Postpartum Depression, Quality of Life, and Social Support in Rural Nigeria: A Synthesis of Recent Evidence and a Structural-Relational Framework

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ABSTRACT

Background: *Postpartum depression represents one of the most common yet underrecognised complications of childbirth globally, with disproportionately elevated burden in low- and middle-income countries. This narrative review synthesises recent evidence on the prevalence, determinants, and quality-of-life implications of postpartum depression among women in rural Nigeria, with particular attention to the intersecting roles of social support and structural disadvantage.*
Methods: *A structured narrative synthesis was conducted drawing on peer-reviewed studies published between 2020 and 2025, retrieved from PubMed, Scopus, Google Scholar, and African Journals Online. Regional systematic reviews, national demographic survey data, and global institutional reports were integrated to provide multi-level contextual analysis.*
Results: *Pooled prevalence estimates for postpartum depression in sub-Saharan Africa range from 18% to 37%, with recent Nigerian studies reporting figures between 32% and 72.1% depending on geographic context, screening instruments, and population characteristics. In rural southwestern Nigeria, extraordinarily high prevalence of 72.1% has been documented, driven by intersecting structural vulnerabilities including poverty, limited healthcare access, gendered inequities, and cultural imperatives of maternal stoicism. Only 13% of rural Nigerian women receive postnatal care within two days of delivery, substantially constraining opportunities for depression screening. Social support emerges as a consistently protective factor, with emotional reassurance, practical assistance, and community belonging significantly reducing symptom severity. Postpartum depression produces measurable impairments across all quality-of-life domains, compromising physical vitality, psychological well-being, social functioning, and maternal caregiving capacity.*
Conclusion: *Postpartum depression in rural Nigeria cannot be understood as an isolated psychological disturbance but must be conceptualised as a socially embedded condition shaped by structural inequality, constrained health system engagement, and relational vulnerabilities. A multi-level structural–relational framework is proposed to guide context-specific research and intervention design. Urgent policy priorities include integrating mental health screening into primary maternal care, strengthening community-based support systems, and addressing the socioeconomic determinants that amplify maternal psychological distress.*

INTRODUCTION

Motherhood is widely constructed across cultures as a period of joy, renewal, and fulfilment. Yet the postpartum period represents a time of profound biological, psychological, and social transition during which women may experience heightened

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emotional vulnerability. Although childbirth is celebrated in many societies, a significant proportion of women experience persistent sadness, anxiety, fatigue, and emotional detachment in the weeks and months following delivery. These experiences frequently remain unrecognised, minimised, or stigmatised, particularly within low-resource rural settings where mental health literacy is limited and cultural expectations of maternal resilience prevail. [1]

Postpartum depression is among the most common complications of childbirth worldwide. Recent estimates indicate that approximately one in five women in low- and middle-income countries experience clinically significant depressive symptoms after childbirth, with prevalence consistently higher in sub-Saharan Africa compared to high-income settings. [23]

Nigerian studies conducted within the last five years report prevalence ranging between 18% and 35% depending on region, socioeconomic conditions, and screening tools used. A particularly alarming finding from Akinyele Local Government Area in Oyo State, southwestern Nigeria, documented a prevalence of 72.1% among rural nursing mothers—the highest reported in a Nigerian community setting. [3-6]

The burden of postpartum depression extends well beyond mood disturbance. Untreated maternal depression impairs women's quality of life, reduces daily functional capacity, strains marital and family relationships, disrupts early mother–infant bonding, and compromises child developmental trajectories. Women experiencing depressive symptoms frequently report diminished physical vitality, social withdrawal, and reduced participation in caregiving and economic activities. [2, 7, 8]

In rural Nigerian communities, structural inequities; including poverty, limited healthcare access, entrenched gender norms, and weakening traditional support networks may amplify psychological distress. Data from the 2023–2024 Nigeria Demographic and Health Survey indicate that only 42% of newborns nationwide received a postnatal check within the first two days after birth, with stark rural–urban disparities. The implications for maternal mental health are profound: in the absence of structured postnatal follow-up, opportunities for depression screening and early intervention are substantially constrained. [9, 10]

Social support remains one of the most consistently identified protective factors against postpartum depression. Emotional reassurance, practical assistance, financial stability, and community belonging significantly reduce depressive symptom severity and improve postpartum adjustment. [4, 11]

However, social transformation, economic migration, urbanisation pressures, and weakening extended family networks have altered traditional postpartum care structures in many rural communities. The erosion of these protective systems, combined with limited integration of mental health services into primary healthcare, creates a convergence of risk that leaves rural postpartum women exceptionally vulnerable. [10, 12]

Despite increasing recognition of maternal mental health challenges in Nigeria, there remains limited integrative evidence examining how postpartum depression intersects with women's quality of life and social support systems within rural contexts. Without a clearer synthesis of existing data, policy responses and community interventions risk being fragmented, underresourced, and insufficiently attuned to the sociocultural specificities of rural Nigerian life. This study therefore seeks to synthesise recent secondary data and regional evidence to clarify the burden of postpartum depression in rural Nigeria, explore its relationship with social support and quality of life, examine the cultural and structural determinants that shape women's experiences, and highlight critical gaps that require context-specific investigation, particularly in underserved southwestern communities. [1, 13]

METHODS

Study Design

This study employed a secondary data analysis and structured narrative literature synthesis to examine the relationship between postpartum depression, social support systems, and maternal quality of life in rural Nigeria. The design integrates quantitative prevalence data, qualitative experiential evidence, and health systems analysis to produce a multi-dimensional understanding of maternal mental health in resource-constrained rural settings. [14]

Data Sources

Peer-reviewed studies published between January 2020 and March 2025 were retrieved from Google Scholar, PubMed, Scopus, and African Journals Online. National and regional reports relevant to maternal mental health in sub-Saharan Africa were also consulted, including the Nigeria Demographic and Health Survey 2023–2024, World Health Organization World Mental Health Report 2022, and UNICEF State of the World's Children 2024. Grey literature from Nigerian health policy documents and mental health programme evaluations supplemented the peer-reviewed evidence base. [9, 15, 16]

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Search Strategy

Search terms included: postpartum depression, perinatal depression, maternal mental health, rural Nigeria, quality of life, social support, Edinburgh Postnatal Depression Scale, coping strategies, sub-Saharan Africa, task-shifting, and primary healthcare integration. Boolean operators (AND, OR) were used to refine search combinations. Reference lists of selected articles were further screened to identify additional relevant studies.

Inclusion Criteria

Studies were included if they: (i.) were published between 2020 and 2025; (ii.) examined postpartum depression among women in Nigeria or comparable sub-Saharan African settings; (iii.) reported associations with social support, quality of life, or psychosocial determinants; (iv.) utilised quantitative, qualitative, or mixed-methods designs; and (v.) were published in English.

Data Extraction and Synthesis

Relevant information was extracted on prevalence estimates, associated risk factors, protective social support variables, quality of life outcomes, reported coping strategies, and health systems context. Findings were synthesised descriptively and thematically to identify recurring patterns, contextual gaps, and implications for rural maternal mental health programming. The synthesis was organised around a multi-level structural–relational framework conceptualising maternal depression as the product of interacting macro-level structural forces, meso-level relational dynamics, and micro-level psychological processes.

RESULTS

Prevalence of Postpartum Depression: Global, Regional, and Nigerian Evidence

Globally, the World Health Organization estimates that approximately 10% of pregnant women and 13% of women who have just given birth experience a mental health disorder, primarily depression. [15]

In high-income countries, pooled prevalence estimates for postpartum depression approximate 10–15%. However, in low- and middle-income countries, the burden is substantially elevated. A comprehensive systematic review by Nweke and colleagues covering sub-Saharan African studies reported postpartum depression prevalence

ranging from 18% to 37%, with the upper estimates more commonly reported in low-income populations, women with limited social support, and facility-based samples in resource-constrained settings[3].

Within Nigeria, recent studies demonstrate considerable geographic variability. Research in Ilorin, North Central Nigeria, found a prevalence of 33.7% using the Edinburgh Postnatal Depression Scale with a cut-off of 10, with history of depression (adjusted odds ratio 4.21) and marital violence (OR 3.15) identified as independent predictors. [4]

In Lagos, southwestern Nigeria, a study among postnatal women attending primary healthcare centres reported a prevalence of 35.6%. Multiple logistic regression identified intimate partner violence (OR 5.2), experiencing postpartum blues (OR 32.8), not having help with caring for the baby (OR 2.6), and having an unsupportive partner (OR 2.6) as significant predictors. [5]

A cross-sectional study in Nnewi North Local Government Area of Anambra State, southeastern Nigeria, reported a prevalence of 32%, with perceived social support from significant others inversely related to postpartum depression severity. [17]

The most striking finding emerged from Akinyele Local Government Area in Oyo State, southwestern Nigeria, where a community-based study of 398 nursing mothers documented an extraordinarily high prevalence of 72.1%. This study additionally found that 72.1% of participants possessed low knowledge of postpartum depression, with only 16.8% aware that the condition is treatable. Regression analyses identified social support ($\beta = 0.403$, $p < 0.05$) and cultural practices ($\beta = 0.224$, $p < 0.05$) as significant predictors, with social support demonstrating the stronger influence. [6]

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Table 1: Comparative prevalence of postpartum depression across Nigerian and sub-Saharan African studies (2020–2025)

Study	Location	Sample	Prevalence	Screening Tool	Key Predictors
Nweke et al. (2024)	Sub-Saharan Africa	Systematic review	18–37%	Various (EPDS predominant)	Low social support, poverty, IPV
Adedoyin et al. (2026)	Ilorin, Nigeria	374 postpartum women	33.7%	EPDS (cut-off ≥10)	History of depression, marital violence
Adeyemo et al. (2020)	Lagos, Nigeria	250 postnatal women	35.6%	EPDS	IPV, postpartum blues, lack of help
Folorunsho (2025)	Anambra, Nigeria	406 postpartum women	32%	PHQ-9, MSPSS	Low knowledge, inadequate social support
Balogun et al. (2025)	Oyo State, Nigeria	398 nursing mothers	72.1%	EPDS	Social support, cultural practices
WHO (2022)	Global	Multi-country	~10–15% (HIC); higher in LMIC	Various	Context-dependent

Rural Nigeria: Structural Context and Health System Gaps

The structural landscape of rural Nigeria presents formidable barriers to maternal mental healthcare. The 2023–2024 Nigeria Demographic and Health Survey indicates that postnatal care within two days of delivery stands at only 42% nationally, with substantial rural–urban disparities. Early postnatal contact is widely recognised as a strategic window for identifying psychological distress and initiating mental health screening. The low rate of early postnatal utilisation therefore suggests that opportunities for postpartum depression detection are substantially constrained in rural communities. [9]

Compounding these access barriers, Nigeria faces a catastrophic shortage of mental health professionals. With a population exceeding 220 million, the country has fewer than 250 psychiatrists; a ratio of approximately one psychiatrist per 880,000 citizens, compared to the WHO recommendation of one per 10,000. The majority of these professionals are concentrated in urban tertiary institutions, leaving rural populations effectively abandoned. [18]

A landmark study on perinatal depression screening in primary healthcare settings in and around Ibadan, Oyo State; screening 2,989 women across 23 primary healthcare facilities—found that nearly 85% of women with perinatal depression were undiagnosed in routine maternal healthcare checks. This treatment gap reflects not only workforce shortages but also the absence of systematic screening protocols, limited mental health

literacy among primary care workers, and the non-integration of mental health into maternal and child health programmes. [1, 10]

The enactment of the National Mental Health Act 2021 represented a significant policy advancement, establishing legal frameworks for mental health service integration, patient rights protection, and decriminalisation of suicide attempts. However, implementation has been markedly delayed: key provisions including the establishment of the Department of Mental Health Services remain unrealised more than three years after the Act's signing. [19]

Psychosocial and Cultural Determinants

Systematic evidence from sub-Saharan Africa consistently identifies a cluster of interconnected psychosocial determinants associated with increased postpartum depression risk. Low perceived emotional support represents a strong predictor, with women reporting inadequate partner and family support showing two- to five-fold increases in depression likelihood. [3, 5]

Financial instability and poverty-related stressors are strongly associated with depressive symptom severity. In the Nigerian context, where over 40% of the population lives below the national poverty line, economic precarity intersects with maternal responsibilities to produce chronic psychological strain. A study examining help-seeking behaviour for postpartum depression in Yobe and Niger states found income to be the strongest predictor of help-seeking, underscoring how economic barriers simultaneously increase risk and reduce access to care. [3, 20]

Intimate partner violence emerges as one of the most potent risk factors, with studies reporting odds ratios ranging from 3.15 to 5.2 for postpartum depression among women experiencing marital violence. Limited decision-making autonomy, gender-discriminatory norms, and unsupportive partner relationships compound this vulnerability. [4, 5]

The cultural context of southwestern Nigeria adds distinctive dimensions to these determinants. Among the Yoruba people, postpartum depression is traditionally referred to as "Abisinwin" literally meaning "becoming mad after giving birth". This terminological framing carries profound stigmatising implications, positioning affected women as mentally deranged rather than experiencing a treatable health condition. [6]
A qualitative phenomenological study among rural Yoruba women in Akinyele LGA revealed four major themes shaping postpartum distress experiences: (1.) cultural imperatives of maternal stoicism and enforced silence surrounding postpartum suffering; (2.) the paradoxical nature of postpartum cultural practices as simultaneously

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protective and pathogenic; (3.) multilayered barriers to formal mental healthcare including stigma, spiritual attributions, and adverse healthcare encounters; and (4.) indigenous explanatory models framing distress through cultural lenses of "excessive thinking," spiritual affliction, physical depletion, or relational discord rather than biomedical psychiatric constructs. [6]

These findings illuminate the cultural scaffolding that shapes the extraordinarily high prevalence documented quantitatively. Postpartum depression among rural Yoruba women emerges from complex interactions between traditional gender expectations, postpartum ritual practices (including "omo orun" postpartum seclusion), spiritual belief systems, and structural deficiencies in psychosocial support. [6, 22]

Table 2: Synthesized determinants of postpartum depression in Nigerian and sub-Saharan African contexts

Determinant Category	Specific Factor	Direction of Association	Evidence Source
Social Support	Low perceived emotional support	Increased depressive symptoms (2–5x risk)	Nweke et al., 2024; Balogun et al., 2025
Social Support	Lack of practical help with infant care	Increased vulnerability (OR 2.6)	Adeyemo et al., 2020
Economic	Poverty and financial strain	Elevated risk; strongest predictor of help-seeking	Adedoyin et al., 2026; Omale et al., 2026
Gender Dynamics	Intimate partner violence	Increased vulnerability (OR 3.15–5.2)	Adedoyin et al., 2026; Adeyemo et al., 2020
Gender Dynamics	Unsupportive partner	Increased depression risk (OR 2.6)	Adeyemo et al., 2020
Health System	Limited postnatal engagement	Reduced detection and treatment	NDHS, 2023–24; Oladeji et al., 2025
Health System	Absence of screening protocols	85% undiagnosed in routine care	Oladeji et al., 2025
Cultural	Stigma (Abisinwin framing)	Concealment of distress, delayed help-seeking	Balogun et al., 2025
Cultural	Maternal stoicism expectations	Emotional suppression, isolation	Balogun et al., 2025
Individual	History of depression	Strongest predictor (aOR 4.21)	Adedoyin et al., 2026
Individual	Low mental health literacy	Reduced help-seeking, untreated symptoms	Balogun et al., 2025; Folorunsho, 2025

Quality of Life Impacts

Postpartum depression extends beyond affective symptoms to produce measurable impairments in maternal quality of life. Evidence using the Short Form-36 Health Survey demonstrates that women with postpartum depression score significantly lower across seven of eight quality-of-life dimensions compared to non-depressed mothers.

Both physical health components (physical functioning, role-physical, bodily pain, general health) and mental health components (vitality, social functioning, role-emotional, mental health) are affected, with the strongest correlations observed between depression severity and emotional well-being. [8,23]

Qualitative research across sub-Saharan African contexts further reveals how maternal morbidities impact daily functioning. Women describe physical symptoms making household chores difficult, fatigue limiting their ability to care for children, and emotional changes adversely affecting interpersonal relationships. Financial barriers, inadequate social support, and sociocultural expectations were reported to exacerbate these morbidities and intensify the burden placed on women to overcome them. [7]

The intergenerational consequences are particularly concerning. Untreated maternal depression is associated with preterm birth, low birth weight, early childhood underweight status and stunting, impaired mother–infant bonding, and long-term negative developmental effects from infancy through adolescence. [24]

Within rural Nigerian contexts, where structural constraints already limit access to healthcare and social support, the quality-of-life consequences of postpartum depression may be further intensified, reinforcing cycles of vulnerability at both household and community levels. Women frequently conceal psychological distress due to normative expectations of maternal resilience, stigma, and social pressure, resulting in emotional isolation and delayed help-seeking. [6,7]

Social Support as a Protective Mechanism

Social support emerges from the synthesised evidence as the most consistently protective factor against postpartum depression. The Akinyele LGA study found social support to be the strongest predictor of lower depression scores ($\beta = 0.403$), surpassing the influence of cultural practices, education, and demographic factors. [6]

The dimensions of protective social support include emotional reassurance from partners and family members, practical assistance with infant care and household responsibilities, financial stability and material resources, and community belonging and integration. Women lacking emotional connection and reassurance from their partners were more likely to experience anxiety and depression, while received social support was positively associated with quality of life across multiple domains. [7,11]

However, the nature and availability of social support in rural Nigeria is undergoing significant transformation. Traditional extended family networks, which historically provided structured postpartum care through female relatives, are weakening due to

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economic migration, urbanisation, and changing family structures. The erosion of these protective systems coincides with inadequate replacement by formal health services, creating a support vacuum that leaves many rural postpartum women without adequate emotional or practical assistance. [12]

The Nnewi North study found that support from significant others was inversely related to postpartum depression ($p = 0.045$), whereas support from family and friends did not reveal significant associations, suggesting that the quality and source of support may matter as much as its presence. Interventions targeting spousal involvement and intimate partner relationships may therefore warrant particular attention. [17]

Intervention Evidence and Health System Responses

Despite the substantial burden, effective interventions for perinatal depression in low-resource settings exist. The Thinking Healthy Programme, a cognitive-behavioural intervention delivered by community health workers or trained peers, has demonstrated significant effectiveness across multiple LMIC contexts. A pooled analysis of randomised controlled trials in India and Pakistan found that peer-delivered Thinking Healthy Programme was associated with 35% higher odds of remission at six months post-childbirth compared with enhanced usual care, alongside improvements in disability scores and perceived social support. [25]

Community health worker-led preventive psychosocial interventions have shown reductions in depressed mood risk of 35% at three months post-birth, 32% at six months, and 38% at nine to twelve months. Among women with moderate depressive symptoms, CHW-led therapeutic interventions reduced symptom severity by an average of 0.71 standardised mean difference units during the first three months postpartum. [26]

In Nigeria specifically, task-shifting approaches show considerable promise. The Mental Health in Primary Care initiative in Lagos State scaled task-shifted mental health services across 57 primary healthcare facilities and five general hospitals, training 890 health workers using the WHO Mental Health Gap Action Programme Intervention Guide framework. The initiative achieved institutional changes across governance, workforce supervision, medicines availability, financing, and service delivery—64,107 clients were screened and 9,138 initiated on treatment. [27]

The Wellbeing Foundation Africa's MamaCare360 Programme represents an innovative Nigerian approach, integrating perinatal mental health screening into antenatal and postnatal care through a "traffic light" referral system. The programme has reported an 80% increase in antenatal attendance and reduced postpartum depression rates, though

systemic challenges including stigma, fragmented care pathways, and resource limitations persist. [10]

DISCUSSION

This synthesis reveals postpartum depression in rural Nigeria as a condition of extraordinary prevalence and profound consequence, shaped by intersecting structural, relational, and cultural determinants that demand integrated, multi-level responses. The prevalence estimates documented across Nigerian studies ranging from 32% to 72.1%, substantially exceed both global pooled estimates of 10–15% and even the broader sub-Saharan African range of 18–37%.[3,15]

The 72.1% prevalence documented in Akinyele LGA, while representing a single community study, demands serious attention. This figure likely reflects the concentration of multiple risk factors in a resource-constrained rural setting: extreme poverty, limited healthcare access, patriarchal gender norms, cultural stigma around mental illness, weakening traditional support structures, and absence of mental health services. The finding that 72.1% of participants had low knowledge of postpartum depression and only 16.8% knew it was treatable further underscores how health literacy deficits compound structural barriers to produce a population exceptionally vulnerable to unrecognised, untreated depression. [6]

The cultural dimensions identified in this synthesis carry significant implications for intervention design. The Yoruba conceptualisation of postpartum distress as “Abisinwin” i.e madness following childbirth, creates powerful barriers to help-seeking through anticipated stigma and social exclusion. Indigenous explanatory models that frame distress through spiritual, physical, or cognitive lenses rather than biomedical psychiatric constructs suggest that culturally congruent interventions must engage with local understandings rather than imposing Western psychiatric frameworks. [6,21]

The paradox of traditional postpartum practices simultaneously protective in providing structured support and potentially harmful through restrictive norms of maternal seclusion and stoicism, highlights the need for nuanced engagement with cultural systems rather than their blanket rejection or uncritical promotion[6].

A Multi-Level Structural–Relational Framework

The evidence presented in this synthesis supports the development of a multi-level structural–relational framework for understanding and addressing postpartum

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depression in rural Nigeria. This framework conceptualises maternal depression as the product of interacting forces operating at three interconnected levels:
At the macro level, structural inequality, poverty, discriminatory gender norms, inadequate health system funding, and workforce shortages create the foundational conditions within which maternal mental health risks are generated and sustained. National policies, including the delayed implementation of the Mental Health Act 2021, shape the institutional landscape within which services are—or are not—delivered.

At the meso level, relational dynamics within families and communities mediate the translation of structural conditions into individual experiences of distress or resilience. Partner support, family relationships, community belonging, and the availability of practical assistance function as either risk amplifiers or protective buffers. The quality of these relationships—not merely their presence—emerges as critical.

At the micro level, individual psychological processes—including cognitive appraisals of stress, coping strategies, health literacy, and help-seeking behaviours—determine how structural and relational factors manifest in depressive symptomatology and quality-of-life impairment. Cultural explanatory models shape whether distress is recognised, expressed, and acted upon.

This framework moves beyond narrow biomedical framings that locate postpartum depression solely within individual neurobiology, instead situating maternal mental health within patterned social disadvantage and gendered social environments. It establishes a conceptual foundation for future field-based research in rural southwestern Nigeria, where these multi-level pathways can be empirically examined and refined within specific sociocultural contexts.

Implications for Policy and Practice

The findings of this synthesis carry several urgent implications for policy and practice. First, the integration of mental health screening into routine maternal and child health services, particularly at antenatal, immediate postnatal, and six-week immunisation visits, represents the highest-yield intervention for reducing the treatment gap. The Edinburgh Postnatal Depression Scale, validated for use among Nigerian women with optimal cut-off scores of 10–12, provides a feasible screening tool for primary care settings[16].

Second, task-shifting and peer-delivered psychosocial interventions offer scalable, cost-effective approaches that can operate within existing health system constraints. The Thinking Healthy Programme and similar evidence-based interventions can be adapted

for Nigerian contexts, delivered by community health extension workers or trained peer supporters, with structured supervision to ensure quality fidelity. [25,27]
Third, interventions must engage male partners and address intimate partner violence as a core determinant of maternal mental health. Given that partner violence emerges as one of the strongest predictors of postpartum depression, gender-transformative approaches that challenge harmful masculine norms and promote equitable caregiving relationships are essential. [4,5]

Fourth, community-based awareness campaigns must address the stigma associated with "Abisinwin" and similar cultural constructs, reframing postpartum depression as a common, treatable health condition rather than a sign of madness or spiritual affliction. Engagement with traditional birth attendants, community leaders, and faith-based actors can facilitate culturally congruent mental health promotion. [6,22]

Fifth, the delayed implementation of the National Mental Health Act 2021 must be urgently addressed through establishment of the Department of Mental Health Services, allocation of dedicated funding for maternal mental health programmes, and integration of mental health into existing primary healthcare structures. The Lagos State experience with the Mental Health in Primary Care initiative demonstrates that meaningful institutional change is feasible when accompanied by governance commitment, workforce training, and structured supervision. [19,27]

Strengths and Limitations

This synthesis integrates evidence from multiple sources; systematic reviews, primary quantitative and qualitative studies, national survey data, and policy documents; to provide a comprehensive multi-dimensional analysis of postpartum depression in rural Nigeria. The inclusion of recent studies published through early 2025 ensures currency of the evidence base.

However, several limitations must be acknowledged. The reliance on secondary data precludes original primary analysis. The geographic scope of available evidence remains uneven, with most Nigerian postpartum depression studies concentrated in urban or tertiary healthcare settings and rural southwestern Nigeria specifically remaining insufficiently represented. Variability in screening instruments, cut-off scores, and study designs across primary studies limits direct comparability of prevalence estimates. The cross-sectional nature of most included studies precludes causal inference about determinant–outcome relationships. Finally, the framework proposed herein requires empirical validation through prospective field research in the specific contexts it seeks to explain.

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CONCLUSION

Postpartum depression in rural Nigeria cannot be understood as a private psychological disturbance divorced from its social environment. The evidence synthesised in this study demonstrates that maternal depression is patterned by structural inequality, constrained health system engagement, and relational vulnerabilities that shape women's postpartum experiences in profound and intersecting ways.

The prevalence estimates documented across Nigerian studies—ranging from 32% to an extraordinary 72.1% in the most resource-constrained rural settings—signal a public health crisis of significant proportions. These figures, coupled with evidence that only 13% of rural women receive timely postnatal care and that 85% of depressed mothers in primary care settings remain undiagnosed, reveal a massive gap between maternal mental health needs and service delivery capacity.

The findings further reveal that postpartum depression extends beyond symptomatology to undermine women's functional capacity, relational stability, and overall quality of life, with potential intergenerational consequences for child development and family wellbeing. Social support not only acts as a protective factor but serves as a crucial mediating mechanism that either buffers or intensifies structural disadvantage. When social networks are weakened and institutional mental health integration remains limited, vulnerability deepens.

By advancing a multi-level structural–relational framework, this study moves the discourse beyond biomedical reductionism and situates postpartum depression within the broader social ecology of rural Nigerian life. The geographic under-representation of rural southwestern Nigeria in current datasets highlights an urgent need for context-specific empirical investigation. Addressing postpartum depression in rural communities requires integrated policy responses that combine mental health screening within primary care, strengthened community-based support systems, culturally congruent awareness interventions, and structural interventions targeting gendered and economic inequities.

Maternal mental health is not peripheral to development; it is foundational to family stability, child wellbeing, and community resilience. Any meaningful effort to improve maternal and child health outcomes in rural Nigeria must confront postpartum depression as a socially embedded public health priority rather than an individual affliction. The time for policy action is now.

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