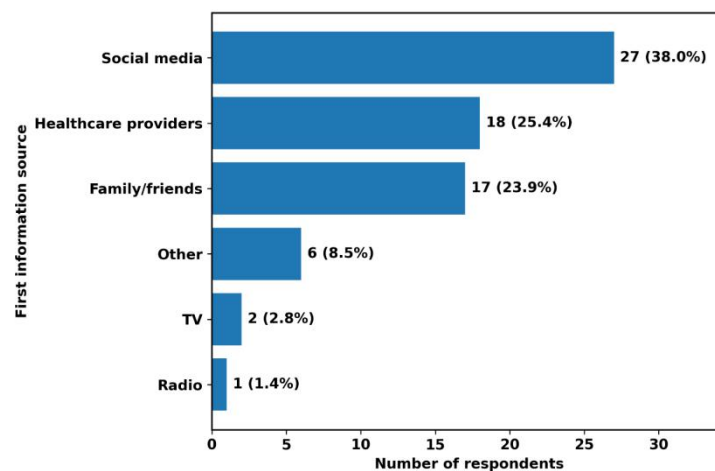


Figure 2. First reported source of postpartum depression information among aware respondents

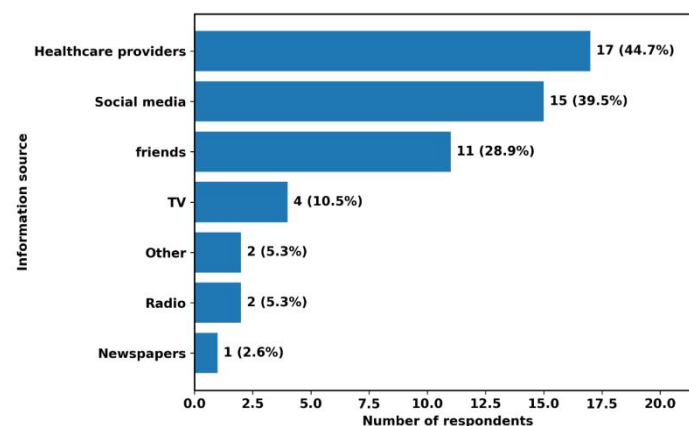


Figure 3. Sources of postpartum depression information received during the previous year

3.4 Perceived Quality and Emotional Effects of Information

Of those 38 who were given postpartum depression information in the past year, 21 respondents (55.3%) said they felt informed after reading the information. But the 14 that responded (36.8%) felt concerned, 2 (5.3%) felt anxious, and 1 (2.6%) felt panicked. The majority of respondents found the information easily understood. 32 respondents (84.2%) agreed or strongly agreed that the information was clear, and 26 (68.4%) found the information relevant to their personal experiences.

3.5 Social and Cultural Perceptions of Postpartum Depression

Table 4 and Figure 4 show social and cultural perceptions of the 71 respondents who were aware. About 47.9% said that their community sees postpartum depression as a health issue. By contrast, 57.7% believed that sometimes it was caused by things related to demonic or spiritual forces, and not just as a health condition. 88.7% agreed that they felt comfortable talking to health care providers about postpartum depression, 80.3% agreed with the same statement regarding friends and 62.0% agreed regarding family members. Fewer than half (52.1%) agreed with the help-seeking of postpartum depression being generally accepted in their communities, and 28.2% were not sure.

Table 4. Social and cultural perceptions of postpartum depression among aware respondents (n = 71)

Statement	Agree/strongly agree n (%)	Undecided n (%)	Disagree/strongly disagree n (%)
PPD is viewed as a health condition in the community	34 (47.9)	9 (12.7)	28 (39.4)
PPD is attributed to demonic or spiritual influence	41 (57.7)	10 (14.1)	20 (28.2)
Cultural beliefs affect how PPD is understood and treated	53 (74.6)	8 (11.3)	10 (14.1)
Comfortable discussing PPD with family	44 (62.0)	12 (16.9)	15 (21.1)
Comfortable discussing PPD with friends	57 (80.3)	6 (8.5)	8 (11.3)
Comfortable discussing PPD with healthcare providers	63 (88.7)	5 (7.0)	3 (4.2)
Seeking help for PPD is acceptable in the community	37 (52.1)	20 (28.2)	14 (19.7)
Cultural beliefs prevent women from seeking help	34 (47.9)	18 (25.4)	19 (26.8)

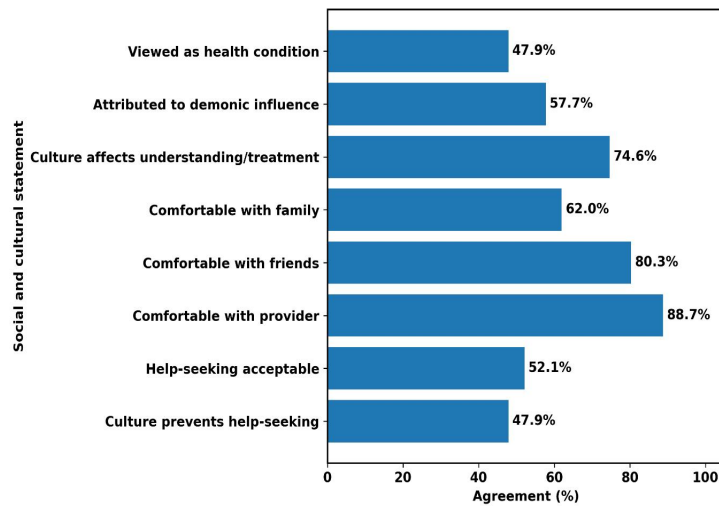


Figure 4. Social and cultural perceptions of postpartum depression among aware respondents

3.6 Help-Seeking Behaviour and Sources of Support

Of the 71 respondents who knew about postpartum depression, 19.7% (14) sought help. 57 respondents (80.3%) did not seek help, as displayed in Figure 5. Most people seeking help (10 of 14 (71.4%)) said they had been given the help they needed by their healthcare providers. Three respondents (21.4%) also relied on family members or friends for support and one respondent each turned to a community health worker or a religious leader for support. No one reported using traditional healers. Fifty per cent of the help-seekers reported that family members or friends encouraged them to seek help, which was the most common factor reported for encouraging help-seeking. 21.4% reported severity of symptoms and 21.4% reported recommendations from health care providers. Fear of stigma or judgement (28.6%) and lack of awareness (28.6%) were the main barriers identified by the principal. The major factors discouraging women from seeking help for postpartum depression are presented in Figure 6.

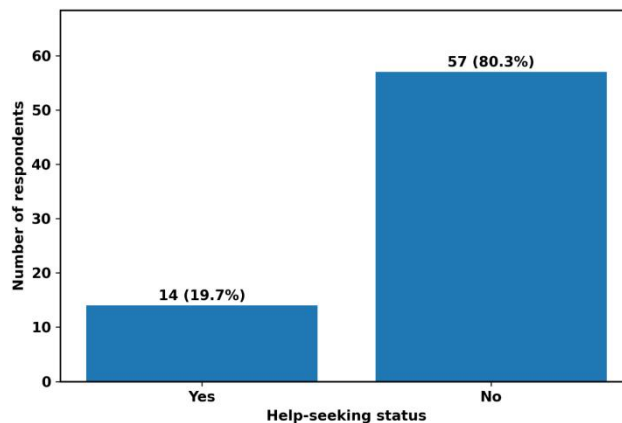


Figure 5. Previous help-seeking behaviour for postpartum depression among aware respondents

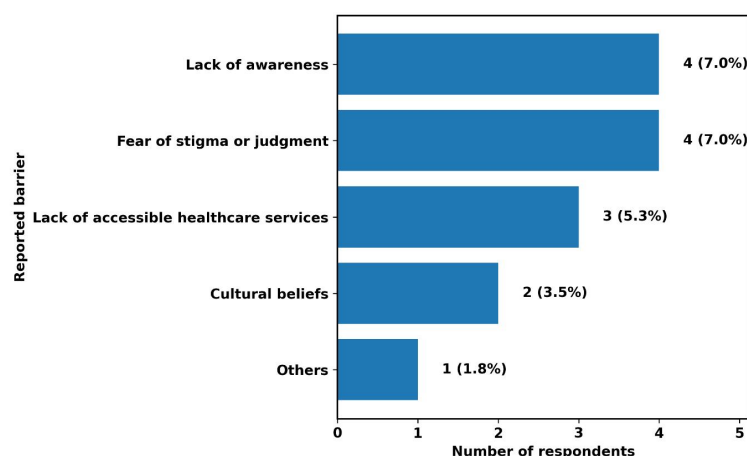


Figure 6. Major factors discouraging help-seeking for postpartum depression

3.7 Factors Associated with Postpartum Depression Awareness

The factors associated with Postpartum Depression Awareness are discussed in 3.7. The findings of bivariate analysis showed differences in awareness of postpartum depression among age groups, educational levels, employment status, religions and age groups of the youngest child and local government areas. Awareness was associated with age, $\chi^2(3) = 11.97$, $p = 0.007$, and local government area, $\chi^2(1) = 15.91$, $p < 0.001$. Education, employment, religion and age of youngest child were also well correlated. Due to small frequencies of expected responses, the results for some of the educational, employment and religious categories must be interpreted with caution and can be verified by collapsing categories or exact statistical tests.

3.8 Summary of Major Results

The results showed that there was low awareness of PPD, with only one out of five participants having heard of postpartum depression as a condition. However, those who did know about postpartum depression showed good knowledge of the symptoms, presence and medical treatment. The main sources of information were social media and healthcare providers, with exposure to information being mostly infrequent. Cultural and spiritual interpretations were still prevalent and were felt to be affecting understanding, treatment and willingness to seek help. There was little actual help seeking; the most common formal source of help was healthcare professionals.

4. Discussion

In this present study, the level of awareness of postpartum depression, information sources, social and cultural perspectives, as well as help-seeking behaviour among women in Northern Nigeria was explored. The results showed a general lack of knowledge about postpartum depression since only 18.7% of respondents had heard about postpartum depression before. However, females with awareness about the condition showed a relatively high level of awareness on symptoms, the possibility of the disease in various backgrounds and the need for professional assistance. This trend could indicate that while knowledge of the true facts among educated women is fairly accurate, the information about mental health after childbirth is less widespread among the general population. Consistent with this, previous studies have shown that better mental health literacy correlates with more positive attitudes towards mental health care and lower levels of stigma related to mental health care (Doğan et al., 2022; Jones, 2022).

Healthcare providers and family/friends were the second and third most frequently cited sources, respectively, followed by social media. Healthcare providers were the primary source of information received over the past year and were cited as one of the most effective sources of information. This discovery reveals the complementary relationship between

digital media and formal maternal health services. While social media can give instant and easily accessible exposure, health care professionals are more likely to be giving accurate, context-specific and clinically appropriate information. However, healthcare workers may have different levels of knowledge and confidence about recognising and communicating about a woman's perinatal depression, and this can impact the quality of information provided to women (Mariana et al., 2022).

The frequency of information exposure was low, with most of the people who reported being informed having heard information about postpartum depression "very rarely. The low level of awareness, despite the various options for communicating, could be due to limited and irregular exposure. The availability of culturally relevant and repeated information via trusted community and health care settings is more likely to influence maternal health practices (Muriithi et al., 2024). Therefore, the provision of information on postpartum depression within the antenatal, postnatal, immunisation clinics and community outreach programs could enhance continuity of exposure.

Interpretations of cultural and spiritual aspects were prevalent in the findings. Over 50% of the people who were aware agreed that the postpartum depression was due to a demonic or spiritual presence, and almost 75% felt that cultural beliefs had an impact on how they understood and treated postpartum depression. These perceptions can cause women to not recognize postpartum depression as a health condition in time and instead turn to informal or religious support instead of mental health care. Qualitative evidence has demonstrated that stigma, cultural interpretations, family attitudes, costs, confidentiality issues and service availability contribute to the way women seek help with their depressive symptoms during the perinatal period (Hu et al., 2023).

However, actual help-seeking was minimal, with only 19.7% of aware respondents reporting seeking help. The two most common factors that dissuaded respondents were: fear of stigma or judgement, and lack of awareness, followed by limited access to healthcare services. The same evidence indicates that awareness of PPD does not translate into professional help-seeking without expecting rejection of social support or feeling unconfident in help-seeking services and minimizing symptoms (Jones, 2022).

However, family and friends were found to be an important source of encouragement toward help-seeking, suggesting a complex process in which maternal mental health decisions are not made in isolation. Intervention with the partner, relatives/caregiver may enhance the recognition, emotional support, and timely referral. In addition to reducing symptoms, parenting/parent-child interventions can have positive effects that go beyond symptom reduction, such as improving maternal functioning, caregiving capacity, and infant developmental outcomes (Adina et al., 2022; Kumar et al., 2023). When a clinical treatment is needed, the evidence supports structured psychological treatment like interpersonal psychotherapy; however, its delivery must meet the resources available in a low-resource context (Kang et al., 2024).

The results also endorse task-sharing approaches that enable trained frontline workers and community health workers to deliver education, identification, referral, and basic psychological support. In Nigeria, there is evidence that interventions by frontline maternal care providers lead to better outcomes for women with perinatal depression (Gureje et al., 2022). Community health workers could also enhance prevention and management efforts in sub-Saharan Africa, especially in areas with few mental health specialists (Feyissa et al., 2026). Factors such as treatment acceptability, support among family members, provider competence and continuity of care (Elias et al., 2024) are also important indicators of the effectiveness of intervention.

5. Conclusion

This study revealed that overall knowledge of postpartum depression was low amongst the women of Northern Nigeria, but respondents who had heard about postpartum depression had relatively good knowledge of its signs and symptoms and need for medical intervention.

Social media, healthcare professionals and family or friends were the primary sources of information, showing that formal and informal communication channels have an impact on the women's understanding of postpartum depression. It was still found that the information was not always presented, however, and this could account for the relatively low awareness found in the broader sample. Cultural and spiritual beliefs were still significant in determining perceptions of postpartum depression. Respondents felt that cultural beliefs affected the understanding and treatment of the condition, and that there was stigma and limited awareness of health services and limited access to care. Women who sought help also reported that their primary source of assistance was from a healthcare provider, but only a small percentage of women were help-seekers. The results show that greater attention needs to be paid to the need to incorporate education on postpartum depression into antenatal, postnatal, immunisation and community health services. Information needs to be conveyed multiple times by trusted healthcare workers, community health workers, social media, families and religious and community leaders.

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