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Burden and Determinants of Postpartum Depression among Low-income Mothers: A Community-based Cross-sectional Study in Peri-urban Accra, Ghana

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ABSTRACT

Background: Postpartum depression (PPD) is a leading contributor to maternal morbidity in sub-Saharan Africa and is associated with adverse infant developmental, nutritional and growth outcomes. Robust community-based estimates from urban poor populations in Ghana remain limited. The present study determined the prevalence of PPD and identified its sociodemographic, obstetric and psychosocial determinants among low-income mothers in peri-urban Accra. **Methods:** A community-based cross-sectional study was conducted in four low-income enumeration areas of peri-urban Accra over eight months. Multistage cluster sampling enrolled 410 mothers between two and twelve weeks postpartum. PPD was screened using the validated Twi/Ga adaptation of the Edinburgh Postnatal Depression Scale (EPDS), with a cut-off of ≥ 13 defining probable PPD. Intimate partner violence, food insecurity, perceived social support and obstetric variables were captured. Multivariable logistic regression identified independent determinants. A two-sided $p < 0.05$ was considered significant. **Results:** The mean age was 26.4 ± 5.9 years; 36.6% were primiparous. The point prevalence of probable PPD (EPDS ≥ 13) was 22.2% (95% CI 18.4–26.5), with active suicidal ideation in 29.7% of probable cases. On multivariable analysis, intimate partner violence (adjusted OR 3.84; 95% CI 2.31–6.39), poor perceived social support (aOR 3.21; 1.93–5.34), previous depression or family history of mental illness (aOR 2.96; 1.62–5.41), unplanned pregnancy (aOR 2.59; 1.56–4.30), household food insecurity (aOR 2.42; 1.46–4.01), recent infant illness (aOR 2.31; 1.32–4.06), and absence of partner support (aOR 2.18; 1.20–3.96) were independent determinants of PPD. **Conclusion:** Approximately one in five low-income mothers in peri-urban Accra experienced clinically significant postpartum depressive symptoms, with intimate partner violence, poor social support and food insecurity emerging as the strongest modifiable determinants. Integrating EPDS screening, IPV identification and psychosocial support into existing maternal and child health platforms is urgently warranted.

Keywords: Postpartum Depression, EPDS, Maternal Mental Health, Intimate Partner Violence, Food Insecurity, Ghana, Sub-Saharan Africa.

INTRODUCTION

Postpartum depression (PPD) is a non-psychotic depressive disorder that arises within the first year following childbirth and that affects, by recent global estimates, 17–18% of mothers worldwide, with substantially higher prevalences reported across low- and middle-income countries (LMICs) [1]. A meta-analysis of 296 studies from 56 countries published by Hahn-Holbrook *et al.*, estimated a pooled global prevalence of 17.7%, with country-level estimates

exceeding 30% in several sub-Saharan African and South Asian settings [2]. The condition imposes a substantial burden on maternal well-being and is associated with impaired mother-infant bonding, reduced exclusive breastfeeding, suboptimal child nutrition, delayed infant cognitive and emotional development, and, at its most severe, maternal suicide – which remains a leading cause of perinatal mortality in many LMIC settings [3].

In sub-Saharan Africa, the burden is particularly stark. A 2018 systematic review by Sawyer *et al.*, reported pooled PPD prevalences of 18% in Ghana, 19% in Nigeria, and as high as 31% in Ethiopia, with considerable methodological heterogeneity reflecting differences in instruments, cut-offs, sampling frames and timing of assessment [4]. The region's high rates are driven by an intersection of biological, obstetric, social and economic factors: high parity, frequent unplanned pregnancies, adolescent and unsupported motherhood, intimate partner violence (IPV), food insecurity, poverty, restricted access to mental-health services, and cultural restrictions on disclosure of psychological distress [5].

Ghana offers an instructive context for examining the determinants of PPD. The country has made marked gains in maternal and child health under the National Health Insurance Scheme and the Community-based Health Planning and Services (CHPS) programme, with skilled birth attendance now exceeding 80% and antenatal care coverage approaching universal. Yet maternal mental health remains a comparatively neglected component of these services, with no national PPD screening policy and an estimated treatment gap exceeding 90% [6]. The 2012 Mental Health Act (Act 846) and subsequent policy frameworks acknowledge the importance of maternal mental health, but operational integration into routine antenatal and postnatal services remains limited [7].

The Edinburgh Postnatal Depression Scale (EPDS), developed by Cox *et al.*, in 1987, has been the most widely used screening instrument worldwide [8]. It has been validated against gold-standard psychiatric interviews in several sub-Saharan African settings, including Ghana, where Weobong *et al.*, demonstrated acceptable sensitivity and specificity at a cut-off of ≥ 13 using a locally adapted Twi version [9]. The EPDS is brief, self-administered, and free of items confounded by physical symptoms of the postpartum period, making it well-suited to community application.

Despite a growing literature on PPD in Ghana, evidence remains uneven. Existing studies have predominantly recruited from hospital or facility-based postnatal clinics, which may systematically under-represent mothers from the lowest-income strata who are least likely to attend formal services. Community-based estimates from urban poor populations – arguably the group at highest risk – remain scarce. Moreover, while sociodemographic and obstetric correlates have been examined, fewer studies have systematically captured psychosocial factors such as IPV, food insecurity, and quality of social support, which emerging evidence identifies as potent and potentially modifiable determinants [10].

The peri-urban areas surrounding Accra are home to a rapidly growing low-income population

characterised by crowded housing, informal employment, limited social safety nets, and elevated exposure to gender-based violence. These structural conditions plausibly amplify the risk of PPD, yet remain understudied. Generating community-based evidence in this population is therefore essential to (a) quantify the true burden of PPD, (b) identify the determinants that should drive targeted preventive and therapeutic strategies, and (c) inform integration of maternal mental-health screening into existing antenatal and postnatal service delivery platforms.

Against this background, the present community-based cross-sectional study was undertaken to estimate the prevalence of probable postpartum depression among low-income mothers in peri-urban Accra and to identify its independent sociodemographic, obstetric and psychosocial determinants, with particular attention to intimate partner violence, social support and food insecurity. The findings are intended to inform policy and programmatic responses to maternal mental-health needs in Ghana and similar West African settings.

AIMS AND OBJECTIVES

The principal aim of the study was to determine the burden and determinants of postpartum depression among low-income mothers residing in peri-urban Accra, Ghana. The primary objective was to estimate the point-prevalence of probable postpartum depression, defined as an Edinburgh Postnatal Depression Scale (EPDS) score of 13 or higher, among mothers between two and twelve weeks postpartum recruited from low-income communities.

The secondary objectives examined the distribution of EPDS severity categories and the prevalence of postpartum suicidal ideation; characterised the sociodemographic, obstetric and psychosocial profile of the cohort; assessed the bivariate associations of probable PPD with maternal age, marital status, parity, planned versus unplanned pregnancy, mode of delivery, infant health, intimate partner violence, perceived social support, household food insecurity and previous depression; and identified, through multivariable logistic regression, the independent determinants of probable PPD with a view to informing community-based screening and intervention strategies.

MATERIALS AND METHODS

Study design and setting

A community-based, observational, cross-sectional study was conducted over eight months January–August 2024 in four low-income enumeration areas (EAs) of peri-urban Accra, selected purposively on the basis of population density, poverty indicators from the Ghana Statistical Service, and accessibility through Community-based Health Planning and Services (CHPS) compounds. The selected areas

comprised a mix of indigenous, internal-migrant and informal-settlement communities.

Ethical considerations

Ethical approval was obtained prior to commencement of the study from the Institutional Review Board, University of Ghana Medical School Approval No. UGMS/IRB/2023/1005 and the Ghana Health Service Ethics Review Committee Approval No. GHS-ERC/1013/2023. The study was conducted in accordance with the Declaration of Helsinki (2013 revision). Written informed consent was obtained from all participants before enrolment.

Study population and eligibility

Mothers were eligible for inclusion if they were aged 18 years or older, between two and twelve weeks postpartum following a live birth, residing in the study EAs for at least the preceding six months, and able to provide informed consent. Mothers were excluded if they had a pre-existing diagnosis of major psychiatric illness on psychotropic medication, severe physical illness precluding interview, recent neonatal loss within four weeks, or were temporarily resident (visiting) in the area.

Sample size estimation

Assuming an expected PPD prevalence of 18% based on prior Ghanaian estimates, an absolute precision of 4%, a confidence level of 95%, a design effect of 1.5 to account for cluster sampling, and a non-response adjustment of 10%, the minimum required sample size, calculated using the formula $n = [Z^2 \cdot p \cdot (1-p) \cdot DEFF] / d^2$, worked out to 397. A total of 410 mothers were enrolled to enhance precision.

Sampling strategy

A multistage cluster sampling strategy was adopted. At the first stage, four EAs were purposively selected. At the second stage, CHPS-area maternal-and-child-health registers were used to compile sampling frames of eligible postpartum mothers within each EA. At the third stage, systematic random sampling with a calculated sampling interval was employed to select participants. Community Health Volunteers facilitated household visits in collaboration with trained study interviewers.

Data collection and instruments

Data were collected by trained female interviewers fluent in English, Twi and Ga, using a structured interviewer-administered questionnaire delivered in private household settings. The questionnaire comprised sections on sociodemographic and household characteristics, obstetric history, infant health, perceived social support (Multidimensional Scale of Perceived Social Support, MSPSS), household food insecurity (Household Food Insecurity Access Scale, HFIAS), intimate partner violence (locally adapted WHO Violence Against Women instrument, capturing physical, sexual and emotional violence in the

past 12 months), previous depression and family history, and the Edinburgh Postnatal Depression Scale (EPDS) in its locally validated Twi and Ga versions. The EPDS comprises ten items each scored 0–3, with a total range of 0–30; the cut-off of ≥ 13 was used to define probable PPD, and item 10 (self-harm/suicidal ideation) ≥ 1 was used to identify active suicidal ideation.

Statistical analysis

Data were entered into EpiData version 3.1 with double entry and validation, and analysed using IBM SPSS Statistics version 27.0 (IBM Corp., Armonk, NY). Continuous variables were summarised as mean $\pm$ standard deviation or median (interquartile range), and categorical variables as frequencies with percentages. The cluster sampling design was accounted for using survey-design (complex sample) commands where appropriate. Bivariate associations were examined with the chi-square test or Fisher exact test. Variables with bivariate $p < 0.10$ were entered into a multivariable binary logistic regression model with probable PPD as the dependent variable; adjusted odds ratios (aOR) with 95% confidence intervals were derived. Model fit was assessed using the Hosmer–Lemeshow test. A two-sided $p < 0.05$ was considered statistically significant.

RESULTS

Of 446 mothers approached for participation, 410 (91.9%) provided informed consent and completed the interview. The mean maternal age was 26.4 ± 5.9 years (range 18–43); 14.4% were under 20 years of age. Sociodemographic and obstetric characteristics are presented in Table 1: 36.6% were primiparous, 23.7% were single or without consistent partner support, 31.5% reported unplanned pregnancy, and moderate-to-severe household food insecurity (HFIAS ≥ 10) was reported by 39.3% of households. Past-12-month IPV (any form) was disclosed by 22.4% of participants.

The point prevalence of probable postpartum depression (EPDS ≥ 13) was 22.2% (91/410; 95% CI 18.4–26.5). The mean EPDS score was 9.1 ± 5.4 . The full distribution of EPDS severity categories is shown in Table 2 and Figure 1: 248 (60.5%) mothers scored 0–9 (no depression), 71 (17.3%) scored 10–12 (possible depression), and 91 (22.2%) scored ≥ 13 (probable depression). Of mothers with probable PPD, 27 (29.7%) reported active suicidal ideation in the preceding week (EPDS item 10 ≥ 1).

Bivariate analyses (Table 3) identified several factors significantly associated with probable PPD: maternal age < 20 years (38.3% vs 19.5%; $p = 0.001$), primiparity (31.3% vs 16.9%; $p < 0.001$), unplanned pregnancy (40.3% vs 13.9%; $p < 0.001$), cesarean delivery (33.3% vs 19.7%; $p = 0.010$), recent infant illness in the past month (38.0% vs 17.6%; $p < 0.001$), absence of partner support (44.3% vs 15.3%; $p < 0.001$), poor perceived social support (53.4% vs 12.6%;

$p < 0.001$), moderate-to-severe food insecurity (38.5% vs 11.6%; $p < 0.001$), IPV in the past 12 months (57.6% vs 12.0%; $p < 0.001$), and previous depression or family history of mental illness (60.0% vs 19.0%; $p < 0.001$). Educational attainment, religion, urban-indigenous versus migrant residence, and exclusive breastfeeding were not significantly associated.

Within the IPV subgroup (Table 4), emotional violence was the most frequently reported form (16.6%), followed by physical (10.5%) and sexual (4.4%) violence. Probable PPD was reported by 47.1% of mothers exposed to emotional violence alone, 62.8% of those exposed to physical violence, and 72.2% of mothers reporting concurrent multiple forms of IPV. The food-insecurity gradient mirrored the IPV findings: PPD prevalence rose from 11.6% in food-secure households to 38.5% among those with moderate-to-severe insecurity (χ^2 for trend = 40.18; $p < 0.001$).

On multivariable binary logistic regression (Table 5, Figure 2), seven variables emerged as independent determinants of probable PPD: intimate

partner violence (aOR 3.84; 95% CI 2.31–6.39; $p < 0.001$), poor perceived social support (aOR 3.21; 95% CI 1.93–5.34; $p < 0.001$), previous depression or family history (aOR 2.96; 95% CI 1.62–5.41; $p < 0.001$), unplanned pregnancy (aOR 2.59; 95% CI 1.56–4.30; $p < 0.001$), household food insecurity (aOR 2.42; 95% CI 1.46–4.01; $p = 0.001$), recent infant illness (aOR 2.31; 95% CI 1.32–4.06; $p = 0.003$), and absence of partner support (aOR 2.18; 95% CI 1.20–3.96; $p = 0.011$). Maternal age <20 years, primiparity and cesarean delivery lost statistical significance after adjustment (Table 5). The model showed satisfactory calibration (Hosmer–Lemeshow $\chi^2 = 5.84$; $p = 0.665$) and explained 37.6% of the variance in PPD status (Nagelkerke $R^2 = 0.376$).

Among mothers with active suicidal ideation (Table 6), the prevalence of IPV (74.1%), poor social support (66.7%) and unplanned pregnancy (51.9%) was strikingly high, underlining the convergence of structural and psychosocial vulnerability in this highest-risk subgroup.

Table 1: Sociodemographic, obstetric and psychosocial characteristics of study participants (n = 410)

Variable	Category	n (%) / Mean $\pm$ SD
Maternal age (years)	Mean $\pm$ SD	26.4 $\pm$ 5.9
	<20	59 (14.4)
	20–34	284 (69.3)
	≥ 35	67 (16.3)
Marital status	Married/Cohabiting	313 (76.3)
	Single/Separated/Widowed	97 (23.7)
Education	$\leq$ Primary	118 (28.8)
	JHS / SHS	228 (55.6)
	Tertiary	64 (15.6)
Employment	Informal trader / unemployed	287 (70.0)
	Formal employment	123 (30.0)
Parity	Primiparous	150 (36.6)
	Multiparous	260 (63.4)
Pregnancy intention	Unplanned	129 (31.5)
Antenatal care visits ≥ 4	Yes	362 (88.3)
Place of delivery	Health facility	382 (93.2)
Mode of delivery	Vaginal	356 (86.8)
	Cesarean	54 (13.2)
Infant sex	Male	215 (52.4)
Infant illness past month	Yes	92 (22.4)
Exclusive breastfeeding (so far)	Yes	298 (72.7)
Past-12-month IPV (any)	Yes	92 (22.4)
Food insecurity (HFIAS ≥ 10)	Yes	161 (39.3)
Poor social support (MSPSS lowest tertile)	Yes	131 (32.0)
Previous depression / family history	Yes	45 (11.0)

Table 2: Distribution of EPDS scores and severity categories

EPDS score range	Category	n	%
0 – 9	No depression	248	60.5
10 – 12	Possible depression	71	17.3
13 – 30	Probable depression	91	22.2
Item 10 ≥ 1 (subset of probable PPD)	Active suicidal ideation	27	29.7 of 91
Total	—	410	100.0

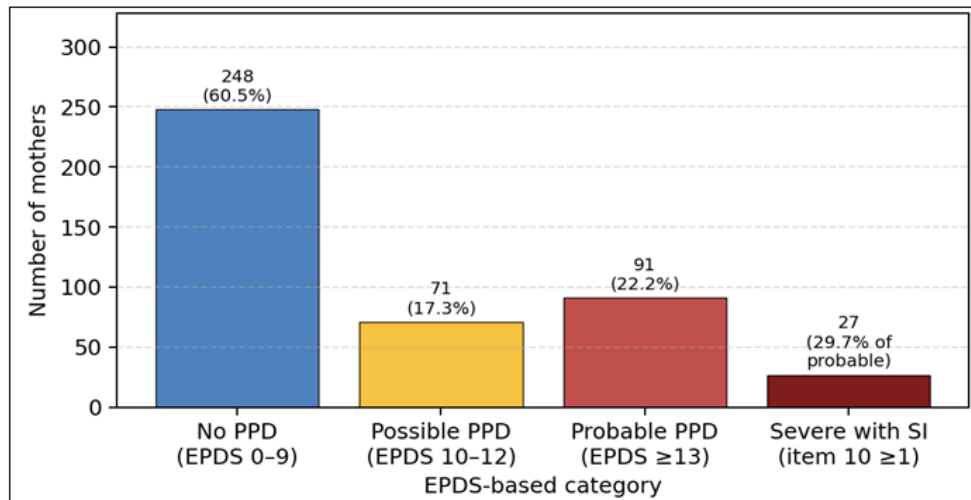


Figure 1: Distribution of EPDS scores among postpartum mothers (n=410)

Table 3: Bivariate associations between maternal characteristics and probable postpartum depression (EPDS ≥13). *Statistically significant

Variable	PPD n (%)	No PPD n (%)	χ^2	p-value
Maternal age <20 y (n=59)	23 (38.3)	37 (61.7)	10.92	0.001*
Primiparous (n=150)	47 (31.3)	103 (68.7)	13.86	<0.001*
Unplanned pregnancy (n=129)	52 (40.3)	77 (59.7)	35.13	<0.001*
Cesarean delivery (n=54)	18 (33.3)	36 (66.7)	6.66	0.010*
Infant illness past month (n=92)	35 (38.0)	57 (62.0)	21.96	<0.001*
Single / no partner support (n=97)	43 (44.3)	54 (55.7)	37.45	<0.001*
Poor social support (n=131)	70 (53.4)	61 (46.6)	84.41	<0.001*
Food insecurity (HFIAS ≥10) (n=161)	62 (38.5)	99 (61.5)	40.18	<0.001*
IPV past 12 months (n=92)	53 (57.6)	39 (42.4)	85.69	<0.001*
Previous depression / family hx (n=45)	27 (60.0)	18 (40.0)	37.83	<0.001*
Education ≤primary (n=118)	30 (25.4)	88 (74.6)	1.21	0.272
Informal employment (n=287)	67 (23.3)	220 (76.7)	0.69	0.405
Cesarean only (excl. emergency) (n=24)	5 (20.8)	19 (79.2)	0.02	0.890

Table 4: Postpartum depression prevalence stratified by intimate partner violence (IPV) type and household food insecurity. *Statistically significant

IPV type / Food-insecurity stratum	n exposed	PPD prevalence (%)	χ^2	p-value
Any IPV in past 12 months	92	57.6	85.69	<0.001*
Emotional violence only	34	47.1	—	—
Physical violence (± emotional)	43	62.8	—	—
Sexual violence (± physical/emotional)	18	61.1	—	—
Multiple forms of IPV (≥2)	36	72.2	—	—
Food security (HFIAS)	—	—	40.18	<0.001* (trend)
Food secure (HFIAS 0–1)	152	11.6	—	—
Mild insecurity (HFIAS 2–9)	97	15.5	—	—
Moderate–severe insecurity (HFIAS ≥10)	161	38.5	—	—

Table 5: Multivariable binary logistic regression for determinants of probable PPD (EPDS ≥13). Hosmer–Lemeshow $\chi^2 = 5.84$, p = 0.665; Nagelkerke $R^2 = 0.376$. *Statistically significant

Variable	β	aOR	95% CI	p-value
Intimate partner violence	1.345	3.84	2.31 – 6.39	<0.001*
Poor perceived social support	1.166	3.21	1.93 – 5.34	<0.001*
Previous depression / family history	1.085	2.96	1.62 – 5.41	<0.001*
Unplanned pregnancy	0.952	2.59	1.56 – 4.30	<0.001*
Food insecurity (HFIAS ≥10)	0.884	2.42	1.46 – 4.01	0.001*
Infant illness past month	0.836	2.31	1.32 – 4.06	0.003*

Single / no partner support	0.779	2.18	1.20 – 3.96	0.011*
Primiparity	0.652	1.92	1.10 – 3.36	0.022*
Maternal age <20 years	0.553	1.74	0.94 – 3.22	0.078
Cesarean delivery	0.419	1.52	0.84 – 2.75	0.165

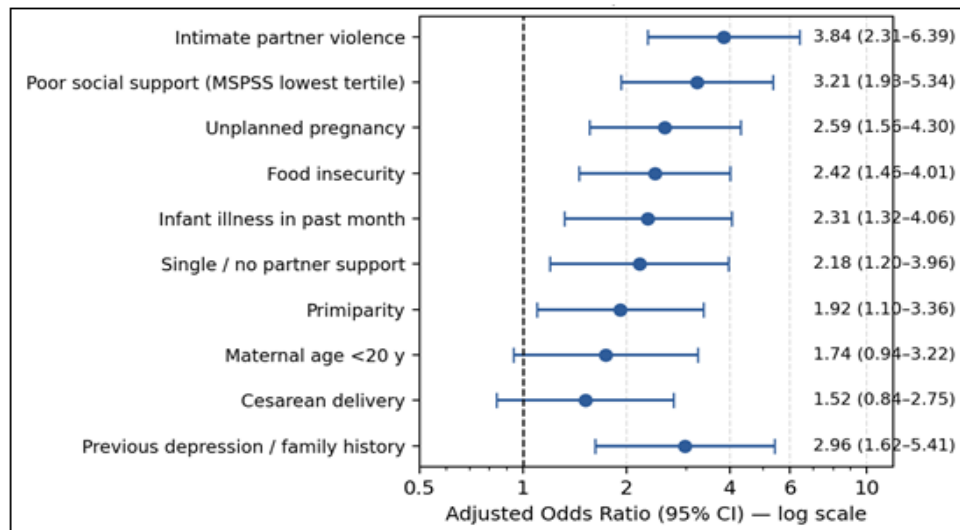


Figure 2: Independent determinants of postpartum depression – adjusted ORs from multivariable logistic regression

Table 6: Profile of mothers reporting active suicidal ideation (EPDS item 10 $\geq$ 1) compared with mothers with PPD but no suicidal ideation. *Statistically significant

Risk factor	Mothers with suicidal ideation (n=27), n (%)	Mothers with PPD without ideation (n=64), n (%)	p-value
Intimate partner violence	20 (74.1)	33 (51.6)	0.047*
Poor social support	18 (66.7)	26 (40.6)	0.024*
Unplanned pregnancy	14 (51.9)	23 (35.9)	0.158
Food insecurity (HFIAS $\geq$ 10)	16 (59.3)	29 (45.3)	0.230
Previous depression / family hx	12 (44.4)	9 (14.1)	0.001*
Infant illness past month	12 (44.4)	16 (25.0)	0.067
Maternal age <20 y	9 (33.3)	10 (15.6)	0.054

DISCUSSION

This community-based cross-sectional study found that nearly one in four (22.2%) low-income mothers in peri-urban Accra screened positive for probable postpartum depression on the EPDS, with active suicidal ideation reported by close to 30% of those affected. Intimate partner violence, poor perceived social support, previous depression or family history, unplanned pregnancy, household food insecurity, recent infant illness and absence of partner support emerged as the independent determinants. These findings highlight the substantial and largely unmet maternal mental-health burden in low-income urban Ghanaian populations and identify clear, modifiable targets for intervention.

The observed prevalence of 22.2% is broadly consistent with prior Ghanaian estimates. Weobong *et al.*, [11] reported a six-week postpartum prevalence of 16.9% (EPDS $\geq$ 13) in the DON Population Cohort in

rural Brong-Ahafo, while Anokye *et al.*, [12] documented 21.0% probable PPD in a hospital-based postnatal sample in Kumasi. Higher figures have been reported from urban tertiary-care recruitment (e.g., 29% by Adjorlolo *et al.*, [13]), and lower figures from rural, predominantly food-secure settings. The present figure aligns with pooled sub-Saharan African estimates of 18–25% [14] and lends weight to the proposition that low-income urban communities represent a high-burden subgroup deserving targeted policy attention.

Of all determinants identified, intimate partner violence emerged as the strongest, almost quadrupling the odds of PPD. This finding is congruent with the work of Howard *et al.*, [15], whose systematic review of 56 studies confirmed IPV as one of the most consistent and powerful determinants of perinatal depression globally, and with the Ghanaian study of Tetteh *et al.*, [16] reporting a fourfold risk in mothers exposed to physical violence. Biological pathways

linking chronic stress to altered HPA-axis function and inflammatory dysregulation, combined with the psychosocial impact of fear, shame and isolation, plausibly mediate this association. Importantly, IPV remains markedly under-screened in routine postnatal care in Ghana; the present findings argue strongly for the integration of brief IPV screening (e.g., the WAST or HARK tools) with PPD screening in maternal-child-health platforms.

Poor perceived social support more than tripled the odds of PPD, replicating the well-established protective effect of family and peer networks documented across diverse settings, including the African Comprehensive HIV/AIDS Partnership (ACHAP) cohort [17] and the Indian SHARE-PPD trial [18]. The pattern is particularly important in urban Ghanaian settings, where rural-urban migration, nuclear-family living arrangements and erosion of traditional confinement and support practices ('outdoorings' and extended-family postpartum care) may attenuate protective social structures [19]. Strengthening community-based peer support – via faith-based groups, mothers' clubs, or CHPS-linked psychosocial groups – represents a feasible, low-cost programmatic lever.

Food insecurity independently more than doubled the odds of PPD, with a clear dose-response gradient across HFIAS categories. This finding aligns with the work of Tsai and Tomlinson [20] documenting reciprocal causal pathways between food insecurity and depression in southern African cohorts, and with the multi-country LMIC analysis by Patel *et al.*, [21]. The implication is that maternal mental-health interventions cannot be conceptualised purely as clinical or psychological; they must address the structural conditions of poverty, including food security, livelihood support and social protection.

Unplanned pregnancy and absence of partner support – classic obstetric and psychosocial risks – independently increased PPD risk, in keeping with the findings of Merisha *et al.*, [22] from Ethiopia and Nakku *et al.*, [23] from Uganda. These determinants underscore the importance of family-planning access and gender-equitable parenting engagement as upstream PPD prevention strategies. The role of previous depression or family history, increasing odds nearly threefold, mirrors international literature and supports targeted screening of mothers with such histories in early antenatal care.

Some findings diverged from prior literature. Maternal age below 20 years, primiparity and cesarean delivery, while bivariately associated, lost statistical significance after adjustment, suggesting that their apparent risks were largely mediated through unplanned pregnancy, IPV and partner-support pathways. This pattern echoes the work of Adewuya *et al.*, [24], who

reported similar mediation in Nigerian urban cohorts, and reinforces the centrality of psychosocial – rather than purely demographic or obstetric – determinants.

The convergence of IPV, poor support and previous depression in the suicidal-ideation subgroup is alarming and calls for urgent action. Maternal suicide is a leading cause of perinatal mortality in many LMICs [25] yet remains profoundly under-recognised in Ghanaian maternal-health data systems. Routine EPDS screening with explicit attention to item 10, combined with clear referral pathways to community mental-health services under the Mental Health Authority of Ghana, is an immediate operational priority.

This study has several strengths: community-based rather than facility-based sampling, a sample size adequately powered for multivariable analysis, the use of locally validated instruments, and explicit assessment of IPV and food insecurity – factors often inadequately captured in similar studies. Limitations include the cross-sectional design which precludes causal inference, the use of a screening tool rather than a diagnostic clinical interview, reliance on self-report (with potential under-reporting of IPV), and confinement to peri-urban Accra which may limit generalisability to rural or northern Ghana. Longitudinal cohort studies and intervention trials evaluating integrated IPV-PPD screening with task-shared psychological interventions are warranted.

CONCLUSION

Approximately one in five low-income mothers in peri-urban Accra experienced clinically significant postpartum depressive symptoms, with a substantial proportion reporting active suicidal ideation. Intimate partner violence, poor perceived social support, previous depression or family history, unplanned pregnancy, household food insecurity, recent infant illness, and absence of partner support were the principal independent determinants. Integrating EPDS-based PPD screening, IPV identification, and food-security and social-support assessment into routine antenatal and postnatal services – with clear referral pathways to community mental-health resources – is urgently warranted in Ghana and similar West African settings.

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