



A Comparative Study of Postpartum Depression Prevalence, Risk Factors, and Cultural Perceptions in India and Ghana (with special reference to Lucknow and Accra): A Review.

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Postpartum depression (PPD) is a pervasive global mental health challenge, significantly impacting maternal well-being, child development, and family dynamics. While extensively studied in Western contexts, there remains a critical dearth of knowledge regarding PPD's prevalence, associated risk factors, and nuanced cultural perceptions in low- and middle-income countries (LMICs). India and Ghana, two nations with distinct cultural matrices and evolving healthcare landscapes, offer unique opportunities for comparative analysis. This review aims to conduct a comprehensive comparative study of postpartum depression prevalence, risk factors, and cultural perceptions in India and Ghana, with a specific focus on urban centers: Lucknow (India) and Accra (Ghana). The review seeks to synthesize existing literature to identify commonalities and differences across these two diverse settings. A systematic review approach will be employed, drawing from published literature in medical, psychological, sociological, and public health databases. Studies focusing on PPD prevalence, psychosocial and biological risk factors, and qualitative research exploring cultural beliefs and practices related to postpartum mental health in India (specifically Lucknow) and Ghana (specifically Accra) will be included. This review reveals varying reported PPD prevalence rates between Lucknow and Accra, influenced by diverse methodological approaches and screening tools. Key risk factors include socioeconomic disparities, lack of social support, domestic violence, and pre-existing mental health conditions, though their relative emphasis and manifestation may differ culturally. Furthermore, the review highlights how traditional beliefs about childbirth, gender roles, and community support systems shape the recognition, interpretation, and management of PPD in both contexts. Cultural perceptions range from spiritual explanations to stigmatization, impacting help-seeking behaviors. A comparative understanding of PPD in Lucknow and Accra underscores the imperative for culturally tailored interventions and policy development. The findings will contribute valuable insights into the global epidemiology of PPD, emphasizing the need for context-specific approaches to screening, prevention, and treatment strategies in diverse LMIC settings. This review will serve as a foundational step towards improving maternal mental health outcomes in India and Ghana and inform broader global health initiatives.

Keywords: *Postpartum Depression, India, Ghana, Cultural Perceptions, Risk Factors.*



1. Introduction

Postpartum depression (PPD) is a significant mental health disorder affecting women globally, characterized by a range of depressive symptoms that emerge after childbirth, often within the first few weeks or months, and can persist for an extended period if untreated (American Psychiatric Association, 2013). These symptoms, which may include persistent sadness, anxiety, irritability, feelings of guilt or worthlessness, sleep disturbances, appetite changes, and difficulty bonding with the infant, can severely impair maternal functioning, child development, and overall family well-being (World Health Organization, 2017). While once underestimated, the global burden of PPD is now widely recognized, with prevalence rates varying considerably across different regions and populations, influenced by a complex interplay of biological, psychological, and sociocultural factors (Fisher et al., 2012).

Despite increasing research attention, the understanding of PPD remains disproportionately concentrated in Western industrialized nations, leaving significant gaps in knowledge regarding its manifestation, risk factors, and cultural perceptions in low- and middle-income countries (LMICs). This disparity is particularly concerning given that approximately 99% of maternal deaths and a substantial proportion of global births occur in LMICs, where women often face unique socioeconomic stressors, limited access to healthcare, and differing cultural expectations surrounding motherhood (Alkema et al., 2017; Gureje et al., 2014). The lack of culturally sensitive research and interventions in these settings contributes to underdiagnosis, delayed treatment, and consequently, poorer outcomes for both mothers and children.

India and Ghana, two rapidly developing nations with rich and diverse cultural landscapes, present compelling case studies for a comparative examination of PPD. Both countries are undergoing significant demographic and

epidemiological transitions, yet their healthcare systems, societal norms, and traditional practices related to childbirth and maternal care differ considerably. In India, a vast country with a population exceeding 1.4 billion, cultural practices such as joint family systems, gender roles, and traditional postpartum confinement practices (e.g., "chhatti" or "sutika") can profoundly influence a woman's postpartum experience and her susceptibility to PPD (Patel et al., 2008). Specifically, Lucknow, a prominent city in Uttar Pradesh, India, offers a valuable regional focus to explore the nuances of PPD within an Indian context. Similarly, Ghana, a West African nation with a population of over 30 million, boasts a mosaic of ethnic groups, each with distinct cultural beliefs and rituals surrounding pregnancy, childbirth, and the postpartum period (Dako-Gyeke & Oduro, 2013). Accra, the capital city of Ghana, serves as a crucial urban center for investigating PPD in the Ghanaian setting, reflecting both traditional influences and the impacts of modernization.

Previous research, though limited, suggests that the prevalence of PPD in India and Ghana may be comparable to or even higher than that reported in Western countries, yet the specific risk factors and the ways in which PPD is perceived and addressed culturally remain underexplored (Chandran et al., 2002; Adewuya et al., 2007). Understanding these contextual variations is critical for developing culturally appropriate screening tools, prevention strategies, and treatment interventions that are both effective and acceptable to the affected populations.

This review aims to conduct a comparative study of postpartum depression prevalence, risk factors, and cultural perceptions in India and Ghana, with special reference to Lucknow and Accra. By systematically synthesizing existing literature, this review seeks to determine and compare the reported prevalence rates of PPD in these two regions, identify and analyze the common and distinct risk factors associated with PPD in Indian

(Lucknow) and Ghanaian (Accra) contexts and explore the prevailing cultural understandings, beliefs, and practices surrounding PPD in these diverse settings. Through this comparative lens, we aim to highlight the shared challenges and unique considerations in addressing PPD in LMICs, ultimately contributing to a more nuanced global understanding of this critical maternal mental health issue.

2. Statement of the Problem

Postpartum depression (PPD) represents a significant global public health challenge, impacting an estimated 10-20% of women worldwide, though this figure is likely higher in low- and middle-income countries (LMICs) (Fisher et al., 2012; World Health Organization, 2017). The consequences of untreated PPD are far-reaching, extending beyond the mother's immediate suffering to compromise infant development, disrupt family cohesion, and impose substantial long-term societal costs (American Psychiatric Association, 2013). Despite its pervasive nature and severe ramifications, the understanding, recognition, and management of PPD remain critically underdeveloped in many non-Western contexts.

Existing research on PPD has predominantly focused on high-income Western countries, creating a significant geographical and cultural bias in the current body of knowledge. This limits the generalizability of findings and the applicability of Western-centric interventions to diverse global populations. Women in LMICs often face a unique constellation of stressors, including poverty, limited access to healthcare, nutritional deficiencies, gender inequality, and different cultural expectations surrounding motherhood, all of which can profoundly influence their vulnerability to and experience of PPD (Gureje et al., 2014; Patel et al., 2008). Consequently, the specific prevalence, contextual risk factors, and culturally-mediated perceptions of PPD in these regions remain largely underexplored and poorly understood.

Specifically, India and Ghana, while both LMICs, represent distinct cultural, socioeconomic, and healthcare environments. In India, a country with immense diversity, the social fabric, traditional postpartum practices, and the structure of family support (e.g., joint vs. nuclear families) in regions

like Lucknow can significantly shape a woman's postpartum mental health (Patel et al., 2008). Similarly, in Ghana, traditional beliefs, community structures, and healthcare access in urban centers like Accra contribute to a unique backdrop against which PPD manifests (Dako-Gyeke & Oduro, 2013). Crucially, the limited data available on PPD from these specific urban settings often lack detailed comparative analysis, hindering the development of targeted, culturally sensitive interventions. Without a clear understanding of the unique interplay of biological, psychological, and sociocultural factors contributing to PPD in Lucknow and Accra, and how PPD is locally understood and managed, current public health efforts risk being ineffective, irrelevant, or even harmful.

Therefore, there is an urgent need for a comparative investigation into the prevalence, specific risk factors, and cultural perceptions of PPD in India (with special reference to Lucknow) and Ghana (with special reference to Accra). Such a study will not only address significant gaps in the global literature but also provide crucial evidence-based insights necessary for the design of contextually appropriate screening tools, prevention strategies, and treatment programs, ultimately improving maternal mental health outcomes and promoting healthier families in these critically underserved populations.

3. Need of the Review

Despite the escalating recognition of postpartum depression (PPD) as a global health priority, significant knowledge gaps persist, particularly concerning its manifestation and management in diverse cultural contexts. While numerous studies address PPD in Western populations, their findings often lack direct applicability to low- and middle-income countries (LMICs) due to profound differences in socioeconomic determinants, healthcare infrastructure, and cultural interpretations of health and illness (Fisher et al., 2012; Gureje et al., 2014). This imbalance in research has led to an incomplete global picture of PPD, hindering the development of truly universal and equitable maternal mental health strategies.

Specifically, there is a pressing need for a comprehensive review that directly compares PPD in distinct LMIC settings. Existing literature on

PPD in India and Ghana, while growing, often consists of isolated studies that do not facilitate direct comparative analysis of prevalence, risk factors, or cultural perceptions across these regions. For instance, while some studies highlight specific risk factors in India (Patel et al., 2008) and others in Ghana (Dako-Gyeke & Oduro, 2013), a synthesis that critically examines how these factors converge or diverge, and how cultural narratives uniquely shape the PPD experience in urban centers like Lucknow and Accra, is conspicuously absent. Such a comparative review is essential for several reasons:

This review will directly address the geographical and cultural bias in PPD research by systematically compiling and comparing data from two distinct LMICs. By focusing on Lucknow and Accra, it will provide granular insights into regional variations that might otherwise be overlooked in broader national or continental analyses.

Understanding the specific cultural perceptions of PPD including local terminologies, traditional coping mechanisms, beliefs about causality, and stigma is paramount for designing interventions that are not only clinically effective but also culturally acceptable and accessible (WHO, 2017). A comparative review will highlight common cultural barriers and facilitators, allowing for the adaptation of global best practices to local realities.

By comparing the prevalence and psychosocial, economic, and biological risk factors associated with PPD in Lucknow and Accra, this review will identify both universal stressors and context-specific vulnerabilities. This detailed understanding is crucial for developing targeted screening tools and prevention programs that allocate resources effectively based on the most salient risk factors in each setting.

Policymakers and public health officials in India and Ghana require context-specific data to make informed decisions regarding maternal mental health. This review will provide a synthesized evidence base that can guide the development of national and regional mental health policies, inform training for healthcare professionals, and advocate for appropriate resource allocation to address PPD effectively in diverse urban environments.

By systematically mapping the existing knowledge and identifying key areas of convergence and divergence, this review will clearly delineate

remaining research gaps. This will provide a roadmap for future primary research studies, encouraging more focused and relevant investigations into PPD in LMICs.

In conclusion, this comparative review is not merely an academic exercise; it is a critical endeavor poised to provide actionable insights into the complex epidemiology and lived experience of PPD in two significant LMICs. By bridging existing knowledge gaps, it aims to contribute substantively to the global effort to improve maternal mental health outcomes and ensure healthier futures for mothers, infants, and families in India and Ghana.

4. Objectives of the Review

This comprehensive comparative review aims to systematically synthesize existing literature on postpartum depression (PPD) in India (with special reference to Lucknow) and Ghana (with special reference to Accra). Specifically, the objectives are:

- To determine and compare the reported prevalence rates of postpartum depression among women in Lucknow, India, and Accra, Ghana, drawing from available studies.
- To identify and analyze the common and distinct psychosocial, economic, and biological risk factors associated with PPD in the specific urban contexts of Lucknow, India, and Accra, Ghana.
- To explore and compare the prevailing cultural perceptions, beliefs, and practices surrounding PPD in Lucknow, India, and Accra, Ghana, including local understandings of symptoms, help-seeking behaviors, and traditional coping mechanisms.
- To highlight the implications of these comparative findings for the development of culturally sensitive and context-specific screening tools, prevention strategies, and treatment interventions for PPD in low- and middle-income country settings.

5. Research Questions

- What are the reported prevalence rates of postpartum depression (PPD) among women in Lucknow, India, and Accra, Ghana, and how do they compare?

- What are the common and distinct psychosocial, economic, and biological risk factors associated with PPD in Lucknow, India, compared to Accra, Ghana?
- How are postpartum depression and its symptoms culturally perceived, understood, and addressed by women, families, and communities in Lucknow, India, compared to Accra, Ghana?

6. Operational Definitions

For the purpose of this comparative review, the following terms are operationally defined as:

6.1. Postpartum Depression (PPD):

Refers to a non-psychotic depressive episode with onset during pregnancy or within four weeks following childbirth (as per ICD-10 or DSM-5 diagnostic criteria). In studies using screening tools, a positive screen for PPD will be defined by the validated cutoff scores used by the respective study (e.g., Edinburgh Postnatal Depression Scale [EPDS] score ≥ 10 or ≥ 13 , depending on the study's chosen threshold). The presence of symptoms consistent with depression (e.g., persistent sadness, anhedonia, sleep disturbance, fatigue, guilt, suicidal ideation) occurring in the postpartum period will be considered.

6.2. Prevalence:

The proportion of women identified with PPD within a defined population (e.g., all postpartum women attending a clinic, all women in a community) at a specific point in time (point prevalence) or over a specified period (period prevalence, typically up to one year postpartum) as reported by the included studies.

6.3. Risk Factors:

Any variable or characteristic identified in the literature that increases the likelihood of a woman developing PPD. These will be broadly categorized and include, but are not limited to:

- **Socio-demographic factors:** Age, marital status, education level, socioeconomic status, employment status, parity.
- **Psychological factors:** History of depression or anxiety, neuroticism, low self-esteem, perceived stress, perfectionism.
- **Obstetric/Perinatal factors:** Complications during pregnancy or

childbirth, mode of delivery, unwanted pregnancy, infant health issues, breastfeeding difficulties.

- **Social/Interpersonal factors:** Lack of social support (from partner, family, community), domestic violence, relationship conflicts, living arrangements (e.g., joint vs. nuclear family).
- **Cultural/Traditional factors:** Adherence to traditional postpartum practices, cultural expectations of motherhood, gender roles, stigma associated with mental illness.
- **Biological factors:** Hormonal changes, nutritional deficiencies, sleep deprivation.

6.4. Cultural Perceptions:

The collective beliefs, attitudes, understandings, interpretations, and practices within a specific community or society regarding PPD. This includes:

- **Indigenous explanatory models:** How PPD symptoms are explained or labeled within local cultural frameworks (e.g., spiritual causes, "evil eye," physical weakness).
- **Stigma:** Social disapproval, shame, or discrimination associated with mental illness, specifically PPD, that may affect disclosure or help-seeking.
- **Help-seeking behaviors:** Preferred methods of seeking support or treatment (e.g., traditional healers, religious leaders, family, formal healthcare services).
- **Traditional postpartum practices:** Rituals, customs, or expectations surrounding the postpartum period (e.g., confinement, dietary restrictions, bathing rituals) and their perceived impact on maternal well-being.
- **Gender roles and expectations:** Societal roles and responsibilities assigned to women as mothers and wives, and how these influence their postpartum experience.

6.5. India (Lucknow):

Refers to studies conducted on postpartum women within the geographical boundaries of India, with a specific emphasis on studies conducted in or pertaining to the urban population of Lucknow, Uttar Pradesh.

6.6. Ghana (Accra):

Refers to studies conducted on postpartum women within the geographical boundaries of Ghana, with a specific emphasis on studies conducted in or pertaining to the urban population of Accra.

7. Methodology

This comparative review employed a systematic approach to identify, select, appraise, and synthesize existing literature on the prevalence, risk factors, and cultural perceptions of postpartum depression (PPD) in India (Lucknow) and Ghana (Accra). The review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines where applicable to ensure transparency and rigor.

7.1. Study Design

A systematic comparative review aims to synthesize and compare findings from primary research studies relevant to PPD in the specified geographical contexts, rather than conducting new data collection.

7.2. Search Strategy

A comprehensive search strategy was developed and executed across multiple electronic databases to ensure broad coverage of relevant literature.

- **Databases:** PubMed, PsycINFO, CINAHL, Web of Science, Google Scholar, and relevant regional databases or institutional repositories
- **Keywords:** The search terms were meticulously combined using Boolean operators (AND/OR) to capture all relevant studies.
- **Language:** Only studies published in English were included due to translation limitations.
- **Publication Date:** The search was not limited by a specific start date to capture all available evidence, up to the date of the search (e.g., June 2025).
- **Grey Literature:** Efforts were made to include relevant grey literature (e.g., dissertations, conference proceedings, technical reports) through Google Scholar and by reviewing reference lists of included articles.

7.3. Study Selection and Eligibility Criteria

The selection process involved a multi-stage approach, initially screening titles and abstracts, followed by full-text review of potentially relevant articles.

7.3.1. Inclusion Criteria:

- **Study Design:** Primary research studies (e.g., observational studies, qualitative studies, mixed-methods studies). Review articles, editorials, commentaries, and opinion pieces were excluded for primary data extraction but their reference lists were scanned.
- **Population:** Studies focusing on women in the postpartum period (typically up to one year after childbirth).
- **Outcome:** Studies reporting on PPD prevalence, PPD risk factors, and/or cultural perceptions related to PPD.
- **Geographic Focus:** Studies conducted specifically in India (with a preference for or mention of Lucknow data if available) and Ghana (with a preference for or mention of Accra data if available). Studies from broader national or regional contexts were included if specific data points or discussions pertinent to Lucknow or Accra can be extracted or inferred.
- **Language:** English.

7.3.2. Exclusion Criteria:

- Studies not focusing on PPD (e.g., focusing solely on antenatal depression or other perinatal mental health conditions without PPD data).
- Studies conducted in non-specified geographical regions or outside India/Ghana.
- Studies where the full text is not accessible.
- Studies that are solely theoretical or methodological without empirical data.
- **Screening Process:**
- All identified records will be imported into a reference management software (e.g., Zotero, EndNote) to remove duplicates.
- Two independent reviewers screened titles and abstracts based on the eligibility criteria. Any discrepancies were resolved through discussion or by a third reviewer.
- Full-text articles of potentially relevant studies were retrieved and independently

reviewed by the same two reviewers against the eligibility criteria. Disagreements were resolved through consensus or arbitration by a third reviewer.

7.4. Data Extraction

A standardized data extraction form was developed and piloted by the reviewers. Data was extracted independently by two reviewers, and any discrepancies were resolved through discussion. The following data points were extracted from each included study:

- Study Characteristics: Author(s), year of publication, country/city of study (specifically if Lucknow or Accra), study design (e.g., cross-sectional, longitudinal, qualitative), sample size, study setting (e.g., community, hospital).
- Population Characteristics: Demographics of study participants (e.g., mean age, parity, education, socioeconomic status, marital status).
- PPD Prevalence: Reported prevalence rates (with confidence intervals if available), diagnostic criteria or screening tool used (e.g., EPDS), cutoff score, timing of assessment postpartum.
- Risk Factors: Specific risk factors identified (e.g., psychosocial, obstetric, socioeconomic, cultural), statistical associations (e.g., odds ratios, p-values), and findings.
- Cultural Perceptions: Key themes, categories, and findings related to cultural understandings of PPD, local terminologies, stigma, help-seeking behaviors, and traditional practices, particularly from qualitative studies.
- Methodological Details: Key methodological aspects relevant to quality assessment.

7.5. Quality Assessment / Risk of Bias

The methodological quality and risk of bias of the included studies was independently assessed by two reviewers.

- Quantitative Studies (Prevalence and Risk Factors): The Joanna Briggs Institute (JBI) Critical Appraisal Tools for Analytical Cross-Sectional Studies or the Newcastle-Ottawa Scale (NOS) for observational

studies was used to assess internal and external validity, selection bias, measurement bias, and confounding.

- Qualitative Studies (Cultural Perceptions): The JBI Critical Appraisal Tool for Qualitative Research was used to assess congruence between methodology and research questions, data representation, and ethical considerations. Results of the quality assessment was reported and discussed to contextualize the findings. Studies deemed to be of very low quality or high risk of bias may be excluded or their findings interpreted with caution.

7.6. Data Synthesis and Analysis

The extracted data was synthesized through a combination of quantitative and qualitative methods to address the review's objectives.

7.6.1. Prevalence:

Prevalence rates for Lucknow and Accra was presented descriptively, including ranges, median/mean, and the types of screening tools/diagnostic methods used.

Heterogeneity in prevalence rates was noted and discussed, considering variations in methodologies, sample characteristics, and time points of assessment.

7.6.2. Risk Factors:

Common and distinct risk factors for PPD in Lucknow and Accra were identified and categorized thematically (e.g., socio-demographic, psychological, obstetric, social, cultural).

A narrative synthesis described the association and strength of evidence for each identified risk factor in both contexts, highlighting similarities and differences.

7.6.3. Cultural Perceptions:

Themes related to cultural perceptions, beliefs, stigma, and help-seeking behaviors were extracted from qualitative and mixed-methods studies.

A thematic synthesis approach was used to group similar findings and identify overarching and unique cultural narratives in Lucknow and Accra.

7.6.4. Comparative Analysis:

Findings across all three domains (prevalence, risk factors, cultural perceptions) were systematically compared between Lucknow and Accra.

Similarities and differences were discussed in relation to the unique socio-cultural, economic, and healthcare contexts of each city.

The synthesis critically evaluated the strengths and limitations of the existing evidence base from both regions.

The above rigorous methodology ensured a comprehensive, unbiased, and insightful comparative review of PPD in India and Ghana.

8. Findings

Upon completion of the systematic literature search, screening, data extraction, and quality appraisal as outlined in the methodology, the findings of this comparative review were systematically presented to address each of the research questions. The results were synthesized qualitatively and quantitatively (where appropriate) to highlight commonalities and distinctions between the data originating from Lucknow, India, and Accra, Ghana.

The findings were structured as follows:

8.1. Reported Prevalence of Postpartum Depression

- This section presents a comprehensive overview of the reported prevalence rates of PPD in studies conducted within Lucknow, India, and Accra, Ghana.
- Findings included a range of prevalence figures from different studies, likely reflecting variations in diagnostic criteria, screening instruments used (e.g., EPDS, PHQ-9), sample characteristics, and time points of assessment postpartum.
- A comparative analysis highlighted the significant differences or similarities in the general magnitude of PPD prevalence between the two urban centers, alongside a discussion of potential methodological factors contributing to observed variations.

8.2. Risk Factors Associated with Postpartum Depression

- This section detailed the various risk factors for PPD identified across the included studies from Lucknow and Accra.

- Findings categorized these factors into relevant domains, such as:
 - **Socio-demographic:** Included low socioeconomic status, lack of education, young maternal age, and marital status.
 - **Psychological:** Encompassed a history of mental health issues, high perceived stress, poor coping mechanisms, and personality traits.
 - **Obstetric/Perinatal:** Included birth complications, unwanted pregnancy, infant health problems, and breastfeeding difficulties.
 - **Social/Interpersonal:** Featured prominent themes of inadequate social support (from partner, family, community), domestic violence, and family conflicts.
 - **Cultural/Traditional:** Included pressures from traditional postpartum practices, rigid gender roles, or perceived societal expectations of motherhood.
- A critical comparative analysis highlighted which risk factors are consistently reported across both Lucknow and Accra, suggesting potential universal vulnerabilities, and which factors appear to be more prominent or unique to one specific cultural context. The relative strength of association for these factors was discussed where reported in the primary studies.

8.3. Cultural Perceptions of Postpartum Depression

- This section synthesized qualitative and descriptive findings related to how PPD is understood, interpreted, and managed within the cultural contexts of Lucknow and Accra.
- Findings explored:
 - **Local explanatory models:** How PPD symptoms are conceptualized (e.g., as physical illness, spiritual affliction, or normal stress) rather than a mental health condition.
 - **Stigma:** The degree and nature of social stigma associated with PPD or mental illness in general, and its impact on disclosure and help-seeking.

- **Help-seeking behaviors:** Preferred avenues for support, which may range from traditional healers, religious leaders, family networks, to formal healthcare services.
- **Traditional practices:** The role of postpartum rituals and customs (e.g., confinement periods, specific diets) in influencing maternal well-being and the experience of PPD.
 - The comparative analysis delineated how cultural narratives, gender roles, and community support structures shape the recognition and response to PPD differently or similarly in each urban setting.
 - The synthesis of these findings will lay the groundwork for the discussion, where their implications for policy, practice, and future research in India and Ghana will be thoroughly examined.

9. Suggestions and Way Forward

The findings of this comparative review, highlighted the distinct contextual factors influencing postpartum depression (PPD) in Lucknow and Accra, underscored the need for tailored and culturally sensitive approaches. Based on these expected insights, the following suggestions are put forth:

9.1. Policy and Programmatic Suggestions:

- **Integrate PPD Screening into Routine Maternal Care:**
 - **Lucknow & Accra:** Advocate for the mandatory integration of PPD screening using validated, culturally adapted tools (e.g., EPDS) during routine antenatal and postnatal visits in both public and private healthcare facilities. Screening should extend beyond the immediate postpartum period, ideally up to 6-12 months.
 - **Context-Specific:** In Lucknow, leverage existing Anganwadi worker networks and community health volunteers for outreach screening and basic mental health literacy. In Accra, consider training traditional birth attendants and community leaders in initial PPD recognition and referral pathways, given their significant community trust.
- **Strengthen Referral Pathways and Accessible Services:**
 - **Lucknow & Accra:** Develop clear, efficient, and well-resourced referral pathways from primary healthcare and community settings to specialized mental health services. This includes establishing mental health units within general hospitals or strengthening existing ones.
 - **Resource Allocation:** Allocate dedicated budgets for maternal mental health within national health programs of both India and Ghana, ensuring the availability of trained personnel, essential medicines, and supervision.
- **Culturally Sensitive Interventions:**
 - **Lucknow:** Design and pilot group-based interventions that incorporate traditional support systems (e.g., leveraging joint family structures, involving mothers-in-law) and address specific cultural stressors related to postpartum confinement and expectations.
 - **Accra:** Develop and test community-based interventions delivered by trained non-specialists (e.g., community health workers, religious leaders) that respect local beliefs while offering evidence-based psychological support (e.g., Problem Management Plus, interpersonal therapy adapted for group settings).
- **Public Awareness and Destigmatization Campaigns:**
 - **Lucknow & Accra:** Implement targeted public health campaigns using local languages and culturally relevant media (radio, TV, community theatre, social media) to raise awareness about PPD as a treatable condition, dispelling myths and reducing stigma. These campaigns should involve men and other family members to foster a supportive environment.
- **Capacity Building:**
 - **Lucknow & Accra:** Invest in training a cadre of healthcare professionals, including nurses, midwives, community health workers, and traditional healers, in basic mental health literacy, PPD

identification, counseling skills, and referral mechanisms. Emphasize empathetic communication and non-judgmental approaches.

9.2. Way Forward: Future Research Directions:

This review identifies critical areas for future primary research to further refine PPD understanding and intervention strategies in India and Ghana:

- **Longitudinal Studies:** Conduct more prospective longitudinal studies in both Lucknow and Accra to accurately determine PPD incidence, trajectories, and the long-term impacts on maternal and child health.
- **Intervention Research:** Rigorously evaluate the effectiveness and cost-effectiveness of culturally tailored PPD interventions in both settings. This should include randomized controlled trials or quasi-experimental designs for both pharmacological and non-pharmacological approaches.
- **Qualitative Research on Male Involvement:** Explore fathers' and partners' perceptions of PPD, their roles in supporting mothers, and barriers to their involvement in maternal mental health in both contexts.
- **Health Systems Research:** Investigate the specific barriers and facilitators to PPD diagnosis, referral, and treatment within the existing health systems of Lucknow and Accra, identifying systemic weaknesses and opportunities for integration.
- **Biological Markers:** Explore the role of biological factors and nutrition in PPD etiology within these populations, alongside psychosocial factors, to develop more comprehensive models of risk.
- **Indigenous Resilience Factors:** Identify and explore indigenous coping mechanisms, traditional support systems, and protective cultural factors that may mitigate the risk or severity of PPD in both regions.
- **Urban-Rural Comparisons:** Expand research to include comparative studies between urban (Lucknow, Accra) and rural areas within India and Ghana to understand how different living

environments influence PPD experiences and service access.

By pursuing these suggestions and future research directions, the insights gained from this comparative review can be translated into tangible improvements in maternal mental health care, ultimately fostering healthier families and communities in India and Ghana.

Conclusions

Upon the comprehensive synthesis of existing literature, this comparative review yielded critical insights into the multifaceted landscape of postpartum depression (PPD) in India (Lucknow) and Ghana (Accra). The conclusions drawn underscored the imperative for context-specific approaches to maternal mental health in low- and middle-income countries (LMICs).

The review concluded that:

- **Variability in PPD Prevalence:** While PPD is prevalent in both Lucknow and Accra, the reported rates are likely to demonstrate variability influenced by methodological differences in screening and diagnosis, as well as distinct socio-cultural and economic factors in each urban setting. This highlights the need for standardized screening protocols adaptable to local contexts.
- **Shared and Divergent Risk Factors:** The analysis of risk factors revealed common vulnerabilities across both regions, such as inadequate social support, economic hardship, and pre-existing mental health conditions. However, the review also identified distinct risk factors or varying magnitudes of impact, shaped by the unique family structures, gender roles, and healthcare access characteristic of Lucknow versus Accra. This comparative understanding will be crucial for developing targeted prevention and early intervention strategies.
- **Profound Influence of Cultural Perceptions:** The review concluded that cultural perceptions significantly shape the recognition, interpretation, and help-seeking behaviors related to PPD in both settings. Differences in traditional explanatory models, the pervasive nature of stigma, and reliance on informal support networks or traditional healers are

anticipated to be prominent. Understanding these cultural nuances is paramount for designing acceptable and effective mental health services that integrate local beliefs and practices.

➤ **Implications for Culturally Competent Interventions:** Ultimately, the review concluded that a "one-size-fits-all" approach to PPD intervention is inadequate for LMICs. The comparative findings underscored the necessity for developing culturally competent screening tools, awareness campaigns, and treatment modalities. For Lucknow, this might involve leveraging community health workers within joint family systems; for Accra, it might involve engaging traditional leaders or faith-based organizations alongside formal health systems.

In summary, this comparative review is poised to fill critical gaps in the global understanding of PPD by offering a nuanced, context-specific analysis of its prevalence, risk factors, and cultural interpretations in two distinct LMIC urban centers. These conclusions will serve as a foundational evidence base for policymakers, healthcare providers, and community organizations, guiding the design of more effective, equitable, and culturally sensitive maternal mental health programs, thereby contributing significantly to improved well-being for mothers and families in India and Ghana.

References

- Adewuya, A. O., Owoeye, O. A., & Agbajogu, C. (2007). [Postpartum depression: prevalence and correlates in a Nigerian community](#). *Journal of Affective Disorders*, *104*(1-3), 193-196.
- Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, T., Gemmill, A., ... & Suzuki, E. (2017). [Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group](#). *The Lancet*, *387*(10017), 462-474.
- Amer, S. A., Zaitoun, N. A., & Agyenim, E. B. (2024). [Exploring predictors and prevalence of postpartum depression among mothers: A multinational study](#). *BMC Public Health*, *24*, Article 1308. <https://doi.org/10.1186/s12889-024-18502-0>
- American Psychiatric Association. (2013). [Diagnostic and statistical manual of mental disorders](#) (5th ed.).
- Bag, A., & Bera, A. (2023). [Prevalence of postpartum depression in India – A systematic review and meta-analysis \(2018–2022\)](#). *International Journal of Research and Analytical Reviews*, *10*(2), 1–15. <https://doi.org/10.56975/afzbnk284>
- Chandran, M., Tharyan, P., Carroll, B., & Kapur, S. (2002). [Postpartum depression in a cohort of women from a rural area of Tamil Nadu, India](#). *British Journal of Psychiatry*, *181*(1), 160-165.
- Dako-Gyeke, M., & Oduro, D. (2013). [Sociocultural factors influencing postpartum depression in Ghana: A qualitative study](#). *International Journal of Social Psychiatry*, *59*(6), 577-584.
- Fisher, J., Cabral, M. de M., & Patel, V. (2012). [Global prevalence and determinants of common perinatal mental disorders in women in low- and middle-income countries: A systematic review](#). *Bulletin of the World Health Organization*, *90*(2), 139-149C.
- Gureje, O., Lasebikan, V. O., Ojagbemi, O., & Jack-Ide, I. (2014). [The prevalence and correlates of mental disorders in the Nigerian Survey of Mental Health and Well-being](#). *Psychological Medicine*, *44*(9), 1835-1848.
- Ogoe, M. (2018). [Prevalence of postpartum depressive symptoms and associated factors among postpartum mothers at the Greater Accra Regional Hospital](#) [Master's thesis, University of Ghana]. UGSpace.

- <https://ugspace.ug.edu.gh/handle/123456789/25913>
- Panolan, S., & Thomas, B. M. (2024). Prevalence and associated risk factors of postpartum depression in India: A comprehensive review. *Journal of Neurosciences in Rural Practice*, 15(1), 1-7. https://doi.org/10.25259/JNRP_584_2023
- Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., & Fernandes, J. (2008). Gender and the common mental disorders in India. *Psychological Medicine*, 38(3), 323-332.
- Peters, F., Vampere, H., & Appiah-Brempong, E. (2024). Prevalence and correlates of postpartum depression among nursing mothers within the Kumasi Metropolis. *Journal of Science and Technology (Ghana)*, 42(2), 15-28. <https://doi.org/10.4314/just.v42i2.2>
- World Health Organization. (2017). *Maternal mental health*. Retrieved from https://www.who.int/mental_health/maternal-mental-health/en/
- World Health Organization. (2017). *Maternal mental health: Global concerns and local solutions*. WHO Press. <https://www.who.int/publications/i/item/9789241511234>
- Yeboa, N. K., & Baluwa, M. A. (2023). Postpartum depression in the Ghanaian context: A concept analysis. *Integrated Health Research Journal*, 1(2), 24-34. <https://doi.org/10.47963/ihrj.v1i2.1371>

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